NATIONAL QUALITY FORUM

Meeting Summary

Cost and Efficiency Technical Expert Panel Conference Calls

The National Quality Forum (NQF) convened seven Technical Expert Panels (TEPs) for the review of eight cost measures. The clinically focused TEPs were charged with evaluating the clinical aspects of the measure specifications and measure construct including the clinical logic, clinical exclusions, the clinical episode definitions, and the clinical factors in the risk-adjustment model. The TEPs were convened over a series of conference calls between April 8 and 15.

Technical Expert Panel	Conference Call Date	Measures Reviewed
Gastroenterology	April 8, 2019	3510 Screening/Surveillance Colonoscopy
Ophthalmology	April 8, 2019	3509 Routine Cataract Removal with Intraocular Lens (IOL) Implantation
Orthopedic Surgery	April 10, 2019	3512 Knee Arthroplasty
Family/Internal Medicine	April 10, 2019	3513 Simple Pneumonia with Hospitalization
Vascular Surgery	April 11, 2019	3511 Revascularization for Lower Extremity Chronic Critical Limb Ischemia
Neurology	April 11, 2019	3514 Intracranial Hemorrhage or Cerebral Infarction
Cardiovascular	April 15, 2019	3508 Elective Outpatient Percutaneous Coronary Intervention (PCI) 3515 ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

Each call began with Ashlie Wilbon, NQF senior director, welcoming the TEP and participants to the conference call, providing opening remarks, and reviewing the objectives of the call. On each call, Ms. Wilbon conducted roll call and asked TEP members to announce any disclosures of interest. Prior to the TEP members' evaluation discussion, the Acumen measure development team provided an overview of the measure development process, the measure construct, and any relevant comments on the clinical logic. The developer explained that these measures are designed to calculate only the costs that the attributed clinician can control, that are risk adjusted, and that were developed with the intention to link the measures to existing quality measures when possible. For each of the measures, the Acumen team invited the co-chairs from the clinical subgroup to share insights and respond to questions as needed. Prior to the meeting, the TEP members completed a preliminary evaluation form with several questions focused on the clinical aspects of the measure; Ms. Wilbon facilitated the TEPs' discussions

based on the responses in the evaluation form, allowing the TEP to pose questions to the Acumen team as needed. At the end of the discussion on each conference call, Ms. Wilbon opened the call to allow for public comment. No public comments were offered on any of the seven calls. See below a brief summary of each call.

Screening/Surveillance Colonoscopy (3510)

The Gastroenterology TEP met on April 8, 2019. The TEP generally agreed that the clinical population was appropriate but raised several questions to the developer to clarify the specifications and the rationale underlying the decision logic. A member of the TEP inquired about the inclusion of diagnostic colonoscopies versus screening colonoscopies where biopsies were taken. The developers explained that the exclusion of diagnostic colonoscopies was a deliberate choice based on discussions by the clinical subgroup during the development process and that pathology codes results are not accounted for in the cost or the measure logic. The TEP also sought clarity on how patients with a history of prior complex colonoscopy or polypectomy are handled. The developer explained that effort was taken to address this population through the addition of clinical factors in the risk-adjustment model to account for patients who have a history of previous complications or reactions to anesthesia. The episode length and triggers were also discussed. The TEP sought clarity on the 14-day pre-trigger window and expressed concerns about unintended consequences of repeat colonoscopies for inadequate prep being pushed out beyond the measurement window to prevent the accumulation of costs within the same episode.

The TEP emphasized the need to link this measure with quality measures and asked NQF how the measure endorsement process accommodates the linking of related cost and quality measures. Ms. Wilbon explained that cost measures submitted into the endorsement process are evaluated individually and that the NQF process does not currently have the criteria or infrastructure to evaluate cost and quality measures together.

Next Steps

The TEP's feedback will be compiled and shared with the Cost and Efficiency Standing Committee as input to their evaluation of the measure for endorsement. The Standing Committee's measure evaluation web meetings will take place on June 27, 2019.

Routine Cataract Removal with Intraocular Lens (IOL) Implantation (3509)

The Ophthalmology TEP met on April 8, 2019. The TEP generally agreed that the clinical population was appropriate but posed some questions to the developer to clarify the rationale of the measure exclusions and expressed some concerns for the developers to consider in future iterations of the measure. The TEP expressed concern about the inability to account for Part D drug data in this measure as pre- and post-procedure prescription eye drops are a significant driver of costs for these episodes and a source of variation in practice. One TEP member raised concern regarding the inclusion of prophylactic and post-operative care of retinal tear in the episode. These retinal tears, although infrequent, are often unrelated to the procedure itself. One TEP member expressed concern about the inclusion of procedural pass through medications. The clinical subgroup co-chair explained that these were intentionally included in an effort to capture all costs during the episode, as there are various options for using more

expensive medications versus others, and there is no evidence that these medications produce better outcomes. One TEP member inquired how resident surgeries are handled. The developer explained there is a GC modifier was included in the model as a risk-adjustment variable to address this concern.

Next Steps

The TEP's feedback will be compiled and shared with the Cost and Efficiency Standing Committee as input to their evaluation of the measure for endorsement. The Standing Committee's measure evaluation web meetings will take place on June 27, 2019.

Knee Arthroplasty (3512)

The Orthopedic Surgery TEP met on April 10, 2019. The TEP generally agreed that the clinical specifications were appropriate, but did express some concerns and raised some questions for developer response. In particular, the TEP was concerned that the actions of a primary care provider, especially when unnecessary imaging (e.g., MRI) is ordered, could unfairly impact a surgeon's costs if it is attributed to the surgeon. TEP members sought clarity on the types of costs that are captured in the 30-day pre-trigger period. The developer explained that hospitalization during that period would not be included; only costs related to pre-operative testing (e.g., lab work, imaging) and treatment (e.g., physical therapy) are included. The TEP also questioned how palliative care costs were handled. While oncology tumor costs are not included, the data are not currently able to differentiate patients who are on palliative care for other chronic health issues to support a measure specification. The developer also clarified that deaths are excluded from the measure.

Next Steps

The TEP's feedback will be compiled and shared with the Cost and Efficiency Standing Committee as input to their evaluation of the measure for endorsement. The Standing Committee's measure evaluation web meetings will take place on June 27, 2019.

Simple Pneumonia with Hospitalization (3513)

The TEP reviewed this measure on April 11 and generally agreed that the clinical specifications were appropriate. The TEP raised a few concerns for the developer's response and consideration. TEP members questioned why only borderline personality disorder was singled out as an exclusion; the TEP was concerned that it seemed to be unfairly singled out versus other mental health conditions that were not addressed. The developer explained that while they would have liked to include other psychological conditions like depression or schizophrenia in the risk model, the data were not sufficient to support that in the specifications. Further, the developers reported that their data analysis showed a cost difference in treating the patients with this diagnosis which warranted the exclusion. The TEP also expressed concern regarding unintended consequences of this measure in that there may be a push to manage more patients in the outpatient setting to reduce costs, thereby compromising patients that may need to be admitted to improve outcomes. For example, patients with mental health disorders or multiple co-morbidities with limited social support may require inpatient treatment to monitor more closely the course of treatment. In response to this concern, the developer explained that they

did attempt to address co-morbidities of other psychiatric diagnoses in the risk model to address this issue.

Next Steps

The TEP's comments and discussion will be compiled and shared with the measure developers as feedback for ongoing improvements to the measure. NQF also will continue to work with the CMS/Acumen team to bring the measure back to NQF for consideration for endorsement.

Revascularization for Lower Extremity Chronic Critical Limb Ischemia (3511)

The Vascular Surgery TEP met on April 11, 2019. The TEP generally agreed that the clinical specifications were appropriate based on the intent of the measure. TEP members were curious about the developer's initial thoughts behind putting all cost utilization toward one surgeon when they are not the only one impacting cost. The developer explained that the measure is only able to gather information that is needed through coordination of care. The measure provides physicians with information that they can act upon for better coordination of care. TEP members sought clarity on the specifications related to the handling of end-stage renal disease patients, which is included in the risk-adjustment model. The TEP also inquired about the rationale for the episode measurement period and questioned whether the episode should be longer. The developer explained the trade-offs of extending the measurement period which would impact data availability and reliability.

Next Steps

The TEP's comments and discussion will be compiled and shared with the measure developers as feedback for ongoing improvements to the measure. NQF also will continue to work with the CMS/Acumen team to bring the measure back to NQF for consideration for endorsement.

Intracranial Hemorrhage or Cerebral Infarction (3514)

The TEP met on April 11, 2019 to discuss this measure. The TEP generally agreed that the measure was clinically appropriate but raised some specific concerns for the developer to respond to and consider in future iterations of the measure. The TEP raised concerns over geographical differences in the availability of post-acute services and how this can impact costs as well as patient outcomes. The developers acknowledged this concern, but they do not currently account for this in the measure specifications or risk adjustment; their data analysis to date has not shown any significant differences. There was also significant discussion between the TEP members and developers on the decision to exclude deaths from the episode. The developers explained the CMS policy decision to exclude deaths from all of the cost measures.

Next Steps

The TEP's comments and discussion will be compiled and shared with the measure developers as feedback for ongoing improvements to the measure. NQF also will continue to work with the CMS/Acumen team to bring the measure back to NQF for consideration for endorsement.

Elective Outpatient Percutaneous Coronary Intervention (PCI) Measure (3508) and ST- Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) (3515)

Due to the similarities between the PCI and STEMI with PCI cost measures, many of the concerns raised and discussion regarding the PCI measure also applied to the STEMI with PCI measure. The summary below encompasses concerns raised regarding both measures. Concerns specific to the STEMI measures are outlined separately below.

The TEP generally agreed that the measures were clinically appropriate but raised some specific concerns for the developer's response. One concern was regarding the lack of adjustment for stage 3 chronic kidney disease (CKD) as this population is very vulnerable to the elevated risks from PCI. The developer clarified that although stage 3 CKD is not included in the risk model, CKD stages 4 and 5 are included. The TEP also expressed concern that deaths were excluded from the episode and the misalignment this would cause with quality measures that focus on mortality. The developers explained that the exclusion of deaths was driven by a CMS policy decision to exclude deaths from all of the episodes. Episodes ending in death tended to result in either very low or very high cost episodes and could skew results to make a provider with multiple deaths appear low cost. For this episode, analysis showed that on average, episodes ending in death had nearly 35 percent higher than expected costs. It is an issue that will continue to be monitored with ongoing use of the measure.

The TEP members discussed possible unintended consequences that could impact physician practice in selecting clinical pathways that are low cost but perhaps not associated with the best outcomes versus those that may be associated with better outcomes and higher short-term cost. The TEP also sought clarity from the developers on the payment standardization process and the attribution rules related to primary and assistant physicians participating in the procedure. The developer explained that the modifier codes used to indicate the involvement of an assistant clinician are used very infrequently. Once more coding education has been provided, the developer will include more logic as needed to accommodate the specifications.

TEP members expressed concern regarding the misalignment of the measurement window with this measure and measures used in the CMS-Bundled Payments for Care Improvement (BCPI) program. This misalignment contributes to measurement burden on physicians and institutions. The developer acknowledged and noted that the episode window was carefully decided upon by the developer's subcommittee when developing the measure.

For the STEMI with PCI measure, the TEP raised some additional concerns specific to this measure. TEP members expressed concern about the length of the episode and the inclusion of costs for skilled nursing facilities (SNF). Specifically, there was concern that individual clinicians may not have control over SNF selection which could be a significant cost driver during the episode. The developer explained while care coordination between the individual clinician and the SNF placement process may be challenging, the intent of including those costs in the episode is to drive improvements in care coordination.

TEP members were curious about the risk adjustment of the measure, noting that the risk adjustment is based primarily upon HCC diagnoses coded in the prior 120 days. The TEP

members noted that conditions such as chronic systolic CHF, diabetes, and CKD stage 4 that have not had been billed for this condition in the prior 120 days would not be captured. The developer excluded patients with STEMI 120 days prior; this would apply to all patients to create a relatively homogenous population of patients and optimize measure validity. The developer was concerned that episodes with more than 120 days might not be seeing the physicians and won't have HCCs coded.

Next Steps

The TEP's comments and discussion will be compiled and shared with the measure developers as feedback for ongoing improvements to the measures. NQF also will continue to work with the CMS/Acumen team to bring these measures back to NQF for consideration for endorsement.