**NATIONAL QUALITY FORUM**

**Moderator: Sheila Crawford**
**June 11, 2014**
**12:00 p.m. ET**

Lindsey Tighe: Hi everyone. This is Lindsey Tighe from NQF. I'm here with Ashlie Wilbon, Ann Philips, and our new product manager, (Clinton Dupe). We are here today for the Phase 3 workgroup call to start looking at the pulmonary measures that we've received for our Phase 3 review.

Our technical expert panel met by conference call two weeks ago to give a preliminary review of the clinical specifications for the measures. And so we're here today to provide the Standing Committee an opportunity to ask any questions about the clinical specifications or any questions about the review or summary that was provided from the Technical Expert Panel call.

Now before we dive into the measures, I do want to move towards some introductions for those who are on the TEP and those who are on the Standing Committee. I will note prior to review of any of these measures, we had our technical expert panel members and also, our Standing Committee members provide us with disclosure of interest forms related to any potential conflicts of interest with these three measures that are being reviewed.

We didn't receive any conflicts that were flagged but we do want to take an opportunity to let the technical expert panel members and also the Standing Committee members briefly say hello and then orderly acknowledge any potential conflicts that they would want their other committee members to be aware of.

So I'll turn it over to Ann to just run through the rolls for the TEP and then the Standing Committee then we'll go from there.

Ann Phillips: All right. Starting with the TEP, Dale Bratzler?

Dale Bratzler: Yes. This is Dale Bratzler here and I have no disclosures.

Ann Phillips: Andrea Gelzer? Peter Almenoff? Alan Baptist?

Alan Baptist: I am here, Alan Baptist and I have no disclosures of interest.

Ann Phillips: Thanks, Alan. Rubin Cohen? William Brendle Glomb?

William Brendle Glomb: Hey, this is Brendle Glomb. I – semi disclosure, I do work for a managed care organization but – who ultimately be responsible for utilizing the measures but otherwise no conflicts or whatsoever.

Ann Phillips: Thank you, Brendle. Stephen Grossbart? Stephen, are you unmute because I think you're on the call?

Stephen Grossbart: I'm on the call. Can you hear me?

Ann Phillips: Yes.

Stephen Grossbart: I have no disclosures.

Ann Phillips: Thank you. David Lang? All right, we will go on to the Standing Committee. Brent Asplin?

Brent Asplin: Good morning. I'm here, I have no disclosures.

Ann Phillips: Thank you, Brent. Lisa Latts? OK, Ariel Bayewitz?

Ariel Bayewitz: Good morning. No disclosures.

Ann Phillips: Thank you, Ariel. Lawrence Becker?

Lawrence Becker: I'm here and no disclosures.

Ann Phillips: Thank you. Mary Ann Clark? Cheryl Damberg?

Cheryl Damberg: I am here and I have no – excuse me, no disclosures.

Ann Phillips: Jennifer Eames-Huff?

Jennifer Eames-Huff: I am here and I have nothing to disclose.

Ann Phillips: Nancy Garrett?

Nancy Garrett: I'm here and I don't have any disclosures.

Ann Phillips: Andrea Gelzer? Stanley Hochberg? Matthew McHugh? Martin Marciniak? James Naessens?

James Naessens: I am here and no disclosures.

Ann Phillips: Eugene Nelson? Jack Needleman?

Jack Needleman: I am here and no disclosures.

Ann Phillips: Janis Orlowski?

Janis Orlowski: I'm here and I have no disclosures.

Ann Phillips: Carolyn Pare? John Rakliff – or Ratliff, sorry. Andrew Ryan? Joseph Stephansky?

Joseph Stephansky: Good afternoon. I have no disclosures.

Ann Phillips: Lina Walker?

Lina Walker: I'm here. I have no disclosures.

Ann Phillips: William Weintraub?

William Wentraub: Here and no disclosures.

Ann Phillips: Herbert Wong? Dolores Yanagihara?

Lindsey Tighe: All right, thanks everyone. Since we have so many Standing Committee members on, I'm just going to do a brief plug now and I'll remind you at the

end, we did send out a SurveyMonkey asking for your votes on the Phase 2 measures, 2431 and 2436 after our post-comment call last week.

If you haven't completed that survey, we would really appreciate it if you did follow that link and complete that survey. I'll remind you again at the end of the call but just wanted to remind you twice.

So getting started on the Phase 3 measures, I just want to briefly walk through the parameters within which the technical expert panel is reviewing these three measures. So they were looking at the clinical logic including a description of the logic, the actual logic itself, the evidence to support it, and the measure trigger and end mechanisms. They may look at the inclusion and exclusion criteria and also the risk adjustment.

We asked them to evaluate the clinical logic asking them to what extent the measure population is clinically appropriate, to what extent the definition is used to identify if the measure population were consistent with the intent of the measure. Looking at the evidence, asking them to evaluate to what extent does the submission adequately describe the evidence that supports the decisions or logics for grouping the claims to measure this clinical condition and working at the trigger and end mechanisms, the length of the episode with the clinical course of this condition.

With respect to inclusion – I'm sorry?

Rubin Cohen: I'm sorry. Hi. I'm sorry, this is Rubin Cohen. I'm sorry for joining late and I have nothing to declare.

Lindsey Tighe: Thank you. Sorry, I should have paused to see if we missed anyone. Is there anyone else who joined?

Martin Marciniak: Yes, here. Martin Marciniak.

Lindsey Tighe: Great. Thanks for joining.

Martin Marciniak: Yes.

Lindsey Tighe: OK. With respect to the inclusion and exclusion criteria, they are looking to see if the clinical relevancy of the exclusion to knowing the target population. So the episode eventually was consistent with the measure intent. Did the exclusions represent a large number or proportion of patients? To what extent is the rationale for clinical exclusions adequately described and clinically relevant, and to what extent are the relevant conditions represented in the codes listed in the submission?

Looking at the risk adjustment model, they are just looking at to what extent the factors included in the risk adjustment model are clinically relevant and also consistent with the measure's intent?

So that is a brief overview of the scope of the TEP. Are there any questions before we jump into the measures? OK. So our fist measure that was reviewed was measure 1560. If we have someone from NCQA on the phone who would want to provide just a very brief introduction to the measure, then we'll ask Dale Bratzler to give an overview of the TEP discussion and the TEP numbers to jump in with any other concerns, flag or comments to make.

Ben Hamlin: Yes. Hi, Lindsey. It's Ben Hamlin from NCQA.

Lindsey Tighe: Hi, Ben.

Ben Hamlin: So both of the relative research used measures for asthma and COPD are a risk adjusted, total annual snapshot of health plan resources that are used to treat people with a specified condition. They are associated for reporting purposes with clinical measures for asthma and clinical measures for COPD from the HEDIS set, those are endorsed under a separate NQF submission process. So the measures we're reviewing today are just the resource use aspect of that, part of our value equation for NCQA public reporting.

Lindsey Tighe: OK, great. Thank you. With that, Ann, if you could just pull up the TEP summary and Dale, if you could just walk us through it? We can take a question by question and just highlight any concerns and then open it up for discussions.

Dale Bratzler: All right. And I'm doing the best I can to keep up with the internet here. As I mentioned, I have limited access. So this measure was discussed by the technical expert panel and I think probably the biggest – probably the longest part of the discussion about this particular measure. So let me highlight a couple of things about this measure. This is not an episode of care measure, this is a measure that looks at all cost of care for patients with a defined diagnosis of asthma and it looks at all cost of care over a one-year period.

It's consistent with other HEDIS measures and that was discussed by the technical expert panel that we understand how the timeframe was defined and the measure population because it is consistent with some other HEDIS measures. I think the biggest part of the conversation was about defining the denominator for patients with asthma. So issues that were discussed included patients who have a single emergency department principle diagnosis of asthma, that was a concern I think to the group. Patients who have multiple offices with the diagnosis of asthma and I think the pulmonologist on our committee can certainly jump in at some point, but one of the big concerns is the validity of the diagnosis of the asthma oftentimes in office records may not be that great.

Again, the denominator definition here is consistent with other HEDIS measures that are NQF-endorsed. And so our committee understood why the definition was developed the way it was but there was some concern that there might be some patients pulled into the measure that might have a diagnosis of asthma based on office visits or ED visit but may not make clinical criteria explicitly for asthma.

So we discussed with the developer the asthma definition diagnosis over a two year period. The cost of care – we looked at over a single year of the measure and I think I'll ask if there are – let me just quickly ask if anybody else on our committee have any other comments about that key issue that we discussed.

William Brendle Glomb: Hi. This is Brendle Glomb. PH pulmonary and – yes, I think again, it had to match the previous measures but it is a extremely imprecise and in many cases, incorrect diagnosis. We've gone from underdiagnosis probably to a condition of overdiagnosis, the pendulum has swung. And the

concern would that be that – these non-true asthmatics will dilute the reporting and results. Just that little commentary. Sorry.

Dale Bratzler: No, that's good. That's exactly what I wanted you to bring up. So that was probably the biggest point of discussion about the measure itself. I don't think there were that many other substantial questions. There were a number of questions about some of the medications that were included in the list so another way to get in to the denominator for the measure is to have a diagnosis of asthma or to be on a list of medications that would be used for asthma and the medication was included.

A few medications is no longer available in the United States and there were questions about other measures and the developer did discuss that that they did, on an annual basis, update the database to be consistent with current formularies that are available in the United States or approved medication. So I think we were fine with that that there is maintenance to the measure and the medication list.

Can you scroll on down a bit further? The measure excludes patients younger than five years of age. I think there were some concern about that. And honestly, I don't remember – NCQA, can you tell us again the rationale for the five-year cutoff?

Ben Hamlin: Yes. That again aligns with the current use asthma measures and it's because our respiratory panels felt that the management of children younger than five was significantly different enough from those – from the five to 64 is that it would require either a separate measure or, you know, a much more complex measure. And so they've – that's the reason for that cutoff.

Alan Baptist: Ann, I'm sorry, this is Alan Baptist from the TEP. Is the – kind of along the same lines as the exclusion of patients above 64 analogous because there are plenty – there are patients above 64 who have had asthma who do not have COPD for example?

Ben Hamlin: Yes. We're actually increasingly testing the upper age limit of this measure. We increased from 50 several years ago when we were able to test the 50 to

64 population and find out the exclusion – effective exclusions. I think we've provided that data in your materials.

We're currently testing now the 65 and older population to see if we can further expand the denominator and that would hold through across all asthma measures, the clinical asthma measures in HEDIS and this relative resource use measures. So if we are successful, we will be increasing the upper age limit.

William Brendle Glomb: This is Brendle again.

Ben Hamlin: (Inaudible) has been more concerned about COPD in the concomitant diagnosis and so we're trying to make – we're trying to look, you know, claims to see how clean those are to validate whether, you know, we can appropriately do that through our claims algorithm.

William Brendle Glomb: Hi. This is Brendle Glomb again. Just to follow through on that same theme, obviously in pediatrics, we recognize that asthma does (inaudible) under age five as well. And it's often difficult to confirm with the absence of spirometry in very young age group but since spirometry is not required for the diagnosis for this measure in the first place, that ought to be also further discussed in future measures. Thank you.

Dale Bratzler: All right. We really did not have any substantial comments about the lengths of the episode – truly, this is not an episode measure but it looks in all cost of care over a calendar period – year period with the patient having to be – have the diagnosis over a two year period so we really had no comments about that. There's no start and stop time for a episode of care here.

We had a good discussion of exclusions from the metric particularly related to other conditions. And I think in general, our discussion was that the exclusions appeared to be appropriate particularly excluding patients with diagnoses such as COPD, chronic bronchitis, certain persons with cancer, HIV, other high cost conditions, end stage renal disease.

So I think there was a pretty good comfortable that appropriate populations were excluded from the measure. The developer also provided information to

us on the proportion of patients actually who get excluded and turned out to be somewhere roughly around 14 percent of the patients that were 55 and younger or up to 51 – 50 I guess. But 51 to 64, almost 40 percent of the patients got excluded primarily because they also had coexisting diagnosis with COPD. So, some question about the diagnosis there but those patients do get excluded from the metric.

So, I'll stop at this point see if there other comments from TEP members about any of those issues but I think we were pretty comfortable with the exclusions.

OK. Lindsey, do you want to go ahead and scroll down or whoever is running the screen.

Jack Needleman: This is Jack Needleman. I just ask a quick a question on the exclusions, were there any – it sounds like there weren't any obvious categories of high cost – non – high cost, non-asthma related conditions that were missed in the exclusions, is that a fair statement?

Dale Bratzler: So, others can comment. I think we talked extensively about other fairly uncommon conditions that might mimic asthma, some of the pulmonary conditions what we discussed. I want to say certain (straws) and some others that we discussed that might show up that would be relatively high cost but I know NCQA had looked at other conditions and found that to be very, very rare in the measure set.

And we did look at the exclusions that included, you know, the conditions that we know would be high cost non-asthma. So, end-stage renal disease, HIV/AIDS, immunosuppressed patients, patients with COPD, chronic bronchitis and others. Those were all excluded. So, I'll ask the TEP, were there any other conditions we had we had concerns about not being excluded?

Brent Asplin: Lindsey, this is Brent Asplin. I had a question about the first point that was raised by the TEP relative to the parts of the inclusion criteria, the denominator. Were there any proposed resolutions from the TEP? And I don't know if there's dialog with the developer around the practicality and pursuing any revision to the denominator?

Dale Bratzler: So Brent, this is Dale. I mean, I think, you know, we raised those concerns about – particularly the single ED diagnosis of asthma or even office visits of asthma, two of more office visits with asthma as a diagnosis. I think in the end, the conversation was that this measure aligned with other NCQA measures and if there is going to be a change, it would require, I think, you know, an alignment across all the NCQA measures. So, I'll defer to NCQA to see if they've had that conversation.

Ben Hamlin: Yes. I mean we have, obviously, we've continue to look the asthma inclusion criteria over the years. And, you know, the reasons it does still exist is a two-year definition and patients has to meet criteria in each year for both years, because that is the most sensitive and specific destination for persistent asthma. And that's available in claims currently. And that is – we test it that way it is found to be, you know, valid and reliable using that two-year definition. We've try to look at a one-year definition and then, we have an increased error rate because of the, you know, certain elements of criteria particularly the ED visits.

I think that we are waiting patiently for ICD-10 and we're doing a lot of co-testing right now to look and see how that will change? And I imagine that once that gets fully implemented, and has some experience and use, we will – you know, obviously, we look at the asthma algorithm. But I think until that time, there's not a lot we can do in claims to further refine the definition.

Dale Bratzler: So for my education and if I understand that if – if the only diagnosis in claims data that a particular patient had was an ED visit with the diagnosis of asthma, they would have to have a ED visit in two separate years with the same diagnosis in order to be included in the denominator, is that correct?

Ben Hamlin: That's correct.

Dale Bratzler: OK. That helped.

Ben Hamlin: And currently the proportion of patients I think is below 8 percent overall who get in with any ED diagnosis and that's what – they kind of follow it in other – any other criteria first before they have any ED visit.

Dale Bratzler: Great, that was my next question. So, I think that's the (weak) of category. I'm allowed to day because (inaudible).

Ben Hamlin: Great, we see that. We see that question a lot about this definition that why we continue we look at it but so far, like I said, it's the most (sensitive) we can get, and if we were going to exclude that, we probably loss about 8 percent of the population which in fact we think, you know, have a valid diagnosis of persistent asthma. So …

Lina Walker: And so, this is Lina Walker. Can I just clarify the point you just made. So, you are saying that 8 percent of the population was diagnosed as asthma just solely from the ED visit over those two periods, the two-year period?

Ben Hamlin: No, 8 percent are the people who – when we look at the member level claims analysis. We see about 8 percent of people who have an ED diagnosis. You know, and who are included in that inclusion population.

The ones you have multiples over, you know, in each year over each year…

Lina Walker: Yes.

Ben Hamlin: … significantly reduces that number. They – few patient – majority of patient tend to get in the combination of medications and outpatient (versus) the diagnosis of asthma. That that's probably the vast majority of patient, how they get in the algorithm.

Lina Walker: OK, thank you.

Larry Becker: This is Larry Becker. So, I've lost track of who said what but early on someone had said that we're tending to overdiagnosis of asthma. And so my question is, well isn't that an important finding of this measure to inform practice?

Ben Hamlin: Well, as a developer I would certainly say yes because I believe that, you know, that the plans would certainly want to look at the resources used for people who have been identified for this, and if they find, you know, wide variety. You know, we don't get the member level data at NCQA for these

results, w get a lot of data but it say the cohorts (inaudible) member of cohorts by age and gender results.

And so, I think, you know, but the plans do have that (enveloped) of information. They can really build that into the pairing the resources use reported against the benchmarks that NCQA provides for this measure and their actual data for members who may or may not actually have the conditions. And I think they can do very sophisticated analysis there so I think this is one of the reasons this measure could be useful to a plan who might be interested in looking that over diagnosis.

Larry Becker: Great, thank you very much.

Alan Baptist: This is Alan Baptist and this is a question again for the developers. Well, the kind of the reverse of that is the under diagnosis in terms of patients being excluded for having COPD and what maybe happening is that and anyone who has any smoking history and any breathing symptoms are called COPD when that may not necessarily be accurate. And, I wonder if using, you know, a smoking history or practice which – it's probably readily available on a lot of data basis. So, that – we're shown to have sensitivity or specificity to try to get a more accurate diagnosis of asthma which is I think is likely – especially as patients get older, there is probably under diagnosis and incorrect diagnosis of COPD based on respiratory symptoms than an older patient who have a minimal smoking history.

Ben Hamlin: I would agree. So, two things. One is that patient with COPD are excluded from our asthma measure however, in our COPD side, patients with asthma are not excluded for the COPD measures. So, effectively what we're looking at is anyone with a diagnosis of COPD so that if it gets shuffled off and the COPD relative resource use measure. And also that holds true for the HEDIS measures.

And with regard to smoking history and smoking status, those are not things that are available in claims but we are absolutely looking at. They're like BMI. We know that there are question that are frequently asked pretty much every visit with every provider. And in our eMeasure work and other, you

know, alternative data set work that we're investigating additional research and trying to specify this measure little better. We're certainly looking at those factors but right now, there are just not available in claims, if they are, they're extremely limited.

The same goes with spirometry. So, you know, again, we're looking at everybody's spirometry but again, in claims, the recording of those spirometry results is not as extensive as we would like to see it certainly, and so, we're hoping that, you know, a more sophisticated measure that using more enhanced clinical data perhaps during the eMeasure might be able to really get at those various set of issues. But right now, were limited to claims that are available.

Dale Bratzler: Any other comments?

The next issue that was discussed fairly extensively though we deferred part of the conversation to the greater NQF conversation about risk adjustment or adjustment of measures based on socioeconomic factors. But, I think there was a strong sense that particularly for asthma, socioeconomic status may have – may influence total cost of care and for patients with asthma. Again, I know, this is part of a greater NQF conversation about the whole issue, socioeconomic status risk adjustment for performance metrics. So, we decided not to spend too much time focused on that.

We did note with the developer that because these are plan level measures, these measures do self-stratify to certain extent. So, Medicaid-based plans do look different in the reporting than commercial plan.

So, to a certain extent, there is some socioeconomic stratification based on the type of plan that actually is participating the measurement. So, I'll ask NCQA again, do you have any comments about that? We did not focus a lot, did not spend too much time arguing the merits of socioeconomic stratification though we recognize for asthma it maybe important.

Ben Hamlin: Yes. So, we're paying…

(Crosstalk)

Female: Yes.

Ben Hamlin: So, I'm sorry. We're paying very close attention to NQF's conversation on socioeconomic status stratification. Currently, the NCQA measures are reported by product line. So, Medicaid plans are reported against Medicaid plans and commercial plans…

Male: She usually is…

Ben Hamlin: … asthma. We do find interestingly enough actually that there are differences. So, in the Medicaid plans particularly to engage for, we tend to see higher rates recorded for children in the – prior to 18 and if Medicaid lands in the commercial side. So, we agree that is probably a lot of SES detail that could be possibly stratified. And it would need to be done very carefully but (inaudible) we're surveillancing the conversation about NQF's guide into that realm.

Lindsey Tighe: Thanks, Ben. Just a quick reminder for those of you that are on the call, if you could mute yourselves. Sometimes a background noise will come and interrupt the call. So, just a quick reminder thanks.

Dale Bratzler: Any other comments about that conversation? And the next question was covariates and we did discuss – I think, we didn't mention earlier some certain high risk conditions that are – the developer and I think we agreed probably quite uncommon but potentially could show up in the denominator for a measure.

So, I'll see if there any other comments but I think that summarizes most of the comments that we made about this particular metric.

Lindsey Tighe: OK. Does anyone from the committee have any question or comment related to the topic of discussion and or to your own review of the clinical specifications for the measure?

Well, hearing nothing we were going to move on to the next measure. And that is measure 1561, it's constructed very similarly to 1560. Ben, I don't

know if you said all you wanted to say, if you have any additional comments before we jump in to that.

Ben Hamlin: You know, I think we've pretty much covered it. I mean again the measure is extremely similar. It is for patients of COPD and unlike the asthma measure on clinical. Well, this measure contains the same high-cost solutions that there are fewer clinical exclusions because as I mentioned before, while we exclude patients with COPD from the asthma measure. We do not do the reverse for the COPD measures. So the concomitant diagnosis from those patients who are aging and from a restricted to an obstructive disease, generally captured by this measure instead of the asthma measure, so …

Dale Bratzler: Can you also just highlight, there are slight differences in the denominator identification in terms of the period of time?

Ben Hamlin: That's correct. This is a one-year denominator. So, just looking for any diagnosis of COPD in a patient's record, you know, one year and not – there's no two-year for this one.

Dale Bratzler: So – thanks. So again, very, very similar measure, constructed the same way. The period of time is one-year period for all costs of care. One of the notable difference that you just heard was that patients can be brought in to the measure in a single year, not two consecutive years of diagnosis. There were some discussions of misdiagnosis of patient with COPD. The developer highlighted that they actually have look at done chart validation of diagnosis such as COPD, chronic bronchitis, emphysema and find that there is fairly consistent correlation with clinical treatment that appears to be COPD.

So, I think we were comfortable that the denominator was appropriately identified but I'll open it up to the TEP to see if they had any other comments about that point.

So, I think we felt fairly comfortable with the inclusion criteria. I'm trying to read the notes here real quickly. Again, I don't think there are any other comments about that, can you scroll on down just a bit further?

Link to the episode again, not an episode measure but on calendar year so, very similar and again consistent with other HEDIS measures. And the beauty of keeping the denominator populations consistent across measures is that, now for health plans you could have measures of quality and measures of cost that have similar denominator. So, truly helping you to get to the value of equation.

The exclusions again, we really did not have too much discussion about those because they were – the exclusion was as noted was not as long but it did include the high cost conditions that you would expect. So, cancer, HIV/AIDS, patients on – end-stage renal disease patients. So, high cost conditions that would be unrelated to COPD appeared to be excluded from the measure. And we really didn't have other – I don't think other conversations about that.

I think we can scroll on down. This conversation actually went relatively quickly after we completed the asthma conversation. We felt that the code used to identify cases were appropriate. They included mostly COPD, chronic bronchitis, emphysema codes. The covariates were identified. Again, we had a brief conversation about socioeconomic status. There were – our feeling as a committee was the socioeconomic status is probably less of a concern for a COPD measure than it would for an asthma measure.

And again, we left that conversation truly to kind of the overall NQF conversation about adjustment of measures based on socioeconomic status. I think truly, those are the primary points we discussed. I'm looking down at the button to see if there are other some any – I can't see what comment was here at the bottom that work group summary.

Lindsey Tighe: OK, are there any comments or questions from committee members about this measure?

Cheryl Damberg: This is Cheryl Damberg. I had a question and it relates to the asthma measures as well about the actionability of this measure at the plan level. And I wasn't sure whether the TEP had discussed any of that.

Dale Bratzler: I'm pretty sure no, we did not. I don't think that was in the list of questions that we were actually asked to consider in our deliberations.

Cheryl Damberg: OK. Thank you.

Lindsey Tighe: Yes, that is – Cheryl, certainly, we're going run through the scope of the TEP (inaudible) of those three measures and then if we have time at the end of the call, we can open it up to a little bit of general discussion about the measures. So, that maybe a better place for that comment.

Dale Bratzler: So again, our conversation about this particular measure was considerably shorter since, you know, we spend a lot of time talking about asthma and some more methodology here.

Jack Needleman: This is Jack Needleman. As we go to conditions with higher cost. With the asthma measure, we were talking about excluding high cost conditions that were unrelated to asthma. When we look at the exclusions here and the non-exclusions, are there are any comorbid or unrelated comorbidities among these patients that don't get them excluded but which might effect the total cost of care that needs to be taken to account and the assessment of the relative cost of the patients.

Dale Bratzler: So I'm going to defer to the developer. So, mainly the CCs are included in some of risk adjustment but I don't believe those conditions are excluded, so I'll defer to the developer.

Ben Hamlin: Yes, you're correct. So, the – we used – we utilize almost the entire CMS-listed CCs to adjust for many of the comorbidities for comparison purposes. There are also is a cost capital of $100,000 on a per member basis. So, any members who achieved that cost capital – their total cost for that year, a cap to $100,000.

We found that very few people – surprisingly even with the ESRD hit that cost cap. However, you know, that does exist to kind of for the outlier patients who maybe really racking up a lot with the conditions for other reasons and go beyond (inaudible) relative achievable by the risk adjustment. We do cap them at $100,000 for that time frame.

Lindsey Tighe: I'm hearing no other questions. I'll take it that we're ready to move on to the next measure. It supposed to be measure 2579 and do we have anyone from the Yale or CMS who wants to provide a brief into to the measure.

Nancy Kim: Hi. This is Nancy Kim. I'm a general internist and hospitalist and (lead) the development of the pneumonia payment measure. So, on behalf of CMS, we developed a pneumonia payment measure and I'll go was to estimate hospital level risk standardized payments for Medicare patient for a 30-day episode of care beginning with pneumonia hospitalization. We standardize payments to account for geography and policy adjustments and the cohort is aligned with CMS's 30-day mortality measure.

Lindsey Tighe: Thanks. Dale, you take it away.

Dale Bratzler: All right. So, this measure used a different methodology. These uses the – a methodology similar to that CMS's use to identify patients for the pneumonia mortality measures that are NQF-endorsed and publicly reported, identifying patients with a principle diagnosis of pneumonia admitted to a hospital. And the episode of care is 30 days from the time of the admission to be consistent with the mortality measure. Again, alignments of that useful information might be able to be provided by the cost of care and quality of care and outcomes of care.

The identification to measure population is based on ICD-9 codes. We reviewed those and we felt that those we're clinically appropriate and consistent with the mortality measure. So, I don't think there was really any further discussion of the actual inclusion criteria.

The time period for the episode was 30 days and it went from the time of admission. It does obviously include post-acute care, cost of care. But again, the timeframe is aligned with the CMS mortality measure.

So, I'll stop real quickly and see if any of the TEP members have any other comments. But we didn't have too many questions about that.

Male: I would like to comment that one of the TEP comments about it was that the measure forms were very, very well-written and that was very easy to follow the logic for development of the performance measure.

So, same methodology – go ahead.

Andrea Gelzer: This is Andrea Gelzer and I was on the call as well for the committee and I was just going to say, I was very impressed. I guess at the lack of or the (inaudible) of questions about this measure. And have the TEP committee (inaudible) that it was very well-written, easy to read. The TEP committee really seems to like this measure.

William Brendle Glomb: Yes. And this is Brendle Glomb. I'll second that that was – it's a very well-written measure, very understandable, (countable) to the measure that's compared with. It'd be very useful for managed care.

Dale Bratzler: Yes. And this measure actually would apply to any acute care hospital. In fact the data is principally fee for service Medicare patients. In terms of (length) of the episode, there were really no comments. It seems logical to align the measure with the CMS mortality measure. So, there were really no comments or questions about the timeframe, the time window.

With respect to the target population, I think conversations that are common to any of the discussion about claim-based measures. There – obviously, there are limitations that are inherent in claims data. So, patients have to continuously enrolled with Medicare for at least a year prior to the admission to be included in the measure. That's largely because of the risk adjustment methodology that's common to both the mortality measure and this resource use measure. They're excluded from the measure, there's incomplete claims data that make sense since you can't look at total cost to care if the patient didn't receive complete care for 30 days or if there's absence of data. And the patients are excluded from the measure if they've been assigned to a hospice care prior to the pneumonia admission and that's also consistent with the mortality measure.

The patients are included if they die within the 30 day timeframe. They are included in the metric system with the mortality measure obviously. Only,

when we look at exclusions, you know, we ask the question. Well, how many patients are being excluded because of these challenges with claims or absence of data? It turns out to be a relatively small percent, only 7.3 percent of the patients in their logic model were actually excluded from the measure because of lack claims data. So, it was a relatively small percentage.

Dr. Kim, I'm going to ask this really quickly if you want to again, talk about the attribution for patients that get transferred just to make sure we let you get it correct for us.

Nancy Kim: Sure, we did discuss the transfer attribution which is the same strategy we used in both pneumonia mortality and in our other payment measures. So, when a patient is transferred from the initial admission at hospital A to a second hospital for the inpatient management of pneumonia, the same pneumonia diagnosis, let's call that hospital B. we tally the payment made to those hospitals A, hospital B and all payments made in the 30-day episode window. And those (inaudible) back to hospital A, the initial admitting hospital. The logic behind that is that hospital A begins the episode window, so that standard start date applies to everybody whether or not there was a transfer involved in the care of the pneumonia patient or not.

When considering transfer attribution, there's really three strategies. The when employed, IE, attributing back to hospital A. You can attribute back to hospital B, the discharging hospital but that changes the start date for those transfer patients and scenarios. And – or you can exclude them. And those (inaudible) in order to align with mortality in our other measures, we would attribute back to hospital A.

The last thing I'll say about pneumonia is that there are only 0.38 percent of patient transferred. So, it's a very, very, very small percentage of our patients that were even in the scenario, also pneumonia.

Dale Bratzler: I'll stop there to see if there any questions or any comments real quickly.

Lina Walker: This is Lina, just a quick question. The patients who are transferred, do you they tend to be more to the cases of pneumonia or are there other reasons for the transfer?

Nancy Kim: Hi, this is Nancy Kim. We didn't really look that on our pneumonia cohort because it was such as small percentage. And the other thing I should say is that these are inpatient to inpatient transfer. These are not ER to inpatient transfers. So, once you're admitted to hospital A, you're admitted for an inpatient admission. And when we have looked at our cohort, normally you've been in that hospital for at least a day or more but we did not – to answer your question directly, we did not look at that on the pneumonia cohort.

Lina Walker: Thank you.

Dale Bratzler: Are there other questions or comments about the attribution?

Again, we look at submission in the inclusion codes, we really have no comments there consistent with the mortality measure. Of course, the exclusions are largely based on absence of the data. There are other wise no specific code exclusions from the performance measure. Risk adjustment for the measure is based again on a similar model to mortality where possible use of comorbid conditions to risk adjust the payment.

Nancy, I think you do a very similar methodology that you do for the mortality, don't you?

Nancy Kim: Yes, we do.

Dale Bratzler: Yes.

Lina Walker: This is a question for the TEP. This is Lina. Is there a high degree of variability in the severity of pneumonia?

Dale Bratzler: So, I'm not sure I understand the question. This is Dale Bratzler. Certainly – there certainly is. I mean, patients who are – I mean, probably the biggest predictor of severity is the ICU admission. I mean there are all sorts of prediction tools that you can use to identify severity of illness. Most patients in low severity classifications never get admitted to the hospital, for those that

do then, at least when we look at mortality of pneumonia patients, the big predictors has been typically intensive care unit admission.

Lina Walker: So just some background. I understand that that developer did not adjust for degree of severity. I was just trying to get a sense of whether the population has – there are large differences in the severity of the population, severity of pneumonia in this population.

Dale Bratzler: So, they don't adjust, they think for the severity of the actual illness at the time of the admission but they do adjust for multiple comorbid conditions. So, certainly age, many, many different diagnosis and other things that might predict patient outcomes.

Lina Walker. I see. And in your assessment, the TEP committee's assessment, you felt that that was sufficient?

Dale Bratzler: So, this is – so, I'm not going to speak for the TEP necessarily, others please weigh in. My sense is that the risk adjustment methodology is the same that used for the pneumonia mortality measure. So, that's already NQF-endorsed and publicly reported currently.

Male: That was my understanding as well.

Nancy Kim: This is Nancy Kim. Yes, it is the same mythology employed in the pneumonia mortality, publicly-endorsed measure.

Janis Orlowski: This is Janis Orlowski. So, the risk adjustment is for medical comorbidities but there is not a socioeconomic adjustment in that measure, is that correct?

Nancy Kim: I'm sorry and this is Nancy Kim. I don't know if the TEP would like to respond or they would like me to respond.

Dale Bratzler: Yes, Certainly, Nancy feel free but…

Nancy Kim: OK.

Dale Bratzler: …I don't think there's any…

Janis Orlowski: I don't this there's SES.

Nancy Kim: We did not.

Janis Orlowski: Yes. I don't think so. I was – it was mostly to clarify. I don't think there was SES adjustment.

Nancy Kim: There is not an SES adjustment when we develop the. We followed the NQF guideline which is explicitly not to adjust for SES but we are aware following discussion of SES like all the other measure developers.

Janis Orlowski: Sure, thanks.

Nancy Kim: Sure.

Dale Bratzler: Are there any other comments? I have to tell you having participated in resource use technical panel a couple of years ago, this process was a lot easier this time that it was the last time so, yes.

Male: I just want to comeback to the question about the heterogeneity or homogeneity of the pneumonia patients. We've got this controls for other comorbidities and the risk adjust that might be affecting cost. But, the – was there sense that the categories of patients that are defined by the pneumonia diagnoses sufficiently homogenous at looking at their cost as group without further division of the group in some way was adequate.

I mean you said there's a threshold for severity to get you into the hospital. So, you know, conditions on being on the hospital, are the patients similar enough controlling for age and comorbidities that we would expect their cost to be similar other than the variations and treatment choices.

Dale Bratzler: So, I don't think we talk had great length about that at the technical expert panel. Nancy, I'll defer to you to see if you have any specific comments related to that question.

Nancy Kim: Thank you. This is Nancy Kim. We do feel it as sufficient because it's a hospital level measures. So, the variation for patient population across hospitals, we don't think – we think would be captured by a risk adjustment

and because it is the same methodology used in our mortality but really what you're trying to do is absolutely find out who the sickest folks are. And we do feel comfortable with this risk adjustment approach.

Male: OK, thanks Nancy.

Nancy Kim: Sure.

Male: So, another way to kind of phrase the question is to ask whether hospitals that have intensive care unit might be more likely to get patients more likely than need intensive care (practice). And therefore, because that's a much more extensive care in inpatient care, in general (fork) here, it might be a bigger factor for the economic outcome than it would be for mortality.

Nancy Kim: Hi. This is Nancy Kim. Again, I'm not sure if the TEP would like me to respond to that or if the TEP would like to respond.

Dale Bratzler: Sure Nancy. Go right ahead.

Nancy Kim: And if I'm overstepping, please somebody, just tell to stop responding.

So, that's a great point. We did not look at that specifically in the pneumonia cohort but our group has done other work looking at the variation in ICU use. And this is (inaudible) experiencing heart failure. And we found that hospitals with more ICU bed did use the ICU more but they provided fewer ICU level of care. So, there was no intubation, there was no (clusters) et cetera, et cetera, et cetera. This is using a non-Medicare dataset although some of the patients were Medicare patients but not all.

So, we actually found that the utilization was based on the supply rather than patient care and needs. Again, not a Medicare population, not the pneumonia cohort but that has influenced some of our thinking. Thank you.

Dale Bratzler: Other comments?

Female: So, and I'm just looking back. So, are individuals who maybe immunocompromised excluded and I don't mean just HIV but are individual who have transplants excluded in the pneumonia.

Dale Bratzler: So, I don't think they're excluded. I think that's part of the model for risk adjustment.

Nancy Kim: That's correct.

Female: So, it's – OK. So if you are – and again, I'm just thinking through the ICU. If you're a hospital that has a large proportion of individuals who maybe immunocompromised either through cancer, through – or through transplant or something, that it gets picked up in the risk adjustment.

Nancy Kim: That's correct.

Female: But I find you last statement surprising about ICU use, but it's probably a numbers thing rather than a – looking at the numbers rather than looking at the actual statement itself because I would think tertiary care centers would have more ICU beds. And they would be utilized in those situations. So, I – they may not be intubated but I will take incubation alone is a measure of ICU use.

And at least, if I hear what you're saying is this, your conclusion is ICU uses associated with having an ICU and I've find that a remarkable statement.

Nancy Kim: Again, I'm sorry I'm not – I'm don't know if I'm suppose to respond. I appreciate your point, I'll be happy to show the reference. But I'm not suggesting that happens everywhere but in this particular setting, that is what we found and that is what we included that your point is well taken.

Female: OK, thanks. Actually, I'd love to see the reference.

Nancy Kim: Sure, I'm happy to bring that or e-mail that …

Female: Great, sure.

Jack Needleman: OK. This is Jack Needleman, just given the standardized pricing methodology that's use in this method. The higher cost of academic medical centers, of tertiary care centers are all going to be washed away in the standardized pricing.

Nancy Kim: Right.

Jack Needleman: As well as the mix of ICU days versus other days. So, all of that is washed away, it's all hidden in the way to pricing.

Nancy Kim: Right.

Jack Needleman: So – in fact, while it's a resource use measure, we don't actually see those differences in resource use captured in this measure.

Female: But Jack, you'd see – since it's a standard price, you'd see if there were more ICU bed usage versus not. But every …

(Crosstalk)

Jack Needleman: No, because the pricing – the pricing is a DRG price.

(Crosstalk)

Jack Needleman: All of that's invincible. The issue of what – you were raising the issue of sicker patients because of the presence of more tertiary services. That's still a possibility. But we were somewhat eased and concerned about that. The actual differences in and we got more actually beds so we use them. That's all hidden. That's not showing up in our resource use measure.

Female: But if you – but in this, if you were, I guess the TEP panel is comfortable that if you're using more ICU that the risk adjustment is – (shouldn't) to explain that is my question.

Dale Bratzler: Well I think so. I mean I think we felt that the risk adjustment methodology is consistent with the pneumonia measure that's already in the public domain, already publicly-reported. And I think we were comfortable with that methodology.

Any other members of the TEP or any other comments about this.

Lindsey Tighe: OK. All right. It sounds like we have exhausted the TEP discussion at this point. So thank you every one.

Male: OK, wait. Can I ask one other question? I wasn't quite sure where to get it in.

Lindsey Tighe: OK.

Male: And it's a clinical question so I really do need TEP expertise here. We don't have the Medicare (report). We don't have the outpatient drug cost here. And there are a number of conditions in which I wouldn't care about that if they were all basically the same across all the patients. We've got fairly standardized post-hospitalization, drug regime, and, you know, people are going to pretty much get that. Or if – so in that case or drug cost relatively, not relative to the other cost that are being captured here. And both of those would say OK, so we don't have some cost so what. But if there're real differences in drug therapies and they have substantial differences in cost. And they might have substantial different impacts on the use of other services that are being captured, then I'd be a little bit more concerned about what's being measured here given the exclusion of the Part D drug cost.

And I understand what they're excluded. I'm not arguing about that. But I'm trying to understand how – so from a clinical perspective, is not having the drug cost in here on issue in terms of really interpreting the cost that are here.

(Crosstalk)

Dale Bratzler: I'm sorry.

Nancy Kim: No, you go ahead. You go ahead first.

Dale Bratzler: Well, no, I said that's based on just availability of the data. Is that correct in the chronic conditions warehouse?

Nancy Kim: It is that, but also only 67 percent of seniors are enrolled in Medicare Part D and it's geographically distributed. So it would …

Male: No, no I said so, I understand why we don't have drug course in here. I'm asking whether drug therapies could potentially – variations, substantial variations exist in drug therapy post hospitalization. And those in turn can influence the course of the treatment and the cost that we are observing here

so we've got unobserved heterogeneity affecting the variation and the cost here.

Andrea Gelzer: This is Andrea Gelzer. I think it's an interesting research question and I – and we all know that the exclusions and the differences in benefits to that that I think that there – it doesn't or not too concerned. And I think the plans in CMS, I mean you have formularies. There are other controls in place that I think minimize heterogeneity. But someone would have to test that hypothesis.

Dale Bratzler: Yes, we did not discuss that.

Male: OK, so now I'm asking for a clinical – clinical judgment here. You guys know how these patients are treated. So is it pretty similar in terms of what drugs are prescribed and or is there a lot of variation what drugs are prescribed in patients once they're discharged.

Female: So, I would say for pneumonia that there's unlikely to be a wide variation in cost. And, you know, most pneumonias will go home on an oral antibiotic that's pretty straight forward. As far COPD, I think there's, you know, inhalers and other oral medication. I'd turn to the TEP folks, is there anything else – there's not and not the same thing as some other conditions where there it can be wide variations in every new therapies. I don't know what does TEP think, but I would say clinically I don't see it being an issue in pneumonia.

Male: I mean I think the inhalers or the inhalers for COPD, there is different categories to choose from. So somebody may – I think the difference is going to be whether somebody is on a two separate types of inhalers, three separate types of inhalers or only one inhaler. You know, the short-acting, the long-acting, the – but the classes of inhalers are the same.

Male: Right.

Male: Just different manufacturers within each class, you may get some variability. Some people order Advair or some people may order Symbicort. I think what the patients are going to go home on generally speaking is what the hospital has through its formulary which they probably get on a sort of cheaper basis

like for example we stock Advair. We don't stock anything else. But that's the only kind of the variability, but the inhalers are the inhalers and there's really only two or three classes of medication right now.

Female: That's true. So back to your question is do we expect wide variability based on …

Male: So wide variability – in brand name or wide variability in class?

Female: No, no, in class?

Male: No, no there is really no …

(Crosstalk)

Female: So neither pneumonia nor COPD which you'd expect dramatic differences in pharmaceutical cost?

(Crosstalk)

Dale Bratzler: Well, so I don't want to mix up measures because in COPD measure does include cost for medications and that's the NCQA measure, so …

Female: Right.

Dale Bratzler: … I don't want to get those confused. But of course the pneumonia measure would risk adjust for the presence of COPD. So it does not have the Part D data, the cost of medications. I think just for the management of the pneumonia itself, you would not expect to see huge variations in cost. You may see variations in cost for management and some of the comorbid conditions but not for the pneumonia itself.

Male: Would there be any reason to include DME, oxygen, et cetera?

Dale Bratzler: Nancy, I don't even know if that's available to you in the chronic condition …

Nancy Kim: This is Nancy Kim. We do include DME – DME payments and claims are all included within the 30-day window.

Male: OK.

Dale Bratzler: Great.

Male: Thank you.

Nancy Kim: You're welcome.

Dale Bratzler: All right, Lindsey, I think we've covered at least the conversation of the technical panel.

Lindsey Tighe: Yes, great. Thank you so much Dale. And thank you all the TEP members who joined. Given that we have about 15 minutes left, certainly those of you who would like to jump off at this point in time you're welcome to.

If there are committee members who want to stay on to have a little bit more general conversation or ask us any questions as you're preparing to submit surveys on the Phase 3 measure, you're welcome to do so.

We'll just again plug that we have the SurveyMonkey out to you all for the Phase 2 measure that we discussed on the comment call last week. The committee opted to revote on them based on the discussion and the information provided during the commenting period. So if you could please check your email, respond to those surveys as soon as you can. If you need the link resent, please let me know. But we're really hoping to wrap that up by tomorrow so that we can focus on the in-person meeting coming in two weeks.

And so that's it. Thank you all who joined. Feel free to jump off. Thank you to the developers who joined and for any one who wants to stay on to have a more general discussion, you're welcome to.

Dale Bratzler: Thank you.

Male: Thanks. Bye-bye.

Male: Thanks.

Lindsey Tighe: For any one staying …

Matt McHugh: Hi. This is Matt McHugh at Penn.

Lindsey Tighe: Yes, hi.

Matt McHugh: I wasn't able unmute my phone quick enough at the beginning but I do not have any conflicts. I just wanted to …

Lindsey Tighe: Thank you for closing the loop on that. We appreciate it.

Matt McHugh: No problem.

Lindsey Tighe: For any of those who are staying on the line, we don't really have any structure per se to this. But if you have any questions, just feel free to ask away or provide a new commentary and we'll go from there.

Martin Marciniak: Sure. Hi, it's Martin. As far as the conflicts I have my natural conflict that's why I work for – so I work for GlaxoSmithKline where I hold a leadership position.

And the comment I'd make and I'm hoping to maybe a little bit of read from those left on line as one of the things I felt relatively satisfied about with respect to the first two measures for asthma and COPD was sort of convergence and view about what the denominator should look like.

And so – and it's based where it's often times difficult to get that denominator appropriately calibrated, at least a feeling by me that it was driving in that direction. Is that an appropriate sense to have at this point?

Dale Bratzler: This is Dale. I'm still here. I think that was certainly the point of our conversation was that though we had some questions about, you know, some – some cases that might get into a metric inappropriately, I think we felt strongly that staying consistent with other NQF-endorsed measures that are looking at the same condition was important. And if changes were made to denominator populations that needed to be considered across all the measures,

not just these resource use measures. So I think we felt very comfortable with that.

Martin Marciniak: Yes, because in the past, that hasn't always been the case, at least as I have worked my way through the literature. So I wanted to make sure that what I thought I was seeing even though I'd heard the conversation on line today because that was in fact – if I was reading it right.

Because the other thing that I thought was kind of satisfying in the clinical side was the idea that for the measurement of asthma that the age, you know, sort of the bottom or the floor age starts at 5. And the acknowledgment of the different practice patterns in part because where I sit there are therapies out there that go – or for the opportunity to start below 5. And so taking a sort of an approach that says here is where it is from a quality perspective and trying to differentiate both at the front and the back end made a great deal of sense to me as well. So …

Lindsey Tighe: Certainly, if there aren't any other questions, don't feel like you need to stay until the end of the hour because we have the extra time wanted to provide an opportunity for you all to have any discussions in advance the in-person meeting.

Martin Marciniak: Sure. And as I had mentioned, I had a previous travel commitment so I won't be able to attend. My question of you would be how would you like to get my vote or if I'm not there, do I not get to vote?

Lindsey Tighe: Our policy is that you have to present, sitting in the discussion to provide your vote. So if you're able to dial in, we can work with you on the web chat to get your vote. Otherwise, we'll certainly provide any commentary for your survey to the committee review as they have the discussion at the in-person meeting.

Martin Marciniak: Fair enough.

Lindsey Tighe: And then once we have the additional calls after the comment period or something like that, certainly we'd welcome you to re-engage.

Martin Marciniak: Very good.

Jack Needleman: Yes, this is Jack Needleman. I have the same problems so I will be providing some comment on the – on the draft and if there's a follow on both after the comment period, I'll just be taking that.

Martin Marciniak: Yes.

Lindsey Tighe: Great.

Martin Marciniak: Sorry (inaudible) about this, I mean with the calendar scheduled during the summer for me has gotten a bit strange, so …

Lindsey Tighe: Yes, I think we're finding that's the case for a lot of people so you're not alone.

Martin Marciniak: OK. Well I'm not alone and I'm in good company so that's always a nice place to be.

So with that, folks I'm going to drop off. I can't remember the last time I actually had a free hour in my calendar, so thank you very much for the call today.

Lindsey Tighe: Enjoy your time back. Thank you for joining us.

Martin Marciniak: Thanks.

Dale Bratzler: So anything else, Lindsey?

Lindsey Tighe: No folks, sounds like everyone's (lining) down. So I guess we'll just go ahead and end now. And thank you again, Dale, and thanks everyone.

Dale Bratzler: OK.

Female: Thank you.

Martin Marciniak: That's good.

Male: Thank you.

(Crosstalk)

Female: Bye-bye.

END