NQF: Cost and Resource Use Phase 2: Cardiovascular Conditions Fact Sheet

Overarching Issues

Appropriateness of attribution approach

Several commenters raised concern that, for the AMI (#2431) and Heart Failure (#2436) measures in particular, it may be inappropriate to attribute the cost of the episode to the hospital as much of the care happens in an outpatient setting. The proposed HF and AMI episode-of-care measures reflect the care of multiple providers across the health care delivery system. Like other measures that reflect the actions of many, attributing the results solely to one part of the system (i.e., hospitals) may not be appropriate. Commenters stated that measures should assess processes and outcomes over which the measured entity (e.g., hospital, physician group) can exercise a reasonable level of control, and that these measures may be more appropriate for an organization accepting bundled payments on behalf of all measured entities.

Committee Response:

The Committee acknowledged this concern; however, the Committee also stated that hospitals are increasingly responsible for care delivered up to 30 days after discharge. Consequently, hospitals are in the unique position of being able to push coordination of care, and this measure may serve as an impetus for this to occur.

Adequacy of risk adjustment model

Several commenters stated that the low r-squared values for the AMI (#2431) and Heart Failure(#2436) measures (0.05 for AMI, 0.03 for HF) indicated that the risk model did not account for enough of the variation in measure scores and may not adequately account for patient case mix and severity. Moreover, commenters believe that the low level of reliability demonstrated illustrated another fundamental flaw of both measures—that they fail to adequately account for complicating conditions that patients have prior to an episode of care. These complicating conditions can markedly affect the costs of treatment, but the current risk adjustment model has limited ability to distinguish between conditions that a patient already has, and those that develop during the episode. Without risk adjustment or exclusions, a measured entity could appear to have higher costs than others simply because it cares for more complex patients.

Committee Response:

The Committee agreed with the developer's response that at lower patient volumes, there is less certainty when estimating cost. The measure uses a continuous outcome which results in a more accurate estimate than would result from a binary outcome. Additionally, the measure uses hierarchical risk modeling that adjusts hospitals with low patient volume towards the mean.

Theme 3 – Approach to addressing transfer patients

For the AMI (#2431) and Heart Failure(#2436) measures, several commenters stated concern that the initial admitting hospital would be attributed cost for the episode when transferring patients to a second hospital, as the initial admitting hospital may have little control over the care that happens after the transfer. Commenters suggested that the developer exclude transfer patients from the measure.

Committee Response:

Prior measures under consideration by this Committee have raised this issue, particularly endorsed measure NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB).
In this measure all beneficiaries who are transferred are excluded from the measure; the Committee discussed the appropriateness of this exclusion at length. The developers explained that during their public comment on the measure, community hospitals argued that they should not be responsible for patients whom they stabilize and transfer to another facility. Facilities that receive transfers argued that they should not be responsible for care that was provided prior to the patients entering their facility. To account for both perspectives, the developer chose to exclude all transfers from the measure. ***The Committee noted that hospitals are increasingly responsible for care delivered up to 30 days after discharge; thus they agreed that hospitals should be responsible for the utilization and associated costs for patients that they transfer to other facilities. The developer acknowledged that it was challenging to address the various perspectives on attribution of transfers but agreed to reconsider the specification based on the Committee's feedback.***

The Committee again acknowledged this concern for these measures and reiterated the upward trend of hospitals' responsibility for care delivered up to 30 days after discharge.

Risk adjustment for socio-demographic factors

Several commenters stated that the risk adjustment models for the measures should capture socio-demographic factors, as there is robust evidence that such factors affect health outcomes, including resource use. The commenters noted that there is an NQF draft report which proposes including socio-demographic variables in risk adjustment models for some outcome and process measures.

NQF Response:

With respect to concerns that socio-demographic factors should be included in the measures' methodology, NQF appreciates these comments and is in the early stages of reviewing our policy on risk adjusting for socio-demographic factors. The report referenced is a draft report that has recently been reviewed during an NQF member and public comment period; the recommendations have not yet been finalized. As such, we ask that Committees continue to evaluate measures according to our current guidelines, that measures not be adjusted for socio-demographic variables. If in the future the recommendations for adjusting for socio-demographic variables become NQF policy, measures needing this adjustment will be updated and reviewed by the Committee through measure maintenance.

Committee Response:

The Committee acknowledged that the timing of the NQF risk adjustment report is not ideal; however, given the current NQF policy on adjusting for sociodemographic variables, the Committee requested

that a recommendation be issued with the measure that when reported, the results should be stratified by sociodemographic variables.

Summary of Measure Evaluation

The following brief summaries of the measures and the evaluation highlight the major issues that were considered by the Committee. Details of the Committee's discussion and ratings of the criteria are included in the draft report.

#1558 Relative Resource Use for People with Cardiovascular Conditions (NCQA): Recommended

Description: The risk-adjusted relative resource use by health plan members with specific cardiovascular conditions during the measurement year; **Resource Use Measure Type:** Per capita (population- or patient-based); **Level of Analysis:** Health Plan, Population : National, Population : Regional; **Costing Method:** Standardized pricing; **Target Population:** Populations at Risk; **Data Source:** Administrative Claims; **Measure Steward:** National Committee for Quality Assurance

This maintenance measure is a condition-specific per-capita measure initially endorsed in January 2012. The Committee was generally supportive of this measure, noting the importance of including cost measures alongside relevant HEDIS quality of care measures to assess health plan and physician group value. The developers demonstrated that the measure is feasible to implement at both the health plan and the physician group level with a minimum of 250 members. The Committee requested quantitative results from the developers demonstrating empirical reliability testing including the results from the systematic evaluation of face validity that were verbally described by the developer during the meeting. This additional information from the measure developers was reviewed during the post-comment call on June 4, 2014; the Committee found the additional information sufficient to affirm their recommendation for endorsement.

#2431 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI) (CMS): Consensus not reached

Description: This measure estimates hospital-level, risk-standardized payment for an AMI episode-of-care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of AMI; **Resource Use Measure Type:** Per episode; **Level of Analysis:** Facility; **Costing Method:** Standardized pricing; **Target Population:** Senior Care; **Data Source:** Administrative Claims; **Measure Steward:** Centers for Medicare and Medicaid Services

This newly submitted measure from CMS is a condition-specific per-episode measure. The Committee noted that AMI is a high-priority area for measuring cost and resource use, along with appropriate measures of quality, noting the incidence of the condition and the cost per episode. The Committee initially expressed concern with attributing post-acute expenses with 30 days of the date admission to the admitting hospital but the developers provided a sufficient rationale that hospitals can act as catalyst in their community to improve care coordination for the patients they treat. The Committee did express concern about the risk adjustment model's ability to capture differences in patient case mix across hospitals as described in the overarching issues section. While the developers submitted results of face validity testing, the Committee expressed concern over the lack of empirical validity testing of the measure as specified. The Committee did not reach the threshold for reaching consensus for this

measure during the in-person meeting; however, after consideration of NQF member and public comments, and additional justification for the measurement methodology and approach provided by the developer, the Committee recommended the measure for endorsement.

#2436 Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Heart Failure (CMS): Consensus not reached

Description: This measure estimates hospital-level, risk-standardized payment for a HF episode of care starting with inpatient admission to a short term acute-care facility and extending 30 days post-admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older with a principal discharge diagnosis of HF; **Resource Use Measure Type:** Per episode; **Level of Analysis:** Facility; **Costing Method:** Standardized pricing; **Target Population:** Senior Care; **Data Source:** Administrative Claims; **Measure Steward:** Centers for Medicare and Medicaid Services

This newly submitted measure from CMS is also a condition-specific per-episode measure. The Committee noted that HF is a high-priority area for measuring cost and resource use, along with appropriate measures of quality, noting that it is a common health condition that drives spending in the Medicare program. The Committee had concerns about attributing costs for heart failure to hospitals, noting that the more appropriate locus of accountability is the ambulatory care primary care provider. The experts also noted that the episode-based 30-day time period for measuring costs does not align with the typical disease progression for heart failure. The Committee shared the concern about the risk adjustment model's ability to capture differences in patient case mix across hospitals as described in the overarching issues section. The Committee did not reach the threshold for reaching consensus for this measure during the in-person meeting; however, after consideration of NQF member and public comments, and additional justification for the measurement methodology and approach provided by the developer, the Committee recommended the measure for endorsement.