TO: NQF Council Members

FR: Frank Opelka, MD, CSAC Chair
Cristie Upshaw Travis, CSAC Vice-Chair

RE: Cost and Resource Use Project

DA: October 16, 2013

NQF recently convened a Cost and Resource Use Steering Committee to review two non-condition-specific cost/resource use measures. Of the two measures, the Committee recommended (17-8) one of the measures for endorsement, #2158-Medicare Spending per Beneficiary Measure (MSBP). Following a public comment period on the measures, the recommended measure was put out for membership vote.

The results of the membership vote were as follows:
There was not clear consensus from the membership regarding the measure, with 43% of councils approving. Representatives of 42 member organizations voted; no votes were received from the Public/Community Health Agency Council. Voting results for the measure are provided below.

2158: Payment-Standardized Medicare Spending per Beneficiary

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	4	0	0	4	100%
Health Plan	4	0	0	4	100%
Health Professional	2	13	1	15	13%
Provider Organizations	2	5	0	7	29%
Public/Community Health Agency	0	0	0	0	
Purchaser	5	0	0	5	100%
QMRI	2	2	0	4	50%
Supplier/Industry	0	3	0	3	0%
All Councils	19	22	1	42	45%
Percentage of councils approving (>50%)					**43%**
Average council percentage approval					56%

*equation: Yes / (Total - Abstain)

At its October 8th conference call, the CSAC reviewed the recommendations from the Cost and Resource Use project, including the Steering Committee deliberations, public and member comments, and member voting results.

Due to the lack of consensus noted among the councils represented in the voting results, the CSAC has requested input from the NQF member councils to gain a better understanding of the perspective of the NQF membership and determine whether consensus among the councils can be reached before making an endorsement recommendation.

This memo includes a summary of the recommended measure, themes identified from and responses to the public and member comments, and a summary of the NQF member voting results.

This project followed the National Quality Forum's (NQF) version 1.9 of the Consensus Development Process (CDP). Member voting on these recommended measures ended on September 23.

Accompanying this memo are the following documents:

1. **Measure Evaluation Summary Table** A summary of the steering committee discussion and vote totals for Measure #2158.
2. **Cost and Resource Use Draft Report** The draft report has been updated to reflect the changes made following Steering Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
3. **Comment table** Staff has identified themes within the comments received. This table lists 59 comments received and the NQF/Steering Committee responses.

ACTION REQUIRED

The NQF council members are asked to provide input to their stakeholder council chairs, either over email or via a scheduled council call during October 2013. The council chairs will represent their stakeholder council's perspective at the November 6-7, 2013, CSAC In-Person Meeting on the Payment-Standardized Medicare Spending Per Beneficiary (MSPB) measure recommended for endorsement.

COMMENTS AND THEIR DISPOSITION

NQF received 59 comments from 25 organizations (including 20 member organizations) and individuals pertaining to the general draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Steering Committee and measure developers, is posted to the Cost and Resource Use project page under the Public and Member Comment section.

Comment Themes and Committee Responses

Measure Specific Comments and Votes: Recommended measure
2158: Payment-Standardized Medicare Spending per Beneficiary (MSPB)

This measure received comments from twenty organizations/ individuals. Three of these comments were supportive, noting that this measure is an important first step "towards an optimal measure of hospital resource use." One commenter noted that the measure "does have methodologic concerns but its intent is clear and necessary."

The remaining comments addressed several themes listed below, along with a description of the comments received.

Exclusion of Deaths

- Two commenters questioned the exclusion of deaths, noting that they "believe the measure would be a stronger measure of costs if patient deaths were included."

- One commenter supported the exclusion of deaths and also called for the exclusion of hospice payments in order to “maintain the internal consistency of the measure.”

Steering Committee Response:
The Resource Use Steering Committee generally agrees with the Commenter that the inclusion of episodes where the patient dies would create a stronger measure. End of life care is a high-cost area for the Medicare program and is important for measurement and improvement. The developer acknowledges that the exclusion was finalized through notice and comment rulemaking based on the fact that these are incomplete episodes where significant data could be missing, but that CMS will consider including episodes in which the beneficiary dies in future updates to the MSPB measure.

Exclusions

- One commenter expressed concern that exclusion of transfer patients from other acute care facilities may affect a larger portion of PPS-exempt Cancer Center patient admissions when compared to PPS Hospital admissions.
- One commenter expressed concern that exclusion of transfer patients could remove more seriously ill patients, which represent significant opportunities for reduced spending.
- One commenter stated that inclusion of Medicare Part D data would result in a stronger measure.

Steering Committee Response:
The committee agrees that additional analysis would need to be conducted to determine the transferability of validity results to a cancer patient population. As specified, the measure currently excludes cancer hospitals.

Furthermore, additional analysis on risk adjustment approach specific to PPS-Exempt Cancer Centers' patient population and the 90-day look back period would need to be conducted before the measure was specified for a cancer patient population.

The Resource Use Steering Committee generally agrees with the commenter that facilities being held responsible for the utilization and associated costs for patients that they transfer to other facilities would foster better collaboration resulting in more efficient and effective care. This collaboration fits with the philosophy of holding a facility responsible for care delivered up to 30 days post discharge.

The Committee agrees that inclusion of Part D data would create a stronger measure. They recognized the limitation in the availability of these data; however, they encouraged the measure developers to consider additional strategies to include these costs in the future.

Attribution

- Commenters cautioned that this measure is only suitable for reporting at the facility level and should not be analyzed or reported at the individual clinician level. Commenters stated concern that the measure has not been tested or specified for this analysis at the individual clinician level.
- Commenters also agreed with the Steering Committee recommendation that this measure be reported with quality measures, in order to provide meaningful information about the efficiency of health care delivery.

Steering Committee Response:
The Steering Committee unanimously agreed that cost and resource use measures must be paired with quality measures in order to understand and make decisions about care. The Committee agrees with the commenter that measures of efficiency, and ultimately value are critical tools needed to improve the efficiency of US health care system, specifically encouraging shared accountability and team-based care.

Measures endorsed by NQF are only endorsed for use at the specified level of analysis that the measure developer has provided testing for; in this case, that would be at the facility level. The Steering Committee has only recommended this measure for endorsement for analysis at the facility level.

Risk Adjustment

- Several commenters stated concern that the risk adjustment methodology was not valid for the following reasons:
    - Lack of a socio-economic status (SES) adjustment (i.e. dual-eligible status).
    - Testing results demonstrating clustering of large, urban, teaching hospitals that treat a large proportion of low income patients with higher MSPB index rates than their community hospital counterparts, possibly due to the risk adjustment not accounting for the ranges of patient complexity that exist between and within MS-DRGs or that case mix is driving he differences in measure score.
    - Risk stratification using MDC criteria alone is inadequate and will introduce significant variability in the MSPB rating based upon patient-specific and diagnosis-specific factors that are not adequately encompassed in the MDC classification.
    - Concern that the 90-day look-back period to capture a patient's comorbidities in order to determine the HCC score is insufficient.

Steering Committee Response:
The Committee reviewed the concern around the clustering of large, urban, teaching hospitals that treat a large proportion of low-income patients raised by the commenters. They voiced concerns on both sides of the issue of including SES adjustment with some members agreeing with the Commenter that disadvantaged patients with multiple complex conditions will require more resources to treat, while other members argued that including SES variables in the risk adjustment model will mask disparities in cost performance among different groups of patients. The Committee acknowledged that hospitals are legitimately held accountable for taking appropriate care of patients within the case mixes and making sure that these patients receive appropriate post-acute care, however, the availability of these support services will vary from community to community.

The Committee recommended that additional work be considered in this area, specifically the appropriateness of including dual-eligibility in risk adjustment models for resource use measurement.

The Committee considered the major diagnostic category (MDC) risk stratification criteria, specifically applying the risk adjustment within MDC to be generally appropriate for this application. For the purposes of performance measurement, factors that are included in the risk adjustment model should be present at the start of care – thus including procedure codes that occur during the measurement period would not be appropriate.

The Committee also expressed concern over the 90-day look back period but ultimately agreed that the performance of the models did have a slightly improved model fit over the models with a year of look-back.

ACTION TAKEN:

- After review and discussion of the comments on this measure, the Committee re-affirmed their decision to recommend this measure for endorsement (Y-17; N-8).

NQF MEMBER VOTING RESULTS

As noted above, consensus was not reached by the NQF membership on the measure, with 43% of councils approving. Representatives of 42 member organizations voted; no votes were received from the Public/Community Health Agency Council. Voting comments for the measure are provided below.

Voting Comments:

- AmeriHealth Caritas: Considering the number of issues raised during comment period, this measure as it stands should be considered a good starting off point for more accurate successor measures.
- Next Wave: We voted to approve the measure as specified and acknowledge that risk adjusting for dual eligibility status could mask performance opportunities. However, we also recognize that costs are consistently and measurably higher when treating patients with complex social disadvantages (language, literacy, low income, lack of informal supports, etc.) to achieve the same health outcomes. Additional costs include providing competent care across many different cultures, patient education that addresses basic literacy as well as health literacy, post-discharge transportation to fill prescriptions and get to MD visits, home visits to assess informal or provide direct post-discharge support in the Community, etc. When applying this measure for Value Based Purchasing, it should be stratified to compare hospitals with similar social determinate/population complexity. Otherwise, hospitals will be perversely rewarded for not admitting these high need patients and penalized if they do admit these high expected cost patients, likely increasing health disparities. This measure application issue should be placed on the agenda of the MAP.
- American College of Cardiology/ American Heart Association Performance Measure TF: This resource measure should be used in conjunction with a quality measure.
- American College of Cardiology: This measure should only be used in public reporting or provider incentive programs when tightly associated with related quality of care measures. No provider should ever be rewarded for lowering costs at the expense of patient care.
- American College of Surgeons: The American College of Surgeons (ACS) has concerns regarding the validity of the MSPB measure. The risk adjustment methodology does not adequately account for socioeconomic status (SES) and therefore does not consider the ranges of patient complexity and circumstances that are out of the provider�s control. As a result, the lack of risk adjustment for SES may unfairly impact providers or facilities that care for disadvantaged populations. Additionally, we realize that the MSPB measure is being considered for endorsement as a facility-level measure but we encourage NQF to recommend against the implementation of this measure as a physician-level measure unless otherwise tested and specified at the physician-level. The ACS opposes reliance on the implementation of measures in

the public domain which were endorsed by NQF for one level of measurement yet implemented at a different level of measurement for which they were not validated.

- American Hospital Association: While we commend CMS for carefully thinking through many aspects of this measure in developing it to respond to a specific legislative mandate in the ACA, we remain concerned that the risk adjustment is insufficient, the testing results are problematic and, as noted by many commenters, there are significant issues with some of the inclusion/exclusion decisions that likely mean this measure" does not yield results that are suitable for comparison purposes. Before receiving the imprimatur of an NQF endorsement we believe more work is needed. We are particularly concerned that there is no adjustment for factors that are totally outside the control of the hospital and individual clinician groups. These are factors related to the resources available in the community served by a hospital or physician group. We talk about these as adjustments for "socio-economic factors" and in a way they are but they are really adjustments for the fact that inadequate primary care wellness care and so forth exist in many communities of lower income and as a result Medicare patients end up in the hospital with many concerns that need to be addressed. We need to attend to these issues before this and many other measures receive NQF endorsement."
- America's Health Insurance Plans: While this measure represents a good start for assessing hospital cost and resource use, we encourage further refinement by CMS. Future iterations of this measure should remove existing exclusions such as deaths and hospitals transfers. These exclusions remove more seriously ill patients, who represent significant opportunities for reduced spending such as spending associated with potential overuse of services provided at end of life.
  We also recommend exercising caution when implementing this measure and drawing conclusions from its use. For example, excluding transfers would solidify fragmentation of accountability and remove motivation for referring and receiving hospitals to collaborate on more efficient and effective care.
- AAMC: We are concerned with the lack of socioeconomic status adjustment in this measure.
- Infectious Diseases Society of America: The Medicare Spending Per Beneficiary (MSPB) measure is concerning since it evaluates costs related to the totality of services furnished to a patient surrounding an inpatient hospitalization. This includes all Medicare Part A and Part B payments during the episode, which spans from 3 days prior to an index admission through 30 days post discharge, with certain exclusions. In the Voting Draft Report, it states, “The Steering Committee unanimously agreed that cost and resource use measures must be paired with quality measures in order to understand and make decisions about care.” Similarly, IDSA believes it is critical that cost measures have a more direct link to the quality measures used to assess value. Conclusions about the value of medical care will have little significance if the cost and quality measures on which they are based focus on different elements of care. The IDSA believes it is important for each physician caring for a patient to understand how he/she contributes to the patient’s total cost of care. However, it is not necessarily appropriate to hold each of these physicians accountable for the patient’s total cost of care. We fear not only physicians being held responsible for decisions outside of their control, but unintended consequences such as physicians not ordering labs prior to prescribing antibiotics in order to minimize costs, which could lead to inappropriate antibiotic use, increased drug resistance, and harm to the patient, as well as the general public. Therefore, until this measure is fully developed and tested to accurately reflect care over which the individual clinician has control, IDSA cannot support endorsement of this measure.