NATIONAL QUALITY FORUM

CONFERENCE CALL OF THE RESOURCE USE STEERING COMMITTEE

June 6, 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 Ophthalmology 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; Taroon Amin, MPH, Senior Director; Ashlie Wilbon, MPH, BSN, Project Manager; Sarah Fanta, Research Analyst, Carlos Alzola, NQF Statistical Consultant.

Others Present: Susan Knudson, Health Partners; Chad Heim, Health Partners; Cheri Zielinski, Ingenix; Thomas Lynn, Ingenix.

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 and to evaluate the Importance criterion for the Ingenix non-condition specific measure.

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. General project information can be found by clicking on the Resource Use project page.

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:

- This measure is restricted to commercial, under 65 years of age population. Is there anything that prohibits its use in the Medicare population?
- Do users have to use the ACG software for risk adjustment?

Developer Response:

- Health Partners is a largely commercial based cost plan so they do not have access to Medicare data. Theoretically, if these full claims were available in the database one would be able to use it.*
- Users are not required to use the ACG software for risk adjustment. Any risk adjustment methodology may be used, as long as they are included in the Society of Actuaries study. Health Partners just has a history of working with ACG software. They have specified the measure to be used at the group level with the risk adjustment methodology developed by Johns Hopkins, if it is NQF endorsed would only be endorsed at the group level with this specific software.

**Please note: NQF endorses the measures only for the populations in which it was tested.*

1. Importance to Measure and Report

This criterion was discussed during the May 2, 2011 Steering Committee Conference call. Please click here for a recording of that conference call.

2. Scientific Acceptability of Measure Properties:

2a. Reliability: This criterion was discussed during the May 2, 2011 Steering Committee Conference call. Please click here for a recording of that conference call.
Discussion 9/6/2011 (Carlos Alzola & Steering Committee Members): Health Partners did a very good job examining the reliability of the data using their commercial database. They did two types of sampling; the first was a 90% sample of the actual values. They selected one patient at a time until they reach 90%; this gives an idea of the influence of extreme values. They selected 90% of the data 500 times and compared the results obtained from the averages to the entire sample; the results showed there is very small change. The difference between the samples is only .9%, so that demonstrates the reliability and that the potential influence of these extreme values is small. The other approach used was a boot strapping technique, which is similar but instead of a 90% sample, the developers selected a sample with replacement, this simulates the reliability – this is a very common methodology. The developers found a very small range of change in the sample population – this has some variability in respect to the sample. It's important to note that NQF does not require developers use a certain type of methodology. The analysis has been done at the provider level and depicts the measure to be reliable.
2b. Validity: This criterion was discussed during the May 2, 2011 Steering Committee Conference call. Please click here for a recording of that conference call.
Discussion 9/6/2011 (Carlos Alzola& Steering Committee Members): The validity was obtained in terms of the risk adjusted and the non risk adjusted values. One would anticipate the values between expected and observed would be close – values of .98 for non risk adjusted to actual money spent. After the measure risk adjustment was applied this correlation went down to .215. When the correlation restricted to different places so they look at the correlation between total resource use to the risk adjusted methods so there were a number of test performed and they show the direction of the correlation, which was high in this case. When the risk adjusted was applied, it was low; it shows that the risk adjustment was doing its job.
2b. Risk Adjustment: This criterion was discussed during the May 2, 2011 Steering Committee Conference call. Please click here for a recording of that conference call.

Discussion 9/6/2011 (Carlos Alzola): The risk adjustment was tested and proven to be effective. It has also been accepted by the Society of Actuaries who conducted a further analysis of several risk adjustment methodologies; this specific type was evaluated as having high correlation with resource use. It is significant to note for consumers that a user ID and password is necessary to access the site. The Johns Hopkins software is proprietary; however they have recently announced the software to be free of charge to health insurance exchanges. For the ordinary user, the software is available for a fee based on a scale from large to small organizations, non profits, etc. ACCs, the open source tools from CMS are not included on this list as this measure predates the ACCs. There is continuous enrollment criteria (including age and gender) looking at availability. When this is pushed from individual physician to a group it removes a great deal of issues, many times physicians are in the same group.

2b5. Identification of statistically significant/meaningful differences:

Discussion: The Steering Committee believes that this sub criterion has been met.

2b6. Multiple data sources:

Discussion: N/A

2c. Stratification for disparities:

Discussion: N/A

3. Usability:

3a. Measure performance results are publicly reported:

Discussion: The data is publicly reported but it's difficult to find on the Health Partners website. Currently the measure is used for benefit design and transparency; there are plans for community collaborations in the future.

3b. Measure results are meaningful/useful for public reporting and quality improvement:

Discussion: The Steering Committee discussed the issue that publicly reported measures may not have the same value for quality improvement. This measure is being reported out to public at large, as well as members of Health Partners and has been for quite some time. During the three year NQF maintenance review this criteria would be looked at even further to see how the measure has progressed. This is a fairly complicated measure for the public, in that sense the methodology may not be fully understandable to the average person. It must be communicated that more resource use does not necessarily mean *better* service. For resource use, it may be up to those producing the consumer reports on how to present it to the public in the most understandable way; the measure would need to be endorsed in order to reach this point.

3c. Data and results can be decomposed for transparency and understanding:

Discussion: On the Health Partners website, they have converted the results to dollar signs. This calculation is available to the public at large. There have also been focus groups conducted in order to gauge the clarity of the information available online. It may be difficult to decipher differences in providers and resource use; at some point there is the issue of hierarchical modeling and how to devise low volume providers by evaluating the measure itself. To some extent, the issue is raised are whether the measure is useful to the public because it does not explain the quality of care or outcome relating to resource use.

3d. Harmonized or justification for differences:

Discussion: N/A

4. Feasibility:

4a. Data elements routinely generated during care process:

Discussion: This measure is based on data that is generated as a byproduct of care. The Steering Committee believes this criterion has been met.

4b. Data elements available electronically:

Discussion: These measures are all available via electronic sources. The Steering Committee believes this criterion has been met.

4c. Susceptibility to inaccuracies/ unintended consequences identified:

Discussion: This measure has met the criteria for inaccuracies and unintended consequences. Third party administrators can work together to match up their coding, this would not be barrier for this measures. There is a great deal of regulatory variation that can be applied to self insured entities, may end up measuring smaller percentages of practices.

4d. Data collection strategy can be implemented:

Discussion: The Steering Committee believes this sub criterion has been met.

1599 ETG Based Non-Condition Specific resource use measure

Description: The measure focuses on resources used to diagnose, manage and treat a population of patients (non-condition specific) during a defined 12-month period of time. The population included in the measurement can be described generally. Examples include a population of individuals enrolled with a health plan, individuals assigned to a patient-centered medical home or accountable care organization (ACO), or a panel of individuals managed by a primary care physician (PCP). A number of resource use measures are defined for this measure set, including overall cost of care, cost of care by type of service, and the utilization of specific types of services. Each resource use measure is expressed as a cost or a utilization count per member per month and comparisons with internal and external benchmarks are made using risk adjustment to support valid comparisons. Risk adjustment is based on the measure of risk

assigned to each individual using the Episode Risk Group (ERG) methodology.
Resource Use Type: Per capita (population- or patient-based)
Data Type: Administrative claims
Resource Use Service Category: Inpatient services: Inpatient facility services, Inpatient services: Admissions/discharges, 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
Care Setting: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Emergency Medical Services, Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Laboratory
Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System Population : County or City, Population : National, Population : Regional, Population : states
Measure Developer: Ingenix, 950 Winter Street, suite 3800, Waltham, Massachusetts, 02451

Steering Committee Recommendation for Endorsement:
Rationale: *Pending Committee's official vote.*

Conditions/Questions for Developer:

- Is this per capita measure calculated by the accumulating all resource utilization for a member?
- Which percentage of the total is excluded from the analysis? The Committee would like the dollar amount in order to deem whether or not this is significant.

Developer Response:

- This measure is member based rather than episode based.
- Ingenix will follow up for the Steering Committee regarding "un-groupable" records and the percentage excluded from the analysis. This measure is only looking at complete episodes and record grouped episodes.

3. Importance to Measure and Report
1a.High Impact: *Pending Committee's Final Evaluation*
Discussion: The Steering Committee has deemed this measure to be highly important to measure and report.
1b. Resource use/cost problems: *Pending Committee's Final Evaluation*
Discussion: The Steering Committee believes the measure has met this sub criterion.
1c. Purpose clearly described: *Pending Committee's Final Evaluation*
Discussion: The Steering Committee believes the measure has met this sub criterion.
1d. Resource use service categories consistent and representative: *Pending Committee's Final Evaluation*
Discussion: The Steering Committee believes the measure has met this sub criterion.

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 which will take place on June 22, 2011 to finish the discussion of the Ingenix non-condition specific measure (#1599) prior to the Steering Committee in-person meeting on June 29-30, 2011. To access the dial-in information and agenda for the June 22 call, please click here.