NATIONAL QUALITY FORUM

Memo

TO: Cost and Resource Use Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments: *Cost and Resource Use Phase 3: Pulmonary Conditions*

DA: September 22, 2014

Background

The draft report and comments received reflect the review of measures in the third phase of a three-phase effort to evaluate and endorse cost and resource use measures. The third phase is focused on pulmonary condition-specific per capita and condition-specific episodes–based measures.

The Cost and Resource Use Standing Committee reviewed three measures; all three were recommended for endorsement.

Recommended:

- **1560: Relative Resource Use for People with Asthma (NCQA)**
- **1561: Relative Resource Use for People with COPD (NCQA)**
- **2579: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for pneumonia (CMS/Yale)**

Purpose of the Call

The Cost and Resource Use Standing Committee will meet via conference call on Wednesday, September 24, 2014 from 12pm-2pm EST. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period on the pulmonary condition-specific per capita and condition-specific episodes cost and resource use measures.
- Provide input on proposed responses to the post-evaluation comments.
- Determine whether reconsideration of any measures or other courses of action is warranted.

During this call we will review comments by exception, in the case the Committee disagrees with the proposed responses.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table).

3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

An agenda for the call is available on the project page. Please use the following information to access the conference call line and webinar:

Speaker dial-in #: (877) 303-3809 (*NO CONFERENCE CODE REQUIRED)*
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?838708
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?838708

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from June 12th through June 30th for the 3 measures under review. A total of 10 pre-evaluation comments were received pertaining to the NCQA Asthma and COPD maintenance measures, raising concerns about risk-adjusted resource use for health plans; and, a newly proposed CMS Pneumonia measure, raising concern about attribution of costs for these episodes to hospitals. These pre-evaluation comments were provided to the Committee prior to their initial deliberations held during the workgroups calls.

Post-evaluation comments

The draft report went out for public and member comment August 14th to September 12th. During this commenting period, NQF received 18 comments from 7member organizations:

Consumers – 0	Professional – 0
Purchasers –2	Health Plans – 2
Providers – 2	QMRI – 0
Supplier and Industry – 1	Public & Community Health - 0

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit discussion, but to focus the Committee on the most common pertinent issues raised within the time allotted for the call.

The comment table contains the commenter's name, comment, associated measure, topic (if applicable), and draft responses for the Committee's consideration. Please refer to this

comment table to view and consider the individual comments received and the proposed responses to each measure.

Measure-specific Comments and Reconsideration of Recommendations

The Committee will be asked to consider any measure-specific comments in their final recommendations. The themes identified among the comments submitted have been associated with each of the measures. They will be asked to determine whether the information submitted warrants a re-vote on the recommendation for endorsement. Given that the measures in this phase of work are similar in structure and approach to those in Phase 2, the themes that have arisen during commenting are also very similar.

1560: Relative Resource Use for People with Asthma & 1561: Relative Resource Use for People with COPD

Theme 1: Reliability and Validity

Commenters raised concern about the validity and reliability of both measures. In particular, they noted that neither measure adequately measures the total cost of pulmonary conditions like asthma and COPD and questioned stability of the measure with lower sample sizes. The incidence of severe asthma and COPD cases is rare and treatment for patients consumes few resources. Further, health plans will have difficulty evaluating the quality and efficiency of care for asthma and COPD. Relative resource use cost measures do not adequately assess efficiency and total costs for specific conditions like asthma and COPD due to the low incidence of severe cases. Commenters proposed that the measure specification exclusions should not include all high cost diagnoses.

> **Developer Response (#1560):** The RAS measure is limited to capturing the resources used by health plan members with persistent asthma. Members are identified as having persistent asthma through claims using a NQF endorsed, validated algorithm. NCQA's Relative Resource Use measures do not measure cost. The current risk adjustment approach provides a satisfactory O/E variance at the conservative min sample size of 200 eligible members and is very specific with regard to assigning health plan members to risk cohorts based on data available in administrative claims. The purpose of the measure is not to map resources to severity, rather to compare health plans' resource use managing their members with persistent asthma with other plans in their peer group.
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> **Developer Response (#1561):** NCQA's Relative Resource Use measures do not measure cost. The current risk adjustment approach provides a satisfactory O/E variance at the conservative min sample size of 200 eligible members and is very specific with regard to assigning health plan members to risk cohorts based on data available in administrative claims. The purpose of the measure is not to map resources to severity or other co-morbidities, rather to compare health plans' resource use managing their members with COPD with other plans in their peer group.

Proposed Committee Response: The Committee has weighed each of these concerns in their deliberations to evaluate this and other relative resource use measures. Based on the NQF criteria for reliability and validity, the Committee agreed the measures have met these criteria.

Theme 2: Usability

While some commenters were not in support of using both measures for public reporting and a decision-making tool for consumers, others indicated strong support of these measures for use by health plans. Those expressing concerns with the usability of the measure noted that the limited usability of this measure would negatively impact both health plans and consumers. Those in support of this measure and its usability noted that this measure facilitates a collaborative network between health plans and providers in order to improve measure results.

Proposed Committee Response: The Committee also weighed these benefits and challenges with the measures' usability when evaluating these measures. Given the intent of these measures as specified is to measure the cost of care from the health plan perspective to care for asthmatics and those with COPD and the current widespread use of these measures by health plans, the Committee ultimately recommended the measures.

Theme 3: Risk Adjustment

During the evaluation of these measures by the Committee, some committee members raised concern with the risk adjustment approach and requested additional clarification from the developers on their approach to risk adjusting and testing the risk model. The r^2 values for both measures were 0.48. This led to questions of the developers to further describe how the value was attained and what it represents. In particular, there were concerns that the current risk adjustment model is unable to discriminate within a specified health condition (i.e., asthma or COPD), as opposed to discriminating across them; by testing the model on a heterogeneous population (including members with asthma, COPD and cardiovascular conditions) it becomes difficult to discern what is causing the variation. This also impacts the coefficients used in the model and raised questions on how those coefficients may have been assigned.

> **Developer Response:** The NCQA developers provided a response to these concerns: NCQA Response

Committee Discussion:

- Based on the developer response, does the Committee have further concerns about the risk adjustment approach for these measures that should be discussed?

2579: Hospital-level, Risk-standardized Payment Associated with a 30-day Episode of Care for Pneumonia

Theme 1: Appropriateness of the Attribution Approach

Commenters raised concern about the attribution approach for hospitalized patients with pneumonia, suggesting that the approach s is inappropriate and only reflects an episode-of-care and not the care of multiple providers across the health care delivery system. Commenters stated that measures should assess processes and outcomes over which the measured entity (e.g., hospital, physician group) can exercise a reasonable level of control, and that these measures may be more appropriate for an organization accepting bundled payments on behalf of all measured entities.

Proposed Committee Response:

The Committee acknowledges this concern; however, the Committee also stated that hospitals are increasingly responsible for care delivered up to 30 days after discharge. Consequently,

hospitals are in the unique position of being able to push coordination of care, and this measure may serve as an impetus for this to occur.

Theme 2: Risk Adjustment for Sociodemographic Status

A few commenters noted that it would be appropriate to stratify the claims to calculate this measure by sociodemographic status (SDS). The purpose for integrating SDS (i.e. low income, poor housing, no/low access to social service, and no/low access to community supports) is to document their negative impact on patient outcomes. These commenters expressed concern about penalizing providers for poor patient outcomes that are exacerbated by non-clinical factors.

Proposed Committee Response: The Committee also recognizes the importance of adequately adjusting for sociodemographic status in the appropriate applications. While NQF continues to work on their implementation of the guidance from the SDS Expert Panel, measures currently under review have been recommended with additional guidance to stratify for SDS, as appropriate.

Theme 3: Validity of Exclusions

A commenter raised a concern about the specification of the measure and proposes the inclusion of the ICD-9 code 507.0 in the denominator for aspiration pneumonia. This code is used for 15% of Medicare patients discharged with pneumonia and this will address the poor risk adjustment for high cost patients that are hospitalized for pneumonia.

The exclusions of admissions for this measure does not provide clinical significance; currently, same day discharges or one day length of stays are not included within the analysis, when these time points could be indicative of highly efficient care.

> **Developer Responses:** We appreciate the commenter's concern. To clarify, the pneumonia cohort specifications were closely aligned with the 30-day pneumonia mortality measure which is NQF endorsed and publicly reported. Initially, aspiration pneumonias were considered a potential complication of care and therefore, they were not included in the pneumonia cohort. However, given the prevalence of this code, we plan to reevaluate including aspiration pneumonia in this measure in the future. We appreciate the thoughtful comment and agreement with our decision to exclude same- or next-day discharges from the measure. Given the shift over time to rapid treatment and timely care, we do plan to reevaluate these exclusion criteria in the future.

Proposed Committee Responses: Based on the NQF criteria for validity, the Committee has agreed that this measure has met the criteria for validity and has recommended it for endorsement.