TO: Consensus Standards Approval Committee (CSAC)

FR: Ashlie Wilbon, Quintin Dukes

RE: Appeals for Cost and Resource Use Phase 2 CMS/Yale Cardiovascular Measures

DA: January 13, 2015

On December 9, 2014, the 30-day appeals period for the (2) CMS/Yale cardiovascular cost measures closed with one appeal. The American College of Cardiology (ACC) has submitted an appeal for each of the CMS/Yale cardiovascular cost measures.

Accompanying this memo are the following documents:

- ACC letter of appeal for both measures #2431 and #2436
- Response to the appeal from the CMS/Yale measure developers

**CSAC ACTION REQUIRED**

The CSAC will review the letter of appeal, the response submitted by the developers and this memo in consideration of the appeal. The CSAC will determine whether to uphold the endorsement decision or uphold the appeal for the following measures:

- #2431: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI) (CMS/Yale)
- #2436: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Heart Failure (HF) (CMS/Yale)

**Background**

Throughout the evaluation process, these measures have been the subject of much debate and discussion from the Steering Committee, NQF membership, CSAC and the Board of Directors (BOD). The key issues that remained central to these discussions (and others focused on cost measures) include:

- Appropriateness of attribution of care coordination and post-hospitalization episode costs to hospitals
- Appropriateness and adequacy of the risk adjustment approaches to account for differences in populations, including low SES patients and those with multiple chronic conditions
- The need to link cost and quality measures for a clearer signal of efficiency
- Use of the measures in accountability programs that may disproportionately penalize some hospitals

After carefully weighing these complex issues from the various stakeholder perspectives, the BOD ratified endorsement of these (2) measures on November 5, 2014, with the following conditions:

- **One-year look-back assessment of unintended consequences:** NQF staff will work with Cost and Resource Use Standing Committee and CMS to determine a plan for assessing potential unintended consequences of these measures in use. The evaluation of unintended consequences will be initiated in approximately one year and possible changes to the measures based on these data will be discussed at that time.

- **Consideration for the SDS trial period:** The Cost and Resource Use Standing Committee will consider whether the measure should be included in the NQF trial period for consideration of sociodemographic status adjustment.
- **Attribution:** NQF will consider opportunities to address the attribution issue.

NQF staff is in the process of developing plans to operationalize and address these conditions.

**Summary of Issues Raised in the Appeal (excerpted from the memo) and A:**

- **Appellant Concern #1: Attribution:** Those who believe holding the admitting hospital accountable for the costs related to an episode in order to motivate them to do a better job of "care coordination" are making a number of assumptions:
    1. The majority of hospitals can perform care coordination without being part of an integrated delivery system or accountable care organization (ACO) that has operational control over outpatient services; it is difficult to assign accountability to an individual or an entity that does not have such control.
    2. The elements of care coordination that are effective are known.
    3. Care coordination actually controls costs.

**NQF Response:** The Cost and Resource Use Standing Committee and the BOD have extensively considered this issue and acknowledge these concerns; however, there was general agreement that hospitals are increasingly responsible for care delivered after discharge. Consequences of ineffective care coordination have been shown to produce adverse outcomes such as medication errors and readmissions to the hospital, resulting in high cost episodes of care. Consequently, hospitals are in the unique position of being able to push coordination of care, and this measure may serve as an impetus for this to occur in an evolving healthcare system.

**Developer Response:** Several key points from the developer's response to this concern have been summarized below. Details for each point can be found in the full text memo.

1. Randomized controlled trials have shown that quality improvements during index admission can directly reduce readmissions.
2. Hospitalizations represent acute illness requiring management post-discharge and decisions made at the hospital directly affect post-discharge care such as readmissions, skilled nursing facilities (SNF), and other inpatient care.
3. Hospitals play a large role in the community and can drive change.
4. Higher payments are not necessarily worse or better than lower payments.

- **Appellant Concern #2: Stand-alone Cost Measures:** We are concerned that stand-alone cost measures like these will be used quickly by CMS and other organizations facing a cost crisis. In such circumstances, some quality measures might be applied, but it is not likely that sufficient emphasis will be placed on quality to counterbalance the motivation given providers to lower costs. Until we can fully integrate meaningful measures of quality with cost measures, we will face this danger, and more importantly, patients may be placed at risk.

**NQF Response:** Both the Committee and NQF acknowledge this concern and agree that cost measures should be linked with quality measures to fully understand the cost in the context of the

quality of care that is provided. The goal of NQF endorsement is to ensure that the field has scientifically sound cost measures that can in turn be linked with quality measures to better understand the efficiency of those being measured. However, measure implementers, including CMS, are ultimately responsible for decisions on how these two types of measures are use to assess provider efficiency. While there is no accepted industry standard, NQF has begun work to explore best practices on how best to link cost and quality measures and the implications on the endorsement process, NQF recently released a report to specifically address this issue. This report will be the foundation for future NQF work as we explore how best to drive the field toward the best practices for linking cost and quality measures to address the types of concerns raised by the Appellant.

Until there is more work and further consensus on how to link cost and quality measures in the most meaningful way, NQF and the Cost and Resource Use Standing Committee strongly recommend that cost measures be reported alongside a quality measure(s), and methodologies used to create overall efficiency scores with quality and cost measures be transparent for stakeholder review. Currently, the AMI cost measure (#2431) is reported on the Hospital Compare website alongside an AMI mortality measure as recommended by the Committee.

**Developer Response:** Several key points from the developer's response to this concern have been summarized below. Details for each point can be found in the full text memo.

1. As a stand-alone measure, this episode payment measures provide transparency about resource utilization that is otherwise invisible to hospitals and the public.
2. CMS has **not** signaled that episode of care payment measures will be used in payment programs.

- **Appellant Concern #3: Sociodemographic Variables:** We are concerned about the poor quality of the risk-adjustment methodology in the measures and prefer stratification by sociodemographic factors with reimbursement tied to performance taking into account each stratum. We urge you to consider placing a moratorium on your Cost and Resource Use efforts until your work on Sociodemographic Risk Adjustment is completed and used as part of the consensus development process.

**NQF Response:** The report and guidance from the Risk Adjustment & Sociodemographic Status (SDS) Expert Panel was not finalized at the time of the Cost and Resource Use Committee's deliberations. While the Committee recognized the concerns with SDS, they were asked to evaluate the measures based on the NQF measure evaluation criteria that was in effect at that time. However, at the time of BOD ratification, the SDS guidance was final and the Board's conditions for endorsement listed above acknowledge that these measures should be considered for the NQF SDS trial period scheduled to begin in January 2015. NQF is currently working with the measure developers to operationalize this condition and anticipate future work to address SDS adjustment of these measures.

**Developer Response:** Several key points from the developer's response to this concern have been summarized below. Details for each point can be found in the full text memo.

1. The same approach to risk-adjustment was used in the publicly reported, NQF endorsed AMI and HF mortality measures. Also, the model was evaluated with several statistical methods

in addition to the quasi-R-square. All other diagnostic tests (over-fitting indices, distribution of Standardized Pearson residuals, and predictive ratios) suggest the model predicts payments well after adjustment for risk factors.

2. We acknowledge that there is a complex relationship between SES with the outcome. SES may reflect clinical severity but also treatments offered or delivered to patients and we do not wish to obscure the latter. We are following the conversation at NQF closely and are committed to developing rigorous measures that are fair to hospitals.
3. As part of measure testing, we conducted internal analyses to examine whether or not hospitals with higher percentages of African-American or Medicaid patients performed worse than their counterparts. We found that there is very little difference in the distribution of Risk Standardized Payments (RSP) within and between these groups.
4. To clarify, CMS has **not** signaled the use of the AMI or HF episode of care payment measure (stratified or unstratified) in any reimbursement or payment program.

- **Appellant Concern #4: Transparency in the Process:** The CSAC apparently voted to approve the measures despite reaching only 40% approval by councils and 62% approval by the Standing Committee on its second vote after 52% approval on its first vote. The results of the CSAC vote do not appear to be available on the NQF website.

  The Board discussion on the measures revealed an understanding of how difficult it has been to develop a consensus around these measures. Several comments were raised regarding the challenge of appropriate attribution of events thirty days post-discharge. Despite recommendations to defer the measure until additional research and review could be performed, the Board passed a motion to approve measures 2431 and 2436 as conditional, with a 1 year review period for unintended consequences. We are appealing this decision and request that NQF post the transcript of this discussion and results on the NQF website.

**NQF Response:** NQF strives to ensure transparency throughout its consensus development process (CDP) and is dedicated to continuous process improvement. The NQF Board of Directors Executive Committee agrees their proceedings regarding measure endorsement issues should be open and transparent. Going forward, their proceedings regarding measure endorsement issues will be open to the public for comment at the start of each call. The transcript for the BOD November 5th discussion on these measures, transcripts on measure endorsement discussions hereafter, and accompanying meeting materials (including the memo with CSAC votes) will be made available online.

**Measure Evaluation Summary Tables**

**LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient**

**#2431 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)**

**Description**: This measure estimates hospital-level, risk-standardized payment for an AMI episode-of-care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of AMI.

**Resource Use Measure Type:** Per episode

**Level of Analysis:** Facility

**Costing Method:** Standardized pricing

**Target Population:** Senior Care

**Data Source:** Administrative Claims

**Measure Steward:** Centers for Medicare and Medicaid Services

**STANDING COMMITTEE MEETING [March 4-5, 2014]**

**1. Importance to Measure and Report**

*(1a. High Priority, 1b. Opportunity for Improvement, 1c. Measure Intent)*

IM.1. High Priority: **H-20; M-1; L-0; I-0** IM.2. Opportunity for Improvement: **H-10; M-10; L-0; I-1** IM.3. Measure Intent: **H-16; M-5; L-0; I-0** Overall Importance: **H-16; M-5; L-0; I-0**

Rationale:

- The Committee agreed that Acute Myocardial Infarction (AMI) is a high-priority area for measurement because it is a common condition that drives spending in hospitals.
- The Committee questioned the opportunity for improvement because the inner quartile of performance gets very narrow after risk adjustment. The developers responded that this measure is intended to be paired with quality measures and that the opportunity for improvement must be considered with the opportunity to improve the quality of care when factoring in the cost of the care provided.
- Additionally, the Committee was concerned with the attribution of post-acute expenses to the admitting hospital. The developers responded that it is critical to capture those costs because the current system is setup to incentivize pushing those payments out into the post-discharge time period. Hospitals can act as catalysts in their communities for improving care and health decision-making.
- The Committee raised a question about the episode definition as 30 days from the date of admission and the potential need for alignment with the Medicare Spending per Beneficiary (MSPB) measure that defines a period of 30 days post-discharge. The developers responded that these specifications are aligned with a corresponding AMI mortality measure to be used together to assess value.

**2. Scientific Acceptability of Measure Properties**

*(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)*

2a. Reliability: **H-3; M-16; L-2; I-0** 2b. Validity: **H-0; M-9; L-7; I-4**

Rationale:

- The Committee raised concern about the ability to assess performance of low volume hospitals given the hierarchical modeling approach and the potential implications it could pose for the reliability and validity of the measure. The developers responded that at lower patient volumes, the less certainty you have about your estimates for cost. This measure uses a continuous outcome so the estimate is more accurate than a binary outcome. Additionally, this measure uses hierarchical risk modeling that adjusts hospitals with low patient volume towards the mean. Furthermore, reporting is only done for hospitals that have 25 or more cases.
- The Committee further questioned the decision to attribute the entire cost of an episode to the initial hospital in the case of a transfer to another facility. The developers responded that the decision was made not to exclude these cases because transfers account for approximately 8 percent of AMI episodes. This represented too many cases to exclude. Furthermore, the initial hospital begins the episode of care

**#2431 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)**

and can have a great influence over the coordination of care.

- The Committee raised concerns about whether the supplied reliability testing was done with the amount of data required by the specification of the measure. The measure is specified for a 12-month period and the testing used combined 2008 and 2009 data. The developers responded that the measure will eventually be implemented with three years of data but when the testing was performed, only two years of data was available. The decision to include three years of data was made to include as many hospitals in the measurement as possible. Many hospitals do not have 25 AMI cases in a year and would therefore not meet the threshold for reporting.
- In addition to the risk adjustment provided in the overarching issues section, the Committee was concerned that the developer did not do empiric measure-level validity testing for the measure as specified. The developers acknowledged that they relied on prior research on risk adjustment testing for mortality measures and also relied on face validity testing with their technical expert panel.

**3. Feasibility: H-18; M-3; L-0; I-0**

*(3a. Byproduct of Care Processes; and 3b. Electronic sources; and 3c. Data Collection Strategy)*

Rationale:

- The Committee had no concerns about the feasibility of the measure.

**4. Use and Usability: H-12; M-7; L-2; I-0**

*(4a. Accountability/transparency (used in accountability w/in 3 yr, public reporting w/in 6 yr, or if new - credible plan); and 4b. Improvement – progress demonstrated (if new - credible rationale); and 4c. Unintended Consequences - benefits outweigh evidence of unintended negative consequences (to patients/populations); and 4d. Measure Deconstruction – can be deconstructed to facilitate transparency and understanding)*

Rationale:

- The Committee raised concern about the number of hospitals falling in the "average" range for the measure – 78 percent. 15 percent were rated "high" and 7 percent "low".
- The Committee did appreciate the data breakdown provided to hospitals as a result of the measure.

**5. Related and Competing Measures**

- No related or competing measures noted.

**Standing Committee Recommendation for Endorsement: Y-12; N-9**

**6. Public and Member Comment: April 21, 2014 – May 21, 2014**

- Several supportive comments for the measure were received, with commenters indicating that the measure addresses an area of high morbidity, mortality, and healthcare costs. Commenters stated that information shared by CMS with hospitals will allow for identification of high/low cost areas and focused improvement. Additionally, commenters raised several issues with the measure, which were discussed during the in-person meeting:
    - Appropriateness of attribution approach
        - Commenters stated that attributing the cost of the entire episode to the admitting hospital may be inappropriate to attribute the cost of the episode to the hospital as much of the care happens in an outpatient setting. Commenters stated that measures should assess processes and outcomes over which the measured entity (e.g., hospital, physician group) can exercise a reasonable level of control, and that these measures may be more appropriate for an organization accepting bundled payments on behalf of all measured entities.
        - The Committee acknowledged this concern; however, the Committee stated that increasingly hospitals are responsible for care delivered up to 30 days after discharge. Consequently, hospitals are in the unique position of being able to push coordination of care, and this measure may serve as an impetus for this to occur.

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- Adequacy of risk adjustment model
  - Several commenters stated that the low r-squared values for the measure (0.05) indicated that the risk model did not account for enough of the variation in measure scores and may not adequately account for patient case mix and severity. Moreover, commenters believe that the low level of reliability demonstrated illustrated another fundamental flaw of both measures—that they fail to adequately account for complicating conditions that patients have prior to an episode of care.
  - The developers explained that at lower patient volumes, there is less certainty when estimating cost. The measure uses a continuous outcome which results in a more accurate estimate than would result from a binary outcome. Additionally, the measure uses hierarchical risk modeling that adjusts hospitals with low patient volume towards the mean.
- Approach to addressing transfer patients
  - Several commenters stated concern that the initial admitting hospital would be attributed cost for the episode when transferring patients to a second hospital, as the initial admitting hospital may have little control over the care that happens after the transfer.
  - The Committee acknowledged this concern; however, the Committee stated that increasingly hospitals are responsible for care delivered up to 30 days after discharge.
- Risk adjustment for socio-demographic factors
  - Several commenters stated that the risk adjustment models for the measures should capture socio-demographic factors, as there is robust evidence that such factors affect health outcomes, including resource use.
  - NQF acknowledged these concerns and clarified that NQF is in the early stages of reviewing our policy on risk adjusting for socio-demographic factors. The report referenced is a draft report that has recently been reviewed during an NQF member and public comment period; the recommendations have not yet been finalized. As such, we ask that Committees continue to evaluate measures according to our current guidelines, that measures not be adjusted for socio-demographic variables. If in the future the recommendations for adjusting for socio-demographic variables become NQF policy, measures needing this adjustment will be updated and reviewed by the Committee through measure maintenance.
  - The Committee acknowledged that the timing of the NQF risk adjustment report is not ideal; however, given the current NQF policy on adjusting for sociodemographic variables, the Committee requested that a recommendation be issued with the measure that when reported, the results should be stratified by sociodemographic variables.

- After considering all comments and thorough discussion, the Committee requested the opportunity to revote on endorsement for the measure. The results of that vote are below:
  - Yes- 14; No-7
- The measure is recommended for endorsement and pursuant with NQF process will be posted for NQF member voting.

**7. NQF Member Voting: [June 17, 2014 -July 2, 2014]**

- Representatives of 17 member organizations voted, with 40% approval.
- These voting results indicated that these measures fell into the “grey zone” indicating no consensus was reached.
- To clarify voting results, NQF initiated a consensus building process through conference calls with council leaders and all NQF members to further discuss the issues.
  - 73 participants from 7 councils with broad distribution across the councils attended the All

**#2431 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)**

Member Call.
- Staff compiled the major themes that arose from these consensus-building calls and shared them with the CSAC.

**8. Consensus Standards Approval Committee (CSAC) Vote: August 12, 2014**

- The Consensus Standards Approval Committee (CSAC) pulled this measure on July 10, 2014, to further discuss NQF Member voting results that implied that consensus was not reached.
- NQF hosted an All Member Call on July 31, 2014, for members to discuss their concerns about the measure.
- CSAC reviewed the member voting results and themes from the All Member Call on August 12, 2014, and endorsed the measure.

**9. Board of Directors Vote: November 5, 2014**

- The EC ratified endorsement with the following conditions:
  - **One- year Look Back Assessment of Unintended Consequences:** NQF staff will work with Cost and Resource Standing Committee and CMS to determine a plan for assessing potential unintended consequences of this measure in use. The evaluation of unintended consequences will be initiated in approximately one year and possible changes to the measures based on this data.
  - **Consideration for SDS trial period:** The Cost and Resource Use Standing Committee will consider whether the measure should be included in the NQF trial period for sociodemographic status adjustments.

**10. Appeals: November 7, 2014- December 9, 2014**

- NQF received an appeal for this measure from the American College of Cardiology (ACC).

**#2436 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF)**

**Description**: This measure estimates hospital-level, risk-standardized payment for a HF episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of HF.

**Resource Use Measure Type:** Per episode

**Level of Analysis:** Facility

**Costing Method:** Standardized pricing

**Target Population:** Senior Care

**Data Source:** Administrative Claims

**Measure Steward:** Centers for Medicare and Medicaid Services

**STANDING COMMITTEE MEETING [March 4-5, 2014]**

**1. Importance to Measure and Report**

*(IM.1. High Priority; IM.2. Opportunity for Improvement; and IM.3. Measure Intent)*

IM.1. High Priority: **H-14; M-4; L-3; I-0** IM.2. Opportunity for Improvement: **H-11; M-9; L-1; I-0** IM.3. Measure Intent: **H-11; M-9; L-1; I-0** Overall Importance: **H-8; M-13; L-0; I-0**

Rationale:

- The Committee agreed that Heart Failure (HF) is a high-priority area for measurement because it is a common condition that drives spending in hospitals and systems.

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**2. Scientific Acceptability of Measure Properties**

*(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)*

2a. Reliability: **H-7; M-11; L-2; I-1** 2b. Validity: **H-0; M-9; L-6; I-5**

Rationale:

- The Committee questioned the description of a "typical heart failure" patient considering that many patients have chronic heart failure and a hospitalization occurs for an acute incidence of the disease. The developer responded that they meant non-LVAD, non-transplant, non-major surgical procedure heart failure patients. These conditions dramatically change the payment outcome. They are sicker patients and were excluded from the measure.
- The Committee also questioned the methodology for choosing the index admission for patients who might have multiple hospitalizations in the same year for heart failure. The developer responded that the hospitalization is randomly selected and any re-hospitalization within 30 days of that index admission would be considered a re-admission and counted in the total hospitalization cost.
- The Committee expressed concern that attributing costs to hospitals was inappropriate for heart failure patients and that the real accountability should be with the ambulatory providers. Furthermore, the 30-day time period for costs does not align with the typical disease progression for a heart failure patient. A longer period, perhaps 12 months, would be more appropriate for the chronic nature of this disease.
- The developer defended the attribution to the hospital by stating that heart failure is a leading cause of hospitalization for the elderly and it represented a high leverage opportunity to measure and evaluate spending. Additionally, the 30-day time period was short enough that the associated spending would be attributable to the hospital admission.
- In addition to the risk adjustment discussion provided in the overarching issues section, the Committee was concerned that the developer did not do empiric measure-level validity testing for the measure as specified. The developers acknowledged that they relied on prior research on risk adjustment testing for mortality measures and also relied on face validity testing with their technical expert panel.

**3. Feasibility: H-16; M-3; L-0; I-0**

*(3a. Byproduct of Care Processes; and 3b. Electronic sources; and 3c. Data Collection Strategy)*

Rationale:

- The Committee had no concerns about the feasibility of the measure.

**4. Use and Usability: H-4; M-10; L-6; I-1**

*(4a. Accountability/transparency (used in accountability w/in 3 yr, public reporting w/in 6 yr, or if new - credible plan); and 4b. Improvement – progress demonstrated (if new - credible rationale); and 4c. Unintended Consequences - benefits outweigh evidence of unintended negative consequences (to patients/populations); and 4d. Measure Deconstruction – can be deconstructed to facilitate transparency and understanding)*

Rationale:

- The Committee had no concerns about the Use and Usability of the measure.

**5. Related and Competing Measures**

- No related or competing measures noted.

**Standing Committee Recommendation for Endorsement: Y-10; N-11**

**6. Public and Member Comment: April 21, 2014 – May 21, 2014**

- Several supportive comments for the measure were received, with commenters indicating that the measure addresses an area of high morbidity, mortality, and healthcare costs. Commenters stated that information shared by CMS with hospitals will allow for identification of high/low cost areas and focused improvement. Additionally, commenters raised several issues with the measure, which were discussed during the in-person meeting:
    - Appropriateness of attribution approach

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        - Commenters stated that attributing the cost of the entire episode to the admitting hospital may be inappropriate to attribute the cost of the episode to the hospital as much of the care happens in an outpatient setting. Commenters stated that measures should assess processes and outcomes over which the measured entity (e.g., hospital, physician group) can exercise a reasonable level of control, and that these measures may be more appropriate for an organization accepting bundled payments on behalf of all measured entities.
        - The Committee acknowledged this concern; however, the Committee stated that increasingly hospitals are responsible for care delivered up to 30 days after discharge. Consequently, hospitals are in the unique position of being able to push coordination of care, and this measure may serve as an impetus for this to occur.
    - Adequacy of risk adjustment model
        - Several commenters stated that the low r-squared values for the measure (0.03) indicated that the risk model did not account for enough of the variation in measure scores and may not adequately account for patient case mix and severity. Moreover, commenters believe that the low level of reliability demonstrated illustrated another fundamental flaw of both measures—that they fail to adequately account for complicating conditions that patients have prior to an episode of care.
        - The developers explained that at lower patient volumes, there is less certainty when estimating cost. The measure uses a continuous outcome which results in a more accurate estimate than would result from a binary outcome. Additionally, the measure uses hierarchical risk modeling that adjusts hospitals with low patient volume towards the mean.
    - Approach to addressing transfer patients
        - Several commenters stated concern that the initial admitting hospital would be attributed cost for the episode when transferring patients to a second hospital, as the initial admitting hospital may have little control over the care that happens after the transfer.
        - The Committee acknowledged this concern; however, the Committee stated that increasingly hospitals are responsible for care delivered up to 30 days after discharge.
    - Risk adjustment for socio-demographic factors
        - Several commenters stated that the risk adjustment models for the measures should capture socio-demographic factors, as there is robust evidence that such factors affect health outcomes, including resource use.
        - NQF acknowledged these concerns and clarified that NQF is in the early stages of reviewing our policy on risk adjusting for socio-demographic factors. The report referenced is a draft report that has recently been reviewed during an NQF member and public comment period; the recommendations have not yet been finalized. As such, we ask that Committees continue to evaluate measures according to our current guidelines, that measures not be adjusted for socio-demographic variables. If in the future the recommendations for adjusting for socio-demographic variables become NQF policy, measures needing this adjustment will be updated and reviewed by the Committee through measure maintenance.
        - The Committee acknowledged that the timing of the NQF risk adjustment report is not ideal; however, given the current NQF policy on adjusting for sociodemographic variables, the Committee requested that a recommendation be issued with the measure that when reported, the results should be stratified by sociodemographic variables.
- After considering all comments and thorough discussion, the Committee requested the opportunity to revote on endorsement for the measure. The results of that vote are below:

| #2436 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF) |
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| o Yes- 13; No-8<br>• The measure is recommended for endorsement and pursuant with NQF process will be posted for NQF member voting. |
| **7. NQF Member Voting: [June 17, 2014 -July 2, 2014]**<br>• Representatives of 17 member organizations voted, with 40% approval.<br>• These voting results indicated that these measures fell into the "grey zone" indicating no consensus was reached.<br>• To clarify voting results, NQF initiated a consensus building process through conference calls with council leaders and all NQF members to further discuss the issues.<br>o 73 participants from 7 councils with broad distribution across the councils attended the All Member Call.<br>o Staff compiled the major themes that arose from these consensus-building calls and shared them with the CSAC. |
| **8. Consensus Standards Approval Committee (CSAC) Vote: August 12, 2014**<br>• The Consensus Standards Approval Committee (CSAC) pulled this measure on July 10, 2014, to further discuss NQF Member voting results that implied that consensus was not reached.<br>• NQF hosted an All Member Call on July 31, 2014, for members to discuss their concerns about the measure.<br>• CSAC reviewed the member voting results and themes from the All Member Call on August 12, 2014, and endorsed the measure. |
| **9. Board of Directors Vote: November 5, 2014**<br>• The EC ratified endorsement with the following conditions:<br>o **One- year Look Back Assessment of Unintended Consequences:** NQF staff will work with Cost and Resource Standing Committee and CMS to determine a plan for assessing potential unintended consequences of this measure in use. The evaluation of unintended consequences will be initiated in approximately one year and possible changes to the measures based on this data.<br>o **Consideration for SDS trial period:** The Cost and Resource Use Standing Committee will consider whether the measure should be included in the NQF trial period for sociodemographic status adjustments. |
| **10. Appeals: November 7, 2014- December 9, 2014**<br>• NQF received an appeal for this measure from the American College of Cardiology (ACC). |