NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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2:00 p.m. ET

Operator: Welcome to the conference, thank you for participating in today's Cost and Resource Use Steering Committee Conference Call.

This conference call will be open to measure developers and the public. However, please remember, this is steering committee's time to deliberate and discuss these very important issues.

Measure developers and the public will have an opportunity to provide comments that will help to inform the committee's discussions when invited to do so by the steering committee's co-chairs, other members of the steering committee or NQF staff.

Please note that this call will be recorded and transcribed. The recording and transcription will be posted to the projects page on NQF website within 7 to 10 business days of the conference call.

Thank you very much for your interest and participation. Please standby.

(Lindsay Tyson): Great, thank you. This is (Lindsay Tyson), NQF. I just wanted to thank everybody for joining us today. In this call, the goal is to discuss the comments received and the additional analysis provided by the developers for Measure 2158 which is the Medicare Spending per Beneficiary measure. I believe Dr. Penson is on the call with us and Dr. (Nelson) was unable to join us, and then I'm joined here by NQF staff, Taroon Amin and Ashley Wilbon and Evan Williamson.

I'll go ahead and set this off. We have asked the developers for Measure 2158 to provide some slides for you all to explain the additional analyses that were performed during the comment period, and after the in-person steering committee meeting. So, I will turn it over to that group and pull up their slides for you all to view.

Sajid Zaidi: OK. Can everyone hear me?

Male: Yes.

Male: Yes.

Male: Yes.

Sajid Zaidi: Great. Good afternoon. My name is Sajid Zaidi. I'm an Associate Research Manager at Acumen LLC and I'm on the Measure Development Team for Measure 2158 Medicare Spending per Beneficiary.

I'd like to thank the committee for this opportunity to provide an update on all the analysis and research we've done since the committee meeting in May. The committee made many suggestions for further analysis during that meeting and I'm happy to say we've had a chance to research almost all of them.

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I just like to begin by quickly recapping the measure specifications. The MSPB measure as you will recall is the spending measure for hospitals. It includes all Parts A and B claims from three days prior to admission to 30 days post-discharge.

There are also certain exclusions which we discussed on subsequent slides such as the exclusion of episodes containing a transfer from one acute hospital to another, and we're aware that some committee members expressed concern with this exclusion and we understand the concern about not capturing the Medicare dollars associated with these episodes.

However, we believe this exclusion was the best approach given the public comments we received on the measure which asked CMS to exclude transfers, as well as the concern with disadvantaging small rural hospitals or academic medical centers since a disproportionate number of transfers are from rural hospitals to urban medical centers. The measure is an all-condition measure and the claims are payment standardized and the episodes are risk-adjusted. And it applies only to IPPS hospitals in the 50 states and Washington D.C.

Next slide, please.

So, this slide lists all the concerns the steering committee had as we understood them and also lists of research we've done in response. I'm not going to read through each of these here since we're going to go through each one in turn but we wanted to include this slide so you have it as a reference and overview.

Next slide, please.

So, the first analysis we did was related to validity. The committee wanted to see correlations of the MSPB measure with other utilization or cost measures. So, the first measure we correlated with was an overall service utilization measure and this is the sum utilization measures for each of the different service types. So, we used in-patient and SNF days, home health visits, physician line items, et cetera. And we found a correlation of 0.22.

Next, we looked at HRR level averages of the MSPB measure and correlated it with an HRR level, risk-adjusted standardized per capita spending average for the Medicare population and we got this as it was published by the IOM committee on Geographic Variation. And we found an HRR level correlation of 0.55.

Next, we did the same correlation with the same HRR level per capita spending but this time for the under-65 commercially insured populations in the MarketScan database. Again, these were published by IOM. And remarkably we find a correlation of 0.37. So, the MarketScan population is an entirely different population with a different payment system and yet it shows

a similar pattern of resource used geographically as the MSPB measure does for Medicare.

We conducted – for the next two, we conducted some of our correlations with subsets of …

Male: Wait, wait – I'm not – it's not clear to me what level the correlation is being done at. Are these patient level – clearly patient level correlation, hospital level correlation, service (inaudible) correlation?

Sajid Zaidi: HRR level correlations, so we took the HRR level average of MSPB scores for hospitals in that region as well as the HRR level per capita spending that was published by IOM.

Male: Thank you.

Sajid Zaidi: Yes, so the next two were for subsets of the MarketScan database, the AMI and stroke cohorts. These are two cohorts which are more likely to use inpatient services. And we found HRR level correlations of 0.14 and 0.28.

The final correlation we did was we constructed a similar – basically an equivalent of the MSPB measure for the Medicaid population for non-dual Medicaid beneficiaries. And we found a correlation of 0.62. So these correlations were all positive and statistically significant, and taken as a whole we believe that these results indicate that the MSPB measure is correlated with other validated measures of utilization and cost.

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So, the committee also asked us to look at stratifications of the measure by hospital and patient level characteristics so that we could see whether MSPB follows the same patterns that are found in literature. We found that larger hospitals, urban hospitals, hospitals with a higher percentage of Medicare patients, teaching hospitals and hospitals in the South and North East have more expensive MSPB episodes.

At a patient level, we also found that black beneficiaries had more expensive MSPB episodes than whites. Women have more expensive episodes than men and dual-eligibles have more expensive episodes than non-duals. And as a reminder, risk adjustment doesn't adjust for race, gender or dual status. All these findings are consistent with the literature, for example, what can be found in the (Dartmouth Hour).

Next slide, please.

So, next we tested the impact of certain exclusions. So, first we tested the impact of the transfer exclusion. We included the transfer episodes and assigned them to both the receiving and transferring hospital and we found that the results were very highly correlated with the original results, correlations of 0.97 and 0.99, depending on the weighting scheme used.

In addition, as I stated before, we believe the transfer exclusion is appropriate due to the comments we received and due to the concerns with disadvantaging small rural hospitals. Yes, so the next exclusion we tested was the outlier exclusion. As you'll recall, the measure excludes episodes that are in the top and bottom 1 percent in terms of their residual. And including outlier episodes results in an MSPB scores that is highly correlated with (regional) results, a correlation of 0.95.

So, I think these two analyses show that even if the committee is concerned about these exclusions, they have very little effects on the final MSPB score.

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So, our final validity analysis was related to risk adjustment and we did a few things here. The first suggestion from the committee was to include diagnoses present on admission in the HCC model. And as you can see, that didn't materially change the R-squared. It went from 0.45 to 0.46.

The second analysis we did was the decile plot analysis to investigate model calibration and I'll show a figure on the next slide, but basically it shows that the mode is fitting well throughout the distribution and it's discriminating between high-cost and low-cost episodes.

The third test we did was to test using the natural log of costs as the dependent variable instead of the level of costs, and we actually found that that's slightly worsened the R-squared of model, although it wasn't – it's not by a lot.

Next slide, please.

So, this figure shows the decile plot analysis that I referred to you, and you can see that predicted spending and observed spending closely track each other throughout the distribution. So that indicates that the risk adjustment model is discriminating well.

Next slide, please.

So, some committee members asked us to break down the total cost variance into the portion due to post-discharge cost variations versus in-hospital cost variation. In the May meeting we did present this breakdown but for non-risk-adjusted costs and the committee asked us to do the same thing for risk-adjusted costs.

So, as you can see in this figure most of the variation and risk-adjusted cost is due to post-discharge cost variation, around 80 percent, and this is because our risk-adjustment model adjusts to the MS-DRG of the initial admission which adjusts the way most of the variation in hospital costs. So in this figure you can see that the black bar is total variation while the blue bar is post-discharge variation.

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So, this is related to reliability. So while we don't have a new analysis for reliability we wanted to clarify some of our findings from the May committee meeting. There is a lot of discussion by the committee about the meaning of our test-retest analysis. So, as a reminder we randomly split our sample into two non-overlapping halves and constructed hospital level MSPB scores for each of these halves. So thus we calculated two sets of MSPB scores on two completely separate tested beneficiaries. And we found a remarkably high level of correlation between these separate sets of MSPB scores. It was 0.84.

So we believe this indicates a highly stable and reliable measure. Some committee members were concerned by the fact that 70 percent of the hospitals in the top quintile in one set were in the top quintile in another set. And I would just reiterate that this is actually a very high number for a quintile stability analysis, as one would only expect 20 percent of hospital stay in the same quintile by random chance. In addition, 90 percent of hospitals in the top quintile in one set remain in the top two quintiles in the other set. So, taken as a whole, the test-retest analysis indicates a stable precise measure.

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I think somebody had requested us to investigate the difference between an 8-month period of performance and the 12 month period of performance. And we conducted that correlation and we found a correlation of 0.97 between these two specifications.

Next slide. So, this is the final slide.

A lot of committee members emphasized the importance of using cost measures in conjunction with quality measures. And we just wanted to reiterate that starting in Fiscal Year 2015 the MSPB measure will be used as part of the Hospital Value-Based Purchasing Program in conjunction with clinical process of care measures, patient experience measures and outcomes measures. In addition, the MSPB measure is already reported on the Hospital Compare website alongside many quality measures. So, we do plan on using the MSPB measure in conjunction with measures of quality.

And finally, some committee members asked how hospitals could actually use this measure to identify cost drivers. And so I wanted to reiterate that CMS provides each hospital with a large amount of information to facilitate this to drill down. So each hospital receive the data files which lists every single MSPB episode that was attributed to them, the beneficiary HIC number, as well as the spending breakdown for each hospital – or a spending breakdown by type of service, period and condition. And the file also identifies the top five providers for each type of service. So, it identifies skilled nursing facility, provider numbers, health agency provider numbers, et cetera. And

the reports also show aggregates spending breakdowns by type of service for the hospital.

So we believe this information allows each hospital to see where it is performing, you know, worse than average and it can also dig down into each individual episode to look at specific examples of what's causing that performance.

So that's – I think that's the final analysis we have. I thank you for the opportunity to present our work and we're happy to answer any questions you may have.

(Lindsay Tyson): OK, this is (Lindsay). We'll just take a few minutes now for the Steering Committee to ask any questions to Acumen about the presentation that they just went through.

David Redfearn: This is David Redfearn, just a sort of a conceptual question. If this is a measure of a sort of a hospital episode and the vast majority of the variation, the cost occurs post-discharge, is it being labeled correctly? Is the measure being labeled correctly? And how are hospitals expected to control that post-discharge cost?

Sajid Zaidi: So we believe that through – there's a lot of opportunity to, you know, discharge planning and coordinating with other providers in the community that there's lot of opportunity to reduce total cost to Medicare. And as specified, the measure is called Medicare Spending per Beneficiary so it includes all spending for a hospital episode which runs from, you know, three days prior to hospital admission to 30 days after hospital discharge.

Male: I appreciate it. (Inaudible).

Sajid Zaidi: David, do you want to respond to that?

David Redfearn: No. But I still have concerns about labeling. And actually, as long I'm on and then I'll shut up. One of the thing that was – one of the issues that was – that some of the commentators pointed out which is the difference between urban and rural hospitals in Minnesota, I think that was the example used. And I

guess my – the conclusion that I drew from that and you guys haven't commented on that issue is how adequate is the risk adjustment that you're doing?

It's not – it raises the issue we had in the discussion about using only 90 days, using HCC model for only the 90 days prior to the indexed admission. And you guys explained that going to 12 months didn't seem to help any of that. But I still wonder a little bit about whether the actual risk-adjustment that's being applied in this case is adequate. And that was – that seem – struck me as the major kind of issue with regard to this measure that was reported by the people that were commentating on it and you guys haven't mentioned that, so I'd be interested in your response to that exact question.

Sajid Zaidi: Yes. That's a good point. We, as you stated, our analysis show that using a 12-month look back actually didn't make any difference to the risk adjustment. I would state that our risk-adjustment model sort of adjusts for everything possible. So not only HCCs and demographics but are also adjust for the MS-DRG which is the largest, you know, the largest driver of healthcare spending in the hospital setting.

So, the other point I would make is on the urban/rural issue. That's a finding that is you can find in the literature for most cost measures. You'll find that urban areas spend more than rural areas regardless of what method of risk adjustment is used, whether it's HCCs or DxCGs, you'll usually find that urban hospitals or urban areas spend more than rural areas. So, I don't think that that finding alone indicates the problem with risk adjustment because it could just be patterns of resource use in urban areas versus rural areas.

David Redfearn: OK, thanks.

Jack Needleman: This is Jack Needleman I got a follow up question on the risk adjustment issues. As you noted, the risk-adjustment measure has pretty good R-square, but as you noted the primary DRG for the patient which embodies the estimated hospital – indeed it has the hospital payment associated with it is part of the risk-adjustment model. So did you do any analysis of the residual variance which you showed with considerable after you excluded the hospital

cost? Did you do any analysis of the residual variance, the variance not explained by DRG and how well the risk-adjustment model performed – the rest of the risk-adjustment model performed on explaining that variance?

Sajid Zaidi: So, are you asking how much the MS-DRG adds to the risk-adjustment model in terms?

Jack Needleman: Yes, but basically – yes, in a slightly different way. I'm saying – I forgot what the R-square was to the total risk-adjustment model, but some of that is explained by the MS-DRG. So, the question is how much of the residual variance, after you take into account the payment to the hospital, say, which is, the core of this measure. Since we're trying to explain the – basically trying to explain the variance in the non-hospital cost, how well does the rest of the your – rest of the risk adjustment do in explaining the residual variance?

Sajid Zaidi: I don't think we looked at that specifically but now we'd be happy to – we'd happy to look at that.

Jack Needleman: I would appreciate that because that that's to me, the real measure of the effect of the risk adjustment in this model. It's not the – it's not the DRG payments that's fixed regardless of the other characteristics of the patient or the circumstances.

David Redfearn: Yes, this is David again. I mean that addresses – that focused on the issue again that most of the variation you're seeing is post-discharge that is non-hospital with back out with the physicians and the follow up care. So, I think Jack is asking a very good question about, is that adjustment is that risk adjustment working well? The MS-DRG, is this going to work pretty well for the hospital? I think we all agreed but since the variation is post-discharge, sort of post to MS-DRG, how was the adjustment working in that context?

Sajid Zaidi: Yes, so we can definitely look at that. I would just say that interpreting that figure that says that – the figure shows that after risk adjustment most of the residual variation is due to post-discharge costs but it doesn't imply that our risk adjustment isn't working well for post-discharge cost. So, that would be an analysis for you to have to do further basically to see what the R-squared is just looking at post-discharge cost and we'll be happy to do that analysis.

David Redfearn: I would appreciate that. And keep in mind you've already supping up variance, so it's basically the R-square on residual variance to direct out the variance from the DRG and you're just trying to estimate the rest of it.

Sajid Zaidi: Yes.

Male: OK.

David Redfearn: OK, it's a …

(Lindsay Tyson): If there are no other comments from the Steering Committee we'll go ahead and move into a discussion of the public and member comments. OK, so we'll use the memo to orient the conversation.

So, we received comments on Measure 2158 from 20 organizations and individuals. Three of the comments were supportive that and they noted that this measure is an important first step towards an optimum measure of hospital resource use. One comment there acknowledged that were some methodologic concerns that the intent of the measure is clear and necessary.

The majority of the comments addressed several themes. The first theme that the comments addressed were the exclusion of death. Two commentaries question the exclusions of death noting that they believe the measure would be a stronger measure if the cost per patient death were included. And one comment here has supported the exclusion of death and also called for the exclusion of hospice same incident in order to maintain the internal consistency of the measure.

And so, I open it up to Steering Committee discussion of the exclusion of death for Measure 2158.

(Lisa Rands): This is (Lisa Rands), I'll just – I mean this was something that that we discussed at the meeting and I had come to it as well but I thought it wasn't – there wasn't a way to do it. I thought that was the issue.

(Lindsay Tyson): OK, I guess we can instead frame it as – and you have (staff, provost) with Steering Committee response to this that the committee agrees with the

commentary that the inclusion of episodes where the patient dies would create a stronger measure. The end-of-life care is high cost for Medicare and important for measurement and improvement and noting that the developers know that the exclusion was finalized (due) notice in comment rule making based on the fact that these are incomplete episodes where significant data could be missing.

I guess for this that we'd like two slides for discussion with the commentary note about the need to exclude hospice payments in order to maintain the internal consistency of the measure.

David Redfearn: This is David again, I mean I'm frankly concerned about excluding deaths and the argument that the episode is incomplete is likely true but I don't know how important that is as an argument since we've already acknowledged that the cost of these death episodes are much higher anyway. So, I wouldn't worry too much about that.

The argument against the transfer, excluding transfers that I understand, that's a very difficult situation about figuring out where to put them. But that the information about death is available. Obviously, we know which patient's died because they've been excluded and you're going to have those cost right up to the death, I would think unless there's something I'm missing, unless there's some other issues that I don't understand.

So, I would have some concern about excluding deaths since so much of that cost is associated with the last, you know, year of life in these patients. I think that's a huge part of this.

Female: I thought the deaths weren't excluded it's just an incomplete episodes were excluded. And so deaths were a part of that but they didn't know which of the incomplete episodes were deaths versus incomplete episodes for other reasons.

David Redfearn: Developer?

Sajid Zaidi: So, I guess in one sense that's right, we only include patients who have enrollment in Parts A and B from three days prior or actually 93 days prior to

admission up through 30 days after discharge. So, I guess that requirement would exclude people who passed away during that time period.

David Penson: So, basically – this is Dave Penson. So, if I understand it correctly if you have a death during the time period you're excluded, is that right?

Sajid Zaidi: Yes, that's correct.

David Penson: Yes, so I think that's what public comments was raising and I think that's what David Redfearn is raising and I'm going to agree with them. I mean I think that introduces tremendous bias.

(Joe Stefanski): This is (Joe Stefanski), I agree actually with the developers on this one and that the high cost of a patient that dies in the last one or two years – that the cost in the last one or two years is very high but they're spread up potentially over very many different hospital episodes. And we're only catching the tail end of the end-of-life cost and here I'd rather leave them out. And I think the hospice cost ought to be still in there.

(Lisa Rands): So, again this is (Lisa), I guess just a question for the developers, (Lisa Rands). I would rather have them in but my understanding is they can't be in just methodologically but there's no way to identify of the incomplete episodes who died and who didn't, is that correct?

Sajid Zaidi: No, we can identify who died and actually in the memo we've submitted there was an analysis on death episodes and we found that episodes where the patient died did have higher spending. Yes, so we can identify patients who passed away.

(Joe Stefanski): So, let me see if I understand how the deaths plays out here since we've got hospice in. Patients who are anticipated to die and going to hospice we've got their hospice cost, if they died during, we'll look at – during the look-forward period, the post acute period, within that period, those patients are excluded. But if patient survives during that period even though they're in hospice they are included.

Sajid Zaidi: Yes, that's correct.

(Joe Stefanski): And do the patients with hospice also have higher cost? Have you looked at that?

Sajid Zaidi: No, we haven't looked at that. I mean the reason we excluded death originally was for the incomplete episode reasons. So, somebody dies let's say on the operating table in the hospital, the entire look forward period of 30 days post discharge is – it's no longer there. So we thought that that would be – it's very difficult to compare an episode like that to episodes where the patient has that full period. And we also thought that mortality measures are also – are already publicly reported, so that aspect of quality is already being publicly reported.

(Joe Stefanski): Right, but if the patient dies on my operating table in the initial admission, there are no post hospitalization costs. If you're using the standard DRG payments for that patient we would expect those patients to be lower. The fact that the patients who die have higher cost suggests that most of the patients who are dying or being discharged from the hospital and is dying somewhere in the post admission process getting a variety of different kinds of care possibly a readmission.

So – and if your image was – they're dying on the table, we're not going to get the full post hospitalization cost here. That simply isn't supported by the fact that they have higher cost.

Sajid Zaidi: I think they have higher cost on average but there are – but I think it's a bimodal. There are some patients who die during the hospital who would have lower cost just by virtue of the fact that they don't have that 30-day post discharge.

So, there's two – there's basically two groups of patients, those who die in the post discharge period and those who die in the hospital. And I think both have the incomplete episode problem but it's just – that problem is more severe for those who die in hospital.

Brent Asplin: This is Brent Asplin. I felt that the exclusion of death was a bigger issue if I remembered correctly in 2165 that it is in 2158, and from a policy standpoint

that longitudinal capture of the greater cost in the last year of life seems to be more important in the total per capita spending measure than it is in this MSPB measure partly because of what we just talked about. It's probably going to be a bimodal distribution here and – I mean it would be interesting to look at it with the deaths in compared to what we have in front of us, or I'm just not sure from a policy standpoint. I think it's more important than the longitudinal per capita cost measure than it is in this episode-based measure.

Sajid Zaidi: Yes.

(Lindsay Tyson): OK, on that note I guess we'll move on to the discussion of other exclusions in the measure. We received comments that – one commentary expressed concern that exclusion of transportation from other acute care facilities may affect a larger portion of the PPS-Exempt Cancer Center patient admission when compared to PPS-Hospital Admission. One commentary expressed concern that exclusion of transportations could remove more seriously ill patient which represents significant opportunity to reduce spending. And one comment just stated that inclusion of Medicare Part D data will result in a stronger measure.

So, the suggested Steering Committee response the – to the first comment we agreed that there be a need for additional analysis to understand the transfer validity of validity result to a cancer patient population however, the measure currently specified to exclude cancer hospitals.

It was also noted that additional analysis on the risk assessment effects specific to PPS cancer, exempt cancer centers patient population and the 90-day look-back period would need to be conducted before the measure specified for cancer patients population.

Based on (inaudible) meeting, the Steering Committee agreed with the commentary that facilities being held responsible for the utilization in associated cancer patients that they transfer to other facilities with faster, better collaboration resulting in more efficient and effective care. This collaboration fits to the policy of holding facility responsible for care

delivered up to 30-day post discharge. And the committee also agreed that inclusion of part D would create a stronger measure.

Are there any comments or questions about the comments or the response?

Sajid Zaidi: Keep going.

(Lindsay Tyson): All right. The next theme of comments was related to attribution. Some commentary have cautioned that these measures is only suitable for reporting at the facility level and should not be analyzed or reported at the individual clinician level. Commentators also agreed with the committee recommendation that this measure needs to be reported with quality measures in order to provide meaningful information about efficiency in healthcare delivery.

The committee response notes of this measure was specified only for the reporting at the facility level, (inaudible) there's only for reporting at the facility level. So the measure if it's recommended for endorsement would only be for analysis at the facility level. And then, the Steering Committee also unanimously agrees that cost and resource use measures must be paired with quality measures in order to understand and make decisions to healthcare.

Are there any comments about these?

Cheryl Damberg: Hi, this is Cheryl Damberg. Regarding the slides that were shown at the start of the meeting around variation and much of these is driven by the post-acute care setting. I guess these raises the issue – at least in my mind about whether there should be some joint accountabilities because, otherwise I guess the option for hospitals is, you know, to stir business to lower-cost providers and help at the market causes change. So, is this something that could be considered for really trying to increase coordination and – I mean essentially that's the concept behind an ACO is you're trying to get everybody to work on bringing down price.

(Lindsay Tyson): Are there anyone from Acumen with a response?

Sajid Zaidi: I don't think we have a response to that. I would just say that, you know, we submitted this measure for hospitals specifically and I don't think I can comment on creating new measures in the future for other provider types but, you know, this measure is specific to hospitals.

(Lindsay Tyson): OK, if there are no other comments we'll move on to the discussion of risk assessment.

Several commentary stated concern that the risk-adjustment methodology was not valid and gave several reasons the first being a lack of a socio-economic status adjustment. Other specific comments to explain this so that CMS's analysis demonstrate that dual-eligible patients have 859 more spending per episodes than other patients. The agency finds that including patient dual-eligible status as a risk adjuster marginally improved the fit of the risk-adjustment model. But the same analysis also demonstrates that about 12 percent of hospitals would have their MSPB measure values changed by more than 1 percentage point of dual-eligible status for inclusion of risk-adjustment model.

About 10.8 percent of hospitals scores would decrease by between 1 and 3 percentage points, nevertheless CMS chose to not include a dual-eligible adjustment in the measure. The second reason, testing results demonstrating clustering of large urban teaching hospitals that treat a large proportion of low-income patients with higher MSPB index rates from their community hospitals counterpart possibly due to the risk adjustment nor accountings of the ranges of the patient complexity that exists between and within the MS-DRGs or that case mix is driving the differences in measure score.

The first comment in this theme, the actual results of the MSPB suggests that the case mix adjustment isn't working properly. In Minnesota, for example, hospitals in urban areas have similar scores clustering around 0.93 and greater than Minnesota have a score of almost all that 7.88 because there are large differences in the types of conditions treated by urban and rural hospitals, it raises a concern that the case mix is driving the differences versus actual differences in invested resources.

For second comment, we thank NQF for the opportunity to comment on the Cost and Resource Use Measures. We have several areas of concerns with this measure that should be addressed prior to endorsement and the MSPB results that have been published by the developer there's notable clustering of large urban teaching hospitals that treat a large proportion of low-income patient with higher MSPB index rate from their community hospital counterparts. We believe this is due to insufficient and clarity adjustment on the measure that does not account for the ranges of patient's complexity that exist between and within MS-DRG.

Since large urban teaching hospitals has a large share of low-income patients have the capability to treat more complex patients or community hospitals often do not and have a higher proportion of complex cases that require more hospital resources and also more likely to have home care or skilled nursing test following the in-patient admission.

This mix of more complex patients could be a contributing factor and the clustering being seen in the results. The way we'd expect that more normal distribution of MSPB results across all hospitals. It's another we're (appropriately) severity and risk adjusted and adjusted for outliers.

Commentaries also raised concerns after the risk stratification using MDC criteria alone is inadequate and will introduce significant variability in the MSPB ratings based upon patients-specific and diagnosis-specific doctors whether or not accurately encompassed in the MDC classification. The last concern that the 90-day was (inaudible) the capture our patients comorbidities in order to determine the HCC score is insufficient.

The suggested Steering Committee response noted that at the meeting the committee members raised concerns on both sides of the issue including SES adjustments. But there's some committee members agreeing with the commentary that disadvantaged patients with more poor complex conditions will require more resource to the treat. Where other members argue either including SES variables in the risk-adjustment model would not match disparities and cost performance among different groups of patients. The committee recommended an additional, where as, we considered (MSES)

specifically the appropriateness of including dual eligibility in risk-adjustment models for recent use measurement.

For committee discussions, is the review on the concern of costing of larger than teaching hospitals that treat a lot of proportion of low-income patients which was raised by the commenter. And also the concern around the actual results of the MSPB in case the mix adjustments that was raised during the comment period. With respect to the major diagnostic category risk status case criteria, the committee found this to be generally appropriate for this application.

With regards for the 90 and look-back period, the committee initially expects concern but ultimately agreed that the use of performance in models did have a slightly improved model set over the models of the year of look back.

Pause that because that was a lot. Potentially we're going to start with any comment on the SES markers inclusion in the risk adjustment model?

Brent Asplin: This is Brent. I want to ask and I'm being curious from an NQF perspective given the consistency of the responses in the Excel file and so forth. You know that the committee recommended additional work in this area and this may or may not be the right forum but do we even have a thumbnail of what the additional work might look like because obviously this SES issue is a broader than just as measure in a context of how we address resource use measures more broadly.

Ashley Wilbon: Hi, yes, this is Ashley. We actually are expecting some upcoming work this fall to begin that is specifically focused around the appropriateness of inclusion of socio-economic status, or markers of socio-economic status in the risk-adjustment model. So it will be a project that we'll be specifically focused on that. We'll be convening experts to discuss those issues and potentially provide some guidance around appropriateness of application of – or inclusion of SES in specific instances, or when it's appropriate, when it's not appropriate and so forth.

So, we are expecting some additional work in this area. Unfortunately, it won't be completed in time to provide any guidance for this committee. So at

this time we're guided by the existing NQF guidance around not including the SES in the risk adjustment model and stratifying for differences at that point.

(Helen): But it's definitely – this is (Helen), definitely works for the discussion on the part of committee obviously.

Ashley Wilbon: Right. I'm not sure if that helps or not but …

Male: Yes, that's helpful thank you.

Ashley Wilbon: OK.

Sajid Zaidi: So Ashley the contents is do not take SES into account and that's being reexamined. Is that the quick version of what you just said?

Ashley Wilbon: Yes, essentially. Our guidance has traditionally been that we would prefer to be able to see those differences rather than having them somewhat masked in risk-adjustment models and use stratifications. But again, I think, you know, given all the concerns about what we've heard about. This measure readmission measures with others. It's an issue we're going to be reopening so I it's really – I think its worth for the discussion on the part of this Steering Committee as well.

Female: Particularly if there's any thoughts around the inclusion of SES in risk adjustments specifically for cost and resource use measures, I think generally the guidance that we had developed previously was developed with quality measures specifically in mind before we had kind of expanded our work in this area. And so, primarily why the upcoming work around the risk-adjustment is so timely as we have, as NQF kind of expanded our scope of the types of measures that we evaluate where these issues are particularly highlighted around risk – I'm sorry, readmissions measures, cost and resource use measures and so forth that are used in – if you will, high-stakes applications.

So, to (Helen's) point, if anyone has any thoughts around including SES or not including SES in risk adjustments particularly for the purposes of measuring cost, we definitely be interested in hearing any input you have.

David Redfearn: This is David Redfearn. I'm comfortable with the rules that you're using now and primarily it's because the risk adjustment methodology is primarily a diagnostic-based methodology. It's trying to measure the underlying conditions of the patient and then translate that into something that you can use to characterize the morbidity of the patient.

When you bring in things like dual-eligible status, SES, things like that, that obviously has influence on cost but for – it's seems to me for a very different reason that has – it's social that has that in terms of, you know, sort of traditional behaviors whether people are likely to seek help for medical problems if it comes up, access, issues things like that. There are all kind of social issues and so, it bothers me a bit to plug both of those very different kinds of things, diagnostic-based and social-based into some measure of risk adjustment adjusting it away.

So frankly, I am very comfortable with the approach that NQF has specified so far and I'm comfortable with it for this measure. I don't think we need to do anything about this measure. I think those are separate issues. If you want to stratify on things like SES to understand that better, that makes a lot of sense to me but I wouldn't be in favor of mixing them into some overall risk adjustment.

Jack Needleman: This is Jack. I got to admit, I'm torn on this issue for this measure because it's going to be used for payment. And the questions that are raised here were up is or about accountability and whether the hospital as the core provider is able to take appropriate actions for patients within the case mixes, you know, within their treatment preview in terms of planning for and making sure they're getting appropriate post-acute care. Some of that is driven by the ability of the hospital to deal with the patients. And I think they're legitimately held responsible for that. They have a language challenged population. You should be able to be accommodating to that. But some of that also has to do with the availability of support services, post-acute services and that's going to vary from community to community.

As well as varied by the types of payment that the patients are bringing into the post-acute stage even though these are all Medicare patients. But those with Medicaid may have a different opportunity set in those with other types of Medigap Policies. So, I'm really torn here about whether we're holding the hospital responsible for the absence of adequate support services in the communities to which they are discharging their patients. But I had to say I'm next, David's point I think we will take it.

David Redfearn: At this point, I agree with Jack. I'm glad that there's going to be more in depth look at this as full for our purposes given the comments in front of us in our need to make decision and vote. I'm sorry to bring us back through this but could I just ask the developer one more time to quickly focus just on the issue of dual-eligible status being in and out of the risk model and why you decided to keep it out in your testing again if any with it? And I know this is redundant, I apologize to the group but it seems like we have a lot of questions on this issue except from the developer. If you could quickly go over that specific question again, it would help me.

Sajid Zaidi: Yes. So, we did not include dual eligibility as a risk adjuster to be consistent with NQF guidelines on not risk adjusting for social – socio-economic status in order to avoid masking disparities in care along those lines. So the analysis we did was looking at what is the difference in risk-adjusted cost between dual-eligible patients and non-dual-eligible patients. And we found a difference $859 per episode. And that's out of an average episode cost of around $18,000 I think.

So it's not negligible but it's not huge either. And as the commenter stated, there were some hospitals for which including this as a risk adjuster would make a significant difference but the – yes, the reason we didn't include it was to avoid masking disparities in care.

David Redfearn: Thank you.

(Lindsay Tyson): And at this point, do we want to move on to discussion of the clustering of large urban teaching hospitals and the concern raised about the case mix adjustments not being sufficient?

Sajid Zaidi: I think we've actually sort of discussed that so far.

(Lindsay Tyson): OK, at this point we have really touched on all of the comments themes that we received. Are there any other discussion points that the committee would like to touch on? Or any specific comments that you'd like to call it explicitly for our discussion?

If not, I guess we'll go ahead and open it up for public comments. Operator?

Operator: Thank you. At this time, if you would like to ask a question or have a comment, please press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And there are no questions or comments at this time.

(Lindsay Tyson): All right, well, at this point I will turn it over to Evan to just lead you through the next steps that relates to the e-mailing that you sent out.

Evan Williamson: Thanks, (Lindsay). Yes, so they mention at the start of the call and maybe another (inaudible), you should have received an e-mail from my e-mail address via SurveyMonkey containing the link to vote to provide your final recommendation on both this measure and 2165 following the call tomorrow.

So we've given everybody a week to vote. The calls will be virtually due next Wednesday September 4th at 6 p.m. Eastern (inaudible) people are on vacation right now, people who weren't able to joined the call to vote. But if you are on your computer right now and you want to submit your final recommendation, feel free to go ahead and do that right now. Otherwise, again, if you want to review any of the materials, you can do that up until next week.

One thing, I do want a remind everybody that the e-mail I received were individualized each length was a specific link for your e-mail address so don't forward that or try to access a different link, you won't be able to. And I want you to save that e-mail because if you want to go and change your recommendation or if you need to use that link that was in the e-mail to access your vote.

So again, if you have any questions on it or you run to any issues, feel free to contact me via email or phone and I'll help you walk through that.

(Lindsay Tyson): All right, and that said we will be back same time, same place tomorrow to discuss the comments on Measure 2165, the total pre capita cost measure. And so thank you all for joining us.

David Redfearn: Hang on a second, this is David. Just to make a – just to be clear. The questionnaire is for both measures right?

Evan Williamson: That's right.

David Redfearn: So theoretically, we should wait until after tomorrow's meeting before we vote again, right?

Evan Williamson: Well, yes, you can – I mean the survey, you can reenter anytime, you can change your vote. So if you want to vote right now on 2158 and then go back in tomorrow and vote on 2165, that's a possibility. And if you want to wait until tomorrow and vote on both of them that's a possibility too.

David Redfearn: OK, thanks.

Evan Williamson: So, yes, whatever you feel comfortable with. And just a reminder I know (Lindsay) said same time, same place. It is a different webinar login tomorrow, in a different conference code so be sure to you use the August 28 agenda for conference call two tomorrow just so we avoid any confusion people trying to redial in to today's number.

Male: Can you resend that because either I (inaudible) or I don't have it?

Evan Williamson: Absolutely, yes, I can send that and right now and then tomorrow, I'll be sending out another reminder with the dial in information. And again through SurveyMonkey, you'll probably be receiving another link tomorrow for the either, serving as a reminder if you didn't submit it today that'll be sent out just to make sure that everybody gets their individualized link again.

Male: Great, thank you much.

Evan Williamson: OK.

Male: Thanks everybody for your help.

Male: All right, thank you. Thanks, everybody.

Female: Bye.

Female: Bye. Thank you.

Male: Bye-bye.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END