NATIONAL QUALITY FORUM

RESOURCE USE STEERING COMMITTEE CONFERENCE CALL

October 10, 2011 (12-2pm ET)

Committee Members Participating: Bruce Steinwald, MBA (Co-Chair), Independent Consultant; Tom Rosenthal, MD, UCLA School of Medicine (Co-Chair); Jack Bowhan, Wisconsin Collaborative for Healthcare Quality; William Golden, MD, Arkansas Medicaid, Lisa Grabert, MPH, American Hospital Association; Ann Hendrich, RN, MSN, Ascension Health; Jack Needleman, PhD, FAAN, University of California, Los Angeles School of Public Health; Mary Kay O'Neill, MD, MBA, CIGNA HealthCare; David Penson, MD, MPH, Vanderbilt University Medical Center; 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 Ophthalmology Associates; Barbara Rudolph, PhD, MSSW, The Leapfrog Group; Dolores Yanagihara, MPH, Integrated Healthcare Association.

NQF Staff Participating: Helen Burstin, MD, MPH, Senior Vice President, Senior Director; Taroon Amin, MPH, MA, Senior Director; Ashlie Wilbon, RN, MPH, Senior Project Manager; Sarah Fanta, Project Analyst.

Others present via phone: Ben Hamlin, NCQA; Chad Heim, HealthPartners, Cheri Zelinski, Ingenix

MEETING PROCESS

Ms. Fanta welcomed the Committee to the call and provided an overview of the call and a summary of the activities to date.

The cycle 1 draft report closed for public and member comment on September 28, 2011; four measures were recommended for endorsement in this report:

- (1598) Total Resource Use Population-based PMPM Index (HealthPartners)
- (1604) Total Cost of Care Population-based PMPM Index (HealthPartners)
- (1557) Relative Resource Use for People with Diabetes (NCQA)
- (1558) Relative Resource Use for People with Cardiovascular Conditions (NCQA)

The purpose of this conference call is for the Committee to:

1. Discuss comments received during the public and member comment period.
2. Provide input to on responses to comments.
3. Provide recommendations on changes to the Cycle 1 draft report prior to the member voting period.

Discussion of Comment Themes

NQF received 93 comments on the draft report from public and NQF members. Comments submitted were generally supportive of the work of the Steering Committee, TAPs and of the draft report. All comments were subject to discussion; however, due to the volume of comments, staff aggregated comments by theme to facilitate the Committee's discussion. The five major themes of the comments are listed below. In response to these themes, NQF staff proposed responses for the Committee to discuss.

Theme 1- Importance of Measures at the Individual and Group Practice Level
Description. Commenters expressed a strong need for measures at the individual and group practice level, encouraging the Committee to evaluate measures at this level of measurement in the same fashion as measures specified at the health plan level.

> *NQF Staff Proposed:* Clarify in the draft report that the Committee also believes that measures at the individual and group practice level are needed. Measures submitted at any level of measurement must be important to measure and report, be scientifically acceptable, usable and feasible. Measures submitted to this project at the individual/group practice level often had difficulty demonstrating adequate reliability and validity. It is important to note however, the evaluation *does not* require a minimum sample size but rather requires measures specified at any level of measurement demonstrate reliability and validity with sample sizes that are likely at the level specified.
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> *Committee Discussion:* The Committee agreed that the proposed staff response adequately captured the Committee's position on this issue and requested that it be further clarified that there is an interconnectedness of the measure's reliability, validity, level of analysis, and resources being measured.

Theme 2- Costing Approach
Description. Comments submitted expressed strong views on both approaches to costing, using actual costs or a standardized costing approach. Some believed that actual costs distort measurement by holding providers responsible for input costs that are outside of their control (i.e. wage rates). Others argued that standardized approaches mask underlying market distortions and regional variation in prices.

> *NQF Staff Propose*: The Committee agrees that both costing approaches could be used in specific applications. For use as a national consensus standard, a measure that uses a standardized costing approach is generally preferred as it allows for comparisons in utilization across regions without the confounding effect of input costs. However, this

preference should not be interpreted as actual costing approaches will never be considered. A measure-by-measure decision should be made on the appropriateness of the costing approach given other measure characteristics (i.e. level of measurement).

Committee Discussion: The Committee's discussion of this theme referenced comments submitted regarding their request during the evaluation process that a single measure should allow for only one costing approach (actual prices paid or standardized pricing). As such, developers that allowed for user flexibility in the costing approach were asked to split their measures into two separate measures where only one approach is specified in a single measure. Developers also had the option to select a single costing approach to be applied to the measure. While there was some disagreement among the Committee, the majority agreed that in order to ensure standardized implementation and comparison across entities, this distinction was necessary. Further, while the Committee did not express a preference for either costing approach, recognizing both costing approaches yield important information for various stakeholders, when making national comparisons of resources, the Committee agreed that resource use (utilization counts) with standardized prices is the most appropriate approach.

Theme 3- Attribution Approach

Description. Numerous requests to clarify the concern over the attribution approach by the measures since the attribution approach was generally submitted as guidelines. Commenters were particularly noted this concern for the measures submitted by Health Partners, however this could be applied broadly.

NQF Staff Propose: While the Committee was concerned about the attribution approach, measures were evaluated acknowledging the attribution approach is a guideline. In the Health Partners measure evaluation, the Committee was concerned that the measure excludes members who do not have a primary care visit thus making it a primary care cost measure which isn't immediately clear from the measure description. This exclusion criterion has been often misinterpreted as related to the measure's attribution approach.

Committee Discussion: The Committee recognizes the array of needs of various stakeholders (health plans, regional collaboratives, etc.) as evidenced by opposing comments for support of more specific attribution approaches, versus allowing flexibility. The Committee affirmed that the flexibility in the resource use submission process for the attribution approach to be submitted as guidelines or specifications should remain.

Theme 4- Complexity of Resource Use Measures

Description. Many agreed that the Committee does not need to strive for resource use measures that are simple and easy to interpret. Resource use measures are inherently complex.

> *NQF Staff Propose:* NQF will clarify the principles for resource measure evaluation indicates that resource use measures and results should be clear and understandable for all stakeholders to interpret. The measure results should be able to be decomposed for transparency and understanding. The Committee recognizes that measures of resource use are inherently complex however this should not limit their ability to be transparent and understandable.
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> *Committee Discussion:* The Committee agreed that the proposed staff response adequately captured the Committee's position on this issue and added that the complexity of these measures is compounded by lack of similar public peer review efforts and published peer reviewed literature about the performance of these measures. As an initial foray in this area, the Committee reaffirmed there is a need for the measures to be understandable, at a minimum to reviewers, as is addressed in the NQF usability criterion.

Theme 5- Linking Quality and Resource Use Measures

Description. Some requested that NQF explicitly make it clear that resource use measures alone do not measure efficiency but rather resource use measures should be used in the context of quality measures.

> *NQF Staff Propose:* NQF agrees that resource use measures should be used as a building block in understanding efficiency and value. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value, and may lead to adverse unintended consequences in the health care system. NQF is encourages future work to determine the specific elements of quality and resource use measures that should be aligned to measure efficiency.
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> *Committee Discussion:* The Committee agreed that the proposed staff response adequately captured the Committee's position on this issue and requested that the term "value", while an important concept to measure, be removed from the response. The Committee emphasized and recognized that measuring efficiency is an evolving concept and is the downstream goal of this contributing effort to evaluate resource use measures.

Discussion of Individual Comments

The Committee was asked to specifically discuss one comment and clarify the final recommendations for measures 1557 & 1558. It was unclear from the Committee discussions whether it was clear that these measures had been specified for use at the health plan and physician group level of analysis, given a minimum sample of 400.

*Comment: "*We support both 1557 and 1558, and strongly urge the Committee to apply them to clinician and clinical group levels as soon as testing criteria are met. It is difficult to justify excluding these levels. Is it customary for measure endorsers to specify minimum sample sizes? This should be done consistently at the appropriate step in the development/endorsement/implementation process."

"We understand that NCQA has been testing some relative resource use measures at the clinical group level with the Integrated Healthcare Association in CA, and found that physician groups have adequate sample sizes for the diabetes RRU measure, along with other promising results."

Committee Discussion: Given the minimum sample size requirements for the NCQA measures (N=400), the Committee confirmed that these measures should be recommended for endorsement for both levels of analysis (health plan and physician group).

The Committee was then given an opportunity to discuss any individual comments that they believed should be addressed by the Committee. No individual comments were identified for discussion at that time.

PUBLIC COMMENT

There were no public comments.

NEXT STEPS

The Steering Committee will meet next during a conference call on December 5 (12-2pm ET) to discuss the cycle 2 draft report comments. Staff will update the Committee responses to the comments and the draft report based on feedback from today's call. Other important dates coming up for the project include:

- October 19-November 17: Cycle 2 draft report posted for public and member comment
- October 24-November 7: NQF member voting for cycle 1 measures
- October 26 (12-2pm ET): Pre-member voting webinar, cycle 1
- November 2 (1:30-3:30pm ET): CSAC discussion of resource use project and cycle 1 recommended measures