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# Cost & Efficiency, Spring 2020 Measure Review Cycle

Standing Committee Orientation

*May 26, 2020*

# Welcome

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# Project Team

- Matthew Pickering, PharmD, Senior Director
- Janaki Panchal, MSPH, Project Manager
- Funmilayo Idaomi, Project Analyst
- Taroon Amin, PhD, MPH, Consultant

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# Agenda

- Welcome and Roll Call
- Overview of the Consensus Development Process (CDP) and Roles
- Overview of NQF's Portfolio of Cost and Efficiency Measures
- Overview of Measure Evaluation Process
- Cost and Resource Use Measure Evaluation Criteria Overview
- SharePoint Tutorial
- Next Steps

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# Cost and Efficiency Standing Committee

Cheryl Damberg, PhD (Co-chair)
Sunny Jhamnani, MD (Co-chair)
Kristine Martin Anderson, MBA
Robert Bailey, MD*
Bijan Borah, MSc, PhD*
John Brooks, PhD*
Cory Byrd*
Michael Chernew, PhD*
Amy Chin, MS*
Lindsay Erickson, MPH*
Troy Fiesinger, MD, FAAFP
Emma Hoo*
Sean Hopkins, BS*
Rachael Howe, MS, BSN, RN
Donald Klitgaard, MD, FAAFP*
Lisa Latts, MD, MSPH, MBA, FACP
Jason Lott, MD, MHS, MSHP, FAAP
Alefiyah Mesiwala*
Jack Needleman, PhD
Janis Orlowski, MD, MACP
John Ratliff, MD, FACS, FAANS
Mahil Senathirajah*
Srinivas Sridhara, PhD, MHS
Danny van Leeuwen, RN, MPH*



*Newly appointed Cost and Efficiency Standing Committee member

# Overview of the CDP and Roles

# NQF Consensus Development Process (CDP)

## 6 Steps for Measure Endorsement

- Intent to Submit
- Call for Nominations
- Measure Evaluation
- Public Commenting Period with Member Support
- Measure Endorsement
  - Consensus Standards Approval Committee (CSAC)
- Measure Appeals

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# Role of the Standing Committee
## *General Duties*

- Act as a proxy for the NQF multistakeholder membership
- Serve initial 2-year or 3-year terms
  - Opportunity to renew for 2 additional years (4 cycles)
- Work with NQF staff to achieve the goals of the project
- Evaluate candidate measures against the measure evaluation criteria
- Respond to comments submitted during the review period
- Respond to any directions from the CSAC
- Refer to the Standing Committee Guidebook for more information

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# Role of the Standing Committee
## *Meeting Participation*

- Meeting attendance
  - *Must notify NQF staff if unable to attend in advance of the meeting*
- Quorum requirements
  - *NQF Quorum=66% of active members*
  - *Committee recommendations can only be made with a quorum of Committee votes*
    - » *Not based on Robert's Rules of Order*
  - Votes may be requested via email if quorum is not reached during the meeting
    - » *Materials (i.e., recording, transcripts) will be sent to inform votes*
  - *Meetings may be cancelled (and rescheduled) if quorum not reached and vote is required*
- Measure-specific disclosure of interest
  - *Must be completed to participate in the measure evaluation discussion (each cycle)*

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# Role of the Standing Committee
## *Measure Evaluation Duties*

- All members evaluate ALL measures being considered for endorsement
- Evaluate measures against each criterion
  - *Indicate the extent to which each criterion is met and rationale for the rating*
- Make recommendations to the NQF membership for endorsement
- Oversee Cost and Efficiency portfolio of measures
  - Promote alignment and harmonization
  - Identify gaps

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# Role of Methods Panel

- Scientific Methods Panel was created to ensure higher-level and more consistent reviews of the scientific acceptability of measures
- The Methods Panel is charged with:
  - Conducting evaluation of complex measures for the Scientific Acceptability criterion, with a focus on reliability and validity analyses and results
  - Serve in advisory capacity to NQF on methodologic issues, including those related to measure testing, risk adjustment, and measurement approaches.
- The Methods Panel review will help inform the standing committee's endorsement decision. The panel will not render endorsement recommendations.

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# Role of the Technical Expert Panel (TEP)

For the Cost and Efficiency Project, TEPs are convened to provide clinical input on clinically focused cost measures.

- Charged with review and providing feedback on clinical logic, episode trigger and end definitions, clinical exclusions, clinical risk factors for risk adjustment
  - Focus on validity of measure specifications
- Qualitative feedback only, no votes collected
- Time-limited convening
- Experts are pulled from existing standing committees, targeted outreach, and public nominations to fill other relevant gaps in expertise

# Overview of NQF's Cost and Efficiency Portfolio

# Cost and Efficiency Portfolio of Measures

- This project will evaluate measures related to Cost and resource use that can be used for accountability and public reporting for all populations and in all settings of care.
- There are currently 10 NQF-endorsed measures within this topic area.

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# Cost and Efficiency Portfolio of NQF-endorsed Measures

- 2579 Hospital-level, risk-standardized payment associated with a 30-day episode of care for pneumonia (PN)
- 3474 Hospital-level, risk-standardized payment associated with a 90-day episode of care for elective primary total hip and/or total knee arthroplasty (THA/TKA)
- 1598 Total Resource Use Population-Based PMPM Index
- 1604 Total Cost of Care Population-Based PMPM Index
- 2158 Medicare Spending Per Beneficiary (MSPB) - Hospital
- 2431 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)
- 2436 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF)

**Most Recently Endorsed**

- 3509 Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- 3510 Screening/Surveillance Colonoscopy
- 3512 Knee Arthroplasty

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# Summary of Portfolio

- All rely on administrative claims data
- Typically count costs based on what is paid by the health plan to the provider/hospital
- Only two endorsed measures consider out-of-pocket costs from patients
- All are risk-adjusted (e.g., HCCs, ACGs)
- All focus on adult population; majority for Medicare population
- Varying levels of analysis (e.g., hospital, clinician, clinician groups)
- Do not capture or represent activity-based costs, production costs (fixed or variable), administrative costs, government funding to support healthcare delivery, or societal costs (e.g., lost wages, sick days)

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# Cost, Resource Use, Efficiency, and Value

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# Measures Included in the Scope of Cost and Efficiency Committee Evaluations

- Cost Measures
  - the actual price paid by health plans for health plan member
  - may also include a member (consumer) cost based on member co-pays, coinsurance, and deductibles
- Resource use measures
  - broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).
  - counts the frequency of defined health system resources; some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use.
- Does not include measures of appropriateness, ED throughput

# Getting to Efficiency and Value

**Current State of NQF evaluation and endorsement of cost and efficiency measures**

- Evaluation of cost and resource use measures by Cost and Efficiency Standing Committee
- Quality measures are submitted and reviewed separately, by the relevant (clinical) standing committees
- Developers are able to submit “paired” measures, but to date, no measure pairs for cost and quality have been submitted (i.e., no efficiency measures)
- No evaluation process or criteria to assess how cost/resource use and quality measures should be used together; left to users to determine as part of implementation

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# Challenges with Cost and Resource Use Measure Evaluation

- Discerning whether there is an opportunity to improve costs/resource use by implementing the measure
- Determining whether social factors should be included in the risk-adjustment model; what impact does it have on performance and rankings?
- Validity testing methodology
- Threshold for reliability estimates
- Attribution approach
- Impact of the inclusion/exclusion of pharmacy costs

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# Cost and Resource Use Measure Evaluation Pipeline

- CMS had a statutory requirement to develop cost measures that cover 50% of Medicare costs (primarily through MIPS)
- Mix of measurement approaches
  - Episode-based, clinician level
  - Cost per capita/spending per beneficiary
- Maintenance reviews
- Ongoing assessment of NQF capacity and process
  - Clinical TEP reviews
  - Timelines
  - Staff and Committee capacity

# Spring 2020 Measure Review Cycle

- Six submitted measures
  - 3561 Medicare Spending Per Beneficiary-Post Acute Care Measure for Inpatient Rehabilitation Facilities
  - 3562 Medicare Spending Per Beneficiary – Post Acute Care Measure for Long-Term Care Hospitals
  - 3563 Medicare Spending Per Beneficiary – Post Acute Care Measure for Skilled Nursing Facilities
  - 3564 Medicare Spending Per Beneficiary – Post Acute Care Measure for Home Health Agencies
  - 3574 Medicare Spending Per Beneficiary (MSPB) Clinician
  - 3575 Total Per Capita Cost (TPCC)

- All six measures were reviewed by the NQF Scientific Methods Panel (SMP) and passed the review

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# Activities and Timeline

- Spring 2020 cycle meeting dates:

| Meeting | Dates |
|---|---|
| Orientation Webinar | May 26, 2020, 12-2pm ET |
| Measure Evaluation Webinar (all-day, virtual) | July 10, 2020, 9am-5pm ET |
| Post comment Webinar | October 1, 2020, 3-5pm ET |

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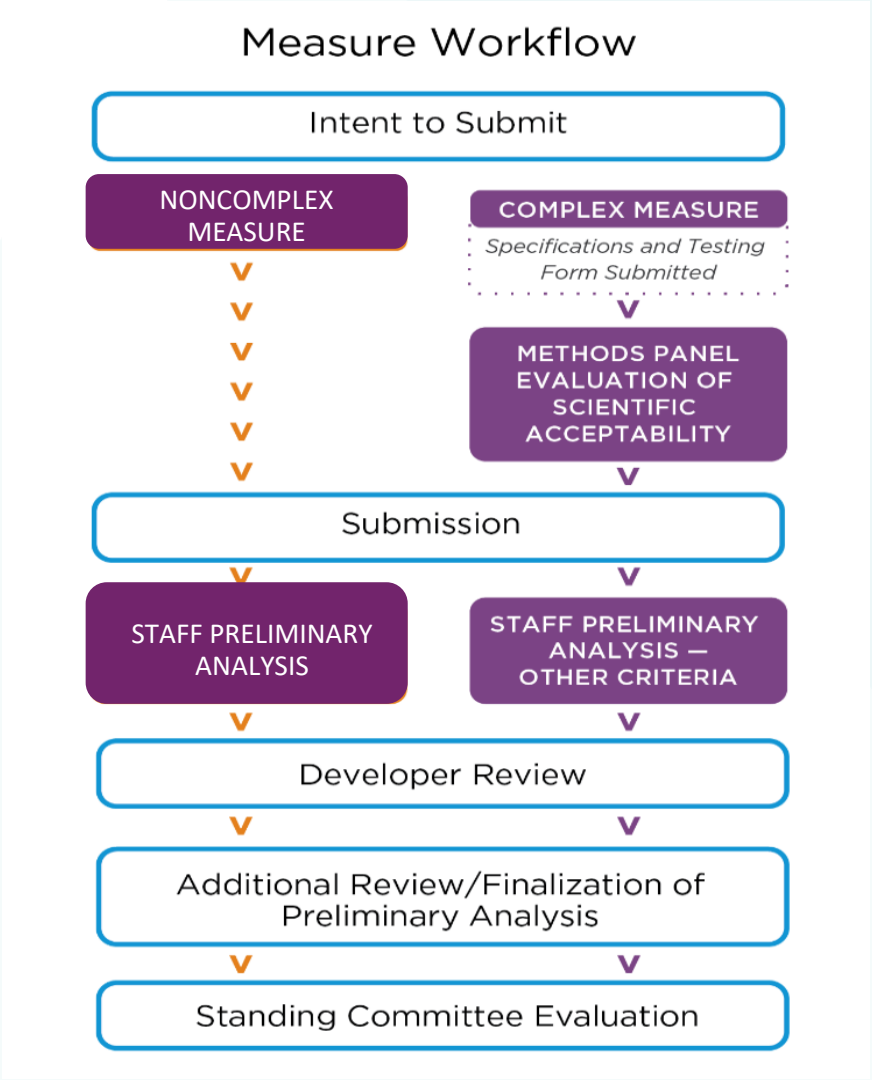
# Questions?

# Measure Evaluation Process Overview

# Measure Evaluation Workflow



# NQF Consensus Development Process (CDP) Measure Evaluation

*Complex Measures*

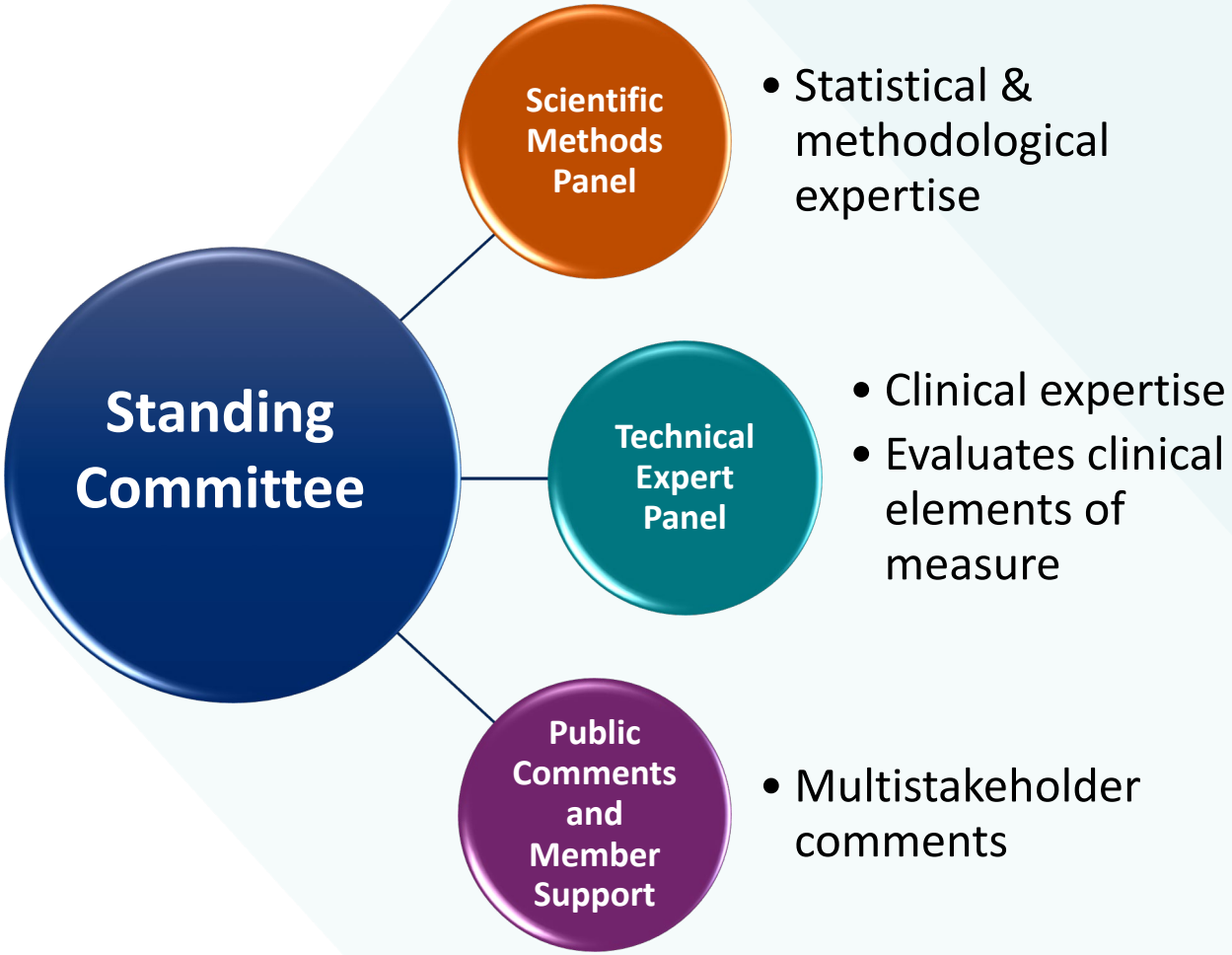
- Outcome measures, including intermediate clinical outcomes
- Instrument-based measures (e.g., PRO-PMs)
- Cost/resource use measures
- Efficiency measures (those combining concepts of resource use and quality)
- Composite measures

*Noncomplex Measures*

- Process measures
- Structural measures
- Previously endorsed complex measures with no changes/updates to the specifications or testing

# Measure Evaluation Inputs to the Standing Committee

- Multistakeholder Committee
- Evaluates all evaluation criteria
- Makes recommendation for endorsement



# Committee Measure Evaluation Process

- **Staff Preliminary analysis (PA)**: To assist the Committee evaluation of each measure against the criteria, NQF staff and the Methods Panel (if applicable) will prepare a PA of the measure submission and offer preliminary ratings for each criteria.
  - The PA will be used as a starting point for the Committee discussion and evaluation
  - Methods Panel will complete review of the Scientific Acceptability criterion for complex measures
- **Member individual evaluation**: Each Committee member will conduct an in-depth evaluation on all measures under review
  - Committee members will be assigned a measure (or parts of criteria for a measure) for which they will serve as lead discussant in the evaluation meeting

# Committee Measure Evaluation Process

- NQF staff compiles votes and redistributes measure worksheet with summary of all members preliminary analyses
- **Lead discussants** are assigned to each measure for committee evaluation meetings
- **Measure evaluation and recommendations at the in-person/web meeting**: The entire Committee will discuss and rate each measure against the evaluation criteria and make recommendations for endorsement.

# Evaluation Process Continues

- **Staff will prepare a draft report** detailing the Committee's discussion and recommendations
  - This report will be released for a 30-day public and member comment period
- **Post-comment call**: The Committee will re-convene for a post-comment call to discuss comments submitted
- **Final endorsement decision by the CSAC**
- **Opportunity for public to appeal endorsement decision** (for endorsed measures only)

# Cost and Resource Use Measure Evaluation Criteria Overview

# NQF Cost and Resource Use Measure Evaluation Criteria for Endorsement

**NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement.**

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The performance measurement enterprise is constantly growing and evolving—greater experience, lessons learned, expanding demands for measures—the criteria evolve to reflect the ongoing needs of stakeholders

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# Major Endorsement Criteria *(page 32 in the SC Guidebook)*

- **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (**must-pass**)
- **Reliability and Validity-scientific acceptability of measure properties**: Goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation (**must-pass**)
- **Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
- **Usability and Use** (**must-pass** for maintenance measures): Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- **Comparison to related or competing measures**

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# Criterion 1: Importance to Measure and Report *(page 34-42)* – (Must Pass)

Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

1a. **High Impact:** The measure focus addresses a demonstrated high-impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use [current and/or future], severity of illness, and patient/societal consequences of poor quality).

-- *AND* --

1b. **Opportunity for Improvement:** Demonstration of resource use or cost problems and opportunity for improvement, i.e., data demonstrating considerable variation in cost or resource use across providers.

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# Criterion 2: Scientific Acceptability of the Measure Properties (pages 42-54) – (Must Pass)

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

2a. Reliability

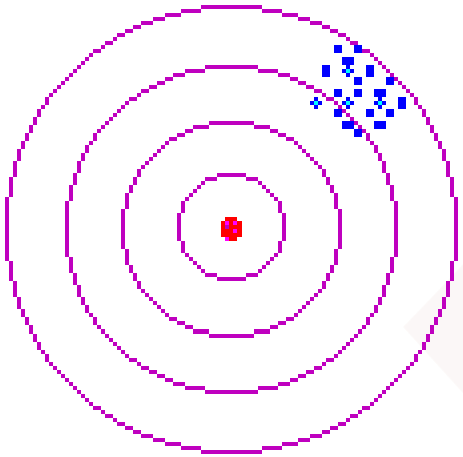
- 2a1. Precise specifications including exclusions
- 2a2. Reliability testing—data elements or measure score

2b. Validity

- 2b1. Validity testing—data elements or measure score
- 2b2. Justification of exclusions—relates to evidence
- 2b3. Risk adjustment—typically for outcome/cost/resource use
- 2b4. Identification of differences in performance
- 2b5. Comparability of data sources/methods
- 2b6. Missing data

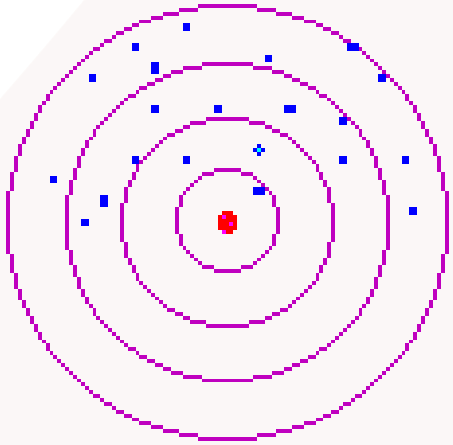
# Reliability and Validity

**Assume the center of the target is the true score.**



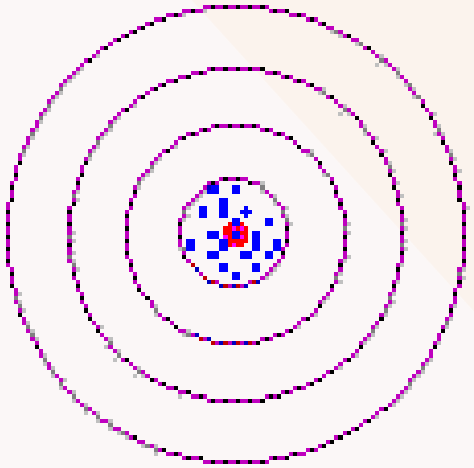
**Reliable Not Valid**

Consistent, but wrong



**Neither Reliable Nor Valid**

Inconsistent & wrong



**Both Reliable And Valid**

Consistent & correct

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# Evaluating Scientific Acceptability—Key Points

Empirical analysis to demonstrate the reliability and validity of the measure as specified, including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

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# Reliability Testing—Key Points

- Reliability of the **measure score** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - Example – Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)
- Reliability of the **data elements** refers to the repeatability/ reproducibility of the data and uses patient-level data
  - Example – inter-rater reliability
- Consider whether testing used an appropriate method and included adequate representation of providers and patients and whether results are within acceptable norms
- Algorithm 2

# Rating Reliability: Algorithm 2

[Screen share Reliability algorithm]

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# Validity Testing

- Empirical testing
  - Measure score – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - Data element – assesses the correctness of the data elements compared to a “gold standard”
- Face validity
  - Subjective determination by experts that the measure appears to reflect quality of care
    - » Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.
    - » Requires systematic and transparent process, by identified experts, that explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

# Rating Validity: Algorithm 3

- [Screen share Validity algorithm]

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# Threats to Validity

- Conceptual
  - Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome
- Unreliability
  - Generally, an unreliable measure cannot be valid
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures
- Measure scores that are generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

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# Criterion 2: Scientific Acceptability

| New measures | Maintenance measures |
|---|---|
| • Measure specifications are precise with all information needed to implement the measure | NO DIFFERENCE: Require updated specifications |
| • Reliability<br>• Validity (including risk-adjustment) | **DECREASED EMPHASIS**: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting)<br>Must address the questions regarding use of social risk factors in risk-adjustment approach |

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## Criterion 3: Feasibility *(pages 54-55)*

Extent to which the required data are readily available, or could be captured without undue burden, and can be implemented for performance measurement.

3a: Clinical data routinely generated and used during care delivery

3b: Electronic sources

3c: Data collection strategy can be implemented

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## Criterion 4: Usability and Use *(pages 55-56)*

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

**Use (4a): Must-pass** for maintenance measures

- 4a1: Accountability and Transparency.
- 4a2: Feedback by those being measured or others

**Usability (4b)**

- 4b1: Improvement
- 4b2: Benefits outweigh the harms
- 4b3. Transparency

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# Criteria 3 and 4: Feasibility and Usability and Use

## Feasibility

| New measures | Maintenance measures |
|---|---|
| • Measure feasible, including eMeasure feasibility assessment | NO DIFFERENCE: Implementation issues may be more prominent |

## Usability and Use

| New measures | Maintenance measures |
|---|---|
| • Use: used in accountability applications and public reporting | **INCREASED EMPHASIS**: Much greater focus on measure use and usefulness, including both impact and unintended consequences |
| • Usability: impact and unintended consequences | |

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# Criterion 5: Related or Competing Measures *(pages 57-58)*

If a measure meets the four criteria and there are endorsed/new **related** measures (same measure focus or same target population) or **competing** measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure.

- 5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- 5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

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# Updated Guidance for ICD-10 Coding

- For CY2019 and beyond, reliability testing should be based on ICD-10 coded data.
- Validity testing should be based on ICD-10 coded data
- If providing face validity (FV), both FV of the ICD-10 coding scheme and FV of the measure score as an indicator of quality is required update

# Social Risk Trial Background

- NQF conducted a two-year trial period from 2015-2017. During this time, adjustment of measures for social risk factors was no longer prohibited
- The NQF Board of Directors reviewed the results of the trial period and determined there was a need to launch a new social risk initiative
- As part of the Equity Program, NQF will continue to explore the need to adjust for social risk
- Each measure must be assessed individually to determine if SDS adjustment is appropriate (included as part of validity subcriterion)
- The Standing Committee will continue to evaluate the measure as a whole, including the appropriateness of the risk adjustment approach used by the measure developer
- Efforts to implement SDS adjustment may be constrained by data limitations and data collection burden

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# Social Risk Trial Standing Committee Evaluation

The Standing Committee will be asked to consider the following questions:

- Is there a conceptual relationship between the SDS factor and the measure focus?
- What are the patient-level sociodemographic variables that were available and analyzed during measure development?
- Does empirical analysis (as provided by the measure developer) show that the SDS factor has a significant and unique effect on the outcome in question?
- Does the reliability and validity testing match the final measure specifications?

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# Questions?

# Example Preliminary Analysis for Measure #3510

- [Screen share example PA]

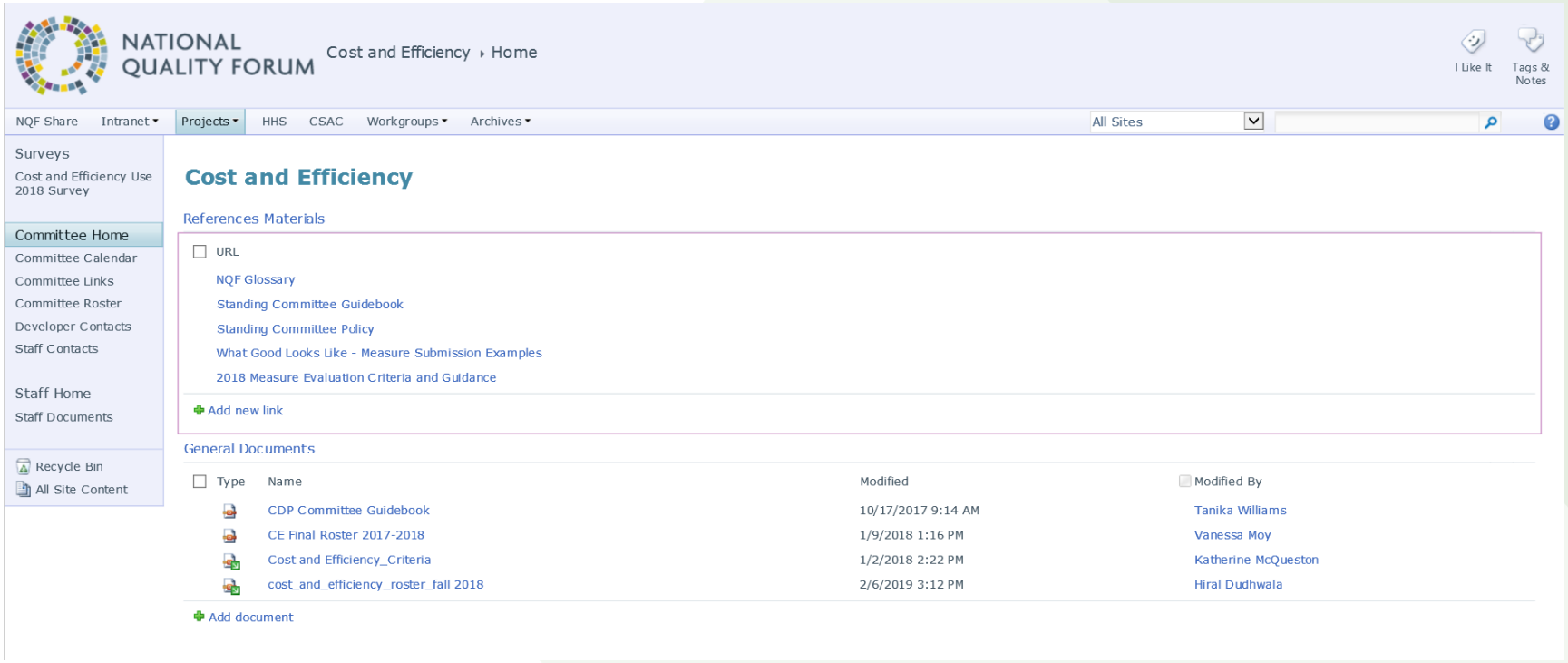
# SharePoint Overview

# SharePoint Overview

http://share.qualityforum.org/Projects/costEff/SitePages/Home.aspx

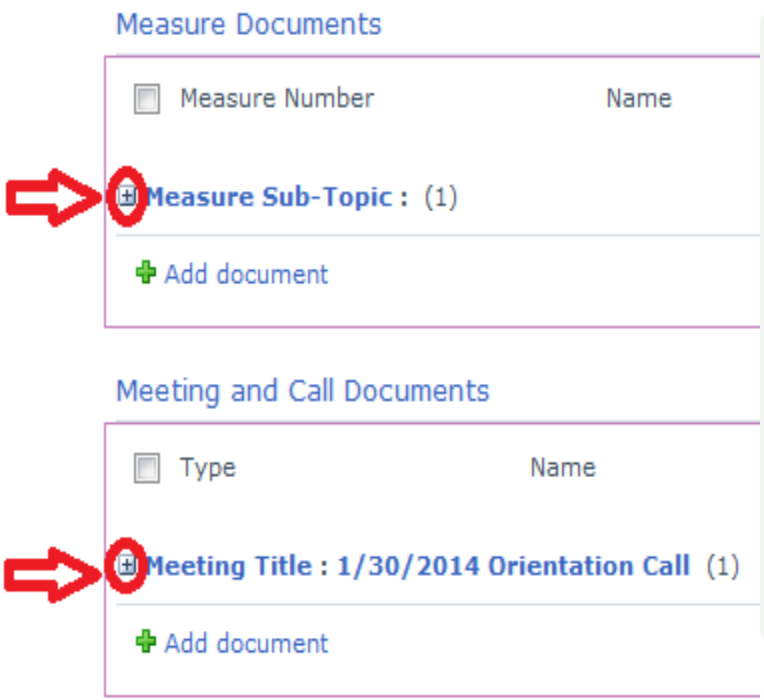
- Accessing SharePoint
- Standing Committee Policy
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings

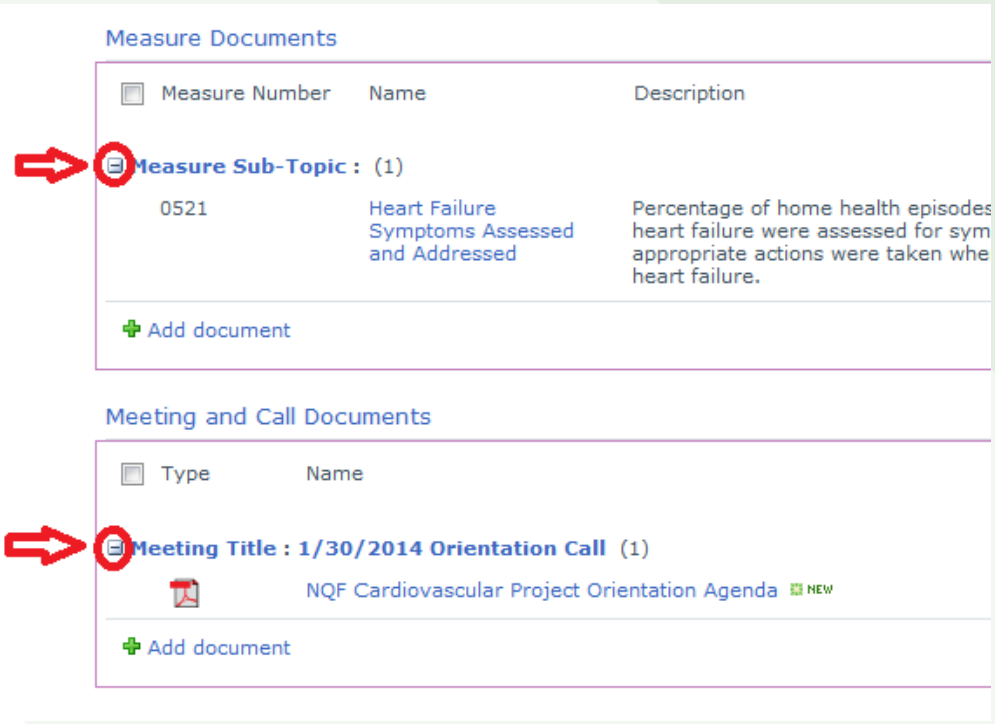
# SharePoint Overview



# SharePoint Overview

- Please keep in mind:



# Next Steps

# Next Steps

**Measure review**

- Measure Evaluation Survey to submit feedback on the measures (we will send it to you by June 10) – feedback due June 23 (~10 Business days)

**All-day, Web Meeting**

- July 10, 2020, 9am-5pm ET

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# Project Contact Info

- Email: efficiency@qualityforum.org
- NQF phone: 202-783-1300
- Project page: http://www.qualityforum.org/Project_Pages/Cost_and_Efficiency.aspx
- SharePoint site: http://share.qualityforum.org/Projects/costEff/SitePages/Home.aspx

# THANK YOU.

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