NATIONAL QUALITY FORUM
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Post Comment Memo

June 1, 2021

To: Surgery Standing Committee

From: NQF staff

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

Introduction

NQF closed the public commenting period on the measures submitted for endorsement consideration to the fall 2020 measure review cycle on April 30, 2021

Purpose of the Call

The Surgery Standing Committee will meet via web meeting on June 1, 2021 from 11:30 am to 2:30 pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period;
- Provide input on proposed responses to the post-evaluation comments;
- Review and discuss NQF members' expression of support of the measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table and additional documents included with the call materials).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Dial-in #: 1-844-621-3956 access code 173 689 5760
Web link: **https://nqf.webex.com/nqf/j.php?MTID=md40b822195f006469d8692bb1861e75a**

Background

Patients undergo surgery to repair injury, relieve symptoms, restore function, remove diseased organs, and replace anatomical parts of the body. Many surgeries are planned, though several types of surgery occur under emergency conditions, such as trauma, fracture, and acute infection. In 2010, 28.6 million

ambulatory surgery visits to hospitals and ambulatory surgical centers occurred, representing 48.3 million procedures.1 In 2014, there were 17.2 million hospital visits that included at least one surgery.2 Of these surgeries, over half occurred in a hospital-owned ambulatory surgical center.2 The projected cost of a hospital stay for surgery in 2013 was $22,500.

The Surgery Standing Committee oversees NQF's portfolio of surgical care measures. Measures in this portfolio address subjects such as perioperative safety, cardiac surgery, vascular surgery, colorectal surgery, and a range of other clinical and procedural subtopics.

On February 12 and 16, 2021, NQF convened a multistakeholder Standing Committee composed of 20 individuals to review eight maintenance measures against NQF's standard evaluation criteria. Six measures were recommended for endorsement, one measure was recommended for inactive endorsement with reserve status, and the Standing Committee did not reach consensus for the remaining measure.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from December 23, 2020 to April 30, 2021 for the measures under review. The majority of the comments received were from the developers of the measure providing extra information. All of these pre-evaluation comments were provided to the Committee prior to the measure evaluation meeting.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on April 1, 2021 for 30 calendar days. The Standing Committee's recommendations will be reviewed by the Consensus Standards Approval Committee (CSAC) on June 29-30, 2021. The CSAC will determine whether to uphold the Standing Committee's recommendation for each measure submitted for endorsement consideration. All committee members are encouraged to attend the CSAC meeting to listen to the discussion. During this commenting period, NQF received five comments from two member organizations:

Member Council	# of Member Organizations Who Commented
Consumer	0
Health Plan	0

Member Council	# of Member Organizations Who Commented
Health Professional	1
Provider Organization	1
Public/Community Health Agency	0
Purchaser	0
QMRI	0
Supplier/Industry	0

We have included all comments that we received (both pre- and post-evaluation) in the comment table (Excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses to each.

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment on the June 1, 2021 post-comment call. Instead, we will spend the majority of the time considering the two topic areas discussed below, and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion. Additionally, please note measure stewards/developers were asked to respond where appropriate. Where possible, NQF staff have proposed draft responses for the Committee to consider.

Comments and Their Disposition

Topic Area 1 – Performance Gap and Reserve Status

NQF #0134 Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft – Consensus Not Reached on Performance Gap

NQF # 0117 Beta Blockade at Discharge – Recommended for Endorsement With Reserve Status

One commenter raised concerns that placing measures on reserve status could be counterproductive. They requested that the Standing Committee recommend active endorsement for both measures.

Measure Steward/Developer Response:
Comment is from the measure steward, so no response was requested.

Proposed Committee Response:

No proposed response at this time.

Action Item:

The Standing Committee will discuss and revote on NQF #0134 at the meeting. The Standing Committee will discuss whether to revote on NQF #0117.

Topic Area 2 – Reliability Threshold, Social Risk Factors, Variation in Performance

NQF #1550 Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

One commenter raised the same concerns about both NQF #1550 and NQF #1551. The concerns raised were that the reliability threshold was not sufficient, that social risk factors should have been included in the risk adjustment, and that there was not enough variation or room for improvement.

Measure Steward/Developer Response:

We thank the Federation of American Hospitals for their comment and have addressed each of their concerns below.

RELIABILITY

In the testing attachment for this measure, we provided both split sample and signal-to-noise reliability. Both the split-sample reliability and signal-to noise reliability results indicate sufficient measure score reliability. Both measures were deemed scientifically acceptable by both the Scientific Methods Panel and the Standing Committee.

As a metric of agreement, we calculated the ICC for hospitals with 25 admissions or more. Using the Spearman-Brown prediction formula, the agreement between the two independent assessments of the RSMR for each hospital was 0.524. The split-sample reliability score represents the lower bound of estimate of the true measure reliability. We calculated the signal-to-noise reliability score for each hospital with at least 25 admissions. We also calculated the signal-to-noise reliability score for each hospital with at least 25 admissions. The median reliability score was 0.87; the 25th and 75th percentiles were 0.74 and 0.94, respectively.

SOCIAL RISK FACTOR ADJUSTMENT

While there is a conceptual pathway by which patients with social risk factors could experience worse outcomes, the empiric evidence, and CMS's policy decision to adjust the measure at the payment/program level, do not support risk adjustment at the hospital level.

In our testing attachment we provided analyses showing that adjustment for social risk factors (dual eligibility and low AHRQ SES) did not have an appreciable impact on hospital measure scores: differences between adjusted and unadjusted measures scores were small, and correlations between adjusted and unadjusted measure scores were near 1. This suggests that existing clinical risk factors capture much of the risk related to social risk.

Importantly, we also found that both the patient-level and hospital-level dual eligibility, as well as low AHRQ SES Index effects, were significantly associated with THA/TKC readmission. The

significance of the hospital-level effects indicates that if dual eligibility or low AHRQ SES Index variables were used to adjust for patient-level differences, then some of the differences between hospitals would also be adjusted for, potentially obscuring a signal of hospital quality.

In additional analyses we have examined the relationship between measure scores and the hospital-proportion of patients with social risk for the hospitals with the highest proportion of patients with social risk (the fifth quintile) and found that there is no significant correlation.

Given these empiric findings, and the recommendation from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) that quality measures should not be adjusted for social risk factors (ASPE 2020), CMS chose not to adjust this measure for social risk factors at this time.

VARIATION IN MEASURE SCORE

The analyses submitting with our testing attachment show meaningful differences in performance and therefore substantial opportunity for improvement.

There are meaningful differences in the distribution – for example, hospitals in the 10th percentile are performing about 24% better than the average performer, and hospitals in the 90th percentile are performing about 20% worse than the average performer.

In addition, the median odds ratio (1.38) suggests a meaningful increase in the risk of complications if a patient has a THA/TKA procedure at a higher-risk hospital compared to a lower-risk hospital. A value of 1.38 indicates that a patient has a 38% increase in the odds of a complications at a higher-risk hospital compared to a lower-risk hospital, indicating the impact of quality on the outcome rate. This variation suggests there remain differences in the quality of care received across hospitals for THA/TKA procedures. This evidence supports continued measurement to reduce the variation.

References:

Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation (ASPE). Second Report to Congress: Social Risk Factors and Performance in Medicare's Value-based Purchasing Programs. 2020; https://aspe.hhs.gov/system/files/pdf/263676/Social-Risk-in-Medicare%E2%80%99s-VBP-2nd-Report.pdf. Accessed May 4, 2021.

Proposed Committee Response:

The Standing Committee notes the concerns raised. However, the comment does not provide additional concerns or information that would require a revote on the evaluation criteria.

Action Item:

Discuss during post-comment meeting.

NQF # 1551 Hospital-Level 30-Day Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

One commenter raised the same concerns about both NQF #1550 and NQF #1551. The concerns raised were that the reliability threshold was not sufficient, that social risk factors should have been included in the risk adjustment, and that there was not enough variation or room for improvement.

Measure Steward/Developer Response:

We thank the Federation of American Hospitals for their comment and have addressed each of their concerns below.

RELIABILITY

In the testing attachment for this measure, we provided both split sample and signal-to-noise reliability. Both the split-sample reliability and signal-to noise reliability results indicate sufficient measure score reliability. Both measures were deemed scientifically acceptable by both the Scientific Methods Panel and the Standing Committee.

As a metric of agreement, we calculated the ICC for hospitals with 25 admissions or more. Using the Spearman-Brown prediction formula, the agreement between the two independent assessments of the RSMR for each hospital was 0.454. The split-sample reliability score represents the lower bound of estimate of the true measure reliability.

We also calculated the signal-to-noise reliability score for each hospital with at least 25 admissions. The median reliability score was 0.77; the 25th and 75th percentiles were 0.58 and 0.88, respectively.

SOCIAL RISK FACTOR ADJUSTMENT

While there is a conceptual pathway by which patients with social risk factors could experience worse outcomes, the empiric evidence, and CMS's policy decision to adjust the measure at the payment/program level, do not support risk adjustment at the hospital level.

In our testing attachment we provided analyses showing that adjustment for social risk factors (dual eligibility and low AHRQ SES) did not have an appreciable impact on hospital measure scores: differences between adjusted and unadjusted measures scores were small, and correlations between adjusted and unadjusted measure scores were near 1. This suggests that existing clinical risk factors capture much of the risk related to social risk.

Importantly, we also found that both the patient-level and hospital-level dual eligibility, as well as low AHRQ SES Index effects, were significantly associated with THA/TKC readmission. The significance of the hospital-level effects indicates that if dual eligibility or low AHRQ SES Index variables were used to adjust for patient-level differences, then some of the differences between hospitals would also be adjusted for, potentially obscuring a signal of hospital quality.

Finally, CMS adjusts for social risk (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) that quality measures should not be adjusted for

social risk factors (ASPE 2020). Given these empiric findings, ASPE's latest recommendations, and CMS' policy decision to adjust for social risk at the program/payment level, CMS chose not to adjust this measure for social risk factors at this time.

VARIATION IN MEASURE SCORE

The analyses submitting with our testing attachment show meaningful differences in performance and therefore substantial opportunity for improvement.

As presented in our submission form, the range of measure scores was 2.5%-9.0% with a mean of 4.0%. In addition, the median odds ratio of 1.25 suggests a meaningful increase in the risk of readmission if a patient is admitted with THA/TKA at a higher risk hospital compared to a lower risk hospital. A value of 1.25 indicates that a patient's risk of readmission is 25% greater in a higher-risk hospital than a lower-risk hospital. This variation in rates suggests there are differences in the quality of care received across hospitals performing THA/TKA procedures on Medicare FFS patients.

References:

Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation (ASPE). Second Report to Congress: Social Risk Factors and Performance in Medicare's Value-based Purchasing Programs. 2020; https://aspe.hhs.gov/system/files/pdf/263676/Social-Risk-in-Medicare%E2%80%99s-VBP-2nd-Report.pdf. Accessed May 4, 2021.

Proposed Committee Response:

The Standing Committee notes the concerns raised. However, the comment does not provide additional concerns or information that would require a revote on the evaluation criteria.

Action Item:

Discuss during post-comment meeting.

NQF Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expressions of support or non-support.