NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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12:00 p.m. ET

Lindsey Tighe: Hi everyone, this is Lindsey Tighe from NQF. I'm here with Ashley Wilbon. We're here today as for the Phase 3 Pulmonary Technical Expert Panel for the Cost and Resource Use project to review the clinical specifications for the three measures that were submitted to the Cost and Resource Use project.

I will go ahead and ask the TEP to introduce themselves. We have Dale Bratzler who is the chair of the TEP.

Dale Bratzler: Thanks, Lindsey. This is Dale Bratzler. I'm a professor in the Colleges of Medicine and Public at the University of Oklahoma and the Chief Quality Officer for the OU Physicians Practice.

Lindsey Tighe: OK. Thanks, Dale.

Do we have Andrea Gelzer on the line? Peter Almenoff?

Peter Almenoff: (Inaudible) I e-mailed you. I'm Peter Almenoff, the Director of Operational Analytics and Reporting and also the Advisor to the Office of the Secretary Department of Veterans Affairs, and a professor of Medicine and bioinformatics at the University of Missouri.

Lindsey Tighe: Thank you. (Allen Baptist) e-mailed. He had something come up and won't be able to join us.

(Ruben Cohen)?

William Brendle Glomb?

William Brendle Glomb: Hi. This is Brendle Glomb. I'm a Pediatric Pulmonologist and Neonatologist (inaudible) specialist from Austin, Texas, and the former Texas Health and Human Services Commission Medical Director and currently the Senior Medical Director for Superior Health Plan, one of the Centene companies. Centene is a national company that does the entitlement program such as Medicare advantage Medicaid, foster care, et cetera.

Lindsey Tighe: Thank you. Stephen Grossbart? Stephen, I see you on the webinar, do you have us on mute by chance?

Stephen Grossbart: At the webinar or I'm talking on the telephone line right now.

Lindsey Tighe: OK, we can hear you now.

Stephen Grossbart: Did you hear me introduce myself?

Lindsey Tighe: No.

Stephen Grossbart: OK. Let me try that again Stephen Grossbart, Chief Quality Officer for Catholic Health Partners based in Cincinnati, Ohio.

Lindsey Tighe: Thank you. David Lang?

David Lang: Gene Immunology and Respirator Institute of Cleveland Clinic.

Lindsey Tighe: All right. Thank you, everyone. I can see from the webinar, guys, that we have a few committee members on the call too. Thank you all for joining us.

I do want to point out that if you want some time back or you have a call scheduled for June 11th where the TEP will be available on the call to share their recommendations with you related to the clinical investigations of the measure. That said, you're welcome to stay on and listen if you would like to, but they'll having their preliminary conversations today.

(Lisa Letts): This is (Lisa Letts), I won't be available for the other meetings so I'll stay on and just sort of be a fly on the wall.

Lindsey Tighe: Great. So I'll just jump right in. We have three measures that we're going to be reviewing on today's call. And so I'll just go over briefly on some of the information we shared on the (inaudible) to TEP as to what we're looking for you to provide input on.

And so we'd ask you to look at the clinical logic which would include the description of the clinical logic, the clinical logic itself, the evidence for it, and then the trigger and mechanisms for the measure. The adjustments of comparability, looking at the inclusions and exclusions criteria and then also looking at the risk adjustment model.

So we played out some questions for you. They align with what you filled out in your survey responses on SharePoint.

When looking at the clinical logic, we're asking to what extent is the measure population clinically appropriate? To what extent at the definitions used to identify the measure population clinically consistent with the intent of the measure. With respect to evidence, to what extent is the submission adequately described the evidence that support the decisions and logic for grouping claim to measure the clinical conditions for the episode.

So the trigger and mechanisms given the condition being measured and the intent of the measure. Describe the alignment of the lengths of the episode with the clinical course of this condition. Looking at the comparability – excuse me, the adjustments for comparability, the inclusion and exclusion criteria. We want to understand the clinical relevancy of the exclusions to narrowing the target populations or the episode. If the exclusion represents a large number proportion of patient, to what extent the rationale for clinical exclusion is adequately describe and clinically relevant and to what extent are development conditions represented in the codes listed.

For risk estimate, we're looking at to what extent are the factors included in the risk model clinically relevant and consistent with the measures intent.

So that was a very brief overview. Does any one have any questions about what we'd asked you to provide input on.

Male: Lindsey was that document I thought I remember that there was going to be some compiled document that was going to be available on SharePoint but I didn't see it.

Lindsey Tighe: No, it was actually integrated into the survey tool that people were filling out. Each of these questions was asked.

Male: No, no, I'm sorry. I thought you're going to send out all of the answers into a document.

Lindsey Tighe: We did. I apologize I sent out the information this morning if you click on the measure document set. That information is there, I can also screen share it if that makes it easier as we go through the call.

Male: You sent it out this morning, OK. I don't have anything, somebody wouldn't mind just trying to get it out for me again I'd appreciate it.

Lindsey Tighe: (Ann), can you maybe shoot an e-mail to the TEP with that?

(Ann): I'm on it right now.

Lindsey Tighe: OK, thanks.

Female: Thank you.

Male: Thank you all, sorry.

Lindsey Tighe: OK, so we do have three measures that we're looking to discuss today and we do have developers present from each of these measures. Do we have anyone from NCQA on the line?

Ben Hamlin: Yes, this is Ben Hamlin and (Bob Brown).

Lindsey Tighe: Hi Ben and (Bob) thanks for joining us. If you would like it would be helpful I think to the group if you could just provide a brief overview on the measures 1560 before we jump into our discussions at the clinical specification.

Ben Hamlin: Sure. Relative Resource Use For People with Asthma is a measures that looks at the total resource used on an annual basis for health plan members who have the conditions identified for Asthma. It is risk adjusted using the ACC model is published by CMS. And it uses on the clinical study, uses clinical factors that are derived from the effectiveness of care measures that are endorsed under a separate protocol.

Lindsey Tighe: All right. Thank you I will go ahead and screen share right now the compiled comments from our TEP members. And Dale, I would ask if you wouldn't mind just leading us through the discussion of this measure.

Dale Bratzler: OK, so the first one comment is about state of intent of the measure to what extent is the measured population clinically appropriate. Different comments here I'll try to summarize them briefly but define population I think the biggest concern I read through all this earlier today I think I'm not sure whose comment it is but the biggest concern about the major population being clinically appropriate is basing the denominator population on a diagnosis of asthma.

I think there's concern that without validation of the diagnosis Asthma often gets put into a problem list but many of the patients when clinically evaluated don't really have Asthma. As noted the population is identified by patients who have a emergency department principal diagnosis of asthma or a principal diagnosis of a hospitalization a single visit. Or multiple office visits with the diagnosis of Asthma or patients identified by pharmacy claims. So four distinctive events for a number of the control of medications used to treat asthma.

So I guess I'd like to hear in NCQA and any particular comments about the first comment that came in or see if there are others if anyone wants to make a comment. I think, you know, the comment that I read was that one of the pulmonologist on the committee found that in their practice they often see patients referred for asthma who really don't meet clinical criteria for asthma.

Ben Hamlin: So this is Ben from NCQA have been from NCQA I wanted to offer one clarification. So it does use the HEDIS asthma definition, it does require two

years, it requires that the criteria be met both years, not over a two-year period and I think that might have been one of the clarifications. So, the algorithm for inclusion requires multiple diagnosis, multiple medication events and consistency year over year. So, it's not just a single event that would get you into the older population for this measure.

Dale Bratzler: Is that true though the hospitalizations are E.D. visit?

Ben Hamlin: If you have concurrent ones in over a two-year period. So, each year you have then it's possible. That is the minority of the patients who end up getting into this measure. However, if you're being treated on an in-patient basis year after year for the condition, the algorithm does include you in the measure.

Dale Bratzler: All right, other committee members, do you have any other questions about this?

William Brendle Glomb: This is Brendle, I'm the one whose comment summarized (it). I completely understand that this is "the accepted" definition that we've used for a long time. When I was on the pulmonary and critical care NQF committee, we struggled with the same definition and I just – I wanted to mention that more for to be thorough. I realized we're – particularly because this measure is being – potentially mirroring a previously accepted measure with regard to asthma, we could very – probably too much from the definition just that they are.

I think that stepping back we have over identified now and in my career in the last 25 and 30 years. While pushing the pendulum obviously go completely the opposite direction under recognition, under diagnosis, couple of decades ago at least in the pediatric community and over diagnosis and over application of the term, so, FYI.

Dale Bratzler: OK. So Lindsey, if you want to scroll up to the next to the question because the next question gets to some of the same issues to what extent the definitions used to identify the major population and clinically consistent with the intent of the measure. And I think Brendle you made some of the same comments about …

William Brendle Glomb: I'm the problem child on the committee.

Dale Bratzler: No, that's – I mean, I thought your comments were very good actually. So …

Ben Hamlin: So, I can address some of the comment as well again. As mentioned, you know, I think a single E.D. visit or single in-patient admission for over, you know, each over both years well, it put you in the measure.

And as far as the medications the – some of the medications that are for inclusion criteria are still in the denominator eligibility population because of the fact that the experts over the years have decided they're not principally recommended medications but there are still some cases where this could be used for treatment of asthma. And therefore, they survived if you will, in the denominator inclusion criteria. That's largely in our other clinical measures, they do not part of the numerator inclusion as far as for treatment therapy goes. But there are some medications that are still out there still approved for use and I used at a low frequency basis but because they are still acceptable, they don't survive in our denominator if you will.

(Rubin Cohen): Yes. Hi, this is (Rubin Cohen). I'm sorry my comments – I couldn't get my comments through. But I had the same issue especially with the – I mean (off of them) based medication and the mast cell stabilizers some of which are not even in existence any more.

Ben Hamlin: So, all medications that are listed are reviewed annually by our pharmacy panel. And, because if they were available on a prior year, we still include them on our list because it requires it a tier denominator but if medications are no longer available as the time window for inclusion criteria sunset, so will those medications from our (inaudible) list.

(Brendan Fetcher): Yes. Again, I think if were looking at this measured de novo with no relation to other previous measures. This would be more important – the important (inaudible), they would have more – we might want to structure the measure differently but because this is in some ways the second half of the previous asthma measure. We're now are going to compare cost with value. We are kind of stuck with the definition. This is one time I would guess.

Ben Hamlin: I do want to comment. We appreciate these comments because I will take it back to our clinical review panel for the next revision of HEDIS. And we'll be sure to incorporate these comments into our review. So we do appreciate these comments regardless.

Dale Bratzler: Okay, very good. Any other panel members have any other comments about question two?

All right Lindsey, why don't you scroll up to number three? Sorry. So to what extent does the submission adequately describe the evidence that supports the decisions or the logic for grouping claims, identifying the major population and exclusions to measure the clinical condition for the episode?

I think similar comments to before – of one of that maybe – I don't know if (Brendan Fetcher) comment about children younger than five but again, I've – as you point out, this was consistent with the other HEDIS asthma measures.

(Brendan Fetcher): Right. It's more of a comment than a criticism. And then it does – that the five year floor that's excluded a fair number of pediatric asthma patients. And so that could be – we might be excluding – (inaudible) information from the measure may not adequately represent what's going on in the younger pediatric population.

Dale Bratzler: Okay. Any other comments about the question number three from the panel?

Question number four actually gets to documentation or describing the alignment of the length of the episode of what triggers the start in time so I'll just quickly make the point that this actually looks at care over a calendar year. Although the patients have to be enrolled for a consecutive two-year period with the health plan, the actual measurement timeframe is a calendar year so it's really not the episode methodology that we'll see in the third measure we talked about today.

Any comments or questions about the measurement timeframe?

Male: It seems reasonable.

(Brendan Fetcher): Yes.

Dale Bratzler: Got it. Okay, describe the clinical relevancy of exclusions to narrowing the target population for the episode condition and clinical course coexisting conditions.

So let me do the easy part first and then, we'll get to the other question. So patients obviously with a variety of active cancers, HIV, AIDS, renal disease or – and patients that have COPD, eczema, cystic fibrosis are excluded from this asthma measure.

One of the comments talked about – and I didn't catch this one, I reviewed the specifications, denied claims. So I'm not sure I completely understand the question. I didn't see that in the specifications so I don't know Brendle that's you or, you know, some other …

William Brendle Glomb: That deny claims concern (inaudible). Again, now remembering, I come from at this point, a payer perspective at this. There are – gosh, there's all kinds of reasons why a claim might be denied. Not the least of which is that the – either on an upfront review of the submission or a post (doctor) review of the claim. It's felt that there's no correlation between the procedures done and the diagnosis, i.e. the diagnosis has been substantiated.

So, I think it's a big leap to say – well, let's say, (broaden) the service for "asthma", we should count it and what they were – what claim was for when, you know, in those patients who now are being identified for the measure because I do think that again, just like my concern, the first time with over-diagnosis, we just see everyday claims that don't – really don't even meet the barest specifications for the diagnosis that they're requesting.

I've again, may be tied to the previous measure and that's the previous definition and so that you have apples to apples that's got to – we have to look at it in that way. However, the facts that we then don't count back feedback within the cost and resource use any denied claim, I think that is an apples and oranges issue and I'm not sure that that makes a good logic to use a denied claim patient in your numerator or in your denominator of all asthma patients.

But then do not count that same claim to our cost and resource use granted you didn't spend anything for it but it is – you've kind of skewed the result of that – how much I don't know but (inaudible).

Ben Hamlin: Yes. Again, the denied claims issue is a common rule in HEDIS for, you know, (inaudible) care measures, the utilization measures do because there are resource use and utilization do look at the paid or expect to be claims.

It is a low proportion of overall and again, if we add the measure, it gives us multiple consecutive years of data. It was the approach that basically had the minimal impact on the measure and we wanted to avoid creating special circumstances for certain measures in the reporting structure in HEDIS versus others so …

William Brendle Glomb: Good. Yes. Again, I don't think it's a huge number by any stretch. I think I agree with you completely, it's probably at a relatively small impact, but I do think it is an impact. And what we're going to be talking about big method numbers, those, you know, it may come in – it may have some effect on the ultimate result.

Dale Bratzler: So that comment about, you know, the minimal impact actually for me goes to the next question which I wasn't able to answer from the documents that were submitted about the exclusions representing a large number of patients. It may be in there, I went through the material a couple times looking for it. I couldn't find, you know, kind of what the denominator was on how many patients actually get excluded from this measure or, you know, it might be useful to know how often denied claims actually put patients into the denominator.

Ben Hamlin: But we don't have the information of denied claims. If you look at table three of page 15 of the measure testing form, it gives you a sampling of the effective – the different exclusions – well, clinical exclusions on the (inaudible) population of the measure. This was only from nine plans, it wasn't a nationwide sample but it was fairly representative as you might expect.

Things like COPD as you increase in the age groups, you've seen increase in the prevalence of those exclusions being applied. However, we don't have any information denied on the absolute affected denied claims on the rate but …

Male: So (Wendy), are you scrolling to that?

(Wendy): I am. Just a second.

Male: Okay.

(Wendy): (Inaudible), what section were you in the measure testing form?

Ben Hamlin: In my folder, it was around page 15, it was table three, the frequency, the impact of the (inaudible) diagnosis in older populations (inaudible) exclusion criteria.

(Wendy): Okay.

Ben Hamlin: Section 2B32.

(Wendy): Okay. Sorry, I have a different numbering strategy going on the page numbers here.

Ben Hamlin: While you're looking for it, I can give you a little bit of overview of, you know, the COPD and the 12 to 55 cohort roughly we saw about 14.2 percent application of exclusions in a population of about 22,000 people in the 51 to 64, that number went out to about almost 40 percent.

So, you know, again, as people sort of age in to the obstructive – restrictive disease, we tend to see an increase in those diagnoses that are appearing. Similar proportions in the Medicaid population to commercial.

Dale Bratzler: Okay, that's helpful. Yes. OK. I don't know why (who) pass that. So from the technical panel, any other questions about exclusion and impact on the measure? Obviously, a lot of patients end up with the diagnosis of asthma that also have a diagnosis of COPD and the older populations.

(Brendan Fetcher): Right, that's a challenge for both for each measure.

Male: Yes.

(Crosstalk)

(William Brendle Glomb): I offered the comments regarding the active cancer, and HIV, AIDS exclusions. I assume that's because such individuals would be cost outliers.

Ben Hamlin: Yes, that's correct.

(William Brendle Glomb): And you know, one of the things that is happening around us is that multi-morbidity is becoming much more common as we all know. So, you know, increasingly we're going to be seeing asthmatic patients who have other conditions including cardiovascular disorders, lupus, diabetes, et cetera.

And my understanding is the intent of this measure and correct me if I'm wrong, but this was my understanding when reading it is that other health service utilization cause will be included in the management of someone with the target condition of asthma, is that not correct?

Ben Hamlin: Any health care utilization that a person who has been identified with asthma is included in the resource use report out for this measure. The issue …

(William Brendle Glomb): If somebody fractures their ankle …

Ben Hamlin: Yes.

(William Brendle Glomb): … the cause of that episode is included in the cause of managing someone with asthma.

Ben Hamlin: Yes, that's correct.

(William Brendle Glomb): So then, base on, I mean, my concern would be based on case mix that if one – if comparing a, I don't know, comparing medical group A to medical group B based on case mix if medical group A happens to have an asthmatic population with the greater proportion of multi-morbidity, they're

going to have higher cost independent of how well they do managing asthma per se.

Ben Hamlin: But this is actually health plan measure that we don't do that – specify this for medical groups and the risk adjustment have 13 separate category cohorts of risk that each patients weighted into. So, patients with additional comorbidities are going to be classified in the high risk cohorts and the generalizing …

(William Brendle Glomb): I mean, in terms of the point I'm raising, you're confident that your model addresses that?

Ben Hamlin: Yes, as far as comparability, the occurrences of these events are fairly consistent across plans given the size of the population that are being reported for each of these plan submissions.

(William Brendle Glomb): Okay, so then in terms of the rate of people fracturing their ankles, I mean that's randomly distributed and that's going to adjust out appropriately.

Ben Hamlin: It's fairly consistently distributed across plans and also the, you know, the avoidance for us was we did not want to get into the identification of conditions specific attribution. So, whether they fractured their ankle because they have an asthmatic attack on the monkey bars and fell up and broke your ankle. You know, we don't want to get in those kind of arguments. It's really, you know, this is a snapshot of the resources that a plan uses to manage someone with asthma regardless of whatever their like looks like really – it's really, but it's all in the aggregate of the health plan level by cohort.

Dale Bratzler: Okay. Any other comment …

Male: Yes, I think it's just – and this may have been taken into account also, so you know, the big question and all these measures is socioeconomic status, health literacy, and it's always to fear that hospital is caring for an underinsured or under privilege if you want population are going to be suffer more because not necessarily medical comorbidity but psychosocial comorbidities. So, again in this sort of taken into account of factored in any way?

Ben Hamlin: (Inaudible) was currently not adjustment for socioeconomic status, their socioeconomic factors. We do report the product line separately, so eight patients who are edible in the commercial product line are reported separately from those in Medicaid and we do for some chronic diseases, see differences in those rates. And we do not compare the Medicaid to the commercial population because we do so those populations are in fact different.

Male: Okay. Thank you.

Ben Hamlin: At the health plan level, this tends to balance that a lot in the peer groups that are being – that were reported the other, you know, for each region, so.

Male: OK.

(William Brendle Glomb): So then let me just – I think this is addressed in the different area and it's something that runs through these three measures and I'm sure other proposed measures who have a medical conditions in terms of the adjustment or lack of adjustment for race, ethnicity, or socioeconomic status. I mean there are clearly measure differences and disparities and outcomes. I mean you can look at an asthma care provider in an exurbia or suburbia compared with an asthma care provider in an urban center. And the – there are huge disparities in terms of rate of hospitalization et cetera.

Ben Hamlin: I agree with you and at the plan level, we find those disparities do not exist necessarily between plans based solely on those factors. The issue is also primarily in the data, so we continually test the available data for race and ethnicity and certain (SDS) factors in each plan to try and attempt to address that – address that head on.

Unfortunately, the plan collection of that data varies almost the full range of zero or 100 percent (to that numbers).

(Crosstalk)

Andrea Gelzer: This is Andrea Gelzer, that's an issue that is common with many plan measures, I mean …

Male: Right.

Andrea Gelzer: … you could say that probably about every NCQA measure. So, I'm not bothered by it.

Dale Bratzler: So, I think it's appropriate to note the conversation about socioeconomic status and those concerns. I know that's much bigger discussion that's going on in NQF about risk adjustment for all performance measures beyond – well beyond this project.

So, I think we should note it in the minutes, Lindsey, but I don't want to spend too much time on the discussion about socioeconomic status and, you know, we all know what has an impact on patient outcomes. And note that we have that conversation then certainly it can take it to the Steering Committee also but I don't want to spend too much time on that because NQF is dealing with that on the much higher level.

Lindsey Tighe: Agree, Thanks.

Dale Bratzler: Any other comments about questions five or six? So, Lindsey, why don't you scroll up to number seven, to what extent is the reaction now for clinically exclusions adequately described and clinically relevant.

So, in terms of the actual exclusions, it doesn't look like there were too many comments and, of course, the concern about the possible non-asthmatics getting into the denominator, but otherwise, were there other comments about the clinical exclusions?

(William Brendle Glomb): Did the webinar freeze or did I freeze?

Dale Bratzler: No, mine moved.

(William Brendle Glomb): I'm still at five or six on the screen, I wonder what that means.

Lindsey Tighe: Try refreshing the browser.

(William Brendle Glomb): I'm doing a retry here. There we are. That's what I needed to do.

Dale Bratzler: All right.

(William Brendle Glomb): Sorry.

Dale Bratzler: Plenty of comments about number seven?

So, number eight is to what extend a relevant condition is represented in the codes a listed in this mission for clinically exclusion plan, the inclusions. Here, when you went to the clinic logic documents, there was an exhaustive list of all the codes that are included there.

Any comments about the codes that were listed?

So, let's move to perhaps the toughest one which is to what extent are in the covariates or factors included in the risk adjustment model clinically relevant and consistent with the measure's intent. And quite honestly, I think this is, you know, place where the NQF is really looking for the TEP to provide input about the risk – particular the clinically relevant risk factors.

So, there are called is these uses the (HCCs) for identifying a risk or with the hierarchical linear – with the some type of regression model, I assume hierarchical model looking at the risk and creating that score for the patient, and then calculating observed and expected ratio of costs.

Male: I think I which of our – whichever of our panel members have concern about including the socioeconomic, I got to agree with that. That did not pertain to my response but overall that (inaudible). If there's a way to eventually factor that I in, I think that's got, you know, the report (inaudible) aspect of this.

David Lang: Yes, David Lang, that was my comment and we – I raised that issue previously. And again as noted here the fallback would be using code of residence which is also been shown to the proxy for a lot of other factors that influence healthcare outcomes, (inaudible) and health service maintenance behaviors.

Male: You bet.

David Lang: Otherwise, I think you're going to have disparities and outcomes that have little to do with the asthma management practices per se.

Dale Bratzler: So, again, I don't want to spend too much time on that. I mean I completely agree with you at the provide level. The question is does it have much impact that the plan level? I think where I was hearing earlier was that didn't have a huge impact at the level of the plan.

David Lang: Could you elaborate on that, please, that distinction?

Ben Hamlin: I think, well, this is Ben from NCQA. I don't think we know necessarily whether it does have a large impact to the plan level. Our investigation so far we've been unable to determine their true impact based on the disparity of data that exist out there between the different plans. So, we've included adjustment in the measure for the things that we can, in fact adjust for at that point time. And we're looking forward to the guidance from NQF, on (STS) and other factors, hoping that will encourage more consistent and better data collection across the board.

Steve Grossbart: You know – Steve Grossbart here. I think it's useful for the committee to think about the fact that you have accrued socioeconomic stratification because you got Medicaid plans, you got commercials plans, you got – and the self-payer excluded. So I mean that is – to some extent, you got a more homogenous population and would otherwise be the great case of a general population.

Dale Bratzler: Yes, that's a good point, Steve.

Male: By the essence and certainly from standpoint of (my) plan that were all Medicaid, one of our products, our foster program uses all of the Medicaid, Google and then our Medicare Advantage plan is probably – are different plan, if that's where that sort of stratification might come into play a little bit.

Dale Bratzler: OK, so we duly noted a (STS) status race/ethnicity, any other concerns about the risk adjustment covariates not necessarily the model itself but the covariates or other clinical conditions.

There was one very, very specific comment about to Churg-Strauss …

(David Lang): I raised that too as to how that's handled (ADPH) or Churg-Strauss patients would be – although not a huge subgroup, but, nonetheless, one would expect that they would have much higher healthcare cost and greater morbidity. And again, you know, referral centers would, you know, disproportionally burden by such to patients.

Dale Bratzler: OK. NCQA, do have any comments about that?

Lindsey Tighe: (Inaudible) anyone from NCQA, do you have any comments?

Ben Hamlin: If the comment how the (HCC) model handle these conditions or whether this would affect the measure …

Dale Bratzler: No. It's …

(David Lang): Are they handled in the model? Are they stipulated in the model?

Ben Hamlin: That I would have to get back to you and I have to looked them up specifically in the (HCC) model. Our queries show that these are not highly prevalent, so it would not effect the measure comparability very much. (Inaudible) populations for that. I think (look) to see if they're actually incorporating the model or not.

Dale Bratzler: OK. Any other comments about the asthma and the resource use measure? We'll have plenty more time to talk about some of this. So I guess, Lindsey, should we move on to COPD?

Lindsey Tighe: Sure and Dale, just in the interest of time if possible. I think our framing for this would be a conversation on, if there are issues that are different from the asthma measure?

Dale Bratzler: Yes, I think that's a good point.

Lindsey Tighe: Ben or NCQA, did you want to provide a brief instruction to this measure before we jump in?

Female: Maybe one thing I'll – anything that's kind of specifically different about the way it's structured or the way the algorithm work might be useful as well.

Ben Hamlin: It's structured exactly the same way either the clinical definition for COPD that we used to cross other HEDIS measures. The resource use is total annual on a PMPM basis for the whole health plan. So, it's (inaudible) identically.

Dale Bratzler: I wanted to make sure I understood. A little bit difference though in the construct of the timeframe. So, it's a calendar year measure again, but do you require the two years continuous enrollment like you did for the asthma measure?

Ben Hamlin: No, we do not.

Dale Bratzler: OK.

Ben Hamlin: The measurement period – measurement year, I'm sorry.

(David Lang): OK. All right. So, any questions about the measure population be clinically appropriate?

William Brendle Glomb: This is Brendle again. I guess into – I kind of asked this and I'd like our – my colleagues to weigh in on how much overlap might we get of non-COPD patients if the more less – or if the less specific diagnosis of emphysema or chronic bronchitis are used. I know that they're often all three used interchangeably but I also know that they cannot be the same disease. So, I'm just asking for (inaudible) identification.

(David Lang): I mean, I think from a clinical point of view, it's not such a big deal. The terms are used interchangeably whether its emphysema or chronic bronchitis. It's basically the same disease. I don't think that's a big deal.

William Brendle Glomb: OK.

(David Lang): Yes. They probably have, I mean, I think like the asthma thing is over diagnosis. And in our hospital like other hospitals are running the COPD program mostly because of the measures for the 30 daily admission. And we're finding a lot of people who are diagnosed with COPD don't really have

COPD. They may retain CO2 for – because of obstructive sleep apnea, let's say, and they could label to COPD and the person has never been exposed to anything and never smoked. But, you know, the same question that we had with asthma over diagnosis.

William Brendle Glomb: OK.

Ben Hamlin: Yes. In this case, we have actually investigated the coding for COPD during an extensive medical record review and the correlation with the diagnostic criteria and what was being coded. For as for COPD, I can't speak to chronic bronchitis and emphysema was highly correlated. So there was – in the ICD-9 codes that are being used to code COPD, we have (inaudible) a high correlation to actually the diagnosis (particularly itself).

William Brendle Glomb: OK. Good to know.

Dale Bratzler: Any other comments about questions either one or two, identifying the measure population?

Question number three focuses on to what extent does the submission adequately describe the evidence supporting decision logic per grouping claims to measure (inaudible)?

Again, similar construct to asthma, so yes, all included, all services provided over to the measurement year are included irrespective to their relationship to COPD. But that's the same as the asthma measure.

Male: Looks like we like that one.

Dale Bratzler: Any other comments about three? So again, the episodes same here that was for asthma to a calendar year based on the diagnosis of COPD. And I assume the COPD diagnosis is only during that measurement year?

Ben Hamlin: Yes, if it's code as present and then member record during the measuring period are included.

Dale Bratzler: OK, all right. Any other comments about number four?

Male: Yes.

Dale Bratzler: OK. Number five clinical relevancy are the exclusions to narrowing the target population to be up so or (inaudible) existing conditions again. I think we find it like – so cancer, HIV, clearly were listed as a exclusions. And I believe when I looked at other documentation, I can't remember when I went to the NCQA website that ESRD patients were excluded.

Ben Hamlin: Yes, that's correct. Another (inaudible) excluded based on a cost not on clinical factors.

Dale Bratzler: Right, right. And similar comment about denied claims that you made before.

Male: Yes.

William Brendle Glomb: Sorry, I had to throw that in again.

Dale Bratzler: No, it's fine. Any other comments about number five? Then number six, do the exclusion represent a large number of patients? Just curious from NCQA, do you have sense of how many patients actually get excluded what the approximately inclusion right if?

Ben Hamlin: No, I don't have an actual rate for this measure. We do look at – so there $100,000 cost cut for (inaudible) that we apply to the members. When we last look at to ESRD and active cancer, it would less than 1 percent of the population actually hit that cap during the measurement period. I don't have exact number for you, I can probably find that somewhere.

Dale Bratzler: So, it's pretty small account sounds like it.

Ben Hamlin: It's a pretty small proportion, yes. Surprisingly, it is.

Dale Bratzler: OK, any other questions about number six?

And then number seven to what extent is a rationale for clinical exclusion for adequately described and clinically relevant. Again, I think as many, many measures not just the ones we're talking today, an active cancer, HIV/AIDS and end stage renal disease are consistently excluded from many of the cost

efficiency measures across many different measure developers just because they're known to be high outlier patients in terms of total cost of care.

Male: Yes.

Dale Bratzler: Some more comments about multi-morbidity. Anything different here? So, please interrupt if you have any comments on.

Male: (Inaudible) answers to number six.

Dale Bratzler: Yes, OK. What extent of relevant conditions represented because listed again supporting documentation, clinical logic documentation had the exhaustive list of all the codes that were included in all the exclusions codes.

Any other comments about number eight? And number nine is about risk adjustment model particularly the covariates. Any other comments about the covariates? Again, we'll make the point, you know, maybe – perhaps a little less of an issue of socioeconomic status though probably could impact the patients.

Male: I would say less than asthma but probably still, you know, there's still disparity.

Dale Bratzler: Yes, yes. And again, I think Steve made the excellent point the different types of plans, one way to do something stratification. So, any other comments about number nine or this particular measure, 1561

Male: And some of this might be a cleaner measure if you will than the asthma side.

Dale Bratzler: Okay. All right, Lindsey, I guess we're ready to move to a new measure, a new methodology.

Lindsey Tighe: Great. Do we have anyone from Yale or CMS to provide a brief introduction on 2579?

Nancy Kim: Sure. Hi, this is Nancy Kim, can you all hear me?

Dale Bratzler: Yes, very well.

Nancy Kim: OK, good. I'm a general internist in academic hospitals, I'm the clinical lead on the development of this measure. Thanks for the opportunity to participate.

So, overarching goal of this measures to estimate hospital level risk standardized payment for Medicare patients for a 30-day pneumonia episode of care that's triggered by a pneumonia hospitalization. And we use chronic condition warehouse data which are Medicare administrative claims data that include 100 percent of patients with primary diagnosis of pneumonia. And these data include payments for the index admission. And at the (inaudible) post-discharge settings, including all inpatient, skilled nursing facility, outpatient, and hospice settings, as well as claims from home health agency, non-institutional providers such as physician services, and independent labs, and durable medial equipment.

There are slight differences in payments that reflect practice patterns. We estimate our payments (inaudible) or standardizing. Essentially, that's the work of removing geographic adjustments like hospice living and wage index, as well as policy adjustments like indirect medical education, disproportionate share payment from our calculations. We pro-rate our payments that begin during the measure window but end afterwards.

And we chose the 30-day window because hospitalizations are expensive and they provide the standardized start time by which the measure hospital. The 30-day window also is a standard measurement window by which to compare hospitals. And decisions made at a hospital affects payment post-discharge. Lastly, this window is aligned with our CMS 30-day pneumonia mortality measure.

Dale Bratzler: All right. Thank you very much. So, I think Dr. Kim made a very important point that – CMS's development of this particular performance measure does align with their pneumonia outcome measure, the re-standardized mortality rate.

So, start of with question number one, based on the intent of the measure, to what extent is the measure population in clinically appropriate? Again the

diagnose – if the denominator population is based on a acute care fee-for-service, 65 or older Medicare patient admitted to the hospital with a principal diagnosis of pneumonia.

Any questions or comments about the identification of the denominator population? It is a quiet group.

Male: I just don't …

(Rubin Cohen): So just at a side – this is (Rubin Cohen), I thought this was very well written, this proposal. I really liked it, that it was very easy to read in and very well put.

Nancy Kim: Thank you very much.

(William Brendle Glomb): I agree with (Rubin), I think it was – I think that's why we're quiet, there's not much left to the imagination here.

Dale Bratzler: Yes. All right. So, let's move to question number two, to what extent is the definition used to identify the major population clinically consistent with the intent of the measure?

Again, any comment about socioeconomic status consideration that the – we'll put that in the list of kind of general overarching comments about the cause of resource use measures. This is a Medicare-only population, a little bit different but there are socioeconomic status and issue there.

(William Brendle Glomb): And the model adjusts for case mix adequately, I mean we're confident about that.

Dale Bratzler: We'll get to that I think at the end – number nine, which is question number nine, the covariates and other things.

(William Brendle Glomb): OK.

Dale Bratzler: But are we convinced that we are comfortable that it identifies population?

(William Brendle Glomb): Yes.

Dale Bratzler: OK. Any other comments about question number two?

Number three is to what extent does the submission adequately describe the evidence, support the decisions and logic per for grouping claims. Identifying the major population exclusion to measure the condition for the episode?

So, again I think the consistency and alignment of the CMS measures here, mortality and cost use. Dr. (Kim) is this is – is the same methodology used on readmission?

Nancy Kim: You can call me Nancy, first of all. And yes, it's a very similar methodology used in readmission, but we mirrored our cohort on the mortality, pneumonia mortality cohort, it's slightly different but yes, it's the same standard methodology that we apply to all of our measures including those that are NQF-endorsed and publically reported.

Dale Bratzler: Right, so you did mirror the mortality measure?

Nancy Kim: Yes.

Dale Bratzler: OK. Any other comments about question number three?

(William Brendle Glomb): I think it reflects what (Rubin) said on the last question. (Inaudible) they didn't require too much the broadness of definition.

Dale Bratzler: So, let's talk about the link of the episode that this is an episode measure, a little bit different in the NCQA measures that we just reviewed. And the trigger for the start of the episode is an acute care, fee-for-service hospitalization, principal diagnosis is pneumonia. And then the time window of 30-day period after admission – standard for all patients.

Any questions or concerns or anything about the episode again aligned with the pneumonia mortality measure that also looks at 30-day mortality after admission?

(William Brendle Glomb): This is certainly common practice on the insurance side and the payer side to choose a 30- or 90-day window depending upon which (inaudible) measurements you're looking at. So, I think that would be very helpful for the plan such that it correspond with what they're trying to do internally already.

Dale Bratzler: Any other comments about question number four?

OK, we'll move to number five, describe the clinical relevancy of the exclusions to narrow the target population of the episode chronic condition or coexisting conditions and measure intent.

So, most of my comments were related to the fact that there are limitations to the claims and because patients have to be continuously enrolled in Medicare for at least the year prior to the admission, it's a restricted group, 65 and older fee-for-service. And then of course, those patients were – the new clinical claims, they just simply are incomplete or if the patient had – didn't have 30 days worth of care after the admission, those patients would also be excluded. Nancy, does that include deaths, patients die (inaudible) …

Nancy Kim: We do include deaths.

Dale Bratzler: … admission.

Nancy Kim: We do include death and we do that deliberately, so that we can compare our payment measure with our mortality measure.

Dale Bratzler: So, patients comes in with pneumonia but dies on, you know, seven days after the admission, they are included than the metric?

Nancy Kim: Correct.

Dale Bratzler: OK, great. And for all of the pneumonia, part of this and other measures they now have an exclusion for patients with hospice assignment prior to the measure (inaudible), but prior.

Any questions about number five or comments about number five?

OK, number six, do the exclusions represent a large number of patients. I actually looked at the logic model in the CMS document and look like 7.3 percent of the eligible patients were excluded based on the exclusion criteria of lack of claims statement and others. So, relatively small percentage.

So, to what extent does the rationale for clinical exclusions adequately described and clinically relevant?

Nancy, you want to – I have been dealt with this in the past. I understand their rationale for the assignment of transfer patients to the first hospital but you want to just talk about that. There were some questions about, you know, the cost associated with the transfer in the second hospital.

Nancy Kim: Sure, I'd be happy to.

So, in transfer scenarios, number one for the pneumonia cohort, the number of transfer is 0.38 percent, so that's if hospital A admits a pneumonia patient, determines if they need to be transferred to hospital B for further care during that index hospitalization in (contiguous) days. We would assign a total episode payments from admission to hospital A to 30 days post-admission to hospital A. That happens for pneumonia in 0.38 percent of cases. It's more common for some of the other conditions like AMI but we'd view that because we define that first index hospitalization as a start of the episode.

There are two other ways to deal with transfers. You could exclude them which we don't like to do because you lose patients and then hospitals from the recording of the measure. Or you can assign the payments made to hospital B, the receiving hospital. But we don't like to do that because we don't think it conceptually flows with your start date, the date of index admission.

And we think that hospital A because it's for inpatients and not hospital AE or the hospital B inpatients. These are hospital A inpatients to hospital B inpatients. And hospital A does their responsibility for some of the decisions that are usually costly because we know that hospitalizations are a big piece of the total episode of care payments. So that's the reason we do that.

Also, it is aligned with the way attribute mortality for pneumonia and our other conditions, and it's aligned with our other payment measures.

Dale Bratzler: I can tell you specifically when we're looking at pneumonia mortality, we just felt there was, you know, not appropriate to hold the second hospital accountable for mortality when they may not have controlled the initial management of the patient or they've received the patient late in the course of their care.

David Lang: Right, understood. Whichever way you do it, it's not entirely clean but – you know, obviously there are issues that may come up with the – at hospital to which the patient is transferred. But I understand the rationale and I appreciate the clarification that it's only 0.38 percent.

Is there an adjustment for – this is David Lang, I raise this – is there an adjustment for admission source?

Nancy Kim: By that, you mean whether the patient comes from SNF or LTACH or something like that?

David Lang: On a nursing home compared with the community resident for instance.

Nancy Kim: No, we have not done that traditionally on our measures because they feel that the place of origin before admission is really a systems' issue. So that somebody coming from a SNF in one region may be clinically similar to somebody coming from home in another region.

David Lang: It would seem to me that even – apart from various factors associated with a person who's 80 years old and living in the community versus 80 years old in a nursing home, even when that person leaves the hospital and goes back to the nursing home, their cost of care are going to be more substantial and, you know, various – you know, the environment in the nursing home may be – may pretend to for (inaudible) than the community resident.

Nancy Kim: Yes, you raise a good point. Something we've definitely discussed. We haven't done that. I can tell you in our cohort, about 8 percent of folks came from a SNF and the way we design that was discharge from a SNF…

David Lang: From a what?

Nancy Kim: … from a skilled nursing facility, a nursing home.

David Lang: OK.

Nancy Kim: Yes, a skilled nursing facility. And the way we define that was either discharged one day prior to admission to your index pneumonia admission. So we did find that 8 percent but we haven't looked to risk adjust for that.

(Off-Mike)

Dale Bratzler: And Nancy, I'm not sure, I mean, 8 percent seems actually low for a nursing home which is an (ICF). I mean, SNF 8 percent might be reasonable but nursing home, I would think that in the Medicare age group, the population proportions of patient it seems to me might be higher than that.

Nancy Kim: Maybe you're right. Maybe we don't know what the right variable is, we've only used the skilled nursing facility.

A nursing – and there was a saying that nursing homes are not captured in CCW data so the closest we can get is SNF because nursing homes are paid for by Medicare. So we need a proxy for that. I mean, if you have a great proxy for that, that we could use in our claim data, you know, something that we would be open to evaluating for sure, but it's not something we can do easily with the claim data that we have at our fingertips.

Dale Bratzler: Yes, yes. OK. Any other comments about description of the clinical exclusions?

All right Lindsey, number eight, to what extent the relevant conditions representing the codes listed submission?

I do not have any concerns here that ICD-9 codes were consistent with the other pneumonia risk standardized outcome, particularly mortality measure.

Well, I guess lastly, always the toughest of the question are the covariates factors included in the risk adjustment model. Clinically, relevant and consistent with the measure's intent.

And here you use the condition categories to do the risk adjustment and in table seven and eight, I believe the logic model or the documentation submitted, you actually provide the point estimates for each of the conditional categories that we're include in the model.

Do you have any other comments, Nancy about that?

Nancy Kim: Nope, I think that's a good characterization of what we've done.

Dale Bratzler: Any other comments about the covariates or risk stratification model?

Nancy, I think I saw a reference to it. You have – have you – maybe a little bit off the topic but, have you done – now that you have, you know, claims-based mortality model and claims-based cost model, have you linked the two?

Nancy Kim: Great question. So, we have done some work more so with our – excuse me, AMI payments and mortality measures, not as much with pneumonia. And when we've look at this is a crude way. This is basically scatter plot with payment on the vertical axis and mortality on the Y – on the X axis. We found that there are really wasn't strong correlation, that's a 30-day myocardial infraction, heart attacks, risk (inaudible) mortality rate with a 30-day AMI to send those payments.

We haven't done as much work with pneumonia but we did find that that's consistent with a larger literature, that the cost and quality don't always track together. There is some heterogeneity within that broader literature but it is not counter to what other folks have published. You know with differences and how they define geography in hospitals and all that stuff. But we have done some preliminary work mostly with non-pneumonia measures.

Dale Bratzler: OK, all right. Thanks. All right, any other comments about the pneumonia cost resource use measure?

Lindsey, I think we made tremendous time today.

Lindsey Tighe: Yes. Thank you, that was fantastic. I will jump back over to our slides. We want to definitely thank you all for joining us. And then I just wanted to give you a high level kind of the next steps for this group.

So, we have this call today and then we will have a call on June 11th. The committee members from the Resource Use Standing Committee will be joining us. Also, the developers will be joining us.

We'll be providing them with a written report of your recommendation but it'll be an opportunity but them to ask any questions that are driven by the written report that we give them or anything that may have come up in their own review relating to the clinical specification for these three measures.

From there, the standing committee is (inaudible) meeting June 25th and 26th. We'll create a draft report of their recommendation that will factor and certainly your recommendation from the clinical specification and we'll share that with you in the committee before it goes out for our public and member comment period in August.

So, those are kind of the immediate next steps for this group, certainly we will draft your recommendations from today and share that with you. Get any additional input that you have before were we push it forward to share with the standing committee.

Are there any questions about kind of the next step for this group?

Male: (Inaudible).

Lindsey Tighe: OK. Well, I'll brief break and just ask the operator if there are any public or member comments, if you open the line please.

Operator: Yes, ma'am. At this time, you do have the public comments, please press star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

There are no public comments or questions at this time.

Lindsey Tighe: Thank you. Well, thank you to Dale for ably chairing this group today and giving every one back an extra 45 minutes. And thank you to all the TEP members who joined us, from the committee members who have been listening in. And also, again, thank you to the developer who joined us to provide those introductions and answer questions. If you have any questions, feel free to reach out to our team but, enjoy the rest of your afternoon.

Dale Bratzler: Thanks, Lindsey.

Nancy Kim: Thanks very much.

Male: Thanks everyone.

Male: Thank you.

Male: Thank you.

END