

NATIONAL QUALITY FORUM

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RESOURCE USE PROJECT:

PHASE II

PULMONARY TECHNICAL ADVISORY PANEL

MEETING

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TUESDAY

JULY 19, 2011

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The Meeting was held at the National Quality Forum, Suite 600 North, 601 13th Street, N.W., Washington, D.C., at 8:30 a.m., Kurtis Elward and Janet Maurer, Co-Chairs, presiding.

PRESENT:

KURTIS ELWARD, MD, MPH, Co-Chair

JANET MAURER, MD, MBA, Co-Chair

GERENE BAULDOFF, PhD, RN

KATHRYN BLAKE, PharmD

DALE BRATZLER, DO, MPH

ZAB MOSENFAR, MD

LINUS SANTO TOMAS, MD, MS

MICHAEL SCHATZ, MD, MS

RICHARD STANFORD, PharmD, MS

NQF STAFF PRESENT:

CARLOS ALZOLA, Statistical Consultant to NQF

TAROON AMIN, MPA, MA, Senior Director

HEIDI BOSSLEY, MSN, MBA, Vice President of Performance Measures

LAURALEI DORIAN, Project Manager

SARAH FANTA, Research Analyst

ANN HAMMERSMITH, NQF General Counsel

SALLY TURBYVILLE, MA, MS, Consultant to NQF

ASHLIE WILBON, MPH, BSN, Senior Project  
Manager

ALSO PRESENT:

BENJAMIN N. HAMLIN, MPH, NCQA Director of  
Performance Measures

SHEILA HEITZIG, Director of Practice and  
Policy, American Academy of Allergy, Asthma  
and Immunology

THOMAS LYNN, MD, Ingenix

CHERI ZIELINSKI, Ingenix

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1 P-R-O-C-E-E-D-I-N-G-S

2 8:35 a.m.

3 MS. DORIAN: Good morning,  
4 everybody. I think we're going to get started  
5 now. I'm Lauralei Dorian, and I think I've  
6 met most of you this morning actually, and if  
7 not, you've probably received some emails from  
8 me over the last couple of weeks.

9 I'm actually quite new to NQF and  
10 I'll be working as a project manager on the  
11 remainder of the resource use program of work.

12 And I would like to say thank you  
13 so much on behalf of everybody at NQF and my  
14 team members for being here today. We really  
15 appreciate the time you've taken out of your  
16 busy schedules to be here and provide your  
17 expert opinions.

18 It's a really crucial part of this  
19 project and we're really appreciative of the  
20 work that you've put in and that you will put  
21 in today. So thank you for that.

22 And I'd also like to say a special

1       thank you to our two chairs, Dr. Elward and  
2       Dr. Maurer. Thank you. Thanks for the work  
3       you've put in and for the leadership you will  
4       provide today.

5                So I think the first thing that  
6       we'll do is I'll have the rest of our team at  
7       NQF introduce ourselves and then I'll hand it  
8       over to Ann Hammersmith, who's our general  
9       counsel at NQF, and she'll go around and have  
10      each of you introduce yourselves and do your  
11      disclosures of interest, which is just a  
12      regular part of what we do, particularly when  
13      committees are meeting for the first time.  
14      And then we'll go through a brief PowerPoint  
15      presentation that we've prepared for you and  
16      then we'll hand it over to your co-chairs to  
17      do their welcomes and thoughts for the day and  
18      take it over from there and lead the day.

19               So I'll have Ashlie start, I  
20      guess.

21               MS. WILBON: Good morning,  
22      everyone. Thanks for joining us. And again,

1 I'm the Senior Project Manager on the project  
2 and happy to have everyone here this morning.

3 MR. AMIN: Hi, good morning,  
4 everyone. My name is Taroon Amin. I'm a  
5 senior director here at NQF.

6 Thank you for all your hard work.  
7 I know there is a lot of work that went into  
8 reviewing these measures, very complex, and we  
9 look forward to this morning's discussion.

10 MS. FANTA: Good morning,  
11 everyone. I'm Sarah Fanta, Project Analyst.  
12 Looking forward to working with all of you  
13 today.

14 MS. TURBYVILLE: Good morning, I'm  
15 Sally Turbyville. I was previously working  
16 with NQF on this project for the past year.  
17 I've transitioned into a consultant role.

18 And in complete agreement, we're  
19 very appreciative of all the hard work and  
20 looking forward today to your opinions as we  
21 work through the measures.

22 MS. BOSSLEY: I timed this just

1 right, didn't I? Heidi Bossley, Vice  
2 President of Performance Measures, and again  
3 to reiterate what staff has said before, but  
4 we truly appreciate all of the hard work. And  
5 we know it's a lot of work we've asked you to  
6 do. So thank you very much.

7 MS. HAMMERSMITH: Good morning,  
8 everyone. I'm Ann Hammersmith, NQF's general  
9 counsel. What we'll do now is combine  
10 introductions with the conflict of interest  
11 disclosures.

12 If you recall, several months ago  
13 we sent you a form that we asked you to fill  
14 out, which you did, and then we reviewed them  
15 in great detail.

16 And what we ask you to do today is  
17 to orally disclose anything that you revealed  
18 on the form or that has happened since you  
19 filled out the form that you believe is  
20 relevant to your service on this committee.

21 Just because you disclose  
22 something does not mean you have a conflict of

1 interest. The idea here is openness,  
2 transparency with each other and so on.

3 We don't expect you to recount  
4 your CV to us. We know that you're all  
5 extremely capable people -- that's why you're  
6 on the committee -- but just note things of  
7 relevance to your service on the committee.

8 Excuse me. I'm glad you're  
9 pulmonary doctors because I seem to be having  
10 a little difficulty here.

11 We are particularly interested in  
12 your disclosure of research support,  
13 consulting relationships, and grant funding  
14 that's relevant to what's before the  
15 committee. I also want to remind you  
16 that you sit on the committee as individuals.  
17 You are not a representative of your employer  
18 or of any organization that might have  
19 nominated you for service on the committee.

20 So with that I'll ask each of you  
21 to identify yourselves, tell us who you're  
22 with, and then if you have any disclosures.



1 So I think I'll start right here.

2 CO-CHAIR ELWARD: I'm Kurt Elward.  
3 I am in practice in Charlottesville and I also  
4 have a clinical professorship at VCU in  
5 Richmond and a research appointment at UVA.

6 I'm involved in a couple of  
7 evaluation projects where we're trying to help  
8 physicians implement quality improvement  
9 guidelines, and those are funded in part by  
10 NIH and in part by some pharmaceutical support  
11 through a foundation, to make sure that  
12 there's no direct handling of money and things  
13 like that. So, is that it? Yes, thanks.

14 CO-CHAIR MAURER: Hi, I'm Jan  
15 Maurer and I'm a pulmonologist. I live in  
16 Phoenix, Arizona, and I work for a company  
17 called Health Dialogue, which is a disease  
18 management company that creates and implements  
19 programs for people to better manage chronic  
20 diseases, of which asthma and COPD are two.

21 I also have a clinical  
22 professorship at the University of Arizona in

1 Phoenix, and I am on the Quality Improvement  
2 Committee of the American College of Chest  
3 Physicians and I sit on the Board of Trustees  
4 of the Chest Foundation. I think that about  
5 covers it.

6 DR. MOSENI FAR: I am Zab  
7 Mosenifar. I'm an academic pulmonologist at  
8 Cedars Sinai in UCLA. I've been there for  
9 about 33 years or so.

10 I have a large fellowship program,  
11 actually the largest in the country perhaps,  
12 and I mainly do research in the COPD area. My  
13 research is funded by NIH and some  
14 pharmaceutical industries.

15 My research right now involves  
16 mainly lung volume reduction surgery in non-  
17 invasive forms via stents and various devices,  
18 and I also work on use of growth hormone on  
19 patients with COPD as well. I have no  
20 conflict.

21 MR. ALZOLA: I'm Carlos Alzola,  
22 and I'm an independent statistical consultant.

1 And I was hired for this project and I put  
2 together these assessment worksheets to help  
3 you evaluate the measures.

4 DR. BLAKE: I'm Kathryn Blake from  
5 Nemours Children's Clinic in Jacksonville,  
6 Florida. I've been doing asthma research for  
7 25 years.

8 I've research support from no  
9 pharmaceutical companies, only from the  
10 American Lung Association and NIH, and I  
11 consult for a project in Missouri looking at  
12 pharmacy and Medicaid claims. That's it.

13 MR. BRATZLER: I'm Dale Bratzler.  
14 My contact information has actually changed  
15 from what's in the materials. I'm actually  
16 with the University of Oklahoma in the College  
17 of Public Health. I'm a professor and  
18 associate dean there.

19 I have no conflicts to report. My  
20 experience with pneumonia, particularly over  
21 the past almost 12 years now, has been  
22 coordinating the National Pneumonia Project

1 for the Centers for Medicare and Medicaid  
2 Services.

3 DR. BAULDOFF: Hi, I'm Gerene  
4 Bauldoff. I'm a clinical professor at Ohio  
5 State in the College of Nursing. My focus is  
6 COPD and pulmonary rehabilitation.

7 I have worked as a lung transplant  
8 coordinator in Pittsburgh. I've worked as the  
9 rehab coordinator at Pittsburgh on the NET  
10 Trial, and I'm on the board of directors for  
11 the American Association of Cardiovascular and  
12 Pulmonary Rehabilitation.

13 DR. SANTO TOMAS: I'm Linus Santo  
14 Tomas. I'm from Milwaukee, Medical College of  
15 Wisconsin. I'm a clinician educator and a  
16 pulmonary as well as an intensive care  
17 specialist, and no conflict of interest.

18 DR. STANFORD: I'm Richard  
19 Stanford. I'm actually at GlaxoSmithKline.  
20 I'm in the Department of Health Outcomes.

21 My background is, I have a  
22 clinical pharmacy degree as well as a Masters

1 in preventive medicine. I have been doing  
2 observational research for the last decade  
3 mainly in asthma and COPD, so I have a lot of  
4 experience I do believe in large databases  
5 such as what we've looked at.

6 I don't have any conflicts outside  
7 of the fact that I work for pharma.

8 DR. SCHATZ: I'm Michael Schatz.  
9 I'm Chief of the Department of Allergy at  
10 Kaiser Permanente San Diego.

11 I serve as the Co-Chair of the  
12 Joint Task Force on Quality Measures, which is  
13 a joint task force of the American Academy of  
14 Allergy, Asthma and Immunology and the  
15 American College of Allergy, Asthma and  
16 Immunology.

17 I've been involved in database  
18 research at Kaiser, including some specific  
19 research looking at quality measures, although  
20 not resource measures. And some of our  
21 research has federal funding, but I do have  
22 funding from GSK, Merck, Genentech and

1 Aeroquin, in terms of research funding, and  
2 serve as a research consultant for Merck,  
3 Amgen and GSK.

4 MS. HAMMERSMITH: Okay, thank you.  
5 And there's no one on the phone, Sarah? Okay.

6 All right, thank you for those  
7 disclosures. Do any of you have any questions  
8 or anything you would like to discuss with  
9 each other based upon the disclosures this  
10 morning?

11 (No response.)

12 Okay, thank you. Have a good  
13 meeting.

14 MS. DORIAN: Great. Thank you,  
15 Ann. Thanks, everybody, we appreciate that.  
16 Now what I'll do is just briefly go over some  
17 of the logistics for today. I'll also  
18 actually have the people in the back introduce  
19 yourselves, if that's all right.

20 MR. HAMLIN: Good morning,  
21 everybody. My name is Ben Hamlin. I'm  
22 Director of Performance Measurement at NCQA.

1 MS. HEITZIG: Good morning, I'm  
2 Sheila Heitzig and I'm the Director of  
3 Practice and Policy for the American Academy  
4 of Allergy, Asthma and Immunology, and the  
5 staff of the Joint Task Force on Quality  
6 Measures for the American Academy of Allergy,  
7 Asthma and Immunology and the American College  
8 of Allergy, Asthma and Immunology.

9 MS. DORIAN: Thank you. So as I  
10 was saying, I'll go over some of the logistics  
11 for today and then just do a brief PowerPoint  
12 presentation to sort of situate you to where  
13 we are in our CDP process.

14 Then I'll hand it over to Ashlie  
15 at that point, who will briefly touch upon  
16 some of the subcriteria that you'll be  
17 discussing. And if at any time you have any  
18 questions, please feel free to jump in.

19 This is a new process for us,  
20 particularly in relation to resource use  
21 measures so we want to learn from your  
22 feedback all the time and we're really open to

1 listening to what you have to say about the  
2 process thus far.

3 So as you know, we have five  
4 measures that we're discussing today, three  
5 from Ingenix and two from NCQA. And we're  
6 fortunate that we have our NCQA team here in  
7 person and we'll have Ingenix on the phone, so  
8 that resource is there for you to use.

9 Usually what happens is at the  
10 beginning of each measure discussion, the  
11 measure developers will give a very brief  
12 introduction of the measure as to what the  
13 measure is about to remind you. And then  
14 they'll be there throughout your conversation  
15 to answer any questions that you might have,  
16 so definitely use that. It's there for you to  
17 use throughout the day.

18 We also have Carlos here for the  
19 first half of the day, I believe, and he's  
20 provided his statistical analysis already and  
21 he will give a brief overview as well if you'd  
22 like to him to, and he'll be really important



1 particularly during the scientific  
2 acceptability component of our conversation.

3 And just a reminder that it's  
4 important for you to speak into your mics  
5 because it is being recorded. And Sarah or  
6 maybe Ashlie later will go over the voting  
7 device that we'll be using.

8 DR. STANFORD: Can I ask a  
9 question?

10 MS. DORIAN: Yes, sure.

11 DR. STANFORD: Have we narrowed it  
12 down to these four? Is that why we're only  
13 going to concentrate on these four?

14 MS. DORIAN: There are five.

15 DR. STANFORD: Excuse me, five.  
16 Pneumonia and then the two COPD and so that's  
17 p

18 MS. WILBON: So yes, we were going  
19 to discuss those in the presentation but now's  
20 a time better than ever.

21 So we initially had, with the  
22 other TAPS, we've actually only gotten through

1 about five or six measures in one day.

2           These measures, as you already  
3 know, are really intense and they take a long  
4 time to get through. So we already kind of  
5 knew at the in-person meeting that we wanted  
6 to narrow the agenda down to a subset of the  
7 measures.           Subsequent to developing  
8 the agenda, ABMS had informed us, actually  
9 just a couple days ago, that they were  
10 withdrawing their measures from the project.  
11 They've been submitting measures in other  
12 topic areas.

13           As you know, this is the fourth  
14 TAP that we've gathered for this project. We  
15 had a cancer TAP, a bone/joint TAP and a  
16 cardiovascular TAP and then obviously you guys  
17 are the pulmonary TAP.

18           And the evaluation process for  
19 those measures, they identified several issues  
20 and they felt kind of through the process that  
21 it was probably best that they withdraw their  
22 measures and focus on refining them and

1 putting some more effort into testing them.

2 So the feedback that we've gotten  
3 up to this point from the experts is that  
4 everyone is really excited about the measures,  
5 that they have got great concepts and they're  
6 a great start on the measures but they did  
7 need a little bit more work.

8 That said, we're focusing today's  
9 meeting on the Ingenix and NCQA measures which  
10 we're going to actually evaluate. We will  
11 have a follow-up conference call on the 2nd.  
12 We had already scheduled two additional  
13 conference calls.

14 We're going to cancel the one on  
15 the 17th, but the call on the 2nd we're going  
16 to keep and we're just going to use that call  
17 to discuss the ABMS measures, even though we  
18 won't be formally evaluating them and rating  
19 them and putting them through the process.

20 We do think it's valuable to have  
21 your input to forward on to them so they can  
22 use that in their refinement process and

1 improving the measures going forward.

2 Our hope is that they would use  
3 this feedback to submit them back to NQF at a  
4 time when they feel like their testing and  
5 their measure specifications are a little bit  
6 more well-refined.

7 So we do still want your input on  
8 those measures, and the analysis that you've  
9 done on them thus far, we will be compiling  
10 that and forwarding it on to the development  
11 team at ABMS.

12 But the timing of everything and  
13 the process thus far -- just that's kind of  
14 where we are at this point. Your work was not  
15 in vain, we will be using it and actually  
16 devoting a whole conference call to kind of  
17 feedback and put on those measures.

18 So does anyone have any questions  
19 about that? But thank you for asking. Okay.

20 MS. DORIAN: Okay, this is just a  
21 brief slide to remind you where we sort of are  
22 in our consensus development process.

1                   We have completed our first two  
2 steps and we're on to Step 3 which includes  
3 recommendations from the Steering Committee  
4 with -- of course based upon your expert input  
5 today.

6                   And then there are many other  
7 steps to follow that, that can potentially  
8 follow it, including public and member  
9 comment, member voting, our CSAC decision,  
10 which is our Consensus Standards Approval  
11 Committee, which is a standing committee  
12 that's responsible for the oversight of NQF  
13 processes and procedures, and so on and so  
14 forth.

15                   So that's just to give you sort of  
16 an idea about where we are in this process so  
17 far. And this is just a representation, so  
18 that you can see that as well.

19                   Now although resource use measures  
20 have been around for a long time and in many  
21 cases have been around a lot longer than  
22 quality measures, they are new to many of you,

1 to most of us and certainly to our NQF  
2 process.

3 And so it was really important at  
4 the beginning of this project that we have a  
5 really clear understanding and definition  
6 around what for this project we're considering  
7 resource use measures.

8 So this is what the Steering  
9 Committee, is that right? -- the agreement  
10 that they came to at that time that you see in  
11 front of you.

12 And so we have, as you may know,  
13 we have completed Cycle 1 of our CDP already,  
14 which included non-condition specific and  
15 cardiovascular and diabetes measures.

16 And we're now on to Cycle 2, which  
17 of course includes pulmonary measures and  
18 cancer and bone/joint measures. So we've been  
19 quite busy. We've been moving along at a  
20 pretty rapid pace.

21 We had a two-day Steering  
22 Committee conference a couple of weeks ago

1 followed by a phone call and then we've also  
2 had a cancer TAP meeting and a bone/joint TAP  
3 meeting, and so here we are today. It's just  
4 our timeline.

5 Another reminder that in terms of  
6 the measure review process, we're the first  
7 ones to receive those measures and we just  
8 review them for completeness and adherence to  
9 our guidelines, and then they go to Carlos,  
10 our consultant, for review, and then on to  
11 you.

12 And I won't spend too much time on  
13 this because I think you already know what  
14 your role is and I know that you had a  
15 conference call earlier to talk about this as  
16 well.

17 But just to remind you that you've  
18 been individually selected for your expertise,  
19 and so it's really important that today you do  
20 that deep dive, based upon your expertise,  
21 into each of the subcriteria, because that  
22 will be extremely important into feeding into

1 what the Steering Committee eventually decides  
2 about endorsement for a measure.

3 So I'll stop here and see if  
4 anybody has any questions about logistics for  
5 the day, any other questions about what I've  
6 gone over, anything about timelines moving  
7 forward, and if not, I'll hand it over to  
8 Ashlie.

9 MR. AMIN: Could I just add  
10 something, Ashlie, before you move on?

11 I just wanted to make a note for  
12 the TAP that really a deep dive in the  
13 scientific acceptability portion of the  
14 measure is really valued as the measure moves  
15 on to the Steering Committee, mainly because  
16 you're the clinical experts in this area and  
17 you're the methodologists in this area.

18 So the Steering Committee will  
19 weigh heavily on the discussions, the  
20 deliberations and the voting across the  
21 measure, but particularly in scientific  
22 acceptability.



1                   So I just wanted to highlight what  
2                   Lauralei mentioned. I just wanted to make  
3                   sure that was highlighted in the discussion.

4                   MS. WILBON: So everyone has at  
5                   this point has hopefully looked at their  
6                   measures and our criteria and is somewhat  
7                   familiar with it.

8                   But I just want to highlight a  
9                   couple things. Now this is our fourth TAP  
10                  meeting and we're getting pretty good at this.  
11                  Unfortunately, it's our last one, we don't  
12                  keep going, but we've got all this wisdom to  
13                  pass onto you.

14                  So I'll just kind of focus on the  
15                  areas where we tend to have the most questions  
16                  and issues in going through the criteria.

17                  Our discussions today will be very  
18                  systematic to the best of our ability, and  
19                  we'll go through each of the subcriteria  
20                  individually and have a hopefully structured  
21                  kind of conversation focused on the intent of  
22                  that criteria.

1                   And as you know, there's four  
2                   criteria, importance to measure and report,  
3                   which is really focused on determining whether  
4                   or not the topic that they've chosen is  
5                   important to measure.

6                   And what we've found actually up  
7                   to this point is that the call for measures  
8                   for this project and the scope of this project  
9                   was very specific as it was. We selected the  
10                  conditions.

11                  Just by virtue of the way we set  
12                  the project up the measures are important, so  
13                  that discussion is generally pretty brief. We  
14                  try to keep it as brief as possible.

15                  We're going to have the co-chairs  
16                  lead the TAP through kind of a discussion of  
17                  each of the subcriteria and get any overall  
18                  input, but really reserve the bulk of the  
19                  discussion and our time in terms of time  
20                  management in the scientific acceptability  
21                  section. So we will be discussing importance  
22                  but it'll be an abbreviated discussion.

1                   The scientific acceptability  
2                   criteria, the goal is to determine whether or  
3                   not you can make valid conclusions about  
4                   resource use, whether or not the measure's  
5                   reliable and valid.

6                   The usability is focused on how  
7                   usable the measure is. Are the results and  
8                   the information that you get out of the  
9                   measure, are they usable for the intended  
10                  audience?

11                  And then feasibility goes to how  
12                  much burden there is with -- it's more focused  
13                  on implementation. So what would it take to  
14                  implement the measure? Is it realistic?

15                  Is it feasible for someone to pick  
16                  up the specifications as written in their  
17                  system or whatever level of analysis that it's  
18                  specified at and implement the measure? So  
19                  that's what feasibility is focused on.

20                  So within importance, I'm just  
21                  going to do a very high level skim here, we're  
22                  going to be determining whether or not the

1 measure focus or the topic of the measure  
2 addresses a national health goal or priority  
3 area and whether it's high impact, whether or  
4 not they've identified a problem area with  
5 opportunity for improvement, whether or not  
6 the purpose and objective of the measure or  
7 the intent of the measure that they have  
8 identified is clear and whether or not the  
9 resource use categories they've selected makes  
10 sense.

11           So based on the topic they've  
12 selected and the service categories that  
13 they've selected, does it make sense based on  
14 what they say they're measuring?

15           Scientific acceptability again is  
16 focused on determining how reliable and valid  
17 the measure is.

18           And then we do have kind of a  
19 dangling subcriteria out there on disparities.  
20 What we found in our discussions with  
21 disparities up to this point with other TAPs  
22 and the Steering Committee is that obviously

1       disparities are really important.

2                   NQF has done, we're actually  
3       gathering a committee now to kind of talk  
4       about how disparities can be measured and how  
5       we should be supporting disparity measurement  
6       in quality improvement and so forth.

7                   But, particularly because these  
8       measures use administrative data, we've found  
9       that there are some limitations in measuring  
10      disparities and reporting that out.

11                   So to this point we've been kind  
12      of framing this disparities discussion around,  
13      is the measure structured or constructed in  
14      such a way that if the data was available that  
15      they would be able to report out stratified  
16      disparity information?

17                   And again, it may be framed,  
18      depending on the condition, particularly for  
19      cardiovascular conditions you may feel like,  
20      our TAP felt like it was very important that,  
21      you know, disparities can be a really  
22      important of how resource use is distributed.

1                   So again, there may be some  
2                   condition-specific things around how  
3                   disparities are reported for resource use  
4                   measures, but in general we've found that  
5                   there are limitations inherently in the way  
6                   the data is gathered for these types of  
7                   measures that makes reporting disparities  
8                   difficult. So just kind of keep that in mind  
9                   in your general context.

10                   So again, our discussion around  
11                   scientific acceptability is focused on  
12                   identifying whether the measure is reliable  
13                   and valid.

14                   And we just wanted to kind of go  
15                   over in a little bit more detail about what  
16                   your high, moderate and low ratings actually  
17                   mean when you're saying that you're evaluating  
18                   the measure.

19                   For a high rating of reliability,  
20                   it means that all the measure specifications  
21                   are unambiguous and likely to consistently  
22                   identify who's excluded from the target

1 population, that it's clear how the resources  
2 and costs are being measured and how to  
3 compute the score.

4 That they have evidence of  
5 reliability of both the data elements, so in  
6 this case it would be the administrative  
7 claims data or the resource use categories and  
8 the measure score.

9 And that the measure score, that  
10 they've identified an appropriate method and  
11 scope of reliability testing for that. So  
12 it's a pretty high standard; it's pretty  
13 unambiguous. They've done everything they  
14 could possibly do to make sure and demonstrate  
15 that the measure's reliable.

16 For validity, again, very high  
17 standard; that the measure specifications are  
18 consistent with the intent; that they describe  
19 any importance to measure criteria; and again,  
20 evidence of validity at both the data element  
21 and the measure score level; again, that the  
22 measure score is appropriate; the measure

1 score validity testing is appropriate method,  
2 scope and within acceptable norms, and that  
3 they've identified any threats to validity and  
4 have addressed them in some way.

5 So a moderate rating for  
6 reliability, one step down, again the  
7 specifications need to be unambiguous, but  
8 that they can demonstrate reliability of  
9 either the measure score or at the data  
10 element level. So it's an either/or for the  
11 medium or moderate score.

12 And similarly for validity, the  
13 specifications need to reflect the intent and  
14 the focus of the measure and they can  
15 demonstrate validity either at the measure  
16 score level or the data element level, or that  
17 they've done systematic assessment of face  
18 validity.

19 So face validity is the kind of  
20 threshold that we ask for in terms of validity  
21 testing when they submit measures.

22 For a low rating of reliability,



1 you may find that some of the specifications  
2 are ambiguous. There's potential for  
3 confusion in identifying who's included and  
4 excluded.

5 It's not totally clear how the  
6 resources and costs are being measured or how  
7 to compute the score, and that they use an  
8 inappropriate measure of reliability or that  
9 the testing that they've done, you don't feel  
10 that the measure is totally reliable.

11 For validity, again the  
12 specifications don't support the evidence that  
13 they cited for the intent of the measure and  
14 that empirical testing that they've done to  
15 demonstrate validity is either not sufficient  
16 or they have not done measure score,  
17 demonstrated validity at the measure score or  
18 the data element level and they have not  
19 identified threats to validity. An  
20 insufficient rating, I think we tend to get a  
21 little bit of confusion around a low score and  
22 insufficient. Insufficient I would say, and

1 I'll open this up to my colleagues to help me  
2 on this one, insufficient we found is either  
3 they haven't submitted anything for you to be  
4 able to demonstrate whether it's high,  
5 moderate or low.

6 Maybe you're missing information,  
7 there is a particular statistic missing that  
8 you would like to see and you don't have the  
9 information you need to determine whether it's  
10 high, moderate or low.

11 MR. AMIN: Or I would just add  
12 that the method they used was inappropriate in  
13 the view of the TAP, so it's either not  
14 provided or is actually inappropriate. So  
15 that would be the sort of threshold for  
16 insufficient.

17 MS. WILBON: Any questions about  
18 that? Okay.

19 MR. AMIN: Can I just add  
20 something extra?

21 MS. WILBON: Sure.

22 MR. AMIN: Just another thing that

1 I would just add to keep in mind. It's really  
2 important to keep in mind that face validity  
3 is an acceptable standard in this process.

4 I know that sometimes we want to  
5 move beyond that for understandable reasons,  
6 but that is an acceptable standard for where  
7 we are with resource use measures broadly.  
8 All the measures will go into a three-year  
9 evaluation. All the measures at NQF go  
10 through a three-year maintenance process where  
11 measure developers will have to demonstrate  
12 how the measure's been used and sort of the  
13 validity of the measure as it's been in use  
14 for three years.

15 So I just wanted to keep that in  
16 mind that face validity is an acceptable  
17 standard for this process right now.

18 MS. WILBON: So some of the  
19 thinking that the Steering Committee did in  
20 the first year of this project was around how  
21 to, one, construct our submission form so that  
22 we could receive or take in the information

1 and the specifications on resource use  
2 measures in the right format so that it could  
3 be evaluated by all of you.

4 That in doing that they identified  
5 kind of five modules, if you will, or five  
6 kind of sections of a resource use measure.  
7 And you should have actually seen this  
8 reflected in the submission form.

9 So we've divided the resource use  
10 measure into these different categories. In  
11 your discussion of scientific acceptability  
12 that you would kind of look at how they  
13 specified each of these sections to determine  
14 how well the measure is specified, if it's  
15 clear and if they're actually measuring what  
16 they say they're measuring.

17 Those five modules that we  
18 identified was the data protocol section, so  
19 these are the beginning steps of how to get  
20 the data ready for implementing the measure,  
21 the clinical logic, which is where obviously  
22 we're hoping that you guys will take a deep

1       dive.

2                   This is where they're identifying  
3       the actual patient population, how they're  
4       including and excluding patients by coding,  
5       ICD-9 codes and so forth.

6                   The construction logic, this is  
7       usually any of their temporal mechanisms, so  
8       when the episode, for instance, would begin or  
9       end, age ranges, different kind of -- not  
10      necessarily around the actual patients'  
11      clinical characteristics, but more so around  
12      how the measure and how the risk adjustment  
13      interacts, how the clinical hierarchies and  
14      stuff, how all that interacts together to form  
15      the measure.

16                  In the adjustments for  
17      comparability, we've actually pulled out how  
18      any stratification methods, the risk  
19      adjustment method and the costing method. So  
20      again, areas that we're hoping that you would  
21      also take a look at.

22                  The reporting guidelines are, for

1 resource use measures we identified, we  
2 realized early on that uniquely for resource  
3 use measures it's very important how the  
4 measure is going to be reported out,  
5 particularly in benchmarking and selecting  
6 peer groups and assignment of peer groups and  
7 the attribution role. So that is going to be  
8 in the reporting section.

9 We did early on identify this as a  
10 section along with the data protocol that  
11 could be submitted as guidelines or  
12 specifications. If it is guidelines, you  
13 should have seen in the measure evaluation  
14 form, it would say Guidelines and then colon.

15 What it means if it's Guidelines  
16 is that there is some flexibility for the  
17 user, so it's not baked into the measure,  
18 particularly for attribution.

19 For instance, if someone wanted to  
20 pick it up and they have a different physician  
21 population that they want to use a variation  
22 on the attribution rules that they would have

1 the ability to do that, but that the  
2 specifications are actually the core of the  
3 measure and that part does not change.

4 So just kind of keep that in mind  
5 as you're reviewing the measure. Those things  
6 that are guidelines are considered flexible  
7 for the user. Any additions on that?

8 MR. AMIN: I would just add in the  
9 process of feedback to the developers, if the  
10 TAP does feel that the guidelines that were  
11 submitted are inappropriate, additional  
12 guidance would be welcome, I'm sure, to the  
13 measure developers on proper or other  
14 attribution rules that seem more appropriate.

15 MS. WILBON: So I'm going to just  
16 quickly skim through some of the subcriteria  
17 for scientific acceptability and then we'll go  
18 ahead and hand it over to the co-chairs. I  
19 know you guys are eager to get started and  
20 stop hearing me talk.

21 So 2a1 of scientific acceptability  
22 focuses on whether or not the specifications

1 are clear so that it can be implemented  
2 consistently.

3           So if I gave the specifications to  
4 a system over here and a system over here, if  
5 they, given that they had the same data  
6 available to them, is the measure specified in  
7 such a way that they would both implement it  
8 in the same way? It's clear that it's general  
9 understanding of how the measure should work.

10           2a2 focuses on whether or not the  
11 reliability testing has demonstrated that the  
12 measure is repeatable and that the measure  
13 score is precise.

14           2b1, and all the 2bs focus on the  
15 validity of the measure, 2b1 is focused on  
16 whether or not the information they've  
17 submitted is consistent with the intent of the  
18 measure and submitted importance and whether  
19 or not the population that they have selected  
20 is supported by their opportunities for  
21 improvement and so forth.

22           2b2 is focused on whether or not



1 the data elements are correct and the score  
2 reflects the cost of care and resources, and  
3 that the validity testing has demonstrated  
4 that the score and the results of the measure,  
5 you can adequately distinguish higher and  
6 lower resource use.

7 2b3 is focused on exclusions,  
8 whether or not the exclusions they've selected  
9 are accurate.

10 2b4 looks at whether or not the  
11 risk adjustment approach adequately  
12 demonstrates discrimination and calibration.

13 And 2b5 is focused on whether or  
14 not there are differences in performance and  
15 that they are statistically significant and  
16 practically and clinically meaningful.

17 2b6 focuses on whether or not,  
18 particularly for measures that specify  
19 different data sources, these measures all use  
20 administrative claims data. So we're going to  
21 kind of take that one out of the pot for these  
22 discussions and kind of make it an n/a.

1 There's not really a reason to kind of discuss  
2 over that when there's only one data source  
3 that's being specified.

4 And then disparities we talked  
5 about. For usability, we're asking in these  
6 subcriteria whether or not the results are  
7 reported to the public. And if they're not  
8 currently reported, if they have a plan to  
9 report them or how it's currently being used  
10 by the public in some way.

11 3b asks whether or not the results  
12 that they've demonstrated for the use of their  
13 measure are meaningful, understandable and  
14 they that they will be useful to the public in  
15 quality improvement and public reporting.

16 And 3c asks you to determine  
17 whether or not the specifications are  
18 transparent and whether or not they're  
19 understandable. So that's obviously a clear  
20 one, important one. I'm not going to spend  
21 time on that.

22 Okay, going to kind of skim over

1 some of these. Feasibility, this is another  
2 discussion that we're going to kind of let the  
3 co-chairs lead the group through. It can  
4 generally be a pretty high level discussion.

5 We've also found that sometimes  
6 usability and also the feasibility discussion,  
7 the same discussion will generally apply to  
8 all the measures from an individual developer.

9 From NCQA or from Ingenix, their  
10 underlying methodology and construct of the  
11 measure's pretty consistent throughout all the  
12 measures. So if you find one measure feasible  
13 it will probably apply to the other measures  
14 from that developer.

15 So where possible, where we can  
16 find efficiencies in our time and so forth.  
17 If you feel like that discussion you had about  
18 a previous measure applies we can kind of say  
19 okay, is there anything different about this  
20 measure that warrants discussion on  
21 feasibility for any of these items? And we'll  
22 kind of keep it going in that way.

1                   4a and 4b, generally we tend to  
2 skip over a little bit or just do a very quick  
3 rating of. It asks whether or not the data  
4 elements are routinely generated. Obviously,  
5 admin claims data are routinely generated.  
6 And 4b asks whether or not the required data  
7 elements are available electronically, which  
8 admin claims data are. So we won't spend time  
9 on those two.

10                   4c asks you to think about whether  
11 or not there are errors or unintended  
12 consequences by implementing the measure and  
13 whether or not the developer has identified  
14 any of those and identified ways to monitor or  
15 minimize those for the implementer.

16                   And then 4d is focused on whether  
17 or not there is a feasible data collection  
18 strategy that can be implemented by using the  
19 measure. So is it feasible for someone to do  
20 all of the tasks around collecting the data  
21 and implementing the measure in their  
22 particular environment?

1 Anything else to add about that?

2 Okay. So Lauralei already went over a lot of  
3 this stuff, but for the meeting today, we're  
4 going to have the developer introduce each  
5 measure before you jump into your discussion,  
6 to give you, kind of just get you warmed up to  
7 the intent of the measure, the general  
8 methodology that they've used.

9 We have Carlos here to kind of do  
10 a brief overview of his analysis of the  
11 scientific acceptability section, particularly  
12 around reliability and validity testing. So  
13 we can call on him, and obviously throughout  
14 that discussion as well if you have any  
15 specific questions.

16 The developer for Ingenix will be  
17 on the phone when we get to those discussions  
18 and they'll be available throughout the  
19 discussion.

20 And then the TAP obviously will be  
21 going through each of the subcriteria one by  
22 one and rating each one at the end.

1                   So, as you know, we did distribute  
2                   that table that had all the assignments for  
3                   each person to kind of lead the discussion of  
4                   part of the measure.

5                   We found that because these  
6                   measures are so big, rather than just  
7                   assigning one whole measure to someone it can  
8                   be a little bit exhausting to go through a  
9                   whole measure and kind of lead that  
10                  discussion, so we've tried to break that up a  
11                  little bit.

12                  And Kurt and Janet will call on  
13                  you when we get to that measure and you can  
14                  point out anything that's important for the  
15                  TAP discussion, anything that you identified  
16                  in your own analysis. You can bring in some  
17                  of the feedback that was submitted in the  
18                  preliminary discussions from your colleagues  
19                  to help guide you through that discussion as  
20                  well.

21                  Just a little bit about your  
22                  voting device. What we've found, I think with

1 some of the other groups is that we'll talk  
2 about, once we get to importance and you guys  
3 have wrapped up that discussion we'll pause  
4 for about five minutes and we'll go and rate  
5 each of the subcriteria with your voting  
6 device.

7 We'll have the voting slides  
8 displayed on this screen up here in front of  
9 us, and as you vote, your results are captured  
10 in real time and there'll be a display of the  
11 distribution of the different ratings so you  
12 can kind of see what will be passed forward to  
13 the Steering Committee.

14 And I think what we've done is all  
15 importance through scientific acceptability,  
16 it tends to be quite long and lengthy. So we  
17 can break that up a little bit.

18 Maybe you want to get through  
19 reliability and vote on those two subcriteria  
20 and then do all of validity as a chunk, or you  
21 can decide how you want to break that up  
22 depending on how the discussion goes and how

1 tired people are getting.

2           So this slide will indicate for  
3 you which button you hit. Usually it's 1 for  
4 high, 2 for moderate, 3 for low or 4 for  
5 insufficient. You shouldn't need to hit send,  
6 but if you make a mistake, before you hit  
7 send, you can hit the triangle button with the  
8 little exclamation point in the middle of it,  
9 type in your new score, and then hit send.

10           So if you mess up, let us know.  
11 We can walk you through that, but it's pretty  
12 simple. We'll ask you to point your remote  
13 towards the laptop here that's up on the box.  
14 That little thing sticking out is the sensor  
15 that picks up your voting device.

16           So kind of point towards there and  
17 it picks everything up. You'll have 60  
18 seconds to vote, so no pressure, but by the  
19 time we get to vote everyone will be ready to  
20 vote and you'll know what you want to put in,  
21 so don't feel any pressure by the time there.

22           So that's it. Thanks for all of



1 your patience in listening to that.

2 CO-CHAIR ELWARD: So it's going to  
3 be a majority vote? So how does that work?

4 MS. WILBON: Yes. So the TAP  
5 ratings, it's more of a -- the Steering  
6 Committee will make the final vote on whether  
7 or not the measure gets recommended, but your  
8 input on how good or bad you feel about the  
9 measure is -- they really rely heavily on your  
10 input on that.

11 So depending on the distribution  
12 of highs, moderates, lows, that's kind of what  
13 kind of gives the Steering Committee an  
14 indication on where the discussion needs to be  
15 at their level and whether or not it should be  
16 recommended. So does that help clarify it?

17 CO-CHAIR ELWARD: Okay, thank you.

18 MS. WILBON: Okay. At this point  
19 I'll go ahead and hand it over to your co-  
20 chairs to get you guys started and we can --  
21 I think we're starting with the NCQA measures.

22 DR. BAULDOFF: I have a quick

1 question.

2 MS. WILBON: Sure.

3 DR. BAULDOFF: Hi. On measure  
4 1608, which is an Ingenix measure, the ETF or  
5 -- I can't. Yes, that their methodology  
6 attachment to the 1608 was actually for  
7 asthma. Is it the same or is there supposed  
8 to be a separate one for COPD? It was in the  
9 PDF that we --

10 MS. WILBON: Right. Was it this,  
11 I'm just trying to, this document here would  
12 be --

13 DR. BAULDOFF: I have it right  
14 here if you need it.

15 PARTICIPANT: It's included in the  
16 --

17 MS. WILBON: Was it that ETG like  
18 their general methodology?

19 DR. BAULDOFF: Yes.

20 MS. WILBON: Okay. Yes, that was  
21 probably an attachment mistake and I  
22 apologize; we didn't catch that. Yes, but

1 generally it's pretty similar for across their  
2 measures, although it may be a little bit  
3 different.

4 They'll be on the phone so if  
5 there were any kind of mis-attachments on that  
6 they can clarify that during the discussion.

7 DR. BAULDOFF: Okay.

8 MS. WILBON: Okay, thank you.

9 DR. BLAKE: I have one quick  
10 question. You may get to this in a minute but  
11 it's really for Carlos.

12 I was curious as to what you had  
13 access to when you did your statistical  
14 analysis. What part of the data, that sort of  
15 thing?

16 MR. ALZOLA: I have access to all  
17 of the same information that you have. I  
18 didn't do any specific -- I didn't do any  
19 hands-on analysis. I look at how they  
20 presented their information and evaluate  
21 whether it's sufficient, it's appropriate for  
22 the goal at hand and sufficient for us to

1 evaluate the goodness of measure. Thank you.

2 MS. WILBON: And it's perfectly  
3 acceptable during the discussion if you feel  
4 like something is missing or you don't have  
5 the information you need, to ask the developer  
6 for that. The staff is here to follow up with  
7 the developer as needed to get it.

8 If you feel like you need  
9 additional information before you can make a  
10 final judgment, we will facilitate that so  
11 that you can get any additional information  
12 you need throughout the process.

13 CO-CHAIR MAURER: Thank you,  
14 everyone. We would also like to welcome  
15 everyone to this panel meeting.

16 This is really exciting: to move  
17 into a new area of measures, and I think a  
18 group of measures that are going to be really  
19 important as value-based care delivery rapidly  
20 becomes dominant across the country. So what  
21 we're going to do is we're going to trade off.  
22 One of us is going to lead one measure and

1 then the next, and Kurt is going to start with  
2 the first measure and we're going to call on  
3 the people who are assigned as noted.

4 But we are going to lead the  
5 importance piece of it first and then talk  
6 about feasibility toward the end. To start,  
7 we're going to do two measures this morning.  
8 We're going to do asthma and COPD.

9 We'll try to make the conversation  
10 run smoothly and I'm sure you'll help us with  
11 that. To begin the first measure, I'm going  
12 to turn it over to Kurt and I think he's going  
13 to have NCQA.

14 CO-CHAIR ELWARD: Yes, thank you  
15 very much. It's really a pleasure working  
16 with you all. I know several of you, and I  
17 appreciate the great amount of work you've  
18 done.

19 I've noticed a lot of people not  
20 only contributed on their assigned measures  
21 but other measures as well. Given the amount  
22 of material, that evidences a great amount of

1 interest and dedication so thank you very  
2 much.

3 So as Janet said, we'll start with  
4 1560 first and then move through these. And  
5 as we go through the agenda, if there's  
6 adjustments that need to be made, things that  
7 can make things go smoothly, we'll be working  
8 on that and I appreciate your thoughts also.

9 So if we can start with 1560  
10 perhaps we can have NCQA talk first about the  
11 overall measure and get an overview of that.

12 MR. HAMLIN: I'm actually going to  
13 introduce both of our measures because the  
14 majority of the methodology is identical for  
15 both measures.

16 Really it's the clinical condition  
17 and the denominator population that differs  
18 between the two. The NCQA measures of  
19 Relative Resource Use are a total annual so  
20 it's all services for members identified with  
21 a clinical condition. There's no attribution  
22 of specific services to the disease state

1       itself.

2                   They use a standardized pricing  
3 methodology and they aren't risk-adjusted, so  
4 we use the standardized pricing based on a  
5 price list that I believe you all had access  
6 to that are generated for us annually that use  
7 a combination of different sources, using  
8 Medicare data and clinically -- I'm sorry, and  
9 adjusted using a number of other different  
10 sources from Ingenix and others to provide  
11 what we call sort of a standardized resource  
12 use that allows us to compare health plan to  
13 health plan, that we use them for health plan  
14 comparisons.

15                   We've been collecting data on  
16 these measures now for five years. The last  
17 two years, this is Year 2 of public reporting  
18 of the results of this data.

19                   So these measures are collected  
20 and publicly reported through our Quality  
21 Compass module. So it's available to  
22 subscribers of Quality Compass.

1                   Specifically for asthma, the  
2                   clinical population uses a very similar  
3                   population of that as defined with the HEDIS  
4                   asthma measure, and we only report the results  
5                   alongside of that HEDIS asthma measure.

6                   So our equation for value includes  
7                   the Relative Resource Use paired with the  
8                   quality measure, so we're reporting both of  
9                   these results together as part of that public  
10                  reporting.

11                  I'm going to leave it there and if  
12                  there're specific questions as we go through  
13                  I'll try and answer them then without  
14                  overwhelming you.

15                  CO-CHAIR ELWARD: Any questions  
16                  for NCQA right now?

17                  (No response.)

18                  Great. Well, in terms of the  
19                  importance it seems like, I think the  
20                  importance of the measure is extremely  
21                  pertinent.

22                  In terms of going through the



1 exact criteria, the overall cost of care of  
2 asthma is huge. I think it's well documented  
3 just how much opportunity there is. And so it  
4 seems like on many scales, the measure's very  
5 important. Any other thoughts about that?

6 Well, perhaps we can go to Kathryn. Would you  
7 like to start us off on scientific  
8 acceptability?

9 MS. WILBON: So sorry. Real quick  
10 before we move on to importance, I mean before  
11 we move on to scientific acceptability, even  
12 though the discussion may be brief, we do  
13 actually have to vote on importance.

14 So if we could just have everyone,  
15 we'll just on the screen, we'll show each of  
16 the subcriteria and we'll have you guys vote  
17 high, moderate, low based on your evaluation  
18 of the measure, if you feel like they've  
19 demonstrated each of these criteria.

20 DR. MOSENFAR: Are we going to  
21 vote again after we hear from the reviewer, or  
22 this is just the last vote?

1 MS. WILBON: No, this is just on  
2 the importance criteria. You'll have plenty  
3 of, you'll have lots of other votes left on  
4 the scientific acceptability, usability and  
5 feasibility. So this is just the first chunk.

6 MS. TURBYVILLE: Yes, the  
7 importance of this problem, you know, it's not  
8 the importance of the measure. It's the  
9 importance of this problem as a health care  
10 cost in the country.

11 DR. MOSENFAR: Yes, thanks for  
12 correcting that.

13 MS. WILBON: So I also just wanted  
14 to point to you real quickly in your folders,  
15 that table that I've actually got up there  
16 will help kind of guide you through the  
17 discussion as well throughout the day so you  
18 can see which subcriteria that we're going to  
19 be talking about, this kind of two-column  
20 table.

21 And we'll have it up on the screen  
22 throughout the day as well to help you get an

1 idea of what we're evaluating.

2 So 1A is the first subcriteria  
3 we'll vote on. It's asking whether or not the  
4 measure focus addresses a specific national  
5 health goal or priority or demonstrates a  
6 high-impact aspect of care. So we'll have  
7 everybody go ahead and vote. Okay, that was  
8 nine high.

9 And we'll move on to 1B, which asks  
10 whether or not -- that the data submitted  
11 demonstrated resource use or cost problems for  
12 improvement variation in delivery in care or  
13 population groups.

14 MS. FANTA: So it's seven high and  
15 two moderate.

16 MS. WILBON: So 1C asks whether or  
17 not the purpose or objective of the Resource  
18 Use Measure and the construct for resource use  
19 costs are clearly described in the submission.  
20 So was the intent of the measure described in  
21 the submission adequately?

22 MS. FANTA: So we have nine high.

1 MS. WILBON: 1D asks whether or not  
2 the resource use service categories that were  
3 identified in the measure are consistent with  
4 the measure intent and the measure concept.

5 MS. FANTA: The results are nine  
6 high.

7 CO-CHAIR ELWARD: Thank you.  
8 Thanks very much. I'm giving Kathryn a few  
9 more minutes. I don't mind --

10 DR. BLAKE: For 2a2 and 2b2, did  
11 you want Mike to go first with the 2a1?

12 CO-CHAIR ELWARD: Yes, you're  
13 right. Well, go ahead.

14 DR. SCHATZ: So let's see, are we  
15 going to put up -- again, I found this very  
16 difficult to apply my clinical expertise to,  
17 but from the best I could tell from my  
18 experience and from what I could read, I  
19 didn't see any problems with, and relying on  
20 the statistical consultant, I didn't identify  
21 any issues in this sub-measure, for this  
22 measure. I'd certainly open it for other

1 input.

2 CO-CHAIR ELWARD: Any other  
3 thoughts?

4 (No response.)

5 All right. And let's go to 2a2.  
6 Kathryn?

7 DR. BLAKE: Mine was actually made  
8 very easy because Carlos had done a lot of the  
9 assessment on the reliability and validity.

10 So for 2a2, can you scroll  
11 it up for 2a2? It was the reliability  
12 testing, and when I looked at that again I  
13 also found this hard to kind of wade through.

14 For instance, when I was reading  
15 the description of the data and the sample,  
16 there wasn't a lot there. But then when I  
17 read more into my sections then I found out  
18 more of what the data and the sample was. So  
19 that sometimes was difficult to get through.

20 In terms of the analytic  
21 method, so the data and the sample, once I  
22 reviewed everything, the data and the sample

1       were adequately described.

2                       When I got to the analytic methods,  
3       my impression was that they didn't really  
4       provide a lot of detail on the analytic  
5       methods. It was more of an overview of what  
6       they looked for.

7                       And I actually had a question about  
8       one part of it and I'll read the sentence  
9       because this is what was confusing. It said,  
10      did notice of public reporting of Relative  
11      Resource Use, RRU result in 2010, result in a  
12      change in the number of make-up of plans that  
13      reported or RRU in 2010?

14                      I think, at least I think one of  
15      those was supposed to be 2009, from what I  
16      understood from what I read previously but I  
17      wasn't sure.

18                      So that was one small question and  
19      I don't think it will change the overall  
20      assessment that I had of this measure. But  
21      overall, I agreed with the overall statements  
22      and comments that they had.

1                   In terms of the testing results,  
2                   they had a sentence in there talking about  
3                   that the range in variation in both the  
4                   submitted data and the final plan results were  
5                   not found to be excessive nor was there a  
6                   significant relationship noticed between the  
7                   health plan total O/E results and plain  
8                   quality results.

9                   And it was kind of a qualitative  
10                  assessment, so I found it kind of difficult to  
11                  ascertain the appropriateness for the testing  
12                  with that being so qualitative. Then in terms  
13                  of their findings statement, I found that  
14                  acceptable.

15                  MS. DORIAN: Thanks, Kathryn.  
16                  Carlos, do you think maybe you could also give  
17                  us a brief overview of your findings on the  
18                  scientific acceptability?

19                  MR. ALZOLA: Sure. Thank you.  
20                  Well, let me start with, how was the measure  
21                  defined? Was it well defined and precisely  
22                  specified? So we look at the several things

1       there.

2                   We look at the clinical logic,  
3       meaning how is the measure defined and what  
4       are the clinical underpinnings that go under,  
5       in defining the measure, what are their  
6       reasoning?

7                   They also look at the construction  
8       logic, so how to go from the database to  
9       actually arrived at the score, at the final  
10      score.

11                  And then the risk adjustment  
12      methodology and the data derivation process.  
13      So all those things are found in various  
14      places in the document.

15                  And so then they say that, in terms  
16      of the clinical logic, they defined what were  
17      the methods that they used to identify the  
18      conditions and the timeframe for  
19      identification and measure.

20                  Like in most measures that we have  
21      reviewed, the conditions are identified by the  
22      diagnosis code and they have a measurement



1 period and an identification period.

2 So they are two years. One year in  
3 which they identify the condition and then the  
4 next year when they measure the resource use.

5 They have some exclusions that they  
6 apply to all their measures and those are  
7 cancers, end-stage renal disease, organ  
8 transplants or HIV/AIDS.

9 And I think even though it's not,  
10 I didn't see it specified explicitly, I think  
11 those patients are considered different and  
12 that excluding those would make the population  
13 more homogeneous because this really costly  
14 patients that could skew the resources.

15 MR. HAMLIN: Yes, that's correct.  
16 They're extremely high cost conditions that a  
17 small proportion of patients could skew the  
18 results using our methodology. So we exclude  
19 them from all measures.

20 MR. ALZOLA: Okay.

21 DR. BLAKE: So does that mean that  
22 you didn't exclude diseases such as

1 cardiovascular disease because they're more  
2 prevalent in the population so would have been  
3 less likely to skew it with a small number of  
4 patients?

5 MR. HAMLIN: We don't exclude them  
6 from the population. The risk adjustment does  
7 take into account comorbidities and stratifies  
8 them by their risk.

9 So cardiovascular conditions would  
10 be accounted for in the risk adjustment  
11 methodology but we don't actively exclude  
12 them. The four exclusions that were listed  
13 are the ones that are because of cost issues.

14 For the asthma population we also  
15 exclude COPD because that tends to be the ones  
16 with, again with the HEDIS quality measure,  
17 there's some factors that affect the measure  
18 on the clinical side. So we're really trying  
19 to look at just asthma alone.

20 One other comment about the annual  
21 analysis just to hopefully clarify some of  
22 those sentences. NCQA for Relative Resource

1 Use conducts an annual report, an analysis of  
2 the results that we receive.

3 Some other things we look at are  
4 we're looking at the types and numbers of  
5 plans that report. We look at the results  
6 from plans that are reported in past years  
7 versus plans that are first-time reporters  
8 this year to determine whether there are any  
9 differences in their status and their results  
10 primarily due to outliers.

11 So we restrict the results that we  
12 consider outliers to be any O/E ratios between  
13 0.3 and 3. And we look to see if there's any  
14 differences in the results of new plans versus  
15 sort of repeat offenders, if you will, or  
16 plans that reported over a number of years.

17 We also do look at specific  
18 correlations between some of the service  
19 categories in the quality scores and the  
20 specific service categories in the pharmacy  
21 scores, if you will, to try and draw those  
22 correlations.

1           To date there have not been any  
2           that we've been able to quantify, if you will,  
3           so primarily, you know, the results are we  
4           report the results and we have not been able  
5           to show any significant correlations between  
6           any of these service categories and their  
7           quality scores.

8           And that annual analysis is  
9           conducted and it's a very standardized  
10          methodology for conducting that analysis and  
11          we try and look at that again year over year  
12          over year.

13          DR. STANFORD: I have a question.  
14          So your exclusions are occurring in the  
15          identification year as well as the measurement  
16          year, or are you just looking at exclusions  
17          within the confines of the identification  
18          year?

19          MR. HAMLIN: So defining the  
20          population, we use a two-year criteria based  
21          upon the HEDIS asthma measure. The  
22          measurement of resource use is only during the

1 measurement year which is a 12-month calendar  
2 year.

3 DR. STANFORD: But the exclusions  
4 are occurring in both years?

5 MR. HAMLIN: Right. The exclusions  
6 would affect the denominator population over  
7 either year, yes, that's correct.

8 DR. STANFORD: And then your  
9 outliers are based on cost outliers, is that  
10 correct?

11 MR. HAMLIN: Right. That doesn't  
12 meet the plan results, exactly.

13 CO-CHAIR ELWARD: Any other  
14 thoughts?

15 (No response.)

16 Okay, a question I had for NCQA is,  
17 it seems that you initially state you're  
18 looking at group practice level, but some of  
19 the measures seemed to be focused more on  
20 health plan or health system work. Can you  
21 address that?

22 MR. HAMLIN: Sure. The measures

1 are valid for any health plan. They're  
2 population-based measures. We use them for  
3 health plans. They have been tested and used  
4 in physician groups.

5           However, you do have to have a  
6 population of at least 400 members for the  
7 methodology to be valid and so it tends to be  
8 larger physician groups that can use the  
9 measures.

10           However, we only at this current  
11 time use them for health plans because that's  
12 what we do and that's where we found the  
13 sufficient sample size.

14           CO-CHAIR ELWARD: Yes, so the unit  
15 of analysis would have to be enough, if you  
16 went to a group practice level, you'd have to  
17 have enough, at least 400 patients.

18           MR. HAMLIN: At least 400 patients  
19 at a minimum to be able to sort of use the  
20 measure in a valid fashion.

21           CO-CHAIR ELWARD: Okay.

22           MR. HAMLIN: And for asthma this is

1 significant, because even at the health plan  
2 level oftentimes we end up excluding plans  
3 because of a lack of sample size. So we only  
4 include people in the analysis that have at  
5 least 400 patients.

6 CO-CHAIR ELWARD: Just one thing,  
7 in Step 1, I think it's Page 12, you define,  
8 I think you use the standard HEDIS criteria.

9 Although one of the  
10 challenges traditionally has been that using  
11 asthma as a principal diagnosis can  
12 oftentimes, you can actually have problems  
13 finding people, especially those who are acute  
14 because they'll come into the ER and they'll  
15 be diagnosed as having bronchitis and asthma.  
16 It's always in the second one.

17 Have you looked at whether or not  
18 you could enhance the measure by adding second  
19 or third diagnostic?

20 MR. HAMLIN: We actually do include  
21 second or third diagnostic and using the two-  
22 year criteria for identification. We tend

1 that we hope that that's a more specific  
2 criteria.

3 We are also currently looking at  
4 additional criteria for future measurement to  
5 be more specific with the new clinical data  
6 that's coming out through more enhanced  
7 systems.

8 But right now we're sort of  
9 sticking with the administrative version that  
10 we've got over two years of looking at  
11 asthmatics.

12 It's diagnosed as, but principally  
13 of many of the people getting using a  
14 combination of diagnosis and anti-asthmatic  
15 medications. So it's that combination over  
16 the two years that defines the persistent  
17 asthmatic population.

18 DR. STANFORD: So back to what you  
19 just mentioned. In your measurement year, are  
20 you taking into account secondary diagnosis as  
21 well or is it all based on the primary  
22 diagnosis of asthma?



1 MR. HAMLIN: No, it's not on  
2 primary diagnosis only. It's on any  
3 diagnosis.

4 DR. STANFORD: Any diagnosis. So  
5 you're looking at any diagnosis that occurs  
6 and you're attributing cost to asthma,  
7 correct?

8 MR. HAMLIN: That's correct.

9 DR. STANFORD: Or were you looking  
10 at all costs? Just cost of asthma?

11 MR. HAMLIN: It's all costs for  
12 anyone identified with asthma. So any  
13 services that are rendered to that person  
14 during that year if they've been identified as  
15 asthma are attributed, yes.

16 DR. MOSENFAR: I had a question.  
17 The fact that most of the asthma's delivered  
18 in smaller health plans, you know, one- or  
19 two- or three-physician groups, have you done  
20 any testing or is it possible to test that if  
21 in two years' time if the ten smallest groups  
22 combined for a variety of reasons and make up

1 larger groups, will this be applicable in  
2 terms of generalizable?

3 MR. HAMLIN: Well, I'm going to try  
4 and answer your question two ways. We have  
5 criteria for plans or groups that combine so  
6 that are, you know, how you would include that  
7 data. Because it's a two-year frame, a lot of  
8 things could happen over that timeframe.

9 So we do have very specific  
10 guidelines on how you can lump the populations  
11 together and which ones you include, which  
12 ones you do not include for the denominator  
13 identification.

14 Again looking at the resource use  
15 over that year you have to have the data for  
16 that year. Whether it's been aggregated or not  
17 is sort of up to the organization itself on  
18 whether they can or cannot report that.

19 So if you have the data over that  
20 two years and the complete administrative data  
21 for that one year for that population you can  
22 report it.

1                   We don't allow any imputation on  
2                   the resource use so there's no assumptions or  
3                   imputation allowed for the resource use side.

4                   CO-CHAIR MAURER:   Could I go back  
5                   to the answer you gave just before about  
6                   picking up asthma as well as chronic  
7                   bronchitis or bronchitis?

8                   In your identification criteria,  
9                   you use asthma.  You use an ED visit or an  
10                  acute inpatient discharge, but asthma has to  
11                  be the principal diagnosis.

12                  It looks to me like the only way  
13                  you would pick up anything other than asthma  
14                  would be in the four outpatient visit  
15                  criteria.  Is that correct?

16                  MR. HAMLIN:  Yes, I'm sorry.  I'm  
17                  trying to do this from memory.  And my  
18                  computer died and I was trying to be green and  
19                  not print things out.  That is correct.

20                  For ED visits it has to be  
21                  principal diagnosis.  For the outpatient it  
22                  can be any diagnosis.  And the proportion of

1 people that come in through the ED is actually  
2 very, very small in the population.

3 And then chronic bronchitis also is  
4 one of the clinical exclusions, so anyone with  
5 an ICD-9 for clinical bronchitis would also be  
6 excluded from this population.

7 CO-CHAIR ELWARD: In the comment  
8 also you made about including total cost. I  
9 mean if a kid, unrelated to his asthma, falls  
10 down and breaks his leg, you know, assuming he  
11 wasn't wheezing and stumbling because he's  
12 short of breath, why does that make sense to  
13 include it in total cost?

14 MR. HAMLIN: Because we're looking  
15 at health plan populations. We're looking at  
16 the total cost for managing a person  
17 identified with his condition.

18 And again it's population-based so  
19 for the plans themselves to understand what  
20 the resource use for this person would be  
21 regardless of how you're attributing these  
22 different services to the asthma or not.

1 I mean again it's harder to make  
2 the argument that the kid fell and broke his  
3 arm because he had an asthmatic attack on the  
4 jungle gym.

5 But again it's really looking at  
6 the, you know, what services are used by this  
7 population identified with asthma.

8 It's not really what services are  
9 attributable directly to asthma, because we  
10 don't want to have to make those distinctions  
11 of what can be attributed and what cannot be  
12 attributed to asthma itself.

13 CO-CHAIR ELWARD: Michael?

14 DR. SCHATZ: Yes, I think the point  
15 is really the converse, which is the  
16 difficulty you run into when you try to say  
17 okay, well, this is asthma, this is not.

18 So I think the balance is in favor  
19 probably of doing it this way because of the  
20 problems on the other side.

21 CO-CHAIR ELWARD: And sort of what  
22 you'd have to do is, if you saw an inordinate

1 amount of cost, you'd have to go back to your  
2 own claims data and say okay, were there  
3 surgical codes or were there appendicitis  
4 codes that would account for that?

5 MR. HAMLIN: And the service  
6 categories that we use are very, very detailed  
7 so you could go back and, I mean the results  
8 are all presented by that.

9 So you could look at if you had an  
10 inordinately high acute inpatient utilization  
11 for this population, you could then go back in  
12 your data and look and see okay, well, what is  
13 this telling me now?

14 But again we just want to capture  
15 everything. It's a snapshot of everything for  
16 managing this population with this identified  
17 condition.

18 CO-CHAIR ELWARD: Thank you.

19 DR. STANFORD: And I think that  
20 probably plays into your sample size. Sample  
21 size having to be large, if you account for  
22 some of the disparities that you may see

1 across plans.

2 CO-CHAIR ELWARD: Thank you. Any  
3 other thoughts about that in terms of 2b? I  
4 think we had a discussion about exclusions is  
5 why I just now, have it, about 2b 4 or 5?

6 DR. BLAKE: Were you finished  
7 Carlos? Did you finish everything?

8 MR. ALZOLA: Just another comment.  
9 They restricted the population to patients age  
10 5 to 50 years old.

11 MR. HAMLIN: A new update.  
12 Actually, that age range has been expanded to  
13 64 now for this next year. We just recently  
14 finished some testing and we're now 5 to 64.

15 MR. ALZOLA: And one other comment  
16 is that, when they tested the measure, they  
17 tested in both commercial Medicaid and  
18 Medicare?

19 MR. HAMLIN: Commercial Medicaid.

20 MR. ALZOLA: Medicaid only?

21 MR. HAMLIN: Right.

22 MR. ALZOLA: Okay.

1 DR. STANFORD: So you didn't test  
2 it in fee-for-service Medicaid, is that what  
3 you're saying? You used commercial Medicaid,  
4 right?

5 MR. HAMLIN: Yes, that's correct.

6 DR. STANFORD: Have you thought  
7 about using fee-for-service? There's a big  
8 difference between managed Medicaid and fee-  
9 for-service Medicaid.

10 MR. HAMLIN: There is. And we've  
11 been looking at new testing options. Right  
12 now, actually, we're looking at some of the  
13 larger database aggregators to see if we can  
14 try and have some new testing.

15 Basically the way we've been  
16 testing in the past is contracting with plans  
17 individually and having them provide data to  
18 NCQA for testing which is a very laborious and  
19 very expensive process.

20 And so we're trying to again look  
21 at some of the variation between the different  
22 plan types to see what their resources might



1 be, but at the moment we're sort of limited to  
2 our current testing strategies. But we do  
3 acknowledge there is some differences and  
4 there's also been some interest in the  
5 Medicare population.

6 We're looking to test the effect  
7 of, and looking at the resource using the  
8 Medicare population. But again we have a very  
9 high threshold for releasing specifications  
10 for a population that we haven't tested very  
11 thoroughly.

12 MS. WILBON: Ben, this is Ashlie  
13 here. Just a quick question. Did you say you  
14 did not test in Medicare? Is that what you  
15 said?

16 MR. HAMLIN: That's correct,  
17 because the age range pretty much precluded  
18 the majority of that population. We would  
19 have had a very hard time finding Medicare-  
20 eligibles with a population of 400 or greater.

21 MS. WILBON: Just a note. We'll  
22 follow up, but on their submission it says

1 that you tested Medicare. So I think we had  
2 a question about that as well.

3 MR. HAMLIN: Sorry about that, yes.

4 MS. WILBON: Yes, we'll just want  
5 to clean that up before we post it. Thanks.

6 CO-CHAIR ELWARD: 2b5, data  
7 analysis? Have we gone that far?

8 DR. BLAKE: Did you want me to do,  
9 let's see. We didn't do 2b2.

10 CO-CHAIR ELWARD: Oh, I'm sorry.  
11 Go back to 2b2, excuse me.

12 DR. BLAKE: Okay. So the data in  
13 the sample: that was the same as previously,  
14 or that I previously discussed.

15 In terms of the analytic method,  
16 the risk categories that they had assigned via  
17 the episode risk groups appears appropriate  
18 and it made clinical sense to group patients  
19 according to their observed mix of episodes.

20 But their other method, categories  
21 based upon age, seemed less appropriate.

22 Maybe I just didn't understand, but it seemed

1 like, you know, severe expensive asthma events  
2 can occur at any age so I wasn't really clear  
3 on why they were categorized based on age.  
4 Can you comment on that?

5 MR. HAMLIN: Sure. The age strata  
6 for the risk adjustment are effectively  
7 designed around, sort of, known utilization  
8 patterns. And we use a fairly large Ingenix  
9 database of the commercial population to  
10 determine those age categories.

11 The age categories on the RRU side  
12 or the Relative Resource Use side are really  
13 truly around utilization.

14 The age categories on the clinical  
15 side are around both sort of clinical  
16 treatment patterns between the children and  
17 adults and also for several reporting  
18 strategies.

19 So our clinical measure is part of  
20 the CHIPRA core set, so we have sort of an age  
21 strata of the 5 to 18s because that's what's  
22 in the Child Health measures.

1                   So there's kind of a difference.  
2                   In the strata for reporting on the RRU side,  
3                   it's based on utilization patterns. On the  
4                   clinical side, it's based on clinical and  
5                   other reporting needs, if you will.

6                   DR. BLAKE: Okay. Then in terms of  
7                   testing results that appeared appropriate, in  
8                   terms of their finding statements, there's a  
9                   mention of four different methods. And I  
10                  couldn't figure out what these four methods  
11                  were whether it was episode of care, disease  
12                  identification. Were those two of the  
13                  methods?

14                  I'm on Page 31 of your document.  
15                  That's where SA 2.4 starts on the bottom of  
16                  Page 30 and continues to on the top of Page  
17                  31.

18                  And there's a bullet on Page 31 and  
19                  you say under methods, four different  
20                  approaches were used by the study to measure  
21                  Relative Resource Use, varying the risk  
22                  adjustment methodology employed and the focus

1 on total services versus disease-related  
2 costs. So I wanted to know what those four  
3 methods were.

4 MR. HAMLIN: We tested several  
5 different risk adjustment methods from the  
6 age, sex, comorbid yes-or-no type method up to  
7 the current HCC stratified population into 13  
8 different risk cohorts by severity of  
9 comorbidity and there was a couple of  
10 variations in between.

11 So we tested several risk  
12 adjustment methodologies to determine what was  
13 the most appropriate for cost-related and  
14 utilization-related factors for this  
15 population. And the current method, the HCC  
16 method was the one that sort of came out on  
17 top, if you will, for the --

18 DR. BLAKE: The which one?

19 MR. HAMLIN: That HCC. We use an  
20 HCC derived, so it uses the same as HCC  
21 approach that we sort of drill down a little  
22 bit.

1                   We don't use the entire HCC  
2                   classifications but we use a good proportion  
3                   of them for categorizing the population. And  
4                   during the early testing, I believe there's a  
5                   2005 report that was included in the materials  
6                   that looks at the effect of the testing of the  
7                   different risk adjustment approaches on the  
8                   Relative Resource Use populations.

9                   DR. STANFORD: Is cost during the  
10                  identification, is that one of your risk  
11                  adjustment measurements?

12                 MR. HAMLIN: During the measurement  
13                 year, yes, because it looks at the -- the HCC  
14                 uses any services delivered during that year  
15                 to appropriately categorize them into one of  
16                 those 13 cohorts.

17                 So it looks at other diagnoses and,  
18                 you know, severity and frequency to put them  
19                 into a severity category.

20                 And it's sort of, you know, 1 is  
21                 asthma with low severity and then 13 would be  
22                 multiple comorbidities, high service

1 utilization and other things that would affect  
2 the cost of that population.

3 DR. STANFORD: Those are cost-  
4 driven. Those are --

5 MR. HAMLIN: They're cost-driven,  
6 yes. They're not clinically driven. No.

7 DR. STANFORD: I'm sorry. So are  
8 you using dollar values in your risk  
9 adjustment or are you using count values?

10 MR. HAMLIN: What we use is the  
11 associated service codes. So we're looking at  
12 ICD-9 and procedural codes to identify them  
13 for services rendered to categorize them into  
14 that population. And then we go back and look  
15 at the number of times those services were  
16 offered to that population and correlate that  
17 with their HHC cohort.

18 DR. STANFORD: Have you looked at  
19 cost in the identification year as part of  
20 your risk adjustment? But I mean have you  
21 compared the two whether they --

22 MR. HAMLIN: Well, we don't

1 actually get actual costs reported at NCQA, so  
2 we don't, the research database that we use to  
3 develop our standardized pricing methodology  
4 has that information in there and they use,  
5 that is how they derive the standardized  
6 prices.

7 So what we're looking at really for  
8 what we get is sort of a PMPM for that  
9 category of all members who meet that risk  
10 criteria.

11 And the determination, I believe  
12 that the steps are laid out for how you would,  
13 you know, categorize someone into that HCC  
14 cohort. It's primarily driven by, you know,  
15 ICD-9 codes that classify the number of  
16 comorbidities they have as well as other  
17 factors that would push them into --

18 DR. STANFORD: That's a yes/no  
19 count. They have one code, It's counted as,  
20 you're not counting multiple p

21 MR. HAMLIN: Multiples are counted  
22 as part of the process. So if you have



1 multiple comorbids, that factors into the risk  
2 adjustment. Multiple comorbids will put you  
3 in a much higher risk adjustment category.

4 DR. STANFORD: What I meant to say  
5 is that, if you have two codes for  
6 cardiovascular disease, for instance, or two,  
7 those are counted as one or two?

8 MR. HAMLIN: They're counted as  
9 two.

10 DR. STANFORD: All right, great.  
11 Thank you.

12 DR. BLAKE: Next I reviewed 2b4.

13 CO-CHAIR ELWARD: Please go ahead.  
14 Thank you.

15 DR. SCHATZ: Well, I think just to  
16 say we heard that the sort of the two main  
17 exclusions are for high cost outliers, which  
18 seems to make sense, and then what is always  
19 a concern with asthma is COPD.

20 So even though the ages, and that's  
21 why the age has historically been so low or at  
22 least one of the big reasons. But with the

1 age range rising to 64, but the ability to  
2 exclude COPD codes, that seems appropriate as  
3 well.

4 The only thing I wondered about  
5 although I think in the high cost arena, by  
6 excluding people with acute respiratory  
7 failure you are excluding potentially poorly  
8 managed patients, which gets at just the whole  
9 reason for, at least one reason for doing all  
10 this, but probably the cost outlier piece  
11 outweighs the situation.

12 But that was the one thing that  
13 occurred to me that, you know, a person could  
14 be excluded. It could have acute respiratory  
15 failure because they just hadn't been properly  
16 cared for, and to exclude them seems  
17 questionable.

18 MR. HAMLIN: So in our recent field  
19 test that we did when we were looking at the  
20 upper age groups, we did look at the effect of  
21 the different clinical exclusions on the  
22 populations of interest.

1 COPD was, by a vast majority, the  
2 biggest effect. About 38 percent of the  
3 people were eliminated from the population.

4 The others, acute respiratory  
5 failure, were very small percentages and so  
6 there's still always some debate on whether,  
7 you know, we should be excluding them or not.

8 But I think at this  
9 point, they were less than three percent I  
10 think at this point so they don't meet our  
11 sort of five-percent threshold of concern.

12 But we continue to look at the  
13 effect of those diagnoses on this population  
14 not year over year, but every time we do the  
15 test we sort of retest these clinical  
16 exclusions on this population to determine,  
17 you know, what the effect on the results might  
18 be.

19 CO-CHAIR ELWARD: And again, going  
20 back to the issue of ER visits, have you  
21 looked at the relative contribution of first  
22 and second diagnoses?

1 I mean, in the health plan I  
2 consult with, with Coventry, we actually  
3 increased our yield about 30 percent when we  
4 went to the second diagnosis code.

5 MR. HAMLIN: Right. The first and  
6 second we have not tested but we have tested  
7 the effect of the, you know, who comes in via  
8 ED visits versus the other algorithm. And  
9 again it was a very small proportion. It was  
10 less than five percent of the population came  
11 in through ED visits overall.

12 But we are continuing to look at  
13 ways of refining the denominator, because  
14 personally I believe, the ED visit is sort of  
15 the weakest link in the denominator chain, if  
16 you will, because it is possible to get people  
17 in there who might have either mild,  
18 persistent or intermittent asthma. You know,  
19 and they have one one year and one the  
20 following year.

21 But again it's sort of at that low  
22 percentage threshold that we're, it's of low

1 concern but it is still of concern for us.

2 CO-CHAIR ELWARD: Michael?

3 DR. SCHATZ: Yes, I mean I think  
4 it's a sensitivity/specificity issue and for  
5 a measure like this, I think we'd prefer the  
6 specificity.

7 CO-CHAIR ELWARD: A couple people  
8 were, in just looking at the overall ratings  
9 a couple of people also expressed some  
10 concerns about this aspect. Any thought?  
11 Gerene?

12 DR. BAULDOFF: Sorry, I keep  
13 forgetting that, that I marked it low. I  
14 think what I was doing was that I kind of  
15 missed a piece there.

16 I was very dependent -- thank you  
17 so much for the statistician review that  
18 really helped a lot, and I really missed the  
19 measure score. I was really going by the data  
20 elements section whenever I marked that low,  
21 so I apologize for that.

22 CO-CHAIR ELWARD: No, that's very

1 helpful. Thanks. Other thoughts on that  
2 aspect? Go to Kathryn next.

3 DR. BLAKE: Did you want Carlos to  
4 talk about the validity section?

5 CO-CHAIR ELWARD: If he would like  
6 to.

7 MR. ALZOLA: Yes.

8 DR. BLAKE: That's what I already  
9 talked about, but then I realized he didn't.

10 MR. ALZOLA: Again, we are looking  
11 here at face validity. That's what most  
12 measures have been focusing on.

13 And they, in support of the  
14 validity of the measure score, they included  
15 a lengthy paper which -- where they compare  
16 these four different risk adjustment  
17 methodologies.

18 It wasn't completely clear to me  
19 how that related to the methodology they  
20 actually selected: the HCCs.

21 The most single thing I that I  
22 found was the methodology where they just made

1 an adjustment by age and sex groups, and they  
2 compared that to the episode treatment groups  
3 approach and they found that they had a really  
4 high correlation.

5 So I think in general terms, that's  
6 good evidence of face validity, but I wish you  
7 had been a little more specific for the method  
8 you actually used. Although I'm not going to  
9 argue with the face validity of the HCCs, but  
10 I just don't think, I thought it wasn't  
11 addressed really in a more specific way.

12 The other evidence that I saw was  
13 how the costs were distributed in the  
14 different lines of service.

15 And one thing they found was that  
16 the majority of costs were attributed to  
17 prescription medications and followed by  
18 inpatient costs, which for an asthma  
19 population seems reasonable and for  
20 clinicians, no. They know better than I  
21 whether that's reasonable or not.

22 DR. SCHATZ: Well, I mean I think

1 and consistent with some prior independent  
2 separately done cost analyses of asthma.

3 DR. STANFORD: Fee-for-service  
4 Medicaid would not fit this category, so it's  
5 actually higher resource utilizations in that  
6 population.

7 MR. HAMLIN: And on the results  
8 side, one of the things we don't actually do  
9 at NCQA is say whether high is bad or low is  
10 good and so on and so forth. Again it's a  
11 snapshot of utilization.

12 I mean we have seen some non-  
13 statistically significant correlations between  
14 high pharmacy and high ED and low inpatient  
15 use for some of these populations, but again  
16 we're presenting the results as they are.  
17 We're not making any value judgments on high  
18 bad, low good, kind of thing.

19 CO-CHAIR ELWARD: Kathryn, go  
20 ahead.

21 DR. BLAKE: Okay, my next section  
22 had to do with risk adjustment and



1 stratification method. This is 2b4.

2 And the risk adjustment appeared  
3 appropriate but I still have to ask, why do  
4 you stratify by gender? Your age  
5 stratification, 5 to 17, 18 to 44 and 45 to 50  
6 seemed appropriate, but why do you stratify by  
7 gender? Is that standard?

8 MR. HAMLIN: Well, it's part of the  
9 fact that we use the same methodology for all  
10 of our measures, all of our risk, our RRU  
11 measures are all stratified by age and gender  
12 categories.

13 The age categories are slightly  
14 different depending on the different measures.  
15 But at this time we feel that it's important.

16 The age and gender are  
17 both weighted as part of the HCC approach, so  
18 there's a weight assigned to each of those  
19 based on utilization from the data that we  
20 used to determine that and then are reported  
21 back out by age and gender categories that we  
22 feel are relevant to utilization patterns.

1                   Whether or not there are  
2 differences between the gender patterns,  
3 again, we're just looking at that to see if  
4 there are any kind of disparities or  
5 differences. We don't do any kind of  
6 reporting by gender only, if you will.

7                   DR. BLAKE: Okay. Do you want to  
8 go on. My next section was 2b5. 2b5 just had  
9 to do with the scoring and I felt that was  
10 fine. The types of scores were frequency,  
11 distribution rates and proportion ratios,  
12 weighted scoring, composite scores, and these  
13 all seemed very appropriate.

14                   The interpretation was appropriate.  
15 The detail score estimation was appropriate  
16 and the discriminating results approach seemed  
17 appropriate as well, unless Carlos has any  
18 other comments on that.

19                   MR. ALZOLA: No. The main thing is  
20 whether, I can see, like, initial comparing  
21 statistically significant versus clinical  
22 significant differences. I didn't see that

1 addressed.

2                   However, the good thing is that  
3 they did provide the actual sample sizes under  
4 formulas to calculate confidence interval and  
5 that's really just about everything anyone  
6 needs to determine whether any differences are  
7 significant in which ever way they want to  
8 interpret it.

9                   CO-CHAIR ELWARD: Thank you. Any  
10 other comments on the section 2 before we go  
11 to Michael? Section 2b. Michael, 2b6?

12                   DR. STANFORD: Well, 2b6 and 2c are  
13 equal to what we heard before because multiple  
14 data resources aren't being used in this and  
15 we sort of agreed that data on disparities is  
16 inadequate.

17                   But I do think that if it were  
18 there from what the guidance before, we would  
19 be able to see that relative to what is being  
20 captured here. And asthma, like  
21 cardiovascular disease, this would be an  
22 important issue.

1 CO-CHAIR ELWARD: Agreed. Thank  
2 you. Any other thoughts about Item 2 overall,  
3 the overall category? Great, thank you.

4 MS. WILBON: So what we'll do now,  
5 if everyone's okay with the discussion and  
6 there aren't any more comments, we'll go  
7 through each of the subcriteria on the voting  
8 tool and have you guys vote. And if we get to  
9 any of the subcriteria and you feel like it  
10 hasn't been adequately discussed we can, you  
11 know, pick up a discussion there. But we'll  
12 go ahead and just run through them and see how  
13 everyone feels about them.

14 CO-CHAIR ELWARD: And if there are  
15 broad discrepancies on any one item, we might  
16 stop and try to work through that.

17 MS. FANTA: So 2a1, is the measure  
18 precisely specified so it can be implemented  
19 consistently.

20 MS. DORIAN: Can you guys try to  
21 keep voting? We're just missing a few votes,  
22 and it won't count it twice if you keep going.

1 MS. FANTA: And the results are  
2 nine high.

3 Moving along to 2a2, does the  
4 reliability testing demonstrate that the  
5 results are repeatable, producing the same  
6 results a high proportion of time when  
7 assessing the same population in the same time  
8 period and/or that the measure score is  
9 precise? And the results are eight high and  
10 one moderate.

11 And now we're going to do a vote on  
12 overall reliability, and that encompasses 2a1,  
13 precise specifications, and 2a2, reliability  
14 testing. Are there any comments that anyone  
15 wants to make before we vote? Okay, then  
16 we'll go ahead. The results are eight high  
17 and one moderate.

18 Moving along to 2b, validity. Are  
19 the measure specifications consistent with the  
20 focus of measurement and the measure intent?  
21 The results are six high and three moderate.

22 Moving along to 2b2, does the

1 validity testing demonstrate that the measure  
2 data elements are correct and/or the measure  
3 score correctly reflects the cost of care or  
4 resources provided adequately distinguishing  
5 high and lower costs or resource use? And the  
6 results are six high and three moderate.

7 Moving along to 2b3, exclusions. Are  
8 exclusions supported by the clinical evidence  
9 or analysis of frequency and distribution? Is  
10 information about impact of exclusions for  
11 patient preference transparent? And the  
12 results are six high and three moderate.

13 Okay, 2b4, risk adjustment. For  
14 Resource Use Measures is there an evidence-  
15 based risk adjustment strategy or rationale or  
16 data to support no risk adjustment or  
17 stratification? Okay, and we have seven high  
18 and two moderate.

19 Moving along to 2b5, are  
20 performance results reported? Do they  
21 identify differences in performance or overall  
22 less than optimal performance? And the

1 results are eight high, one moderate.

2 Okay, and now this is an overall  
3 vote on validity that encompasses that the  
4 specifications are consistent with resource  
5 use and cost problem validity testing risk  
6 adjustment and identification of meaningful  
7 differences. The results are five high and  
8 four moderate.

9 MS. WILBON: One last vote on  
10 disparities.

11 MS. FANTA: Okay, so 2c, if  
12 disparities in care have been identified, do  
13 measure specifications, scoring, and analysis  
14 allow for identification of disparities  
15 through stratification or results or is there  
16 rationale or data justifying why  
17 stratification is not necessary or feasible?  
18 Okay, so the results are five high, three  
19 moderate, and one insufficient.

20 CO-CHAIR ELWARD: Thanks very much.  
21 Usability, Kathryn?

22 DR. BLAKE: I had usability. This

1 was fairly straightforward. For current use  
2 I found that is acceptable.

3 For the use in public reporting  
4 initiative I found that was accessible. For  
5 the use in, what's Q, by quality improvement,  
6 in my notes I put non-applicable. Oh, he  
7 didn't have anything in there. That's right.  
8 There's nothing in there, so not applicable.

9 And the same for the use in other  
10 accountability functions, that's not  
11 applicable because they said Relative Resource  
12 Units measures are not used for accreditation  
13 scoring. So those two didn't apply.

14 Then in terms of 3, let's see in  
15 terms of 3b for understanding or usefulness of  
16 the description of the data, method, and  
17 results, I have to say NCQA did an excellent  
18 job in this respect. I found it very  
19 straightforward and easy to interpret.

20 In terms of the interpretation of  
21 the score the observed to expected ratio for  
22 their interpretation of the data I found



1 acceptable. The detail score estimation I  
2 also found acceptable and the discriminating  
3 research approach I also found acceptable.

4 MS. DORIAN: Kathryn?

5 DR. BLAKE: Yes.

6 MS. DORIAN: Just one question.  
7 Would you mind just telling us a little bit  
8 around why you found these acceptable, or if  
9 anybody else has any comments just for our  
10 notes?

11 MS. WILBON: And summarize what  
12 they have, because everyone might not have  
13 reviewed the measure. So everyone can vote,  
14 we just need to kind of have a summary of what  
15 they had in there and then what your judgment  
16 was.

17 DR. BLAKE: I don't remember much.  
18 I tried to put down in my notes what I felt  
19 like was important to bring up in terms of  
20 problem areas. I didn't do as well in putting  
21 in what was appropriate comments. So if I  
22 think of it as we go along then I'll bring it

1 back up.

2 MR. HAMLIN: I can give you an  
3 overview of what we do if anyone is  
4 interested.

5 So as I mentioned earlier these  
6 results are published in through our Quality  
7 Compass module which publishes the individual  
8 plan results by detailed service category and  
9 also with their quality score.

10 Now obviously since Relative  
11 Resource Units are much more complex measures  
12 it requires a little bit more interpretability  
13 and so we have subsequently published several  
14 resource -- we have a dedicated web page that  
15 describes our methodology in great detail.  
16 We've conducted a number of webinars that sort  
17 of outline Relative Resource Use and how we go  
18 about calculating them and how you might go  
19 about using them. In addition, we've also  
20 created several documents. Some are very  
21 brief, what we call four-pager for specific  
22 stakeholders like purchasers and employers.

1                   Also there's another more detailed  
2 document that explains how you might use the  
3 results and how you might interpret the  
4 results.

5                   So here you can see a sample report  
6 for the different service categories for, I  
7 hope this is for asthma. So this is what the  
8 results might look like.

9                   And then we have these additional  
10 documents and resource guides that will help  
11 all stakeholders, targeted to specific  
12 audiences that will help them interpret these  
13 scores.

14                   And also we offer some  
15 opportunities, since I mentioned we only  
16 receive aggregate plan level standardized cost  
17 data.

18                   We then also have programs where we  
19 go back to the plan and say okay, well, if you  
20 plug in your actual costs, your real costs  
21 using the same methodology here's how you  
22 might be able to identify opportunities to

1 improve some of your utilization patterns.  
2 You know, here's where you can look for  
3 opportunities to reduce costs if you will.  
4 But again we don't have that data, but we  
5 offer a lot of education around how you might  
6 be able to identify opportunities using your  
7 own data. You can plug into this same  
8 methodology and therefore try and understand  
9 where you can identify those opportunities.

10 Often it's not the high utilization  
11 low cost areas, but sometimes it's the lower  
12 utilization higher cost areas that you can,  
13 when you go back and plug this in you can  
14 actually find some significant opportunities.  
15 And so again we work with plans individually.

16 We also, again, publish these  
17 resource documents, make them available  
18 broadly to the public through our public  
19 website for anyone who's interested in either  
20 the methodology or the opportunities. But  
21 they are very complex measures, and so that's  
22 why we provide this much information.

1 CO-CHAIR ELWARD: Yes, I noticed a  
2 couple places where you reference in the  
3 measure that you have to go to a website and  
4 get a login and password. That's just a  
5 formality, right? I mean is there --

6 MR. HAMLIN: Actually there is no  
7 more login and password anymore. So the  
8 standard pricing tables are now moved to our  
9 public website so the updated URLs which I'm  
10 not sure were in these two measures.

11 I believe we updated them on the CV  
12 and diabetes ones, now are just really  
13 available to anyone who wishes to use them,  
14 and we encourage their broad use.

15 CO-CHAIR ELWARD: Yes, the ones in  
16 there still want you to log in and all that.

17 MR. HAMLIN: Okay. Yes, there was  
18 no required subscription. We were initially  
19 tracking who was logging in and how many  
20 people were logging in.

21 Checking them now, it's just moved  
22 up to a more public site where you just go

1 directly and it takes you right to that site.

2 DR. STANFORD: Can you -- in  
3 treating my question around standard pricing,  
4 so when you say standard pricing across health  
5 plans, how are they implementing that within  
6 the confines of their data? Is that an  
7 aggregated or is that an individual?

8 MR. HAMLIN: They look for  
9 individual codes, so they look for ICD-9, they  
10 look for CPT, UB revenue for some service  
11 categories, and there's actually a  
12 standardized price in those tables that is  
13 assigned to that specific code. And they do  
14 that for each of the service categories so the  
15 prices are adjusted for whether they're  
16 inpatient or outpatient.

17 So it depends on where you find it  
18 you'll apply a specific code. They then  
19 aggregate that and report that to us at the  
20 plan aggregate level, but they have to do the  
21 individual member level mapping. So it's a  
22 fairly significant effort for reporting these

1 measures.

2 CO-CHAIR ELWARD: How often do you  
3 have a review of the usability, I mean from  
4 the feedback you get? How often does that  
5 occur?

6 MR. HAMLIN: Annually. We,  
7 actually even more frequently nowadays,  
8 because when the measures went public last  
9 year, the results went public last year, we  
10 had this sort of blitz of information and  
11 feedback. And we try and sort of recycle that  
12 and get that back out again to the public in  
13 a regular fashion.

14 But we're always taking, you know,  
15 right now we're doing sort of an experience  
16 analysis if you will. We're contacting  
17 clients directly and finding out what their  
18 experiences were.

19 We're contacting some of the  
20 employer groups and finding out what their  
21 experiences were with this information, how  
22 they used it and how we can then tailor that

1 to try and improve the guidance documents that  
2 we provide to people.

3 So it's a continuous thing, but at  
4 a minimum we annually look at the results of  
5 the individual plans and how they compared and  
6 where they moved and how they did.

7 You can't trend this information  
8 year to year because we calculate the expected  
9 on all the plans that submit every year to  
10 NCQA so there's some variation there. But we  
11 are looking at other ways now with enhanced  
12 data to try and perhaps create some trending  
13 strategies too for plans.

14 CO-CHAIR ELWARD: Yes, and it may  
15 be my intellectual limitation, but one of the  
16 things it seems would be nice is to have some  
17 actual examples, you know, with imaginary data  
18 that somebody could go through and play with  
19 a little bit and say okay, here's how it makes  
20 sense.

21 Just to draw out, you know, if I  
22 have a population of 5,000 and I had these



1 variables, what would it look like? Just to  
2 give people an idea of how they would use it.

3 MR. HAMLIN: We've been doing that  
4 annually at our HEDIS update conference. So  
5 it's a day and a half conference, and then we  
6 save that second afternoon solely dedicated to  
7 RRU and that's where we do the opportunities  
8 to improve. And so we do exactly that.

9 We take fake data and we show them  
10 the opportunities calculations based on that  
11 fake data and the different variables that  
12 would affect that. And anyone's welcome to  
13 come in and sit in on those. I mean you have  
14 to register for the conference then you can go  
15 in.

16 And we actually have people who,  
17 experts who will go through and walk you  
18 through all those calculations, and we use  
19 sort of fake data sets to do that. So that's  
20 part of our annual presentations but we also  
21 do some webinars of that as well.

22 CO-CHAIR ELWARD: Okay, thank you.

1 That's helpful.

2 DR. STANFORD: I always get hung up  
3 on these measures around public accountability  
4 and public reporting. Who do you think the  
5 primary user, I mean we talk about publicly  
6 reporting.

7 Who's using this the most do you  
8 think? I mean is it purchasers or is it the  
9 health plans themselves?

10 MR. HAMLIN: I think actually right  
11 now, my impression is equally both. So plans  
12 are using it to identify their, you know, how  
13 they compare to their peers. Because we only  
14 report plans in peer groups, so HMO only, PPO  
15 only. They're only compared to other HMOs in  
16 their region, HHS region, which is fairly big.

17 The purchasers are the ones who  
18 really are driving the need for this  
19 information. So the purchasers and some of  
20 the large employers want to see this because  
21 it's what they want to use.

22 You know, previously all they had

1 was a premium price that they could say well,  
2 you know, you're charging me this premium and  
3 you're charging me this premium. Here's your  
4 HEDIS quality scores.

5 But this now is one more piece of  
6 information that they can then bring into that  
7 conversation so they can look at specific  
8 plans based on premium, utilization, adjusted  
9 for, you know, their peer group and also the  
10 quality scores as well.

11 And so we're finding that plans are  
12 interested in their results themselves and  
13 that purchasers are interested in the  
14 different plans and how they look compared to  
15 each other, you know, like year by year.

16 So we're seeing a lot of, an  
17 increase in our Quality Compass registrations  
18 on the purchaser/employer side which has been  
19 nice for us.

20 DR. STANFORD: And then the other  
21 thing that goes along with that, you had  
22 mentioned earlier that you really haven't

1 found associations with at least most of your  
2 quality metrics. And I assume most of the  
3 quality metrics are the HEDIS measures and  
4 primarily processes of care.

5 I mean have you looked at outcomes?

6 I mean obviously the goal here I think with a  
7 lot of these resource measures is to improve  
8 value.

9 You know, a lot of people talk  
10 about improving quality, but frankly I haven't  
11 seen many of these measures that I've looked  
12 at that actually have evidence that they  
13 correlate with quality.

14 MR. HAMLIN: It's hardest with  
15 asthma, I'll be perfectly honest, because we  
16 only have one quality measure to associate,  
17 more are coming.

18 But again we only use HEDIS  
19 measures, HEDIS quality measures that have  
20 fulfilled the full process, which means we  
21 cannot have first year measures that are not  
22 publicly reported on the HEDIS side. So we

1 are expanding that.

2           There are two measures coming, but  
3 again they haven't finished that process yet.  
4 So I think as we enhance the quality side we  
5 will start to see more correlations that will  
6 be more statistically significant or valid.

7           But we again have a very small and  
8 very high threshold for what we consider  
9 statistically significant correlations versus  
10 what we, we sort of see some correlations but  
11 we're not going to report those out because we  
12 want to really keep the bar very high there.

13           So I expect as the quality side  
14 gets better particularly with enhanced  
15 information as we move more into admin plus  
16 electronic medical record information on the  
17 quality side, I think those correlations will  
18 start to become much more apparent and we'll  
19 be willing to make those public announcements  
20 of those correlations. But right now we see  
21 some but we're not going to publish those.

22           CO-CHAIR ELWARD: That does raise

1 a question, this is primarily going to be from  
2 claims or --

3 MR. HAMLIN: Yes -- data.

4 CO-CHAIR ELWARD: Okay.

5 DR. BLAKE: Going back to the  
6 question, I can't remember who asked how I  
7 came up with what was acceptable. I went back  
8 and I was just relooking at some of the  
9 descriptions, and part of the resource use  
10 refers you back to items earlier.

11 And those earlier items really just  
12 define how the data is described, which again  
13 is in terms of observed and expected ratios  
14 which makes very intuitive sense. So I  
15 thought that the reason for that was  
16 appropriate.

17 When they looked at levels of  
18 analysis it was by group practice, by health  
19 plan, by delivery system, by national  
20 population, by regional population, and again  
21 that to me made appropriate sense.

22 And then there was further

1 discussion which we've already talked about of  
2 why a sample size of 400 was the minimum  
3 cutoff for the estimates.

4 So looking at all that, and we've  
5 talked about it some before, that's why I  
6 rated most of these acceptable.

7 CO-CHAIR ELWARD: Thank you very  
8 much. Any other thoughts, comments? I guess  
9 we're ready to vote.

10 MS. FANTA: Okay, so moving along  
11 to 2a, usability. Are the measure performance  
12 results reported or suitable to report to the  
13 public at large in national or community  
14 reporting programs? Is there evidence that  
15 the measure performance results are available  
16 for public reporting? Okay, so we have eight  
17 high and one moderate.

18 3b, did submitted information  
19 demonstrate that results produced by the  
20 measure are meaningful, understandable and  
21 useful for information for quality improvement  
22 and public reporting or was a credible

1 rationale presented? Okay, six high and three  
2 moderate.

3 3c, are the data and result details  
4 maintained such that the Resource Use Measure  
5 including the clinical and construction logic  
6 for defined unit of measurement can be  
7 decomposed to facilitate transparency and  
8 understanding? And the results are eight  
9 high, one moderate.

10 Moving on to feasibility,  
11 feasibility discussion.

12 CO-CHAIR ELWARD: Okay, all right.  
13 That's where we'll -- in terms of looking at  
14 4a, for clinical measures required data  
15 elements routinely generated, that seems that  
16 that's the case.

17 And 4b, I think it's just very well  
18 outlined in there. For the required data  
19 elements being available in electronic health  
20 records, it doesn't appear that that's the  
21 case. It appears that it's administrative  
22 data. Is that correct?



1 MR. HAMLIN: Currently it's only  
2 administrative data that's used for that.

3 CO-CHAIR ELWARD: Are there any  
4 plans of being able to draw that out of EMRs?

5 MR. HAMLIN: There's guidance for  
6 plans that use EMRs to map to the claims codes  
7 that they would use for then standardized  
8 pricing, yes, but that was, I do not believe  
9 that part was included because that's a  
10 separate set of guidelines. But we have that  
11 methodology that's available.

12 DR. STANFORD: You're linking the  
13 two. You're not saying electronic medical  
14 records only, you're linking the electronic  
15 medical records p

16 MR. HAMLIN: So these are  
17 officially claims only, but for systems that  
18 use electronic medical records for their  
19 billing and other, we actually have a  
20 methodology that allows them to map those to  
21 an appropriate claims code that would then be  
22 standardized price that could then be included

1 in this methodology, so it's an additional  
2 step at the current time.

3 CO-CHAIR ELWARD: On item 4c,  
4 susceptibilities between accuracy errors or  
5 unintended consequences related to measurement  
6 can be judged to be inconsequential.

7 I think they did a good job  
8 recognizing where the challenges are and, you  
9 know, that they understand that there's still  
10 issues around data collection methods that can  
11 vary and errors derived from other sources may  
12 affect the results. So I think they've  
13 addressed that well, and I thought that was  
14 adequate.

15 4d, the data collection and  
16 measurement strategy can be implemented as  
17 demonstrated by external programs or testing  
18 that is not identified varies to operational  
19 use.

20 My impression in looking at what  
21 you've addressed says that the measure's  
22 currently in use anyway. The data collection

1 strategy sounds like it's fairly  
2 straightforward. Well, not straightforward,  
3 but well established, I'll put it that way.

4 Can you tell us whether there have  
5 been feedback in terms of any difficulties  
6 people have had in terms of operationalizing  
7 this?

8 MR. HAMLIN: Well, I mean as you've  
9 heard it's a very laborious process. We lay  
10 it out in a stepwise fashion for plans and  
11 programmers to go through and really  
12 understand what has to be programmed, what has  
13 to be done in order to report the measures.

14 All the data has to go through a  
15 certified auditor before it's reported to NCQA  
16 so auditors can go back and look for errors in  
17 the reporting.

18 And we also can as part of our  
19 annual analysis we look at outliers. So the  
20 number of people who are identified as  
21 outliers so their results are just off the  
22 chart if you will, and we go back to those and

1 we sort of ask why.

2 But really nowadays the number of  
3 outliers is significantly -- is less than half  
4 a percent for some measures, less than one  
5 percent for others.

6 So it really, you know, over the  
7 four to five years of reporting measures we  
8 sort of ironed out all the issues with  
9 collecting and reporting the data and most  
10 plans now are able to report. And like I said  
11 I think we have one or two outliers a year out  
12 of a thousand or so plans that report.

13 So we'll go back and work with  
14 those findings to find out, you know, we have  
15 validations built into the reporting systems,  
16 so validation alarms will come on if something  
17 is before this that's flagged as sort of an  
18 outlier or flagged as questionable, and the  
19 auditors then will go back and also work with  
20 the plans to understand, you know, what  
21 they're reporting is valid.

22 CO-CHAIR ELWARD: Are there

1 different levels of user or support? Are  
2 there variable charges for this level of  
3 support versus being able to, for people who  
4 have questions?

5 MR. HAMLIN: Nowadays really we  
6 sort of have a, you know, if you have trouble  
7 and want to contact us you can work through  
8 our system and, you know, hire somebody to  
9 come over and help you.

10 We don't really have much of that  
11 anymore because now like I said, that happened  
12 much in the past when we were still collecting  
13 data and there were many more outliers. Now  
14 we've essentially published everything on the  
15 website. The methodology is transparent.

16 And this year moving forward, we're  
17 actually going to be pushing out XML  
18 specifications, so it's even more detailed and  
19 more, sort of less room for interpretation, if  
20 you will.

21 So we're going to be using an XSD  
22 XML strata for these measures, not just a Word

1 document that a programmer's going through and  
2 trying to interpret.

3 We're giving them the programming  
4 and that they can go through and they have to  
5 do certain mapping to do that. So we're  
6 really trying to facilitate the complex  
7 process through any tools we can.

8 CO-CHAIR ELWARD: All right, thank  
9 you. That was a little bit of addition. I  
10 realize that the data collection search,  
11 you've been doing this. It's already in use,  
12 so that's probably not applicable.

13 MR. HAMLIN: Yes. And we have  
14 noticed a significant decrease in outliers  
15 over the years to the point now where we're  
16 significantly less than one percent out of all  
17 the plans.

18 CO-CHAIR ELWARD: Thanks. Any  
19 other thoughts, questions, or comments about  
20 feasibility?

21 MS. FANTA: All right. So moving  
22 along to 4a, are the required data elements

1 routinely generated and used during care  
2 delivery? Example, blood pressure, lab test,  
3 diagnosis, medication order. So eight high,  
4 one low.

5 CO-CHAIR ELWARD: Any other  
6 thoughts? Any questions about the, I don't  
7 want to single people out, but are there  
8 anyone that frequently had challenges with  
9 that? Okay.

10 DR. STANFORD: Well, I'm the low.

11 MS. DORIAN: Can you use your mic?

12 DR. STANFORD: Oh, I'm sorry. This  
13 is strictly administrative claims data  
14 according to what NCQA is saying, which is in  
15 general just fine.

16 So I don't -- my interpretation of  
17 that is that, do we have these elements in the  
18 confines of the data set. And we don't,  
19 unless you have the ability to link it to some  
20 kind of electronic medical record. So that's  
21 why I said low.

22 DR. SCHATZ: But they're not

1 required data elements for this either.

2 DR. STANFORD: No, that's true.

3 But the examples you're saying are blood  
4 pressure, lab tests. So my interpretation of  
5 it is are these available for the actual  
6 assessment, and they aren't.

7 MS. WILBON: Yes, so just to  
8 clarify. The examples in that are actually  
9 probably more so for a quality measure. I  
10 think we've kind of borrowed some language for  
11 our criteria from the quality measure  
12 criteria. So we probably shouldn't have had  
13 those examples in there. It can be a little  
14 bit confusing.

15 But I think the best way to frame  
16 it is based on how they've specified the  
17 measure for the data elements that they are  
18 asking for. In order for someone to implement  
19 the measure would those data elements be  
20 available electronically?

21 MR. HAMLIN: So lab test performed,  
22 diagnosis codes and medication dispensed are



1 all routinely available in the claims data,  
2 and we use those for these measures. And  
3 those have been tested, and they have been  
4 shown to be reliable.

5 DR. STANFORD: I'm sorry, but for  
6 this particular asthma measure you don't use  
7 any laboratory values, correct?

8 MR. HAMLIN: No, but we do report  
9 laboratories as a service category, so  
10 laboratory use for asthma.

11 DR. STANFORD: Yes or no? It's yes  
12 or no.

13 MR. HAMLIN: Well, it's  
14 standardized laboratory. Like it's a ratio  
15 that's reported to observe to a respective  
16 laboratory. Diagnostic laboratory use for  
17 people with asthma is a service category.

18 DR. STANFORD: Like spirometry, for  
19 instance.

20 MR. HAMLIN: We use any submitted  
21 laboratory claim. Any of those, again,  
22 procedure codes that are used for laboratory,

1 CPT primarily.

2 DR. STANFORD: Right.

3 CO-CHAIR MAURER: And do you use  
4 the values or just that fact that it's been  
5 done?

6 MR. HAMLIN: Well, it is actually,  
7 it's a priced category. So it is something  
8 where we look, you look for CPTs with  
9 modifiers, and those have specific prices  
10 assigned, and the aggregate doesn't report  
11 those. It's a price service category for  
12 asthmatics, for people with persistent  
13 asthmatic.

14 MR. BRATZLER: Well, one thing I  
15 didn't notice is what, you have pharmacy data  
16 consistently for all the plans, or I know that  
17 was a problem with some of the measures I  
18 reviewed. So you consistently --

19 MR. HAMLIN: There's still, you  
20 know, for some PBMs there are still some  
21 difficulties.

22 But we do require that the plan,

1 the member have pharmacy benefit for these  
2 measures, and the plans are responsible for  
3 obtaining that information to report the  
4 measure.

5 So, yes, the pharmacy is reported  
6 separately from the other medical components,  
7 partially because we want to see the  
8 correlations but also partially because there  
9 is some differences in the data.

10 CO-CHAIR ELWARD: So just getting  
11 clarification with the staff. So in general  
12 how we would be looking at 4a is to take off  
13 the first clause in the parentheses. Just  
14 saying the required data elements were  
15 routinely -- okay.

16 MS. WILBON: That's okay. That's  
17 one of the challenges we've had throughout  
18 this process, so I understand that. So did  
19 you --

20 DR. STANFORD: Can I go back and  
21 revote?

22 MS. WILBON: Yes, can we revote?

1 Okay.

2 DR. STANFORD: It wouldn't be low,  
3 it would be high.

4 MS. WILBON: Okay. All right.

5 CO-CHAIR ELWARD: Thank you. No,  
6 thanks for clarifying. That was just very  
7 helpful.

8 MS. WILBON: It's helpful for us as  
9 well because we can kind of clean that up  
10 going forward, so thank you.

11 MS. FANTA: Nine high.

12 Okay, 4b, are all the required data  
13 elements available in electronic health  
14 records or other electronic sources? If not,  
15 is a credible near term path to electronic  
16 collection specified? Eight high, one  
17 insufficient.

18 CO-CHAIR ELWARD: The only reason,  
19 I put that down just because I wasn't sure.  
20 You said it was in development, and I wasn't  
21 sure that there was specific criteria in how  
22 to do that yet, am I right?

1 MR. HAMLIN: Which was in  
2 development?

3 CO-CHAIR ELWARD: As far as mapping  
4 to electronic data records.

5 MR. HAMLIN: Yes, for EHRs on the  
6 quality side we're retooling all the asthma  
7 measures we have which is about 12 right now,  
8 and enhancing those and how you would capture  
9 that out. But on the resource use side we're  
10 still looking at administrative claims.

11 CO-CHAIR ELWARD: Okay. Do people  
12 feel comfortable with that? Okay.

13 DR. BLAKE: How would they even get  
14 data out of the medical record given there's  
15 p

16 CO-CHAIR ELWARD: You'd have to  
17 create it. If I understand you'd have to,  
18 they would know better, but I think you'd have  
19 to create a mapping program so that one data  
20 element that you have in your EMR directly  
21 quote "means" or relates to the billing  
22 record. I mean it's challenging.

1 DR. BLAKE: Yes, okay.

2 CO-CHAIR ELWARD: Sort of a  
3 crosswalk.

4 DR. BLAKE: Is that what you're  
5 saying is being done of some sort?

6 MR. HAMLIN: Well, each plan is  
7 responsible for, you know, again we have  
8 guidelines on how to map using EHRs. I think  
9 there actually is a separate guidance document  
10 that maps to that.

11 So, you know, capitated plans that  
12 use an EMR particularly have to do a pretty  
13 significant mapping exercise to track the  
14 utilization patterns and map those to the  
15 administrative claims codes that are published  
16 in the SPTs, in the Standard Pricing Tables.

17 Again it's an additional  
18 layer of complexity, and I think in the future  
19 when, you know, the standards in EMRs for  
20 maybe a CCD might be more broadly used, we'll  
21 probably specify for those as well. However,  
22 at this current time it's the plan responsible

1 for mapping and the auditor responsible for  
2 ensuring that that mapping's appropriate.

3 MR. BRATZLER: I would only point  
4 out though for this particular criterion the  
5 EHR is not required. It's simply, is it  
6 available in an electronic source, which  
7 includes administrative claims data. So the  
8 answer is yes. The data is all from  
9 administrative claims, at least as you read  
10 this.

11 CO-CHAIR ELWARD: Got it. Then  
12 I'll change mine to one.

13 MS. FANTA: Okay, so we're going to  
14 revote on that. Nine high.

15 Okay, 4c, are susceptibilities to  
16 inaccuracies, errors, or unintended  
17 consequences and the ability to audit the data  
18 items to detect such problems identified?  
19 Seven high, two moderate.

20 And lastly, 4d, can the data  
21 collection strategy be implemented? Is the  
22 measure already in operational use or did

1 testing demonstrate that it is ready to be put  
2 into operational use? Eight high, one  
3 moderate.

4 DR. BLAKE: Can I ask just a  
5 general question? Do the health plans pay in  
6 order to have their -- to be assessed for  
7 their efficiency and things like that? Is  
8 this something that's required of health plans  
9 or do they voluntarily do it and then pay a  
10 fee, say, to NCQA to do this?

11 MR. HAMLIN: So reporting to NCQA  
12 is all voluntary. Health plan accreditation  
13 has fees associated with it, so it's a base  
14 fee plus on a per member charge.

15 We actually have a number of plans  
16 that are not accredited that do report  
17 measures to NCQA to be sort of included in the  
18 calculation mix, but it's all voluntary.

19 CO-CHAIR ELWARD: Thank you, good  
20 question. Thank you, we're right on time, and  
21 I think it was a great discussion, especially  
22 starting off for the first one I think we got



1 a long ways, since we're about ready to take  
2 a break and spend about five minutes.

3 I'm sorry, 15 minutes. Okay, don't  
4 want to work you too hard. So 15 minutes and  
5 we'll start again just around 11:00. Great,  
6 thank you. And we'll be doing 1561.

7 (WHEREUPON, the meeting in the  
8 foregoing matter went off the  
9 record at 10:42 a.m. and went back  
10 on the record at 11:06 a.m.)

11 CO-CHAIR MAURER: Okay, we'll get  
12 started on the second measure, which is the  
13 Relative Resource Use for People with COPD.  
14 It's the second and last NCQA measure for  
15 today. And I will start with the importance  
16 piece of it.

17 So does it focus on a significant  
18 national health priority? It's the first,  
19 fourth leading cause of death in this country,  
20 and it's heading toward the third leading  
21 cause of death. It' the only one of the top  
22 four that's actually increasing in its

1 percentage.

2 It's the third largest global  
3 disease burden, expected to be by 2020.  
4 Twelve million people in the U.S. are  
5 diagnosed with COPD, and it's thought that  
6 there are about 12 million that aren't, with  
7 a 125,000-plus deaths per year currently due  
8 to COPD.

9 Now in terms of lb, which is the  
10 demonstration of resource use or cost, the  
11 most recent statistics suggest that there's  
12 about \$18 billion per year spent in direct  
13 cost and another \$14 billion in indirect cost  
14 in this country. And it's a particular burden  
15 in Medicare patients because as we all know  
16 it's a disease of older people.

17 In terms of the purpose, objective  
18 of the measure and whether or not there are  
19 opportunities for improvement, there's  
20 obviously increasing morbidity and mortality  
21 which suggests that there might be  
22 opportunities for improvement.

1 NCQA in presenting this measure has  
2 identified a lack of control of risk factors.  
3 They have identified a lack of control of  
4 preventive measures such as influenza, a  
5 variation influenza vaccination.

6 They've identified medication  
7 adherence as an issue, and the increasing  
8 implications of the financial and disease  
9 burden in the country, so there are multiple  
10 areas in which improvement can be achieved.

11 In terms of variation in care  
12 across different populations, there appear to  
13 be higher mortality rates in African  
14 Americans, though most of this disease is  
15 reported in Caucasians.

16 The mortality in women is also  
17 increasing, and in Caucasian men the mortality  
18 appears to have leveled off though it has not  
19 in the African American population as I  
20 mentioned.

21 There isn't a lot of referencing of  
22 the disparities. There's a lot more out there

1 in the literature about disparities in care  
2 than is actually referenced here.

3 The purpose of this measure is to  
4 measure the total costs in COPD patients. Now  
5 Ben is going to mention more about this, but  
6 as the measure is described in the document  
7 that was submitted, it sounds like it applies  
8 only to people who are newly diagnosed  
9 requiring 730 days prior without any COPD  
10 diagnosis. However, I mean then that is a  
11 criteria that is currently applied to the  
12 HEDIS spirometry measure.

13 However, Ben tells me that that was  
14 erroneously put into this measure and that  
15 this measure is actually supposed to apply to  
16 anybody with a single diagnosis claim for COPD  
17 in the measurement year.

18 So it's very different from what it  
19 actually says in the measure. So think of it  
20 in the way that I guess that it's intended  
21 because you'll fix that, right?

22 MR. HAMLIN: This is one of the

1 issues where we have, in pairing this measure  
2 with quality measures, for COPD we use two  
3 quality measures from HEDIS both of which have  
4 very different eligible population  
5 identification algorithms.

6 The RRU side is fairly simple in  
7 that it uses a COPD chronic bronchitis or one  
8 other diagnosis code. I can't remember,  
9 emphysema -- thank you, during the measurement  
10 year to include.

11 However, that's paired with the  
12 quality measure side and I think in the form  
13 we weren't specific about defining the  
14 different ways.

15 So on the quality side we do it  
16 this way, on the RRU side we do it this way.  
17 I think that could have been much more clear,  
18 and I think that may have been where a lot of  
19 the confusion was.

20 So the identification population  
21 that's listed in SA-2 defines the SPR and the  
22 PCE populations on the quality side, and we

1 just didn't make that explicit I think in our  
2 description of how we define this population.

3 So we're going to go back  
4 in and make some significant corrections to  
5 make sure that's explicitly clear that that's  
6 how we do it for the quality and then the RRU  
7 is done as I mentioned.

8 CO-CHAIR MAURER: Thanks, Ben.  
9 This measure is also designed to measure total  
10 costs of that population in a 12-year period.  
11 It's a calendar year measurement, and it is  
12 designed to be used by health plans primarily.  
13 It does not attribute costs specifically to  
14 providers or to practices.

15 Okay, any questions about the  
16 importance? Did we get everything that we  
17 need?

18 Okay, so our discussers for this  
19 measure are Kurt, Richard, and me, and Kurt is  
20 going to start with 2a1.

21 MS. WILBON: Janet, real quick.  
22 We'll just vote on importance.

1 CO-CHAIR MAURER: Oh, sorry. I  
2 forgot about the voting.

3 MS. WILBON: No, it's okay. Unless  
4 there's any discussion on any of the things  
5 that Janet brought up, we'll just go ahead and  
6 again vote and if you have any discussion to  
7 add as we go through we can do that as well.

8 MS. FANTA: So 1a is does the  
9 measure focus address a specific national  
10 health goal priority or was data submitted  
11 that demonstrated a high impact aspect of  
12 health care? And the results are nine high.

13 1b, was data submitted that  
14 demonstrated resource use or cost problems for  
15 improvement? For example, variation in the  
16 delivery of care across providers and/or  
17 population groups, disparities in care.

18 MR. BRATZLER: Can I ask just a  
19 clarification? So one thing I noticed  
20 consistently was discussion of variations  
21 usually was related to clinical care and not  
22 resource use. Now subsequently they show

1 variations in resource use and in after the  
2 development of the model but p

3 CO-CHAIR MAURER: It translates,  
4 you know.

5 MR. BRATZLER: Yes, it probably  
6 does. I just wanted to highlight that, that  
7 in all of the conversations ran variations  
8 particularly in these submissions, most of the  
9 discussion was in variations in clinical care  
10 and clinical quality and things like that  
11 rather than, since these are Resource Use  
12 Measures. So I'm sure there's resource use  
13 variations on those.

14 MS. FANTA: Okay, so we have seven  
15 high and two moderate.

16 1c, is the purpose objective of the  
17 Resource Use Measure including its components  
18 and the constructs for resource use cost  
19 clearly described? Okay, and we have eight  
20 high, one moderate.

21 1d, are the resource use service  
22 categories types of resource use costs that



1 are included in the Resource Use Measure  
2 consistent with and representative of the  
3 measure concept? Okay, and we have nine high.

4 CO-CHAIR MAURER: Now we'll go  
5 ahead with Kurt's doing 2a1, and then we'll  
6 have Ben give us any more information.

7 CO-CHAIR ELWARD: This is the item  
8 on the definition and precise specifications  
9 that can be implemented consistently within  
10 and across organizations. They mention EMR,  
11 did we leave off EMR category in there?

12 Based on the quality of the assets  
13 so I'm not sure that would qualify, but it  
14 appears that they have defined the measure  
15 well.

16 Under S4 the target population is  
17 left blank, but I'm understanding that that is  
18 a population of COPD diagnosed within the last  
19 -- records are available.

20 And the data dictionary and the  
21 code tables are available, so I thought they  
22 did a good job in terms of how you count the

1 service, looking at the E&M codes, pharmacy  
2 codes, so I was fine with that.

3 In terms of -- any questions on,  
4 yes?

5 DR. SANTO TOMAS: Just to clarify  
6 that I thought that earlier Dr. Maurer had  
7 mentioned that although the initial intent was  
8 to limit it to those who had been newly  
9 diagnosed, and is that by spirometry? But  
10 actually you're going to revise that.

11 CO-CHAIR ELWARD: I made the  
12 comments in reference to that. Before it  
13 wasn't clear.

14 DR. SANTO TOMAS: So we were  
15 advised though to include actually anybody who  
16 has been diagnosed with chronic bronchitis.

17 MR. HAMLIN: Right. So, yes, I  
18 think the clarification point was in here in  
19 the clinical framework we were describing the  
20 quality side, and we didn't distinguish that  
21 adequately from the resource use side. So the  
22 resource use looks at anyone with a diagnosis

1 during the measurement year of COPD. On the  
2 quality side we have a couple different ways  
3 of identifying people for the quality measures  
4 alone.

5 So there's a little difference  
6 there, and I think we just need to be more  
7 explicit about how we describe that in the  
8 form.

9 CO-CHAIR ELWARD: So with the  
10 clarification that Janet helped with, I think  
11 that was well done.

12 CO-CHAIR MAURER: Okay, is there  
13 anything else that you want to add about that,  
14 Ben? Is that p

15 MR. HAMLIN: Again, these are  
16 admin-based measures only. We're looking for  
17 aligning with QDM now, so you need to update  
18 your form. It's not QDS anymore.

19 However, that's right now they're  
20 administrative only. And we have found that  
21 all these data points are available, the  
22 pharmacy, the diagnosis codes. They're all

1 reliable within the administrative claims that  
2 we receive from the plans.

3 CO-CHAIR MAURER: Okay, thank you.  
4 Now for these measures that are, sort of use  
5 the same methodology come from the same place.  
6 We're going to try to pick up only the things  
7 that are really different between the measures  
8 because we've already talked about a lot of  
9 the general stuff.

10 So, Carlos, do you want to tell us  
11 if there's anything different about this from  
12 the asthma measure in the reliability and  
13 validity?

14 MR. ALZOLA: No. The same  
15 methodology was used for everything in terms  
16 of risk adjustment and how they demonstrated  
17 reliability and face validity. The only  
18 difference is in the selection of the  
19 populations.

20 CO-CHAIR MAURER: Okay, thank you.  
21 So, Richard, then do you want to talk about  
22 2a2?

1 DR. STANFORD: Yes. I think we can  
2 take a lot of what we just talked about from  
3 the asthma measure and bring it over to the  
4 COPD measure, and I appreciate the  
5 clarification around the one-year measurement  
6 and the one-year identification period which  
7 is similar to what we did for the asthma part  
8 of it.

9 So if you look at 2a2, which is the  
10 reliability testing. And testing demonstrates  
11 that the results are repeatable, producing the  
12 same results a high proportion of the time.  
13 I rated this as a moderate.

14 The issues that I have with  
15 reliability testing is this issue around  
16 multiple populations being studied. And I  
17 don't recall you guys saying this data is in  
18 the Medicare population. Maybe I misread  
19 that, but I don't think it has been tested in  
20 the Medicare fee-for-service population.

21 MR. HAMLIN: Specifically fee-for-  
22 service, we haven't distinguished that from

1 just the general commercial Medicare  
2 provision, but it has been tested.

3 DR. STANFORD: Which there is a  
4 slight difference and I appreciate what you're  
5 saying, is basically Medicare-eligible  
6 populations in the confines of a commercial  
7 dataset, which those folks could be retirees  
8 as well but not necessarily. You're one of  
9 the new Medicare population.

10 So but overall, I think it was well  
11 done outside of the fact that maybe just some  
12 more data in a select population would be very  
13 helpful.

14 MR. AMIN: Can I just add a  
15 clarification, Ben? So the testing population  
16 listed on the application includes Medicare,  
17 but this is the same clarification that you  
18 provided us for the other measure that it's  
19 really intended for commercial?

20 MR. HAMLIN: This one is actually  
21 commercial Medicare and Medicaid because of  
22 the age range. The age range is different.

1                   The asthma we did not test Medicare  
2                   because of the age range cutoff at 64  
3                   precludes the majority of the Medicare  
4                   population. And those that might qualify  
5                   earlier would not meet the small sample size  
6                   requirement.

7                   MR. AMIN: Okay, so it would  
8                   include Medicare?

9                   MR. HAMLIN: This one does include  
10                  Medicare, yes. What we don't distinguish is  
11                  we don't distinguish the fee-for-service  
12                  versus the general eligible population in  
13                  Medicare. We might be able to in the future,  
14                  but at this point in time we include all  
15                  Medicare together and report it Medicare/HMO.

16                  DR. STANFORD: So were you able to  
17                  separate out the MAPD folks versus the  
18                  Medicare-eligible individuals?

19                  MR. HAMLIN: We did not do that,  
20                  no. In the future we might be able to as we  
21                  increasingly gain more data, but right now  
22                  we're sort of, if it's aggregate data. But

1 it's still a huge volume and so we're trying  
2 to break into slowly into what we're expecting  
3 from the different plans and who we're  
4 comparing.

5 DR. STANFORD: So to me I think  
6 that how I usually state those populations is  
7 that they're Medicare-eligible as opposed to  
8 when you say Medicare, most people think fee-  
9 for-service dataset, which is fine. I think  
10 there's a little bit of differences between  
11 the populations but I'm okay with that.

12 CO-CHAIR MAURER: And there is no  
13 upper age limit on this?

14 MR. HAMLIN: Not at the current  
15 time, no.

16 CO-CHAIR MAURER: Okay.

17 DR. STANFORD: Well, there's no  
18 upper age limit, but what is the upper age  
19 limit in these datasets? Isn't it around 85  
20 years of age?

21 MR. HAMLIN: Death.

22 DR. STANFORD: But technically



1       there is.

2                       MR. HAMLIN:  Yes, technically there  
3       is.  You know, anyone who dies during the  
4       measurement year is excluded from the measures  
5       so, you know, it is anyone who's alive.

6                       CO-CHAIR MAURER:  Okay.  Any other  
7       comments?

8                       CO-CHAIR ELWARD:  I noticed in, it  
9       may be more appropriate in the calculations,  
10      but I noticed that the population in each  
11      service category by cohort is, I'd like to  
12      understand a little bit better.  It's 42 to 44  
13      and then it jumps from 45 to 64, you know,  
14      clinically speaking for COPD seems a little  
15      strange for me.

16                      MR. HAMLIN:  Right.  That again is  
17      because the resource use categories are based  
18      on utilization not on the clinical side.

19                      So the clinical strata on the  
20      quality measures may be different from the  
21      resource use strata that are reported out for  
22      the ACC service categories.  And there are

1 some weird ones when the age range is limited  
2 from 40 and up.

3 The resource use categories,  
4 because again they apply across a number of  
5 different measures, they are sort of  
6 restricted to 18 to 44 and if you start at 40  
7 then you kind of go from 40 to, you know.

8 So there is some weirdness in the  
9 strata on the resource use side, but again  
10 those are derived from utilization patterns in  
11 the datasets that we have. They're not  
12 necessarily clinically relevant.

13 CO-CHAIR MAURER: So that brings to  
14 mind another question that I have. Somewhere  
15 in here it says that you want to kind of marry  
16 the resource use with the quality measures.  
17 And if you're going to use different  
18 stratifications and so on, how are you going  
19 to do that?

20 MR. HAMLIN: Well, the quality  
21 measures aren't risk adjusted right now. So  
22 we're basically comparing a risk adjusted

1 population to a more non-risk adjusted quality  
2 measure.

3 As the quality measures further  
4 increase and perhaps in the future become risk  
5 adjusted, we might be able to compare specific  
6 populations to specific populations.

7 But because the quality measures  
8 are, you know, population-based non-adjusted  
9 HEDIS measures that's really all we can do.  
10 So you're looking at specific subsets of the  
11 population compared to a population that will  
12 heap quality measure.

13 And we only report, the results are  
14 sort of plan level, total population, total  
15 medical against the quality measure and the  
16 total pharmacy against the quality measure.  
17 We don't report each male 18 to 44 against a  
18 quality measure specifically because of that  
19 very reason. Does that make sense?

20 CO-CHAIR MAURER: Do you have a  
21 question, Richard?

22 DR. SCHATZ: No, I just wanted to

1 clarify this difference in clinical versus  
2 resource. The ages that are listed in this  
3 measure are because they represent relatively  
4 homogenous resource use categories, correct?

5 MR. HAMLIN: Correct. That's  
6 correct. And it's mostly derived from  
7 experiential over the last five years of this  
8 and the datasets we've been using to determine  
9 these categories. But they don't follow  
10 clinical logic. That's where the disconnect  
11 is.

12 DR. SCHATZ: Well, just to clarify  
13 one thing. And within the quality measures  
14 results are reported with different strata.  
15 But are results reported in these different  
16 age strata or just adjusted for it?

17 MR. HAMLIN: They're adjusted for  
18 and the plan gets a report that gives them the  
19 detailed information both regional and  
20 national for each of these individual age and  
21 gender cohorts.

22 How much of that is publicly

1 reported is still under debate. Most of that  
2 right now is just in aggregate, so it's plan  
3 level not by individual HCC cohort if you  
4 will.

5 But that information is available  
6 so you can, we provide to the plan and  
7 researchers are allowed to buy a data download  
8 extract which is an enormous file, they can  
9 then use for research purposes.

10 But right now the public reporting  
11 is only this sort of high level aggregate plan  
12 level population reporting.

13 DR. SCHATZ: But again, that is  
14 where Janet's point would make sense that if  
15 the age strata are reported then it would be  
16 nice to see some harmonization.

17 CO-CHAIR MAURER: Well, and they  
18 state that they want to kind of bring them  
19 together.

20 MR. HAMLIN: Right.

21 CO-CHAIR MAURER: Any other  
22 comments about this? Are we at 2b1? That

1 would be Kurt.

2 CO-CHAIR ELWARD: I think the  
3 measure specifications are consistent. As the  
4 specification I think is clearly delineated.  
5 I think it's on S6-1 and it looks at both  
6 demographics, complete data or any clinical  
7 diagnoses.

8 Again one of the challenges with  
9 this measure will be, and I think we talked  
10 about this before, is whereas asthma has  
11 relatively few comorbidities for a lot of  
12 people, COPD has a lot of comorbidities going  
13 on.

14 And that's going to be, you know,  
15 it may be difficult to know whether you're  
16 measuring COPD or their CHF. So it'll be, you  
17 know, if you can give me any clarification on  
18 how you're going to approach that I think that  
19 would be helpful.

20 MR. HAMLIN: Well, our current  
21 approach is that in, you know, by risk  
22 adjusting to the specified level using the

1 HCCs and the 13 different cohorts were  
2 comparing relatively similar plan populations  
3 to each other.

4 We're not necessarily able to sort  
5 of draw conclusions about resource use with  
6 the number of comorbidities, but at least  
7 we're drawing what we think are fair  
8 comparisons between plans by using that risk  
9 adjustment that takes the multiple  
10 comorbidities into account over a scale versus  
11 just a yes/no which was sort of our previous  
12 iteration of how we adjusted.

13 So we're comparing it Plan A and  
14 Plan B relatively equitably by ranking how  
15 much of a train wreck these patients are to  
16 each other.

17 CO-CHAIR MAURER: And you're  
18 recording total cost, so you don't really care  
19 as long as they're risk adjusted.

20 MR. HAMLIN: Right.

21 DR. SCHATZ: Just in this issue of  
22 the cost quality issue, can you briefly remind

1 us what the quality measure for COPD?

2 MR. HAMLIN: The quality index that  
3 we use is a combination of two measures so we  
4 use the diagnosis of, I'm using spirometry to  
5 confirm a new diagnosis of COPD as one HEDIS  
6 measure.

7 The other one is the  
8 pharmacotherapy for exacerbations which has  
9 actually two rates in it.

10 So the quality composite that we  
11 use is actually a weighted composite using a  
12 weighting of the two results in the PC or the  
13 exacerbations measure, plus the results from  
14 the spirometry measure.

15 So it's a combination as a weighted  
16 average of those. And that's what the quality  
17 score is for this measure unlike asthma which  
18 just has one which makes it easy but the COPD  
19 has use of the weighted composite.

20 DR. SANTO TOMAS: Since there's  
21 administrative data, although at least in  
22 those, if you use it for those patients with,



1 had spirometry you're not actually able to get  
2 that particular number, right?

3 MR. HAMLIN: Well, the spirometry,  
4 yes, uses an administrative data measure that  
5 uses the procedural codes for spirometry and  
6 it's pretty limited.

7 It's looking at particular visits,  
8 you know, with particular providers to ensure  
9 we're not getting, we had a lot of noise in  
10 the past with spirometry just showing up in  
11 records from respiratory therapists and things  
12 like that.

13 But we think we've refined the  
14 quality measure side to be fairly specific to  
15 a confirmation of a new diagnosis. And those  
16 are available in claims code and that is a  
17 HEDIS measure that's been around for a number  
18 of years and we have found it to be reliable.

19 DR. SANTO TOMAS: Now when we were  
20 talking about the asthma you had mentioned, I  
21 don't know how fair it is to kind of ask that  
22 about this too but, you know, having linked to

1       electronic medical records, but is there a  
2       thought of that with this as well?  Mainly I  
3       ask only because one of the main drivers of  
4       utilization in COPD is how severe the COPD is.

5               And of course, yes, these people  
6       have a lot of comorbidities.  But the  
7       attribution to the COPD itself as far as  
8       utilization is related to the severity of the  
9       COPD.

10              MR. HAMLIN:  Right.  So we won't be  
11       attributing specific procedures to the COPD  
12       itself, but I think future iterations as the  
13       version 3.x of the QDM is released we are  
14       designing electronic medical records  
15       specifications on the quality side that take  
16       those different factors into account.

17              All the steps of the care  
18       coordination process and staging of the  
19       disease will be included in those specs.  But  
20       those are specs that are still in development  
21       under contract to CMS.  Those will not be in  
22       this until they've been thoroughly vetted and

1 validated through our usual process.

2 CO-CHAIR MAURER: It must be very  
3 hard to get disease severity, because I  
4 noticed in none of the measures did it really  
5 talk about disease severity.

6 DR. STANFORD: Yes, and asthma and  
7 COPD both have issue around, you know, you  
8 don't really have the severe event.

9 What you do have though, for  
10 instance, in COPD is probably maybe easier to  
11 do than asthma, is that we know that multiple  
12 drug therapy is related to disease severity  
13 and compliance is actually related to disease  
14 severity.

15 The more compliant a COPD patient  
16 is probably the higher severity levels they  
17 have, which goes to this issue, it's almost a  
18 chicken and egg issue. Like if you have a  
19 high cost patient you're going to have a high  
20 cost patient.

21 So that's why I was asking earlier  
22 around, you know, what your risk measurements

1       were in terms of your risk adjustments.  
2       Because if you take a COPD patient who's a  
3       high utilizer that's probably a much more  
4       severe patient than a low utilizing subject  
5       which with the goal guidelines they're all,  
6       it's some that's based on exacerbations as  
7       well.

8                       So when you take that into account,  
9       does that help with the risk adjustment or is  
10      that something that you don't do?

11                     MR. HAMLIN:  It wouldn't help with  
12      the risk adjustment.  Again, you know, on the  
13      quality side we kind of cover either end of  
14      the spectrum and not a lot in between because  
15      that's the limitation of the administrative  
16      claims.

17                     I expect that in the future we'll  
18      be able to begin to look at some of those  
19      correlations in the middle of the spectrum  
20      that we can then relate to the utilization  
21      side.  Right now we're still just looking at  
22      the snapshot because that's all we can do.

1 I mean again there's lots of  
2 interesting work, but we need more information  
3 before we can start testing those ideas. And  
4 so we're not just there yet but it's  
5 definitely on the plate.

6 I mean the COPD measures are like  
7 the asthma measures, very high priority moving  
8 forward and using clinically enriched data to  
9 start comparing to the utilization side, but  
10 right now we're just tracking what we can.

11 CO-CHAIR MAURER: Other comments on  
12 this one? Okay, I think we're at 2b2, and  
13 that is Richard?

14 DR. STANFORD: That's the validity  
15 testing and it really is around demonstrating  
16 that the measure elements are correct and  
17 measure the score correctly.

18 I guess my questions that I have  
19 and probably may fall in line with 2b3, is  
20 this issue around outliers. So I mean did you  
21 treat outliers in this particular population  
22 similar to how you treated in the asthma

1 population?

2 MR. HAMLIN: We look for O/E ratios  
3 below 0.3 or above 3 and those are identified  
4 as outliers.

5 But again for the results from last  
6 year and I'm expecting the results any day for  
7 this year that proportion to be very, very  
8 low. It's less than one percent. So again  
9 the plans are doing a very good job of  
10 providing the right data to us and calculating  
11 these appropriately.

12 DR. STANFORD: And how do you  
13 handle length of stay? Handle length of stay  
14 the same way or is it just when you do  
15 standard costing?

16 MR. HAMLIN: It's part of the  
17 standard costing process and it's recorded as  
18 a calculated metric in the results.

19 So you see average length of stay,  
20 days in average length of stay in that plan  
21 report that is given out. Those are  
22 components of that plan report, so it's there.

1 DR. STANFORD: Okay, great. So I  
2 was being, I think I rated it as a high from  
3 the standpoint of validity testing.

4 CO-CHAIR MAURER: Any other  
5 comments on validity testing similar to the  
6 asthma validity testing? And Kurt, you have  
7 2b3 which we might have covered a bit.

8 CO-CHAIR ELWARD: Yes, I think the  
9 exclusions were well stated. They're very  
10 similar to the ones in asthma I think and I  
11 didn't see anything that, it all seemed very  
12 reasonable and important in that age group.

13 CO-CHAIR MAURER: Okay. And 2b4,  
14 Richard? Risk adjustment.

15 DR. STANFORD: Yes, and I think you  
16 have clarified some of the issues I had and I  
17 think it's fine. I think what you've done is  
18 in the scope of the data that you have.

19 You know, you can only do what's  
20 there in front of you. So I think risk  
21 adjustment in terms of, and I like the way you  
22 presented it in terms of it's really around

1 comparison across populations.

2 And cardiovascular disease to your  
3 point is probably the most to me I would think  
4 the biggest driver especially around severity  
5 of that disease.

6 And counting multiple instead of  
7 yes or no is I think is a much better, precise  
8 measurement in terms of risk adjustment. So  
9 I was fine with how they did that.

10 CO-CHAIR MAURER: Gerene, I think  
11 you rated this one low. I'm wondering if you  
12 had anything specific you wanted to bring up.

13 DR. BAULDOFF: No, I'm inclined to  
14 change my vote at this time.

15 CO-CHAIR MAURER: Okay. I just  
16 don't want to miss anything that people have  
17 identified.

18 DR. BAULDOFF: No, I don't have  
19 anything else to bring up.

20 CO-CHAIR MAURER: Okay. 2b5,  
21 Richard?

22 DR. STANFORD: Yes, it was the



1 same. I think what they've done currently to  
2 look at the score is fine and there was a lot  
3 of detail in how they did it.

4 I mean I think NCQA did a nice job  
5 of presenting their data at least from my  
6 standpoint in understanding exactly what was  
7 done.

8 CO-CHAIR ELWARD: One question I  
9 had and this may not be what NCQA will  
10 provide, but should that be a health plan or  
11 a physician group that says okay, I've got  
12 COPD patients that are causing, that really  
13 have a lot of utilization.

14 Can I use that data to break down  
15 how much would be used for COPD medication as  
16 well as cardiovascular medication? Can I  
17 break that out using your datasets?

18 MR. HAMLIN: The data that I have  
19 access to, no. But the plan could, in fact,  
20 go in and look at and categorize their  
21 pharmacy by category if they wanted to and  
22 apply the same methodology. What it wouldn't

1 give you is, you know, the expecteds are  
2 calculated for each plan individually.

3 So on the pharmacy side you  
4 wouldn't be able to look at CV medications  
5 expected versus -- COPD medications expected  
6 because, you know, we calculate that using all  
7 sort of plan data so we couldn't be that  
8 specific.

9 But you could, if you have  
10 particularly high utilization on the pharmacy  
11 side and, you know, perhaps on the inpatient  
12 side you might be able to break that pharmacy  
13 down individually and see where you're -- if  
14 it's skewed in one direction or the other.  
15 But you couldn't relate it back to the  
16 expected calculation because that's a group of  
17 all pharmacy.

18 CO-CHAIR ELWARD: Oh, yes. It  
19 would not be expected. I mean one of the  
20 challenges still with COPD is there's less but  
21 still a significant amount of clinical sort of  
22 nihilism among, but what can you do about

1 COPD. So that getting the right medications  
2 to the people has been a particular challenge  
3 over the last few years.

4 So it could be the high utilizers  
5 have real high pharmacy costs but they're for  
6 all the complications not the medications that  
7 they need.

8 MR. HAMLIN: Okay, thanks.

9 CO-CHAIR MAURER: Other comments  
10 about that? Are we doing 2b6? Skip the b6,  
11 and 2c, disparity?

12 MS. WILBON: 2c we can briefly talk  
13 about.

14 CO-CHAIR MAURER: So that's yours  
15 too, Kurt, the disparities.

16 CO-CHAIR ELWARD: Again it appears  
17 that there's attention to that. I think the  
18 same issues apply as applied for asthma.

19 I think it's even more important to  
20 have the differences in racial disparities  
21 able to be identified, and I think they do  
22 that.

1 MR. HAMLIN: It's currently  
2 information not available in admin claims  
3 reliably. The recent test showed all the way  
4 from zero to 98 percent availability of  
5 race/ethnicity data in the administrative  
6 claims.

7 So we're not there yet where we  
8 can, that we know the standard that we can  
9 apply. So we do gender. That's all we have  
10 right now.

11 CO-CHAIR ELWARD: Oh, I'm sorry.  
12 So you don't do race?

13 MR. HAMLIN: Well, we would measure  
14 it if we could, but every time we test it,  
15 there are plans that are actively not  
16 collecting race/ethnicity data for a whole  
17 host of reasons and we keep testing to see  
18 what the availability of the data is in these  
19 datasets, and again we see the range from zero  
20 to about 98 percent.

21 So we just can't include that as a  
22 factor because it's not there in the claims.

1 And you can't push that.

2 DR. BLAKE: Why would the plans not  
3 collect this data? You would think that would  
4 be a driver of costs.

5 CO-CHAIR ELWARD: I can give you a  
6 cynical answer, but the one that I've heard is  
7 that if you don't record racial disparities  
8 you can't be sued for it.

9 CO-CHAIR MAURER: There's some  
10 issue about giving race too. We can't require  
11 that people give their race.

12 DR. STANFORD: It's not a required  
13 field for health care in general. A lot of  
14 the racial data within these datasets is  
15 actually survey data.

16 Yes, I mean they don't have, some  
17 are trying to actually take Census data and  
18 plop it on top of there, but that's not a  
19 very good way to do it.

20 You can get race in the Medicaid  
21 data, but you have to go to each individual  
22 state for that. There's not aggregated in a

1 large Medicaid dataset.

2 MR. HAMLIN: There's also some  
3 issues of provider recorded versus patient  
4 reported. So there's some consistency issues  
5 as well, but I've also heard many cynical  
6 answers of, you know, protectionism and fear  
7 of protests and lawsuits and other things.

8 CO-CHAIR ELWARD: Although on the  
9 other hand I've heard a couple of medical  
10 directors simply say, actually one person  
11 walked in the office the other day and said,  
12 you know, we really need to be doing better  
13 about racial disparities.

14 And I looked around and said, where  
15 did that get in the business plan? But I  
16 think there are some people who really are  
17 looking at that more carefully. But it's  
18 unfortunate.

19 CO-CHAIR MAURER: Yes, it's hard to  
20 make interventions if you don't know who they  
21 are, you know?

22 Okay, any other comments about

1       disparities with respect to COPD? So that  
2       brings us to usability, and that's mine.

3                   Are we going to vote?

4                   MS. WILBON: That's okay. She's  
5       trying to get us done early here which is we  
6       appreciate that. We're going to go ahead and  
7       vote on the subcriteria for scientific  
8       acceptability.

9                   MS. FANTA: Okay, so I'll start  
10      with 2a1. Is the measure precisely specified  
11      so it can be implemented consistently? We  
12      have nine high.

13                   2a2, does the reliability testing  
14      demonstrate that the results are repeatable  
15      producing the same results a high proportion  
16      of time when assessed in the same population  
17      in the same time period and/or that the  
18      measure score is precise? Eight high, one  
19      moderate.

20                   Okay, now we're going to vote on  
21      overall reliability testing which includes  
22      precise specifications and the reliability

1 testing. And the results are seven high, two  
2 moderate.

3 Okay, 2b1, validity. Are the  
4 measure specifications consistent with the  
5 focus of measurement and the measure intent?  
6 Eight high, one moderate.

7 2b2, does the validity testing  
8 demonstrate that the measure data elements are  
9 correct and/or the measure score correctly  
10 reflects the cost of care or resources  
11 provided, adequately distinguishing high and  
12 lower costs or resource use? Six high, three  
13 moderate.

14 Okay, 2b3, exclusions. Are  
15 exclusions supported by the clinical evidence  
16 or analysis of frequency and distribution? Is  
17 information about impacted exclusions for  
18 patient preference transparent? Four high,  
19 five moderate.

20 Okay, 2b4, for Resource Use  
21 Measures is there an evidence-based risk  
22 adjustment strategy or rationale or data which



1 supports no risk adjustment or stratification?

2 Six high, three moderate.

3 2b5, are performance results  
4 reported? Do they identify differences in  
5 performance or overall less than optimal  
6 performance? And we're just missing one vote.

7 If everyone could vote one more  
8 time, please. It won't count your vote twice  
9 so if we could just keep voting. Got it,  
10 okay. So we have five high and four moderate.

11 And now is the vote on overall  
12 validity testing, which includes  
13 specifications which are consistent with the  
14 resource use or cost problem validity testing  
15 risk adjustment or identification of  
16 meaningful differences. Four high, five  
17 moderate.

18 And then 2c, if disparities in care  
19 have been identified do measure specification  
20 score in data and analysis allow for  
21 identification of disparities through  
22 stratification or results or is there a

1 rationale or data justifying why  
2 stratification is not necessary or feasible?  
3 Five high, four moderate. On to usability.

4 CO-CHAIR MAURER: So we have kind  
5 of a Supreme Court on the validity and  
6 reliability.

7 And I'm just wondering, before we  
8 move on to usability does anyone feel that we  
9 need more discussion around this or are we  
10 really reflecting sort of the impreciseness of  
11 the data that we can gather and the inability  
12 to make it more maybe clinically relevant?

13 DR. MOSENFAR: COPD is just a vast  
14 area with a lot of comorbidity. So I think  
15 what you're seeing is really a true reflection  
16 of the mixed feelings about it that it really  
17 encompasses a lot of comorbid factors. Asthma  
18 is a much tighter disease.

19 DR. SANTO TOMAS: Yes, I mean I  
20 would in a sense echo that concern in a sense  
21 that if this is to be used for quality  
22 improvement, benchmarking and other things

1 that may not have been even originally  
2 intended for use, it then becomes at some  
3 point it becomes a disincentive to clinicians  
4 to look at this and all and say well, why am  
5 I being dinged for this?

6           When again, as he said, you know,  
7 COPD unlike asthma is a little harder to put  
8 into a good niche just because, although the  
9 comorbidities definitely, you know, heart  
10 failure and other cardiac problems definitely  
11 affect its course or at least hospitalizations  
12 and other resource use.

13           But a lot of it is driven by the  
14 severity of the disease itself. I mean and  
15 there are different, you know, from a simple  
16 as their, you know, patient's weight and  
17 nutritional status and those kind of things  
18 which I don't know how much of that is taken  
19 into account.

20           I mean some of that could probably  
21 be looked at in the administrative data as  
22 well. I mean, you know, malnutrition, for

1 example, as in a sense reflective of maybe how  
2 severe the disease is.

3 But there's just so much there that  
4 is really when we talk about risk or severity  
5 it doesn't really reflect the severity of the  
6 COPD but more of the comorbidity.

7 CO-CHAIR MAURER: So what I'm  
8 hearing is that you're saying that this is a  
9 much more heterogeneous disease than we're  
10 talking about with asthma, and the inability  
11 to actually record facts about the disease  
12 itself in that person you think might impair  
13 our ability to really look, you know, really  
14 accurately at the resource use?

15 DR. SANTO TOMAS: Yes, I think I'm  
16 hoping, I don't know how much of this is being  
17 done already in, for example, acute renal or  
18 kidney disease, but I believe there are either  
19 modifiers or codes.

20 For example, if you have somebody  
21 with chronic renal disease then you have, you  
22 know, then you have the stages, which maybe

1 we're not there yet with COPD.

2 And like as I said I think in renal  
3 disease they actually could classify, you  
4 know, this is stage 1, stage 2.

5 But I think maybe instead of  
6 pushing something, which I recognize is very  
7 important, it is a major driver of resource  
8 use in health care in general, but maybe it's  
9 premature until we fix this prerequisites. I  
10 know it's --

11 CO-CHAIR MAURER: Well, maybe also  
12 something that's bothering you and me too, is  
13 that we don't have a comparison between the  
14 use of these nondisease specific risk factors  
15 and actually disease specific risk factors.  
16 So we don't know if they really reflect the  
17 same thing exactly.

18 DR. SANTO TOMAS: Yes.

19 DR. STANFORD: Yes, and I think the  
20 other thing is how I see this from a data  
21 administration and risk factors is the heart  
22 failure, cardiovascular disease component.

1 And is there a way to marry the two as one  
2 measure? Because to me a lot of the risk  
3 factors for COPD costs are really related to  
4 how these patients, if they have comorbid  
5 cardiovascular disease, for instance, may be  
6 related to, equally related to not only their  
7 COPD treatment but also their cardiovascular  
8 disease treatment.

9 So those costs that are driven by  
10 total cost may actually be a factor of both of  
11 those equally. So I mean have you thought  
12 about that as well?

13 MR. HAMLIN: We are actually  
14 looking at different composites of the  
15 Relative Resource Use, so we're looking at  
16 utilization of COPD and CV if you will.

17 But for now the best we can do is  
18 a population to population balance and  
19 comparison between one population of a plan  
20 and another on the data that's available.

21 So we feel that these are the best  
22 measures of utilization for comparison of one

1 plan population to another as long as they're  
2 within a specific peer group that we can do  
3 with the data that's available.

4 We are looking at additional ways  
5 of incorporating total cost information and  
6 various composites of different disease states  
7 as a utilization measure.

8 But again there's, that it sort of  
9 falls into the same issue of attribution on  
10 the episode-based measurement approach, you  
11 know, which ones that are actually more  
12 relevant than others and how do you adjust for  
13 that and so on and so forth. So, you know,  
14 this is the best in class at the moment until,  
15 you know, further clinical information is  
16 available for us to use through other means.

17 But again that's why we've pretty  
18 much limited it to the population plan level  
19 comparison at this point because we feel that  
20 there are a whole bunch of host of factors,  
21 and we've had this problem with the quality  
22 side as well.

1                   For our COPD measures we're really  
2                   missing a great component in the coordination  
3                   of care and staging of the disease and so on  
4                   and so forth, but that's just not in admin  
5                   claims and we're reluctant to, and it's not  
6                   even really in a lot of medical records as  
7                   well.

8                   A lot of that's done through  
9                   disease management companies or other, you  
10                  know, employer programs or things like that  
11                  that just are not part of that sort of record  
12                  if you will that we can ask plans to use to  
13                  report measures to us.

14                 So we're always thinking about  
15                 innovation there, but like I said this is kind  
16                 of the best we can do at this moment in time  
17                 given the information that's available. And  
18                 that's why we do limited to the plan to plan,  
19                 large population to large population.

20                 We were hoping that, or the  
21                 assumption is that most of those variations  
22                 will balance out, because one plan population



1 when it's risk adjusted for severity of other  
2 disease states will look relatively similar to  
3 another plan population in a peer group that  
4 has the same risk adjustment approach for  
5 factors of cost utilization.

6 CO-CHAIR MAURER: So let me ask the  
7 group. Does this discussion accurately  
8 reflect the concerns that we saw up on the  
9 voting? Does anybody have anything else to  
10 add? Okay.

11 So we'll move to usability. This  
12 one is mine and this is, are the measure  
13 results reported to the public at large? Yes,  
14 they are. They are, we heard about the sort  
15 of standard reporting that NCQA does and I  
16 ranked 3a as high.

17 The measure performance results are  
18 considered meaningful, understandable and  
19 useful to the intended audience for both  
20 public reporting and informing quality  
21 improvement.

22 I've used the quality results which

1 are similar to, which are reported in a very  
2 usable way and I believe that the relative  
3 resource results are also reported in a very  
4 usable way.

5 And based on the examples that  
6 were given with the submission, I believe that  
7 these are very usable and understandable.

8 3c is, data result and detail are  
9 maintained such that the resource use  
10 including the clinical and construction logic  
11 can be decomposed to facilitate transparency  
12 and understanding.

13 And I believe that NCQA does that  
14 for the health plans that report to you. And  
15 I also, one thing I also want to mention about  
16 NCQA is they do do very extensive audits of  
17 their material and they do this over several  
18 domains on a regular basis.

19 And I think that's a really good,  
20 the quality control that they do that way by  
21 auditing. So I ranked all three of these  
22 high. Now we can vote.

1 MS. WILBON: Yes. Just what we've  
2 been doing kind of as staff, particularly  
3 across measures from the same developer, is to  
4 kind of share the voting results that you had  
5 for the other measure particularly around  
6 usability and feasibility, which I would say  
7 can be generalized to a developer.

8 Usually the underlying kind of  
9 construction and methodology are the same  
10 across all the measures. So what we'll do is  
11 I'll have Lauralei kind of read aloud your  
12 ratings for the other NCQA measures just so  
13 you kind of have an idea, not that you have to  
14 duplicate it but so we're kind of consistent.

15 And if there's anything different  
16 about this particular measure that you think  
17 needs to be identified before we vote so that  
18 can be kind of reflected in the votes we'll do  
19 that, okay?

20 MS. DORIAN: I guess I'll go  
21 subcriteria by subcriteria. So for 3a  
22 everybody said eight high and one moderate.

1 (Off microphone comments)

2 MS. DORIAN: Keep going? Okay, 3b  
3 was six high and three moderate. 3c, which is  
4 transparency was eight high and one moderate,  
5 and that's all.

6 MS. WILBON: So generally highs and  
7 a few moderates in there, so just so you have  
8 a little bit of context as you're voting.  
9 That'd be great, thanks. You can go ahead and  
10 vote.

11 CO-CHAIR MAURER: And feasibility?

12 MS. WILBON: We'll vote on  
13 usability and then we'll come back.

14 DR. SANTO TOMAS: That was from the  
15 previous one.

16 MS. WILBON: For the previous NCQA  
17 asthma measure, yes.

18 MS. FANTA: So 3a, are the measure  
19 performance results reported or suitable to  
20 report to the public at large in national or  
21 community reporting programs? Is there  
22 evidence that the measure performance results

1 are available for public reporting? Nine  
2 high.

3 3b, did submitted information  
4 demonstrate that results produced by the  
5 measure are meaningful, understandable and  
6 useful for information for quality improvement  
7 and public reporting or was a credible  
8 rationale presented? Five high, four  
9 moderate.

10 3c, are the data and result details  
11 maintained such that the Resource Use Measure  
12 including the clinical and construction logic  
13 for a defined unit of measurement can be  
14 decomposed to facilitate transparency and  
15 understanding? Six high, three moderate.

16 Okay, you can move on to the  
17 feasibility now, discussion.

18 CO-CHAIR MAURER: Okay. So the  
19 first one is, are feasibility, are the  
20 required data elements routinely generated and  
21 used, are generated in the same way that  
22 they're generated for asthma through

1 administrative claims? So yes.

2 And the next one is, the required  
3 data elements are available in electronic  
4 health records or other electronic sources.  
5 They're all transmitted electronically through  
6 the IDSS system I think?

7 MR. HAMLIN: Yes, currently.

8 CO-CHAIR MAURER: And 4c is  
9 susceptibility to inaccuracy, errors or  
10 unintended consequences.

11 Again, this extensive auditing  
12 process that they have helps to, you know,  
13 mitigate this and they chop off either end at  
14 0.33 and 3.0, so they do mitigation around  
15 inaccuracies and errors, which is I think as  
16 much as probably can be done with the data.  
17 So I ranked these all high.

18 MS. WILBON: If there's anything  
19 different again for feasibility from this  
20 measure or from the asthma measure I would  
21 just kind of encourage you to voice that now  
22 before we go ahead and vote.

1                   Otherwise, again, we can have  
2                   Lauralei read the ratings, but I think if we  
3                   can be consistent that would be great.

4                   CO-CHAIR MAURER:   Okay, I'll go  
5                   ahead and read the ratings then.   We had nine  
6                   high for 4a, the byproduct of care.   Nine  
7                   high, available electronically.

8                   Seven high and two moderate for  
9                   susceptibility to inaccuracies.   And eight  
10                  high and one moderate for barriers to use.   So  
11                  are you all ready to go ahead and vote?

12                  MS. FANTA:   So 4a, are the required  
13                  data elements routinely generated and used  
14                  during care delivery?   Nine high.

15                  4b, are all the required data  
16                  elements available in electronic health  
17                  records or other electronic sources.   If not,  
18                  is a credible near term path to electronic  
19                  collections specified?   Nine high.

20                  4c, are susceptibilities to  
21                  inaccuracies, errors or unintended  
22                  consequences and the ability to audit the data

1 items to detect such problems identified? Six  
2 high, three moderate.

3 And 4d, can the data collection  
4 strategy be implemented? Is the measure  
5 already in operational use or did testing  
6 demonstrate that it is ready to be put into  
7 operational use? Okay, eight high, one  
8 moderate.

9 CO-CHAIR MAURER: Okay. So we're  
10 a little bit early but what we're thinking we  
11 might want to do is break early, come back  
12 early and that'll help with the people who  
13 have transportation issues later on in the  
14 afternoon. Is that okay with everybody?

15 So we're ten minutes early so we  
16 should come back at 12:30.

17 MS. DORIAN: Katie, are you there  
18 on the line?

19 OPERATOR: I am.

20 MS. DORIAN: Can we open it to  
21 public comment at this time if anybody's  
22 there?



1 OPERATOR: Sure. And if you'd like  
2 to make a comment, please press star 1 on your  
3 telephone keypad at this time. And we have no  
4 comments at this time.

5 MS. DORIAN: Great, thank you.

6 CO-CHAIR MAURER: Timing still  
7 stands. Come back at 12:30.

8 (Whereupon, the above-entitled matter  
9 went off the record at 12:03 p.m. and resumed  
10 at 12:38 p.m.)

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12:38 p.m.

CO-CHAIR ELWARD: Tom, are you here from Ingenix?

DR. LYNN: Yes, I'm on the line.

CO-CHAIR ELWARD: Thank you very, very much for being here.

DR. LYNN: No problem.

CO-CHAIR ELWARD: Let me explain how we've done this today. We've been taking the measures and then addressing the overall importance as the first issue, and that's what Janet and I have been doing.

And then initially going over some of the -- well, actually what we'll do is we'll turn it over to the rest of the panel to ask questions about the overall importance issue, and then I'll turn it over to you to see if you can explain the measure and talk a little bit about it and have some other questions answered if needed.

And then we'll be going through

1 each item and having individuals report on  
2 that and outline what their response is to  
3 various criteria that we have. And we'll be  
4 touching base with you intermittently for  
5 questions that they'll raise.

6 DR. LYNN: Sounds good.

7 CO-CHAIR ELWARD: Okay, great.

8 Thanks. The next on our agenda is 1605, which  
9 is the ETG-based Asthma Resource Use Measure.  
10 And we're relying on Michael and Kathryn again  
11 to help us out.

12 The overall importance of the  
13 measure I think is very similar to what we had  
14 this morning. It focuses on clearly a  
15 national priority and one that's high impact.

16 This is the measure that describes  
17 the overall use of resources for asthma care,  
18 and specifically it says that it focuses on  
19 resources used to deliver episodes of care for  
20 patients with asthma.

21 And it will be defined as episode  
22 treatment groups using that methodology and it

1 describes the unique presence of condition for  
2 patients and the services involved in  
3 diagnosing and managing and treating asthma.

4 The measure that's proposed does  
5 demonstrate cost problems and the opportunity  
6 for improvement, and also I think outlines  
7 some of the experience that the developers  
8 have had. So I think that's acceptable.

9 I think the purpose and objective  
10 of the Resource Use Measure has been defined  
11 and the service categories at least in my  
12 reading seem to be very consistent with what  
13 they're describing what they're trying to  
14 measure and of what's important. So I would  
15 say it meets criteria in all of those.

16 Any thoughts or questions? Do we  
17 need to vote on that? Okay.

18 MS. FANTA: Okay, so for 1a, does  
19 the measure focus address a specific national  
20 health goal priority or was data submitted  
21 that demonstrated a high impact aspect of  
22 health care? We're just missing one vote. So

1 we have nine high.

2 Moving along to 1b, was data  
3 submitted that demonstrated resource use or  
4 cost problems for improvement that is  
5 variation and the delivery of care across  
6 providers and/or population groups? Okay, and  
7 the results are eight high, one moderate.

8 1c, is the purpose objective of the  
9 Resource Use Measure including its components  
10 and the construct for resource use costs  
11 clearly described? Seven high, two moderate.

12 And 1d, are the resource use  
13 service categories that are included in the  
14 Resource Use Measure consistent with and  
15 representative of the measure concept? And  
16 the results are seven high, two moderate.

17 CO-CHAIR ELWARD: Thank you. Tom,  
18 we'd like to hear from you about the measure  
19 1605 and how, perhaps give us some background  
20 that might help us as we start consideration  
21 of the measure.

22 DR. LYNN: Sure. I think this is

1 a measure that's part of our sweep of creating  
2 episodes around diseases and conditions called  
3 the episode treatment grouper.

4 And the purpose of this rule and  
5 that product is to identify claims that should  
6 be part of an episode of asthma and then it  
7 divides those episodes into year-long segments  
8 of, treat asthma as a chronic disease.

9 This particular rule then goes on  
10 to identify how you would aggregate episodes  
11 of asthma across entities and measure how cost  
12 effective the treatment was with statistical  
13 methodologies.

14 In addition to that, these episodes  
15 are severity adjusted using clinical markers  
16 that come from within the episode that we call  
17 condition status factors, and clinical markers  
18 that come without the episode of possible  
19 morbidity.

20 And we are able to create a  
21 severity model for asthma and use these  
22 clinical-only markers not utilization markers,

1 just clinical diagnostic markers to identify  
2 higher cost episodes of asthma differently  
3 from lower cost episodes of asthma.

4 I want to say that the story for  
5 COPD is pretty similar. And there is one sort  
6 of special feature for asthma and COPD that  
7 has not applied to rules prior, and that is  
8 that grouper assumes that you can't have  
9 asthma and COPD at the same time.

10 So the grouper takes a special  
11 step, and if you do have both of those  
12 episodes at the same time due to some sort of  
13 coding error that the grouper will make a  
14 determination about which one is correct by  
15 counting the number of face-to-face  
16 connections between a provider and a patient.

17 And whichever episode has the most  
18 they're merged together and become either  
19 asthma or COPD.

20 So that's one special consideration  
21 for these two episodes that has not come up  
22 before in discussion of our measures.

1 DR. SANTO TOMAS: I'm sorry. Can  
2 you repeat that? How did you try to  
3 distinguish the two or p-

4 DR. LYNN: Yes, so if you have two  
5 episodes running concurrently, one asthma and  
6 one COPD, then the grouper looks at, when you  
7 read the description about how the grouper  
8 works, it looks at the anchors which are,  
9 anchor records are records where the claim  
10 represents a face-to-face encounter between a  
11 clinician and a patient, and it counts those  
12 encounters. And whichever episode has the  
13 most that's how you label the episode and it  
14 lets those merge together.

15 So for example, if you had an  
16 episode of asthma that had four or five office  
17 visits and then at one point there was an  
18 office visit that was coded as COPD instead of  
19 asthma, then instead of having one asthma  
20 episode that's sort of missing a claim and one  
21 COPD episode that's very small, we merge them  
22 together and we say hey, this asthma had five



1 -- and the COPD only had one. So we're going  
2 to merge these episodes together and make them  
3 one episode and we're going to call it asthma.

4 DR. STANFORD: This is Richard  
5 Stanford. Can you give me an example of what  
6 would be a minimum ETG? Like what would go  
7 into a score to base somebody as an asthma  
8 episode minimally, like what would be the  
9 minimum criteria for that?

10 DR. LYNN: Minimum criteria would  
11 be that there would be an office visit or some  
12 sort of encounter between a clinician and a  
13 patient.

14 In the case of asthma it would  
15 mostly likely be an office visit but it could  
16 be an emergency room visit or it could be an  
17 admission. But the minimal ones probably  
18 would be the office visit and that claim can  
19 start an episode of asthma.

20 DR. STANFORD: And that's based off  
21 of an ICD-9 code, is that correct? Or is that  
22 based off of other codes as well?

1 DR. LYNN: That's a great question.  
2 So it's mostly based on the ICD-9 code for  
3 asthma, but it's also based on in order to, we  
4 only let certain claims start episodes.

5 Those are claims that we call  
6 anchors, and that requires that the provider  
7 be a clinician or that has a certain procedure  
8 code that shows that the clinician and the  
9 provider, you know, were face-to-face.

10 So it mostly uses the diagnosis  
11 code, but it uses the provider's specialty and  
12 the procedure code to make sure that it's a  
13 claim that we give the power to start an  
14 episode to.

15 CO-CHAIR MAURER: I have a question  
16 as well. I didn't quite understand. Let's  
17 say you have a patient who has an anchor  
18 record that starts an asthma episode grouping,  
19 and a month later they break their leg and  
20 they have that as a primary diagnosis and  
21 asthma as a secondary diagnosis.

22 Is that a record that starts

1 another anchor for broken leg or does that go  
2 into the asthma treatment group?

3 DR. LYNN: That's a great question.  
4 So the second, let's assume the second one is  
5 an anchor record. I think you said that and  
6 I appreciate that. The second one is an  
7 anchor record.

8 Then what would happen is that  
9 there would be, there's a set of tie-breaking  
10 logic that we go through to see whether that  
11 claim should group to broken leg or should  
12 group to asthma. And also there's a check to  
13 make sure that the procedure code makes sense  
14 for asthma.

15 So let's take an example. If the  
16 procedure was say we put a cast on your foot  
17 so you broke your foot. And the person dies,  
18 you put a diagnosis code of fractured foot on  
19 that claim and a diagnosis of asthma because  
20 they had, you know, they knew they had that  
21 sort of comorbidity.

22 Then the grouper says look, you

1 don't put casts on people's feet for asthma.  
2 So it doesn't do anything. It doesn't group  
3 the asthma episode at all. It has no effect  
4 with the asthma episode.

5 So now let's take an example where  
6 it was an office visit. The office visit and  
7 then the first diagnosis code is fracture of  
8 the foot and the second diagnosis code is  
9 asthma.

10 Then what the grouper would do, it  
11 goes through a bunch of tie-breaking logic,  
12 but one of the last tie-breaking logics is  
13 that the foot fracture was the first diagnosis  
14 code on the claim and asthma was the second  
15 one.

16 So an office visit could have had  
17 an effect on asthma or it could have had an  
18 effect on fracture of the foot. So what the  
19 grouper will do is it'll start an episode of  
20 fracture of the foot and the claim will  
21 actually group to that episode.

22 But the claim will have some effect

1 on the asthma episode in that it will, it can  
2 gather other claims to it and it has a what we  
3 call a phantom relationship with asthma. So  
4 it restarts the claim period for asthma.

5 It allows other claims related to  
6 asthma to group to the asthma episode through  
7 this anchor, but the claim itself would not  
8 group to that episode.

9 CO-CHAIR ELWARD: Michael?

10 DR. SCHATZ: On I think that  
11 related question, so certain costs that are  
12 not felt to be attributable to asthma during  
13 the year-long episode are not attributed to  
14 asthma. They don't end up in the quote, total  
15 cost, for asthma? Am I correct or not?

16 DR. LYNN: That's correct.

17 DR. SCHATZ: So there is a  
18 determination by the grouper or by something  
19 as to what would be really related to asthma  
20 versus what wouldn't?

21 DR. LYNN: That's correct.

22 CO-CHAIR ELWARD: It sort of holds

1 it, in my understanding in reading one of the  
2 documents that it sort of holds it as a what  
3 you call a phantom episode and then at some  
4 point the logic says okay, yes, this really  
5 was part of the asthma code, or there's a  
6 decision point where it drops off. Is that  
7 right?

8 DR. LYNN: Yes. So and we have a  
9 phantom relationship, so we have, let's say  
10 we'd take that example a little further and,  
11 you know, the office visit was for foot  
12 fracture and asthma.

13 And while they were fixing their  
14 foot they realized that they were having a  
15 little trouble with the asthma so maybe they  
16 did a peak flow test and they charged for it  
17 or something like that.

18 Then the peak flow test which can't  
19 sort of continue the asthma episode itself  
20 because that does not have the power of being  
21 an anchor, but it will group through the  
22 asthma episode via that office visit that had

1 the asthma ICD-9 code attached to it. So that  
2 office visit, although the dollars don't go to  
3 asthma itself, that peak flow test gets to the  
4 asthma.

5 CO-CHAIR ELWARD: Okay.

6 DR. STANFORD: So maybe I didn't  
7 read the document well enough, but so this  
8 level of analysis, it's at the ETG level or is  
9 that patient level? I mean that's where I was  
10 a little bit confused.

11 For instance, can a single patient  
12 have multiple ETGs and be kind of multiple  
13 times or is once they've been categorized as  
14 an asthma episode you don't include any other  
15 episodes within the confines of that patient  
16 only for another ETG? I guess is what I'm  
17 asking.

18 DR. LYNN: Yes, so in the case  
19 we're describing where someone during a year  
20 or during sometime has claims related to  
21 asthma and claims related to the foot  
22 fracture, what the grouper does is it says,

1 and this stuff that is related to the foot  
2 fracture is in a separate episode.

3 Remember, this is part of a sweep,  
4 well, it's part of a product that groups all  
5 episodes. So we put that into a foot fracture  
6 episode and then we only put the claims  
7 related to asthma into the asthma episode.

8 DR. STANFORD: Right. So I guess  
9 my question is, you're saying that the  
10 episodes are 365 days, is that correct?

11 DR. LYNN: That's correct.

12 DR. STANFORD: All right, so each -  
13 -

14 DR. LYNN: Like a foot fracture  
15 wouldn't be because that's an acute illness,  
16 but yes, asthma --

17 DR. STANFORD: An asthma episode is  
18 365, so in essence a patient is only counted  
19 once and an ETG is related to one patient.

20 DR. LYNN: That's correct. Now you  
21 could group two or three years worth of data,  
22 but a single patient is only going to have one



1       asthma episode every year, but you could group  
2       three years of data and have three episodes of  
3       asthma.

4                   DR. STANFORD:   May I assume we can  
5       ask any questions about the --

6                   CO-CHAIR ELWARD:   Please, please.

7                   DR. STANFORD:   Yes.   Am I correct  
8       that I believe I read that you allow missing  
9       pharmacy data?

10                  DR. LYNN:   Okay, so here's what we  
11       do about pharmacy data.   If the member has  
12       eligibility for pharmacy data, for pharmacy,  
13       in other words we have their pharmacy data,  
14       then we obviously group it to the asthma  
15       episode.

16                  If a member does not have pharmacy  
17       data, then we don't group pharmacy data to the  
18       episode.   And then in the analysis of the  
19       episode one of the adjusters for the episode  
20       is, did you have pharmacy data during this  
21       episode?

22                  And it has to be that you've had

1 pharmacy eligibility during the entire  
2 episode. If you only had it for part of the  
3 episode then we don't group pharmacy, or we  
4 don't take into account the pharmacy dollars  
5 for that episode.

6 And sort of once you've created the  
7 episode there's a subsequent analysis, and  
8 during that analysis if there is an episode of  
9 asthma, there's an expected value for an  
10 episode of asthma that has pharmacy data and  
11 a different expected value for an episode of  
12 asthma that does not have pharmacy data.

13 And there's one of those for each  
14 of the severity adjusters for asthma, for each  
15 of the severity levels for asthma.

16 DR. STANFORD: So do I understand  
17 you correctly then, in the presentation of the  
18 information in each severity stratification  
19 there's a mean cost per episode with pharmacy  
20 data and a mean cost per episode without  
21 pharmacy data?

22 DR. LYNN: That's correct.

1 DR. STANFORD: Well, while I'm  
2 talking then in terms of what's presented, I  
3 gather that what's presented are severity  
4 stratified results as was mentioned.

5 You mentioned that a composite is  
6 constructed. Is that composite presented as  
7 well? And how exactly is that weighted or  
8 semi-exactly, how does one make a composite  
9 out of these different strata?

10 DR. LYNN: Yes, sure. So the, I  
11 think asthma has three levels. I'm not  
12 positive about that. If asthma has three  
13 levels and there's with and without pharmacy  
14 data, then you basically have six buckets,  
15 right?

16 So you take the data across all of  
17 the data that you have to analyze. And we  
18 also, you know, we do the analysis differently  
19 for different peer groups.

20 So if you were doing an analysis of  
21 pulmonary doctors taking care of asthma, you'd  
22 only look at episodes of asthma taken care of

1 by pulmonary doctors, and you'd look at the  
2 six different strata and you'd calculate  
3 across all of the data that you had for this  
4 analysis. What's the average cost in each one  
5 of those strata? So you have six expected  
6 values.

7 And then if a doctor, just take a  
8 simple case. We'd never do it for a doctor  
9 that had three cases, but just to sort of keep  
10 it from getting, you know, us having to be  
11 computers and we just be human beings.

12 But you could have a doctor that  
13 had two cases where they were level 2 and they  
14 had the pharmacy data, and maybe one case  
15 where it was level 1 and they didn't pharmacy  
16 data.

17 So you take the actual dollars  
18 spent on those three cases that the observed  
19 cost, and you divide that by the mean of the  
20 severity level 1 without pharmacy data plus  
21 the mean of the severity level 2 with pharmacy  
22 data plus the mean of severity level 2 with

1 pharmacy data.

2           So it's the observed cost divided  
3 by the expected cost and that gives you a  
4 ratio. And of course if you sort of did that  
5 for the whole set of data you'd get 1. So the  
6 expected value for that measurement is 1.

7           And of course, obviously you can  
8 expand that idea to many, many cases of asthma  
9 and, you know, you could expand that idea to  
10 the asthma and COPD or asthma and COPD and  
11 pneumonia as long as they were diseases that  
12 you would expect that specialty is there for.

13           MR. BRATZLER: Yes, I don't  
14 remember for the asthma measure. I know in  
15 the pneumonia measure it states that, I guess  
16 at the plan level I'm assuming you can either  
17 use actual payments or you can use the  
18 standardized resource costs for the episode.

19           DR. LYNN: That's correct. And it  
20 depends on what your interest in it. It also  
21 depends on the data you have available.  
22 Sometimes you may have data that doesn't have

1 price. It has all the utilization but it  
2 doesn't have the exact price, so you could  
3 standard price the data instead of that.

4 The other thing is you maybe  
5 you're not interested in the overall cost,  
6 you're really interested in trying to get at  
7 utilization. And then in that case you can  
8 use the standard price to get actual  
9 utilization.

10 Other times, you know, you want to  
11 look at utilization in the setting of the  
12 contracted rate and you want that to be a part  
13 of the analysis then you would use real  
14 dollars.

15 MR. BRATZLER: Boy, I think that'd  
16 be obviously particularly relevant if you were  
17 trying to compare across plans or across  
18 provider groups to use some, so the actual use  
19 of the actual cost would be misleading.

20 DR. LYNN: Again it depends on what  
21 you want to know. But if you wanted to know  
22 utilization, the actual cost would be included

1 and they should be using standard pricing.

2 CO-CHAIR ELWARD: Other questions  
3 right now? Great. Thanks, Tom.

4 Well, then let's start off with  
5 2a1. Michael? We may have discussed some of  
6 this already, but p

7 DR. SCHATZ: Right. Well, two  
8 things I'd say. Number one, I think that one  
9 concern with 2a1 is given that it's not  
10 necessarily standardized costs, the playing  
11 field I'm concerned is not level.

12 So that I don't think it can be  
13 implemented consistently across organizations  
14 if one organization is using standard cost and  
15 another is using actual payments. So I'm  
16 concerned at least as I see the definition of  
17 this measure, I mean the criterion.

18 And then, and I really defer to  
19 Carlos then on the rest of this, but I see  
20 that risk adjustment methodology is part of  
21 2a1, at least a part of Carlos's report, and  
22 he does not feel that there is sufficient

1 detail according to the report. And so I  
2 defer to you, Carlos, for any other comments  
3 on 2a1.

4 MR. ALZOLA: Yes, the risk  
5 adjustment methodology is presented in a way  
6 that's a little bit mechanical in the sense  
7 that they present coefficients, they divide  
8 the range of risks into four groups, and  
9 without giving much explanation about what are  
10 the goodness of fits of the measures and the  
11 calibration of the risk adjustment model. So  
12 when you're looking at the ratios of service  
13 that's expected, it's important to see how  
14 well we're predicting the low end and the high  
15 end to really be able to assess whether those  
16 people are really high, are being efficient or  
17 not.

18 So basically what I would like to  
19 see in this submission is more information on  
20 the R-squares and the calibration of the  
21 models and also how they chose the cutoffs to  
22 the right, the risk score into four groups.



1 CO-CHAIR ELWARD: Tom, can you  
2 address that? I mean on the one hand I also  
3 understand that you're trying to get to a  
4 level that's quite a bit beyond what normally  
5 we see presented.

6 So we really appreciate that, but  
7 can you give us an idea of what Carlos, or  
8 address what Carlos has raised?

9 DR. LYNN: The best way to address  
10 it is to provide that information on which I  
11 can't do off the top, but we could definitely  
12 provide on the information that Carlos has  
13 requested.

14 CO-CHAIR ELWARD: So you have done  
15 the analysis and have the, you know, of the R  
16 values and things that Carlos has mentioned?

17 DR. LYNN: I can't say that we've  
18 done specifically for asthma, we actually did  
19 it for diabetes, but it's doable with the data  
20 that we have.

21 MR. ALZOLA: Yes, we saw it for  
22 diabetes and the R squares were good. I like

1 to see that. The one thing that wasn't there  
2 with the diabetes information was the  
3 calibration.

4 So how do the observed relate to  
5 the predicted? Some kind of graph of care  
6 would be very useful there.

7 DR. LYNN: And Carlos, I apologize.  
8 I'm not a statistician. I understand enough  
9 of this stuff to be, well, some of the stuff.  
10 So if my folks have any questions about what  
11 calibrations that we can get --

12 MR. ALZOLA: That's fine. But they  
13 would know what I'm talking about.

14 DR. LYNN: Yes, that's great.

15 CO-CHAIR ELWARD: Well, Tom, can  
16 you give us an idea just to make sure everyone  
17 knows, how do you develop the coefficients?

18 DR. LYNN: Sure.

19 CO-CHAIR ELWARD: I mean you  
20 explained some of that, but just to help us  
21 understand, you know, where they come from in  
22 the, based on your dataset. And do you go

1 backward from total utilization and then  
2 derive those or how do you do that?

3 DR. LYNN: Right. So first of all,  
4 our coefficients are calculated using a large  
5 dataset. We do have I believe it's either 25  
6 or 30 million members worth of data. It is  
7 all standard price, so the coefficients are  
8 based on a standard priced claim.

9 So basically what is done is that  
10 you create a bunch of episodes of asthma  
11 through the standard grouping process that  
12 we've been talking about. And then we identify  
13 clinically with input from a pulmonologist,  
14 what's sort of the wide net.

15 If you were going to cast a wide  
16 net study, what clinical concepts affect the  
17 resource utilization on asthma what would they  
18 be? And we'd get a set of concepts and we  
19 develop markers that are only based of course  
20 on diagnostic information.

21 And then we run a model of, it's  
22 basically a regression model, with all these

1 clinical markers. Some of them are internal  
2 for the episode which we call condition status  
3 markers.

4 And then there are markers that are  
5 outside of the asthma episode that basically  
6 said hey, this person has congestive heart  
7 failure at the same time and this person had  
8 renal failure at the same time that had an  
9 indirect effect on the cost of asthma, because  
10 the actual cost is actually their episode.

11 So we do a model and then we  
12 present results to the expert, clinical  
13 expert, and then we know what's statistically  
14 significant and what wasn't and what's  
15 clinically significant and what wasn't. And  
16 then we come up with a finalized set and then  
17 we run it through the progression models and  
18 come up with those coefficients.

19 CO-CHAIR ELWARD: Okay, just so I'm  
20 clear, when the, say a pulmonologist gives you  
21 weights.

22 DR. LYNN: No, no, no, no. No, the

1 pulmonologist doesn't give us weight. What he  
2 gives us is what the markers.

3           So what we do with the  
4 pulmonologist, if he says hey, you know, if  
5 you have status asthmaticus, you know, in  
6 effect the resource utilization for asthma,  
7 and I think that if you have congestive heart  
8 failure it would indirectly affect the  
9 resource utilization for, of asthma. And they  
10 tell us what are the clinical concepts. And  
11 we ask them to cast a wide net because, you  
12 know, if they pick something that doesn't have  
13 a relationship it'll show up a little bit. So  
14 it's more important in that first step to  
15 include this.

16           But there's no way anybody no  
17 matter how brilliant they were, a clinician,  
18 could figure out what the coefficients are.  
19 So we let the model tell us what the  
20 coefficient is and then we review the results  
21 with the expert to help us, you know, come up  
22 with a final set.

1 MR. AMIN: Tom, we're having a  
2 little bit of trouble hearing you. You're  
3 going in and out a little bit. If you can  
4 either talk into the phone a little bit more,  
5 I don't know if you're on speaker phone, but  
6 that would help just because it's a very  
7 important part of the conversation. We don't  
8 want to miss anything.

9 DR. LYNN: Absolutely. Is that  
10 better? I apologize.

11 MR. AMIN: It seems to be, yes.  
12 Thank you.

13 CO-CHAIR ELWARD: Great, thanks.  
14 Other things before we go onto the specific  
15 elements? All right. Then let's start with  
16 2a1, which I think you've addressed.

17 And Kathryn, do you have 2b2?

18 DR. BLAKE: 2a2? Yes, I had 2a2.  
19 Do you want to scroll it for me so everybody  
20 can see? So this is Tom? Is that who's on  
21 there? So Tom, I'm reviewing the data and  
22 sample aspect of this. And I had a question.

1                   You have 25 million member sample  
2                   to pick from. Why did you, or what was the  
3                   reason for picking four million of those for  
4                   the face validity testing, seven million for  
5                   the reliability evaluation and 75,000 for the  
6                   content validation testing? Why did you pick  
7                   those subgroups and how were they picked?

8                   DR. LYNN: Oh my gosh. I don't  
9                   know.

10                  DR. BLAKE: Sorry.

11                  DR. LYNN: Sorry.

12                  DR. SANTO TOMAS: Was that just a  
13                  technique as far as sampling and validation?  
14                  I don't know, maybe Carlos could even --

15                  DR. LYNN: I'm sorry, I don't know  
16                  the answer to that question. Is Dan Dunn on  
17                  the line by any chance? I'm sure he's not.

18                  MR. ALZOLA: Can you repeat the  
19                  question?

20                  DR. SANTO TOMAS: I'm just guessing  
21                  it's a technique for validation like meaning,  
22                  you know, certain proportion of your sample

1 you pick for well, testing, and then later on  
2 you kind of test your, like coefficients and  
3 see if that actually still applies, right? Is  
4 that --

5 DR. LYNN: Right. I know we looked  
6 at two different payers basically to do some  
7 of that validation work. But I don't know  
8 whether p-

9 DR. BLAKE: I guess I was just kind  
10 of wondering, I mean why wouldn't you just  
11 pick, you know, seven million for all of them  
12 or something like that since you have a 25  
13 million person database?

14 I mean maybe it doesn't affect the  
15 results at all. I was just curious. And when  
16 I was looking at it and wondering if there  
17 were differences between those three  
18 populations that could have impacted the  
19 results, that's where I'm coming from. But if  
20 we don't have the answer now that's okay.

21 And I guess the other thing that I  
22 didn't see and I couldn't find anywhere was



1 just some more characteristics of the  
2 population such as ages and things like that  
3 I couldn't find anywhere. So that would have  
4 helped a little bit when I looked at some of  
5 the other information.

6 In terms of the analytic methods,  
7 they seemed appropriate and your expected  
8 results were compared with benchmark database  
9 using regressions, which I thought was  
10 appropriate.

11 But tell me, why did you compare  
12 two different softwares? I couldn't really  
13 get why you were comparing SAS with the  
14 Resource Utilization Measures software.

15 DR. LYNN: What we were doing there  
16 is just trying to show that our SAS prototype  
17 comes up the same answer as our actual  
18 application.

19 So there was a question about  
20 repeatability of results and that's one of the  
21 ways we tried to show that we always get the  
22 same answer.

1 DR. BLAKE: Did you come up with  
2 some sort of I guess component of SAS software  
3 that you used and was the Resource Utilization  
4 Measure, is that something that's proprietary  
5 that is yours?

6 DR. LYNN: Right, so basically what  
7 this is is that we used SAS to write the  
8 prototype of the methodology and then we have  
9 a I think it's a C++ version that's actually  
10 packaged and sent out to people.

11 So it's a comparison between  
12 running the data through those two, but  
13 they're coded to do the same thing.

14 DR. BLAKE: But again going back,  
15 why do you need two different softwares?

16 DR. LYNN: Well, again we're trying  
17 to answer the question is if you use our  
18 method and you run it through two different  
19 creations of that method you come out with the  
20 same.

21 DR. BLAKE: Okay.

22 DR. LYNN: It's sort of an obvious

1 thing but we felt like the NQF asks that  
2 question. If you run it two different times  
3 do you get the same answer?

4 DR. BLAKE: Okay. So that's clear.  
5 And then the results, the consistency between  
6 the two softwares was obviously very good in  
7 your testing results.

8 DR. LYNN: Right.

9 DR. BLAKE: In that section,  
10 testing results, you said that there was a lot  
11 of consistency among the groups, the peer  
12 groups for instance.

13 What were you basing consistency  
14 on, because like in the pediatric peer group,  
15 and this might be getting into too much detail  
16 that you might not have on hand, but like  
17 there was a more than say two-fold difference  
18 in maybe the cost per episode.

19 I mean that doesn't seem consistent  
20 to me, but am I missing what you're trying to  
21 measure as consistent? Because it said that -  
22 -

1 DR. LYNN: I'm sorry. I can't see  
2 exactly what you're looking at.

3 DR. BLAKE: You provided a table  
4 and this is the table for reliability and  
5 validity testing.

6 And in these tables you have your  
7 pulmonary peer group, pediatric peer group,  
8 family practice and internal medicine peer  
9 groups.

10 And if I understood what you were  
11 doing correctly, you were comparing to look at  
12 consistency across these nine different  
13 organizations, health care organizations.

14 DR. LYNN: Right.

15 DR. BLAKE: And the comment in what  
16 you provided was that they were consistent.

17 So I was wondering what you were  
18 using to call something as being consistent,  
19 because when I looked at it, just my  
20 eyeballing it like under the pediatric peer,  
21 there was a lot of variability, a two-fold  
22 difference between the health care

1 organizations.

2 So are you talking about something  
3 different than what I was interpreting it as?  
4 Am I making sense?

5 DR. LYNN: I don't think we were.  
6 I'm sorry, I can't see that. I can't find the  
7 exact table that you're looking at. Can you  
8 tell me what section it's in like SA 3?

9 DR. BLAKE: It was on Page 41 and  
10 the top of Page -- no, excuse me. The bottom  
11 of Page 40 and the top of Page 41. You  
12 reference the table SA Reliability Validity  
13 Testing.

14 And when I went to that table, this  
15 was your table that has different peer groups,  
16 pulmonology, pediatrics, family practice and  
17 internal medicine with the nine health care  
18 organizations.

19 MS. WILBON: Tom, this is Ashlie  
20 from NQF. So the committee is looking at the  
21 PDFs that are posted online. You have access  
22 to those, correct?

1 DR. LYNN: Well, I have access to  
2 what we used to build those.

3 MS. WILBON: Okay, yes. It  
4 probably would help to, just because they're  
5 referring to page numbers that are consistent  
6 with the documents we have posted online.

7 But if you refer to your attachment  
8 you have for SA, Item SA Reliability Validity  
9 that was attached to the document, they're  
10 looking at the results across peer groups tab.  
11 It's an Excel spreadsheet.

12 DR. LYNN: Yes, I've got it now,  
13 sorry.

14 MS. WILBON: Okay.

15 DR. LYNN: Results across peer  
16 groups.

17 MS. WILBON: Comma utils.

18 DR. LYNN: Right, comma  
19 utilization, okay. And then we have, so  
20 specifically we were looking at peer,  
21 pediatric peer definitions and we were looking  
22 at, because these aren't, is what I'm looking

1 at is different severity so you'd expect there  
2 to be differences.

3 DR. BLAKE: I'm sorry, I couldn't  
4 hear that.

5 MR. ALZOLA: I think you're looking  
6 at the next aisle on the spreadsheet which is  
7 --

8 DR. LYNN: Yes, it's reliability --

9 MR. ALZOLA: -- results across peer  
10 groups. And I think we're talking about the  
11 reliability across HCOs.

12 DR. LYNN: Right. Yes, so the  
13 episode quantity, so the two-fold difference  
14 if we're looking at pediatric peer definition.

15 DR. BLAKE: Right. Like cost per  
16 episode for instance.

17 DR. LYNN: Yes, from a low is like  
18 709 to a high of 1,057?

19 DR. BLAKE: That, yes, that and  
20 there's another one under the family practice  
21 group, a low of 70 and a high of, what was the  
22 high? A high of 153, for instance.

1 I mean is that what you're, is that  
2 consistent? Is that what you're saying is  
3 consistent?

4 DR. LYNN: Yes, that's what we're  
5 saying is consistent. There are no other  
6 differences here around, you know, there's  
7 differences around what the geographies --  
8 that so we're arguing that that's consistent.

9 DR. BLAKE: Say that last thing  
10 again. I couldn't hear it. Your voice  
11 dropped off.

12 DR. LYNN: Oh, I'm really sorry. Is  
13 that better?

14 DR. BLAKE: Yes.

15 DR. LYNN: Oh, we're arguing that's  
16 consistent because there are, you know,  
17 differences in what geographies these health  
18 plans are pulling from and other things like  
19 that that could make these different, so we  
20 felt like that was pretty consistent. I mean  
21 family medicine goes from 854 to 1,074, 1,090?

22 DR. BLAKE: Yes.



1 DR. LYNN: I mean, you know, these  
2 are completely different populations except  
3 that they're all commercial so we didn't do  
4 any statistical measure to say that that was -  
5 -

6 DR. BLAKE: I mean it might have  
7 helped if you had said consistency in  
8 everything is within all the NCOs, or health  
9 care organizations are within 30 percent of  
10 each other or something like that just to give  
11 us some sense of what you were describing as  
12 consistency.

13 And on this same one, how come for  
14 the pulmonology group you don't provide the  
15 data across the nine different health care  
16 organizations? You have it for the  
17 pediatrics, the family medicine and the  
18 internal medicine. But why wasn't it there  
19 for the pulmonology groups?

20 DR. LYNN: I think sometimes we  
21 have challenges in our data figuring out what  
22 the provider specialty is and it's easier in

1 the primary care.

2 DR. BLAKE: Okay. All right, well,  
3 thank you.

4 CO-CHAIR ELWARD: This is Kurt.  
5 I'm just wondering if I, while Kathryn's  
6 getting prepared for her next comment, under  
7 let's say the family practice peer definition,  
8 this second version where we have, start with  
9 episode quantities, specialist visits per  
10 thousand.

11 Why do those end up being like a  
12 thousand, like 16 or 28 specialist visits per  
13 thousand? Is that, seems like that might be  
14 a little bit, that's a lot of specialty  
15 visits. Do you know how that's, it just seems  
16 like that's a lot of, pretty high rate.

17 I'm sorry. I'm on the tab,  
18 reliability across HCOs.

19 DR. LYNN: Yes, I got it.

20 CO-CHAIR ELWARD: And then the one  
21 that's, just two peer definitions per group.  
22 There's family practice peer definition and

1 then the table just below that which is the  
2 same thing. It says episode quantities,  
3 specialist visits per thousand.

4 Is that -- you calculate just how  
5 many visits that are coded as specialist  
6 visits per thousand episodes that are --  
7 pardon?

8 DR. LYNN: Per thousand episodes.  
9 That's correct.

10 CO-CHAIR ELWARD: Okay.

11 DR. LYNN: It does seem a little  
12 high.

13 CO-CHAIR ELWARD: I guess, Michael?

14 DR. SCHATZ: I'm getting confused  
15 now. The issue of reliability of course sort  
16 of implies that you've got, you're doing the  
17 same. If you had, if it should be the same it  
18 is the same.

19 But when you're comparing across  
20 groups there's all, I mean if it were the same  
21 we wouldn't be doing it. So I guess I'd go  
22 back to Carlos.

1                   The analyses that really reflect  
2                   reliability, do they reflect reliability and  
3                   the things that don't appear to be repeatable,  
4                   should they vary? I guess I now don't know  
5                   how to interpret these data when it comes to  
6                   reliability.

7                   MR. ALZOLA: Okay. When I look at  
8                   reliability, at first I look at that as the  
9                   ability to replicate the resource. So and  
10                  there are a couple ways of looking at that.

11                  One thing they did was to do the  
12                  two software, the independent software  
13                  development approach, so that's a way to  
14                  validate their software. So if you, it's  
15                  very, it's common to use from the surgical  
16                  industry.

17                  You have two independent  
18                  programmers do the same process and they would  
19                  all of arriving at the same results. So if  
20                  they start from the same data, and using two  
21                  independent software approaches you arrive at  
22                  the same results, then you can say that the

1 results are reproduced.

2 On the other hand, when I look at  
3 these tables I look at them more from the  
4 point of view of validity. And honestly they  
5 talk about reliability across HCOs, I didn't  
6 see much use for it in terms of what we're  
7 trying to assess here.

8 Yes, there are going to be  
9 differences across HCOs, especially since we  
10 are not using standardized prices. Whether  
11 the differences are too big or too low, I  
12 really can't say.

13 DR. BLAKE: That's a good point.  
14 I think it was difficult. I wasn't sure if  
15 they were or were not using standardized  
16 pricing, and I think that would've made a more  
17 clear, you know, whether or not we were  
18 looking at changes across the, or differences  
19 across the HCOs, which would've been relevant  
20 if pricing were standardized.

21 Or like Mike, like you were saying,  
22 if from their 25 million population, they had

1 taken a subset of seven million and run the  
2 testing, and another seven million and run the  
3 testing, and another seven million and run the  
4 testing, and then if you got consistency among  
5 those three groups of seven million, then you  
6 would say that there was reliability there.

7 And that's how I would come from it  
8 from, you know, my background. And that's why  
9 I'm having a harder time I think,  
10 understanding it from this perspective.

11 CO-CHAIR MAURER: That would still  
12 be pieces of the same, that population  
13 would've been gathered in the same way so that  
14 would be okay. But it would be even better,  
15 wouldn't it, Carlos, to have a different  
16 population that comes from a different source  
17 to run it against?

18 DR. ALZOLA: It would be about the  
19 same as comparing two different HCOs. There  
20 will be differences then. Why? Why is  
21 because they are different, and how different  
22 they should be, I really can't say.

1 CO-CHAIR MAURER: Well, comparing  
2 them in two different populations is one of  
3 the things that's mentioned in the measures  
4 that are sent, you know, as part of that, as  
5 part of measuring reliability. So is that not  
6 so important then?

7 DR. STANFORD: But these are such  
8 a vast number of populations.

9 CO-CHAIR MAURER: Yes, I know.

10 DR. STANFORD: That even minor  
11 differences really go away. I don't see much  
12 of a statistical issue with this.

13 This is, you're talking seven  
14 million people. People predict elections of,  
15 you know, a country that 140 million people  
16 vote by a thousand people, this is a very  
17 robust statistical system. I think we are  
18 nickel-and-diming this.

19 MR. AMIN: Can I just add one piece  
20 of guidance here? In the reliability  
21 criteria, it asks whether it produces the same  
22 results a high proportion of the time when

1 assessed in the same population, in the same  
2 time period.

3 So this threshold of split sample  
4 validation would be sufficient, as Carlos is  
5 describing. So it doesn't necessarily have to  
6 be, while that's clearly a more robust method  
7 to evaluate across different populations, it  
8 doesn't, a split sample validation approach is  
9 sufficient.

10 MR. BRATZLER: But you're confusing  
11 the term validation, or you just used the word  
12 validation. So I completely agree with you on  
13 reliability.

14 MR. AMIN: Right.

15 MR. BRATZLER: They demonstrated a  
16 great reliability. I have the bigger problem  
17 with validity because it's been tested in  
18 their dataset, and that's where I struggle a  
19 bit with the, you know, that with these  
20 measures that haven't been tested across  
21 different sources of data for checking  
22 validity.



1 MR. AMIN: That's fair.

2 MR. BRATZLER: But reliability, I  
3 completely agree with you. They meet the  
4 definition.

5 DR. BLAKE: Okay, and then their  
6 finding statement I thought was appropriate  
7 and fine, so that's the end for 2a1. Is 2b2  
8 next? Let's see.

9 CO-CHAIR ELWARD: 2a?

10 DR. BLAKE: 2b1, okay.

11 DR. SCHATZ: And you'll get my  
12 interpretation of 2b1. My concerns would be  
13 that number one, the asthma costs are not  
14 transparent. There is some determination as  
15 to what's an asthma cost and what's not an  
16 asthma cost, and that's not transparent. So  
17 I interpret that as being a validity issue.

18 And I personally think that since  
19 pharmacy costs are greater than 50 percent, to  
20 have any information presented when pharmacy  
21 costs aren't available is not valid.

22 So I really am concerned that, you

1 know, that any results are going to be  
2 presented, when greater than 50 percent of the  
3 costs are not represented. So those to me are  
4 two validity issues as I interpret 2b1.

5 CO-CHAIR ELWARD: Although one  
6 thing, if they make it clear, I mean on the,  
7 you know, to Ingenix's credit, if the data  
8 aren't there they aren't there, but they can  
9 at least say hey, it's not, and they can say  
10 it is.

11 DR. SCHATZ: Well, and people can  
12 look at it differently. I just think that  
13 when what isn't there is greater than 50, is  
14 likely to be greater than 50 percent, to see  
15 the less, I mean to see the other end, I guess  
16 what I'm saying, I'd rather have it not there  
17 than even try to interpret information that  
18 doesn't have the majority of the cost.

19 Again with the concept that is this  
20 measuring what you're trying to do, the cost  
21 of asthma care, and you've got a component  
22 that doesn't include more than 50 percent

1 that, I mean again we don't have to argue  
2 about that. That's a concern --

3 DR. LYNN: No, right.

4 DR. SCHATZ: -- and I mean, no  
5 question, I'd rather have it stratified that  
6 way than not know, but I just question whether  
7 that's useful information when that's such a  
8 high proportion of the cost of asthma.

9 DR. LYNN: Right, and I just want  
10 to point out that, note that I think, you  
11 know, I think that's a good point. I'm not  
12 going to argue with that point.

13 But just to say that that would be  
14 a pretty easy change to the methodology that,  
15 you know, we'd rather that you guys -- well,  
16 we can say that you look at the pharmacy  
17 information to do this instead of trying to do  
18 that.

19 CO-CHAIR ELWARD: I'm just  
20 wondering how, well, NCQA has the same problem  
21 though, right, if they don't have access to  
22 pharmacy data.

1                   They just don't look at it.

2                   (Off microphone comments.)

3                   CO-CHAIR ELWARD: I'm just  
4 wondering if they can yes or no though.

5                   (Off microphone comments.)

6                   CO-CHAIR ELWARD: Pardon, go ahead.

7                   MS. TURBYVILLE: So that's right,  
8 a measure can, in its specifications, state  
9 you must have this medical benefit, you should  
10 be in the minimum, and you'll see others that  
11 say you must have pharmacy to report it, so  
12 that's right.

13                   And what Ingenix has done is they  
14 say if you have pharmacy data, you know,  
15 that's I'm guessing ideal. If you don't,  
16 they're giving you an alternative. They just  
17 say don't combine them.

18                   But I think, Tom, you broke up a  
19 little bit on what you were responding to the  
20 committee that Ingenix would or would not, I  
21 didn't hear what you said in response to the  
22 pharmacy benefit being a requirement or not?

1 DR. LYNN: Can you hear me better  
2 now. I'm really sorry I've been having  
3 trouble with the, is that better? I just took  
4 my headphones off.

5 MS. TURBYVILLE: For now it is, so  
6 we'll let you know if it breaks up again.

7 DR. LYNN: Yes, so what I'm saying  
8 is, you know, we could certainly entertain,  
9 more than entertain, you know, that if we felt  
10 like this should only be done with folks that  
11 have pharmacy information, you know, we could  
12 make that change.

13 CO-CHAIR ELWARD: Okay, so you  
14 could do that then?

15 DR. LYNN: Yes, that would be  
16 pretty straightforward.

17 MS. ZIELINSKI: Well, this is Cheri  
18 with Ingenix. I think it's also important to  
19 know that pharmacy is not a requirement --

20 DR. STANFORD: She just said that  
21 pharmacy is not a requirement to get into the  
22 episode of asthma care.

1 DR. SCHATZ: To get into the  
2 episode, right.

3 DR. STANFORD: Correct. I guess  
4 that has to be.

5 DR. SCHATZ: Right, right. I mean  
6 that, I'm glad of that. Again, my concern is  
7 still there.

8 CO-CHAIR ELWARD: Let's go to 2b2,  
9 the validity testing.

10 DR. BLAKE: In terms of 2b2, some  
11 of my comments were the same as under the  
12 reliability, so I won't repeat those.

13 But I thought that the face  
14 validity was appropriate under the analytic  
15 method. And my comments under the testing  
16 results and the finding statement are similar.

17 CO-CHAIR ELWARD: Carlos, can you  
18 mention something about validity? In your  
19 comments you raised some concerns.

20 MR. ALZOLA: No, not really. I  
21 think that the only concern I may have raised  
22 is whether the database would be sensitive of

1 the over 65 population.

2 But the measure is, even though it  
3 includes people, I mean it's designed to work  
4 with people over 65 and is not being  
5 considered for that group. So that was my  
6 only concern.

7 CO-CHAIR ELWARD: But you had  
8 mentioned the data integrity checking wasn't  
9 found?

10 MR. ALZOLA: It was not found, but  
11 this is a very large database vendor so they  
12 really, and I'd be shocked if they didn't do  
13 any, a very thorough checking of their data.

14 DR. STANFORD: This is the impact  
15 data?

16 MR. ALZOLA: Don't know.

17 DR. STANFORD: Is it the impact  
18 data?

19 DR. LYNN: Yes. It's the --

20 MR. ALZOLA: Impact, yes, I know.

21 DR. LYNN: Yes, the impact dataset.  
22 It's actually, that's what it is. I don't

1 know why somebody knows the impact database.

2 DR. STANFORD: Because I use impact  
3 a lot.

4 DR. LYNN: Okay.

5 DR. STANFORD: The thing about the  
6 impact data which is to issue around costing,  
7 is that all of the costing data is pretty  
8 standardized across multiple health plans.

9 So if you're going to do a  
10 validation test this is what you do it in  
11 because you don't have issues around paid  
12 amount versus charged amount versus no amount.  
13 So it's appropriate into your point, a lot of  
14 that's already been done ahead of time to make  
15 sure that it does meet those standards.

16 CO-CHAIR ELWARD: So it should have  
17 a very high level of data integrity?

18 DR. STANFORD: Yes.

19 CO-CHAIR ELWARD: Okay, perfect.  
20 Thanks.

21 MR. ALZOLA: And just being, go  
22 where what I seen in the submission that that



1 was the only pondering. I had to complete  
2 that section and I didn't see it, but I really  
3 didn't have any reason to suspect it.

4 CO-CHAIR ELWARD: All right. So  
5 that should be a strong point then. Okay,  
6 thank you.

7 Then exclusions, Michael?

8 DR. BLAKE: Me? Is that me?

9 DR. SCHATZ: I think it might be  
10 me.

11 DR. BLAKE: Oh no, sorry.

12 CO-CHAIR ELWARD: 2b3.

13 DR. SCHATZ: Well again, Carlos,  
14 maybe I'll defer to you because you did seem  
15 to have concerns about the exclusions. That  
16 there wasn't sensitivity analysis, reasons  
17 aren't really addressed.

18 Again, just I'm not sure this fits  
19 into exclusions, but I am again concerned as  
20 to there are obviously certain costs excluded,  
21 but it's not transparent what they are  
22 relative to what are considered by the group

1 are non-asthma costs.

2 MR. ALZOLA: I have the benefit of  
3 having reviewed many of their measures so they  
4 know how they work. So a lot of the things  
5 that I list in here is because they do not  
6 show in the submission.

7 But I have learned through other  
8 reviews of how they choose their outliers.  
9 Why do they exclude the low outliers and how  
10 they define the high outliers.

11 And I think and, Tom, you can  
12 correct me if I'm wrong, is that the reason  
13 they exclude the low outliers is because they  
14 tend to be incomplete episodes. So it's not,  
15 all the data is not there and the cost would  
16 be artificially low.

17 And as for the high outlier, they  
18 Winsorize so they just exclude like the top  
19 two percent or something.

20 Again, that's not explicitly  
21 mentioned, but I think that's how they've done  
22 it in other measures and I'm guessing that's

1 how they did it here.

2 DR. LYNN: Yes, it's done the same  
3 way, where we do exclude the costs if it's the  
4 fifth percentile. We exclude all episodes  
5 that are below that cost. That our thinking  
6 is that many of those are incomplete for some  
7 reason, or mistakes, or rule out diagnoses,  
8 things like that.

9 And then we cap the high ones  
10 because they're real, they really happened.  
11 We just don't want to necessarily, you know,  
12 include all of those dollars in the cost of  
13 that episode. So that's why we do what we do.

14 DR. SANTO TOMAS: And then maybe  
15 just to clarify or follow-up on awhile ago, we  
16 mentioned those people who have both the  
17 diagnoses of asthma and COPD. So I take it  
18 then the reverse of what you said a while ago,  
19 then if somebody has both diagnosis, if  
20 somebody has more COPD, then do you exclude  
21 those patients then?

22 DR. LYNN: So what we do is we

1 would, right, we would include those cases.

2 DR. SANTO TOMAS: So you would  
3 exclude actually those?

4 DR. LYNN: We would exclude them  
5 from the asthma role, they'd be included in  
6 the COPD role. But yes, we exclude them from  
7 this role.

8 CO-CHAIR MAURER: In the previous  
9 measures we were looking at before lunch, very  
10 high costs, people like cancer patients and  
11 transplants and so on were excluded.

12 Does it turn out that when you  
13 Winsorize the top two percent, you're  
14 effectively excluding those kind of patients,  
15 or how does that work?

16 Because you certainly could have  
17 dual diagnoses of say lymphoma and asthma, and  
18 asthma could be the first diagnosis on the  
19 claim in some cases.

20 DR. LYNN: Yes, so I think that,  
21 you know, that the rules that you were looking  
22 at before, I wasn't in this morning but I know

1 that there are an overall, in the past they've  
2 been in overall patient cost. Whereas, we're  
3 trying to divide out the costs directly  
4 associated with asthma.

5 So, you know, that's less of an  
6 issue because you're right, I mean if  
7 sometimes the episode, if sometimes the claim  
8 has the asthma first and lymphoma second, it  
9 may end up in asthma. But only under narrow  
10 circumstances where the claim could be for  
11 either one of those things.

12 In other words, even if the first  
13 code on a claim for say a bone marrow, well,  
14 not for lymphoma but some sort of, you know,  
15 some sort of lymph node procedure, even if the  
16 first code's asthma and the second code's  
17 lymphoma it's still going to group with  
18 lymphoma. But there are cases where that  
19 could happen.

20 But it's basically, you know,  
21 trying to not include in the denominator  
22 things that, of the cases that may have been

1 extremely complicated or extremely costly.

2 And you can include them but you  
3 only include them at the dollar amount, at the  
4 threshold, the 95th percentile threshold. And  
5 there's many reasons why, you know, something  
6 may be very high cost.

7 CO-CHAIR ELWARD: Other questions?  
8 Let's go to 2b3, the exclusions.

9 DR. BLAKE: That's mine, 2b3, no.

10 CO-CHAIR ELWARD: I'm sorry, yes.

11 But 2b --

12 DR. BLAKE: 2b4?

13 CO-CHAIR ELWARD: Sorry, so any  
14 other thoughts on 2b3? I'm sorry. All  
15 right, 2b4?

16 DR. BLAKE: This was the risk  
17 adjustment information. So this is a question  
18 for you, Tom. When you determined your  
19 severity levels, this is based not on what I  
20 guess we as clinicians call different  
21 severities of asthma, but this is based upon  
22 the comorbidities that were assigned to an

1       asthma episode?

2                   DR. LYNN:   Right.   So we take  
3       those, we have coefficients for each of the  
4       markers whether they're condition status which  
5       are inside the episode, or comorbidities which  
6       are outside the episode.

7                   Can everybody hear me okay?

8                   MS. WILBON:   Yes, we can hear you.

9                   DR. LYNN:   Okay.   And we build a  
10       score which is a real number for how much, you  
11       know, based on the clinical markers with the  
12       expected resource utilization for that episode  
13       of asthma, compare it to the average cost of  
14       all episodes of asthma.

15                   And then what we do to actually  
16       pick the level is we take a distribution of  
17       that real number and we look at places where  
18       the number is relatively, the severity score  
19       is relatively flat for a period of time and  
20       then they jump up in certain cases.

21                   And that's how we choose where we  
22       have our different severity levels, trying to

1 maximize the homogeneity of the bucket that's  
2 created by that threshold.

3 We also want to choose, create  
4 buckets that have a number of cases of, you  
5 know, a high enough percentage of cases that  
6 our users won't have trouble creating expected  
7 values for those buckets.

8 So those are the two criteria we  
9 use when we create the severity level from the  
10 severity score.

11 DR. BLAKE: Okay. All right, thank  
12 you. So that answers the question. I feel  
13 like that was appropriate.

14 And the same goes for the  
15 stratification method, with what he just  
16 described that appeared to be appropriate as  
17 well.

18 DR. BAULDOFF: I have a quick  
19 question. I had some concerns about the risk  
20 adjustment just because I didn't see the  
21 specific detail related to the asthma that we  
22 had discussed earlier.



1 I guess my, or just for  
2 clarification, if because they were able to do  
3 it for diabetes and that it can be done for  
4 asthma, do we base our vote by what we've seen  
5 here? Or do we base our vote on what we know  
6 that they're able to fill in for us?

7 MS. WILBON: We'll be asking you to  
8 base your vote today on what you have in front  
9 of you. We'll get the additional, and we'll  
10 be documenting your rationale for those  
11 ratings.

12 That, your ratings along with your  
13 rationale for that, will be passed on, and any  
14 additional information that they give us  
15 between now and the Steering Committee  
16 meeting, that will go to the Steering  
17 Committee. But that's kind of in an effort to  
18 kind of keep the process moving.

19 But obviously, the object of using  
20 you guys is to identify issues like that so  
21 that the Steering Committee can evaluate them.  
22 So we'll just be asking you to evaluate what

1 you have and then we'll move that forward.

2 CO-CHAIR ELWARD: Yes. Tom,  
3 there's an item on 17 of your ETG construction  
4 logic, Asthma 2, the Microsoft Word version.

5 I think my impression in looking at  
6 that is that you already have done analyses of  
7 how comorbidities affect this and the risk  
8 adjustment. Is that correct?

9 DR. LYNN: Yes. So that's part of  
10 creating the models, right, is looking at how  
11 the comorbidities affect the cost of the  
12 episode.

13 CO-CHAIR ELWARD: Okay. Can you  
14 describe for us how you've done that risk  
15 adjustment, how you've tested that? Seems to  
16 be some, you know, uncertainty about how  
17 refined that is.

18 DR. LYNN: Right. So what we can  
19 do to look at how refined it is, is to provide  
20 the R-squared for the different severity  
21 levels, and how that predicts resource  
22 utilization.

1                   And that's something we have not  
2                   done but can provide to you. It's something  
3                   that we did for diabetes because when it was  
4                   evaluated they asked for us to do that.

5                   CO-CHAIR ELWARD: Okay. Michael?

6                   DR. SCHATZ: Well again, as I read,  
7                   Carlos, your report, it looks like a lot of  
8                   the information you would've liked to have  
9                   seen wasn't there. So based on what is here,  
10                  do you think we have enough information to  
11                  answer that question?

12                  MR. ALZOLA: Personally, I need to  
13                  see that information about R-squares and  
14                  calibration to answer.

15                  DR. BLAKE: At this point you would  
16                  consider it insufficient to be able to make an  
17                  assessment?

18                  MR. ALZOLA: Yes.

19                  CO-CHAIR ELWARD: And number 5?

20                  DR. BLAKE: 2b5?

21                  CO-CHAIR ELWARD: Yes.

22                  DR. BLAKE: This is type of score

1 and the four types for a continuous variable  
2 count, rate or proportions, and ratio.

3 And I could not find this S12  
4 Sample Score Report to see exactly what they  
5 were doing. I don't know if you all are able  
6 to pull it up.

7 So while you're doing that, my  
8 interpretation though that they, of the  
9 description of what they provided seemed  
10 appropriate in terms of the interpretation.

11 And then in the detail score  
12 estimation, they again provided observed  
13 versus expected ratios, which was appropriate.

14 But they did have in there, they  
15 referenced Section S9.5, which doesn't seem to  
16 have anything to do with continuous cost  
17 measures. It had to do with complementary  
18 services. So I think that was just a wrong  
19 reference to a section in there.

20 Is that what you thought? Were you  
21 able to pull up that?

22 MS. DORIAN: Do you know what page

1 that's on, Kathryn?

2 DR. BLAKE: That's the S12 Sample  
3 Score Report? Okay. So those are ratios?  
4 Number of -- well, quite honestly I'm not sure  
5 how that report helps understand anything.

6 I mean they said, the types of  
7 scores are continuous, variable, count, rates  
8 and proportions, and ratios. Is that what  
9 that is there?

10 MS. WILBON: So my interpretation  
11 is, in the form that we give them to fill out  
12 online we instruct them to select the  
13 different types of scores they report out  
14 using so, and various parts of the report they  
15 probably utilized those different types of  
16 scores.

17 DR. BLAKE: Okay.

18 MS. WILBON: It might help perhaps  
19 if Tom could kind of walk through a sample  
20 report and explain how the scores are used and  
21 what information that provides by the  
22 different types of scores, which was the

1 purpose of that section.

2 DR. BLAKE: Okay.

3 CO-CHAIR ELWARD: Yes, Tom, can you  
4 go through if you have a S12 sample score?  
5 There aren't any asthma measures on that, but  
6 again, as Ashlie mentioned, maybe you could  
7 walk us through how this would work.

8 DR. LYNN: Right. So what,  
9 basically what is done, I mean the main  
10 measurement is the O/E ratio.

11 And what the process, it's an O/E  
12 ratio metric, is to look at the different  
13 buckets of the asthma based on the severity  
14 score, and whether or not they had a pharmacy  
15 benefit or not.

16 And then assign a cost to those,  
17 an expected cost to those buckets, which is  
18 the average of all of the episodes across the  
19 peer group based pediatrician. And that gives  
20 you the expected value for each of a  
21 physician's episodes.

22 So the numerator of the O/E ratio

1 is the cost of all the episodes of asthma.  
2 The denominator of that ratio is the expected  
3 costs for each one of those episodes come  
4 together that we calculated across the peer  
5 group for each of those severity buckets. And  
6 that's how you get the observe to expected  
7 ratio.

8 And then there's a technique that's  
9 referenced in lots of RAND work, some on these  
10 sorts of measurements that creates a standard  
11 error for around that O/E ratio, and we use  
12 that methodology to create a confidence  
13 interval around that measurement.

14 DR. BLAKE: Thank you, that makes  
15 it clear.

16 CO-CHAIR ELWARD: And then 2b6?

17 DR. SCHATZ: Well, that's easy  
18 because they aren't.

19 CO-CHAIR ELWARD: And 2c.

20 DR. SCHATZ: And again, well, I  
21 mean I think if data were available I do think  
22 it'd be there.

1 CO-CHAIR ELWARD: Okay. Let's go  
2 to use, do you want to go to that? Well, just  
3 --

4 DR. STANFORD: Well, can I ask, I'm  
5 sorry. And I know about if the data were  
6 available it would be there.

7 And maybe it goes back to what  
8 Carlos was talking about not having the data.  
9 And if you're generating these episode groups,  
10 how would that factor into your, how would  
11 these disparity measures factor into that  
12 episode group? Or is that just an outside  
13 variable that patients are stratified by that  
14 outside variable as opposed to the episode  
15 treatment group, right? Is that what --

16 DR. SCHATZ: Yes, well, I mean  
17 you're right. I mean that's a good question.  
18 If the information were there, one could  
19 theoretically use it the way people would  
20 want. But I guess that's a good question to  
21 ask.

22 Are there any of the measures you



1 use that, Tom, that you adjust for gender,  
2 race, ethnicity, socioeconomic, something?  
3 How would that figure in, especially where if  
4 you had information on socioeconomic status or  
5 race/ethnicity, for example, how would that be  
6 figured in such a measure?

7 CO-CHAIR ELWARD: And Tom, we also  
8 realize that that's hard to get.

9 DR. LYNN: No, no, right, right.  
10 So we do have, we do that for of course gender  
11 and age because we have that. We don't do it  
12 for these other markers that, you know, we all  
13 think would be very interesting, including me.

14 You know, I think what you would do  
15 is, potentially it would be another marker in  
16 the model, right. So the race would be a  
17 marker in the model, or the socioeconomic  
18 status would be a marker in the table, and you  
19 could see how that affected the cost.

20 You know, one of the potential  
21 concerns is that just some of these markers  
22 have a, for example, I've seen some evidence

1 that, you know, a socioeconomic marker that  
2 marks someone as low income is sometimes,  
3 those folks are actually less expensive,  
4 because they live in places where they don't  
5 have access to care and it may be harder for  
6 them to go to the doctor and those sorts of  
7 things, when they're in the commercial  
8 population particularly.

9 So, you know, I think you'd have to  
10 look at, you don't want to create a  
11 methodology that says that you should spend  
12 less money taking care of folks without, with  
13 fewer resources.

14 So although I think we would all  
15 like to have those markers and we'd all like  
16 to use them, I think you'd have to be a little  
17 careful with them.

18 DR. SCHATZ: But I guess I'd make  
19 the point that when you've got potentially ten  
20 different results, I'm thinking four severity  
21 levels, a composite with and without pharmacy  
22 data, you'd almost have to use it in the model

1 as opposed to stratification by those factors.

2 And I would submit that maybe  
3 stratification would be more useful. So I  
4 think it's a bit of a disadvantage to have so  
5 many outputs. It sort of precludes  
6 stratification for this situation, which I  
7 think might be better. Anyway, it's just an  
8 observation.

9 DR. STANFORD: It does say  
10 stratification and not including it in a risk  
11 adjusted model.

12 MS. WILBON: Right. And I'll just  
13 clarify as well that the criteria for this  
14 does indicate that if there is a valid  
15 rationale for why it's not addressed in the  
16 measure that that is sufficient. Why it's not  
17 feasible is part of the criteria. So again,  
18 just kind of context for why you're voting.

19 CO-CHAIR ELWARD: Any other items  
20 before we vote on -- my own, I was just  
21 talking with Ashlie.

22 It seems like there are a number

1 of, you know, the ETG methodology is action in  
2 many ways very exciting because it has, you  
3 know, the potential to get past just overall  
4 utilization.

5 And so you just dump everything  
6 into the box and see what people cost, as  
7 opposed to, you know, looking at a specific  
8 episode of care. At the same time there are  
9 a lot of questions about how you can do it  
10 right.

11 So my understanding is we can  
12 submit what we, we should vote on these today  
13 and, you know, with what we have.

14 But there would be an opportunity  
15 for us to feed specific questions back to  
16 Ingenix and say, can we receive these answers  
17 again in clarification, the R-squared values,  
18 things like that, so we could reassess that at  
19 some point?

20 MS. WILBON: So I would just say,  
21 particularly since this discussion, there's  
22 been a lot of I think just trying to

1 understand the underlying methodology for  
2 this.

3 As we go through each of the  
4 subcriteria, staff can try to summarize kind  
5 of what we've got.

6 And I think it's going to be really  
7 important for us to make sure that we've  
8 actually captured your sentiment about each of  
9 those, and make sure that we've captured any  
10 follow-up items for that particular criteria.

11 So if, co-chairs, it'd be great if  
12 you could kind of help summarize maybe what  
13 you heard. We can make sure that we've  
14 reflected that in our notes.

15 So that as we move forward, and I  
16 think a lot of this discussion, even though  
17 it's a little arduous for this measure, I  
18 think a lot of the things you'll find as we  
19 move forward to the other Ingenix measures,  
20 again just like NCQA, a lot of the stuff will  
21 carry forward and then we can pull out some of  
22 the condition specific stuff.

1                   So we appreciate the deep dive  
2                   because this is the stuff that we really need  
3                   to address and move forward.

4                   DR. SCHATZ: Well, then I think in  
5                   that regard I guess I'd make one other point.

6                   MS. WILBON: Sure.

7                   DR. SCHATZ: One of the things that  
8                   stratifies this is disease specific, and that  
9                   seems to be heavily related to exacerbations.

10                  And what concerns me a little bit  
11                  is, again if we're trying to look at overall  
12                  management practices that are positive, people  
13                  end up with exacerbations can be thought of as  
14                  a failure.

15                  And yet by adjusting for the  
16                  exacerbations you're sort of eliminating that.  
17                  Now I know you can look and see what  
18                  proportion of patients fit into various  
19                  things.

20                  But I mean I agree with you, Kurt,  
21                  that it is nice to try to dive down and get at  
22                  different segments, but again I would just add

1 to the mix here, this concern that the disease  
2 specific exacerbation issue may hide some poor  
3 care issues, as a concern.

4 CO-CHAIR ELWARD: And Tom, am I  
5 understanding this correctly that what would  
6 also trigger an episode of care would be like  
7 a planned visit for asthma? Like if I decide  
8 to have one of my asthma patients in and treat  
9 them but code it as asthma, that would start  
10 an episode of care, is that correct also?

11 DR. LYNN: That's correct.

12 CO-CHAIR ELWARD: All right.

13 DR. SCHATZ: Yes, unless it's, I  
14 mean starting an episode that's good. I'm  
15 concerned about the severity stratification.

16 CO-CHAIR ELWARD: Well, with that  
17 one, let's go --

18 DR. STANFORD: I'm sorry.

19 CO-CHAIR ELWARD: Yes.

20 DR. STANFORD: Can I ask one  
21 question before I answer this question?

22 CO-CHAIR ELWARD: Okay.

1 DR. STANFORD: Because it's going  
2 to help me answer this question.

3 CO-CHAIR ELWARD: Yes, please.

4 DR. STANFORD: So this, Tom keeps  
5 talking about the logic of the program and how  
6 it's going to relate to getting a patient into  
7 a particular episode group.

8 From a plan level perspective, and  
9 this comes out with the issue about  
10 implementation consistently, how does a plan  
11 implement this particular program in their  
12 database? I mean is it, that's my question to  
13 Tom, I guess.

14 CO-CHAIR ELWARD: Yes, Tom, do you  
15 understand the question?

16 DR. LYNN: I think so. I mean, you  
17 know, we have a lot of different customers who  
18 are doing, were using this methodology and  
19 they may use them for, you know, we have  
20 employers that use them for measuring their  
21 employees.

22 And we have, you know, they're done



1 for certain sort of financial analysis. But  
2 they're also used for measurement and they  
3 have been used for pay-for-performance  
4 programs along with quality metrics. They  
5 have been used for public reporting of scores.

6 Now having said that, we don't  
7 necessarily use asthma alone in that  
8 particular case. We may use asthma along with  
9 other episodes that are treated probably by a  
10 different speciality which helps define a peer  
11 group. So those are the ways that some of our  
12 customers use this methodology.

13 CO-CHAIR MAURER: I can see how  
14 plans would use this. I mean if they have a  
15 group, if they can look across a set of  
16 pediatricians and look at their different  
17 costs of care, they can use that for pay-for-  
18 performance.

19 It means one thing about this  
20 methodology unlike NCQA, is it attributes to  
21 an individual provider, to a practice, to a  
22 much more granular level that can be rolled up

1 to, you know, plan level actually.

2 DR. STANFORD: And what I'm really  
3 looking at is the, what is the programming  
4 burden on a health plan? For instance, if I'm  
5 a small health plan with very limited  
6 resources in even being able to do this type  
7 of programming, will I be able to do it? As  
8 opposed to, you know, if I'm United Healthcare  
9 or Aetna, easily I can find somebody to do it.

10 That's what I'm talking, that's  
11 what my question really is around. How simple  
12 is it for somebody to implement?

13 DR. MOSENFAR: I guess I can think  
14 of that, they're such a massive silo data with  
15 a bunch of little silos.

16 So if they have your company that  
17 your particular interest in the silo sub A,  
18 you could go to them and say that, you know,  
19 what is your database for silos subtype A, and  
20 they can really extract it and give it to you.

21 Although, you're right though, your  
22 massive silo may not be applicable to your

1 company, but those subtypes will be  
2 applicable. So I think that's really the  
3 issue.

4 MS. WILBON: Tom, could you kind of  
5 expand on that a little bit for the committee,  
6 and this is actually kind of going to come in  
7 again in the usability and feasibility  
8 discussion.

9 I think it's a very important  
10 question. I wonder if we should maybe table  
11 it until we come back and then we'll queue Tom  
12 to kind of bring that back, if that's okay  
13 with everyone.

14 We can get through the scientific  
15 acceptability. Again, I think all this  
16 discussion is going to help us for other  
17 measures, and even though we're moving slow,  
18 it'll help us later.

19 DR. LYNN: Do you want me to talk  
20 about that when we talk about feasibility  
21 then?

22 MS. WILBON: Yes, I think that

1 would be better.

2 DR. LYNN: Okay. Great.

3 MS. WILBON: Thank you.

4 CO-CHAIR ELWARD: And more or less  
5 not to delay for the -- going back to what  
6 Michael had said earlier, whether you use  
7 charges and how you create the user inputs.  
8 I mean you mentioned, I'm trying to recall  
9 your point again, because I thought it was a  
10 really important one.

11 DR. SCHATZ: Well, I was concerned  
12 that different plans can do it differently.  
13 They can use what was actually paid or they  
14 can use standardized costs. And so I think  
15 comparing across plans, I mean I can see it  
16 within a plan, you know, Janet's point is  
17 good.

18 But across plans, where one plan  
19 uses standard costs and one plan uses payment,  
20 and now you want to compare. I think that's  
21 difficult.

22 CO-CHAIR MAURER: But isn't what

1       Ingenix does, just produce the groups, and  
2       then you who have purchased it from them do  
3       what you want to do with it? Isn't that, if  
4       you want to use standardized costs, you do  
5       that or whatever, no?

6                   CO-CHAIR ELWARD: Well, Tom, yes,  
7       can you answer that for us? I mean do you  
8       have a preferred way of doing it? Or how do  
9       you handle that because you can get a bunch of  
10      different versions of the same thing.

11                  DR. LYNN: Right. And that's of  
12      course what, you know, you guys are helping to  
13      start this ball. But, you know, we have  
14      clients, and if I say anything wrong Cheri  
15      will jump in if she's on the line.

16                  But we have clients that sort of  
17      use this product at different levels. So, you  
18      know, we have large clients that they just  
19      purchase the episode creation part and then  
20      they have their own proprietary methodology  
21      for, you know, creating the O/E ratio or doing  
22      some other measure of costs.

1                   And then we have smaller clients,  
2                   not always smaller clients but clients that  
3                   are maybe less technically sophisticated, that  
4                   would buy the product that not only has the  
5                   ETG in it, but also does these calculations to  
6                   create an O/E ratio and implement, you know,  
7                   most of that net level of methodology as well.

8                   So it depends on the client's IT  
9                   sophistication, and some are more  
10                  sophisticated and they build that second part  
11                  themselves.

12                  And they're less sophisticated  
13                  than, or they don't want spend the money I  
14                  should say on that second part, then they buy  
15                  a product that has that built in as well.

16                  MS. ZIELINSKI: Yes, I would just  
17                  add to that. This is Cheri. You know, we  
18                  have never really came out and said this is  
19                  the right way to attribute providers to  
20                  episodes. This is the right way to make peer  
21                  groups, because each, you know, each user,  
22                  each application of the product really calls

1 for different ways and different methods to do  
2 those kinds of post-grouping activities.

3 So that is why like, you know,  
4 sometimes a provider can get a report card  
5 using ETGs from Aetna, you know, and their  
6 methods are different than what CIGNA's report  
7 cards would be using ETGs as well.

8 So there are post-processing  
9 decisions. We give guidance. You know, we've  
10 told people how different options to do things  
11 and why they would pick one option over  
12 others. But there has not been any, you know,  
13 this is the way to do X.

14 DR. LYNN: And we have white papers  
15 on those subjects.

16 MS. ZIELINSKI: Correct.

17 CO-CHAIR ELWARD: Thank you. Why  
18 don't we go ahead and vote then, unless  
19 there's other questions. Go ahead, for  
20 reliability.

21 MS. FANTA: So I'll start out with  
22 2a, reliability. Is the measure precisely

1 specified so it can be implemented  
2 consistently? Okay, so two high, six moderate  
3 and one low.

4 MR. AMIN: I'm going to attempt to  
5 summarize a little bit of the discussion to  
6 make sure that we have it all captured.

7 It's not meant to be exhaustive,  
8 but if there are other inputs, please, because  
9 the conversation sort of went along multiple  
10 of the criteria at the same time.

11 So there was a bit of discussion  
12 around what the comparison of without pharmacy  
13 claims would mean, the interpretability of  
14 that would be complex to say the least.

15 The comparability between actual  
16 prices and standardized prices, more detailed  
17 on the R-squared which actually goes a little  
18 bit more in the risk adjustment but was  
19 discussed at this point too.

20 Where the cutoffs are determined  
21 for the severity levels, and I think that was  
22 the majority of what we had discussed.



1 CO-CHAIR ELWARD: And I guess one  
2 way of my looking at it is, is while the  
3 flexibility of their, you know, input and  
4 analysis is a strength for their clients, it  
5 may be a challenge in terms of creating a  
6 generalizable measure that could be used, that  
7 people would know is consistent across the  
8 plans.

9 MR. AMIN: Okay, thank you.

10 MS. FANTA: Okay, and moving onto  
11 2a2. Does the reliability testing demonstrate  
12 that the results are repeatable, producing the  
13 same results a high proportion of time when  
14 assessed in the same population, in the same  
15 time period and/or that the measure score is  
16 precise? Okay, and the results are three  
17 high, five moderate and one low.

18 MS. WILBON: And so for this one  
19 and I'll open it up to my colleagues to piggy  
20 back on anything that I have. Again, I'm  
21 going to try to attempt to summarize with some  
22 of my notes here.

1                   But that they use some split sample  
2 testing in terms of trying to determine  
3 reliability, but then later it was thought  
4 that maybe this method is more applicable to  
5 validity testing.

6                   They were missing a few details  
7 about how the testing population was  
8 identified and some of the characteristics of  
9 that population.

10                  But that repeatability was also  
11 demonstrated by the programming of the measure  
12 and the two different, not different databases  
13 but in the two different software between SAS  
14 and their Resource Use Measure software.

15                  There was some discussion in  
16 reference to the scientific acceptability,  
17 reliability and validity attachment and how  
18 consistency was determined.

19                  But ultimately with input from  
20 Carlos, that the TAP felt that there was  
21 reliability demonstrated based on what they  
22 have submitted at the threshold level of

1 repeatability and reproducibility.

2 DR. BLAKE: Ashlie, I think, yes.  
3 Early on I think you didn't have it quite  
4 right.

5 MS. WILBON: Okay.

6 DR. BLAKE: At least how I recalled  
7 it. When we talked about the split sample,  
8 that had to do more with reliability not  
9 validity.

10 MS. TURBYVILLE: Not to call anyone  
11 out, but given Carlos' input and the split  
12 sample demonstrating the repeatability, which  
13 is what this criteria focuses on, it doesn't  
14 touch into the validity part, if someone could  
15 speak to maybe why they were a low moderate or  
16 the low voter on this particular criteria, it  
17 would help us understand how to communicate  
18 that.

19 Yes, just so that the data are  
20 repeatable, producing the same results in the  
21 same population at the same time period.

22 DR. BLAKE: I mean I'll speak to

1 that because I brought it up. Is I didn't  
2 really understand why they had those three  
3 separate populations of different sampling  
4 sizes, and each use for a different  
5 measurement of types of repeatability or  
6 validity.

7 Because I would think that you  
8 would take a portion of the larger population  
9 and test it multiple times in order to look  
10 for reliability. So that's why I squirmed as  
11 a moderate.

12 MS. WILBON: Anyone else who is on  
13 that threshold want to add to Kathryn's?

14 CO-CHAIR ELWARD: I guess I was on  
15 the moderate range. It's just that I  
16 understand that the data may be there, I would  
17 just like to see them. And so I didn't feel  
18 comfortable giving a high measure until I  
19 actually saw that there was some, they could  
20 provide some of those data.

21 MS. WILBON: So better  
22 communication on the approach as well as more

1 presentation of the data?

2 CO-CHAIR ELWARD: Yes.

3 MS. WILBON: Yes.

4 DR. STANFORD: Yes, I was the low  
5 person. And that was why I graded it low, was  
6 the issue around just not being able to see  
7 the, I mean based on what we had discussions  
8 around the reliability, it's a pretty low  
9 hanging fruit to be able to get just, you  
10 know, repeating it one or two of multiple  
11 times.

12 So it's not something that they  
13 shouldn't be able to provide us in terms of  
14 detail information. So I'm sure I'll be  
15 rating them moderate or high. Just based on  
16 what I have in front of me, I can't go above  
17 that.

18 CO-CHAIR MAURER: I think that's  
19 going to be a --

20 DR. MOSENFAR: I mean all metrics.  
21 Sorry. I mean all metrics show that the data  
22 is very detailed, but it's just, it's not

1       there yet in terms of analysis and  
2       availability, so that's the point, sorry.

3                   CO-CHAIR MAURER:   And I think  
4       that's a problem that we're going to see as we  
5       go along here, is that we are asked to take a  
6       lot on faith.  You know, it may've been shown  
7       in diabetes, but diabetes isn't asthma, you  
8       know.

9                   MS. TURBYVILLE:  That's very  
10      helpful, thank you.

11                  MS. FANTA:   And now we will vote on  
12      overall reliability testing which encompasses  
13      precise specifications and reliability  
14      testing.  Okay, so we have eight moderate and  
15      one low.

16                  DR. SCHATZ:   Well, and again I  
17      think by the words here something has to be  
18      implemented consistently across organizations.  
19      And what are the values of being able to  
20      customize, it I believe, fatally interferes  
21      with consistently interpreting that across  
22      organizations.

1 MR. AMIN: And I would add, there  
2 was a little bit of discussion, I'm not sure  
3 that it totally fits in this category but it  
4 was a discussion around whether the database  
5 was representative of the over 65 age group,  
6 was another concern that we'd have.

7 CO-CHAIR ELWARD: Although I  
8 wouldn't expect it to be for asthma. Oh, I'm  
9 sorry, COPD.

10 I would say one of the things that  
11 would be encouraging is if Ingenix could  
12 provide us with, you know, a plan for how they  
13 would handle the balance of, you know,  
14 customization versus if this were to be a  
15 measure.

16 I mean people could potentially do  
17 anything they wanted with the database on  
18 their own, but for cross-plan compares that  
19 this is going to be a national measure, could  
20 there be some criteria that they would say,  
21 this is the way it should be reported if  
22 you're going to report it and expect it to be

1 compared nationally. So it's just a thought.

2 MS. FANTA: Okay, moving along to  
3 2b1. Are the measure specifications  
4 consistent with the focus of measurement and  
5 the measure intent? Okay, so we have two  
6 high, five moderate, one low and one  
7 insufficient.

8 CO-CHAIR ELWARD: Anyone want to  
9 comment on --

10 DR. BLAKE: I said insufficient  
11 based upon what we had talked about when  
12 Carlos gave his opinion, and I asked him if  
13 this would be insufficient.

14 DR. SCHATZ: And I continue to be  
15 concerned that if asthma costs are the focus,  
16 and not being able to be transparent in terms  
17 of what's an asthma cost as well as, you know,  
18 my belief that anything presented without  
19 pharmacy data for asthma is not meaningful.

20 CO-CHAIR ELWARD: Good point.

21 MS. FANTA: 2b2. Does the validity  
22 testing demonstrate that the measure data



1 elements are correct and/or the measure score  
2 correctly reflects the cost of care or  
3 resources provided, adequately distinguishing  
4 a high and lower cost or resource use? One  
5 high, four moderate, two low, two  
6 insufficient.

7 CO-CHAIR ELWARD: We could ask who  
8 the optimist is. But I mean I join the  
9 insufficient category just because of the  
10 same, you know, that would like to see this,  
11 you know, I have some sense that that'll be  
12 deliverable, but I share some of Michael's  
13 concerns also.

14 CO-CHAIR MAURER: I also think  
15 based on Carlos' comments and others, that we  
16 don't have the data in front of us, you know.

17 MS. FANTA: Moving along to  
18 exclusions, 2b3. Are exclusions supported by  
19 the clinical evidence or analysis of frequency  
20 and distribution? Is information about impact  
21 of exclusions for patient preference  
22 transparent? One high, seven moderate, one

1 low.

2 MS. WILBON: So I can try to recap  
3 a little bit of what I have in my notes here.  
4 Based on some of the analysis that Carlos did,  
5 he mentioned that he would've liked to see a  
6 sensitivity analysis to the exclusions. That  
7 was missing.

8 It's not totally transparent how  
9 the grouper is identifying outliers in  
10 exclusions. I guess, sorry I don't have the  
11 rest of that. It was just a brief cutoff  
12 sentence there.

13 That they do use Winsorization for  
14 the top two percent, and identification of  
15 outliers for incomplete episodes are excluded.  
16 That they cap the high costs and so not all  
17 the high cost episodes are included.

18 MR. AMIN: I think that generally,  
19 I think the conversation was around who was in  
20 that excluded population, and some statistics  
21 in some way would've been helpful I think for  
22 the TAP in their review, especially in the

1 high cost population that was Winsorized, who  
2 they represent.

3 MS. FANTA: All right, and then  
4 2b4. For Resource Use Measures, is there an  
5 evidence-based risk adjustment strategy or  
6 rationale data to support no risk adjustment  
7 or stratification? One high, four moderate,  
8 two low, two insufficient.

9 MR. AMIN: Seems like the majority  
10 of the conversation here was around the R-  
11 squared values providing that for the TAP. Is  
12 there anything else in particular?

13 MS. WILBON: I'll just add there  
14 was some discussion around how comorbidities  
15 impact the severity ranking, and how the  
16 severity ranking, how exacerbations for asthma  
17 are, I guess computed in the severity ranking  
18 and addressed in the total cost for the  
19 episode. Is that right?

20 DR. BLAKE: I was the high person,  
21 and I was thinking I was focusing what on, the  
22 last part that you just said, Ashlie, I'd kind

1 of forgotten about the R-squared stuff.

2 About when he said that it was  
3 based on both exacerbations or like an office  
4 visit. So that's why I thought that was  
5 appropriate and I rated it high.

6 MS. FANTA: 2b5. Are performance  
7 results reported? Do they identify  
8 differences in performance or overall less  
9 than optimal performance? Eight moderate, one  
10 insufficient.

11 MR. AMIN: I think the only thing  
12 I have here as far as the discussion goes, was  
13 the S12 report that Kathryn brought up during  
14 the discussion around the confidence interval  
15 of those point estimates, what they actually  
16 mean, the interpretability of those measures.  
17 And yes, just I'll leave it at that.

18 DR. BLAKE: And then there was the  
19 table S9.5 that didn't have anything to do  
20 with detail score estimation, so I think they  
21 just had the wrong, they were referencing the  
22 wrong section. It had to do with

1 complementary services. It didn't have  
2 anything to do with detail score estimation.

3 MS. FANTA: Okay, and then we can  
4 move along to overall validity testing, which  
5 encompasses specifications consistent with  
6 resource use, cost problem, validity testing,  
7 risk adjustment and identification of  
8 statistically significant or meaningful  
9 differences. Six moderate, one low, two  
10 insufficient.

11 2c. If disparities and care have  
12 been identified, do measure specification,  
13 scoring, and analysis allow for identification  
14 of disparities through stratification or  
15 results, or is there a rationale or data that  
16 justifies why stratification is not necessary  
17 or feasible? Two high, six moderate, one  
18 insufficient.

19 MR. AMIN: Just to summarize some  
20 of the concerns in this area, which I believe  
21 they're reflected in these scores, were a lot  
22 of the points that Michael brought up around

1 the number of outputs across the various  
2 severity levels.

3 Stratified by race would make  
4 interpretability also relatively complex, and  
5 the current stratification factors on  
6 severity, which actually may be a result of  
7 poor care.

8 MS. WILBON: Did we capture I think  
9 everything? At least we'll have the ability  
10 to go back and listen, and look at  
11 transcripts, but do we feel like we've  
12 captured everything? Okay.

13 DR. SCHATZ: And again, I think  
14 this is where we wanted some additional  
15 information.

16 But just one general piece of  
17 information, Tom. You do list in the  
18 application that a lot of people use these  
19 measures but as you had mentioned, not clear  
20 how much is asthma alone versus the whole  
21 suite. Is there any information about how the  
22 asthma measure specifically has been used?

1 DR. LYNN: There isn't, because we  
2 really don't have, if we have customers that  
3 are using asthma specifically, I don't know  
4 about it.

5 Almost all of our uses are in the  
6 area of measurement, or combining asthma  
7 measure with the COPD measure with the  
8 pneumonia measure, and potentially even wider  
9 than that.

10 DR. SCHATZ: So again my concern  
11 would be, I just, in trying to answer these  
12 questions of usability, you know, in theory  
13 the concerns that have been raised up to now  
14 would put some questions. And then in  
15 reality, how it's been used or how useful it  
16 is, we don't know. And so I guess those are  
17 my concerns.

18 CO-CHAIR ELWARD: Other thoughts,  
19 I mean any other comments on 3a? Okay. Oh,  
20 3b?

21 DR. SCHATZ: Yes, I was sort of  
22 lumping all of the usability to some extent,

1 which I maybe shouldn't have.

2 CO-CHAIR ELWARD: It seems like  
3 they can be reported. It's evident strictly  
4 looking at 3b's criteria, that they need to  
5 be, there needs to be a careful explanation.  
6 It'd be easy for people to misunderstand what  
7 the measures mean in terms of the, it being  
8 understandable and useful to the intended  
9 audiences.

10 And not to take away the importance  
11 of what ETGs represent because episodes of  
12 care are huge, you know, hugely important in  
13 terms of thinking about what, you know, what  
14 actually happens to a patient with asthma.

15 And specifically what kind of  
16 specific care they get. But it seemed like  
17 there were a lot of questions that we had  
18 about, when you report these what are they  
19 going to mean to people? It's just public  
20 consumption.

21 DR. SCHATZ: Yes, I mean I think 3a  
22 definitely could be publicly reported. It's



1 more 3b, you know, is it meaningful and  
2 useful, where I guess I have more questions.

3 I think 3c, other than the asthma  
4 cost which maybe that too could be decomposed,  
5 I think that 3c probably does if you look hard  
6 enough, allow you to really get into it. But  
7 I don't know if that makes it usable.

8 CO-CHAIR ELWARD: Yes, it seems  
9 like we can break it down even more.

10 DR. SCHATZ: Yes, I mean I guess my  
11 biggest concern would be with 3b, and partly  
12 that I just don't know.

13 CO-CHAIR ELWARD: Other comments  
14 from others on -- Tom, do you have any  
15 responses to Michael's comments about, you  
16 know, how to handle the reporting issues, or  
17 how your users are addressing the differences  
18 in the different reports that can be produced?

19 DR. LYNN: Well, I think this is a  
20 different reporting system that can be  
21 produced with the different methods that can  
22 be used. You know, we don't have, obviously,

1 complete control over how our users use the  
2 product.

3 We do have some ideas about how  
4 they use it. The question is really around  
5 some of the choices that we allow. Like  
6 whether they use standard price or whether  
7 they use their own price. I think that's one  
8 of the big ones.

9 And I think we probably, that might  
10 be close to 50/50. And it depends on whether  
11 the focus is on the dollar amount or is the  
12 focus on actual utilization. And so I think  
13 it's used both ways in that regard. I don't  
14 know if that answered the question.

15 CO-CHAIR ELWARD: Okay. That's  
16 helpful. Can you give us some other thoughts  
17 about, or information about how when we  
18 decompose the results, maybe that's not the,  
19 sometimes I'm not sure that's the best term,  
20 unless we're talking pathology.

21 DR. LYNN: Right.

22 CO-CHAIR ELWARD: But deconstruct

1 the measures for, or how some of your  
2 customers have deconstructed the measures to  
3 answer specific questions?

4 DR. LYNN: You mean how they might  
5 have used asthma? Oh, oh, I'm sorry. Well,  
6 I guess the question is, you mean how they  
7 would've used asthma specifically out of a  
8 list of diseases, or how they would use the  
9 different metrics, like number of ER visits  
10 and in dollars for laboratory for a  
11 measurement?

12 CO-CHAIR ELWARD: I'm thinking  
13 about when they had questions about their  
14 asthma care, saying how would they break down  
15 different aspects.

16 For example, being able to say  
17 okay, for a given number of patients who have  
18 asthma, how can we break down what impacts  
19 their ER use?

20 Or can we even get to some of  
21 Michael's concerns about, you know, under-  
22 prescription of care? Or just how they've

1 addressed the asthma, understand their asthma  
2 measures better.

3 DR. LYNN: Well, I think, you know,  
4 if you look at what some of the metrics were  
5 that were included with this, you know, there  
6 are ways to sort of drill into different  
7 aspects of care to see how they may be driving  
8 the score. And, you know, that too, and  
9 that's why we included those here. So how we  
10 recognize that the measurement is more  
11 effective if there is ways to get it where the  
12 drivers are.

13 As far as underutilization, we  
14 certainly feel that, you know, these sort of  
15 cost measurements should be used alongside  
16 some quality measures that may help evaluate  
17 that.

18 CO-CHAIR ELWARD: Yes, I think when  
19 I look at the best, some of the best material  
20 you presented for that I think is that SA  
21 reliability validity testing.

22 Where you really do have a lot of,

1 seems like there are a lot of data on how you  
2 can break it down by lab encounters, ER visits  
3 and patient days, things like that.

4 DR. LYNN: Right, try to get at  
5 drivers, right.

6 CO-CHAIR ELWARD: Okay. All right.  
7 Any other, before we go to any other  
8 questions, comments? Okay. Go ahead.

9 MS. FANTA: 3a. Are the measure  
10 performance results reported or suitable to  
11 report to the public at large in national or  
12 community reporting programs? Is there  
13 evidence that the measure performance results  
14 are available for public reporting?

15 Oh, did someone leave the room?

16 (Off microphone comments)

17 MS. FANTA: Oh. So at least we're  
18 just missing one then. Got it. Okay, so two  
19 high, four moderate, two low and one  
20 insufficient.

21 MR. AMIN: I just want to confirm  
22 that these scores reflect the major concern

1 that Michael brought up around how the asthma  
2 measure itself would be used as opposed to the  
3 suite of measures that would come with the  
4 Ingenix product, is that correct, or is there  
5 others?

6 (Off microphone comments)

7 CO-CHAIR ELWARD: And also, how the  
8 public would interpret a given report given  
9 the variation that, you know, flexibility that  
10 they have.

11 MR. AMIN: Okay, so that would  
12 likely be in 2b. They're in 3b also I would  
13 bet.

14 CO-CHAIR ELWARD: Yes.

15 MS. FANTA: Okay, 3b. Did  
16 submitted information demonstrate that results  
17 produced by the measure are meaningful,  
18 understandable and useful for information for  
19 quality improvement and public reporting, or  
20 was a credible rationale presented? Six  
21 moderate, two low, one insufficient.

22 CO-CHAIR ELWARD: And I think the

1 rationale is, I guess you've mentioned it.

2 MS. FANTA: 3c. Are the data and  
3 result details maintained such that the  
4 Resource Use Measure, including the clinical  
5 and construction logic for defined unit of  
6 measurement, can be decomposed to facilitate  
7 transparency and understanding? Three high,  
8 five moderate and one low.

9 CO-CHAIR ELWARD: Thank you very  
10 much. Let me go over the measures for  
11 feasibility.

12 You know, in looking at the  
13 criteria in terms of, are that the required  
14 data elements do seem to be routinely  
15 generated and used during care delivery to the  
16 extent that they can record lab tests, things  
17 like that. I think it seems like the  
18 feasibility of getting those reports is very  
19 high. The required data elements are  
20 certainly available. That's not a problem.

21 Susceptibility to inaccuracy,  
22 errors, or unintended consequences. It seems

1 like they paid a lot of attention to that.

2 I'm not sure that there were  
3 sufficient evidence, you know, with what we  
4 saw today, to answer all those questions, and  
5 it would be helpful to get more information  
6 from you all, Tom.

7 And maybe you can answer this  
8 before we vote, about how you've dealt with or  
9 identified inaccuracies and adjusted for  
10 possible errors, as with any measure that we  
11 review.

12 Actually it seems like the data  
13 collection measurement strategy has been  
14 implemented by a lot of your customers, and  
15 has been used fairly extensively.

16 The major question is whether it's  
17 been used in external reporting programs. Can  
18 you answer the, probably two issues?

19 One of them is how you address or  
20 identify inaccuracies or errors. And second,  
21 how has it been used by your customers in  
22 terms of external reporting programs?



1 DR. LYNN: Right. So the first  
2 question is the product has built into it a  
3 number of error checks, so we can identify if  
4 there is a large number of claims that are  
5 outside of the reporting period, or have  
6 invalid procedure codes, or those sorts of  
7 things.

8 And we have benchmarks for what we  
9 expect those values to be. So our customers  
10 know that when they run their data that they  
11 have an expected number of say invalid  
12 procedure codes that's not reported to be  
13 effective. So we do have error checking  
14 inside the grouper to do that sort of work.

15 The other answer to the question  
16 is, we do have clients that are publicly  
17 reporting data based on, you know, the episode  
18 grouper methodology, but they usually do it  
19 aggregated across multiple episodes.

20 But, you know, asthma and pneumonia  
21 and COPD, for example, like we've been talking  
22 about, I don't know of clients that are

1 breaking it down to the disease level.

2 CO-CHAIR ELWARD: Yes. You mean  
3 they use the whole package of services. It's  
4 not like they lump all the costs of asthma and  
5 CHF together. I mean they obviously have  
6 different reports that they look at.

7 DR. LYNN: Well, you can drill down  
8 to different reports. Using that O/E ratio  
9 you can come up with an aggregated score  
10 across the data, and we have clients who do  
11 that. It just changes the expected value in  
12 the denominator, right.

13 CO-CHAIR ELWARD: Other items on 4?  
14 Questions about that? Okay, go ahead.

15 MS. FANTA: 4a. Are the required  
16 data elements --

17 MS. WILBON: So quickly I just  
18 wanted to, Richard, you had a question earlier  
19 that we tabled for feasibility discussion. I  
20 just want to make sure we get back to that.

21 For Tom, there was a question about  
22 how it's implemented like at the health plan

1 or something like, I don't know if you  
2 remember, sorry. Hopefully, okay, you could  
3 recap that, that would be great.

4 DR. STANFORD: Yes, evidently Tom  
5 has mentioned that the health plans that he  
6 has in his examples here all use this outside  
7 of Ingenix, is my assumption.

8 But my overreaching question is  
9 around, you know, how much burden is this on  
10 a programmer to implement into maybe a smaller  
11 health plan or even a larger health plan for  
12 that matter, sort of a, and I think Tom  
13 mentioned the sort of the less sophisticated  
14 customer. Just what is the overall  
15 programming burden?

16 MS ZIELINSKI: I can take that,  
17 Tom. Actually, you know, I'm going to give  
18 you the dreaded, "it depends" answer.

19 I mean, you know, if somebody comes  
20 and it's a small shop and they're familiar,  
21 you know, with ETGs, and understands the  
22 product and the processes that are needed to

1 be required to get the data ready to be  
2 grouped, and then to perform the post-grouping  
3 steps needed to get from output to report, you  
4 know, it's a pretty seamless and  
5 straightforward process.

6 For those that are not as  
7 experienced or, you know, just starting from  
8 scratch with the fee of the, you know, there's  
9 unlimited training involved. Help desk  
10 support, those things, you know, that can  
11 assist somebody in from a base level  
12 knowledge, to being able to process groupers  
13 and program the groupers to run correctly.

14 You know, it takes some input from  
15 the analyst and the business part of the group  
16 to instruct the programmer how to configure  
17 the product. You know, which things they want  
18 to turn on and which things they want to turn  
19 off in the configuration.

20 That might be some testing that is  
21 involved, you know, looking at outputs if you  
22 put something on, and then looking at outputs

1 if you put something off.

2           You know, and then the third answer  
3 I would provide here is, you know, there's  
4 also options that we have here at Ingenix  
5 where we take the data, run it for them, or we  
6 have a product that's called PCQ Connect that  
7 kind of takes their outputs and gets it into  
8 report-ready formats for them, so they don't  
9 have to do the manual processes after the data  
10 has been grouped.

11           So, you know, there is some, while  
12 it is a complicated process, there is a great  
13 level of support that's provided for them to  
14 be able to be successful in the shortest  
15 amount of time.

16           CO-CHAIR ELWARD: Thank you. Thank  
17 you.

18           MS. FANTA: So we'll go ahead and  
19 vote on 4a. Are the required data elements  
20 routinely generated and used during care  
21 delivery? Just waiting on one vote. So we  
22 have seven high, and two moderate.

1                   Moving along to 4b. Are all the  
2                   required data elements available in electronic  
3                   health records or other electronic sources?  
4                   If not, is a credible near term path to  
5                   electronic collection specified? Seven high,  
6                   two moderate.

7                   4c, are susceptibilities to  
8                   inaccuracies, errors, or unintended  
9                   consequences, and the ability to audit the  
10                  data items to detect such problems identified?  
11                  Okay, one high, and eight moderate.

12                  And lastly, 4d. Can the data  
13                  collection strategy be implemented? Is the  
14                  measure already in operational use, or did  
15                  testing demonstrate that it is ready to be put  
16                  into operational use? Okay, four high, four  
17                  moderate and one insufficient.

18                  (Off microphone comments)

19                  MS. TURBYVILLE: Just a quick  
20                  question on a and b which was about the  
21                  electronic sources.

22                  Is it the moderate votings

1 primarily about the pharmacy data not always  
2 be consistently available? Or is there  
3 something that I missed in the conversation  
4 that would, not trying to persuade vote  
5 changes, just want to make sure we understand  
6 the moderate votings on the first two  
7 feasibilities, which are about the electronic  
8 data being routinely available, and then --

9 DR. MOSENFAR: I think they had  
10 the data. Actually I voted high on the second  
11 one, but they have the data. It's just a  
12 question of how to get the data in presentable  
13 shape.

14 MS. TURBYVILLE: That there would  
15 be a lot of work for the users to do that to  
16 map it to the --

17 DR. MOSENFAR: No doubt they have  
18 tremendous amount of detailed data which would  
19 be applicable to pneumonia as well, but the  
20 question of, you know, is a little shop is  
21 going to be able to use it or not.

22 CO-CHAIR ELWARD: I think if they

1 use Ingenix, you know, as their primary source  
2 they will have very little trouble.

3 Well, thank you very much. I think  
4 given the amount of time, you know, we've  
5 spent a lot of good time on this and I think  
6 it will make the other two go easier.

7 But let's go ahead and take a ten-  
8 minute break and then we will reconvene and  
9 start working on the COPD measures.

10 CO-CHAIR MAURER: Actually we're  
11 going to do pneumonia next.

12 CO-CHAIR ELWARD: I'm sorry,  
13 pneumonia, yes. We have --

14 CO-CHAIR MAURER: Zab has to leave  
15 so we're going to run through his stuff as  
16 soon as we get back.

17 CO-CHAIR ELWARD: So pneumonia's  
18 next. Thank you for correcting me on that.  
19 And Tom, you can put, you know, that on mute.

20 (Whereupon, the above-entitled matter  
21 went off the record at 2:54 p.m. and resumed  
22 at 3:05 p.m.)



1 CO-CHAIR MAURER: I want to get  
2 started because we're going to lose Zab here  
3 pretty soon.

4 Okay, so we're going to do the ETG  
5 Based Pneumonia, the Ingenix measure. And  
6 we'll start off with the importance.

7 This is a measure that's to  
8 evaluate episodes of pneumonia. This is an  
9 acute ETG, meaning that it has, I believe it  
10 has a defined clean period after it. It isn't  
11 classified as a chronic condition, so there  
12 will be kind of a period at which it kind of  
13 washes out.

14 The proposers say that this is an  
15 important measure because there were like  
16 589,000 hospital discharges in males, and  
17 643,000 hospital discharges in females per  
18 year. And there are about 175,000 of these  
19 are pneumococcal pneumonia.

20 They've looked at their own  
21 database and found out that 0.4 percent of  
22 their population gets pneumonia.

1                   The U.S. records about 55,000-plus  
2 deaths due to pneumonia or influenza every  
3 year, most of which are from pneumonia. And  
4 it is, the combination of pneumonia and  
5 influenza are the eighth leading cause of  
6 death in the country. This is a cost to the  
7 health care system of \$34.2 billion direct,  
8 and \$6 billion indirect.

9                   And the proposers suggest that  
10 there is an ability to achieve improvement  
11 through reductions and variation in care based  
12 on their assessment that using one as a sort  
13 of an average care that the variation ranges  
14 from 0.48 to 1.32, and even higher variation  
15 among specialty groups of scores of 0.25 to  
16 1.21. And pharmacy varies from 0.8 to 1.15,  
17 so they say that there is a significant  
18 variation in care.

19                   And also preventive approaches such  
20 as pneumococcal vaccine are not used as much  
21 as they could be to help reduce the rate of  
22 that type of pneumonia.

1                   So I think it is a important  
2                   measure. It has significant resource use.  
3                   There are ways in which improvement could be  
4                   addressed.

5                   And in setting up their episode-  
6                   based groupings, they have described in some  
7                   detail the service categories that are going  
8                   to use, and it maps to providers and  
9                   practices, and in an aggregate level to the  
10                  health plans if you want it to.

11                  I think that's about it for  
12                  importance. Okay. Now we vote, unless  
13                  somebody would like to --

14                  MS. FANTA: Oh, perfect, okay. So  
15                  1a, high impacts as the measure focus  
16                  addresses specific national health goal  
17                  priority or was the data submitted that  
18                  demonstrated high impact aspect of health  
19                  care? So we have eight high.

20                  And moving along to 1b. Was data  
21                  submitted that demonstrated resource use or  
22                  cost problems for improvement that is

1 variation in the delivery of care across  
2 providers, and/or population groups? So  
3 again, we have eight high.

4 1c, is the purpose, objective of  
5 the Resource Use Measure including its  
6 components and the construct for resource use  
7 or cost clearly described? Okay, and eight  
8 high.

9 And lastly, 1d. Are the resource  
10 use service categories that are included in  
11 the Resource Use Measure, consistent with and  
12 representative of the measure concept? Seven  
13 high, one moderate.

14 CO-CHAIR MAURER: Okay, I'm going  
15 to, Dale, you're the first one with 2a1, and  
16 then we're going to go to Zab and have him do  
17 several of his so he can get through them,  
18 okay.

19 MR. BRATZLER: So much the same  
20 issues that we just discussed with asthma. So  
21 essentially the methodology is the same. You  
22 identify an anchor record.

1           You first start with all your  
2           claims, determine what category they fit in,  
3           and then identify an anchor record. And then  
4           tie all the additional records subsequently to  
5           that anchor record that represent, or could  
6           represent pneumonia care, including pharmacy,  
7           clinical services, inpatient, other types of  
8           measures.

9           So basically the construct is the  
10          same. I think it's important to note that  
11          this is pneumonia. It's not community-  
12          acquired pneumonia. It's not health care. It  
13          includes all forms of pneumonia.

14          Patients with HIV, CAP, health care  
15          associated, immunocompromised, the whole  
16          spectrum of pneumonia care.

17          The risk adjustment works  
18          essentially the same way. They've developed,  
19          identified comorbid conditions that are each  
20          assigned severity weights.

21          And I think my biggest concern was  
22          how those severity weights were actually

1 determined, because I've spent a lot of time  
2 doing severity on pneumonia. I just don't  
3 know what the methodology was for assigning  
4 different weights.

5           And they have different weights for  
6 elderly. And again, since we don't have much  
7 information about the measure population that  
8 they actually used to develop the measure, and  
9 what proportion are actually in that elderly  
10 age group, I just don't know how they came up  
11 with different weights for elderly versus the  
12 younger population.

13           I'd raised several issues before  
14 during our discussion with asthma, the costing  
15 method, the actual payments versus standard  
16 payments, standard adjusted payments.

17           So the clean period is 180 days.  
18 So the patient basically, once they have that  
19 anchor record diagnosed with pneumonia, all  
20 records that are tied to pneumonia care until  
21 they have no episodes of care tied to  
22 pneumonia for 180 days, then that patient is

1 then out of that.

2 Just as we saw with the other  
3 measures, a patient could be potentially in  
4 several anchored records. So they could be in  
5 the pneumonia group, and they could be in a  
6 diabetes group if they have an anchor record  
7 there also, it works the same way.

8 When I did the initial evaluation  
9 I rated this high because very clearly, highly  
10 detailed description of how to go through and  
11 develop the measure, very well spelled out.

12 My biggest concerns at this point  
13 are around, how you do the risk adjustment?

14 And the other thing is I've spent  
15 12 years arguing with clinicians, particularly  
16 the pulmonologists in the room, that we need  
17 to make sure that we've separated community-  
18 acquired patients from health care associated  
19 patients, patients with immunocompromised  
20 conditions, and they're all rolled up into  
21 one.

22 And so I think that makes it

1 tougher, from the face validity for the  
2 clinician at the bedside, to figure out who  
3 you're actually addressing with this measure,  
4 which is just generically pneumonia which  
5 includes a really a broad array of patients  
6 here over time.

7 CO-CHAIR MAURER: Other comments?  
8 Can you tell me where you found the clean  
9 period, because I looked for it and couldn't  
10 find it.

11 MR. BRATZLER: Well, I think it's,  
12 yes, I actually just went through and did a  
13 search.

14 In the example they talk about  
15 viral pneumonia, which I think is one of their  
16 examples that falls into this category,  
17 because viral pneumonia does fit in this  
18 pneumonia measure, and that example used 180  
19 days, so I made that assumption.

20 CO-CHAIR MAURER: Oh, okay.  
21 Because I looked for that.

22 MR. BRATZLER: Yes, it's in those



1 last documents.

2 CO-CHAIR ELWARD: I think it's in  
3 the logic model.

4 MR. BRATZLER: Maybe.

5 CO-CHAIR MAURER: Maybe, you know,  
6 they give other clean periods, but I didn't  
7 see the pneumonia one.

8 CO-CHAIR ELWARD: Tom, are you  
9 there?

10 DR. LYNN: Yes, I am.

11 CO-CHAIR ELWARD: Yes, were we  
12 correct in saying that the clean period for  
13 pneumonia is 180 days?

14 DR. LYNN: Yes, that's correct.

15 CO-CHAIR MAURER: Okay. Any other  
16 comments? No. Okay, so Zab, we're going to  
17 move onto 2a2.

18 DR. MOSENFAR: Sure. Can you move  
19 the 2a2 up there? Anyways, I echo Dale's  
20 comments. This is a tremendous, vast amount  
21 of data of pneumonia.

22 Every pneumonia of the possible

1 causes that you can think of, it's in this  
2 data pool. And it's going to require some  
3 sophisticated user to have access.

4 And although that same, the  
5 comments about statistics apply to this as  
6 well so my comments and vote, actually it's  
7 going to be across the board at the moderate  
8 level. Because the data is there and the  
9 question is that you have to be very  
10 sophisticated to get to this data.

11 I don't think an average user  
12 without having a robust statistician will be  
13 able to, either they should help or someone  
14 else, they should have someone like Carlos  
15 next to them, and I see Carlos is missing here  
16 so I'm going to be handicapped.

17 But I think using his comments from  
18 the prior discussions will be the same  
19 applicable. The data is there. The  
20 statistics could've been there. It's not  
21 quite there, the details.

22 CO-CHAIR MAURER: So we need more

1 information, more detail from Ingenix?

2 DR. MOSENIFAR: I think the  
3 information is there, it's just the way it's  
4 going to be user friendly.

5 CO-CHAIR MAURER: Oh, okay.

6 DR. MOSENIFAR: That's really the  
7 question.

8 MR. BRATZLER: Well, I mean, and  
9 maybe Tom can help answer this, but my issue  
10 is, is specific weights are assigned to many  
11 comorbidities and they may be appropriate, I  
12 just don't know how they came up with the  
13 weights.

14 CO-CHAIR MAURER: How they got  
15 that.

16 MR. BRATZLER: For all these  
17 various comorbidities and they have a separate  
18 set for the elderly population, how that was  
19 generated. You know, what proportion of the  
20 population that they've tested these measures  
21 on fit the definition of elderly? That's also  
22 not clear.

1 DR. LYNN: I can answer that  
2 question, particularly about that one. We  
3 had, you know -- this is commercial data,  
4 right. So we have over 65 folks in our  
5 commercial data, either because the primary  
6 insurance is, you know, the insurance health  
7 plan acts, or because we have some data where  
8 health plan acts, it has some sort of, you  
9 know, has taken on Medicare responsibility for  
10 a member.

11 And that's why we have some members  
12 over 65. It's not a high number. I think  
13 it's probably like eight percent of the  
14 population that we used to create focus.

15 MR. BRATZLER: And so that's  
16 important because at least, and my knowledge  
17 is much greater on inpatient pneumonia where  
18 two-thirds of the patients are probably of  
19 Medicare age group versus the younger age  
20 group.

21 My other question is, when these  
22 risk adjustment methodologies were developed,

1 were they ever tested for different  
2 populations? So for instance, well, if you  
3 don't have many Medicare patients you can't do  
4 it.

5 But one example would be the  
6 patient that comes in from an ambulatory  
7 setting versus the patient that comes in from  
8 the nursing home setting.

9 And without a lot of Medicare data  
10 you probably can't identify, but kind of  
11 lumping all of the community-acquired patients  
12 with the health care associated patients.

13 It may be appropriate and maybe the  
14 risk adjustment addresses it, I don't know.  
15 But I just wonder whether it's been tested,  
16 kind of, for that validity at the clinician  
17 level, about whether these four strata of  
18 severity levels adequately really divide up  
19 the patients into severity.

20 I mean what can you actually do  
21 with data at the end of the day? Can you  
22 change quality, other than just looking at

1 resource use?

2 DR. LYNN: Well this is a Resource  
3 Use Measure. But to answer that question, we  
4 have not looked at it like the Medicare  
5 population or Medicaid population.

6 Matter of fact, you know, if we  
7 were going to use it in a purely Medicare  
8 population then, and as a matter of fact we're  
9 working on that right now, we would create new  
10 weight.

11 If we used it for Medicaid we'd  
12 create new weight. So we don't really, you  
13 know, this is meant to be used in a commercial  
14 population.

15 CO-CHAIR MAURER: Any other  
16 comments?

17 CO-CHAIR ELWARD: In answer, Tom,  
18 maybe you can follow along with what Dale was  
19 mentioning. Can you break down the measure by  
20 different types of pneumonia?

21 For example, if you wanted to say,  
22 how are we doing with, you know, pneumococcal

1 network, bacterial pneumonia versus viral  
2 pneumonia. Can you create separate reports on  
3 that?

4 DR. LYNN: You can create separate  
5 reports on viral and bacterial pneumonia. I  
6 don't know. I can't remember whether we have  
7 a pneumococcal condition status factor, off  
8 the top of my head.

9 CO-CHAIR MAURER: Well, your  
10 condition status actually lists a whole set of  
11 bacteria separate condition statuses that you  
12 add.

13 DR. SANTO TOMAS: There's no ICD-9  
14 code for community-acquired pneumonia, but  
15 there's an ICD-9 code, for example, I mean,  
16 you know, there's no health care associated  
17 pneumonia, but there's a ventilator associated  
18 pneumonia, I think it's a modifier as a  
19 complication to, you know, there's a pneumonia  
20 and it's a modifier.

21 So I think at least some of those  
22 you could maybe tease out. I'm not sure if

1 that's included in the, I tried to search the  
2 methodology. I don't think I saw that in  
3 particular.

4 But those are things that I think,  
5 you know, clinically that is important. I  
6 mean those are usually of course, high  
7 resource utilizers, those kind of  
8 complications.

9 CO-CHAIR ELWARD: This is Kurt  
10 again. I'm just also wondering whether, you  
11 know, in general when NQF is looking at  
12 measures, I think you tend to be more global  
13 in your measures, is that correct?

14 I mean it's not like you look at  
15 diastolic versus systolic CHF in your  
16 congestive heart failure measures. Or, how do  
17 you separate diabetes? For example, do you go  
18 into gestational diabetes, Type I, Type II,  
19 you don't do that?

20 MS. WILBON: Yes, so I'm going to  
21 take a stab at this and I'm going to open it  
22 up to Heidi and Sally to piggyback on.



1                   We do encourage more global  
2                   measures, but I think where there are clinical  
3                   differences in populations, we would probably  
4                   encourage like stratification of those  
5                   different types, of the differences between  
6                   those clinical groups can be identified.

7                   I think that would probably be our  
8                   recommendation, how we've done in other  
9                   measures, where they would stratify for like  
10                  Type I and Type II diabetes or something like  
11                  that. And Heidi or someone can piggyback or -  
12                  -

13                  MR. BRATZLER: So the clinical  
14                  quality measures for pneumonia, we have  
15                  certain ones that are kind of the broad  
16                  population of hospital-based pneumonia  
17                  patients.

18                  And then we have ones that are  
19                  specifically community-acquired based on the  
20                  fact that there are only guidelines for that  
21                  population for certain things.

22                  MS. TURBYVILLE: Just a little, in

1 addition to other measurement at first. The  
2 steering committee did make a statement and a  
3 guiding principle at least for this first  
4 effort that they were interested in seeing  
5 broad resource use measures.

6 But again Ashlie's absolutely 100  
7 percent correct. That shouldn't be to the  
8 detriment of whether or not clinically it  
9 makes sense to combine them. But they were  
10 looking for across settings, across services,  
11 and so whether this works the way it is, is  
12 clinically is really what we're hoping to hear  
13 from you all.

14 DR. MOSENFAR: Nosocomial  
15 pneumonia is really a different kind of a  
16 pneumonia. Ventilator associated pneumonia is  
17 a different kettle of fish, so it will be  
18 disservice actually to combine CAP with HAP.

19 MS. TURBYVILLE: And those can be  
20 differentiated through ICD-9 codes or  
21 otherwise?

22 DR. SANTO TOMAS: Yes, when I tried

1 to look, the only one that had, again was  
2 ventilator, in fact, not hospital-acquired but  
3 just ventilator associated pneumonia does have  
4 a --

5 CO-CHAIR ELWARD: VAP has a  
6 separate.

7 DR. SANTO TOMAS: Yes, VAP has a  
8 separate, V-A-P.

9 MR. BRATZLER: Yes, so now I would  
10 say that you can't, just from ICD-9 codes  
11 alone, you can't differentiate health care  
12 associated from, you can VAP, but not health  
13 care associated pneumonia, from community-  
14 acquired pneumonia, you can't do it.

15 CO-CHAIR MAURER: Well, health care  
16 associated is really a new designation in the  
17 last five years, right.

18 MR. BRATZLER: Right, and there are  
19 ways to do it. I mean if you looked at the  
20 ABMS, they actually tried really hard to  
21 separate the two groups. And I'm not saying  
22 that that's a flaw.

1                   A broader measure may be okay.  
2           What I can't tell though is if you happen to  
3           be a clinician that had a relatively large HIV  
4           population, does the risk adjustment  
5           adequately address that immunocompromised  
6           population of patients who may have much  
7           tougher pneumonias to treat?

8                   Or you have a much sicker  
9           population that gets gram-negative pneumonias  
10          because they're in nursing homes or something.  
11          So that's what I can't tell, is how those  
12          weights for the risk adjustment were  
13          developed.

14                   DR. LYNN: I just wanted to, yes,  
15          point out and you said it, and I appreciate  
16          it. But the markers are there for risk  
17          adjustment, not for hospital-acquired or  
18          community-acquired, but for, you know, the bug  
19          identified.

20                   CO-CHAIR MAURER: I was just going  
21          to say before Zab walks out the door, you have  
22          validity and outcome measures. Do you have

1 any specific comments you want to give us?

2 DR. MOSENIFAR: Specifically again,  
3 the data is there. All the data is there,  
4 it's just the same comments that in terms of  
5 accessing the data is the difficulty. A good  
6 statistician will have no difficulty, but I  
7 had difficulty really getting into information  
8 that I wanted to know.

9 So I have no doubt that the data is  
10 there because the number of patients that they  
11 have really studied is just vast. I'm sure if  
12 it's analyzed carefully and with a robust  
13 statistician, I have no doubt that every bit  
14 is there, but it was not available to me.

15 (Off microphone comments)

16 CO-CHAIR MAURER: He said he would  
17 vote moderate across the board I think, don't  
18 you?

19 Okay. All right, so 2b1, Dale?

20 MR. BRATZLER: So 2b1, I also rated  
21 moderate. And here again, I think this  
22 largely got to, so here part of it is the

1 inclusive target population, and again my  
2 biggest concern was kind of this broad  
3 category of pneumonia across the board.

4 And secondly, the exclusions. The  
5 only exclusions again are the low outliers.  
6 The high outliers are Winsorized, and there  
7 really are no other exclusions as we've seen  
8 with some other measures, so that's around  
9 high cost outlier patients who are anything  
10 else.

11 So this is broad, broad measure  
12 looking at pneumonia with any potential  
13 comorbidities or other things hopefully  
14 adjusted for in the risk adjustment.

15 But I think my other concern was  
16 partly here around the validity of whether  
17 this measure would reflect appropriately other  
18 populations such as the elderly, like Medicare  
19 because of the age limitations of the  
20 derivation cohort, I'll call it.

21 CO-CHAIR MAURER: Well, so can you  
22 use it at all do you think in the elderly

1 population? I mean if there's a really small  
2 number of people that it's been --

3 MR. BRATZLER: Well, I think we  
4 don't have enough information to know that to  
5 be honest. I can't tell, you know, how they  
6 built that risk adjustment, and they have  
7 different scores, different weighted scores  
8 for elderly. I just don't know how they came  
9 up with them, if they have a small population  
10 that they were able to test.

11 DR. LYNN: Yes, what we did is, we  
12 only used the different one, if it was  
13 statistically significant to be different. So  
14 if we couldn't tell if it was the smaller  
15 sample size, then we used the overall one.  
16 And it came of course, we submitted this to be  
17 used in a commercial population.

18 MR. BRATZLER: Yes.

19 DR. LYNN: Not necessarily to be  
20 used for Medicare.

21 CO-CHAIR MAURER: So I think what  
22 I'm hearing from you, Dale, though is that we

1 really need to see how this risk adjustment  
2 was done more specifically.

3 MR. BRATZLER: So I think that's  
4 pretty much the same discussion we had for the  
5 asthma measure.

6 CO-CHAIR MAURER: This one, yes,  
7 yes.

8 MR. BRATZLER: That part isn't very  
9 transparent.

10 CO-CHAIR MAURER: Yes. Okay 2b2,  
11 this was Zab's, but do you have any comments  
12 about the same comments you just made, you  
13 mentioned.

14 DR. BRATZLER: I've already covered  
15 it.

16 CO-CHAIR MAURER: Okay, exclusions.

17 MR. BRATZLER: Well, again there  
18 are none. I mean except for the low outliers.

19 CO-CHAIR MAURER: Well, there's the  
20 upper end.

21 MR. BRATZLER: Well, they're  
22 Winsorized, and the lower outliers are



1 excluded. But those are the only exclusions,  
2 so there are no other exclusions on the  
3 measure.

4 CO-CHAIR MAURER: Any comments  
5 about that? Any other comments? Okay, Zab  
6 again had 2b4, but do you have any comments?  
7 We talked about risk adjustment already, you  
8 did. So nothing more on that?

9 MR. BRATZLER: No.

10 CO-CHAIR MAURER: Okay. Linus, you  
11 read this one too? No?

12 DR. SANTO TOMAS: Yes.

13 CO-CHAIR MAURER: Yes, okay. Okay,  
14 2b5, this one was Zab's. Did you have any  
15 comments, Dale or Linus? This is, data  
16 analysis demonstrates that methods for scoring  
17 and analysis of the specified measure allow  
18 for identification of statistically  
19 significant and meaningful data.

20 MR. BRATZLER: Yes, so I was  
21 impressed with the data that they have, but  
22 there are substantial variations in resource

1 use between different providers within  
2 specialties and others.

3 So I have no doubt that they  
4 identified differences in resource use. How  
5 that relates to quality or outcomes or  
6 anything else, I don't know. But I think  
7 their analytic methods are detailed and they  
8 demonstrated variation which doesn't surprise  
9 me.

10 CO-CHAIR MAURER: But do we have  
11 the populations appropriately separated or  
12 risk adjusted to really assess meaningful?

13 DR. SANTO TOMAS: Yes, no, I think  
14 it goes back to, as far as being meaningful,  
15 not knowing exactly what those pneumonias are,  
16 you know, how much of that variation is  
17 because of what the nature of that pneumonia  
18 is, whether it's community-acquired, health  
19 care associated, or ventilator associated  
20 pneumonia.

21 CO-CHAIR MAURER: Any other  
22 comments about that? 2b6, we're not doing.

1 And that leaves us --

2 MR. BRATZLER: Then for 2c.

3 CO-CHAIR MAURER: 2c, that's --

4 MR. BRATZLER: 2c, I would've said  
5 if the data were available it would probably  
6 be feasible, just likely not available.

7 CO-CHAIR MAURER: Okay. All right.  
8 Now we need to vote. Well, this is quick.

9 MS. FANTA: Okay, 2a1. Is measure  
10 precisely specified so that it can be  
11 implemented consistently? Three high and four  
12 moderate.

13 MR. AMIN: Okay, I'm going to just  
14 try to do a little bit of recapping because we  
15 likely will have the time, but I just want to  
16 make sure that we're capturing it even though  
17 a lot of the issues will be similar.

18 Here there was a discussion around  
19 two major issues which will likely play out  
20 across the different criteria, but the  
21 separation between community-acquired and  
22 health care-acquired, or ventilator-acquired

1 pneumonia, it really is a grouping of all  
2 three of them.

3 And concern about the severity  
4 level across the strata and whether that is  
5 appropriate, a lot of information wasn't, more  
6 information would've been provided there it  
7 would be helpful. And also the severity  
8 weights for the risk adjustment model.

9 MR. BRATZLER: The only other thing  
10 I would add is, again we discussed with the  
11 asthma measure that if you're using the  
12 measure to compare across plans then you need  
13 to have consistent cost data across plans.

14 MR. AMIN: Right, correct. Thank  
15 you for that.

16 MS. FANTA: Okay, 2a2. Does the  
17 reliability testing demonstrate that the  
18 results are repeatable, producing the same  
19 results a high proportion of time when  
20 assessed in the same population in the same  
21 time period, and/or that the measure score is  
22 precise?

1 MR. AMIN: I would, before we  
2 actually start voting on this one, real quick.  
3 Sorry, Sarah.

4 MS. FANTA: Yes.

5 MR. AMIN: Even though we got that  
6 one high vote, this is, just want to remind  
7 what this criteria is really aiming at, which  
8 is whether the data is reproducible in the  
9 same population.

10 So although there is some concern  
11 that the TAP noted around the specificity of  
12 the measure score, let's try to make sure it's  
13 specific to this criteria. Thank you.

14 MS. FANTA: Six high and one  
15 moderate. Okay, now we're going to vote on  
16 overall reliability testing including precise  
17 specifications and the actual reliability  
18 testing. Three high, three moderate and one  
19 insufficient.

20 MR. AMIN: Not to put anybody on  
21 the spot, but maybe we can have a little bit  
22 of discussion around with the moderates and

1       insufficients are here specifically.

2                   CO-CHAIR MAURER: Does anyone want  
3 to volunteer? I'm not getting --

4                   MR. BRATZLER: 2b3. 28, I'm sorry,  
5 I'm on the wrong page, I'm sorry.

6                   (Off microphone comments)

7                   MR. BRATZLER: Oh, it's overall,  
8 yes.

9                   CO-CHAIR MAURER: Well, it's a  
10 combination of 1 and 2, I mean basically, and  
11 so you had some moderates on one of those.

12                   MR. AMIN: So it was the two basic  
13 issues that we had discussed prior? I just  
14 want to make sure there's nothing else. If  
15 there is nothing else, that's okay, I don't  
16 want to drag it out.

17                   (Off microphone comments)

18                   MS. FANTA: All right, 2b1. Are  
19 the measure specifications consistent with the  
20 focus of measurement and measure intent? Four  
21 high and three moderate.

22                   2b2, does the validity testing

1 demonstrate that the measure data elements are  
2 correct and/or the measure score correctly  
3 reflects the cost of care or resources  
4 provided, adequately distinguishing high and  
5 lower costs for resource use? Five moderate  
6 and two low.

7 CO-CHAIR MAURER: Okay, and I think  
8 this reflects a concern about whether this is  
9 one population, you know, or whether it's  
10 multiple populations. And we don't know that  
11 based on the data we've been given. That  
12 would be my interpretation. Others?

13 CO-CHAIR ELWARD: I think the only  
14 thing I just want to make clear with Tom is  
15 that given this measure, you can separate out  
16 just the types of bacterial pneumonia or can  
17 you separate out, I mean for me one of the  
18 issues is, can you separate out the various  
19 types of pneumonia either by ICD-9 code or by  
20 site of admission?

21 DR. LYNN: Yes, we're separating  
22 them out by the type of pneumonia, the

1 bacteria, in the case of bacterial types. And  
2 we're not stratifying them of course, we're  
3 just using them as markers for severity  
4 adjustment, risk adjustment.

5 And we do not use, where they, you  
6 know, whether this was diagnosed in a hospital  
7 or diagnosed in the office, and part of that  
8 is related to not wanting utilization to drive  
9 risk or severity.

10 Maybe we need to do that in this  
11 particular case or, but that's why we did it,  
12 because we're sensitive to not having markers  
13 of utilization drive costs, drive our severity  
14 scores for cost.

15 DR. SANTO TOMAS: Maybe just one  
16 thing to think about is as you try to sharpen  
17 this particular measure further is, you know,  
18 one, most people who are diagnosed as an  
19 outpatient community, we've never really  
20 checked for what bacteria they have, we just  
21 treat them.

22 Second, even for those who are



1 admitted to the hospital, in the best  
2 perspective and in fact, you know, kind of  
3 design study, so this is not even how practice  
4 is done so you would think they would have a  
5 better yield.

6 But even in those you only get like  
7 50 percent is the best reports of how much we  
8 are able to identify an organism.

9 So that means a lot of this  
10 pneumonias that you would see coded as  
11 pneumonia would really have no organism  
12 specified. Although, I mean you could list  
13 all the possible organisms, but most of them  
14 would actually have no organism specified at  
15 discharge.

16 MS. TURBYVILLE: Does that mean you  
17 don't think it's possible?

18 CO-CHAIR ELWARD: No, just  
19 practically speaking either the cultures don't  
20 show up or they get treated quickly enough  
21 that, and people forget their cultures or they  
22 just or, you know, I haven't see the last time

1 somebody, you know, even one of my  
2 pulmonology colleagues actually ask for a  
3 sputum culture. I just can't remember when  
4 that happened last.

5 CO-CHAIR MAURER: So they have  
6 condition status they assign to, I mean they  
7 assign different, as a condition status they  
8 assign different organisms, bacterial  
9 organisms in the methodology they gave us. So  
10 they would only be able to do that less than  
11 half the time, probably.

12 MR. BRATZLER: That's true, but  
13 that's the reality of pneumonia. Most of the  
14 time you treat empirically, most of the time.  
15 So that bothers me less than all the other  
16 comorbid conditions, or underlying conditions  
17 that might effect their severity of illness  
18 and their resource use.

19 CO-CHAIR ELWARD: Maybe  
20 differentiating between the different types of  
21 pneumonia doesn't make that much difference.

22 CO-CHAIR MAURER: Well, but that

1 and, in fact, that's maybe the case that you  
2 shouldn't use these bacteria's condition  
3 status or something like that, you know.

4 MR. BRATZLER: I guess if you've  
5 got the information, it's useful. So if you  
6 know if somebody's got gram-negative pneumonia  
7 you can probably predict higher resource use.

8 So I think if you've got it, it's  
9 just we just, and I think they recognize that  
10 most of the time you don't have that  
11 information.

12 So again, I think a lot of this  
13 could be potentially cleared up if we had just  
14 a better understanding of the risk adjustment  
15 methodology, kind of the face validity of  
16 these four strata.

17 They divide them into four  
18 categories of risk based on this weighted  
19 score, and that's what I just don't quite  
20 understand.

21 I've used a lot of different risk  
22 stratification protocols for pneumonia

1 patients, but I just don't have enough  
2 information in the materials to know how they  
3 assigned risk scores and whether those four  
4 categories, you know, to a clinician really  
5 make sense. And I'm sure they've had somebody  
6 look at it. I just don't know what it is.

7 DR. STANFORD: Tom, you mentioned,  
8 you piqued my interest around this issue  
9 around not using resource utilization in your,  
10 can you go over that again and explain your  
11 rationale for not using resource use as part  
12 of your risk adjustment?

13 CO-CHAIR MAURER: You mean,  
14 utilization?

15 DR. LYNN: Yes, I mean if you're  
16 trying to measure whether someone's, you know,  
17 managed resources well, which is what we're  
18 looking at here, finding that.

19 Then even though it would improve  
20 your R score and you can improve your  
21 predictability, you can't really, it's  
22 circular to say, well, you know, you waited in

1 the hospital so you spent more money.

2 So that's one of the reasons that  
3 we try to limit the impact utilization on the  
4 severity score. What we're trying to do is  
5 look at, what's the diagnostic description and  
6 how does that lead to increased utilization?

7 Because if you say or you do  
8 something that is parallel to, if you're in  
9 the hospital then you spend more money, then  
10 are you really looking at how well they  
11 managed the case?

12 Now, you know, again, that's why we  
13 did what we did. We think it's the right  
14 thing to do but, you know, I understand there  
15 would be some, you know, discussion about  
16 that.

17 DR. STANFORD: Yes, and I  
18 understand that. I think that's why you  
19 probably need to stratify by that resource  
20 use. I understand what you mean. I was a  
21 little bit confused around what the  
22 identification time period was, what the

1 measurement time period was.

2 So in that particular case, you'd  
3 want to stratify by that inpatient use or  
4 outpatient use, whatever that may be.

5 DR. LYNN: Right. And we, you  
6 know, we get the opposite message sometimes,  
7 right, that we should because, you know, we  
8 talk about unintended consequences and if,  
9 would that clause be open to put their  
10 patients in the hospital. You know, then  
11 their expected cost for that episode would go  
12 up.

13 CO-CHAIR MAURER: Well, and then by  
14 definition --

15 DR. LYNN: That's another argument.  
16 I'm not necessarily, I'm just representing  
17 that argument.

18 CO-CHAIR MAURER: Yes, and by  
19 definition ventilator associated pneumonia  
20 starts out in the hospital, you know.

21 DR. LYNN: Right. And that's a  
22 good point.

1 CO-CHAIR MAURER: Other comments  
2 about --

3 MR. BRATZLER: Well, like I said,  
4 I would just say again I actually don't have  
5 big arguments with the methodology, and I  
6 think your assessment of not using resources  
7 in the risk adjustment is appropriate.

8 And I just, you know, what I think  
9 about is, if I had a patient that was, if my  
10 anchor record was a patient that came into the  
11 hospital from a nursing home, and versus the  
12 patient who is a walking, you know, 30 year  
13 old that had mycoplasma pneumonia where I  
14 think the resources might be very different in  
15 terms of use, does the risk adjustment  
16 adequately differentiate those two patients?  
17 And that's what I couldn't tell from the  
18 information.

19 For me the big deal is, does the  
20 risk adjustment methodology adequately  
21 separate patients that should be separated  
22 well?

1 DR. LYNN: And it's a tough answer.  
2 It's a tough question to answer, and not just  
3 in providing information, which maybe if we  
4 give the, you know, the R-squared information  
5 about pneumonia may help.

6 But, you know, one of the  
7 challenges we all have with this is that there  
8 really isn't a gold standard. I mean how much  
9 are you supposed to spend on someone who, you  
10 know, has a staphylococcal pneumonia versus a,  
11 you know, gram-negative pneumonia?

12 You know, part of the challenge is  
13 no one knows what that is and so you can't  
14 really compare to some sort of gold standard.  
15 That's one of the challenges. It's a  
16 challenge in evaluating as well.

17 MS. TURBYVILLE: And one thing to  
18 add, Dale, you had also mentioned about the  
19 transfer from the nursing home into a  
20 hospital, with pneumonia, and had also hinted  
21 that it was clear that the data are not also  
22 available.



1                   And just as a reminder, this  
2                   measure like some others, because it was  
3                   tested on the commercial populations, means it  
4                   would be endorsed only for use in commercial  
5                   populations.

6                   So hopefully that at least  
7                   addresses some, though clearly not all yet.  
8                   Hopefully we'll see future measures that can  
9                   capture that information.

10                   MR. BRATZLER: Right. I mean when  
11                   I read any of these measures, it's all about,  
12                   is it useful for public accountability across  
13                   different populations, in different, you know,  
14                   and so that's where I struggle a bit. But I  
15                   do recognize this was tested with the  
16                   commercial population. I do understand that.

17                   MS. TURBYVILLE: Hopefully one day  
18                   we'll have those data soft forms, right,  
19                   you're absolutely right.

20                   MS. FANTA: Moving along to 2b3.  
21                   Are exclusions supported by the clinical  
22                   evidence or analysis of frequency in

1 distribution? Is information about the impact  
2 of exclusions for patient preference  
3 transparent? Missing two votes.

4 Just missing a, maybe these are  
5 giving out.

6 CO-CHAIR MAURER: Where is it, I  
7 wonder if somebody's battery's dead.

8 Yes, you got them.

9 DR. LYNN: You mean that literally  
10 or figuratively?

11 MS. FANTA: Okay. So we have two  
12 high, four moderate and one low.

13 MR. AMIN: Since the exclusions  
14 were really cost exclusions, I think the  
15 concerns of the TAP were the effect of those  
16 exclusions and what they actually, you know,  
17 some more data around what the effect of the  
18 exclusions were, would be, you know, would add  
19 value.

20 MS. FANTA: Okay, 2b4. For  
21 Resource Use Measures, is there an evidence-  
22 based risk adjustment strategy or rationale or

1 data to support no risk adjustment or  
2 stratification? One high, three moderate, two  
3 low and one insufficient.

4 MR. AMIN: Sounds like additional  
5 detail on the risk adjustment methodology, and  
6 potentially stratification on different types  
7 of diseases that's in this cohort would be  
8 needed.

9 CO-CHAIR MAURER: Yes.

10 MS. FANTA: All right, 2b5. Are  
11 performance results reported? Do they  
12 identify differences in performance, or  
13 overall less than optimal performance? Two  
14 high, four moderate and one insufficient.

15 Okay, now here's the vote on  
16 overall validity testing which includes  
17 specifications which are consistent with the  
18 resource use or cost problem, validity  
19 testing, risk adjustment or the identification  
20 of meaningful differences.

21 MR. AMIN: Sarah?

22 MS. FANTA: What?

1 MR. AMIN: Quick, I'm just sorry.  
2 It's taking me a little bit to process the  
3 scores. Can we go back one?

4 MS. FANTA: Yes, yes.

5 MR. AMIN: Can we go back one? I'm  
6 sorry.

7 MS. FANTA: That's okay.

8 MR. AMIN: We did have quite a bit  
9 of discussion around the score for the asthma  
10 measure and also the pneumonia, about what the  
11 point estimates and the interpretability of  
12 the point estimate, and the confidence  
13 intervals.

14 But it would also be interesting,  
15 I'm interested to know the insufficient that  
16 seems to be a little bit stronger than how we  
17 were voting before. If there is anything else  
18 that I missed on?

19 DR. STANFORD: Well, I think I  
20 missed this part because I was looking at  
21 Tiffany and I was looking at my notes p

22 MS. FANTA: Use the, your

1 microphone, sorry.

2 DR. STANFORD: I was confused about  
3 the question because I was trying to think,  
4 did we go over this somewhere? Did we have a  
5 discussion about the p

6 MR. AMIN: Yes, we went, Kathryn  
7 went over the report for the asthma measure.

8 DR. STANFORD: Right, but in terms  
9 of this particular one?

10 MR. BRATZLER: It's the same.

11 DR. STANFORD: Is it? Okay.

12 MR. AMIN: I think that's how it  
13 was.

14 DR. STANFORD: And that was my --

15 MR. AMIN: Okay.

16 DR. STANFORD: That was, so I would  
17 change it to that one.

18 MR. AMIN: I didn't meant to  
19 influence the --

20 DR. STANFORD: My former reference  
21 is basically around this measure, not  
22 necessarily across all of them.

1 MR. AMIN: Oh, okay.

2 MS. FANTA: We'll revote on that  
3 one then. Okay.

4 MS. WILBON: So just to clarify,  
5 this is a revote on whether or not the measure  
6 demonstrated differences in performances,  
7 statistically meaningful differences in  
8 performance. Sorry, you know what I mean.

9 MS. FANTA: Okay, so for 2b5, seven  
10 moderate.

11 DR. SANTO TOMAS: That's what  
12 happens when you take a vote, regression to  
13 the mean.

14 CO-CHAIR MAURER: You're doing a  
15 delphi here, I should keep until it goes  
16 toward the mean.

17 MS. FANTA: Okay, now we'll vote on  
18 the overall validity testing which I already  
19 mentioned before, so unless somebody needs me  
20 to repeat it, we're good.

21 CO-CHAIR MAURER: It is a long day,  
22 isn't it, Sarah?

1 MS. FANTA: And again, seven  
2 moderate.

3 CO-CHAIR MAURER: We've regressed  
4 to the mean.

5 MS. FANTA: All right, for 2c. If  
6 disparities in care have been identified, do  
7 measure specification scoring analysis allow  
8 for identification of disparities through  
9 stratification of results, or is there a  
10 rationale or data that justifies why  
11 stratification is not necessary or feasible?  
12 Okay, so we have two high and five moderate.

13 CO-CHAIR MAURER: Usability?

14 DR. SANTO TOMAS: Yes.

15 CO-CHAIR MAURER: And this is  
16 Linus?

17 DR. SANTO TOMAS: Well, obviously  
18 there's a lot of examples given that they're  
19 saying, you know, I think like nine health  
20 care organizations are using it.

21 My main concern, which has been I  
22 think kind of mentioned previously is, if

1 we're looking for something more global could  
2 be seen across the board, if this is going to  
3 be something public then in that particular  
4 sense, I guess I don't know how usable it  
5 would be.

6 I could see how, even not  
7 distinguishing, for example, you know,  
8 community-acquired pneumonia versus health  
9 care associated pneumonia.

10 But for a particular organization,  
11 and if they're do this in this in a segmental  
12 way, you know, just all their primary care  
13 physicians, all the encounters in the  
14 outpatient, then they could do it in that way  
15 I guess.

16 But if it's something more to be  
17 used in a global sense, then I think then it's  
18 usability may be less because then I don't  
19 know how to interpret, I guess the results  
20 that may come out from that.

21 Again, just the not being able to  
22 distinguish what is community, what is in the



1 hospital.

2 CO-CHAIR ELWARD: That's a great  
3 point, Linus. I'm just wondering, from NQF's  
4 standpoint, are you interested in measures  
5 that are more helpful across, you know, across  
6 plans and across different strata, or can be  
7 used by say, large health systems to know  
8 where they stand?

9 I mean I'm sure both are important.  
10 But of the, you're looking for the more  
11 generalizable measures? I mean public  
12 reporting, I would think so, but --

13 MS. WILBON: Yes, again I'll take  
14 a stab at this, and then Heidi and Sally, or  
15 Taroon can piggyback.

16 So in terms of level of analysis,  
17 which is generally the area in the submission  
18 form where we ask the developer to indicate at  
19 what level this measure would be able to  
20 apply, like what level of analysis the measure  
21 would be able to applied.

22 They would check different boxes.

1 The boxes that they check, we expect them to  
2 also demonstrate in their testing data, that  
3 it is actually like the data that you would  
4 get from applying the measure at that level,  
5 is actually meaningful and useful.

6 So it's more of a, I guess a user,  
7 I mean a developer defined item in this  
8 submission.

9 However, even though we want broad  
10 measures across all different types of level  
11 of analysis, we don't want a measure to be  
12 submitted at the group level and then using it  
13 at the, and then it gets publicly reported at  
14 the physician level. That's not the  
15 intention.

16 We want to make sure that how ever  
17 it's submitted and the intended use, that it's  
18 been tested at that level, that the testing is  
19 sufficient and that it's used at that level.  
20 So am I making sense or no?

21 MR. AMIN: And I would just add,  
22 the only thing I would add to that, Ashlie, is

1 based on this discussion it also should be  
2 clinically relevant. I mean so that's an  
3 interpretation question for the TAP to decide.

4 So and that would really fit sort  
5 of into 3b, where we're talking about whether  
6 it's meaningful for it's intended purpose.

7 The intended purpose being, as  
8 Ashlie described, how the measure is specified  
9 and then making sure that it's clinically  
10 meaningful. But that would be up to you guys  
11 as experts to make that decision.

12 DR. SANTO TOMAS: So I think I may  
13 have made this a medium when I first looked at  
14 it, but the more I look at it now I'm actually  
15 veering more towards really the low as far as  
16 usability.

17 If, just looking, or taking into  
18 account what you've just said as far as, how  
19 it's going to be interpreted and used in a  
20 more general term.

21 CO-CHAIR MAURER: Without knowing  
22 more about how the risk adjustment affects the

1 --

2 DR. SANTO TOMAS: Risk adjustment  
3 and specification of, you know, classifying a  
4 particular kind of pneumonia.

5 MR. AMIN: Could I, I just don't,  
6 look, could we just get a little bit more  
7 clarity for me now, because this question of  
8 generalizability, I don't know that we're  
9 necessarily giving guidance on the question of  
10 generalizability.

11 The measure has it's intended  
12 purpose which has been specified at which  
13 level of analysis, and it needs to be  
14 clinically relevant for that level of  
15 analysis.

16 But the question of  
17 generalizability I don't think that we're  
18 necessarily giving any guidance on. So I  
19 wouldn't want anybody to make a decision based  
20 on NQF guidance on generalizability, so just  
21 that being clarified.

22 DR. SANTO TOMAS: Yes, about

1 pneumonia, right, but without subdividing that  
2 further how useful is this going to be?

3 MR. AMIN: Right. And that's, so  
4 I would classify that as sort of the clinical  
5 logic behind it. If it doesn't clinically  
6 make sense to you as a clinical expert that  
7 the measure of the population, how it's  
8 defined isn't clinically coherent, that's  
9 totally understandable.

10 So that, but I also would reference  
11 that a lot of that is, it does come in 3b in  
12 that it's meaningful. But it's also, a lot of  
13 it was covered in scientific acceptability.  
14 So that's just how p

15 CO-CHAIR ELWARD: If we're  
16 thinking, again compartment of quality, but  
17 mostly just, how much does it cost to take  
18 care of your pneumonia patients?

19 It seems like the measure would  
20 have pretty good reliability on how much it's  
21 going to cost us.

22 What the health plan would need to

1 do or would then say okay, it costs X amount  
2 of dollars. We need to parse it out by the  
3 type of pneumonia we had. If we're doing  
4 really well, we don't want to, you might not  
5 want to bother with it anyway.

6 But if we want to rank ourselves,  
7 we would have the, and maybe Tom, you could  
8 answer this for me. Would we then be able to  
9 break it down by, I may keep asking the same  
10 question a different way, but we would only be  
11 able to break it down by bacterial versus non-  
12 bacterial, right?

13 DR. LYNN: Yes, the rule is  
14 stratified so that viral is looked at and  
15 bacterial is looked at in different episodes.  
16 But then the severity adjustment is based on  
17 more detail. But in most cases it's just  
18 whether or not, or what the organism is like.

19 CO-CHAIR ELWARD: Okay.

20 DR. LYNN: And I think there was  
21 two questions embedded in there, but I  
22 answered at least one of them I think.

1 CO-CHAIR ELWARD: Okay. No, that's  
2 okay.

3 CO-CHAIR MAURER: So I'm not really  
4 sure that will tell you what kind of pneumonia  
5 you, I don't think it's generalizable. I mean  
6 I don't hear that it's generalizable,  
7 necessarily from what we know, do you?

8 CO-CHAIR ELWARD: Well, if we're  
9 looking at just how much does it cost to take  
10 care of pneumonia. You know, all it covers,  
11 at least it doesn't, seems like it allows, if  
12 they're all measured the same way.

13 I mean again going back to the  
14 issue of, whether you do different types of  
15 charges, but in terms of population it seems  
16 like it's fair across the board. I'm not  
17 sure, does that make sense?

18 I mean everybody will have to split  
19 it out, but it does give you an idea of, at  
20 least it's measured the same way across  
21 populations in terms of what type of pneumonia  
22 you're looking at, essentially just lumps it

1 all together.

2 CO-CHAIR MAURER: Exactly.

3 MS. TURBYVILLE: So maybe one way  
4 to think about this is to, you know, different  
5 criteria and usability get to different  
6 issues.

7 So like 3a talks about, is it being  
8 used right now? 3b is, would it as it's being  
9 used and as it's specified, would it be  
10 actionable and meaningful for examining  
11 resource use in pneumonia?

12 And then 3c has another aspect.  
13 So, you know, is the score interpretable, so  
14 does it tell you if it's high or low resource  
15 use for the population?

16 CO-CHAIR MAURER: Yes.

17 DR. SANTO TOMAS: I guess just some  
18 of the, going back to, once you have that  
19 particular measure out there and you could  
20 have unintended consequences, right, as far as  
21 how it's used.

22 So that's I guess my main concern.



1 Without being able to divide into segments  
2 that particular, this broad pneumonia, that  
3 even if you tried to say oh, we're just  
4 looking at whether it's bacterial or viral.

5 Because I'm guessing that if you  
6 actually looked at all the submitted claims,  
7 they're probably going to come out as the  
8 pneumonia non-specific as the majority.

9 I don't know, that would be my  
10 guess. But meaning the minority would  
11 actually go into bacterial or viral.

12 MS. TURBYVILLE: So question to  
13 help us, it sounds like it's a real issue with  
14 the administrative claims data and it's  
15 ability to support what would be useful  
16 differentiation among the different types of  
17 pneumonia, for actionability.

18 And even if, it would even hinder  
19 a health plan, for example's, ability to drill  
20 down into their results and really see.

21 Am I understanding correctly?

22 DR. SANTO TOMAS: Well, you know,

1 again you can tell me whether it's possible or  
2 not, but if the administrative data claim, I  
3 think I heard a while ago that it can be done.

4 But can it really be done, for  
5 example, to look at whether that patient has  
6 been in the hospital or some long-term acute  
7 facility in the past, you know, 60 days, those  
8 kind of stuff.

9 MR. BRATZLER: So I think we're  
10 getting bogged down here.

11 CO-CHAIR MAURER: Yes, I do too.

12 MR. BRATZLER: And so I think we  
13 all agree that we need more information about  
14 the risk adjustment methodology to see whether  
15 or not it adequately helps us feel comfortable  
16 that you can broadly define these.

17 I can tell you, NQF has already  
18 endorsed, it's already publicly reported the  
19 hospital related pneumonia mortality, which  
20 does not separate health care associated from  
21 community-acquired pneumonia. It's pneumonia  
22 mortality.

1           It's got a detailed risk adjustment  
2 methodology, but it is a pneumonia mortality  
3 measure. Not a community-acquired pneumonia,  
4 a pneumonia mortality.

5           So there are examples out there  
6 already that NQF has endorsed, and they're  
7 already publicly reported measures that rolled  
8 up pneumonia as a category.

9           So I'm not going to argue against  
10 doing that. I just want to know more about  
11 whether it clinically, you know, whether a  
12 clinician can do something with the results.

13           If you're in a health plan, this is  
14 a health plan measure, a commercial plan,  
15 whether you can do something.

16           And whether, you know, the doc that  
17 takes care of mostly really sick patients,  
18 immuno-compromised, others that get pneumonia,  
19 whether their data is adequately risk adjusted  
20 to separate them from Kurt's primary care  
21 office, that he is primarily treating, you  
22 know, walking patients with pneumonia.

1 MR. AMIN: I would just add, point  
2 of information just to the end of that, was  
3 that there was a question while we were giving  
4 guidance around the level of analysis.

5 I just want to make sure that the  
6 way this measure is specified on page 38, the  
7 level of analysis is at the clinician  
8 individual and at the clinician team level,  
9 among others which are at a higher level.

10 So just keep that in mind as part  
11 of this discussion that Dale just pointed out.

12 MR. BRATZLER: And that's important  
13 if you're profiling at the physician level,  
14 unless you're comparing them across groups.

15 MS. FANTA: Yes, let's vote. So  
16 3a, usability. Are the measure performance  
17 results reported or suitable to report to the  
18 public at large in national or community  
19 reporting programs? Is there evidence that  
20 the measure performance results are available  
21 for public reporting? So we have six moderate  
22 and one low.

1 MS. WILBON: So we're whispering  
2 because we're trying to again monitor the  
3 whole internal consistency thing. And 3a is  
4 one of those things that is, one of those  
5 subcriteria that's probably the same for all  
6 Ingenix measures.

7 So we just wanted to, actually  
8 wanted to remind you of this before the vote,  
9 but we didn't get to it in time, but so you  
10 kind of hear how you voted on this for the  
11 other Ingenix measure.

12 MS. DORIAN: Which was 1605, and  
13 you voted two high, four moderate, two low and  
14 one insufficient.

15 MS. WILBON: So if you're okay with  
16 that, that's fine. But I just wanted to kind  
17 of call that to everyone's attention, so we're  
18 being internally consistent as much as  
19 possible.

20 CO-CHAIR MAURER: The only thing to  
21 me that's not really consistent there is the  
22 insufficient. You know, I think the moderates

1 and the lows are close enough. And I don't  
2 remember why that was insufficient before.

3 MS. FANTA: So moving onto 3b. Did  
4 submitted information demonstrate that results  
5 produced by the measure are meaningful,  
6 understandable and useful for information, for  
7 quality improvement and public reporting, or  
8 was a credible rationale presented? So one  
9 high, five moderate and one low.

10 Moving onto 3c. Are the data and  
11 result details maintained such that the  
12 Resource Use Measure, including the clinical  
13 and construction logic for a defined unit of  
14 measurement, can be decomposed to facilitate  
15 transparency and understanding? Do you want  
16 to share this first?

17 MS. WILBON: So this again, before  
18 you guys vote is another one where we figure  
19 would be pretty similar to the other Ingenix  
20 measures, just based on kind of common  
21 construction logic.

22 MS. FANTA: And your ratings on the

1 previous one were three high, five moderate  
2 and one low.

3 One high, five moderate, and one  
4 low.

5 CO-CHAIR MAURER: Ashlie, just to  
6 comment on your statement that these are  
7 pretty consistent, there is actually quite a  
8 bit of difference between pneumonia and  
9 asthma.

10 Asthma and COPD should look pretty  
11 much alike, but this is a much more  
12 heterogeneous disease, and that really the  
13 discussion has been about how heterogeneous --

14 MS. WILBON: Yes, okay, that's  
15 fair.

16 CO-CHAIR MAURER: -- this  
17 hospitalization --

18 MS. WILBON: That's fair, that's  
19 fair. And as long as you feel like that's  
20 reflected in the ratings, then we're fine with  
21 that.

22 CO-CHAIR MAURER: Yes.

1 MS. WILBON: Okay, thank you.

2 CO-CHAIR ELWARD: And that's just  
3 some of my votes were based on what was just  
4 said about the fact that NQF already has an  
5 overall global pneumonia measure.

6 Because I thought, well if we're  
7 already doing, you know, if that's been good  
8 enough then maybe I need to kind of cut them  
9 a little more slack. Not taking away anything  
10 that Dale's been saying, which is exactly on  
11 target.

12 CO-CHAIR MAURER: To me, underlying  
13 a lot of this discussion is, we need the  
14 information. We haven't been given the  
15 information, you know.

16 Okay, feasibility. The required  
17 elements are routinely generated and used  
18 during care delivery? Yes, that's true. They  
19 are electronic. That is also true. They use  
20 entirely electronic data elements.

21 Susceptibility to inaccuracy or  
22 errors on unintended consequences and



1 measurement? You know, I guess that this is  
2 reflected somewhat in the discussion that  
3 we've had. We don't really know the answer to  
4 that I would say.

5           Although, you know, as we heard  
6 before this is a huge database. They maintain  
7 it very well. It's productized so, you know,  
8 they have to maintain it for their clients.  
9 So they obviously do a lot of work to keep a  
10 high level of data integrity.

11           So any other comments about  
12 feasibility? We just don't have a lot of the  
13 information because they haven't provided it  
14 to us.

15           MS. TURBYVILLE: Just to jump in  
16 really quickly, because I know the day is  
17 getting very long and this could be me  
18 misinterpreting as well.

19           So one of the things to think about  
20 in feasibility, the testing does help to  
21 demonstrate if it can done, but also if  
22 they've adequately demonstrate that it is

1 being done. Keeping in mind that a lot of the  
2 users won't be using their database, they'll  
3 be using their own database --

4 CO-CHAIR MAURER: Their own  
5 database, yes.

6 MS. TURBYVILLE: -- to measure  
7 their own physicians.

8 CO-CHAIR MAURER: Yes.

9 MS. TURBYVILLE: Or their own  
10 compare organization to organization.

11 CO-CHAIR MAURER: Well, they've  
12 definitely demonstrated it can be done and  
13 they use, a lot of health plans use it.

14 MS. FANTA: Okay, it looks like  
15 we're ready to vote on 4a. Are the required  
16 data elements routinely generated and used  
17 during care delivery? Seven high.

18 4b, are all the required data  
19 elements available in electronic health  
20 records or other electronic sources? If not,  
21 is a credible near term path to electronic  
22 collections specified? Again, seven high.

1                   4c, are susceptibilities to  
2                   inaccuracies, errors or unintended  
3                   consequences, and the ability to audit the  
4                   data items to detect such problems identified?  
5                   One high, five moderate and one insufficient.

6                   MR. AMIN: I mean the question I  
7                   would have is that from the discussion it  
8                   seemed like the majority of these data  
9                   elements would be available.

10                   The way the measure is currently  
11                   specified, it seems the majority of these data  
12                   would be available from electronic sources.  
13                   Is there any other discussion that we want?

14                   MS. TURBYVILLE: This is 4c.

15                   CO-CHAIR MAURER: It's a long day.

16                   MR. AMIN: I will stop.

17                   MR. BRATZLER: So 4c, for 4c, this  
18                   one I'll just say, that I think one of the  
19                   issues that Carlos brought up is just the  
20                   issue about how the data is cleaned, or what  
21                   do you do with missing data, or how much is  
22                   there.

1 I mean, then did make general  
2 comments about they encouraged the plans to  
3 have, you know, rigorous data, but so just  
4 there was a little, in my opinion just a  
5 little insufficiency of information about  
6 that. And what do you do if the plan doesn't  
7 have pharmacy data, and those types of things,  
8 or if it's missing.

9 MS. FANTA: And lastly, 4d. Can  
10 the data collection strategy be implemented?  
11 Is the measure already in operational use, or  
12 did testing demonstrate that it is ready to be  
13 put into operational use? Five high and two  
14 moderate.

15 MS. TURBYVILLE: So now it's big  
16 decision time.

17 CO-CHAIR ELWARD: Yes, I think the  
18 measure is enough like asthma that we can go  
19 through it. What I'd like to do is as we go  
20 through each measure, if the issues are  
21 similar, you can say so and we'll move on.

22 If you have noted something that's

1 specifically different as it pertains to COPD,  
2 let's focus on that, okay?

3 MS. TURBYVILLE: And especially any  
4 kind of clinical inadequacies of the  
5 construction of this measure.

6 CO-CHAIR ELWARD: Exactly.

7 MS. TURBYVILLE: Keeping in mind  
8 that you guys really represent a large amount  
9 of clinical expertise that will help the  
10 Steering Committee. So in particular,  
11 anything that's not quite right for the COPD  
12 measure would be helpful.

13 MR. AMIN: One other process  
14 suggestion that I might have, and you can  
15 disregard as the chairs, but it might be  
16 helpful to go through criterias, subcriteria,  
17 by subcriteria and just vote as we go.

18 CO-CHAIR ELWARD: Oh.

19 MR. AMIN: And that way Sarah can  
20 just read it, we have the discussion. It's  
21 when you feel like it's sufficient, Sarah can  
22 just vote.

1 CO-CHAIR ELWARD: Yes, I'll keep it  
2 short.

3 MR. AMIN: So it's not, you know --

4 CO-CHAIR ELWARD: You will be  
5 introducing some variation in that process.

6 MR. AMIN: I recognize that.

7 CO-CHAIR ELWARD: Inconsistency, it  
8 is.

9 DR. BLAKE: I have a quick  
10 question.

11 CO-CHAIR ELWARD: Yes.

12 DR. BLAKE: We may have talked  
13 about this before, but based on what Mike kept  
14 bringing up about the percent of health care  
15 costs related to the pharmacy charges being  
16 about 50 or more percent, is that similar for  
17 COPD?

18 CO-CHAIR ELWARD: No.

19 DR. BLAKE: What is it for COPD?

20 MR. AMIN: No, it's about 20  
21 percent.

22 DR. BLAKE: Okay. Thank you.

1 CO-CHAIR ELWARD: Oh good, okay.  
2 That's very helpful. Thanks, that's a very  
3 good point. Why don't we go with, let's see  
4 we'll start of with Linus, 2a1? Oh, I'm  
5 sorry, oh 1a, okay. Well, I'll -- thank you.  
6 I'm trying to speed up too much.

7 I think definitely I would say the,  
8 it's the same issues as before with COPD for  
9 the NCQA measure, and I think they've done a  
10 very nice job of just iterating the high  
11 impact and that it addresses it appropriately.  
12 Okay.

13 MS. FANTA: Okay, 1a. Does the  
14 measure focus, address a specific national  
15 health goal, priority, or was data submitted  
16 that demonstrated a high impact aspect of  
17 health care? We're just waiting on three  
18 votes.

19 MS. FANTA: Seven high. 2b, or 1b.  
20 Was data submitted that demonstrated resource  
21 use or cost problems for improvement?

22 CO-CHAIR ELWARD: Yes, and I think

1 they did a good job of presenting that also.

2 MS. FANTA: Waiting on one vote.

3 Seven high. 1c, was the purpose and objective  
4 of the Resource Use Measure clearly described?

5 Seven high. And 1d, are the  
6 resource use service categories consistent of  
7 the measure concept? Six high and one  
8 moderate.

9 CO-CHAIR ELWARD: Okay, thank you.

10 MS. FANTA: Yes.

11 CO-CHAIR ELWARD: Thank you. Linus  
12 can you start us off with 2?

13 DR. SANTO TOMAS: Yes, so measure  
14 is well defined, oh sorry, so as far as the  
15 measure being well defined, within it's own  
16 context I think it is. It could be  
17 consistently implemented across organization.

18 Yes, I think that this may straddle  
19 some of the other subsequent numbers. My main  
20 concern with this really is, just the risk  
21 stratification as well as what it calls COPD  
22 severity, is not really a COPD severity, but



1 actually more of comorbidity severity.

2 DR. STANFORD: I have a question  
3 around the, how they determined their ETG.  
4 The choice of 180 days, I'm a little bit, I  
5 don't quite understand why they chose that.  
6 For asthma they used 365, so why would they  
7 not use the same time frame for COPD, since  
8 they're both chronic diseases?

9 CO-CHAIR ELWARD: Yes, Tom, it's a  
10 good question, do you know?

11 DR. LYNN: I don't have a good  
12 answer for that, why we chose that for COPD.  
13 And kind of a decision made a long time ago,  
14 but, you know, if these kinds of episodes get  
15 chopped up into year-long episodes, it doesn't  
16 make that much difference.

17 CO-CHAIR MAURER: Are you sure it's  
18 180 days though, because I thought that they  
19 said that any product p

20 DR. SANTO TOMAS: I thought they  
21 did say 180 days also.

22 DR. LYNN: Let me see.

1 DR. SANTO TOMAS: I didn't notice  
2 though that the asthma was, yes, until you  
3 pointed it out.

4 DR. STANFORD: You were talking, on  
5 the ETG it says --

6 Well, it says here --

7 DR. SANTO TOMAS: Oh, I think this  
8 is the one, isn't this the one that you were  
9 pointing out a while ago, which is --

10 DR. STANFORD: It says for chronic  
11 bronchitis, the clean period is 180 days  
12 consistent with most, with a more chronic  
13 illness. While asthma is, asthma basically is  
14 365.

15 CO-CHAIR MAURER: I'm sure in here  
16 some place, they say it's a year too.

17 DR. STANFORD: I could not find  
18 that, and if it is in here I apologize.

19 MS. TURBYVILLE: It's on Page 26.

20 CO-CHAIR ELWARD: On Page 26?

21 MS. TURBYVILLE: It's page 26,  
22 S9.3.

1 DR. LYNN: I'm referring to the  
2 original to see what it really is.

3 MS. TURBYVILLE: So we're going to  
4 be looking at S9.3, Page 26, Response by  
5 Ingenix.

6 It says once an episode is  
7 triggered, a year-long episode is created.  
8 Maybe there's contradiction in this  
9 submissions, Richard, so just --

10 DR. STANFORD: Okay, I'm sorry.

11 DR. LYNN: Yes, so it's going to be  
12 created. It's going to be made into a year-  
13 long episode and the clean period has a much  
14 more profound effect on the acute diseases.  
15 It has either essentially no affect on the  
16 comorbidity, I mean on the year-long chronic  
17 disease types of episodes.

18 Because if you started a new  
19 episode in the same year it would be combined  
20 based on the year, not the fact that there was  
21 a period of inactivity.

22 We still need it for various, you

1 know, we use this internally. And it should  
2 be, it probably should be different, but it  
3 actually doesn't have an impact on the  
4 grouping.

5 DR. STANFORD: As a guideline, the  
6 episode included resource focus 12, okay, so  
7 it is a 12-month period?

8 DR. LYNN: Yes, it is definitely a  
9 12-month period.

10 DR. STANFORD: Okay.

11 MS. TURBYVILLE: So Tom, we'll want  
12 to take a look at the entire submission and  
13 make there isn't, you know, some  
14 contradictions somewhere in there as well.  
15 And we'll get back to you on if it needs to be  
16 updated.

17 DR. LYNN: Yes, absolutely. Thank  
18 you. And I apologize for any confusion I  
19 caused.

20 CO-CHAIR MAURER: For 2a2. Oh,  
21 going to vote.

22 CO-CHAIR ELWARD: I'm sorry, we

1 want to go ahead and vote on 2a1, right?

2 Okay.

3 MS. FANTA: 2a1, is the measure  
4 precisely specified? Four high, three  
5 moderate.

6 CO-CHAIR ELWARD: And I think that  
7 reflects in part, as far as I'm concerned that  
8 it's more consistency than the pharmacy  
9 database.

10 CO-CHAIR MAURER: There we go. For  
11 2a2, actually this is very similar to the  
12 asthma ETG, and so therefore they have the  
13 same strengths and weaknesses. I really  
14 didn't have anything else additional. I don't  
15 know if anyone else has anything else  
16 additional.

17 CO-CHAIR ELWARD: Any other  
18 questions? Let's go to 2a2.

19 MS. FANTA: Okay. Does the  
20 reliability testing demonstrate that results  
21 are repeatable? Five high, two moderate.

22 And then moving onto overall

1 reliability. Four high, three moderate.

2 CO-CHAIR ELWARD: Thank you.

3 DR. SANTO TOMAS: Yes, so is there  
4 evidence presented in the measures  
5 specifications allowed to demonstrate  
6 variations and resource use across providers  
7 and population groups? And then does the  
8 measure and risk adjustment methodology  
9 address this variability allowing for fair  
10 comparisons?

11 Again just as far as that  
12 particular part of the methodology, it's more  
13 of the risk adjustment that I have concern  
14 with, which has been voiced earlier.

15 CO-CHAIR ELWARD: Other comments?

16 All right.

17 MS. DORIAN: Just to confirm, we  
18 are on 2b1.

19 MS. WILBON: Yes, I was --

20 MS. DORIAN: Is that what you were

21 --

22 MS. WILBON: I'm trying to make

1 sure the one you read didn't sound like 2b1.

2 CO-CHAIR ELWARD: Well, I think you  
3 were on 2.

4 MS. WILBON: Oh, okay, you read  
5 that 2b1, the measure specifications are  
6 consistent with the evidence presented.

7 CO-CHAIR MAURER: You sure you want  
8 the Carlos' sheets?

9 MS. WILBON: Oh, okay.

10 CO-CHAIR MAURER: Carlos is kind of  
11 principle to replace it.

12 MS. WILBON: Okay.

13 CO-CHAIR ELWARD: Oh. Okay. So the  
14 question is, we want to know whether the  
15 specifications are consistent with the  
16 evidence.

17 MS. WILBON: Yes, that would be the  
18 intent of the measure.

19 MS. FANTA: Two high, five  
20 moderate.

21 CO-CHAIR MAURER: For 2b2, again  
22 it's similar for data elements. It's

1 absolutely pretty much right on track with the  
2 asthma. For a measure score it is absolutely  
3 similar. I think that's it for my information  
4 so that should wrap it up from 2b2.

5 CO-CHAIR ELWARD: Go ahead.

6 MS. DORIAN: For both Ingenix?  
7 Just the asthma, okay. Well, then that was  
8 one high, four moderate, two low and two  
9 insufficient.

10 MR. AMIN: And I believe the  
11 concern there for asthma was, while the face  
12 validity was appropriate the testing method  
13 with the customization was a question around  
14 the, right, and then comparing the  
15 standardized prices versus the real prices.

16 MS. WILBON: And I think Dr.  
17 Schatz, or Mike's issue with the pharmacy  
18 costs at 50 percent being half of the claims,  
19 was an issue for him and he wasn't quite sure  
20 that it was actually measuring cost of asthma  
21 care being that some of that would be missing.

22 So I think the question that



1 Kathryn had before about, if that same issue  
2 applied to COPD, may or may not weigh, and  
3 your ratings may be different based on how  
4 high or how much you weighted that issue  
5 before.

6 CO-CHAIR ELWARD: Yes. Well, the  
7 issue around, which charges do you take into  
8 account for would still pertain.

9 MS. FANTA: So we're voting on  
10 whether or not the measure score reflects the  
11 cost of care resources provided. Seven  
12 moderate.

13 MR. AMIN: So 2b3?

14 CO-CHAIR ELWARD: Yes, please.

15 MR. AMIN: So exclusions are  
16 supported by, so my main thing with this is  
17 aside from the exclusions or beyond  
18 administrative reasons for exclusion it  
19 actually doesn't specify any clinical reasons  
20 for it.

21 I mean just an example, age, for  
22 example should really be something, you know,

1 if somebody is labeled COPD, younger than 40,  
2 then that should raise a flag. Or it doesn't  
3 take into account, you know, or rather  
4 competing diagnosis, asthma in particular.

5 Then I guess how you handled that  
6 with the asthma previously is again, you count  
7 how many episodes are asthma, and somebody  
8 diagnosed them with COPD, is that, I guess  
9 that's the same way, right.

10 But then that should be specified  
11 as far as an exclusion. If somebody has more,  
12 a particular patient having a diagnosis of  
13 both, you know, just make that clear then,  
14 that those patients who have more asthma  
15 episodes should be excluded I guess in this  
16 case.

17 DR. STANFORD: But they're not  
18 excluded. I don't think they're excluded.

19 DR. SANTO TOMAS: I thought a while  
20 ago that if somebody was diagnosed with asthma  
21 --

22 DR. STANFORD: Oh, like they're

1 more asthma.

2 DR. SANTO TOMAS: -- yes, so,  
3 popularity vote.

4 DR. STANFORD: They're more asthma.

5 DR. LYNN: Yes, their results is  
6 they're excluded. And we can explain, I think  
7 what we were doing there, but we didn't put it  
8 in the exclusion area. I understand why maybe  
9 we should have.

10 DR. SANTO TOMAS: And some people  
11 actually have both, so that's the other thing.

12 CO-CHAIR ELWARD: Asthmatic  
13 bronchitis, that's a nice try. But just to  
14 clarify, were there any exclusions like end  
15 stage renal failure, things like that? None,  
16 okay.

17 DR. SANTO TOMAS: So really it's  
18 just administrative that they mentioned,  
19 administrative --

20 CO-CHAIR MAURER: They may come out  
21 at the upper end when they Winsorize it.

22 CO-CHAIR ELWARD: When they

1 Winsorize it, that's a way they did that, yes.  
2 Okay.

3 MS. FANTA: So we're voting on  
4 whether or not exclusions are supported by  
5 evidence. One high, six moderate.

6 CO-CHAIR ELWARD: 2b4?

7 CO-CHAIR MAURER: 2b4, again the  
8 risk adjustment methodology was similar again,  
9 back to the same issues that we had. While  
10 they had a nice description of how they  
11 actually developed their approach, there  
12 wasn't a lot of modeling that was presented,  
13 and that there wasn't the detail that we had  
14 discussed as a group that we would've liked to  
15 see in asthma. The same thing is happening  
16 here.

17 CO-CHAIR ELWARD: And I think our  
18 votes were three high, four moderate and one  
19 low. What's that, b4?

20 MS. DORIAN: I actually have one  
21 high, four moderate, two low and two  
22 insufficient.

1 MS. FANTA: So we're voting on the  
2 risk adjustment strategy. Four moderate,  
3 three low.

4 CO-CHAIR ELWARD: And that's based  
5 on the problem with the R-squared is missing.  
6 So that could be corrected if they, yes, but  
7 that's going to be important. Right, go  
8 ahead. 2b5?

9 DR. BAULDOFF: 2b5 is having to do  
10 with risk factors identified. I'm so sorry.  
11 Risk factors identified are associated with  
12 statistically significant and clinically  
13 meaningful differences.

14 Carlos found that there was  
15 nothing. The one thing I did make a note of  
16 was, does the practical significance, is it  
17 indicated by the relative cost ratio, which  
18 was reflected on pages 32 and 33, was the only  
19 other thing that I brought out there.  
20 Otherwise, it is extremely similar to what we  
21 found in asthma.

22 MR. AMIN: And the issues that were

1 discussed in asthma, I would just add were the  
2 confidence intervals, the point estimate and  
3 the report that Kathryn brought up. The S12  
4 report and the S9, detailed list and nation  
5 score report.

6 MS. FANTA: So we're all set to  
7 vote on 2b5. If they identify differences in  
8 performance or less than optimal performance?  
9 Seven moderate.

10 And now it's overall level of  
11 validity testing. Seven moderate.

12 MR. AMIN: Yes, so the last one,  
13 disparities. If they have been identified, I  
14 mean really as far as this, it looks like  
15 there should be only two that I found that  
16 they're looking at as far as demographic  
17 features, age and gender, which is in a sense  
18 similar to if you just --

19 CO-CHAIR ELWARD: That seems to be  
20 a problem for all the measures throughout.

21 MS. FANTA: Okay. Go ahead and  
22 vote on whether or not disparities are

1 identified or if there's justification for why  
2 they're not. Two high and five moderate.

3 DR. STANFORD: I think it's the  
4 same issues around, I apologize. It's the  
5 same issues that we stated around the asthma  
6 measure as well.

7 I like the fact that they have used  
8 them in other managerial organizations, but  
9 it's difficult to understand exactly across  
10 what types and sizes and how these are being  
11 used. So I think I rated them as a moderate  
12 for usability.

13 It would be nice, and this is true  
14 for even the NCQA stuff, it would be nice to  
15 see these testing in much more broader  
16 populations, much more broader data sets.

17 It would've been nice to have  
18 everybody use the same database basically. It  
19 would've been nice to see that.

20 MS. FANTA: All right, so 3a is, if  
21 the measure results are publicly reported.  
22 Oh, sorry.

1 MS. DORIAN: Shall I, I'll remind  
2 everybody quickly of your votes on the  
3 previous one which were two high, four  
4 moderate, two low and one insufficient.

5 MS. FANTA: Seven moderate.

6 DR. STANFORD: And this was the  
7 question around, this issue around, is it  
8 considered to be an, I was taken around this  
9 issue around understandable and useful to  
10 intended audiences.

11 It is a measure that would be  
12 useful. I think the issues around, can it be  
13 implemented in these health plans in a very  
14 user friendly fashion. So if it can be, I  
15 think that Ingenix has come out with a ways  
16 for them to actually do that, then it would,  
17 you know, increase its usability.

18 But in terms of what we're asking  
19 for 3b, I think it does lend some useful  
20 information for the health plan in and of  
21 itself. Now across health plans, it's  
22 difficult to know because of the issues around



1 standard costing.

2 MS. FANTA: Six moderate, two low  
3 and one insufficient.

4 MR. AMIN: And I think the low  
5 ratings there for asthma reflected a question  
6 of the interpretability of the actual point  
7 estimate.

8 MS. FANTA: So you can go ahead and  
9 vote on whether or not it's usable for quality  
10 improvement and public reporting. Just  
11 waiting on one vote. Seven moderate.

12 DR. STANFORD: Right, so the last,  
13 3c is around, can it be, can you decompose it  
14 and look at other measures? According to what  
15 they've showed us they are able to just  
16 aggregate and look at individual components of  
17 the costs.

18 MS. FANTA: Three high, four  
19 moderate.

20 CO-CHAIR ELWARD: Yes, I'll talk  
21 about feasibility. The required elements I  
22 think is exactly the same as we had before,

1 they are routinely generated, used during care  
2 delivery so I would, I think that's a high.  
3 Let's go ahead and vote.

4 MS. FANTA: Go ahead and vote on  
5 that. All right, we have five high and two  
6 moderate.

7 CO-CHAIR ELWARD: Feasibility in  
8 terms of all the data elements are available  
9 on electronic health records, or I would say  
10 not, but in electronic sources. So I would,  
11 I think this is similar to before. So we can  
12 go ahead and vote.

13 MS. DORIAN: Yes, and you  
14 previously voted seven high and two moderate.

15 MS. FANTA: And we have seven high.

16 CO-CHAIR ELWARD: And I think you  
17 can foresee from my recollection of what we  
18 did with asthma. It looks like they can  
19 identify inaccuracies and errors, and they  
20 have a program to address that. I don't think  
21 there's, other thoughts about that, some  
22 concerns?

1 MS. DORIAN: You did vote one high  
2 and eight moderate last time.

3 CO-CHAIR ELWARD: Okay. Go ahead  
4 and open the vote.

5 MS. FANTA: Three high and four  
6 moderate.

7 CO-CHAIR ELWARD: Okay, and the  
8 last one I think it's clear that it has been  
9 implemented in an operational use by certain  
10 health plans. So, okay, go ahead and vote.  
11 I think we did all seven before, didn't we?  
12 Oh, all high?

13 MS. DORIAN: You did four high,  
14 four moderate and one insufficient.

15 CO-CHAIR ELWARD: Oh, yes, right,  
16 thank you.

17 MS. FANTA: Three of six high and  
18 one moderate.

19 DR. LYNN: I think you guys are  
20 exactly on time.

21 MS. TURBYVILLE: Impressive, Tom?

22 MS. WILBON: So operator, Katie,

1 can you open the line to see if there's anyone  
2 there for a public comment?

3 OPERATOR: Certainly. And if you  
4 have a comment, please press star 1 on your  
5 telephone keypad at this time. And we have no  
6 comments at this time.

7 MS. WILBON: Okay. You guys  
8 finished in record time, I think from that  
9 last measure, which is great. You're going to  
10 probably get out of here 15 minutes early.

11 So again, I just wanted to thank  
12 everyone for your efforts today, really great  
13 work. We got through all the measures.

14 Staff will be going over the next  
15 few weeks, we've had several meetings, we'll  
16 be going over all of our notes, compiling  
17 everything, doing follow-up with the  
18 developers.

19 The items that you guys have  
20 questions about we will be following up with  
21 the developer on, and we will forward your  
22 ratings based on the measure as is.

1                   But we will forward that additional  
2 information to the Steering Committee so they  
3 can address those gaps that you identified,  
4 along with the information that they  
5 submitted.

6                   We will have a follow-up conference  
7 call on August 2nd. We did actually schedule  
8 an additional call for the 17th, so you can  
9 take that off your calendars.

10                   We did two calls up front because  
11 we weren't sure how, we knew we weren't going  
12 to get through everything at the in-person  
13 meeting, but at the time we still had the ABMS  
14 measures on our plate so we were kind of  
15 anticipating that additional discussion.

16                   What we're going to do is we're  
17 going to contract, or smush all the ABMS  
18 measure feedback. My brain is really  
19 compressed.

20                   CO-CHAIR ELWARD: Smushed.

21                   MS. WILBON: Thank you. Shortened,  
22 compressed that discussion into one conference

1 call. We'll go through the measures and by  
2 the criteria, but probably not in the detail  
3 that we do here. Just so they have some  
4 feedback to carry forward as they refine their  
5 measures.

6 CO-CHAIR MAURER: So we're not  
7 going to wait for ABMS to revise whatever they  
8 felt like they needed to revise before we see  
9 it again?

10 MS. WILBON: No, they're actually  
11 taking them out of the process. So the review  
12 that we're doing for them on the August 2nd  
13 call is really more of a professional kind of  
14 courtesy for the effort they've put in, and  
15 the fact that we do actually want them to  
16 bring their measures back to NQF at some  
17 point.

18 They've put in a lot of work and  
19 they do have a really good concept for these  
20 measures and we want to try to help them, you  
21 know, get them to the level that they'd be  
22 ready to bring back into the process.

1 DR. BLAKE: And would this group be  
2 involved with that at that later date?

3 MS. WILBON: Yes, so the people who  
4 have already, you guys have already reviewed  
5 those measures so that input will be, that you  
6 entered into the Survey Monkey tool, we'll be  
7 compiling that and submitting that to them in  
8 addition to any of the verbal kind of  
9 discussion about the measures.

10 And the team will be thinking about  
11 how we can kind of, along with the co-chairs  
12 to figure out how we can kind of truncate that  
13 discussion in a useful way to get, I think  
14 it's like six measures, in a two-hour time  
15 frame.

16 So we'll kind of do some thinking  
17 about that and hopefully structure the call to  
18 kind of get through that in that two hour.

19 CO-CHAIR ELWARD: So we should be  
20 prepared. If we've reviewed the ABMS measure,  
21 we should be prepared to talk about those?

22 MS. WILBON: Yes, particularly

1 those that were assigned as a primary reviewer  
2 for those measures.

3 We'll kind of be leaning on you to  
4 give your input on those, and hopefully that  
5 will generate some discussion and feedback  
6 from others. But yes, we are still interested  
7 in your feedback on those measures.

8 DR. BLAKE: So after August 2nd,  
9 will we still be involved with ABMS as they  
10 move forward?

11 MS. WILBON: No. No, they're going  
12 to be removing them from the process. Staff  
13 will take on the responsibility of compiling  
14 that feedback and getting it back to them.  
15 And then they're going to kind of continue on  
16 their own path too.

17 MS. BOSSLEY: And I would just add  
18 that we know at some point we will have  
19 another project that it focuses on resource  
20 use, and our hope is that at that point,  
21 they'll be able to bring the measures back.

22 And then we'll figure out if we're



1 using the same structure as we did for this  
2 first project or not, but yes.

3 MS. WILBON: The Survey Monkey will  
4 still be available. You're welcome to do  
5 that, but the call on the 2nd, I mean if you  
6 would rather just kind of give your input  
7 verbally, we'll be prepared to take that.

8 We're going to record the call and  
9 all that so, but if you have enough that you  
10 feel like you need to write it down and you  
11 won't be able to articulate it verbally, we'll  
12 take either one. So we're open to whatever is  
13 convenient for you on that. Any other  
14 questions?

15 I want to thank our co-chairs for  
16 getting us done 15 minutes early. You guys  
17 did a great job today. Way to push through  
18 everyone, and we'll be in touch, okay. Thank  
19 you.

20 CO-CHAIR ELWARD: Well, we really  
21 want to thank all the members, but  
22 particularly you all as the staff here, really

1       amazing, you know.  Sally, Sarah, Lauralei,  
2       Ashlie.

3                       (WHEREUPON, the meeting in the  
4       foregoing matter was concluded at 4:50 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Pulmonary Technical Advisory Panel

Before: Kurtis Elward and Janet Maurer, Co-Chairs

Date: 07-19-11

Place: Washington, DC

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