NATIONAL QUALITY FORUM

Moderator: Cost & Resource Standing Committee
September 24, 2014
12:00 p.m. ET

Taroon Amin: Good afternoon, everyone. This is Taroon Amin. I'm joined by my colleagues, Quintin Dukes, the project manager for this work, and Ann Philips. We're here to welcome you to the National Quality Forum Post Comment Call to discuss the public and member comments for the Cost and Resource Use Phase 3 Pulmonary Commission section of this work.

The call today, the purpose of today's call is to discuss the comments that were received during the post-evaluation public and member comment period on the pulmonary condition-specific per capita and condition-specific episode of care, cost and resource use measures.

We are looking to provide input – we are looking for you to provide input on the proposed responses to the post-evaluation comment that were provided in your comment memo.

We are also looking for you to determine whether reconsideration of any of these measures or any other course of action is warranted based on the comments that we received from NQF membership.

Before we get started with that agenda, I'm going to turn it over to Quintin to do a quick roll call of committee members and developers who are on the call. Quintin, if you would please.

Quintin Dukes: Thank you, Taroon. So, I will begin by calling out Brent Asplin? Ariel Bayewitz? Larry Becker?

Larry Becker: Here.

Quintin Dukes: Mary – can you say that one more time? Is that Larry?

Larry Becker: Yes.

Quintin Dukes: Hi, Larry. He's here. Mary Ann Clark?

Mary Ann Clark: Yes, I'm here.

Quintin Dukes: OK. Cheryl Damberg? Nancy Garrett?

Nancy Garrett: Yes, I'm here.

Quintin Dukes: OK. Andrea Gelzer? Stanley Hochberg? Lisa Latts? Martin Marciniak? Matthew McHugh? James Naessens?

James Naessens: I'm here.

Quintin Dukes: OK. Jack Needleman? Eugene Nelson? Janis Orlowski? Carolyn Pare?

Carolyn Pare: I'm here.

Quintin Dukes: OK. John Ratliff? Andrew Ryan? Joe Stephansky?

Joseph Stephansky: Here.

Quintin Dukes: Thomas Tsang? Lina Walker? Bill Weintraub?

William Weintraub: Here.

Quintin Dukes: OK. Herbert Wong?

Herbert Wong: Here.

Quintin Dukes: Dolores Yanagihara?

Dolores Yanagihara: Here. Yes, I'm here.

Quintin Dukes: OK. (Peter Alaminoff)? OK, Alan Baptist? (Dale Bradford)? (Ruben Cohen)? And (William Glove)?

OK, and also if any of the developers are from NCQA or Yale, can you please state your name at this time.

Nancy Kim: Hi, it's Nancy Kim from Yale.

Quintin Dukes: OK.

Benjamin Hamlin: Ben Hamlin from NCQA.

Quintin Dukes: We have Nancy Kim. And who is from NCQA?

(Crosstalk)

Quintin Dukes: OK. And (Amy), can you make sure that developers from Yale and NCQA also have open lines please.

Operator: Yes, they all have open line.

Quintin Dukes: OK, thank you. All righty. Well then, I will turn it back over to Taroon.

Taroon Amin: Thank you, Quintin. And we just want to make sure that everybody is able to see – I know, Quintin, just want to make sure that the post comment memo is available for people to see on screen share. I just want to confirm that the committee is able to see that.

I'll just walk through the purpose of the call again today. The purpose of the call is to review the comments that we received and then provide – just review our proposed responses to be sure that the committee is comfortable with the proposed responses, and then any determine any actions going forward. Is anybody on the call able to see the comment memo that's on the screen?

Male: Yes.

Male: Yes.

Female: Yes.

Taroon Amin: OK, great. All right, great. So just to remind everybody, re-orient, I know maybe of you have been with us since the beginning and many of you have been through the three phases of this project. So I just want to make sure that we're all in the same page about the phase that we're discussing.

So this is the third phase of the three-phased effort related to the specific conditions-specific measures. So the three measures that we're discussing today are 1560, the Relative Resource Use for People with Asthma, developed by NCQA; 1561, Relative Resource Use for People with COPD, also developed by NCQA; and 2579, the hospital-level, risk-standardized payment associated with the 30-day-episode-of-care for pneumonia, developed by Yale under contract for CMS.

So the main material that we'll be using for – to drive today's discussion is the comment memo, so you can find that on the screen share. Please let us know if you're having any trouble finding that.

Just as a background, the draft report and the preliminary recommendations by the panel were submitted for public comments during August 14th through September 12th. During this period, we receive 18 comments from seven different member organizations.

Just to facilitate the conversation, and again not to limit any conversation, what NQF is – NQF staff has done is to group the comments according to various themes for each of the different measures. There were similar comments that we receive for 1560 and 1561. So we decided to group those comment together, thematically. However, if any of the committee members have – wants to discuss any of the specific comments that we received that were in the comment table, we'll have some time at the end of today's or toward the end of today's call to discuss those.

So I'll begin with the discussion on 1560 and 1561, the first comment – the first thematic comment that we received from commenters was around the reliability and validity.

Commenters raised concerns about the validity and the reliability of both measures. In particular, they noted neither measure adequately measures the total cost of pulmonary conditions like asthma and COPD and questioned the stability of the measure with lower sample sizes. The incidence of severe asthma and COPD case is rare and the treatment of the patients – of patients consumes few resources.

Further, health plans have difficulty evaluating the quality and efficiency of care for asthma and COPD. Some commenters felt that the relative resource use cost measures do not adequately address efficiency and total cost for specific condition like asthma and COPD due to low incidence of severe cases. Commenters proposed that the measures specification exclusion should not include all high cost diagnosis.

The developer provided response on each of those two different comments. So I just want to make sure that we are on the bottom of page three in terms of the screen share.

For some odd reason, actually Quintin, I'm not able to see this going to share. I'm not sure – I'll reload that. But it seems like the committee is not having any trouble, so just to want to make sure that we're at the bottom of the page three here. I'm just displaying the committee responses. Oh, here we go. Thank you. I can see it now. Yes. OK, that's great.

So I'll turn it over to the committee to discuss theme one and the developer responses, particularly focused on whether the question that I'm asking to committee members, is whether the proposed response which is the committee has weighed each of the concerns and that each of these concerns is under deliberation. And the committee, generally agrees that the criteria for reliability and validity have been met for these measures. Whether this proposed response is sufficient, given the committee's discussion during their in-person meeting, also in light of the developer responses on these comments.

So, I would open it to the committee discussion on theme one of reliability and validity as it relates to 1560 and 1561. Are there any comments by the committee members?

Joseph Stephansky: This is Joe Stephansky. I think the developer responses are correct. Our proposed committee response is OK, although this is tied to the discussion on risk adjustment, a couple more pages down.

William Weintraub: Bill Weintraub. I agree.

Taroon Amin: OK. Any other comments from the committee members?

OK, we'll move to theme two around usability. And again, this is related to the two NCQA measures. The basic comments that we received were while the commenters were not in support of using both measures for public reporting and the decision making tool for consumers, others indicated strong support of these measures for use by health plans. Those that express concerns about the usability of this measure noted the limited usability of this measure that would create negatively impact both health plans and consumers. Those in support of this measure and its usability noted that the measure facilitate a collaborative network between health plans and providers in order to improve measure results.

And again, based on the committee response that's been proposed here is that the committee has also weighed the benefits and challenges related to these measures usability when evaluating the measures. And given the intent of these measures as specified to measure the total – the cost of care from the health plans' perspective, that the benefits essentially outweighs the harms of the measure.

So I'll again – I'll open this for committee discussion to react to the committee response and the comments around the usability of this measure.

Joseph Stephansky: All right. This is Joe Stephansky …

Mary Anne Clark: Mary Anne Clark. Oh, I was just going to say I think that's appropriate because it's designed to – primarily, for health plan comparison. So it seems appropriate to me, appropriate response as well.

Joseph Stephansky: This is Joe Stephansky. I've actually used some of this data in looking at health plans for use by our association. So I think, as a group, all of these measures work quite well together.

Nancy Garrett: And this is Nancy Garrett. I remember that we discussed this as well within our committee and the fact that having these measures at the provider level really would be more actionable. But I think the response is appropriate, and indeed these are being used widely by health plans. And I think that it's – I think that endorsing it for that purpose is appropriate.

Taroon Amin: Thanks for that feedback. Are there any other comments by any other the committee members, related to usability?

OK. So moving on, on theme three, related to risk adjustment. Before I begin on this topic, I'll ask our colleagues from NCQA after I walk through the comments, we will bring up the response – the written response. And if you have any other comments that you would like to provide to the committee, we welcome those as well.

So this first – the third comment, the third theme is related to risk adjustment, during the evaluation of these measures by the committee, some committee members raised concern with the risk adjustment approach and requested additional clarifying information from the developers on their approach to risk adjusting and testing the risk model.

The R squared values for both measures was 0.84 and this led to questions of developers to further describe how the value was attained and what are it represents. In particular, there were concerns about the current risk adjustment model whether it's able to discriminate within a specified health condition, i.e., asthma or COPD as opposed to discriminating across them by testing the model on heterogeneous population including those members with asthma, COPD and other cardiovascular conditions. It becomes difficult to discern what's causing the variation. This may also impact the coefficients

that are used on risk adjustment model and raise some questions about how this coefficients maybe – may have been assigned.

Those were the summary of some of the comment that we received. I will turn it over to our colleagues at NCQA if you would like to provide any additional discussion in addition to what you've provided in written form. And, Quintin, if you wouldn't mind, please opening the NCQA written response just so that it's available for the committee members to see on screen.

Clearly, it's been provided to the committee in advance with this meeting, but I just want to make sure that it's available for you to be able to see on the screen as well. Ben, do you have ah that you would like to add or, (Bob)?

Benjamin Hamlin: No. I think at this time, we just would like to – if there's any questions the committee may have about our response.

Taroon Amin: OK. I'll open it up to the committee discussion of theme three, risk adjustment.

Joseph Stephansky: Hi. This is Joe Stephansky again. I actually like what they've done to the HCC categories and the strata that they've created. Given, you know, my most – my experience with looking at HCCs has been looking at Medicare Advantage plan. And essentially, what we're really doing here is not discriminating across asthma and COPD together. We're looking at persons with asthma and that a whole slew of comorbidities were accepted inside the HCC model and their assigned weights. I just really like the way it's done.

Herbert Wong: This is Herb Wong, and I would agree with Joe's assessment there.

Taroon Amin: OK. Are there any other comments from other committee members related to the response by developer?

Joseph Stephansky: We're a very talkative group today.

Taroon Amin: I know, it sounds like it, Joe. OK. Well, that's all right. If everybody's satisfied with the response, that's good.

So we'll move on. We're going to – I think one of the main questions that was raised here is whether there is any further concerns about the risk adjustment approach.

We haven't developed or proposed a response here, but what I'm hearing form the committee – the lack of discussion, is that the committee is generally satisfied with the risk adjustment approach that's been used by the developer. And, you know, the committee's recommendation would move forward as we had during the in-person meeting. Is there, you know, just want to make sure that that's generally the sentiment of the panel. Is there anyone that disagrees with that?

OK. So moving on, we're moving on now to a discussion on 2579, hospital-level, risk-standardized payment associated with 30-day-episode-of-care for pneumonia. Theme one, related to the – appropriateness of the attribution approach. Commenters raised concern about the attribution approach for hospitalized patients with pneumonia, suggesting that this approach – this approach is inappropriate and only reflects an episode of care and not the care of multiple providers across the heath care delivery system.

Commenters stated that measures should assess processes and outcomes over which the measured entity, for example, the hospital or physician group, can exercise a reasonable level of control. And these measures maybe more appropriate for an organization accepting bundled payment on behalf of all measured entities.

I will – the proposed response that – so I'll just leave the proposed response up there to see if the committee is in general agreement, essentially, maybe I'll just walk through it.

The committee acknowledges this concern, however, the committee also states that hospital are increasingly responsible for care delivered up to 30 days after discharge, and consequently hospitals are in a unique position to be able to support care coordination to their patients. And this measure may help to move that agenda forward.

So I'll open the discussion on theme one around the appropriateness of the attribution approach for 2579 for discussion by the panel.

Brent Asplin: This is Brent Asplin. And I think that's an appropriate response. I think the wording there sounds very good.

Joseph Stephansky: This is Joe Stephansky. I just maybe we've – and you know what I'm going to say. And that I did agree with the comment from Alyssa Keefe, who is from the California Hospital Association that – maybe we want to say that a majority of the committee or most of the committee agreed. I still have problems with this kind of an attribution, and the way that this attribution in this – and other measures may affect hospital finance.

Taroon Amin: OK. Thanks.

Joseph Stephansky: The other thing, I think, we are going to see if we still – if this committee goes on, the committee – if issues of attribution are going to become more and more critical going forward, particularly once we look more at socioeconomic – sociodemographic risk adjustment. And we're going to have to comeback and revisit some of this attribution issues, particularly done at the physician level, but also at the acute and post-acute provider level.

Taroon Amin: Are there any other comments by other committee members? OK. Joe, I think that was a good transition actually to theme two.

Risk adjustment for sociodemographic status, a few commenters noted that it would be appropriate to stratify the claims to calculate this measure based on sociodemographic status. The purpose of integrating SDS adjustment is to document the negative impact that they may have on patient outcomes. These commenters express concern with panelizing providers for poor outcomes that maybe made worst by non-clinical factors.

The proposed committee response here is that while the committee recognizes the importance of adjusting adequately, particularly for sociodemographic factors in appropriate applications. Again, the committee is waiting for NQF to put together the application or implementation of the guidance from the SDS panel. And the measures are currently under review have been

recommended under the, you know, with additional guidance to stratify for SDS as appropriate. But essentially, the committee is operating under the current guidance that was in place at the start of this project, which has been part of the staff guidance to the committee, prior and during this process of evaluation.

So I know that that may not necessarily be satisfactory for the committee – many members of the committee. But again, we can open that after discussion as well.

Nancy Garrett: So this is Nancy Garrett. And so, this expert panel work is done and the recommendation is final for this robust trial period incorporating the sociodemographic variables. And so, what I hear you saying is that, it's too late to ask the (providers) to incorporate that because it wasn't in place at the start, is that right?

Taroon Amin: That is correct, Nancy. We had the discussion for both this project and for readmissions, we made a commitment to the developers who were submitting measure into this project that they would be held to the criteria and this is not simply related to the SDS issue but the criterion that's in place at the beginning of the project would be the criteria that's use for evaluation.

We recognize that that is significantly an issue from any members of the panel but we are working on putting together a trial period that will be likely to put into to place at the beginning of the year, in 2015. And we will accept a notion or ad hoc review request by any member of the public that feels that any particular measure should be adjusted for SDS factors and would welcome that during the trial period.

And I would imagine that many – some of these measures may fall into that category. However, given where we are in this project timeline, it would be unfair to expect the measure developers to make that change while the change was occurring during this project – during the time of this project was in place. So, yes, that's, in summary, what we're describing here.

Nancy Garret: OK. Thanks, Taroon.

(Joseph Stephansky): The CSAC process was rather – there are some strong opinions there anyway and I think we just have to kind of live with the process that is now being put into play.

Taroon Amin: I will note for the committee, I know we've had a number conversation during in person meeting, a number of you have contacted me after the CSAC discussion on the SDS issue. I will – we will note in the final report and along these comments that many of the members, while they disagreed necessarily or are unhappy with the fact that we are, you know, staff, NQF staff, NQF policy is requiring us to move forward under the prior guidance, that there is a ask to be consider this during the trial period. And we'll make sure that that's documented in the report and appropriately acknowledged even though many of you – committee members may not be completely satisfied with that as a result.

(Joseph Stephansky): That's good.

Nancy Garrett: So, how that would work, Taroon, is during the trial period, there will be a reconsideration of measures that had recently been endorsed? Or are you just talking about new measures as they come through?

Taroon Amin: Well, NQF has an ad hoc review process, and then process is designed to any member of the public can raise, you know, can submit a request for an ad hoc review if the underlying evidence for a measure has change or NQF policy has changed. And measures – and particularly measures would be uniquely affected. And we would need to have some of the rationale presented. And any measure that's endorsed whether, it's new or – I mean, new coming in or prior endorsed measures would be – are appropriate for submitting an ad hoc review.

And so, we assess these ad hoc review request and contact the developer and then we will sort of go through an ad hoc review which would be specifically targeted on the issue that's been raised by the member. So if it's a change evidence, we'll look at the evidence as it relates to the measure specification and how the discussion just on that. If it's related to the appropriateness of the risk adjustment model, we may extract just that portion of the measure and

have the discussion about how this affects the continued endorsement of this measure going forward. And ask for additional information from the developer as it relates to the ad hoc review request.

So does that answer your question, Nancy?

Nancy Garrett: That does. Thank you.

Taroon Amin: OK. So, any other comments on this theme two?

OK. So moving on to theme three, around the validity of exclusions. One commenter raised the concern about the specification of the measure as it proposes the inclusion of ICD-9 code 507 in the denominator for aspiration pneumonia. This code is use for 15 percent of Medicare beneficiaries discharged with pneumonia and this will address – and this will address potentially the poor risk adjustment for high cost patients that are hospitalized with pneumonia.

The exclusion of admissions for this measure does not provide clinical significance. Currently, same day discharges or one day – one day length of stay are not included within this analysis when these times points could be indicative of highly efficient care.

And the developers proposed a response to this comment. The proposed response that we've provided for the committee is based on the NQF criteria of validity. Generally, the committee believes that this has met the criteria and continues to recommend this measure for endorsement. I'll open that up for a committee discussion.

Mary Ann Clark: I think we had – this is Mary Ann Clark. I think we did have a little discussion with CMS on this topic of, you know, and they were thinking about – that they could take a look at this in terms of determining whether something was present on admission because there's an availability – a way to do that now with the claims data. And they had not, originally, I think considered that. So – but I don't think that that's going to be implemented for this particular version.

Taroon Amin: Right, right. Nancy, is there anything else that you would like to provide to the committee in addition to the developer's response that's indicated here?

Nancy Kim: Hi. This is Nancy Kim from Yale. Can you hear me? Sorry.

Taroon Amin: Yes.

Nancy Kim: I just want to point out that that second comment, where they were talking about the one-day length of stay, they did also have a previous part of the same comment that they agreed with the exclusion. But that had been the sort of editorial to their agreements to the exclusion. And I do want to reassure the committee that we are reevaluating aspiration pneumonia because of the (POA) as the committee member mentioned.

And we are also, just largely, across all measures reviewing the one day length of stay for exclusion since everything really is moving towards more rapid treatment.

I will say that the aspiration pneumonia issue seems to be an issue that is not specific to the pneumonia payment's measure but all of the pneumonia measure that are publically reported and NQF endorsed.

Taroon Amin: OK. Thank you, Nancy. Are there any other comments by the committee members?

OK. Thank you very much. So that to conclude sort of the discussion around the themes. I'll just open it up for – if anyone has any comments about any of the particular comments that we're received, that were in the comment table. I want to make sure that if there're any specific issues or specific comments that other members of the committee felt needed to be addressed, please free to raise them now, and we can discuss any specific comments that were not covered by the staff review and the themes that have been identified by the staff.

OK. I'll take as a vote confidence of the staff's review of the comments. And with that, I think that sort of concludes the evaluation of the specific comments that we received for this project.

I'll just turn it over to Quintin to walk through the next steps of this project. And before we get to that, I'll just – I believe we do a public comment period, I'm sorry. I don't seem that I have that on my notes. Quintin, is that appropriate to open to public comments, to see if there's any public comment from folks that are on the phone?

Quintin Dukes: Yes. I can definitely see if we had anyone submit any comments that way.

Taroon Amin: OK. And operator, can you open the line to see if there's any public comments from folks on the call? Operator?

Operator: Yes, sir. At this time, if you would like to make a public comment, please press star one.

Quintin Dukes: OK. So over the web, we have no questions at this time from the audience members.

Taroon Amin: OK, great. Thank you. So …

Operator: And there are further no comments.

Taroon Amin: Thank you, Operator. So, maybe we can just move then to the next steps for the committee.

Quintin Dukes: OK. So for phase three, the next step will be member vote and that will begin on September 6th and it will end on September 20th. And also, we will be going to CSAC which schedule at this time for November 12th, and then the board of director's review for phase three will be December 3rd. And of course, as we get closer and closer to these milestones, we'll be sending out reminders and they'll be accompanied by memos also.

Taroon Amin: OK. Thank you very much, Quintin. I just wanted to close out the call today by thanking all of you, committee members, for participating. I know maybe of you has been with us since the beginning of our cost and research use measurement work and then, obviously, this very intensive three-phase effort

with the multiple phases, in fact, interacting with one another. So, you know, we've had a number of calls and meetings at a very rapid pace.

So a profound thank you from the NQF staff particularly, Ashley, Quintin, Lindsey Tighe has been working with us on this and Ann Phillips as well, on, you know, sticking with us and participating, obviously we're not at the end of phase three, but this is sort of the last big lift from the committee members. And so again, a profound thank you on that, and again, thank you to Brent Asplin and Lisa Latts, who've been providing leadership to this group up to this point.

Are there any other comments from any other members of the steering committee?

Joseph Stephansky: Yes. This is Joe Stephansky. Just one question really for Nancy from our CMS/Yale developer, when are we going to see or can we expect to see at some point in the near future a combination cost and outcome measures, say on pneumonia? Is there any plan for you to come through with that kind of a measure? An efficiency measure?

Male: Great question.

Susannah Bernheim: I don't know if Nancy is unmute or – but this is Susannah Bernheim from the Yale team, can you hear me?

Joseph Stephansky: Yes.

Susannah Bernheim: So, I don't have a great answer, which is something we thought a lot about, you know, for now, what I can say is that, CMS has planned with the first of these measures, not pneumonia, but the AMI-1 is that, it will be on hospital compare along side mortality measures. So that you can look how hospital do on both at the same time. But I don't think that there is a definite plan for how those measures would be combined (about a lot of things).

Joseph Stephansky: We look forward to see what you have in mind.

Susannah Bernheim: Great.

Taroon Amin: OK, all right. Any other comments by committee members?

OK, all right. Everybody, thank you very much for all of your time and enjoy the rest of the week. Thank you very much.

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