

Technical Expert Panel (TEP) Charter

Project Title:

End-Stage Renal Disease Evaluation of Potential Prevalent Comorbidity Adjustments in the Standardized Hospitalization Ratio (SHR) and the Standardized Mortality Ratio (SMR)

Dates:

July – December 2015

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) to evaluate the potential of including prevalent comorbidities in the SMR and SHR risk adjustment models. The contract name is End Stage Renal Disease (ESRD) Quality Measure Development, Maintenance, and Support. The contract number is HHSM-500-2013-13017I. Motivation for this project comes from public comments expressing interest in considering the addition of more recent measures of patient health status to the risk-adjustment models, which now adjust for comorbidities at incidence. This work is part of a larger project to reevaluate the SMR and SHR measures.

Project Objectives:

The University of Michigan Kidney Epidemiology and Cost Center, through its contract with the Centers for Medicare and Medicaid Services, will convene a technical expert panel to evaluate the potential of including prevalent comorbidities in the SMR and SHR risk adjustment models. Specific objectives will include:

- Review of the comorbidity adjustment in the current NQF endorsed SMR and SHR measures
- Consideration of what, if any, prevalent comorbidities would be appropriate to include in each measure.

TEP Objectives:

NQF Measure Evaluation Criteria require that a risk-adjustment methodology be based on patient factors that influence the measured outcome (but not factors related to

disparities in care or the quality of care) and are present at start of care”¹. Therefore, two conditions should be met for the inclusion of a comorbidity as a risk-adjuster: (1) the comorbidity must be substantially related to the outcome being measured and (2) the comorbidity should not reflect the quality of care furnished by the provider/facility being evaluated. The TEP will be asked to consider the following questions:

1. What comorbidities should be included as adjusters for SMR and SHR, based on their statistical and clinical relationships to the outcomes?
2. What comorbidities should be excluded based on the likelihood that they may be a result of facility care?
3. What data sources should we use to identify prevalent comorbidities?
 - a. Do the sources of data available to identify prevalent comorbidities introduce bias into the models?
 - b. If so, are there steps that can be taken to address this problem?
4. How do we specify the length of time over which a prevalent comorbidity is measured?
 - a. Does the timing of prevalent comorbidity reporting introduce bias into the models?
5. What are the unintended consequences for the use of proposed prevalent comorbidities in the models?
 - a. What can be done to mitigate the unintended consequences?
6. Given currently available data, what prevalent comorbidities would one definitely adjust for and not adjust for? What measures of patient health status are missing from currently available data that are important to collect?

Scope of Responsibilities:

The role of each TEP member is to provide advisory input to UM-KECC about the inclusion of prevalent comorbidities in the SHR and SMR measures for the US ESRD population.

Role of UM-KECC: As the CMS measure developer contractor, UM-KECC has a responsibility to support the development of quality measures for ESRD patients. The UM-KECC moderators will work with the TEP chair(s) to ensure the panel discussions focus on the development of draft specifications for the inclusion of prevalent comorbidities in the SMR and SHR, as recommended to the contractor. During discussions, UM-KECC moderators may advise the TEP and chair(s) on the needs and requirements of the CMS contract and the timeline, and may provide specific guidance and criteria that must be met with respect to CMS and NQF review of revised candidate measures reflecting prevalent comorbidities.

¹ A Blueprint for the CMS Measures Management System, v. 11. July 2014.

Role of TEP chair(s): Prior to the in-person TEP meeting, one or two TEP members are designated as the chair(s) by the measure contractor and CMS. The TEP chair(s) are responsible, in partnership with the moderator, for directing the TEP to meet the expectations for TEP members, including provision of advice to the contractor regarding measure specifications.

Duties and Role of TEP members: According to the CMS Measure Management System Blueprint, TEPs are advisory to the measure contractor. In this advisory role, the primary duty of the TEP is to review any existing measures in terms of comorbidities included as adjusters, and determine if there is sufficient evidence to support the inclusion of specific proposed comorbidities as measure adjusters, and relatedly, suggest measure specifications. TEP members are expected to attend conference calls in July and August 2015, attend one in-person meeting in September of 2015 (dates are yet to be determined) in Baltimore, MD, and be available for additional follow-up teleconferences and correspondence as needed in order to support the submission and review of the candidate comorbidity adjusters by NQF. Some follow up activities may occur after data collection and testing have occurred.

The TEP will review, edit (if necessary), and adopt a final charter at the first teleconference. A discussion of the overall tasks of the TEP and the goals/objectives of the ESRD quality measurement project will be described. TEP members will be provided with a summary of current clinical practice guidelines, literature, and review of other related quality measures prior to the in-person meeting. TEP members will be asked to submit additional studies to be included in the literature review. A review of the CMS and NQF measure development criteria will also be covered during the teleconference.

During the In-Person Meeting: The TEP will review evidence to determine the basis of support for proposed measure(s). The key deliverables of the TEP at the in-person meeting include:

- Recommending draft measure specifications,
- Assisting in completing the necessary documentation forms to support submission of the measures to CMS for review, and to the NQF for endorsement
- As needed TEP members may be asked to provide input to UM-KECC as they prepare responses to public comments

At the end of the two day meeting the TEP chair(s) and TEP members will prepare a summary of recommendations. As necessary, the TEP chair(s) will have additional contact with UM-KECC moderators to work through any other issues. This will include votes for draft and final measures. After the In-Person Meeting (approximately September – December, 2015): TEP members will review a summary report of the TEP meeting discussions, recommendations, draft measure specifications, and other necessary documentation forms required for submission to the NQF for endorsement.

Guiding Principles:

Potential TEP members must be aware that:

- Participation on the Technical Expert Panel is voluntary.
- Input will be recorded in the meeting minutes.
- Proceedings of the in-person meeting will be summarized in a report that is disclosed to the general public.
- Potential patient participants may keep their names confidential, if they wish to do so.
- If a TEP member has chosen to disclose private, personal data, that material and those communications are not covered by patient-provider confidentiality.
- All questions about confidentiality will be answered by the TEP organizers.
- All potential TEP members must disclose any current and past activities that may pose a potential conflict of interest for performing the tasks required of the TEP.
- All potential TEP members must commit to the expected time frame outlined for the TEP.
- All issues included in the TEP summary report will be voted on by the TEP members
- Counts of the votes and written opinions of the TEP members will be included, if requested.

Estimated Number and Frequency of Meetings:

- TEP members should expect to come together for one to three teleconference calls prior to the in-person meeting held September 2015, in Baltimore, MD.
- The in-person meeting
- After the in-person meeting, additional conference calls may be needed.

Date Approved by TEP: August 26, 2015

TEP Membership:

Name, Credentials, and Professional Role	Organizational Affiliation, City, State
Caroline Steward, APRN, CCRN, CNN <i>Advanced Practice Nurse (Hemodialysis)</i>	Capital Health System Trenton, NJ
Roberta Wager <i>Renal Care Coordinator</i> <i>Member of Forum of ESRD Networks</i> <i>Beneficiary Council</i>	Forum of ESRD Networks Boerne, TX
Mark Mitsnefes, MD, MS <i>Professor of Pediatrics</i> <i>Program Director</i>	Cincinnati Children’s Hospital Medical Center and University of Cincinnati Cincinnati, OH
Dana Miskulin, MD, MS <i>Staff Nephrologist</i> <i>Associate Professor of Medicine</i>	Tufts Medical Center, Tufts University School of Medicine Boston, MA Outcomes Monitoring Program, Dialysis Clinic Inc. Nashville, TN
Jennifer Flythe, MD, MPH <i>Research Fellow</i> <i>Assistant Professor of Medicine</i>	University of North Carolina at Chapel Hill Chapel Hill, NC
Eduardo Lacson Jr, MD, MPH <i>Nephrologist</i>	American Society of Nephrology Lexington, MA
Lorien Dalrymple, MD, MPH <i>Associate Professor</i>	University of California, Davis, Division of Nephrology. Los Angeles, CA
David Gilbertson, PhD <i>Co-Director</i> <i>Director of Epidemiology and Biostatistics</i>	Chronic Disease Research Group Minneapolis, MN
Danielle Ward <i>Member of Forum of ESRD Networks</i> <i>Beneficiary Council</i>	Forum of ESRD Networks Birchwood, WI