NATIONAL QUALITY FORUM

CONFERENCE CALL OF THE RESOURCE USE STEERING COMMITTEE

May 2, 2011

Committee Members Participating: Doris Lotz, MD, MPH (Co-Chair), New Hampshire Department of Health and Human Services; Bruce Steinwald, MBA (Co-Chair), Independent Consultant; Paul Barnett, PhD, VA Palo Alto Health Care System; Jack Bowhan, Wisconsin Collaborative for Healthcare Quality; Jeptha Curtis, MD, Yale University School of Medicine; Lisa Grabert, MPH, American Hospital Association; Ann Hendrich, RN, MSN, Ascension Health; Mary Kay O'Neill, MD, MBA, CIGNA HealthCare; David Penson, MD, MPH, Vanderbilt University Medical Center; Doris Peter, PhD, Consumers Union; Steve Phillips, MPA, Ortho-McNeill-Janssen Pharmaceutical, Inc.; David Redfearn, PhD, WellPoint; Jeffrey Rich, MD, Mid-Atlantic Cardiothoracic Surgeons Ltd.; William Rich, MD, Northern Virginia Opthalmology Associates; Tom Rosenthal, MD, UCLA School of Medicine; Barbara Rudolph, PhD, MSSW, The Leapfrog Group; Joseph Stephansky, PhD, Michigan Health and Hospital Association; Dolores Yanagihara, MPH, Integrated Healthcare Association.

NQF Staff Participating: Sally Turbyville, MA, MS, Senior Director; Ashlie Wilbon, MPH, BSN, Project Manager; Sarah Fanta, Research Analyst; Ann Hammersmith, JD, General Counsel.

Others Present: Susan Knudson, Health Partners; Kevin Campbell, Health Partners; Kavita Choudhry, Centers for Medicare and Medicaid; Maureen Dailey, The American Nurses Association

MEETING PROCESS

Ms. Wilbon welcomed the Steering Committee and thanked them for their participation. The purpose of this conference call was to discuss the non-condition specific measures submitted by Health Partners.

The measure developers and stewards were available on the call to respond to questions from the Committee as needed. A NQF Member and public comment period occurred at the end of the call; no comments were made at that time. The audio recordings can be found by clicking here and the call transcripts can be found by clicking here. General project information can be found by clicking on the Resource Use project page.

DICLOSURE OF INTEREST & ROLL CALL

Ms. Hammersmith led the Steering Committee through a roll call and the disclosure of interest process. At this time, each of the Steering Committee members was asked to disclose any explicit or perceived conflicts of interest. In particular, the Steering Committee members were asked to disclose if they are involved with possible competing resource use measures, even if they have not been submitted to NQF for endorsement. Aside from those mentioned below, there were not additional conflicts of interest.

- Mary Kay O'Neill: Chief Medical Officer for CIGNA in the Pacific Northwest, brother is a Health Analyst for Group Health of the Pacific Northwest.
- Doris Peter: Involved in work with Consumer Reports, license information from some organizations that have submitted measure, such as NCQA.
- Jeff Rich: Mid-Atlantic Cardiothoracic Surgeons, former government employee and ran the Medicare Fee for Service program.
- Barbara Rudolph: Leapfrog Group, which currently has three severity adjusted length-of-stay resource use measures, which have not been submitted to NQF.
- Dolores Yanagihara: Integrated Healthcare Association in California, has total cost of care measure, worked with Thompson Reuters to develop it, has also negotiated contracts with NCQA and has worked on resource use development for both her program and Thompson Reuters.

MEASURE EVALUATION SUMMARY

The following summary includes a preliminary review of the non-condition specific measure submitted by Health Partners. The measure developer gave an overview of the General methods approach and the measure submitted to the project.

1598 Total Cost of Care and Resource Use Population-based PMPM Index
Description: Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Separating out and reporting the resource use index along with the Total Cost of Care index provides a more complete picture of population based drivers of health care costs. Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. The Resource Use Index (RUI) is an underlying risk adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. Resource Use Type: Per capita (population- or patient-based) Data Type: Administrative claims, other Resource Use Service Category: Inpatient services: Inpatient facility services, Inpatient services: Evaluation and management, Inpatient services: Procedures and surgeries, Inpatient services: Imaging and diagnostic, Inpatient services: Lab services, Inpatient services: Admissions/discharges, Inpatient services: Labor (hours, FTE, etc.), Ambulatory services: Outpatient facility services, Ambulatory services: Emergency Department, Ambulatory services: Pharmacy, Ambulatory services: Evaluation and management, Ambulatory services: Procedures and surgeries, Ambulatory services: Imaging and diagnostic, Ambulatory services: Lab services, Ambulatory services: Labor (hours, FTE, etc.), Durable Medical Equipment (DME) Care Setting: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Behavioral Health/Psychiatric : Inpatient, Behavioral Health/Psychiatric : Outpatient, Dialysis Facility Level of Analysis: Clinician : Group/Practice, Population : Community Measure Developer: HealthPartners
Steering Committee Recommendation for Endorsement: Rationale: *Pending Committee's official vote.*
Conditions/Questions for Developer: • The measure's resource use index relies on total care relative resource use categories, these are constructed so they are additive across various sites of care and then adding in pharmacy data. How was this done? • Is the data distorted due to billed charges? • Is the Steering Committee charged to look at the resource use or the total cost of care? • What is the attributable population in this measure? • How are variables in geographic location accounted for? • The Committee determined there were actually two measures of cost described within the measure submission as presented:

Resource use index and a total cost index. There was some discussion on which should be evaluated for the purposes of this project or whether the measures should be considered as a pair. Because this project is not accepting paired measures, the Steering Committee has agreed to evaluate the resource use index, which appears to be most applicable to the goals of this project at this time.

Developer Response:

- Health Partners relies on sector specific relative value units, the billed charges across the sectors of care are used to build relativity. The payments are then appropriately adjusted. There are then final quality checks for thresholds. This method will eventually be patented and shared with the community.
- The measure uses billed charges and is calibrated among sectors of care in order to control for confounders.
- The measure calculations within the measure may be used independently; however, they are better used in partnership with one another.
- The measure uses the billed amount to allow for the claims (the most standard piece of information), then go across the different components and applies the discount rate. The adjustment factor is for the paid/billed ratios.
- The attributable populations (which are scalable to different units of analysis) are PPO and HMO. Look at practice specialty of physician and claims history and attribute patients to clinic with the majority of visits.
- Depending on the application and the user, the measure can be flexible and usable across different locations. In the market there are multiple hospitals with different price points, cost points may be consistent however the price they charge may be different.
- Actual paid (allowable inclusive liability) amount is used in the measure; the billed amount is used only to gauge the relativity (e.g., Inpatient to outpatient services).

Steering Committee Follow-up: N/A

If applicable, Questions to the Steering Committee: N/A

1. Importance to Measure and Report

1a.High Impact: *Pending Committee's Final Evaluation*

Discussion: This measure is considered highly important and relates to NPP/national goals.

1b. Resource use/cost problems: *Pending Committee's Final Evaluation*

Discussion: This measure may require follow up; it doesn't explain much as an isolated measure. However, it does inform providers of areas where there is overuse or underuse – given the fact of overuse and waste is an issue there is a place for this in the resource use project.

1c. Purpose clearly described: *Pending Committee's Final Evaluation*

Discussion: This criterion has been met because the measure is targeting an area known to have variation, relevant service categories and the objective has been clearly described.

1d. Resource use service categories consistent and representative: *Pending Committee's Final Evaluation*

Discussion: This criterion has been met. The supporting information provided by the measure developer also helps to demonstrate this.

2. Scientific Acceptability of Measure Properties:

2a. Reliability: *Pending Committee's Final Evaluation*

2a1. Well defined/precise specifications:

Discussion: Health Partners (HP) uses regional and national data; there is a great deal of actionable data at this level. It may be difficult to be transplanted to other systems. Since this is a population measure, its missing whether or not people are described on an individual basis and then tied to a region, this makes it difficult to determine whether or not this was appropriately specified. From a population basis there could be a risk group; this specificity may be difficult to obtain for other organizations. HP has conducted use of measure according to attribution, the total eligible individuals may only have pharmacy claims or are not using any services, this component of the measure is flexible across systems. This measure is intended for a commercial population, non-users would not be attributed, yet it is possible to adapt to the system. Attribution is standard; however it is flexible to change. The patient has to be a user of primary care services to be included; attribution (prospective and retrospective) at the physician level, the peer groups are based on the group the physician belongs to. The measure has been tested on groups that have at least 600 patients, group practice level. High claims data are not excluded but rather truncated after a certain threshold, resulting in roughly 5-8% excluded. These individuals are excluded based on the published guidelines in Society of Actuaries, as well as to avoid insurance risk. The pharmacy relative values come from using the average billed amount in order to get the line item details, the paid amount is the paid to billed ratio.

2a2. Reliability testing:

Discussion: Assumption that clinical and administrative claims data is accurate from a coding perspective, which is true for the majority of resource measures. For claims data, the hospital based claims take more time to process than professional claims – time frames need

to be taken into account when applying them to this measure. The measure developer informed the Steering Committee that the timeline of 3 months is specified; all claims are electronic and therefore arrive quickly into the system. The Steering Committee believes the reliability matrix is acceptable. 2b. Validity: *Pending Committee's Final Evaluation* 2b1. Specifications consistent with resource use/cost problem: *Discussion:* This section appeared to be sufficient and meets the criterion. This measure excludes patients who have not had a primary care visit, however within the system this may be giving all the information needed to feed back to providers on how they are utilizing services. 2b2. Validity testing: *Discussion:* Adequate sample size, large area 19 providers across approximately 200 hospitals. Health Partners have nearly 7,000 members who are Medicare/Medicaid recipients. HP has about 700,000 total members within the marketplace area (including CMS data/commercial data) and the non-user rate is around 9%. Roughly 50% of the data presented in the validity sample comes from commercial data. Since this measure has only been tested in a commercial population, it will only be NQF endorsed in a commercial population. Peer group averaging as a benchmark, if that is a sufficient measure in all markets. Within a commercial network and scheme, it may work, however it is not clear how these will be utilized. 2b3. Exclusions: *Discussion:* This measure excludes sub-populations that haven't had primary care visits. The measure also excludes "never users" and "super users" by truncating them out. The group-oriented market may exclude those outside the group. HP has not seen this as a problem, as there is a low non-user rate. The bulk of members are attributed in this model through primary care, a smaller percent only see a specialist. Those who are over the age of 65 are excluded because they are not the total cost of resource use data available. Hospital claims are not associated with bulk of memberships; they are not Medicare Advantage patients so the measure is unable to produce full measure of resource use or cost. 2b4. Risk adjustment: *Discussion:* Health Partners uses the ACG risk adjustment method developed by Johns Hopkins, the most recent 9.0 version, they have a long standing market history of using this product. HP relies heavily on research conducted by the Society of Actuaries that concluded a number of commercially available risk adjustment methodologies are satisfactory for this purpose. 2b5. Identification of statistically significant/meaningful differences: *This sub-criterion will be discussed during an upcoming conference call.* 2b6. Multiple data sources: *This sub-criterion will be discussed during an upcoming conference call.* 2c. Stratification for disparities: *This sub-criterion will be discussed during an upcoming conference call.*
3. Usability: *This criterion will be discussed during an upcoming conference call.* 3a. Measure performance results are publicly reported: 3b. Measure results are meaningful/useful for public reporting and quality improvement: 3c. Data and results can be decomposed for transparency and understanding: 3d. Harmonized or justification for differences:
4. Feasibility: *This criterion will be discussed during an upcoming conference call.* 4a. Data elements routinely generated during care process: 4b. Data elements available electronically: 4c. Susceptibility to inaccuracies/ unintended consequences identified: 4d. Data collection strategy can be implemented:

PUBLIC COMMENT

There were no public comments.

NEXT STEPS

Ms. Wilbon indicated that project staff will continue with preparations for the next Steering Committee conference call based on the Committee's availability. An additional call will be scheduled to finish the discussion on the HealthPartners measure (#1598) and begin discussion of the Ingenix non-condition specific measure (#1599) prior to the Steering Committee in-person meeting on June 29-30, 2011.