

NATIONAL QUALITY FORUM

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RESOURCE USE CARDIOVASCULAR/DIABETES
TECHNICAL ADVISORY PANEL MEETING

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TUESDAY

MAY 10, 2011

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The Technical Advisory Panel met at the offices of National Quality Forum, Suite 600 North, 601 13th Street, N.W., Washington, D.C., at 8:30 a.m., Jephtha Curtis and James Rosenzweig, Co-Chairs, presiding.

PRESENT:

JEPHTHA CURTIS, MD, FACC, Co-Chair, Yale
University School of Medicine

JAMES ROSENZWEIG, MD, Co-Chair, Boston Medical
Center and Boston University School of
Medicine

MARY ANN CLARK, MHA, Neocure Group
CONSTANCE HWANG, MD, MPH, Resolution Health,
Inc.

THOMAS MARWICK, MBBS, PhD, Cleveland Clinic
DAVID PALESTRANT, MD, Cedars-Sinai Medical
Center*

BRENDA PARKER, PharmD, GlaxoSmithKline

KATHERINE REEDER, PhD, RN, University of
Kansas School of Nursing

WILLIAM WEINTRAUB, MD, Christiana Care Health
System

NQF STAFF:

TAROON AMIN, MPH

HEIDI BOSSLEY, MSN, MBA

HELEN BURSTIN, MD, MPH

SARAH FANTA

ANN HAMMERSMITH, JD

SALLY TURBYVILLE, MA, MS

ASHLIE WILBON, MPH, BSN

ALSO PRESENT:

CARLOS ALZOLA, MS, Data Insights

BEN HAMLIN, MPH, National Committee for
Quality Assurance (NCQA)

TODD LEE, PharmD, PhD, American Board of
Medical Specialties (ABMS)*

TOM LYNN, MD, Ingenix

KEVIN STROUPE, PhD, ABMS-REF*

KEVIN WEISS, MD, MPH, American Board of
Medical Specialties (ABMS)*

* Participating via telephone.

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

2 (9:00 a.m.)

3 MS. TURBYVILLE: Good morning and
4 welcome, everyone.

5 I want to give Helen Burstin as
6 well as the two Co-Chairs, Jeff and James a
7 chance to welcome you at this time.

8 DR. BURSTIN: Good morning,
9 everybody. Helen Burstin, I'm the Senior V.P.
10 for Performance Measures at NQF. Thank you
11 for coming to what I think will be an
12 incredibly interesting meeting. This is our
13 first foray into resource use measures. We'd
14 had a brief one phone call with the steering
15 committee, but this is our first in-person
16 meeting. So we really do view the resource
17 use measures as being critical building blocks
18 toward getting to measures that get us at
19 value. And Jeff has already had a measurement
20 framework a couple of years ago that made it
21 very clear that we don't believe these
22 measures in isolation -- should be used in

1 isolation, and should always be coupled with
2 quality measures to get at value. So we
3 really do view these as being important
4 building blocks that will ultimately help us
5 knit those together in better measures of
6 efficiency and value.

7 So we've got a great team working
8 with you today, and thank you.

9 CO-CHAIR CURTIS: Hi, Jeptha
10 Curtis. Thanks to everyone for all the time
11 you've already put on this project in advance
12 of all the time we're going to do in the next
13 two days. I think it's going to be a very
14 intense kind of meeting with something of a
15 process, potentially an iterative process
16 where, as we work through this new process or
17 this -- these new sets of measures.

18 This is the first time, as Helen
19 said, that resource use measures have been
20 evaluated by the NQF, and we are the first TAP
21 within the resource measure process. So this
22 is the first time that these criteria have

1 been implemented, which is challenging. And
2 so we are -- maybe it's not the right analogy,
3 but I think we're all, to a certain extent,
4 going to be feeling our way in the dark and
5 relying on each other to bring the issues
6 forth.

7 The advantages, that there are, I
8 think three measures, measure developers that
9 are represented in this set of measures, and
10 so within each, there's seven ABMS measures
11 that I think all have very common themes to
12 them. So as we're discussing the first one,
13 I expect that we'll probably end up spending
14 a lot of time going through that. And once we
15 get that traction, that will help us
16 facilitate us going through the rest of the
17 measures.

18 I think the one thing that I want
19 to be aware of or make you guys, something to
20 be cognizant of is, there's this possibility
21 of drift in our evaluation as we're going
22 through them, that the criteria or the

1 threshold that we're setting for the first
2 measure as we're going through it may change
3 over time. And so I don't think there's a
4 formal way of being aware of it, aside from
5 having -- asking the NQF staff to sort of keep
6 us on target and potentially bring us back to
7 measures if they get the sense that we've
8 drifted away and are applying a different
9 threshold than we did originally.

10 And in terms of keeping us on
11 timelines, I think we will be using the
12 parking lot with some frequency for some
13 issues that we don't think we'll be able to
14 resolve in a timely fashion, but that are
15 important enough that they would need to be
16 fed back to the measure developers or
17 addressed in a group format going on.

18 So with that, I'll turn it over to
19 Jamie.

20 CO-CHAIR ROSENZWEIG: Yes, hi, I'm
21 Jamie Rosenzweig. I'm co-chairing this
22 meeting along with Jephtha, and I'm -- whereas

1 Jephtha is a cardiologist and most of these
2 measures relate to cardiology, I am an
3 endocrinologist and my focus has always been
4 related to diabetes, although to a large
5 extent I've done a lot of work related to
6 cardiovascular risk in diabetes.

7 And so I will be focusing at least
8 more on the diabetes-related measures and also
9 the comorbidity aspects for the -- that apply
10 to the processes that we'll be reviewing.

11 I have a background in quality
12 improvement measure development, cost and
13 resource uses to a certain extent is a newer
14 field for me, although I've done work related
15 to costs -- disease management programs and
16 the costs and how they affect the costs of
17 care. So this is going to be a very
18 interesting process. And although I think we
19 want to be able to keep on schedule, I think
20 since we're the first of various groups that
21 are going to be dealing with these particular
22 types of measures for NQF, we need to make

1 sure that we cover these areas adequately.
2 And I think what we'll -- you know, we'll have
3 to do the best we can to be able to fit -- to
4 be able to take care of as much as possible
5 during the time allotted.

6 I would mention that we have
7 excellent vendors here who are providing very
8 interesting ways of looking at these
9 processes, and the ways of looking at them are
10 very interesting and also very different. But
11 they're not only -- they won't only -- one
12 particular process may apply more effectively
13 for certain disease states than they will for
14 others. And some of the disease states we're
15 talking about have many more acute related
16 problems, and others are much more chronic and
17 less self-limited in terms of times of
18 episodes of care.

19 So we're going to have to really
20 look at each disease state independently to a
21 certain extent and see how they apply to these
22 particular approaches.

1 And I want to thank everyone for
2 their extensive efforts on really a -- going
3 through a tremendous amount of material in
4 order to prepare for this meeting.

5 MS. WILBON: And while everyone's
6 kind of going through introductions, we have
7 our general counsel, Ann Hammersmith, here.
8 She's going to walk us through the disclosure
9 of interest process. So since this is our
10 first time evaluating measures, we do need
11 everyone to kind of go around and disclose any
12 conflicts of interest and maybe as you call
13 their names they could -- just allow them to
14 give a brief introduction of themselves and
15 disclose their interests at that time, as
16 well.

17 MS. HAMMERSMITH: Good morning,
18 everyone. As you recall, we sent you a
19 disclosure of interest form and policy several
20 weeks ago, maybe a month ago even, which you
21 filled out. And we vet these very carefully,
22 so if you're sitting on the committee, it's

1 highly unlikely that we regard you as having
2 a real or apparent conflict of interest.

3 But in the spirit of openness,
4 we're going to ask you to go around the table
5 and disclose any interests that you believe
6 are relevant to your service on this panel, in
7 particular any grants or consulting
8 arrangements that you have that are -- that
9 you believe are related to the material before
10 the committee.

11 What I'd ask you to do is go
12 around the table, identify yourself, tell us
13 who you are with. You don't need to recount
14 your resume but obviously we are interested in
15 what your background is. I also want to
16 remind you that you sit on this committee as
17 individuals. You do not represent the
18 interests of any group, including your
19 employer or any group that may have nominated
20 you to sit on this committee.

21 So with that, I will turn to my
22 right and start with you, Ms. Reeder. NQF

1 staff, you don't need to disclose anything.

2 DR. REEDER: Hello, my name is Kay
3 Reeder, from Kansas University Medical Center
4 in Kansas City, Kansas. I have an NIH five-
5 year K99 R00 awarded August 2010 through July
6 15, and I'm a consultant for a cardiology
7 fellowship in Iowa, and -- remotely. And I do
8 work with the Iowa Health System based in Des
9 Moines. I have no conflicts of interest.

10 MS. PARKER: Hi, good morning,
11 Brenda Marie Parker. I often say Marie, so
12 that's why I include that. I have a
13 background in pharmacy and a Master's in
14 Public Health and Health Outcomes. I've
15 managed patients with diabetes and
16 cardiovascular conditions, mainly chronic
17 conditions. I work for GlaxoSmithKline in the
18 applied outcomes group there and have no
19 conflict of interest.

20 MS. CLARK: Hi, I'm Mary Ann
21 Clark, I work for a small health care
22 consulting firm, Neocure Group, based here in

1 D.C. We work with medical device
2 manufacturers on health economics and
3 reimbursement-related issues. I have a lot of
4 experience in the cardiovascular area. I
5 formerly worked for a Boston scientific
6 corporation evaluating technologies there.
7 And many, many years ago, I worked on the
8 Harvard RBRVS Study with Bill Hsaio. And in
9 terms of conflicts, because I work for a
10 consulting firm, we have a lot of
11 cardiovascular device companies as clients,
12 large and small. So that's my disclosure, I
13 guess.

14 DR. HWONG: Hi, good morning. I'm
15 Connie Hwong, I'm the director of Clinical
16 Affairs and Analytics at Resolution Health
17 which is a wholly owned subsidiary of
18 Wellpoint. I'm a general and internal
19 medicine physician. My experience with
20 quality measures is we do, at Resolution
21 Health, a lot of physician quality profiling.
22 We also are measure developers and we have 25

1 NQF-endorsed clinically enriched claims-based
2 quality measures which are primarily process
3 measures.

4 The physician quality profiling we
5 do is also coupled with efficiency scores, so
6 that is some of the sort of working experience
7 I've had in terms of the applications of
8 quality measures and efficiency. I have no
9 conflicts to disclose. Thank you.

10 CO-CHAIR ROSENZWEIG: I'm James
11 Rosenzweig. I'm a director of Diabetes
12 Services at Boston University School of
13 Medicine and Boston Medical Center. I am the
14 -- with respect to conflicts of interest, I am
15 the Chair of the Performance Measures
16 Subcommittee of the Endocrine Society and also
17 member of their Clinical Affairs Core
18 Committee. And I represent the Endocrine
19 Society at the American Medical Association
20 Physician Consortium for Performance
21 Improvement.

22 I was the former Chair of the

1 National Diabetes Quality Improvement
2 Alliance, which was the original group that
3 put together a set of quality and performance
4 measures for diabetes that were eventually
5 submitted to NQF. I've been on a number of --
6 I've been on two other, I think, diabetes
7 Technical Expert Panels in the past. The one
8 last year related to episodes of care.

9 With respect to specific conflicts
10 of interest, I'm on the Scientific Advisory
11 Board of Alere Medical, which is a disease
12 management company, for which I receive a
13 small honorarium. And I have a -- I've been
14 involved in several educational programs
15 through Boston University that are supported
16 by unrestricted educational grants for CME-
17 related activities from several organizations,
18 including the Hearst Foundation and Sanofi-
19 Aventis.

20 CO-CHAIR CURTIS: Jephtha Curtis, I
21 work at Yale University in the Yale Center for
22 Outcomes Research and Evaluation. I am a

1 clinical cardiologist and interventional
2 cardiologist as well as a health services
3 researcher.

4 My experience in quality metrics
5 in general is -- has been in the development
6 of outcomes measures. I've been part of the
7 team at Yale that has developed the six
8 publicly reported outcomes measures for AMI,
9 pneumonia and heart failure, for better or
10 worse. And I have more recently been involved
11 with additional measures for PCI mortality and
12 readmission, none of which I think represent
13 a conflict of interest for this particular
14 endeavor. And -- with the exception, I guess
15 I do receive salary support under the CMS
16 contract for measure development.

17 That should be it.

18 DR. WEINTRAUB: Good morning,
19 everybody. I'm Bill Weintraub. I'm Chairman
20 of cardiology at Christiana Care in Delaware,
21 professor of medicine at Thomas Jefferson
22 University and professor of Health Sciences at

1 the University of Delaware. I was at Emory
2 University for many years, and I'm professor
3 emeritus of medicine and public health as an
4 investigator. I'm a cardiovascular
5 epidemiologist. I've had federal funding for
6 the last 30 years and hope to continue doing
7 that for the next 30 years. We'll see.

8 I have been very involved with the
9 American College of Cardiology and the
10 American Heart Association. I was one of the
11 people that developed the National
12 Cardiovascular Data Registry and remain on the
13 Registry Board. I'm also on the informatics
14 committee and I'm the incoming Chair of the
15 Data Standards Committee for -- or a task
16 force, really, for -- which is a combined task
17 force of the American Heart Association and
18 the American College of Cardiology.

19 At the AHA, I'm on the advocacy
20 committee and I'm the incoming president of
21 the Great Rivers affiliate. I have many
22 relationships with industry, all of which I've

1 disclosed, but I don't believe any of them are
2 conflict of interest for these activities.

3 Thank you.

4 DR. MARWICK: My name is Tom
5 Marwick, I'm a cardiologist at Cleveland
6 Clinic. My interest is in cardiovascular
7 imaging and particularly in outcomes research
8 related to that. I have a number of grants
9 related to technical developments with
10 industry, but none that are pertinent to this
11 activity.

12 MS. HAMMERSMITH: Thank you for
13 those disclosures. Are there any panel
14 members on the phone?

15 DR. PALESTRANT: Yes, my name is
16 David Palestrant. I'm a stroke neurologist
17 and neurointensivist at Cedars Sinai Medical
18 Center. I built both programs here at Cedars
19 so I have some background in performance
20 metrics.

21 I have -- my disclosures are I'm
22 OPI and PI on numerous multi-center studies

1 for which I receive no direct funding. And I
2 have no other conflicts.

3 MS. HAMMERSMITH: Okay, thanks.

4 Is there anyone else on the phone?

5 (No response.)

6 MS. HAMMERSMITH: Do any of you
7 have any questions of me or anything that you
8 want to discuss with each other based on the
9 disclosures that have been made today?

10 (No response.)

11 MS. HAMMERSMITH: Okay, that's the
12 usual response. Thank you. Have a good
13 meeting.

14 MS. WILBON: Thank you, Ann. So
15 now that everyone on the TAP hopefully is a
16 little more familiar with each other, staff,
17 I guess we should introduce each other. I
18 think we had opportunity to hopefully greet
19 each one of you as you came in but we'll --
20 I'll start with Sally and we can introduce
21 ourselves.

22 MS. TURBYVILLE: Good morning,

1 everyone. I am Sally Turbyville, and we have
2 all met via phone. I'm very pleased to see
3 everyone here today. I'm the senior director
4 on this project working along with the rest of
5 the team who will introduce themselves. And
6 we are really looking forward to today. We
7 acknowledge that there are a lot of materials
8 involved and that this is new, so we expect
9 some bumps along the way. And we look to you
10 to understand if there's anything we can do to
11 improve the process in real time or looking
12 forward as we continue to work with all of you
13 through this project. So welcome.

14 MR. AMIN: My name is Taroon Amin.
15 I am assisting the team as a senior director
16 on this project, as well. I will be tasked
17 with the effort of making sure that the
18 measure evaluation drift is minimal. So I
19 look forward to the discussions over the next
20 two days.

21 MS. WILBON: So good morning. I'm
22 Ashlie Wilbon, I'm the project manager on the

1 project. And it's nice to finally put faces
2 to names and, yes, I'm the person who's been
3 sending all those emails to you. So thank you
4 for your patience. And it's been -- it's a
5 new process for us all and we're trying to do
6 our best not to inundate everyone and
7 realizing that it's a lot of information. So
8 thank you, everyone, for reviewing everything
9 and for being here today.

10 And I'll be just taking notes
11 through the process and making sure that we've
12 captured everything throughout the course of
13 the meeting and making sure we're sticking to
14 our process. Thanks.

15 MS. FANTA: Good morning,
16 everyone. I'm Sarah Fanta, Research Analyst,
17 NQF, working on this project with the rest of
18 the team. I'm really looking forward to
19 working with all of you during this process.

20 MS. WILBON: So I think we'll
21 start with the folders that everyone got. I
22 just want to walk you through what's in that

1 folder. There will be several materials in
2 there that you might want to refer to
3 throughout the day.

4 So the first paper in the right
5 side of your folder should be an agenda,
6 followed by, I believe, either -- I took -- I
7 moved some of my papers around, so it's either
8 the slides that we're going to go over or the
9 roster, followed by the measure review
10 assignments that we sent out. So each measure
11 is on the left followed by -- next to the
12 assigned reviewers and the lead discussant is
13 in bold. So that will be -- we'll talk a
14 little bit more about what's involved for the
15 lead discussant in a few minutes. But that
16 list for you to refer to.

17 That is followed by a table of the
18 submitted measures with the title, description
19 and developer. And that should be followed by
20 the actual resource use evaluation criteria,
21 which includes the notes in that packet. That
22 is followed by the table of -- the side-by-

1 side table of the criteria and the measure
2 submission items that we sent out. I suspect
3 that, as we start getting through -- getting
4 into the actual subcriteria ratings, that that
5 will be very helpful to pull out.

6 That should be followed by the
7 summary that we sent out on Friday. We've
8 compiled all of the online measure evaluations
9 that had been submitted as of, like, Friday
10 evening and we sent that out. And then we did
11 the same thing last night. So the document
12 following that is what was submitted as of 5-
13 9.

14 So we were hoping that, for the
15 lead discussants, as you're introducing the
16 measure and summarizing what's been evaluated
17 so far, that you'd be able to use that
18 information to kind of give everyone an idea
19 of, you know, where people agreed or
20 disagreed. And what people's general feeling
21 was about the measure for those who submitted
22 their evaluation.

1 And then followed that --
2 following those two documents are the travel
3 memo that we sent via email along with the
4 reimbursement form. It's on paper. We sent
5 you the Excel file as well, so as you're here,
6 please remember to keep all your receipts.
7 Meals should be itemized receipts and you can
8 either write it down on paper or, you know,
9 type it in to the Excel spreadsheet when you
10 get back home and send that in when you do
11 your -- at the end of the trip when you submit
12 your reimbursements to NQF.

13 So you should also have -- I'm
14 sorry if I missed it -- is a table that has a
15 side-by-side of the reliability and validity -
16 - evaluating reliability and validity. So
17 we'll be referring to that, as well. It's a
18 cheat sheet to kind of, as we're evaluating
19 scientific acceptability as to the types of
20 things you should be looking for, as you're
21 rating things high, moderate or low. So
22 again, it's another piece of information to

1 add to your already exploding brains, I'm
2 sure.

3 All right. So I'm going to --
4 we're going to go ahead and just do a quick
5 introduction to the meeting and hopefully get
6 out of the way some of the process-oriented
7 things and goals for the meeting and what
8 we'll be looking for today.

9 So our agenda, we've already done
10 our roll call and DOI and we're going to get
11 into some of the goals and objectives for the
12 meeting.

13 So we've mentioned already a
14 couple times today that, you know, one of our
15 main goals, in addition to understanding the
16 consensus-development process, we'll do a
17 quick review of that, really understanding the
18 subcriteria-evaluation process. And as Jeptha
19 mentioned, it's going to be sort of an
20 iterative process. This is the first time
21 we've applied the criteria that we've
22 developed for resource use measures to the

1 resource use measures in this process.

2 So and as we're beginning the
3 measure review process, we'll start with the
4 measure overview, which will be started with
5 the measure developers giving a brief overview
6 of the measures and then the lead discussant
7 jumping off the discussion for the TAP.

8 That will lead into the discussion
9 of the measures by each of the subcriteria,
10 and then we'll have you rate each of the
11 subcriteria with using your remotes. And
12 those will be the final ratings that we will
13 use and forward on to the steering committee
14 who will look at what you guys have discussed
15 and how you've rated the subcriteria. And
16 then make their recommendations on the overall
17 criteria and ultimately the measure.

18 And again, we're -- you guys are
19 the first group. You're our guinea pigs, so
20 to speak, so throughout the process we're
21 going to be looking to find ways to either
22 find efficiencies or improve as we go along.

1 So with the consensus-development
2 process, we start with the project-specific
3 topic. This project was funded by HHS and
4 it's been going on for a while. But for this
5 consensus-development process, we're actually
6 reviewing the measures. Once we have the
7 project topic, we gather the steering
8 committee and the TAPs to review the measures
9 and give us their expert opinions on -- based
10 on the criteria.

11 Once we've got those
12 recommendations, we pull together a draft
13 report and we put that out for public and
14 member comment. And after the public and
15 member comments on that, we bring it back to
16 the steering committee, usually to provide any
17 inputs. Sometimes it may change some of
18 their, you know, views on how they have
19 evaluated the measures.

20 We then put it out for member
21 voting. The public and member comments, the
22 member votes then go to the CSAC for review.

1 And our CSAC, or Consensus Standards Approval
2 Committee, is an overarching body that reviews
3 the recommendations of all the committees and
4 TAPs that -- for each of our projects to make
5 sure the process was adhered to and that the
6 recommendations that were made should move
7 forward to the Board for ratification.

8 And once the Board has ratified
9 the measures, we put those measures out for
10 appeals in case anyone has any final comments
11 about the measures. So that's, in a nutshell,
12 a high-level overview of the consensus-
13 development process. And again, we're focused
14 right there where the yellow and the red
15 circles are.

16 So for this particular project,
17 we've divided into two cycles. And these next
18 few slides you've already seen before, but we
19 figure repetition is the best way to approach
20 it at this point; there's so much information.
21 So for this first cycles, we're only looking
22 at the cardiovascular diabetes and non-

1 condition-specific measures. So we tried to
2 take off a smaller chunk to start with,
3 realizing this was a new process, and learn
4 from the process for this first cycle, and
5 hopefully apply any things that we've learned
6 towards the next cycle, which has pulmonary,
7 cancer and bone joint measures.

8 So the measure review process, we
9 start out with the staff review, once the
10 measures were submitted. So even though you
11 guys got the measures about two and a half
12 weeks ago, we've been working with the
13 developers the last two months to try to get
14 the submission forms to a point where they
15 were complete enough and responsive to the
16 question and to a point that we felt like was
17 good enough to pass on to you guys to begin
18 review. So there's been a lot of work before
19 you get that to make sure that it's ready to
20 pass on for review.

21 We just obtained -- yay - our
22 statistical consultant who will be attending

1 the meeting today, starting at about 10:00
2 a.m. to 2:00 p.m. today. He's really going to
3 be focusing on the risk-adjustment methodology
4 and the testing -- reliability and validity
5 testing information that was submitted with
6 the measures. We've asked him to focus on
7 each of the measure developers, based on kind
8 of what Jephtha was saying, that a lot of the
9 measures submitted by an individual developer,
10 they used kind of the same methods throughout
11 each of the measures, regardless of what the
12 focus of it was. So we're going to have
13 Carlos come and answer any -- share with you
14 what his analysis was of each of those
15 developers' methodology, so you have an
16 opportunity to ask questions. And hopefully
17 what he's able to share with you on those
18 first three developers will help you carry
19 through for the rest of the meeting those
20 principles to help you apply going forward.

21 So the -- on the -- I guess the
22 left side, the steering committee has already

1 started reviewing the non-condition-specific
2 measures. We had a conference call with them
3 last week, I believe. And then you guys are
4 on the right side with the TAP evaluation of
5 the condition-specific measures, starting out
6 with cardiovascular. And as I mentioned, what
7 you guys -- however you guys -- the ratings
8 that you guys submit today will be passed on
9 to the steering committee for their evaluation
10 of the overall criteria and recommendations
11 for endorsement.

12 So the role of the TAP at this
13 point is to evaluate the candidate measures
14 against the NQF evaluation subcriteria to
15 identify the strengths and weaknesses of the
16 measure focusing on the clinical logic and
17 provide guidance, again, to the clinical
18 applications of the measures. Again, the
19 composition of the TAPs is quite different
20 from that of the steering committee. We
21 purposely kind of made the TAPs really heavy
22 in methodologists and clinicians who are

1 focused on the condition area of the measures.

2 So what we're going to be trying
3 to focus on today as we're evaluating the
4 measures, we understand having gone through
5 our first call with the steering committee
6 that there's going to be a period where
7 everyone's just trying to understand in
8 general the concept of the measures. So you
9 know, kind of ask any questions of the
10 developer that needs to go on so everyone's
11 comfortable with taking a deeper dive into the
12 measure. And once we're ready to do that
13 deeper dive, we're really going to try to keep
14 it focused on the criteria.

15 So ultimately what we need you
16 guys to do is feel comfortable with rating the
17 criteria based on what was submitted for the
18 measure on a scale of high, medium or low, so
19 that that can be passed on to the steering
20 committee.

21 And we'll -- also in your folder,
22 you should also have a paper with the voting

1 instructions on there. And I think before we
2 do our first voting using those remotes, we'll
3 kind of go over the mechanics of it. But
4 essentially, Sarah will be controlling the
5 slides over there and we'll just ask you to
6 hit 1, 2, 3, 4 or 5, based on the subcriteria
7 that will be on the screen. You just hit your
8 number, and it -- the results will show up on
9 this little -- this big screen over here to
10 the right. And that's what we'll be capturing
11 for the steering committee.

12 Again, this is just a high-level
13 timeline for Cycle One. We're obviously at
14 the CV/Diabetes TAP meeting today. We have a
15 steering committee meeting coming up at the
16 end of June. We've actually just scheduled a
17 follow-up steering committee call on June 6th
18 to continue their discussion of the non-
19 condition-specific measures.

20 The goal of Cycle One is to have
21 some -- some measures endorsed by the end of
22 this year, so realizing that this is our first

1 time, again, we wanted to chunk it out so we
2 end up with something by the end of the year.

3 Cycle Two starts with our first
4 TAP meeting at the end of June as well, and
5 we're hoping to have those -- some of those
6 measures through the endorsement process by
7 March of 2012.

8 And I'm going to go ahead and
9 pause there and ask for any questions, and
10 then hand it over to Sally to go into a little
11 bit more detail about the evaluation process.
12 Does anyone have any questions or --

13 DR. MARWICK: How will you use the
14 scores?

15 MS. WILBON: The scores that you
16 guys are submitting today: the high, medium,
17 low? So what we do is we compile that and do
18 a document along with the rationale that you
19 guys associate with each of the ratings. So
20 if you rated something high, we're going to be
21 looking for you to explain why you think it
22 should be rated high. That information goes

1 on to the steering committee, and they use
2 that to determine overall whether or not the
3 measure should be recommended, so they're not
4 starting from scratch.

5 A lot of the steering committee
6 members aren't clinicians -- there are some
7 clinicians on there, but there aren't a whole
8 lot of clinicians. So they're really going to
9 be looking to you guys for that guidance on
10 those parts of the measure to make a broader
11 recommendation on the measure to move forward
12 through the process.

13 Any other questions before we move
14 forward?

15 (No response.)

16 MS. WILBON: Okay, thank you.

17 MS. TURBYVILLE: Thanks, Ashlie.

18 So we want to spend a little bit
19 of time talking to you about the evaluation
20 process. But first, before we get started, we
21 want to make sure that we're all on the same
22 page in how the steering committee defined

1 resource use for this project.

2 As Helen mentioned, there was an
3 early-on acknowledgment that resource use
4 measures by themselves are not measures of
5 efficiency, but that they're really important
6 building blocks to contribute to that
7 understanding. And so NQF made a decision to
8 embark upon an endorsement process for
9 resource use measures.

10 And in that effort, last year when
11 we were working with the steering committee,
12 we wanted to make sure we had a common
13 definition in moving forward. And basically
14 there are measures that compare health
15 services counts, and they can be in terms of
16 units, so frequencies, or they can be
17 monetized so it can be a standard dollar
18 applied or an allowable charges, et cetera.
19 Really it's up to the measure developer to
20 determine how they want to count the services
21 and then they should provide the context and
22 the reason for that approach.

1 So we are going to ask you today,
2 as Ashlie mentioned, to evaluate and rate the
3 submitted measures as they're specified
4 against the NQF resource use evaluation
5 subcriteria. And as we go through this
6 process, it will be by measure, and we will be
7 looking for you to rate against the evaluation
8 subcriteria sequentially. And so as we get
9 into it, I think the process will be a little
10 bit clearer.

11 So as you know, there are four
12 major subcriteria, and they are importance to
13 measure and report, scientific acceptability
14 of the measure properties, usability of the
15 measures and whether or not it's actually
16 feasible to implement the measures as they're
17 specified.

18 We also, while we did not ask the
19 measure developers, because this is the first
20 resource use project, to attempt to harmonize
21 their measures against any existing endorsed
22 measures. As we go through the process, there

1 may be, for example, age bands or other areas
2 where we may ask measure developers to go back
3 and harmonize. And that's basically looking
4 for them to have some amount of similarity.
5 It may not come up, and if there's a decision
6 to not attempt to harmonize, we'll be turning
7 to the TAPs or the steering committee to
8 justify those particular decisions.

9 So I want to go into a little bit
10 detail about the subcriteria, since that's
11 what all of you will be focusing on for the
12 measures. And I have also borrowed
13 extensively from the testing task force report
14 that we sent to all of you earlier on. But
15 it's quite lengthy, and given that there's a
16 lot of materials of the measures to review, I
17 wanted to use this as an opportunity to
18 summarize it the best that I can so that you
19 have a nice, robust set of tools as you move
20 forward.

21 So the first area is about the
22 measure's focus is important. So the first

1 criteria doesn't necessarily get into how the
2 measure is specified being important; it's
3 have the measure developers chosen an area,
4 topical area, that it's important to measure
5 area resource use. And some of the ways the
6 subcriteria support these decisions is if
7 they're looking in an area that's a national
8 health goal or priority area or high impact.
9 And it's also, is it a problem area.

10 We also ask you to evaluate and
11 rate whether or not the purpose and objective
12 that they have submitted is clear and
13 resonates well with the topical area that they
14 have chosen. And certainly whether or not 1-D
15 subcriteria is about whether or not, given the
16 area that they're measured, the resource use
17 categories that they've selected: does it make
18 sense?

19 So we will be asking you to rate
20 those subcriteria as far as it being an
21 important area to measure.

22 Scientific acceptability is where

1 we first start to dive into as the measure is
2 specified, in trying to think through the
3 reliability. So is the -- are the results
4 consistent and potentially consistent when
5 nationally implemented, and validity. So is
6 the measure, as specified, credible?

7 They have these two, the first
8 two, 2.A and 2.B actually have a lot of sub-
9 subcriteria, if you have. So in order to
10 assess reliability, there are actually two
11 subcriteria under that. And then validity is
12 the one that's quite lengthy with six sub-
13 subcriteria. If you can come up with a better
14 word for that, I'm open to it.

15 But anyway -- so in thinking about
16 what the task force recommended in their
17 report, they did recommend that empirical
18 evidence of reliability and validity should be
19 expected for all measures endorsed by NQF.
20 And certainly for resource use measures, given
21 the high complexity already, the steering
22 committee and NQF agreed that, in order for a

1 measure to be evaluated, there must be
2 empirical reliable and validity testing. But
3 we'll get into validity and talk about the
4 exceptions that are made there.

5 So although the testing task force
6 also recognized that, although reliability and
7 validity are not static properties and can
8 really vary under different conditions of
9 implementation, for example local practices of
10 coding, structure of the data platforms, the
11 purpose of the testing for NQF endorsement is
12 to demonstrate that a measure can be reliable
13 and valid when implemented as specified.

14 So we have to have a jump of faith
15 that people will implement them as specified.
16 We know certainly in the real world there is
17 a tendency maybe to tweak that, but it is --
18 our charge is to think about the measure as
19 specified.

20 So while implementing and
21 reporting the measure is expected to lead to
22 improvements in documentation, data coding and

1 data capture and thus improvements in
2 reliability and validity -- this is an
3 important point -- the assumption of approved
4 reliability and validity over time applies to
5 all measures.

6 We know this as a fact; once we
7 start reporting, we expect those improvements
8 to happen. It doesn't negate the need to
9 demonstrate reliability and validity during
10 the time of our endorsement consideration. So
11 we can expect that the reliability and
12 validity testing will have some limitations,
13 and certainly we can expect reliability and
14 validity to increase once it's implemented.
15 We still will rely on you to determine how the
16 reliability and validity testing is presented
17 today, where the measure is now and if it
18 meets the subcriteria.

19 So as I said, there are two sub-
20 subcriteria under reliability. The first is
21 whether or not the measure is clearly and
22 precisely specified in a way that it will be

1 implemented consistently once endorsed, or if
2 endorsed.

3 The other subcriteria under that
4 is about repeatability of the measure data or
5 the measure score is precise. And so there's
6 two ways that they can meet 2.A.2.

7 So evidence of reliability can be
8 accumulated over time, so NQF does allow the
9 measure developers flexibility in how they
10 want to demonstrate the reliability of the
11 measures. And the scope of the testing may be
12 relatively small in scale for initial
13 endorsement. We do expect further analysis
14 once a measure that is endorsed comes up for
15 maintenance review. The reliability and
16 validity testing would be expected to be at a
17 higher bar. So this first initial endorsement
18 process, the testing task force acknowledges
19 that the scope of reliability and validity may
20 be limited.

21 It's also important to note that
22 reliability and validity testing may be

1 conducted for either the data elements -- so
2 the data elements on which the measures rely
3 on to run -- or the measure's score as it is
4 computed. And this will have implications as
5 you walk through considering and weighing in
6 whether or not they're meeting that. And
7 we'll get into how that's rated in a minute.
8 In fact, that cheat sheet that has the
9 reliability and validity goes -- has a cross-
10 walk in the difference between data element
11 reliability and validity and measure score,
12 one being preferred potentially over the
13 other.

14 So that's it for reliability.

15 Precise specifications, the
16 measure is demonstrated to be repeatable. So
17 for the validity, there is a lot more sub-
18 subcriteria to think about. First, starting
19 with whether the measure specifications are
20 consistent with the evidence that they
21 presented in the important section,
22 particularly under criteria and subcriteria in

1 1.B. So, you know, they provide us
2 information of what the purpose and the goal
3 of the measure is under importance. At this
4 point, as the measure is specified, is this
5 consistent with what they said the purpose of
6 the measure are.

7 So for example, if they were
8 saying that it's important to measure the cost
9 of care for diabetes, and then the measure as
10 specified is about knee replacement, you may
11 want to think about whether or not that meets
12 their purpose. An absurd potential example,
13 though just trying to point to what we're
14 looking for.

15 The other 2.B.2 is also, again,
16 getting to the data elements are correct or
17 the score reflects the costs of care. It also
18 asks you to think about whether or not the
19 measure score can distinguish from higher and
20 lower resource use.

21 Validity testing of data elements
22 typically is about agreements with another

1 authoritative source of the same information.
2 It can be from both published and unpublished
3 sources. So what kinds of testing or validity
4 assessment of the administrative databases are
5 occurring. And it can also include systematic
6 testing of face validity. And so that is an
7 adequate validity assessment. It comes in as
8 a lower bar, but acknowledging that some of
9 the empirical analysis for validity testing,
10 especially in this initial endorsement, may be
11 beyond what is able to be done. If the
12 measure hasn't been implemented much outside
13 of a database, it may rely heavily on that
14 face validity assessment.

15 There is also other types of
16 validity testing. We are, as Ashlie said,
17 having a consultant to help us support all of
18 you in determining if the testing that they've
19 used is adequate. But things like looking at
20 the computed score against another measure
21 that is considered valid, or looking at the
22 correlation's relationships of that measure

1 score with something, another measure that is
2 looking at the same thing. So there are
3 different approaches in assessing validity
4 important to think about.

5 Again, we will -- unfortunately
6 the consultant just started on Friday, so I
7 mean, he's done a very good job in assessing
8 six of the measures, but -- and will be here
9 for question and answers. But moving forward,
10 it will be a lot -- you'll get that input much
11 earlier on. So we would have liked to have
12 gotten it to you a couple of weeks ago.

13 So data analysis -- moving on to
14 the other two criteria under this -- is
15 looking at demonstrating that the methods for
16 scoring of analysis allows for identification
17 of statistically significant results, and
18 probably in this situation, practically
19 meaningful differences in performance. So you
20 know, even if it's -- seems like a small
21 difference, is that meaningful to those who
22 are measuring?

1 And then also, the potential for
2 evidence of overall less than optimal
3 performance. So is there evidence that,
4 somewhere out there, there is less than
5 optimal performance?

6 This last element, 2.B.6, I want
7 to talk a little bit about, so it talks about
8 the comparer results are demonstrated when
9 there are different data sources being used.
10 And primarily this gets at to when there are
11 different options of data sources. So
12 certainly we have acknowledged the difficulty
13 of stitching together different data sources.
14 But what this criterion and subcriterion is
15 really getting at is, if there is an option to
16 use different data sources in replacement of
17 each other to produce the measure.

18 So for example, a measure
19 developer may provide someone the option of
20 computing a clinical target area, let's say a
21 diabetes population. Using administrative
22 data, or if they think their administrative

1 data isn't very complete, they may say you can
2 go to the medical record.

3 We would expect measure developers
4 to have tested those different options to see
5 that they're coming up with comparable
6 results. This is a little bit different of
7 what we expect to see in resource use measures
8 where we expect and probably want them to be
9 using pharmacy data to calculate -- to include
10 in the resource use estimation as well as the
11 inpatient claims data, as well as the
12 ambulatory claims data. We wouldn't expect
13 the ambulatory claims resource use to be
14 comparable to the inpatient resource use
15 because they don't actually represent the same
16 costs.

17 So I just want to make sure you
18 understand the distinction of what this
19 subcriterion is really getting at.

20 Any questions?

21 CO-CHAIR CURTIS: Practically, are
22 there any examples where this is relevant in

1 this --

2 MS. TURBYVILLE: I didn't see any.
3 I did not -- I mean, I've looked at most -- at
4 least a couple from each vendor. I did not
5 see any of them providing an option to go to
6 the clinical record or EHR option or anything.
7 It's -- the measures I've seen are all
8 administrative-based and include different
9 sources of that administrative data. But
10 that's really to pull in the different costs
11 and it's not options. It isn't you can use
12 this or that.

13 DR. MARWICK: I have a question as
14 well. So is your expectation that this
15 information will be obtainable at some stage
16 in the future or is it obtained now? It's
17 just that, in terms of specifics, I don't see
18 much evidence of this material in the
19 documentation that I've looked at. I've seen
20 generic statements about how it might be
21 obtained, but not actually a data set that I
22 could compare.

1 MS. TURBYVILLE: Right. So most -
2 - I would imagine most of the developers
3 didn't present any information to support this
4 because they're not providing options of which
5 databases to use in replacement of each other.
6 But I think this -- I might be understanding
7 correctly, this gets into usability and who
8 the audience and the users of these measures
9 are. Am I getting that right? So how would
10 they obtain the data necessary to run the
11 measures?

12 DR. MARWICK: Well, I think it's a
13 bit before --

14 MS. TURBYVILLE: Okay.

15 DR. MARWICK: -- usability,
16 really. I think it relates to some of the
17 material that you're talking about already.

18 MS. TURBYVILLE: Okay.

19 DR. MARWICK: I mean, what I
20 struggle with -- and I'd be interested to hear
21 what other people on panel say -- is that
22 although they talk about generically how they

1 could be used, there's no example of it
2 actually being used to -- you know, for
3 example, to understand the impact of different
4 levels of risk and so on.

5 So what I'm having difficulty
6 understanding is, are we voting today on
7 whether this is something that's feasible or
8 are we voting today on whether they've
9 actually achieved this target?

10 MS. TURBYVILLE: So very good
11 question. Depending on -- some of the
12 measures are currently in use. Others, like
13 AMBS-REF, they've developed them, they've
14 tested them in databases, but they haven't --
15 and they acknowledge this in their submissions
16 -- they haven't been implemented in a broad
17 manner.

18 The testing that they did on
19 database is acceptable for us to review at an
20 initial endorsement -- as I said, the testing
21 task force acknowledges that the scope of the
22 testing may be limited in the -- may be

1 limited in the initial endorsement process.
2 We would expect any measures that get endorsed
3 today, when they come back for maintenance,
4 which at minimum would be within three years,
5 that they would provide more data to support
6 how it's being implemented.

7 Now, to the extent that there is
8 an assumption that users will have access to
9 the data necessary, yes, I think in order to
10 follow the specifications as specified,
11 someone who wanted to use one of these
12 measures would need to have access to the data
13 that would support the specifications. If I'm
14 answering your question correctly. And
15 please, anyone on the TAP, if you -- yes?

16 DR. WEINTRAUB: Let me explain a
17 little bit more on Tom's question, because I'm
18 troubled by this, too. You know, the measures
19 are real -- these look like a good idea, but
20 the developers themselves make it clear that
21 this is -- they're not really ready for
22 primetime.

1 So I guess the disconnect is, if
2 it's clear that they've developed something
3 but the testing of it is really fairly
4 minimal, I don't see how we can be asked to
5 endorse it. I don't quite understand what
6 we're being asked to do if the developers
7 themselves feel it's not quite ready.

8 MS. TURBYVILLE: I'm not sure that
9 the developers -- I -- don't think it's ready.
10 I would only hope that they're submitting the
11 measures for endorsement if they do. I think
12 some of them acknowledge that they're not at
13 the point where they have had time and
14 opportunity to implement them broad. But the
15 NCQA measures, for example, and the Ingenix
16 measures are currently in use widely. So --

17 DR. WEINTRAUB: That's not the
18 ones that I mean.

19 MS. TURBYVILLE: Okay. Well I
20 think as we get into them measure by measure,
21 if you see some of that, that is definitely
22 important to bring to the attention to

1 everybody. But that's -- now, to the extent
2 that you have concerns about the reliability
3 and validity findings or the testing approach,
4 absolutely we expect you to rate those and
5 have your -- bring your expertise to this
6 table. It's just important to acknowledge the
7 guidance of the tasking force. It's not to
8 take away from the work of this group.

9 CO-CHAIR CURTIS: So just to --

10 MS. TURBYVILLE: Please, Helen.

11 CO-CHAIR CURTIS: I'm sorry,
12 Helen.

13 The -- we're not accepting
14 promissory notes in this case, right? We're
15 evaluating on the evidence we have in front of
16 us. And to the extent possible, if they don't
17 meet up -- and I think usability is kind of
18 where a lot of these are falling down. We
19 just accept what they have and move on. But
20 again, we're not extrapolating or imputing.

21 DR. BURSTIN: And I'll just add
22 that sometimes things may not feel ready for

1 primetime because they aren't actually in use.
2 But we do accept testing of reliability and
3 validity, even if it's not in widespread use
4 as at least evidence for reliability and
5 validity.

6 I think I have heard from --
7 there's some confusion. Some of them, for
8 example, indicated the measure is probably for
9 quality improvement but not potentially for
10 other accountability functions. Those are the
11 important questions to query the developers,
12 and that's why they're here.

13 MS. TURBYVILLE: Okay. Another
14 one of the subcriterion under validity is
15 about disparities and whether or not any
16 identified disparities are then addressed in
17 some kind of stratification approach for
18 measure scoring. We can talk about how
19 relevant that is or is not for these measures,
20 and we look to you to provide that guidance.

21 So usability, I think, certainly
22 is going to be, as it always is, an important

1 criterion. And it's really thinking about who
2 the intended audiences are and the intended
3 users. And can the measures and the results,
4 in particular, of the measures -- this really
5 focuses on the results as well -- would they
6 support decision making.

7 So one of the things we're looking
8 for, are results reported to the public?
9 Certainly we acknowledge, and there are
10 exceptions allowed, that they're available to
11 the public. So maybe they're not posted on
12 the public web, but there is an approach to
13 make sure people are receiving the benefit of
14 the results. Are the results meaningful? Are
15 -- can the audience, the intended audience,
16 understand them, and will they be useful for
17 public reporting and quality improvement?

18 We're looking for transparency and
19 understanding of the supported measures. So
20 for example, for someone who is being measured
21 by these measures, are they able to understand
22 how they're being measured?

1 And then we also spoke a little
2 bit about the harmonization. We're not sure
3 how that will pan out in resource use, and
4 we'll continue to support the experts as we
5 review the measures to look for or make --
6 provide rationale for that particular sub-sub-
7 subcriteria.

8 And then feasibility. Are the
9 data elements in which are required, or the
10 data sets, to run the measures routinely
11 generated? Are they generally available? Are
12 they available electronically? I think all
13 these measures are built on administrative
14 data, so I suppose the exception would be if
15 they're looking for some administrative data
16 source that is rarely available.

17 And then also thinking about
18 susceptibility to errors of the measures. Any
19 unintended consequences of the measures
20 themselves and kind of weighing in if those
21 errors are unintended consequences or
22 inconsequential themselves. Or at least can

1 be minimized or monitored. So we may
2 acknowledge that there are some unintended
3 consequences but, you know, if they can be
4 monitored or minimized, is that something that
5 the steering committee can rate on.

6 And then also certainly that the
7 measure is implementable as specified.

8 Yes, please.

9 CO-CHAIR ROSENZWEIG: Going back
10 to the previous slide, 3.B -- oh, I'm sorry.
11 Going back to the previous slide, 3.B, when
12 you're talking about harmonization, are you
13 talking about harmonization of the particular
14 measure sets here with the other measure sets
15 here, or are you talking about harmonization
16 with the quality measures that NQF has already
17 endorsed?

18 MS. TURBYVILLE: Good question,
19 thank you.

20 We are not talking about
21 harmonization with the quality measures.
22 Because we have not done a resource use

1 project, the only harmonization possible for
2 this effort, and based on where we are now in
3 thinking about efficiency in general, would be
4 harmonization against each other, the measures
5 that have been submitted under this project,
6 if there's any that is applicable.

7 So we are not looking for the
8 measure developers to harmonize against
9 endorsed quality measures.

10 CO-CHAIR ROSENZWEIG: Thank you.

11 DR. BURSTIN: But at the same
12 time, though, I think -- as I'm thinking about
13 a diabetes example, for example, Jamie, if it
14 would seem very strange, for example, to
15 combine insulin-dependent, non-insulin-
16 dependent diabetes on a quality measure. I
17 think those are sort of lessons you might want
18 to bring to this, even if they're not directly
19 measures to be harmonized.

20 MS. TURBYVILLE: Right.

21 DR. BURSTIN: As an example.

22 MS. TURBYVILLE: So any questions

1 about -- I know I just threw a lot at you.
2 But my hope is it will help throughout the
3 next couple of days. At least you'll have
4 them also in the slides to work through.

5 I wanted to spend a little bit of
6 time talking about the measure modules and how
7 we came up with them. Really, we came up with
8 five measure modules to allow us to
9 accommodate for the different types of
10 resource use measures that we expected to see.
11 And it was really for the purpose of
12 collecting the specifications in a more
13 standard manner, so that we didn't have to
14 make adjustments for every single type of
15 resource use measures.

16 And the measure modules, as I
17 said, there were five. And within each of
18 those five domains, so to say, or modules,
19 together they built the measure as a whole.

20 So one thing to note as we go
21 through the measure modules themselves, and
22 you would -- you will have seen these on

1 previous documentations, is that last year, in
2 working with the steering committee, they
3 determined that, for the purposes of
4 widespread implementation, that measure
5 details for some of the modules could be
6 submitted by the measure developers as
7 guidelines. So guidelines being where we
8 allow for some flexibility. And you -- as we
9 go through them, you'll see where they are.
10 And others must be specifications. And
11 specifications mean there is no flexibility
12 for the users. And they -- in order for them
13 to state that they are using an NQF endorsed
14 measure, they must follow the specifications
15 to the letter, okay?

16 So the data protocol steps
17 typically is something that NQF doesn't gather
18 for quality measures. But it was determined
19 by the steering committee that it was still
20 very important, given the newness of the
21 resource use measures, to, at minimum, have
22 the measure developers submit some guidelines

1 around that. Or if they really felt that
2 these needed to be set in stone for their
3 particular measurement approach, that they
4 would submit them as specifications.

5 And in the submission document
6 that you received, the evaluation forms,
7 you'll see, it will either say -- and this is
8 the measure developer telling us whether
9 they're submitting them as guidelines or
10 specifications. I believe most of them
11 submitted them as guidelines.

12 The clinical logic measure module,
13 completely specifications. And the clinical
14 logic components are the -- all the clinical
15 steps that build, you know, the clinical,
16 homogenous, sometimes not as homogenous,
17 populations in which the resource use is being
18 compared to.

19 And then we have the construction
20 logic module, also completely specifications.
21 They should be followed to the letter. And
22 they include the steps beyond the clinical

1 logic. They would be, for example, while they
2 may be related to the clinical area, they are
3 not the underpinnings. They would be, for
4 example, stop and end date, so 30 days after
5 measure resource use or only include ages 18
6 to 55, et cetera. There are those kinds of
7 particular algorithms.

8 Adjustments for comparability,
9 again, specifications. They should be
10 followed to the letter. They include the risk
11 adjustment approach, any stratification. It's
12 important to note for resource use the
13 stratification could be for acknowledging
14 socioeconomic differences, for example, as we
15 discussed before.

16 Stratification could also be an
17 approach that the measure developer wants
18 people to use to make it more actionable. So
19 let's say they're looking at a patient
20 population of diabetes that includes Type I
21 and Type II. And it's quite large. They may
22 specify that those two populations be

1 stratified when reporting out so that those
2 who are being measured can see the difference
3 between their Type I and Type II resource use,
4 as a very generic example.

5 And then in thinking about how the
6 measures are reported, also an area in which
7 NQF doesn't typically endorse for quality
8 measures, the steering committee felt that it
9 was important for the measure developers to
10 think more about this and, at minimum, provide
11 well thought-out guidance to users, but still
12 allow for some flexibility. Because depending
13 on the user and the perspective, they may need
14 to adjust how they report that information
15 out.

16 Or they can opt to make its
17 specifications set in stone, you know, to the
18 letter. So again, it's that data protocol,
19 which includes data cleaning steps, where we
20 allow for guidance or specifications.

21 And then the last module,
22 reporting, where we allow for guidelines or

1 specifications.

2 I see some -- are there any
3 questions? I see -- yes.

4 MS. CLARK: Well, I guess I do
5 have a question on the last one, the reporting
6 guidelines where -- how is a decision made to
7 make that an either/or? Because it seems like
8 -- is one of the goals to compare, be able to
9 compare reports or data output across plans or
10 entities that implement this? And if it is,
11 then there needs to be something to -- you
12 know, similar reporting, correct?

13 I mean, if we're saying that the
14 construction logic and the clinical logic has
15 to be specified, it just seems like the
16 reporting would also need to be consistent
17 across entities that are implementing this.

18 MS. TURBYVILLE: That's a great
19 question. And this was a lengthy conversation
20 amongst the steering committee members as well
21 as, you know, acknowledging that NQF doesn't
22 typically get into how measures are reported.

1 We endorse the specifications.

2 So that aside, kind of in the
3 backdrop, the steering committee had a lengthy
4 conversation and acknowledged that different
5 users -- and again, we need to maybe think
6 about who the intended users of these measures
7 are. Is it an individual physician or is it
8 a larger body that is then going to profile
9 clinical sites or physicians?

10 But the reason why they've decided
11 they need flexibilities, for example -- and
12 some of them are users of measures, one user
13 may be really interested in comparing provider
14 organizations. And if they want to use an NQF
15 endorsed measure that only provides
16 specifications on how to profile individual
17 physicians, they would not have the benefit of
18 using an endorsed measure.

19 Others would need to profile
20 physicians within an ACO. Others would need
21 to profile health plans, as you mentioned.
22 And so, because in this type of component

1 you're actually talking about what is the peer
2 group, if they identify only one peer group in
3 the specification, it really limits the
4 ability for the measure to be implemented in
5 other peer groups.

6 So while we want some well
7 thought-out guidance on how you might identify
8 a peer group, we -- the steering committee
9 wanted us to acknowledge that there is a huge
10 number of peer groups that may benefit from
11 the use of an endorsed measure focusing -- you
12 know, making sure that clinical and
13 construction logic is valid.

14 Yes?

15 CO-CHAIR CURTIS: And just to
16 follow up on that, I think, from my
17 recollection, the steering committee -- that's
18 how I was bringing it up was that these are
19 not the end unto themselves. This is a step
20 on the way to value.

21 And so for considering it from
22 that perspective, I think it's more important

1 that the specifications and validity and
2 reliability are intact, and less so that the
3 way that it's going to be reported is
4 important. Because this is just going to be
5 the denominator for value or -- depending on
6 how you calculate it. But -- so I think
7 that's why this is a gray area within it
8 that's not going to be as set in stone as we
9 evaluate the measures.

10 That's my two-cents.

11 MS. CLARK: Just another comment,
12 then. I mean, you're commenting about
13 different people, the reports could be for
14 different types of entities, whether it's a
15 physician or hospital, or whatever.

16 I guess I'm just curious though,
17 because most of the measures, or at least the
18 ones I looked at, all used administrative
19 claims data. A physician's not going to have
20 access to the broad -- you know, the claims
21 data. It's the payer that's going to have
22 access to that. So how -- how would -- I

1 mean, I could see if a physician wants, you
2 know, a specific type of report, but they're
3 not going to be the ones that are having
4 access to this information to implement, nor
5 would they --

6 MS. TURBYVILLE: No, I think
7 that's right. So payers are probably some of
8 the more primary intended users, you know,
9 coalitions, community efforts. You know, it's
10 going to be situations in which they have
11 aggregated administrative data that include
12 enough patients or members or populations to
13 actually support measuring resource use, so
14 that's right.

15 And depending on how much data
16 they have, they may not even have enough to
17 get down to an individual physician level,
18 right? So you're absolutely right. The users
19 in many respects, and I would actually
20 wouldn't mind the TAP exploring this further,
21 I think are probably limited right off the
22 bat. Initially, you need to estimate your

1 comparative results.

2 So did anyone want to add to that?

3 DR. PALESTRANT: I -- can you hear
4 me?

5 MS. TURBYVILLE: Yes, is that
6 David?

7 DR. PALESTRANT: Yes, can you hear
8 me?

9 MS. CLARK: Can you turn that up?

10 DR. PALESTRANT: Can you hear me?

11 MS. CLARK: No.

12 DR. PALESTRANT: I'll try to speak
13 louder. Can you hear me now?

14 MS. TURBYVILLE: Not really.

15 DR. PALESTRANT: Okay, I'll try to
16 call back. Maybe it's a bad line.

17 MS. TURBYVILLE: Now we can hear
18 you a little bit better.

19 DR. PALESTRANT: Can you hear me
20 now?

21 MS. TURBYVILLE: Go ahead, David.

22 DR. PALESTRANT: Okay. Can you

1 hear me?

2 MS. TURBYVILLE: Yes.

3 DR. PALESTRANT: I mean, I have
4 some issues that are sort of across -- I think
5 it sounds like many of the people on the
6 committee are thinking the same things. These
7 are issues that go across the board throughout
8 the measures.

9 We are being asked to individually
10 endorse each of these measures. And some of
11 the things that come to mind straight off were
12 these are going to be very important metrics
13 as we go forward with health care reform. Yet
14 there is huge uncertainty about this data. A
15 lot of the measures, from what I can see, have
16 not really been validated in any great extent,
17 nor do we even know that by measuring this,
18 and therefore changing the way we would
19 practice medicine to reach this score, will
20 actually affect the cost of care.

21 So you know, once it has an
22 endorsement, my concern is that it's been out

1 there with an endorsement, what's the
2 mechanism to sort of ensure that this is not -
3 - that if this doesn't prove to be valid or
4 actually have the effect on value of health
5 care, what's the next mechanism then to sort
6 of retract these measures?

7 MS. TURBYVILLE: Thank you, David.
8 That's a very great question.

9 At minimum, these measures would
10 come up for maintenance endorsement review
11 within three years. So -- and that's standard
12 for all NQF endorsed measures. So once a
13 measure goes through an initial endorsement,
14 and even after they go through a maintenance
15 review, there -- we reconvene the steering
16 committees and expert panels, depending on
17 what the effort needs, to review the measures.

18 Once again, gather -- you know, we
19 expect the measure developers to submit more
20 information about how they're being used, and
21 you know, there may be more questions about,
22 from the experts, whether there are some

1 inconsequential consequences or are they
2 monitoring them, et cetera?

3 So within three years at minimum,
4 these measures would go through that
5 maintenance review which, in many respects, is
6 very similar to the initial. It's not a
7 cursory effort, it's really a revisiting of
8 the measures looking -- allowing for measure
9 developers to submit new, hopefully improved
10 measures, et cetera.

11 CO-CHAIR CURTIS: But I guess the
12 concern is really how are these measures going
13 to be used, once they have that seal of
14 approval? And you know, I think we struggled
15 with this at the steering committee level as
16 to how specific we could get with the
17 endorsement. And I think we've talked about
18 potentially the NQF really only evaluates
19 measures that -- or endorses measures that are
20 intended for public reporting. Yet some of
21 these measures may not be suitable for public
22 reporting, in the absence of a link to

1 quality.

2 And so I think it's worth maybe
3 taking that back up to the steering committee
4 level to see if, in fact, we should have
5 endorsed for some purposes but not for all
6 purposes. On the other hand, that doesn't
7 really -- all the measures that NQF approves
8 have the potential to be misapplied in the
9 population, so I don't think this is different
10 from any of those.

11 DR. BURSTIN: I'll just add in
12 that, in general, NQF does not specifically
13 endorse measures for specific purposes. While
14 there is now a new partnership that NQF had
15 formed at NQF that I think is being called the
16 Measures Application Partnership, which is now
17 in the process of working to develop criteria
18 to select measure for particular uses.

19 In this instance, though, you
20 should assume that any measure that goes
21 forward, that you have been recommended, goes
22 through the whole process, commenting, voting,

1 approved by the board, et cetera, is deemed
2 appropriate for a multitude of accountability
3 uses. And so I think you need to consider
4 that in your deliberations quite
5 intentionally.

6 But again, you know, consider the
7 fact that a good number of the folks who want
8 these measures the most are actually community
9 alliances and groups like that who have
10 absolutely no cost information at the current
11 time. So it's not clear that data will always
12 flow down to the physician level or the
13 clinician level. It may wind up being at a
14 higher level of aggregation.

15 DR. WEINTRAUB: Well, suppose we
16 feel that a measure is appropriate for some
17 uses but not for others. So suppose we feel
18 a measure of resource use is appropriate at
19 the hospital system level but inappropriate at
20 the level of the physician. Can we make it
21 clear that we think it's -- or is that beyond
22 our scope?

1 MS. TURBYVILLE: Yes. And there
2 is an actual component of the measure
3 submission, and so the specifications, that
4 ask the measure developer to cite what the
5 appropriate unit of analysis is and certain
6 the TAP and the steering committee can say, we
7 think the unit analysis should not include the
8 physicians, but it's okay to include -- et
9 cetera. So that would be something that you
10 would -- we would facilitate that through to
11 the measure developers.

12 DR. MARWICK: Could I seek some
13 clarification between what we're discussing
14 now and the timeline? I mean, I could see a
15 number of these as being works in progress
16 where eventually a useful measure would be
17 constructed. But at the moment, in my
18 opinion, the measure is not useful.

19 I have the impression that you're
20 committed to approving at least some of these
21 in the course of this year. That fills me
22 with some disquiet, I'd have to say.

1 MS. TURBYVILLE: So as is true
2 with NQF endorsement process for this, the
3 expectation is that the measures that are
4 coming are fully specified and have been
5 tested adequately. You're right, the timeline
6 does not allow the developers a lot of
7 latitude to go back and especially respecify
8 a measure, because they would have to then
9 figure out how to retest it within the
10 timeline.

11 Often we can expect that they can
12 make some adjustments, if it becomes critical
13 in order for the measure to move forward. But
14 there -- and we rely on the measure developer
15 to state what they can and cannot accommodate,
16 if there are requests for them to make
17 adjustments. But you're absolutely right,
18 these should be -- for today, what we're
19 looking are their full specifications, knowing
20 that there may be some back and forth, but
21 their ability to make drastic change is very
22 likely to be limited.

1 Again, that would be up to them to
2 react to, but you can imagine them having to
3 change a specification, get it through their
4 experts, test it, et cetera, would be
5 certainly a time crunch.

6 DR. MARWICK: So you're still
7 committed to approving some, even if they're
8 not satisfactory, correct?

9 DR. BURSTIN: No. We will only
10 put forward the measures that this group, the
11 steering committee, the membership, the
12 broader population, agrees are acceptable.
13 And it may very well be there will be very few
14 measures at the end of this process, and
15 that's okay. It's our first foray into
16 resource use.

17 I think that we will see the
18 measures continue to get refined. We will
19 likely see measures coming forward in the
20 future that actually do combine cost with
21 quality. I think the issue is at this point,
22 we know we -- we just knew we needed to get

1 off the dime and start somewhere. And there's
2 obviously a great deal of interest in having
3 these measures out there.

4 I will tell you, at the population
5 level in particular, a lot of these
6 communities that are working in community
7 alliances have nothing to assess where they
8 are. So for a lot of folks, there is a sense
9 that we should, at least, start, see what's
10 out there, see what's doable, find out -- a
11 lot of what emerges out of these projects
12 actually is suggestions for improvement,
13 suggestions for additional work to be done.

14 So I see this as a first step in a
15 path.

16 DR. MARWICK: Sometimes bad
17 information is worse than no information.

18 DR. PALESTRANT: I think without
19 linking this to quality, you're -- you know,
20 I think it's an admirable first step. But
21 without having a link to quality, what are we
22 measuring? I mean, that's essentially the big

1 question. Sure, if we give no care it costs
2 less. But that's not our metric. Our metric
3 really is outcome. And that is an essential
4 model of value.

5 And if we're going to be measuring
6 value at some other criteria, using different
7 databases, how can we be sure that these
8 databases and costs are actually the same
9 databases that are going to be used for
10 measuring outcome?

11 DR. BURSTIN: This is Helen
12 Burstin. I'll try that.

13 In general, when we've talked
14 about this to date, there has been an
15 expectation that we see these measures as
16 building blocks. Not ones to be used on their
17 own, but ones that we at least needed to begin
18 to understand their construction, the issues
19 involved in them. The committee spent a great
20 deal of time thinking through what -- how our
21 current evaluation criteria, which are really
22 designed for quality measures, work or could

1 be adapted to make it fit for research use
2 measures.

3 Again, it's really just this first
4 foray into it. I think a lot of the general
5 outcome measures we have ultimately could be
6 knitted together with some of these resource
7 use measures, the more longitudinal measures,
8 for example. You know, a diabetes measure
9 over a year, for example, some of the logical
10 outcomes are easier than I think perhaps some
11 of the other conditions.

12 Again, we expect this to be a
13 journey, and it's just our first step on it.
14 Nothing will come out of this that people
15 don't agree is ready for primetime.

16 CO-CHAIR ROSENZWEIG: Could you
17 just describe the implications of NQF
18 endorsement, what it exactly means in terms of
19 if a plan -- does it mean that a plan -- a
20 plan is free to use this if it doesn't have
21 NQF endorsement? Or I remember the government
22 organizations need NQF endorsement?

1 DR. BURSTIN: So the basic
2 guidance for an NQF endorsement is NQF is a
3 standard-setting organization under the
4 National Technology Transfer and Advancement
5 Act. So essentially as a national standard-
6 setting organization, it makes us the measures
7 of first choice.

8 Essentially, when the federal
9 government -- and in particular it mainly is
10 applicable to government, although
11 increasingly as we're seeing harmonization
12 across the broader quality enterprise, a lot
13 of plans are also looking towards NQF for
14 endorsement. There is an expectation that
15 they will look for NQF endorsed measures first
16 and use only -- and use non-NQF enforced
17 measures if NQF measures are not available, or
18 if they could justify the use of a non-NQF
19 endorsed measure.

20 Actually, as part of ACA, there
21 needs to be a posting in the Federal Register
22 when the federal government chooses to use a

1 non-NQF endorsed measure and explain the
2 logic. So it does have a fair amount of heft
3 there.

4 But again, keep in mind plans can
5 use anything they want, and they already do
6 use a good number of the commercial groupers
7 here, and the costs associated with them.

8 DR. WEINTRAUB: Another thing to
9 give a little perspective from someone who's
10 been involved in cost effectiveness analysis
11 now for over 20 years. This has been said
12 about cost effectiveness analysis, if you've
13 seen one cost effectiveness analysis, you've
14 seen one cost effectiveness analysis.

15 And a standardized approach to
16 costing would actually be very, very, very
17 helpful, but as Tom says, bad information is
18 sometimes worse than no information. So
19 ultimately this has got to be gotten right,
20 because these measures will be -- will be used
21 really extensively, and I think far beyond
22 what we're even dreaming about here today.

1 Especially if they're really -- if they can be
2 validated well. She said it's going to be
3 hard to go back and respecify. Well people
4 may have to go back and respecify, but -- in
5 what I've read, I'm less concerned about the
6 specifications than the testing and the
7 validity, which I think for measures like
8 this, and as you say it's your first foray,
9 this has really got to be very, very
10 extensive.

11 Now the ones that I read were not
12 the ones that are being used, so I'm looking
13 at ones that are earlier in the process. But
14 I think that the validations, so that we can
15 believe it and so that others can believe that
16 these measures are really measuring cost, has
17 got to be pretty rock-solid. And that's for
18 someone who's spent years measuring cost, I
19 can tell you it is extraordinarily difficult
20 to do.

21 MS. TURBYVILLE: Great. So I
22 think at this time we're ready to hand it over

1 to Jephtha and Jamie. Though I think we also -
2 - pardon me, before we do that, I think we
3 want to talk about the voting, right?

4 So if you look at your cheat sheet
5 that looks like this. And then Sarah's going
6 to talk about how the scaling works, which has
7 another cheat sheet on the second page, the
8 smaller table that looks like this.

9 Just for your reference -- yes,
10 that second page -- it outlines the tasking --
11 the testing task force guidance on what high,
12 moderate, low, indicate for reliability and
13 validity. So you'll see the first column is
14 a validity rating. And you'll see a "high,"
15 what you want to expect to see: evidence of
16 reliability and validity. And then that would
17 be moderate to high. And whether or not it
18 passes scientific acceptability for that
19 particular component would be yes.

20 You can see for the low ratings,
21 that indicates a no for passing scientific
22 acceptability based on your ratings. So I

1 just want to make sure that we're all at least
2 on the same page of what high, moderate, low
3 means. And as we all get fatigued throughout
4 the day, you have this to refer to if need be.

5 Okay? All right, great.

6 CO-CHAIR CURTIS: So we're 25, 30
7 minutes behind schedule already, which is not
8 bad for the first hour and a half. And I
9 think, per the agenda, we're supposed to start
10 off with Measure 1571, which I'm the lead
11 reviewer, and I believe Mary Ann is the
12 secondary reviewer.

13 I think, in terms of process, you
14 know, we have -- how do we get your attention?
15 You know, you can flag your keychain or you
16 can fold up your tent and we'll try and get
17 everybody involved in this to have comments.

18 I think the one question I have
19 is, do we have -- in previous efforts we've
20 had flash drives that have had all the measure
21 specifications so that everyone can have them
22 in front of them. Okay, I think it --

1 MS. WILBON: We do have flash
2 drives, and we also have, I think in the
3 packet that we sent out, there's links -- if
4 you guys have access to the internet, there's
5 links to each of the measure packets on that.
6 So you can -- either one, whichever is easiest
7 for you. If you're having trouble accessing
8 the internet, we definitely have flash drives
9 we can pass around for you to download, and
10 we'll try to bring it up on the screen as
11 well. So just raise your hand if you --

12 CO-CHAIR CURTIS: I think this
13 will be important since, you know, only two
14 people have seen the -- really gone through it
15 in great detail, and make sure we're talking
16 about the same thing.

17 But I think we can try it on the
18 screen --

19 MS. WILBON: Yeah.

20 CO-CHAIR CURTIS: -- but we may
21 have to, in the next set of measures, go so
22 that we're all looking at the individual

1 screens.

2 CO-CHAIR ROSENZWEIG: What's the
3 URL for the internet?

4 MS. WILBON: For the measures?

5 CO-CHAIR ROSENZWEIG: Yes, I don't
6 have all the measures. I just have the ones
7 that were sent to me.

8 MS. WILBON: Oh, okay. Why don't
9 I give you the thumb drive.

10 CO-CHAIR ROSENZWEIG: Oh, the --

11 CO-CHAIR CURTIS: But for
12 everybody.

13 MS. WILBON: The links are
14 actually in a document that we sent out in the
15 pre-meeting -- the pre-meeting email. So if
16 you don't have access to that then we will
17 pass around the thumb drive. We have a few
18 thumb drives we can circulate, if you need
19 access to the documents.

20 CO-CHAIR CURTIS: I think, since
21 we expect it's going to take about an hour to
22 go through this, why don't we take a five-

1 minute break for restrooms and come back
2 quickly then.

3 (Whereupon, the above-entitled
4 matter went off the record at 10:23 a.m., and
5 reconvened at 10:32 a.m.)

6 CO-CHAIR CURTIS: So I think maybe
7 we should get going so we don't fall even
8 further, which is going to happen. But I think
9 everyone's back at the table now.

10 So we are scheduled to go through
11 1571, which is an ABMS measure, acute
12 myocardial infarction episode of care for
13 post-acute period, parentheses, days 31 to
14 365.

15 As I mentioned, I'm the primary
16 reviewer and Mary Ann is the secondary
17 reviewer on it. And it should be -- for the
18 people who have it on their computer and can
19 bring it up, and we'll bring it up although
20 it's a little hard to read. I don't know if
21 we can make that slightly bigger.

22 So I'm going to walk through the

1 measure fairly linearly, trying to respect the
2 time-frame. We sort of set aside an hour to
3 go through this and obviously there will be a
4 lot of cross-cutting issues with the other six
5 ABMS proposed measures.

6 So the overarching picture here is
7 that it's -- they're trying to characterize
8 resource use and costs associated with AMI
9 care during the post-acute period. And
10 they're defining that post-acute period as 31
11 to 365 following an index AMI event. And I'll
12 -- yes, resource attribution is at the level
13 of the individual provider, the other key.
14 It's specified using exclusively
15 administrative data. Although they do say
16 other, and I'm not sure what other means. But
17 I don't see it anywhere else in the
18 application.

19 It's I think a little odd to
20 consider this in isolation because this really
21 is a paired measure with the acute episode,
22 the first 30 days of the AMI care, as well as

1 -- and this would be the paired measure --
2 with the follow-up care. And I think probably
3 the issues raised on this application are
4 going to be almost identical to those of the
5 earlier phase.

6 The measure developer I believe is
7 not on the phone.

8 MS. WILBON: We can double-check.
9 Kevin, are you on the phone?

10 DR. WEISS: Kevin Weiss is here.
11 We've got Todd Lee.

12 MS. WILBON: Todd Lee as well?

13 DR. WEISS: And we have Robin
14 Wagner.

15 MS. WILBON: And you have Robin,
16 okay. Do you know Kevin, we're having a hard
17 time hearing people on the phone, so we ask
18 that you speak up. They have adjusted the
19 volume, but it's still not as loud as we would
20 like.

21 DR. WEISS: Okay. Well, mindful
22 of that, is this a little bit more helpful?

1 MS. WILBON: Yeah, that's much
2 better.

3 DR. WEISS: And also, with
4 apologies, I'm going to be boarding a
5 international trip shortly, but I'll be here
6 for a while.

7 MS. TURBYVILLE: Okay. So do you
8 want to take some time, Kevin, to introduce
9 the measure and the approach that ABMS-REF
10 already took in developing the measures that
11 they're going to review today.

12 DR. WEISS: It would be a
13 pleasure. And I want to thank the committee
14 for the opportunity and NQF for sponsoring
15 this review.

16 Let me start by saying that I have
17 to just put a small note that this is
18 technically not ABMS, the American Board of
19 Medical Specialties, but it's the American
20 Board of Specialties Research and Education
21 Foundation, the REF. That's not an
22 insignificant difference because I think one

1 of the issues, because of ABMS is the
2 question, because ABMS is a standard-setting
3 organization for physician certification, is
4 this something that is directly going to be
5 moved directly into the certification MOC
6 program. And currently that is not slated as
7 these are new measures, and it's the first
8 time for the ABMS-REF to work in this
9 environment.

10 Notwithstanding, what I'd like to
11 say is, the way that these measures were
12 developed were based upon the interest of
13 getting the provider community, principally,
14 but not exclusively, the physician community
15 to fully develop and endorse a set of resource
16 use measures that they themselves felt had
17 strong face validity. And then build from
18 that face validity into all the other
19 constructs of a good measure specification.

20 They were built with a very keen
21 interest, and that is that they were viewed to
22 be eventually paired with quality metrics so

1 that resource use and quality could be brought
2 together for the concept of value or
3 efficiency. So these were constructed not on
4 -- based upon resource use flow of data but
5 rather based upon the literature surrounding
6 the quality of care of episodes.

7 So the episodes were derived from
8 a clinical perspective. The timing of the
9 episodes were derived from the perception
10 that, of experts in the field, as to what the
11 literature would suggest that the episode that
12 is being thought of in usual clinical care.
13 And so you'll see them constructed that way.
14 The AMI measure was constructed that way and
15 it's broken into two pieces for that following
16 reason, as well as attribution.

17 As far as attribution, we looked
18 at all the measures to try and get to the
19 level of individual physician attribution, if
20 it was felt appropriate. But we were very
21 clear with the measure work groups that
22 developed these measures that the providers

1 and our technical advisory committee who
2 oversaw the process, to say that if we felt
3 that it was inappropriate to do physician
4 attribution, that we would propose higher
5 aggregation where it was appropriate. And the
6 paired measures you'll be looking at first
7 from us, first this longitudinal or follow-up
8 care for AMI and its paired measure of acute
9 AMI are very different because the 30-day
10 measure, which you'll be reviewing, I believe,
11 tomorrow now, is not being viewed as an
12 attribution to a physician. It's more of a
13 system measure, and that will be explained
14 more tomorrow if you're -- if you would like
15 us to.

16 And this measure, after 30 days,
17 it was felt that care does -- of a patient
18 does move into individual physician care with
19 actual patient or consumer choice. And so
20 that's where one could begin to try and seek
21 an attribution at individual physician level.

22 So with that in mind, we recognize

1 -- and you'll be seeing a common theme, and we
2 heard it even in your discussions, about the
3 nature of where we have developed these
4 measures, in terms of advanced testing. We
5 recognize, as you do, that ideally these
6 measures would have a community-based field
7 testing, or some type of field testing. We
8 are in the process of doing field testing. We
9 have several communities who are getting our
10 data and are beginning to evaluate that.
11 We've worked with a couple of other data sets,
12 and those we can talk about as well.

13 However, we do feel these measures
14 are fully specified and have gone through a
15 rigorous review process of the specification
16 and the initial validity and reliability
17 testing, and felt confident that they met
18 those criteria that NQF presented. We hope
19 that the pretty clear face -- face valid issue
20 of lack of community testing is not going to
21 be the key issue that holds these back, but we
22 would respect wherever the committee goes on

1 that, of course. But as long as you know that
2 we feel that the next step is field testing,
3 and we're actively engaged in that process.

4 I'll stop here. That was just a
5 very brief overview, but in case you have any
6 general questions you'd like to ask before you
7 get into more details on the AMI measure
8 specifically.

9 CO-CHAIR CURTIS: So it doesn't
10 seem like there are any specific questions
11 yet. But I know we will be -- or I will be
12 addressing questions to you, if not other
13 members of the committee, as we go along.

14 So I think with that, let's leap
15 into the specific criteria that we're
16 addressing today. And the first is the issues
17 of importance to measure and report. And I
18 think that probably for most of these
19 measures, the important issue is not going to
20 be the major one that we're evaluating. And
21 so I don't want to spend too much time on
22 that, although I'm certainly willing to open

1 it up for discussion if people think
2 differently.

3 But of course, this is a measure
4 of AMI care and resource use associated with
5 the care of AMI patients, which are a high-
6 risk, vulnerable population who consume a lot
7 of resources and are vulnerable to lots of
8 adverse outcomes. So they cite the usual
9 panoply of information suggesting that this is
10 an important population, and I agree.

11 And in addition, the -- so I
12 think, is that 1.A criteria? So I don't know,
13 do you want to do that as we go along or
14 finish importance and then vote? Okay.

15 In addition, 1.B is the
16 opportunity for improvement in disparities.
17 And again, they do a fairly light literature
18 review citing variations in the care and
19 outcomes of this patient population. But
20 again, I don't think it's one that is terribly
21 contentious.

22 I will say, though, in specific to

1 this measure, is that I don't see any evidence
2 that they're providing -- I'm sorry, they
3 don't providing any evidence that there are,
4 in fact, variations in this post-acute care
5 time-frame. And while I know, as a clinician,
6 that they do exist in terms of the intensity
7 of monitoring and likelihood to treat
8 medically versus refer for surgery or
9 percutaneous interventions, I know that that's
10 there, but I don't see any empiric evidence to
11 back that up, which I thought was a little bit
12 of a limitation of their importance.

13 Mary Ann?

14 MS. CLARK: I just want to echo
15 that, because that's what I found as well. It
16 seems like this is definitely an important
17 area, this post-acute care period, but there
18 were no citations on variation and resource
19 use across that time period that I saw.

20 CO-CHAIR ROSENZWEIG: Citations of
21 variation were actually in the pre-30-day
22 period, looking at the references. I don't

1 know, I didn't go through all of them in
2 detail, but several of them specifically
3 seemed to refer to acute -- sort of not the
4 post-acute care, but the more closer to acute
5 care.

6 CO-CHAIR CURTIS: Agreed. That
7 may just be the limitations in the literature,
8 which really have not traditionally focused on
9 this post-acute care, or broken that out. You
10 know, there have been certainly long-term
11 ones, like three, five-year outcome studies of
12 AMI populations. But breaking this part of it
13 out, there just may not be literature there.

14 I don't know if the measure
15 developer wants to comment on that?

16 DR. MARWICK: Could I ask some
17 guidance about the voting here?

18 So in relation to our voting about
19 this, are we assessing it in terms of the
20 importance that we perceive or the degree to
21 which that measure has been addressed in the
22 document? What I have in mind is that there

1 may very well be measures that we understand
2 are very important but in fact have not been
3 well defended in the document. And if they
4 are -- if our support is important in terms of
5 getting that material released, it could end
6 up being sort of embarrassing that this is not
7 a well-prepared document that's finally
8 approved.

9 DR. WEISS: Kevin Weiss. Did you
10 want me to address that question? You asked
11 if the measure developer would like --

12 CO-CHAIR CURTIS: That would be
13 great.

14 DR. WEISS: We, along with you,
15 recognize that there is no literature that
16 really speaks to this period. When we brought
17 our panel of experts together we said to them
18 that in many cases there is a very weak bit of
19 literature that defines variability in
20 resource use. We wanted to use their clinical
21 experience collectively to sort of clearly
22 identify what they saw in practice as an area

1 for potential resource variability.

2 What they specified here was,
3 although there is no resource -- not a --
4 there was not really a body of literature,
5 that there was a high degree of perceived use
6 of intervention in a time period where the
7 guidelines do not speak to the need for these
8 interventions. Specifically, extra stress
9 testing and extra invasive percutaneous
10 treatment. So the lack of literature does not
11 bespeak the missing of that literature, at
12 least to our knowledge.

13 DR. BURSTIN: And in terms of the
14 importance question that was raised, we would
15 very much like you to stay grounded in the
16 criteria. So your voting on the criteria
17 should reflect directly the questions the
18 criteria asks you as what you see in that
19 application, not a broader context.

20 DR. WEINTRAUB: I might just
21 comment in general on the issue of disparities
22 and resource use. I've participated in

1 literature on disparities and participated for
2 years in literature on costing for years. And
3 these are literatures that almost don't
4 overlap.

5 You know, I think that that's one
6 that we're going to have to, to some extent,
7 give them a bye on, because that literature
8 isn't going to all of a sudden come into
9 existence in the next couple of years in any
10 robust way.

11 DR. PALESTRANT: I'm not sure if
12 anybody else can speak further --

13 CO-CHAIR CURTIS: Yes? What was
14 the question? I'm sorry.

15 DR. PALESTRANT: Oh, sorry, can
16 you hear me?

17 CO-CHAIR CURTIS: Yes.

18 DR. PALESTRANT: Yes, this is Dr.
19 Palestrant, can you hear me?

20 MS. TURBYVILLE: We can hear you
21 really well now.

22 DR. PALESTRANT: Okay. The -- if

1 anybody is in the room who is more of an
2 expert in cost analysis and resource use, I
3 mean, I know that there's some discrepancy
4 regarding the document's data. Yet all of
5 these -- all of these measures are really
6 referring back to the document data and sort
7 of citing it as absolute. Aan anybody comment
8 on what the sort of -- the thinking right now
9 is, in terms of that data?

10 DR. WEINTRAUB: Yes, I can comment
11 on it.

12 From the point of view of
13 variability, especially regional variability
14 and resource use, there the data are -- as
15 opposed to healthcare disparities, on
16 gender/age/race -- the data on geographic
17 variability, much of which comes from data, is
18 pretty exquisite. There we know there
19 certainly is variability in resource use
20 almost anywhere you look.

21 DR. PALESTRANT: Right. I know
22 from personal experience that, in some of this

1 data, by simply changing or increasing the
2 coding that one is doing in institutions, one
3 can affect that data. And not really changing
4 anything in terms of your resource use or
5 anything else that you're doing, but simply
6 having people document more clearly what the
7 diagnostic codes are, changes our outcomes in
8 terms of observed/expected.

9 This is -- you know, I guess it
10 gets back to this point, what is a real valid
11 measure on an institutional level?

12 CO-CHAIR CURTIS: So I think
13 that's a very important point, and we'll
14 probably come back to that as we get to the
15 measure specifications. But I'm going to
16 table it for the discussion of the importance.

17 Okay. So then -- and then we
18 didn't get to, but Bill alluded to, the issues
19 of the disparities. And certainly there are -
20 - there is documentation of disparities in the
21 quality of care delivered by age, race, gender
22 and socioeconomic status. Again, I don't

1 think that there's a lot of information about
2 disparities in terms of resource use or cost.

3 And again, we'll get -- I think
4 come back to this in the review. But I think
5 it's something that's important to consider in
6 all these measures is, in fact, do we need to
7 consider disparities in resource use? And is
8 that something that's important for measure
9 stratification? But certainly we'll come back
10 as we go through the measure criteria.

11 So moving to the opportunity to --
12 sorry, not the opportunity to improve but the
13 -- for measure intent, I think it's fairly
14 straightforward. I'll just read what the
15 measure developer wrote. "The intent of the
16 measure is to provide an estimate of the
17 overall resource use associated with an AMI
18 care and identify components of care that are
19 most associated with high costs. Providers
20 can be compared in terms of their relative
21 resource use, compared to their peers and
22 reasons for differences in cost can be

1 identified. Ultimately the measure needs to
2 be combined with quality for a measurement of
3 efficiency of care."

4 So I think that was a pretty nice
5 description of the intent of the measure. And
6 I didn't have any particular criticisms of
7 that.

8 And then regarding -- sorry, is
9 that 1.D? 1.C, sorry.

10 1.D is -- I've lost my train.

11 MS. TURBYVILLE: 1.D is about the
12 resource use service categories being
13 consistent with the intent of the measure.

14 CO-CHAIR CURTIS: Right. And so
15 we'll get into that, I think, as we get to the
16 specifications. But my overall impression was
17 that they were, in fact, consistent with the
18 intent of the measure. So I'll leave that
19 open for anyone else to comment on, Mary Ann
20 specifically.

21 MS. CLARK: So yeah, the different
22 categories of resource use that they had, and

1 this was consistent across all those measures
2 that I was evaluating. I think there was a
3 little bit of a lack of clarity on how those
4 were being defined. If you can -- I don't
5 know if you can find those in the document,
6 the resource use groupings, categories.

7 MS. TURBYVILLE: For the
8 categories?

9 MS. CLARK: Yeah.

10 MS. TURBYVILLE: Yeah.

11 MS. CLARK: There you go. So
12 there was just a little bit of clarity that I
13 think needed to be provided here. For
14 example, it's broken out into broad categories
15 of inpatient versus ambulatory services --
16 whoops.

17 And then within each of those
18 broad categories, it's further broken out into
19 several different components.

20 Well, I guess my question is, how
21 is -- how are physician services captured in
22 this? You know, there's going to be a

1 physician component to any inpatient or
2 outpatient service that's being provided. So
3 I'm just wondering where that's actually
4 captured? For example, you have inpatient
5 facility services under inpatient. And then
6 procedures and surgeries. I mean, I guess I'm
7 just wanting a little more clarity on how
8 those categories are defined.

9 Same thing for outpatient. You
10 have outpatient facility services and then
11 procedures and surgeries. Is that what the
12 distinction is? I'm not quite sure how those
13 are defined.

14 MS. TURBYVILLE: Before I hand it
15 over to Jephtha, I do want to note that these
16 are check boxes that NQF put out there for
17 them to check which services. So -- but I
18 don't -- so they could check another if we
19 didn't encompass the universe.

20 MS. CLARK: Uh-huh.

21 MS. TURBYVILLE: But Jephtha, I
22 didn't know if you had a response to the

1 details of the questions, but there was
2 approximately how that works.

3 MS. CLARK: Oh, yeah.

4 CO-CHAIR CURTIS: Yeah. I mean, I
5 guess I just didn't recognize that there were
6 any missing domains here. I mean, I think
7 physician services would be under the
8 evaluation and management of both the
9 inpatient and the outpatient, and that the
10 procedures and surgeries would cover the
11 actual interventions, per se.

12 So I thought it was comprehensive
13 -- well, at least I couldn't think of any
14 domains that were missing.

15 MS. WILBON: And also just to
16 note, in the specifications section, there is
17 a question that asked them to actually define.
18 These are the resource use service categories,
19 so I think some of your questions may have
20 been addressed, or should have been addressed
21 in that section. And it may be a little more
22 clear when we get down to that in the

1 specifications.

2 CO-CHAIR CURTIS: So in the
3 interest of moving along, you know, I think we
4 could probably vote on the importance criteria
5 then. And I guess you should take out your
6 keychains and remind us what's high and what's
7 low?

8 MS. TURBYVILLE: Yes.

9 MS. WILBON: So on the monitor
10 here over to my left, your -- well, some of
11 your right -- is the -- we'll be pulling each
12 of the subcriteria on the screen and you can
13 see the definitions for high, medium and low.
14 Once we hit the timer, you'll have -- once we
15 hit "start" you'll have 60 seconds to enter
16 your vote.

17 If you voted and then you want to
18 change it, there's a hazard key on there, like
19 a triangle with an exclamation point in there.
20 Hit that button, enter your new rating and
21 then hit "send." So if you mess up your
22 score, hit the hazard key, enter your new

1 rating and then hit "send," and then it will
2 recalculate it. And then once everyone has
3 submitted the -- the results of the voting
4 will show up on the screen?

5 MS. CLARK: How did you know if
6 it's one, two, three?

7 MS. WILBON: It's high is one,
8 moderate is two, low is three, insufficient is
9 four and not applicable is five.

10 CO-CHAIR ROSENZWEIG: So we're
11 really voting on what we believe to be --

12 MS. WILBON: Right, based --

13 CO-CHAIR ROSENZWEIG: -- the
14 importance? So at least in theory, if we've
15 read some of the others and they provide
16 evidence for importance --

17 MS. WILBON: Yeah.

18 CO-CHAIR ROSENZWEIG: -- we're
19 actually voting on what we perceive as the
20 importance for this measure?

21 MS. WILBON: For this particular
22 measure.

1 CO-CHAIR ROSENZWEIG: It's not how
2 well they particularly described it?

3 MS. WILBON: Yeah, well, it's
4 based on what they submitted. So I'm -- as
5 Jephtha mentioned before, we're not implying or
6 making any extrapolations based on what they
7 submitted. So if they --if you felt like what
8 they submitted may not have been incomplete
9 and that may be the rationale that was
10 provided by the developer, there not being
11 evidence in the literature, whatever, however
12 you feel that what they submitted, based on
13 what the subcriteria is, that's what you're
14 rating should be based on.

15 CO-CHAIR ROSENZWEIG: So really,
16 we're voting on how they submitted it as
17 opposed to what the truth -- whether or not we
18 view this -- the importance to be high or low?

19 MS. WILBON: Right.

20 CO-CHAIR ROSENZWEIG: Okay, I'm
21 sorry, I --

22 MS. WILBON: It's based on what

1 they submitted, yes.

2 CO-CHAIR ROSENZWEIG: Okay.

3 MS. CLARK: Compared to the
4 subcriteria?

5 MS. WILBON: Right. Is everyone
6 clear on that?

7 CO-CHAIR CURTIS: It's important
8 to verify.

9 DR. HWONG: I guess what could be
10 interesting is, I mean, what you could is, you
11 know, we're talking about diabetes and we
12 think they are -- in terms of what we
13 understand about diabetes, variation care,
14 potential disparities in the management of
15 that, we're really -- you know, for one
16 measure may rank the importance as high, even
17 though, you know, let's say they're both
18 measures that look at chronic care of
19 diabetes.

20 I'm just saying that like somehow
21 you'll have some sort of discrepancies in sort
22 of high versus moderate versus low, even

1 though it's really talking about the
2 importance of this condition in terms of
3 management of chronic care.

4 And if that's the case, that's
5 okay, we'll just -- you know --

6 MS. TURBYVILLE: Right. So I
7 think, though, and that comes out in the
8 justifications, when we ask all of you to
9 justify the high, medium, low, so that either
10 the developer, especially for importance, may
11 say, okay, we'll submit more evidence. Or if
12 it's really an issue that cannot be -- it's a
13 hurdle that they can't meet -- Helen, I don't
14 know if you had anything to --

15 But it's really important to stay
16 focused on the subcriteria as has been
17 determined by the steering committee and kind
18 of public scrutiny and based and rooted in
19 criteria that NQF has used for a long time.

20 So the first one is the measure
21 addressing an important focus area. And by
22 demonstrating that either it hits on one of

1 the DHS national priorities, or it's a high
2 impact area of health care, which -- large
3 numbers, et cetera.

4 CO-CHAIR CURTIS: So I take it I'm
5 supposed to go through the voting. So then on
6 -- starting on subcriteria 1.A, whether the
7 measure addresses a specific national health
8 goal priority, or the demonstrated high-impact
9 of health care affecting large numbers, et
10 cetera.

11 So submit your vote.

12 CO-CHAIR ROSENZWEIG: We can't
13 vote twice?

14 CO-CHAIR CURTIS: The number and
15 then "send," correct?

16 CO-CHAIR ROSENZWEIG: Oh, the
17 number and then "send." Oh, send?

18 MS. WILBON: No.

19 CO-CHAIR CURTIS: Oh, just the
20 number. Got it.

21 CO-CHAIR ROSENZWEIG: Say that
22 again?

1 MS. WILBON: So it actually tells
2 us how many responses.

3 CO-CHAIR CURTIS: So unanimous for
4 high for 1.B demonstration of resource use for
5 cost problems and opportunity for improvement.
6 And go ahead and send.

7 And let me just ask while we're
8 voting, I mean, I think as the reviewer, no
9 one has the benefit of my pre-review because
10 I failed to submit it. So I will feel free to
11 give you that as I go along.

12 MS. WILBON: And Dr. Palestrant,
13 if you could be using the document I sent you
14 to enter your ratings, that would be great.

15 DR. PALESTRANT: Oh, okay. Just
16 email the rating to you?

17 MS. WILBON: Yeah, you can just
18 collect them through the course of the day and
19 send them to me at the end of the day.

20 DR. PALESTRANT: Okay.

21 MS. WILBON: All right. Thanks.

22 CO-CHAIR CURTIS: Five moderates,

1 two highs and one insufficient.

2 For 1.C, the purpose of the
3 objective resource use measure and the
4 construct for resource and costs are clearly
5 described in that measure of intent. And I
6 rated that as high.

7 Seven highs and one moderate.

8 1-D is one of the ones we might
9 have to come back to, upon further reflection,
10 but at least we'll get a preliminary vote at
11 this point. The resource use service
12 categories that are included in the resource
13 measure are consistent with and represented
14 above the conceptual construct represented by
15 the measure. And I rated this as high.

16 And more evenly split between high
17 and moderate.

18 Okay. So moving on to the heart
19 of the application, which is the measure
20 specifications, and evaluating it using 2.A.1,
21 2.B.1, et cetera, we're going to walk you
22 through -- it's a little hard to walk through

1 all of them, but I think we kind of have to.

2 You might want to keep in mind
3 what I'm considering the other cheat sheet,
4 which is the submission items that are
5 affiliated with each individual criteria,
6 which is, I guess, page 2 of the evaluating
7 resource measures. And so for 2.A.1, for
8 instance, go over the general approach for
9 resource use measures, et cetera, et cetera.

10 My feedback to the steering
11 committee and NQF would be that there are way
12 too many sub -- or I will call them
13 microcriteria as opposed to sub-subcriteria,
14 to be evaluated within one larger subcriteria.
15 But I'll leave that open for other people's
16 feedback as well.

17 So the general approach, as the
18 developer discussed, was that they started
19 with a work group working in conjunction with
20 analysts to derive what I think are fairly
21 clinically sensible approaches to defining a
22 coherent population and coherent outcome, and

1 a reasonable risk adjustment methodology. The
2 talk about it's an iterative process, that
3 they went back and forth refining the -- and
4 specifically the outcomes, not so much the
5 population that's being used. And they
6 provide I think fairly ample supporting
7 information as to the data dictionaries, et
8 cetera.

9 So with regards to the specific
10 resource use measure, this is a standardized
11 cost measure using administrative data. The
12 target population is patients admitted with a
13 index principal discharge diagnosis of acute
14 AMI. But the outcome period, as mentioned
15 before, is 31 to 365 days. So the post-acute
16 phase care of this patient population.

17 Regarding F-6-1 and 6-2, the data
18 preparation inclusion, which I believe are on
19 pages 10 and 11 of the PDF, they make
20 guidelines, as opposed to specifications, as
21 to how to handle the cleaning process. But
22 mainly defer to the individual providers as

1 having the internal expertise and allowing
2 leeway for specific handling of data.

3 They do strongly recommend that
4 missing data not be included and that no
5 approaches for imputation be utilized, which
6 I think seems reasonable, and I think is
7 consistent, at least across the two developers
8 that I reviewed.

9 CO-CHAIR ROSENZWEIG: Can I just
10 ask you, is the definition of 31 days after
11 acute MI a recognized interval in the
12 cardiology community that defines post-acute?
13 I mean, it's not after discharge from the
14 hospital or something like that?

15 CO-CHAIR CURTIS: Right. So the
16 measure developer doesn't specify why that
17 interval was chosen or selected. I infer or
18 assume -- there is literature supporting 30
19 days as sort of a reasonable timeframe for the
20 acute care. So if you think about the
21 publicly reported measures for AMI mortality
22 and readmission, they utilize a 30-day post-

1 discharge as their episode.

2 And so this is consistent with
3 that and I would imagine they selected this
4 particular timeframe, breaking it out of 30
5 and 31 to 365 as being one step in the
6 harmonization of resource use measure with a
7 quality measure. But again, I could ask the
8 measure developer to commend specifically on
9 that.

10 DR. WEISS: This is Kevin. Can
11 you hear me okay? I switched to a cell phone.

12 But the answer is "yes," if you
13 can hear me. It's because we first developed
14 the acute measure, which really was based upon
15 very, very substantive literature as well as
16 a convention within the cardiology community.
17 And it was recognized that there needed to be
18 an extended period which seemed to be also
19 based in one-year outcomes in the cardiology
20 literature. And we started at the 31 and went
21 to the end of one year, which would provide a
22 nice eventual harmonization with outcomes

1 measures, if we went that way.

2 Is that -- are you able to hear me
3 okay?

4 CO-CHAIR CURTIS: Thank you.

5 Bill?

6 DR. WEINTRAUB: Yeah, so it's in
7 the clinical trial literature, a lot of
8 analyses that are zero to 30 days and 30 days
9 to a year. There's nothing particularly about
10 costing in that period, but it does harmonize
11 with other measures of outcome.

12 CO-CHAIR CURTIS: So with
13 microcriteria 6.2, data inclusion criteria,
14 again they are fairly clear that they're
15 basing it on the finalized cohort as opposed
16 to any preliminary cost data. So this is
17 something that would not subsequently change.
18 So the database is finalized and complete.

19 They recommend -- and we'll get
20 into the specifications, but in order to
21 calculate the risk-adjusted costs and
22 utilization, they require that enrollees have

1 at least 24 months of continuous medical and
2 pharmacy benefit enrollment, including both
3 the identification year and the measurement
4 year, or I'd say that that's recommended. But
5 I assume it's almost a requirement.

6 They know, however, that the
7 measure was tested on enrollees with at least
8 320 total days of coverage during each year,
9 which I assume is a nod to the practicalities
10 of the database that they had to develop the
11 measure.

12 So any comments on that particular
13 element?

14 DR. HWONG: Right. So in essence,
15 they're defining continuous eligibility with
16 that criteria of having at least 320 days?

17 CO-CHAIR CURTIS: At least pre-
18 and post-period.

19 DR. HWONG: Uh-huh.

20 CO-CHAIR CURTIS: I think that's a
21 function that they had two years of data -- it
22 must have been at least two and a half years

1 of data to work with to derive it, because the
2 index submissions took place, I think, between
3 July of '06 and December of '06.

4 And then regarding the data
5 exclusion criteria, 6.3 --

6 MS. CLARK: Just one last comment
7 on that. It would seem like you'd need at
8 least three years worth of data to do that
9 type of analysis. Because if somebody had
10 their AMI at the end of the year, you know,
11 you're not going to have the full follow-up
12 period, but yet you need a full year of look-
13 back in order to assign the hierarchical
14 condition category risk adjustment method.

15 So I think three years is probably
16 the minimum.

17 CO-CHAIR CURTIS: I would agree
18 with that. And if you look at the dropout
19 from the inclusion criteria from the cohort of
20 studies, you see that there is substantial
21 dropoff. We'll come back to this, but I think
22 they lost about 30 percent or more of the

1 population, maybe 40 percent of the population
2 didn't have continuous enrollment in both the
3 pharmacy and the services providers.

4 And does the developer want to
5 comment on that time period for assessment,
6 because I think that is a real reality of --
7 that you would require three years as
8 specified, or up to three years, if you're
9 using a calendar year.

10 DR. WEISS: I'd like to see if --
11 Dr. Todd Lee is with us, and maybe he could
12 jump in?

13 CO-CHAIR CURTIS: Yeah.

14 DR. LEE: The committee is exactly
15 right. It requires a three-year timeframe to
16 be implemented in the way that we've specified
17 the measure.

18 DR. HWONG: Can I just ask -- I'm
19 sorry -- one other clarifying question?

20 So the acute, you know, MI has --
21 in terms of making sure that it has to occur
22 during the measurement year. But in order to

1 assess the resource utilization, could you --
2 does this end up having variable like follow-
3 up time to the end of the measurement year?

4 I'm hoping that makes sense. But
5 if the AMI -- if your acute MI happens in
6 December 1st and the end of your measurement
7 year is December 31st, you have one month of
8 follow-up to look at resources -- or rather,
9 let me say two months, because it's a 30 to,
10 you know, 365 --

11 CO-CHAIR CURTIS: Right, but the -
12 - and I think that's why it's a three-year
13 measure --

14 DR. HWONG: Yeah.

15 CO-CHAIR CURTIS: -- is that for
16 that patient admitted on December 30th, they
17 have to have one-year following. So a three-
18 year measure.

19 DR. HWONG: Okay, very good. So
20 in some ways, we could specify kind of when
21 the event has to occur in the relative
22 timeframe? Like -- and maybe I missed that,

1 if it's very specific. But it has to have --
2 you know, the event has to have a full 12
3 months, you know --

4 CO-CHAIR CURTIS: Right, and they
5 do specify that you do need the continuous --
6 or the continuous enrollment so you have both
7 the --

8 DR. HWONG: Both, okay.

9 CO-CHAIR CURTIS: -- upstream for
10 risk adjustment and the downstream for
11 accounting costs --

12 DR. HWONG: Okay.

13 CO-CHAIR CURTIS: -- and research
14 use.

15 DR. HWONG: Perfect, thanks.

16 CO-CHAIR CURTIS: Okay. So then
17 regarding 6.3, data exclusion criteria, it's
18 fairly straight-forward is that they recommend
19 eliminating all rejected and unpaid claims,
20 which again seems consistent across
21 developers.

22 They also recommend getting a --

1 because they're attributing to the level of
2 the physician, they recommend generating a
3 uniform specialty for all providers, and not
4 utilizing claims where you cannot identify a
5 single provider using a hierarchy that we will
6 come back to.

7 And finally, converting missing
8 and zero quantities at a minimum -- to a
9 minimum of one to allow for pricing of these
10 services, which I have to confess is beyond my
11 specific level of expertise in costing, so
12 I'll defer to the cost experts.

13 DR. WEINTRAUB: Can you -- well,
14 just let's look at that again.

15 CO-CHAIR CURTIS: So -- sorry. To
16 repeat it, so they're converting zero or
17 missing quantities to a minimum value of one.
18 It allows for pricing of these services.

19 Would you then clarify that --
20 would the developer clarify that rationale for
21 that particular decision?

22 DR. WEISS: Sure. So this has to

1 do with just the quantity field. If the
2 quantity field has a missing value but yet
3 there is a submitted claim that has made it
4 through and has a dollar value associated with
5 it, we did not want to get rid of that
6 information. Rather, we assigned the quantity
7 units to one in that case, so when we're
8 calculating our average costs, we still use
9 the actual paid claim in that calculation.

10 CO-CHAIR CURTIS: And for some of
11 your costs, I think ancillary services, when
12 you're sort of average -- developing an
13 average cost for a service, would that tend to
14 lower the average cost, I assume? And number
15 two, how frequent is that in the data set?

16 DR. WEISS: Unfortunately I cannot
17 answer the second question off the top of my
18 head. I don't know -- we don't have our
19 programming folks on the phone to answer the
20 frequency with which it occurs.

21 And I am also unsure of which
22 direction the bias would go in. It really

1 depends on the amount of that claim, for which
2 there is missing quantity information So if
3 it's a high-dollar value claim that happens to
4 have a missing quantity information, it could
5 bias the average cost upward, and vice versa.

6 But I can look in some of our
7 files and find -- see if I can find the answer
8 to those things.

9 CO-CHAIR CURTIS: Thank you.

10 And then finally, regarding
11 missing data, to reiterate that they recommend
12 not using imputation to replace missing data.
13 So I'm going to pause there. So that's sort
14 of the data handling and processing part, I
15 believe. Is there more that I'm missing? No,
16 I believe that's it.

17 So next, moving on to the more
18 clinical framework of the measure, which
19 starts with criteria 8.2 and beyond. This is,
20 again, the resource use from 31 to 365 days
21 that's attributed at the level of the
22 individual providers.

1 For inclusion criteria, and this
2 is starting on page 12, I think they applied
3 fairly straightforward, or to me what rational
4 decisions limiting the population to 18 to 85.
5 Now the 85 warrants the high-end exclusion,
6 patients above 85 warrants a little bit of
7 thought. Their rationale is that it's a
8 different population in whom treatment
9 decisions may be significantly different than
10 in younger populations. And so that the
11 resulting costs may have biases probably lower
12 rather than higher. That seemed like a
13 reasonable choice to me, but again could be
14 interpreted both ways.

15 DR. WEINTRAUB: Well, if I was
16 developing, I wouldn't do that. And you know,
17 we've moved away from the idea of upper -
18 high-end limits for clinical trials. And
19 given that this is about acute myocardial
20 infarction, acute myocardial infarction is
21 common in elder, including the very -- the
22 elderly and above 85 wouldn't be my choice.

1 I don't think it's wrong, it just wouldn't be
2 my choice.

3 CO-CHAIR CURTIS: That's fair.
4 But also when you look -- if you get to the
5 exclusion criteria, the percent of the
6 population that it applied to, I think it was
7 less than one percent, or a very, very small
8 number of claims. That's particular to this
9 commercial database. Obviously if this were
10 a CMS database, it would be a different matter
11 altogether.

12 DR. WEINTRAUB: We expect that
13 that's what's going to be most commonly
14 applied. That's the fastest-growing portion
15 of our population.

16 MS. TURBYVILLE: Just to be clear,
17 so depending on where the measure is tested --
18 for example, this measure has been tested in
19 the commercial database -- that's what we're
20 endorsing it for use in, is the commercial
21 population. I just wanted to make sure we're
22 all on the same page on that.

1 CO-CHAIR CURTIS: Okay. So then
2 the other specific inclusion criteria is that
3 they have -- the index is an admission for --
4 with an ICD-9 at 410.XX, excluding X.2, which
5 suggests a, in fact, an acute MI and not
6 subsequent care of a patient with a prior MI,
7 that they are applying it to a calendar year
8 measurement. They have specific exclusion
9 criteria, notably in terms of enrollment
10 criteria and both medical and pharmacy
11 benefits. And they do apply a requirement of
12 a length of stay of greater than one day,
13 which is probably -- has to do with, you know,
14 face validity of whether or not it was
15 actually an MI. And I think even in the days
16 of decreasing length of stays, nobody's going
17 to discharge somebody with a less than -- or
18 at one day.

19 CO-CHAIR ROSENZWEIG: So if a
20 person is -- has a subsequent MI in this
21 interval period, that's considered part of the
22 -- subsequent to the original MI or does the

1 clock start ticking again?

2 CO-CHAIR CURTIS: Right. So
3 there's only one index admission per calendar
4 year because it's a 365-day follow-up. So you
5 can't have more than one index admission. The
6 subsequent MI would either follow up within
7 the 30-day measure or it would be counted as
8 part of the outcomes for the 31 to 365.

9 I think there will probably be
10 different criteria for the acute care, to
11 address that specific issue. But practically
12 one admission with an MI per patient per year.

13 CO-CHAIR ROSENZWEIG: So the index
14 admission could be within the 365-day period
15 of a previous MI?

16 CO-CHAIR CURTIS: It wouldn't
17 count as an index in that case.

18 CO-CHAIR ROSENZWEIG: It wouldn't
19 count?

20 CO-CHAIR CURTIS: Would not. And
21 so in this case -- well, let me think about
22 that. I believe it's -- and you'll have the

1 measure developer comment on that, but my
2 understanding was that it was within a
3 calendar year, one index per patient.

4 DR. WEISS: That is correct. It
5 is only a single event during a calendar year
6 period. So in the example that's been talked
7 about, the second even would group with the
8 very first event and would not count as a new
9 AMI index event for this measure.

10 CO-CHAIR ROSENZWEIG: Suppose a
11 person had an MI in September of 2009 and then
12 had another MI in March of 2010. The March
13 one would be the index for that year, because
14 it's in a new calendar year?

15 DR. WEISS: I may have missed the
16 point -- what calendar year timeframe are you
17 measuring? If you're looking at 2009, if
18 you're identifying events during calendar year
19 2009, then the event in September would be
20 your index event. The index -- the event in
21 2010 would not get counted as a new event for
22 that individual.

1 CO-CHAIR ROSENZWEIG: Okay. Just
2 wanted to clarify.

3 DR. MARWICK: I think the question
4 is, if you're -- if the year you're examining
5 is 2010 and somebody had an infarct in 2009,
6 do you still count the 2010 infarct?

7 CO-CHAIR ROSENZWEIG: That's my
8 question.

9 DR. MARWICK: Right.

10 CO-CHAIR CURTIS: So I would say
11 for the 2009 measure, the first one would
12 count. And in the 2010 measure, the second
13 admission would count as a new index?

14 DR. MARWICK: The second admission
15 would count -- so it would count but, in fact,
16 the patient would have had a previous MI,
17 correct?

18 CO-CHAIR CURTIS: Correct. The
19 only MI's that are excluded are those within
20 the 30 days and immediately preceding that
21 admission.

22 DR. WEINTRAUB: Maybe our

1 statistical consultant can comment on that.

2 I mean, it's not going to happen all that
3 often, but by doing this, you have a problem
4 with the interclass correlation, and at least
5 it should be counted for.

6 CO-CHAIR CURTIS: It probably
7 isn't terribly important.

8 DR. WEINTRAUB: How statistically
9 can you handle people that are showing up in
10 a measure twice with an index event or three
11 times?

12 CO-CHAIR CURTIS: But let me be
13 clear. They're not counting -- assuming that
14 the measure is at the calendar year, they're
15 not showing up in the same measure in the same
16 calendar year. And that's true of all
17 measures that we have for outcomes, process,
18 et cetera.

19 MR. ALZOLA: So do we just not
20 worry about it at all?

21 DR. WEINTRAUB: I don't think it
22 would happen in a proportion high enough that

1 it would make any difference.

2 MS. CLARK: Also I was thinking
3 about that as well, in terms of, you know,
4 they're looking at various -- well one
5 stratification, I guess, people with
6 congestive heart failure. Well, they may have
7 more higher costs. You know, the -- I guess
8 the HCC score is probably adjusting for
9 previous MI, I'm assuming. So if a patient
10 had another previous MI, in another year you
11 may think that their costs would be higher if
12 they have one in the year you're measuring, I
13 guess. So maybe it's accounted for the in HCC
14 adjustment method? I'm not sure.

15 CO-CHAIR CURTIS: I would think,
16 to a certain extent, yes.

17 DR. WEINTRAUB: Okay.

18 CO-CHAIR CURTIS: So then there's
19 additional step three, identifying patients
20 with other exclusion criteria. And in this
21 case, I think most of them are reasonable and
22 take their lead from other measures, excluding

1 patients with active cancer, end stage renal
2 disease, liver disease or HIV AIDS conditions
3 which would be likely to be associated with
4 increased costs and maybe not being --
5 complicating the -- or making a more
6 heterogeneous population.

7 So that seemed reasonable to me.
8 But the one that I did focus on was discharge
9 to a -- excluding patients discharged to a
10 skilled nursing facility at the termination of
11 the index hospitalization. And the rationale
12 that's provided is that, I think, difficulty
13 identifying and characterizing the costs
14 associated with this population, and -- I'm
15 trying to find the specific verbiage on it.
16 There was a rationale. But to me, that seemed
17 like a very dicey proposition, to
18 systematically exclude a fairly significant
19 population who would be expected to use a lot
20 of resources and may have unintended
21 consequences in the worst-case-scenario of
22 preferentially sending people out to avoid

1 being measured.

2 MS. CLARK: I think maybe what the
3 issue is with that, though, is that once you
4 get into skilled nursing care, for Medicare,
5 for example, they don't cover very many days
6 in skilled nursing. And then it will transfer
7 over to Medicaid. So you're looking at a
8 different claims database. You may be -- if
9 Medicare were to implement this, for example,
10 they're only going to get their costs and not
11 those that get transferred into a Medicaid
12 program that would be paying for the skilled
13 nursing care.

14 So I don't know if that's why or
15 not. That wasn't specifically laid out, but -
16 -

17 MR. ALZOLA: May I? I think the
18 issue with excluding patients due to mortality
19 or transfer to another facility is that it's
20 initial censoring. You don't know the cost
21 after they are discharged from the hospital.
22 Even though that should be attributed to them,

1 it's not -- it's not known.

2 And in the case of mortality, just
3 for the fact that they die, the cost is
4 censored that way. So it's --

5 CO-CHAIR CURTIS: I don't think
6 they're censoring for death at all. But I
7 guess, for me, for this particular measure,
8 for this interval, 31 to 365, you know, there
9 are a lot of patients who would be potentially
10 discharged to short-term rehab which I think
11 would still qualify as a snip. They may be
12 out of that rehab facility at 31 days. So
13 again, I just don't quite understand it. It
14 doesn't feel terribly comfortable.

15 Can I ask the measure developer to
16 provide the rationale for that?

17 MR. WEINSTEIN: Sure. The
18 rationale is reflective of the discussion that
19 we -- when they're censored in our acute
20 period, from day 1 to 30, we are fearful that
21 we can't measure resources that are being
22 consumed that are in the skilled nursing

1 facility. And because this is intended to be
2 a parallel measure, we didn't want to put
3 those individuals back into this post-acute
4 period.

5 CO-CHAIR CURTIS: Which I guess is
6 just beyond me, as to whether or not that's a
7 reasonable decision.

8 DR. LEE: An addition note from
9 developer, and that is, empirically it leads
10 to a very small number of exclusions on this
11 particular exclusion. We wanted to err on not
12 giving false information on this one because
13 of the unknown ability to capture the data.

14 I add one more piece in and that
15 is that this measure is attributable to the --
16 most attributable to the individual
17 physicians. And so it would complicate it
18 even more so.

19 So erring on the fact that there
20 would be a small population that would
21 potentially be excluded from information here,
22 particularly in this commercial population, we

1 just -- it was a conservative exclusion.

2 CO-CHAIR CURTIS: So --

3 DR. WEINTRAUB: Well, the problem
4 that comes up, of course, is if there's
5 variability in this. And do we lose our
6 ability to examine that variability why this
7 exclusion? And how big a problem is that
8 likely to be?

9 CO-CHAIR CURTIS: So I guess based
10 on the fact that it's a small population in
11 this commercial data set, that it's probably
12 not going to be that impactful. But I would
13 provide the feedback to the provider -- to the
14 developer that it's something we would want to
15 see more data on as it becomes available. Or
16 perhaps some sensitivity analyses to
17 understand what its potential effect could be,
18 depending on different proportion of patients
19 being discharged to rehab or to SNF.

20 So moving on, you know, specifying
21 on page 13, this is not an all-resource use
22 measure, this is a -- the outcome is specified

1 to services that are likely, in the opinion of
2 the developer, related to the care of the AMI
3 patient. And this is really the key, and I
4 think it's probably consistent across all the
5 different ABMS-REF measures. Which I'm just
6 going to use ABMS, understanding that it's not
7 accurate, because it's easier to say.

8 So if you look at page 13, they
9 give you the DRG-ICD-9 codes, et cetera, that
10 are used to specify resource use in this
11 population in this timeframe. And by and
12 large -- and to develop this, I think they
13 went back and forth with their working group
14 trying to identify the codes that were most
15 likely to be attributable, and that I think it
16 was, again, an iterative process where they
17 added or subtracted codes.

18 If you look at the highlights,
19 they're capturing all codes with the
20 discharged primary diagnosis inpatient of AMI,
21 unstable angina, arrhythmias, pacemaker
22 placements, cardiographs, PCI's, CABG,

1 coronary artery atherosclerosis and heart
2 failure, which seems fairly comprehensive on
3 the one hand.

4 On the outpatients, they relaxed
5 the criteria a little bit in that it's a
6 similar range of ICD-9 and ICD-9-DRG's, et
7 cetera. But that associated in either in the
8 primary or secondary position. And that
9 rationale for that is that the ordering of
10 codes in the outpatient setting is less -- I
11 guess less important, is the word that they
12 used, or perhaps less relevant. So -- and I
13 would say, maybe more arbitrary. But that's
14 a key decision in the characterization of this
15 outcome.

16 MS. CLARK: May I just make a
17 comment here?

18 CO-CHAIR CURTIS: Sure.

19 MS. CLARK: So I think these codes
20 need to be updated for the most -- for the
21 current codes that are in use. I noted some
22 discrepancies in the PCI codes for inpatient

1 ICD-9 codes. Those are outdated codes and
2 they need to be changed to make them more
3 current.

4 And also it may be just a cut-and-
5 paste issue, but under outpatient events,
6 those are all inpatient codes. So I mean,
7 those need to be -- at least the group there
8 that we're looking at on the screen, it has
9 all DRG information, which is not relevant for
10 outpatient.

11 And then I was also curious about
12 maybe adding some additional codes that would
13 be relevant or could be relevant for this
14 population, which would be the use of IVUS and
15 fractional flow reserve, as well as coronary
16 CT angiography. Whether they might want to
17 include those.

18 CO-CHAIR CURTIS: Right. And
19 those overlap exactly with what I was
20 thinking, in terms that there are outdated
21 codes. I pick up on the CPT -- this is, I
22 assume, hospital outpatient services would use

1 CPT codes potentially, as opposed to the ICD-9
2 procedure codes.

3 And that's actually something that
4 would need to be rectified before we go,
5 because this could not -- this measure could
6 not be implemented using the codes that
7 they've specified.

8 Developer, can you respond to
9 that?

10 (No response.)

11 CO-CHAIR CURTIS: I'm sorry, could
12 you hear us?

13 DR. WEISS: Yes, I'm sorry, I was
14 on mute.

15 That would be easily rectified if
16 there was an interest in this --

17 CO-CHAIR CURTIS: We can't hear
18 you.

19 MS. TURBYVILLE: Kevin, you're
20 fading out.

21 DR. WEISS: I apologize. I'm in
22 my last stages of getting ready to get in the

1 airplane.

2 And is Dr. Lee here still as well?

3 DR. LEE: Yes, Kevin, I'm still
4 here.

5 MR. WEINSTEIN: Okay. So what
6 we're saying is there would be no problem for
7 us to -- I think the word used was "rectify,"
8 look at those and get those identified. The -
9 - I'll just leave it there. That seems very
10 straightforward and well-appreciated.

11 DR. WEINTRAUB: So I want to just
12 comment on sort of the general philosophy in
13 costing. Do you want to cost the --
14 everything that occurs during an episode, or
15 do you want to try and be specific? There's
16 no perfect answer to that, but I think you see
17 in this discussion some of the problems have
18 been that ensue, if you try and -- if you
19 don't cost everything.

20 Obviously the problem with costing
21 everything is, you add a fair amount of noise.
22 How relevant is the knee replacement with --

1 that occurs nine months after myocardial
2 infarction? On other hand, you have problems
3 with both error of including things that you
4 didn't mean to include, not including other
5 things that you should. And then you have
6 problems of how do you deal with that
7 attribution?

8 So what do you do with the
9 pneumonia that occurs two months after a
10 hospitalization for heart failure? Is that
11 relevant or not? Well, yes and no. There's
12 no perfect answer to that.

13 And you know, it seems to me that
14 relying on the developers of these to make
15 that decision is probably not where that
16 decision ought to be made. That should
17 perhaps be part of the instructions on how to
18 develop these measures in the first place.

19 CO-CHAIR CURTIS: I think that
20 it's within the realm of their discretion.
21 They can specify it how they want and we can
22 evaluate it for our biases and preferences.

1 But I think it's a good point. This is not by
2 any means a global list of all the things that
3 can be direct results of AMI care and the
4 index admission and the part beyond.

5 And so there were decisions and
6 assumptions that were made here, and I think
7 they depended heavily on the input from their
8 working group. And the question I guess for
9 the group here is, is that sufficient? Is
10 this compelling?

11 Do you want to get into the
12 results? I think we can look at that a
13 little bit. But I want to look at one
14 specific part which is in the slides, the
15 accompanying slides at page, I think, 10 or
16 11. Sorry, let me see where I started
17 highlighting. Slide number 9 for -- so it's
18 after the application, there's Power Point
19 slides of some sort in PDF format. And then
20 slide 9 shows the top 20 non-AMI related
21 imaging in the post-acute episode.

22 And I guess my assumption, this

1 wasn't terribly well labeled. My assumption
2 was that these were codes that would not
3 necessarily have been entered into the
4 resource use measure. But I want to confirm
5 that.

6 DR. WEISS: That's exactly
7 correct.

8 CO-CHAIR CURTIS: All right. And
9 so when I looked at this list, it made me a
10 little concerned in that -- I don't know if
11 you can pull it up, Ashlie, but we'll get
12 there eventually. But you look in -- under
13 codes that were not captured routinely,
14 including in the registry you have "Chest pain
15 NOS," which -- with the cost of 86,000
16 associated with it. And that's, you know,
17 SPECT imaging used for the evaluation of chest
18 pain NOS.

19 And that is, to me, even though
20 it's not captured by an AMI or arrhythmia or
21 heart failure code, that's the care of the
22 patient most-MI. And in fact, that's -- I'm

1 surprised it's that low of a frequency.
2 Because when you're filling out the
3 requisition for a stress test, you click
4 whatever is conveniently -- whatever your eye
5 rests on immediately. And so that's a problem
6 for me. And I'll throw that out for other --
7 but there are lot of other ones like that.
8 CHF, NOS, shortness of breath, precordial
9 chest pain, all associated with and in this
10 case imaging studies that I think are probably
11 in the appropriate framework for inclusion in
12 the measure.

13 So I know you did an iterative
14 process, I just wonder if it was iterative
15 enough.

16 DR. WEISS: If I may respond?
17 Just because I'll be having to step off
18 shortly and handing this over to Dr. Lee and
19 Robin Wagner, you're -- the committee has --
20 you go to this discussion, this is a central
21 one that we, as a developer, worked through.

22 We heard pretty clearly from the,

1 principally, physicians. I'll call it our
2 provider community, because we did have other
3 providers on our work groups. But that the
4 total cost did not seem to have strong face
5 validity in terms of their understanding of
6 care of these issues and also in terms of
7 attribution, such that they did not want to go
8 down the development route.

9 And what that led to us is to
10 actually go through the iterative process
11 which we felt we got to that pretty clear
12 demarcation where that set of experts were
13 able to say, this is going to include 80, 90
14 percent of what we need. And there will be
15 some missing but that one would look to say
16 that it's not a matter of missing unless it's
17 a question of, do we sense that there's going
18 to be any directionality that we can build in
19 or argue for why, if this is -- or this little
20 residual is missing, it would be important?

21 And what they captured was the
22 important stuff and grabbed as much of the

1 important directs costs as possible. We are
2 pretty committed, because of the way that we
3 developed these, to believe that the providers
4 need to have a set of measures that they feel
5 that they understand and that they feel they
6 can take action on with relationship to the
7 condition under study. And that can be
8 matched to the quality metrics.

9 So that was a fundamental decision
10 we made early on. What we hope you would look
11 at is, on some of these cost sets, because
12 there is no right demarcation. It will be a
13 gray line as to when to include and not
14 include costs, that we avoided things that
15 were -- we did not miss things that are higher
16 frequency that seem to be related. But on the
17 same hand that we also avoided anything that
18 would lead to a directional bias and not
19 wrestle that one to the ground.

20 Let me just check with Dr. Lee if
21 there's anything that he might want to add to
22 that reflection?

1 DR. LEE: No, Kevin, I don't have
2 anything to add.

3 DR. WEISS: I'm not sure if that's
4 helpful to the committee, but at least you'll
5 -- as you go through our measures, you'll
6 understand that very specific reason why we
7 took that approach.

8 CO-CHAIR CURTIS: And I understand
9 that every measure that we're evaluating has
10 had to make hard decisions as to how they're
11 specifying it. So -- and certainly this is --
12 yours is clearly demarcated and you have a
13 rationale. But I do still have that concern.
14 And I guess if there were not as big variation
15 in coding practices, both across regions and
16 by physicians, I would have less concern. But
17 I think that's a pretty wide variation, so
18 it's not distributed at random.

19 DR. MARWICK: Can I just add a
20 point about this? I'm concerned about the
21 non-MI related imaging that actually includes
22 a bunch of things that probably are pertinent

1 to the MI. The assessment of mitral valve
2 disease, for example.

3 CO-CHAIR CURTIS: That are --

4 DR. MARWICK: Right, yeah.

5 CO-CHAIR CURTIS: Okay. So of
6 note, and we'll come back when we evaluate the
7 criteria.

8 But continuing on page 14 -- and I
9 realize that we've got 36 pages to get through
10 here, so we're not really going to be on
11 track. But hopefully, it's generalizable to
12 a lot of the measures, and so this is a
13 worthwhile investment. But -- I know, if you
14 feel like I'm hogging the microphone and need
15 to move on, just kick me under the table.

16 In terms -- okay. So regarding --
17 so that takes care of the inpatient and
18 outpatient surgeries, procedures, et cetera.
19 Moving to pharmacy services.

20 They're again, trying to apply
21 restricted -- so they're not looking at all
22 the pharmacy services utilized, but those that

1 are relevant to AMI care. And so they specify
2 beta blockers, ACE inhibitors, ARB's, Plavix
3 with the lower medications and nitrates. And
4 these are all, I think, reasonable choices.
5 What's more instructive is what's not included
6 and also brings up the issue of the
7 maintenance of these measures, which is going
8 to be substantial accounting for different
9 changes in coding over time as well as changes
10 in the pharmacologic treatment of these
11 patients. So prasugrel is not in here, which
12 probably wouldn't have been in the '06, '07.
13 Ranolazine, I think however, would have been,
14 which is a very expensive treatment for
15 chronic angina.

16 And then notably is the absence of
17 the diabetes medicines, which I assume is a
18 cognizant choice. But to me, aggressive care
19 of a diabetic patient with an MI is sort of
20 critical in the overall assessment of the care
21 of the patient.

22 In addition, there's a long list

1 that you can see -- maybe enlarge a little bit
2 -- of injectable medicines which are broken
3 out. But I wouldn't expect any of these to be
4 applied outside the acute care setting. So
5 I'm not sure how that's different than -- or
6 how that would not be included in the bundled
7 payments to hospitals for inpatient stays.

8 Any other comments from the group
9 before I ask the provider?

10 DR. WEINTRAUB: So the only things
11 that will happen is, if you want to compare
12 groups and you don't include certain things,
13 you see very rapidly what will happen. So if
14 you want to compare diabetics to non-diabetics
15 but you don't include diabetes medications,
16 obviously you're going to create a problem in
17 interpretation.

18 CO-CHAIR CURTIS: But I'm
19 confused. What's your conclusion from that?

20 CO-CHAIR ROSENZWEIG: Is it
21 appropriate --

22 DR. WEINTRAUB: I don't know, it's

1 a problem. You've got to decide -- you know,
2 you've got to decide what things means.
3 You've just got to make decisions on
4 understanding. My choice would be to include
5 the diabetes medications. I think yours is
6 the same, Jephtha. I'm just pointing out what
7 would happen if you don't.

8 CO-CHAIR CURTIS: And so let me
9 ask the measure developer just again to
10 explain the rationale further.

11 DR. LEE: So I'm going to -- this
12 is Todd Lee. I'm going to assume that Kevin
13 may have had to leave us. But the rationale
14 for medication was just like the rationale for
15 all of the other services, in that the advice
16 we received from our clinical work group was
17 to focus on services that are direct -- they
18 think most directly related to care of AMI.

19 The diabetes medications were not
20 included because we're focused on AMI care
21 here. Now granted, there might be a
22 correlation between having an AMI and having

1 diabetes. But if there was a differential
2 case mix of diabetics across providers and we
3 include diabetes medications as part of an AMI
4 measure, that's going to potentially bias some
5 of our resource use measures. And for that
6 reason, we focused specifically on AMI-related
7 medications.

8 Now in terms of the sort of
9 injectable list that's there, part of that was
10 when we went through the data, we identified
11 some codes in our HCPCS claims that were not
12 grouping into our episode because they did not
13 have the relevant ICD-9 code, and the work
14 group wanted to include those medications as
15 part of -- as part of this episode.

16 So in most cases, I believe those
17 were bundled into a hospital claim, but there
18 were certain circumstances where they did show
19 up in the data.

20 CO-CHAIR CURTIS: Thank you. So I
21 -- just to push you a little bit on that,
22 though, you know, it seems odd that you're

1 including lipid-lower medications, which is a
2 Class I indication for that class of medicines
3 post-AMI, but so is, I believe, the -- you
4 know, in terms of the guidelines, they
5 recommend aggressive care with a goal
6 hemoglobin A1c.

7 So I don't know, I don't know if
8 you can draw a bright line. I think I'd
9 believe it more if you said, well, this is
10 being addressed in the diabetes measure, in
11 sort of a complimentary measure as opposed to
12 excluding it wholeheartedly. I would think
13 that the risk adjustment, if it is robust,
14 would account for the differences in the case
15 mix where the diabetes should be identified
16 most often upstream in that 12 months prior.

17 DR. WEINTRAUB: It's certainly
18 true that the diabetic subgroup will have
19 higher costs, by numerous studies. There's
20 also, you know, recent data suggesting that
21 very intensive diabetes control might be
22 associated with worse cardiovascular outcomes,

1 including worse mortality.

2 DR. WEISS: This is Kevin Weiss
3 again. Can you still hear me?

4 CO-CHAIR CURTIS: Yes.

5 DR. WEISS: So I'm able to track
6 this a little bit. But it -- so first there
7 is a diabetes measure that you'll be seeing
8 that actually does capture these costs. And
9 recognizing the impact of blood pressure and
10 lipid management as part of diabetes control.

11 But keep in mind on this measure
12 that we do adjust for case mix of diabetes, so
13 that a physician who is being evaluated, or at
14 least a -- the output of this resource use
15 measure, at whatever aggregate level that it's
16 used at, will actually be able to balance the
17 fact that, if there are higher or lower
18 patient populations with diabetes, without
19 necessarily having to bring in the diabetes
20 costs, per se, into the specific costs
21 associated with the care of these patients who
22 are post-MI.

1 So there's a very strong internal
2 consistency in how the working groups wanted
3 this developed.

4 DR. WEINTRAUB: So let me push on
5 that a little further. Let's say that you
6 want to compare physicians on post-MI care in
7 diabetics. Would that -- and there, the use
8 of diabetic medications may be very important.
9 Then you would say that you couldn't use this
10 measure, you wouldn't use it and you would
11 have to go to the diabetes care measure to do
12 that?

13 DR. WEISS: No, no. I wasn't
14 suggesting that. I was suggesting that if one
15 was looking at diabetes care, then that was
16 identified in a separate measure activity that
17 you'll be reviewing.

18 DR. WEINTRAUB: All right.

19 DR. WEISS: What I'm saying here
20 is that it was viewed that the clinical work
21 group was very -- they were very cognizant, as
22 you would expect them to be of the fact that

1 a patient with diabetes have higher prevalence
2 of comorbid cardiovascular illness and its
3 principal major outcome.

4 However, in terms of managing the
5 cost of cases with CAD, that they wanted it to
6 be very specific through those types of costs
7 that were associated with CAD care, and
8 recognizing that the diabetes mix within
9 populations would be able to be managed by an
10 adjustment and risk adjustment model.

11 DR. WEINTRAUB: But I think
12 there's actually a problem there, in
13 interpretation that's difficult. So that if
14 you have variation in let's say comparing
15 health care systems, not the level of
16 physician but health care systems. And one
17 health care system post-MI really emphasizes
18 good diabetes care and one doesn't.

19 So at least in that, something is
20 -- we can't adequately look at post-MI care in
21 the subgroup of diabetics if you don't account
22 for their variation in care.

1 Now you could say that's true of
2 anything, but when it's not really terribly
3 interesting, when you look at osteoarthritis.
4 But the diabetes -- because that's not a usual
5 subgroup. But the diabetes/non-diabetes
6 subgroups are -- that's always of particular
7 interest in considering patients with ischemic
8 heart disease.

9 CO-CHAIR CURTIS: So I think in
10 the interest of moving forward, we should move
11 this to the parking lot. But you've heard
12 that there is some concern about that
13 exclusion criteria specifically. And I guess
14 I would ask -- because this gets into the next
15 criteria -- is why you didn't stratify the
16 measure by that. You opted to stratify by the
17 presence of heart failure in the 12 months
18 prior, which I think is appropriate because
19 that's a higher risk population, that the risk
20 model may not adjust for completely. But how
21 did you decide just to stratify based on that?
22 Why not other things like cardiac arrest or,

1 you know, COPD or diabetes?

2 DR. WEISS: So the -- within the
3 12-month cycle again of this measure that's a
4 little less than -- we tested on an 11-month
5 cycle, we looked for those --

6 CO-CHAIR CURTIS: Kevin, you faded
7 completely. I don't know if they've closed
8 the doors on the plane yet.

9 DR. WEISS: I apologize. Is this
10 a little bit better?

11 CO-CHAIR CURTIS: Yes.

12 DR. WEISS: For the -- look within
13 the 12-month cycle of the measure, and what
14 interventions would actually relate to
15 research use and associated outcomes in that
16 12-month cycle? And the one that was very
17 clear was the comorbidity of heart failure,
18 which was a proxy for the severity of
19 myocardial injury. And there's a strong
20 literature that supports that as being a
21 highly predictive of different outcomes.

22 That was the only reflection of

1 severity that we were able to gain from that
2 discussion. It was recognized that diabetes
3 does affect outcomes, but it's really not
4 short-term, it's really intermediate, long-
5 term outcome in terms of its impact. And
6 again, so it wasn't viewed as a need for
7 stratification but rather as a -- built into
8 the risk adjustment, so that it was accounted
9 for but not highlighted.

10 CO-CHAIR CURTIS: Fair enough. So
11 then I think we're going to start breaking off
12 bigger chunks as we go along here.

13 The one important thing regarding
14 8.6 concurrency of clinical events, all the,
15 I believe, ABMS measures are specified as
16 stand-alone measures. They cannot be rolled
17 up into any sort of a composite measure, which
18 I think is important for considering all of
19 these. And seems reasonable if it's, you
20 know, trying to drill down on a particular
21 population, but not exclude the possibility of
22 overlap or conflation across conditions.

1 Then in terms of -- starting to
2 move to 9, you get into the construction
3 logic. And I'm not going to go into the
4 details of this, but basically they identify
5 the relevant population, identify the relevant
6 outcomes using the codes that they've
7 prespecified, and sort of count them up and
8 apply a standard costing to them, which begins
9 on -- sorry -- I guess 9.7 is where you start
10 to get into it, where they apply to specific
11 types of services of inpatient, outpatient,
12 pharmacy and ancillary.

13 The costing, they've used a
14 standardized cost approach, which uses either
15 information from DRG's or supplemented DRG's
16 plus flags for major surgery. They use
17 similar -- sorry, for outpatient services,
18 they use an average across the whole
19 population. And I'm a little at odds as to
20 how much detail to go into at this level.

21 To me, the standardized costs that
22 they were calculating all seemed very

1 reasonable. And I don't know if other people
2 had concerns based on their reviews of similar
3 measures by this developer.

4 MS. CLARK: Yes. I just had some
5 questions about exactly how this -- these
6 standardized costs were being calculated.
7 Because they're not -- it's not clear how it's
8 done. So it's really not transparent for me,
9 in terms of if I were going to go replicate
10 this, how would you actually do it.

11 Especially on the outpatient
12 costs, I'm wondering what they did?

13 CO-CHAIR CURTIS: So would the
14 developer comment on that?

15 DR. WEISS: Sure. So we -- for
16 each type of procedure -- so if you took a
17 specific CPT code and ICD-9 code combination,
18 we calculated the average paid amount for that
19 specific combination across our data set, and
20 used that as the average cost for the type of
21 claim that was submitted.

22 CO-CHAIR CURTIS: And so for that

1 example, did you derive that average cost in
2 all populations in the measure or just the --
3 I'm sorry, just the population in the measure
4 or in the entire population in the database?

5 DR. WEISS: It was across the full
6 data set. Not just -- it was not just limited
7 to the population within the measure.

8 DR. WEINTRAUB: So basically your
9 standardized costs are average payments?

10 DR. WEISS: Yes.

11 DR. WEINTRAUB: All right. So
12 with respect of -- on costs, long ago I
13 remember a lecture hearing, there's charges,
14 payments and costs and they have nothing to do
15 with each other. So one has to watch out.
16 You know, to do something like this, you need
17 standardized costs, but there's no such thing.
18 And any time you're trying to do a cost
19 analysis, you're trying to come up with some
20 kind of proxy for societal costs, which is
21 what you really want. But there is no one
22 measure of that.

1 And I think in terms of developing
2 measure like this, this is just critically
3 important, you know, for those of us who write
4 and need this kind of literature, you read it
5 and even when you're reading the literature
6 published in the best journals, you always
7 have this level of skepticism. Do I really
8 believe these costs are right? If you
9 compare, for instance, the papers I've written
10 to the papers that Mark Hlatky's written on
11 cost of revascularization, you'll find that
12 his are considerably higher than mine. He's
13 using a different costing approach. Is he
14 wrong and I'm right? Or am I wrong and he's
15 right? No. You know, there's just no perfect
16 answer to this.

17 If you could say that -- if you
18 could always get the scaling right, it doesn't
19 matter what the real cost is because it's a
20 matter of scaling the different items of
21 resource use. But then at the end of the day,
22 do you believe it? Do you believe these

1 scales get it right?

2 CO-CHAIR CURTIS: So I think for
3 purposes of this evaluation, though, I mean,
4 I think the concerns are -- but they made
5 their assumption, they made their decision,
6 and we're just evaluating that decision. But
7 I want to make sure that --

8 DR. WEINTRAUB: It's not the
9 decision of anybody else.

10 CO-CHAIR CURTIS: Right. And does
11 anyone else have any specific questions about
12 the methodology they used to get the
13 standardized costs?

14 DR. HWONG: Can I further
15 understand how the NCQA relative resource use,
16 you know, standardized daily price tables
17 actually factor into this? I'm just trying to
18 understand how the ABMS measure is utilizing
19 those.

20 DR. WEISS: I'm sorry, I was on
21 mute. The NCQA -- we started with trying to
22 use the NCQA price tables across all of our

1 measures so that we'd have a single
2 standardized price, but we found that there
3 was a lot of services that happened within our
4 data set that did not show up in that
5 standardized price table. And what we ended
6 up doing was creating our own standardized
7 price sets across our measures. But we still
8 used the NCQA price table methodology for all
9 of our inpatient events.

10 DR. HWONG: I see. So it's
11 limited to the inpatient facility events?

12 DR. WEISS: That's right.

13 DR. HWONG: Okay, thank you.

14 MS. CLARK: I just wanted to -- I
15 know we kind of -- we were talking about the
16 different stratifications previously, and I
17 think we might have skipped over a little bit
18 of the detail on that. I know that they're
19 just looking at congestive heart failure, and
20 they were saying that the reason that that was
21 chosen was a measure -- as a measure of
22 severity. But I think stratification, while

1 it was also described as looking at it based
2 on demographic criteria, age, sex, race and
3 there definitely was some literature that
4 supported that there was variation in those
5 groups. And I guess we didn't see anything
6 addressed on reporting in those categories.
7 So I'm just -- or stratifications. So I'm
8 just curious why those weren't addressed.

9 DR. WEISS: So the primary
10 stratification that our work group was
11 interested in was the work group that Kevin
12 mentioned previously. We are limited in the
13 ability to look across age groups primarily
14 because of the commercial data set that we
15 used to test this out. It might be very
16 important to compare, you know, a Medicare
17 aged population to a commercially insured age
18 population.

19 And so I think part of the reason
20 behind not going down the route of age
21 comparisons was the relatively homogeneous age
22 group that we have in our commercially-insured

1 test data set.

2 MS. CLARK: Well, what about some
3 of the others? Sex and race that seem to fall
4 --

5 DR. WEISS: So race is very
6 difficult-slash-impossible to identify in the
7 data that we used. And the work included sex
8 as a variable in our risk adjustment model
9 rather than going through a stratification
10 process.

11 MS. CLARK: Okay. And just one
12 other comment on this. I know you were making
13 mention of the differences in resource use, I
14 guess, or severity levels based on trying to
15 identify STEMI versus non-STEMI, and that's
16 not possible in this data. That's definitely
17 something that needs to be considered then
18 when ICD10 goes into effect because you will
19 have that distinction at that point. So that
20 measure will have to be revised, I would
21 assume.

22 CO-CHAIR CURTIS: Well see, you

1 have that in the current data, it's just
2 nobody believes it. And so this stands in
3 contrast, actually, to the Ingenix measure for
4 AMI where they actually do attempt to stratify
5 -- or, yes, I think stratify by severity, and
6 one of the criteria is submyocardial versus
7 AMI.

8 So again, key decision across the
9 different developers having different
10 decisions.

11 DR. MARWICK: Could I just ask
12 about stratification based on the initial
13 treatment? As I understand it, the only
14 stratification here is full heart failure.
15 But you might consider the nature of the
16 original intervention at the time of
17 presentation in those 30 days. That would --
18 presumably you're capturing that in that
19 analysis. But that would port over to this as
20 being an important potential stratification.

21 DR. WEISS: Yes, we certainly do -
22 - did look at the initial intervention as part

1 of our acute measure, and as you would expect,
2 found some major differences in resource use
3 across what if somebody had a CABG or a PCI.
4 And our work groups are -- you know, sort of
5 that was their underlying hypothesis. And so
6 that variability was a key component of --
7 capturing that variability was a key component
8 of our acute resource use.

9 Now we did not explore those
10 interventions as stratification during day 31
11 to 365. The work group did not choose to
12 investigate that as a potential stratifying
13 criteria in -- during this time period for AMI
14 measure. And you know, I can't comment on the
15 clinical rationale behind that. They just did
16 not choose to go in that direction.

17 CO-CHAIR CURTIS: Do you think it
18 might come back to how eventually it will be
19 harmonized with the quality measures, in that
20 for the quality aspect you're not going to
21 want to adjust for things that could represent
22 complications of care during the index

1 admission. The index event here is the
2 admission for MI 30 days previously. So I
3 think they probably would like to avoid
4 adjusting for anything that occurred in that
5 interval from admission to 30 days that could
6 be a complication.

7 MR. ALZOLA: I have a question.
8 If your study finding by heart failure, how
9 can you have a coefficient in your risk model
10 for heart failure?

11 DR. WEISS: Yes, I mean that's a
12 good question. That was part of our risk
13 adjustment calculations over the whole
14 population. When we reported out by
15 stratification of heart failure, we reported
16 it out after our implementation of our risk
17 adjustment model, simply reporting heart
18 failure versus no heart failure patients. The
19 risk adjusted calculations were done on the
20 population as a whole.

21 MR. ALZOLA: So your risk
22 adjustment, your study find on the report and

1 not in the model?

2 DR. WEISS: That's correct.

3 MR. ALZOLA: Okay.

4 CO-CHAIR CURTIS: So moving on to
5 the next segment which is attribution. The --
6 let's start on 28. There's a fairly clear
7 plan for attribution to the physician level
8 which says, dependent on thresholds for the
9 proportion of patients -- proportion of
10 encounters provided by a single or multiple
11 provider.

12 So if you look at S.11.1, if a
13 single provider is providing at least 70
14 percent of the episode's E&M's during that
15 time frame, is there E&M's for AMI-related
16 care that would be attributed to that single
17 physician? If however no one meets that
18 threshold of 70 percent, you could have
19 multiple attribution across different
20 physicians if they were all physicians who had
21 30 percent. So up to three physicians could
22 have that patient's costs attributed to them.

1 And then if nobody has at least 30 percent of
2 the E&M codes, then it is not attributed to
3 anyone.

4 And so I recognize that there are
5 assumptions and -- made in this, but again it
6 seemed fairly reasonable, as good as any other
7 method of attribution that I'd seen.

8 CO-CHAIR ROSENZWEIG: Could I ask
9 a question about that? So I mean, the number
10 of E&M codes may still represent a very small
11 proportion of the total costs. I mean, if the
12 patient is seeing -- if the patient is seeing
13 someone as an outpatient provider, they could
14 rack up a lot of E&M costs, but they might
15 represent five, ten percent of the total cost.
16 If there's another person who's doing the --
17 this CABG during that time, or if there's
18 another person who's doing the radiological
19 procedure, you know, the whatever the --
20 whatever -- you know, spiral CT scan for
21 whatever it is.

22 So the question, is that a fair

1 attribution? And then when you have -- if you
2 have less than 70 percent -- if you have a
3 bunch of providers who have less than 70
4 percent of the total, are you attributing the
5 total costs to each of those people or are you
6 -- how do you split it up?

7 CO-CHAIR CURTIS: My understanding
8 is they attribute the whole cost to each of
9 those, as opposed to trying to proportion it
10 out.

11 But getting to the first part of
12 your question, I think that at the end of the
13 day they're trying to identify someone who is
14 more or less responsible for the AMI care of
15 this patient. And so it's not going to be the
16 person interpreting the spec study, it's not
17 going to be the person doing the cath
18 necessarily. It's going to be the person
19 who's seeing them and making those management
20 or -- decisions.

21 DR. MARWICK: I think there's a
22 problem there. That is that there's somebody

1 hiding behind the curtain who's actually --
2 who is actually charging, potentially charging
3 a lot of money but that isn't showing up in
4 the E&M measures at all. If for example you
5 take somebody who's being managed in primary
6 care but is sent as a consultation to see a
7 cardiologist, and then ends up having a CABG,
8 the decision that drives the cost there is
9 made by somebody else completely. And it's --
10 and so the primary practitioner is the person
11 who's carrying the responsibility.

12 CO-CHAIR CURTIS: I don't know,
13 but to me that's sort of what the role of the
14 primary care physician and/or the cardiologist
15 who did the initial consultation is, is in
16 fact to do that. And it should be
17 attributable to them.

18 Now they do specify -- and I may
19 butcher this, so if the measure developer
20 wants to comment, please jump in. But you
21 know, it can be attributed to across peer
22 groups. So there can be a primary care

1 physician who's -- to whom these costs are
2 attributed as well as a cardiologist to whom
3 these costs are attributed. So the fact that
4 it's a single measure, a stand-alone measure
5 I think comes into play here, where it makes
6 that feasible. But there aren't -- I mean,
7 again, this is a decision that has to be made.

8 I guess the converse, if you just
9 attribute it to the actual physician who
10 provided the care, then the nuclear
11 cardiologist or the cardiologist interpreting
12 nuclear studies is going to rack up immense
13 costs, just because that's the part that
14 they're reading. So I'm not sure what the
15 alternative is.

16 DR. MARWICK: So I think the
17 solution is that, at the moment, of the level
18 of granularity that we have with the data at
19 the moment, this is something that should be
20 attributed to on a group basis, or on a
21 facility basis, rather than on an individual
22 basis.

1 DR. WEINTRAUB: Then you have
2 problems, of course, follow-up care may not be
3 -- may be spread across the facilities.
4 Extraordinarily difficult. But Jephtha, I
5 think you let them off too easily if primary
6 care physician sees a patient six times and is
7 providing excellent detailed care measurable
8 of this fact that the patient has recurring
9 chest pain. Sent to a cardiologist who caps
10 the patient, sends the patient to a surgeon.

11 I think that not only are -- you
12 don't get the attribution right, but the
13 problem of the distribution of costs is going
14 to be extraordinarily weighted towards those
15 high-profile events that not only do you have
16 attribution role, but you have problems of the
17 distribution when you're looking at relatively
18 rare, relatively high costs.

19 I think it becomes impossible at
20 the level of the individual physician, and
21 perhaps doable at the level of the facility.
22 But works best in closed-in systems where all

1 of the resource use are related to that
2 facility. That doesn't happen most of the
3 time.

4 DR. HWONG: Yes, hi, I just want
5 to echo that opinion. So maybe the measure
6 developer could think about in future
7 iterations, you know, something where there's
8 more of this sort of shared accountability.
9 I think probably what can happen is, if you do
10 have this primary care physician that's really
11 acting, you know, as his true primary care
12 physician, they could very easily rack up
13 those 70 percent E&M's. And then the
14 cardiologist involved, you know, throughout,
15 you know, wouldn't actually be identified or,
16 you know, have this sort of opportunity for
17 feedback or input.

18 I understand that they have this,
19 you know, second tier, if it's less than 70
20 percent and you get 30 percent or something,
21 maybe you'll include -- maybe that will
22 probably grab some more specialists. But

1 maybe something, again, the measure developer
2 could do is say, okay, you know, there are
3 some attribution logic choices, you know,
4 depending on the philosophy of how you want to
5 implement this.

6 If you're trying to do things in
7 terms of quality improvement for groups and
8 care coordination, et cetera, it might be good
9 to highlight -- you know, figure out who those
10 individuals are. Because again, if you -- the
11 preponderance is, you know, 70 percent, it's
12 really just, you know, your internist, your
13 family practitioner, et cetera. There may be
14 a specials group that, you know, would not be
15 able to benefit from this information.

16 CO-CHAIR ROSENZWEIG: Yes, in
17 addition, you know, the patient may be seeing
18 a primary care provider for a whole lot of
19 other reasons, you know, upper respiratory
20 infection, the cardiovascular disease will
21 still be listed as one of the codes for the
22 visit.

1 And so they may be seeing them for
2 a whole lot of different things. And once they
3 send them to a cardiologist, even if they say
4 -- if they're considered the gatekeeper in a
5 managed care plan, it's really the
6 cardiologist's decision often that rules
7 whether or not these various tests are being
8 done. So I question the issue of, you know -
9 - I mean, and they're in large number. And
10 you -- this particular system may also be
11 attributed to point of service type plans as
12 well, where the primary care physician has no
13 control over whether or not these tests are
14 being done.

15 CO-CHAIR CURTIS: So just of note,
16 though, in the actual attributions scheme now
17 that they have in the accompanying slides, the
18 majority of these patients were -- episodes
19 were attributed to a cardiologist. So I think
20 it's a fair point that you could, you know,
21 say, well, let's just define all cardiologist
22 care and let's define all primary care, and

1 attribute one within each peer group.

2 So there are other options that
3 they could explore. But it seems to work to
4 a certain extent. It has some face validity
5 that the majority of episodes are attributed
6 to the cardiologist.

7 DR. WEINTRAUB: But that's a
8 problem. You know, most of the time it's
9 going to work out, but some of the time it
10 won't. And do we have a sense of how often
11 it's not going to work out and how often it's
12 going to be nonsense?

13 CO-CHAIR CURTIS: Well, I think
14 one of the things that's concerning in that
15 same episode is, if you get into the -- and I
16 think it's in the reliability and validity
17 testing -- that in this data, at least 35, 40
18 percent of cases were not attributable to a
19 particular physician at all. That there was
20 incomplete information about the physician.
21 And so that is concerning.

22 And I don't know if the measure

1 developer could comment as to whether or not
2 that was specific to the data set tested or if
3 that represents a global problem that would
4 really be a barrier to implementation of the
5 measure at all?

6 DR. WEISS: Yes, I can't speak to
7 how the ability to identify providers across
8 multiple data sets. It certainly was an issue
9 in our attribution methodology for testing
10 within this commercial data set. That we were
11 not able to identify an attributable provider
12 with certain claims for a large portion of the
13 claims that we had.

14 CO-CHAIR CURTIS: So I think that
15 would be something that would need -- you
16 know, since this is attributed to the
17 physician level, that's pretty critical if 30
18 percent of the claims are not attributable at
19 all. You know, that's introducing much more
20 noise than anything else we've discussed so
21 far.

22 MS. CLARK: All right. There's

1 this question, but I wonder if it would make
2 sense to try to attribute it to the physician
3 who actually sees the patient on their initial
4 admission for the AMI and manages their care
5 from that point? I don't know if that's a
6 reasonable thing or not.

7 CO-CHAIR CURTIS: I think it's
8 another choice. I'm not sure if it's a better
9 choice. Just because there are so many
10 hospitalists who it could be attributed to.

11 We're slowly working our way
12 through here. We're almost at the end of the
13 2.A.1 criteria. So only fourteen and a half
14 more measures to go -- thirteen and a half.

15 (Laughter.)

16 CO-CHAIR CURTIS: The -- so moving
17 on from attribution and the peer group
18 methodology. I'm going to -- I think we've
19 touched on that enough for this discussion.

20 They then move into 11.5, 11.6,
21 which is the detail measure, outliers and
22 thresholds which I think is key for all of

1 these resource use, how are they accounting
2 for very high outliers. In this case, they
3 propose ones arising at the 99 percentile such
4 that any value higher than 99 percentile is
5 set to 99 percentile, and it's a subtly
6 different approach across different
7 developers. But I think at least they've
8 defined how they would approach that. And it
9 seemed, again, I don't think there's a gold
10 standard for saying one Winsorization
11 threshold is better than another, you know.

12 And then in terms of sample size
13 requirements, they do not specify any minimum
14 sample size necessary for public reporting,
15 which is -- I think gives them flexibility in
16 terms of it, but I guess cause for caution on
17 my side as to, you know, is one or two cases,
18 at the physician level, meaningful in terms of
19 even providing that as feedback to the
20 physician. Does it really impact them or mean
21 anything.

22 But I would almost give them the

1 out to say that that just gives them more
2 feedback or more leeway in terms of how they
3 are applying the measure when it actually gets
4 implemented.

5 DR. WEINTRAUB: Yes, the issue of
6 sample size here is important, and really
7 complicated. And it's complicated because the
8 distributions of costs are going to be so
9 skewed with relatively small percentage of the
10 population having very high costs.

11 I think this is really
12 extraordinarily difficult. I don't have an
13 answer to it, but I'm worried about it, and I
14 wonder, as a statistical consultant, I'm sure
15 it's something that you've thought about?

16 MR. ALZOLA: Yes, I don't have an
17 answer, either. I mean, the problem is that,
18 to make the measure useful, you're really
19 going to have to have a relatively large
20 sample size to really estimate the costs. And
21 for many facilities, especially small
22 facilities, they don't see many AMI patients

1 in any given month.

2 CO-CHAIR CURTIS: Much less
3 providers. I mean, it's hard enough doing it,
4 you know, half of hospitals admit less than 25
5 AMI's a year. How many physicians are going
6 to fall into that sum? So a single calendar
7 year, more likely than not, isn't going to --
8 especially if you're using commercial
9 database. You know, out of 25,000,000 covered
10 patients, only, what, 20,000 MI's were found.

11 And at the end, once you got down
12 to the attributable level, it was 3,800 or so
13 patients who were included. And so you're
14 getting to very small numbers very quickly.

15 CO-CHAIR ROSENZWEIG: To what
16 extent can this measure be used for external -
17 -

18 CO-CHAIR CURTIS: Do you want to
19 repeat that?

20 CO-CHAIR ROSENZWEIG: To what
21 extent can this measure be used for external
22 accountability? I mean, if you can't get the

1 statistically significant differences between
2 physicians, are there any provisions that this
3 measure would not be used for external
4 accountability, at least on the provider
5 level?

6 CO-CHAIR CURTIS: I think it's a
7 concern, if you don't have enough cases, how
8 can you be held accountable with statistical
9 power --

10 CO-CHAIR ROSENZWEIG: Exactly.

11 CO-CHAIR CURTIS: But let me throw
12 that out to the measure developer. How would
13 you approach this issue of the small number of
14 cases, as well as the overall noise among all
15 the things that we've discussed?

16 DR. WEISS: I think these are very
17 valid concerns, and we don't have enough
18 information yet to be able to provide a good
19 estimate of the sample size that will be
20 required. I think that will be important for
21 continued maintenance of these measures and
22 understanding exactly how these measures are

1 being used.

2 Our initial efforts were focused
3 on identification of the resource use, hoping
4 to get this to the provider level. We
5 acknowledge that there needs to be some
6 additional work around identification of the
7 sample size that's sort of sufficient to be
8 able to provide very sort of robust estimates
9 of relative resource use.

10 That being said, it may provide
11 some initial benchmarking through, you know,
12 a handful of cases just to give providers a
13 sense of where they lie. You know, the intent
14 is that these would be used as information
15 tools to help to identify variability and
16 resource use. And as such, I think that even
17 with small numbers of cases, there is the
18 potential value for using these measures to
19 identify cases of incredibly high costs or
20 high resource use or what might be driving
21 those, and the variability within there.

22 DR. WEINTRAUB: So the extreme of

1 this is pointed out to me by Jephtha, and he's
2 putting it out to me on the AMI post-acute
3 care. And I think it's going to run through
4 all these. It ran through the three I looked
5 at. If you look at inpatient facility costs
6 in particular, you see that the 75th
7 percentile is at zero, 95th percentile is
8 almost \$26,000. That's really rather extreme.

9 So what you're going to have is,
10 until you probably get into -- I don't know,
11 but I would imagine until you get into the
12 thousands, what you're going to have is almost
13 impossible to look at the individual
14 physician. But even the facility, a small
15 facility is going to be almost impossible.
16 Certainly well into the hundreds.

17 Am I making sense?

18 MR. ALZOLA: Yes. May I say this,
19 that you perform some simulations --

20 DR. WEINTRAUB: Yes.

21 MR. ALZOLA: -- as to how many
22 cases you would need to estimate -- to see the

1 reality, and wide your confidence in these
2 are. Let's start with 10, 15, 20 and so on,
3 and see what -- if you can get a reasonable
4 sample size with a relatively narrow
5 confidence, you know.

6 DR. WEINTRAUB: Yes. So I
7 completely agree with that, and that's the
8 kind of simulation that really should be done,
9 really now. That can be done with what's at
10 hand now.

11 DR. WEISS: Sorry, if I could jump
12 in around this conversation. One thing to
13 keep in mind is that part of what we're
14 reporting are ratios of observed to expected
15 costs. And granted there's a huge degree of
16 variability in the observed costs that we see,
17 that you've pointed out in that distribution,
18 over the average cost of an episode. That is
19 all reflected to a risk adjusted cost, and so
20 now we've got a range of observed to expected
21 ratios.

22 And granted, there can be a large

1 range there also, but it can help to reduce
2 the amount of variability we see relative to
3 the huge -- the large skewedness in the cost
4 distribution.

5 CO-CHAIR CURTIS: So the thing
6 that's defining that, though, is as you note,
7 the thing that's driving costs is, you know,
8 additional revascularization procedures,
9 predominantly on the inpatient basis, right?
10 And that's not randomly distributed, that's
11 distributed by the severity of their disease
12 and the proportion of patients with pre-vessel
13 disease who may not have been taken care of in
14 the first 30 days.

15 And so it's -- without that
16 granularity of anatomic data, your risk
17 adjustment methodology really can't take that
18 into account. But you've done the best you
19 can with the data you have.

20 DR. WEISS: Plus -- this is Kevin
21 -- that's the assumption that care is being
22 delivered, let's say appropriately, that there

1 may be a lot of other revascularization and/or
2 other invasive activities going on that may,
3 in fact, not be consistent with guideline
4 care. And I think that we recognize that's a
5 part of why we're trying to put these measures
6 into practice, to see what that looks like.

7 DR. WEINTRAUB: Fair enough. I
8 mean, that's what you'd like to do. But the
9 question is, can you pull it off? Because the
10 problem is that you're going to have a
11 variability because of the relatively small
12 number of patients that any one provider, and
13 even most facilities see. And then the
14 relatively small number of revascularizations.

15 Now if you have an extreme outlier
16 of someone who's doing, I don't know, 20 when
17 they should be doing four, that's one thing.
18 But the problem is that you're going to have
19 this variability just in the stochastics of
20 this. So then how can you get around it? The
21 person who takes care of 20 MI's, most of them
22 will have no revascularizations. The person -

1 - the people who just have one all of a sudden
2 stand out.

3 CO-CHAIR CURTIS: And I don't
4 necessarily think that's a problem for this
5 part, right? I mean, it is -- simply, it is
6 measuring -- this is a methodology for
7 defining the costs or resource utilization.
8 It only becomes a problem when you extend it
9 to inferences of quality and value. And
10 that's the concern.

11 CO-CHAIR ROSENZWEIG: Yes, I would
12 agree with that. And so I -- would it be
13 unreasonable for NQF to specifically require
14 some statement in this context, to make sure
15 that if one of these measures is to be used
16 for external accountability, especially at the
17 provider level, that they need to actually
18 demonstrate that their -- you know, that their
19 statistical basis for it, and rationale for
20 it?

21 Otherwise, a measure like this
22 could be misused, and in very significant

1 ways. I mean, especially with all of the
2 paper for performance schemes out there
3 currently.

4 CO-CHAIR CURTIS: So Sally, I
5 don't know if you want to comment.

6 MS. TURBYVILLE: I actually
7 deferred to Helen. So the question being,
8 would NQF feel comfortable in the reports or
9 elsewhere saying that, while there's no
10 specifications necessarily on what kinds of
11 statistical properties the measures should
12 meet for public accountability, would we say
13 that users should have a statistical approach,
14 and also be transparent about that when they
15 report these measures, so that there's a
16 little bit more confidence that they have that
17 kind of additional, yet critical --

18 DR. BURSTIN: I think it's very
19 reasonable for the steering committee to add
20 that.

21 DR. WEISS: And just to note from
22 the developer, we would appreciate that extra

1 statement by NQF.

2 CO-CHAIR ROSENZWEIG: I mean, one
3 of the problems that has come up, though, that
4 we've actually dealt with in the past with
5 diabetes measures, is that even if you specify
6 that physicians should not be held
7 accountable, what happens is that, if the plan
8 is held accountable, they may often on their
9 own put into place paper performance schemes
10 for physicians that are not necessarily based
11 on good data, that can -- in other words, the
12 plans themselves could misuse it.

13 So I think some sort of directive
14 from NQF with respect to this issue would be
15 extremely helpful.

16 DR. LYNN: Tom Lynn. I'm from --
17 I'm obviously not the rule developer, but --
18 can you hear me now?

19 But I think this is something
20 obviously relates to all of us. And NQF,
21 through the physician, hospital and quality
22 guidelines, has already made recommendations

1 about use of cost measures. And that document
2 requires that you do something to show that
3 the decisions you're making, based on cost,
4 are statistically significant. That whatever
5 benchmark you're comparing to, that the
6 measurement you're using shows that you're
7 only making decisions on folks that are
8 statistically different from that benchmark.

9 And we certainly -- and I'm sure
10 Kevin and his group would join us in saying,
11 we absolutely think they should not be used
12 any other way.

13 CO-CHAIR CURTIS: I guess the --

14 DR. PALESTRANT: This is David
15 Palestrant. You know, part of what we've been
16 asked to establish are the reliability and
17 validity, to define that we think that this
18 is, you know, high moderate or low.

19 But I find it difficult to -- when
20 we have all these different questions, and
21 it's very nuanced data, very difficult to get
22 to. But it really calls for the fact that you

1 cannot call this reliable unless you know if
2 it's reliable to X or reliable to Y. Do you
3 understand what I'm saying? So it's clearly
4 not reliable if you're judging a physician
5 who's had two patients, but it may be reliable
6 for a physician who's had 100 patients. It
7 may not be reliable -- it depends on what you
8 -- you know, it depends on what you're looking
9 at. And this is a very broad -- this is very
10 broad data.

11 DR. WEINTRAUB: I want to make one
12 more point about statistical significance.
13 It's all very nice, but there's a huge leap
14 from statistical significance to causality.
15 And at the end of the day, we want to believe
16 that the measures that were put forward for
17 everybody in the country to use are not just
18 statistically significant, but when we say
19 something, it's got -- it's never perfect.
20 You know, perfect is the enemy of the good.
21 But some reason to believe that it's causal.
22 That's a very high standard.

1 DR. WEISS: Just to note, from
2 Kevin, if I may, and that is, I think by the
3 nature of the discussion and the fact that our
4 colleagues from Ingenix are actually exactly
5 as concerned as suggested, this is a more
6 generic issue across the measures. And
7 anything that can be done to address this
8 would be really important to the field.

9 CO-CHAIR CURTIS: Agreed. So
10 Sally, just let me ask, do you want to pause
11 now, or should we vote on this particular
12 criteria of 2.A.1 or should we try to get
13 through reliability, validity? Which I think
14 we've really discussed on an ad hoc basis, and
15 I think we could get through quickly. But I
16 want to be sensitive.

17 MS. TURBYVILLE: Yes, I think we
18 should definitely vote on the ratings on
19 2.A.1. And so we're bumping up against lunch,
20 so it's really up to you guys to decide. It's
21 waiting, but we also want to make sure we give
22 the public a good opportunity to comment. So

1 our plan was, once you guys close out here,
2 and then want to move to lunch, right before
3 we go to lunch we would open it up to the
4 public comment.

5 So if you want to try and move
6 through the next section, you know, I think we
7 should go for it if we feel like we're picking
8 up speed here and, you know, don't want to
9 break in between some of the thoughts.

10 CO-CHAIR CURTIS: Yes, I'd rather
11 just --

12 MS. TURBYVILLE: Okay.

13 CO-CHAIR CURTIS: I'm going to do
14 a dictatorship. We're going to keep going
15 until we finish this, so then I can stop
16 talking afterwards.

17 (Laughter.)

18 CO-CHAIR CURTIS: -- peacefully go
19 to sleep.

20 So in terms of -- so then move to
21 2.A.2, which is reliability testing,
22 demonstrating that the results are repeatable,

1 producing the same results in a hyper portion
2 of the time when it's based on the same
3 populations and the same time and that the
4 measure score is precise.

5 So when we get to that, that's
6 scientific acceptability, 1.3 through 1.4, am
7 I right that we're going to go through all
8 these and then vote on all the 2 criteria, or
9 should we vote on 2.A.1 first?

10 MS. TURBYVILLE: We could vote on
11 2.A.1 and -- it might be good to vote on 2.A.1
12 and 2.A.2 together, since they both map to
13 reliability.

14 CO-CHAIR CURTIS: Okay.

15 MS. TURBYVILLE: And then also you
16 can take benefit of Carlos at the table, if
17 you want him to provide any overview as well.
18 So I'll leave it to you to ask him as you see
19 fit.

20 CO-CHAIR CURTIS: Okay. So I
21 think that if you -- it's a little hard to go
22 through, but if you can bring up the slide for

1 the accessory slide number one that shows the
2 inclusion-exclusion criteria effect.

3 So they validated or assessed this
4 measure in the commercial available Thomas
5 Reuters data set with 25,000,000 lives. When
6 they're talking about validity testing, they
7 acknowledge that they are primarily focusing
8 or accepting face validity --

9 The diagram, yes. Sorry.

10 So I'm sorry, it's slide four.

11 So when they -- again, this is how
12 precisely specified is the measure when they
13 apply their criteria of continuous coverage,
14 standard NCQA exclusion criteria, age
15 restriction, et cetera? I think that, to me
16 at least, you get from 10,000 patients at the
17 start down to 3,800 patients at the end,
18 whereas there are concerns about the
19 individual exclusion criteria, I think at the
20 end it is precisely defined. So I think that
21 if you replicate this across -- in the same
22 data set or across other data sets, you would

1 have a similar ability to come to the same
2 cohort.

3 So from that standpoint, I think
4 it's precisely defined.

5 And then you get into how they are
6 -- proposed attribution logic or
7 identification of related and unrelated
8 services, et cetera. We've really touched on
9 that I think extensively at this point. Where
10 there are choices that they made in terms of
11 related and unrelated services that they feel
12 represents the majority of AMI attributable
13 care is captured in the measure, with some
14 acceptance of loss based on -- if you keep
15 scrolling down, the unrelated procedures that
16 we looked at before, slide nine. Non-AMI
17 related imaging is an example.

18 And when you look at the
19 incorporation of the risk adjustment, they
20 don't really provide necessarily data on this,
21 but you know, they are using HUC, which is an
22 accepted risk adjustment methodology specific

1 to cost, which seemed in only using the 12
2 months prior for risk adjustment. So that
3 seemed fairly specifically placed.

4 And assessment of the physician
5 attribution, we touched on this. I think
6 that's slide 14, where applying the 3,700
7 cases that they had, 47 percent had
8 insufficient provider ID so they couldn't
9 attribute to any physician. Within that 1,500
10 left over, you had 70 percent attribution to
11 a single provider, 1,100 patients, and then a
12 smaller proportion in which the episodes were
13 attributed to two or three providers, and only
14 half a percent in which there was no provider
15 attributed.

16 So again, this is -- we could
17 argue about whether or not this is the right
18 form of attribution, but I think it's a
19 precise attribution once they get to a
20 criteria. So if they could fix the whole in
21 terms of identifying physicians, then it could
22 be precisely attributed for the measure --

1 purposes of the measure.

2 So then you get into testing
3 results and the findings statement. When they
4 did this, and again, we've touched on this
5 already, but when you start looking at the
6 outputs from the measure, which I think I'm
7 going to call page 17, we get into that issue
8 of how this looks. And so the bottom is the
9 sum of costs across providers. I'm sorry, the
10 sum of costs across patients, the variance.
11 And you see that, indeed, there is significant
12 variance in the total costs assessed across
13 patients ranging from 646 in the lowest fifth
14 percentile to 3,800 or 3,700 in the 95th
15 percentile. But that data is incredibly
16 skewed, based on whether or not the patient
17 had been admitted and/or had undergone
18 procedures to a less or the outpatient
19 facility costs.

20 So there is variation across, but
21 we've raised the concerns as to whether or not
22 this is, in fact, stable case -- or being

1 driven by measures that the risk adjustment
2 methodology couldn't account for.

3 And then getting on to slide 18,
4 19, et cetera, you sort of see how this would
5 work using region as a proxy for provider, in
6 this case. Among the 3,800 episodes that they
7 were assessing, you can see that northeast,
8 the care is different than it is in the south
9 and west. And you might wonder as to that,
10 because it is sort of the inverse of what we
11 find on population studies. It probably has
12 to do, in my off the cuff opinion, as to that
13 this is the post-acute episodic care. So the
14 west may use earlier care in the first 30 days
15 whereas the northeast may be doing more of the
16 care, their invasive procedures after the
17 first 30 days. But again, that's highly
18 speculative on my part.

19 But again, the conclusion though
20 is that, in this risk adjusted costing or
21 resource use methodology, there is a variation
22 in the cost as assessed by the ratio of

1 observed to expecteds.

2 I'll pause there for a second.

3 And then they replicated at the
4 state level as opposed to region. And I just
5 want to go down to the bottom, the last slide
6 that they have, which is the sample report.
7 It kind of shows how this potentially could be
8 applied to the physician level. I believe
9 that this is not specified for AMI, it's not
10 using the AMI data, probably I think it might
11 have been diabetes, although that's not
12 specified on this slide.

13 But using similar methodology,
14 there are differences in observed costs,
15 predicted costs and the observed to expected
16 ratio at the level of the provider, within a
17 certain specialty. And that that can be
18 benchmarked against peer groups, non-peer
19 groups and the national average in a way that
20 you could potentially use this to identify
21 physician level differences and resource
22 utilization.

1 So again, I'll pause there. I
2 went kind of racing through that, and there
3 were a lot of elements. But again, I do feel
4 like we discussed most of them up front.

5 Carlos, I don't know if you want
6 to specifically talk about how they used the
7 observed to expecteds in your take on the risk
8 adjustment methodology as a whole?

9 MR. ALZOLA: Yes, the risk
10 adjustment methodology, it seems they use an
11 appropriate method. They use something of a
12 regression where they could use a log model.
13 Which one of those, you just look at them and
14 see which one works best. It doesn't -- you
15 have to be really practical on how you use
16 that information.

17 What I didn't see, which I was
18 expecting, was how good the model feeds were.
19 There weren't any -- there wasn't any
20 calibration curve to see where predicting or
21 under-predicting specific reasons. I wouldn't
22 be surprised that, if -- to see that we are

1 almost under-predicting for the really
2 expensive cases. It's very typical.

3 And so there were no r squares and
4 not any of that kind of information.

5 CO-CHAIR CURTIS: Right. In fact,
6 they stated that they calculated the r squares
7 and residual means, et cetera --

8 MR. ALZOLA: Right.

9 CO-CHAIR CURTIS: -- but it wasn't
10 present in the application. I don't know if
11 that was how they interpreted the specific
12 criteria out of the application or not. But
13 I think that's something that we would really
14 want to see or need to see by the time of the
15 steering committee review.

16 MR. ALZOLA: And so there's one
17 more additional comment, with respect to the -
18 - how they calculated the observed expected
19 ratios. They did it on an individual basis,
20 so they calculated the observed for an
21 episode, divided by the expected for that
22 episode and summarized those.

1 It is more typical to look at the
2 observed for all -- the ratio for all the
3 observeds for a provider and divide by the
4 expected ones. And it's not that what they
5 did is wrong, it's -- it has other properties.
6 But I am not so sure of what the statistical
7 properties of that approach are. But the
8 other standard approach is more -- the
9 statistical properties are well known, and
10 it's really -- it's all -- that information is
11 all here to provide it in that way.

12 CO-CHAIR CURTIS: So let me ask
13 the measure developer to comment on that
14 particular decision of grouping or calculating
15 individually the observed and expecteds?

16 You might be on mute?

17 DR. WEISS: Oh, sorry. I've got
18 to remember to push that button.

19 Yes, we -- we intended to measure
20 this -- we wanted to assess the variability
21 within individual patients. And so we were
22 interested in observed to expected at the

1 individual level. But like I mentioned, you
2 know, you can roll this up and the information
3 is available here to calculate it across in
4 any level of measure you'd like to.

5 We focused on the individual
6 because we wanted to understand variability
7 within individual patients and how that was
8 then attributed to providers. We -- you know,
9 we have all sorts of data that we could have
10 provided on the performance of doing it at the
11 individual level, the performance of our risk
12 adjustment model. So that information is easy
13 to supply to NQF if that's necessary as part
14 of the further evaluation of these episodes.

15 CO-CHAIR CURTIS: I think that
16 would be good.

17 MS. TURBYVILLE: Jeptha, could you
18 or the measure developer clarify what's going
19 to be provided so I can put it in my notes?

20 DR. WEISS: We can provide data or
21 information on the performance of our risk
22 adjustment models that the panel is asking

1 for.

2 MS. TURBYVILLE: Great, thank you.

3 MR. ALZOLA: One thing that would
4 be important to see is what were the candidate
5 variables for the risk model and which are --
6 and how you ended up selecting the ones you
7 ended up selecting.

8 DR. WEISS: Okay.

9 CO-CHAIR CURTIS: So I think we
10 should move to the voting component, starting
11 with 2.A.1. Let me first open it up, does
12 anyone else on the panel have any specific
13 comments or requests for clarification?

14 (No response.)

15 CO-CHAIR CURTIS: So for 2.A.1,
16 you can see there, you know, all these
17 different microcriteria. I don't know if --
18 and I think we -- it will probably just depend
19 on your individual preference and take. You
20 can sort of assess this as sort of a rolled
21 up, like global the average criteria or you
22 could apply -- I think if you're that

1 concerned about any one of the individual
2 criteria is not met, that that may be a killer
3 for a fatal flaw for you for the measure. And
4 I don't necessarily think we have direction
5 from the steering committee as to how to apply
6 that.

7 MS. TURBYVILLE: So this
8 subcriteria does apply to the entire
9 specification. So you're right, if there are
10 certain components of it, for example, the
11 clinical logic, that you feel is not met, and
12 then therefore -- and it's met in such a way
13 that the specification is not precise enough,
14 we would want that to be reflected in the
15 criteria. But we will also ask for rationale.
16 So in particular, for low and moderate, I want
17 to take some time so that for adjustments that
18 the developer can make, they can. And
19 otherwise, we're capturing that information.

20 CO-CHAIR CURTIS: And when you say
21 we were going to provide the rationale, who's
22 going to provide the rationale? We've been

1 talking for two and a half hours, but are we
2 doing that offline or at real time?

3 MS. TURBYVILLE: I think we can
4 summarize some of what we've heard, and then
5 we'll pause and ask the TAP to let us know if
6 we have missed anything.

7 So for example, we heard that the
8 codes need to be updated to the most recent
9 version of CPT-ICD-9. So we'll do that after
10 you vote and rate. And if we miss anything
11 that is, you know, pertinent to this rating,
12 you can provide it to us at that time.

13 CO-CHAIR CURTIS: So, perfect. So
14 then moving forward on 2.A.1, the measure is
15 well defined and precisely specified so that
16 it can be implemented consistently within and
17 across organizations and allow for
18 comparability.

19 And go ahead and vote.

20 So it's quite heterogeneous with
21 one high, four moderate, two low and one
22 insufficient. It's a little hard to say, I

1 don't know, do we average that or --

2 MS. TURBYVILLE: No, the steering
3 committee will see the exact frequency in the
4 number, so we don't attempt to try and create
5 some kind of overall.

6 CO-CHAIR CURTIS: Okay. So we
7 then summarize kind of what we heard?

8 MS. TURBYVILLE: Yes. So some of
9 the things I heard that need to be updated are
10 the length of the data required needs to be
11 aligned with the measurement time span itself.
12 Some clarification, how the standard prices
13 are approached, a little bit more clarity and
14 transparency around that. There -- sorry --

15 MR. AMIN: There were specific
16 concerns around -- I'm just going to add with
17 you, if that's okay?

18 MS. TURBYVILLE: Sure, go ahead.
19 Yeah.

20 MR. AMIN: Specific concerns
21 around the exclusions -- or on the exclusion
22 criteria of excluding patients to the skilled

1 nursing facility.

2 MS. TURBYVILLE: Yes, and there
3 was some question about the Rx, and so
4 response back, that is the pharmacy response
5 back from the measure developer about a little
6 bit more in detail about how they're going to
7 be updated through maintenance, especially the
8 pharmacy codes, but codes in general. As well
9 as the HCPCS that were included, a bit more
10 rationale around that.

11 And there was some question about
12 the sample size recommendations provided.
13 Some of that from the TAP came back to NQF to
14 think about statistical criteria, or at least
15 statements about encouraging or requesting
16 that users of these measures are providing --
17 are using sound statistical approaches.

18 There is some missing information
19 on how the model fits for the selected risk
20 adjustment approach, and so there's a request
21 for that information to be submitted, along
22 with a description of the candidate variables

1 that were examined and how they were selected
2 in the final risk adjustment model.

3 MR. AMIN: The only thing else I
4 would add is, there was a strong discussion
5 around the attribution approach on concerns of
6 purely defining attribution, based on E&M
7 codes.

8 Is there anything else that we
9 should --

10 CO-CHAIR CURTIS: It seems like a
11 lot.

12 MS. TURBYVILLE: And so, you know,
13 we'll facilitate this with the measure
14 developers and they'll determine how to
15 respond back to all of you.

16 Thank you.

17 MR. AMIN: Yes, there -- I would
18 just add one more. There was discussion
19 around the stratification approach for race
20 and sex. So that was added into the
21 discussion.

22 CO-CHAIR CURTIS: Okay. So for

1 criteria 2.A.2, reliability testing,
2 demonstrates that the results are repeatable,
3 producing the same results a high proportion
4 of the time when assessed in the same
5 population in the same period. And that the
6 measure score is precise.

7 And if we can go ahead and vote on
8 that.

9 Again, sort of a normal
10 distribution around moderate.

11 (Laughter.)

12 CO-CHAIR CURTIS: And again, do we
13 need to summarize the feedback? I don't there
14 was anything specific to this.

15 MS. TURBYVILLE: Yes, I think we
16 covered it in the first.

17 CO-CHAIR CURTIS: 2.B.1, the
18 measure specifications are consistent with the
19 evidence presented to support the focus of
20 measurement under criteria 1.B. The measure
21 is specified to capture the most inclusive
22 target population indicated by the evidence,

1 and exclusions are supported by the evidence.

2 Most moderate; six moderate and
3 two high.

4 2.B.2, validity testing
5 demonstrates that the measure data elements
6 are correct and the measure score correctly
7 reflects the cost of care or resources
8 provided, adequately distinguishing higher and
9 lower cost or resource use.

10 Two high, five moderate and one
11 low.

12 2.B.3, exclusions are supported by
13 clinical evidence or supported by sufficient
14 frequency of events. Its measure
15 specifications for scoring the included
16 computed exclusions so the effect of the
17 measure is transparent. And I don't think
18 it's applicable here, patient preferences are
19 taken into account.

20 Go ahead and vote.

21 Two highs, four moderates and two
22 lows.

1 For criteria 2.B.4, for outcome
2 measures or other measures, i.e., resource
3 use, when indicated and evidence-based risk
4 adjustment strategy as specified, and based on
5 patient and clinical factors that influence
6 the outcome but not related to disparities in
7 care or quality of care and are present at the
8 start of care.

9 Go ahead and vote.

10 Three highs, three moderates, and
11 two lows.

12 So for -- we're on 2.B.5, right?
13 Data analysis demonstrates -- data analysis
14 demonstrates methods for scoring analysis of
15 identification of statistically significant
16 and practically/clinically meaningful
17 differences in performance.

18 Go ahead and vote.

19 Four moderate and four low, no
20 high.

21 2.B.6, if multiple data sources
22 are specified, demonstration that they produce

1 comparable results. I believe it's not
2 applicable. Do we need to officially vote on
3 that?

4 MS. TURBYVILLE: No.

5 CO-CHAIR CURTIS: 2.C, if
6 disparities in care, have measure
7 specifications and scoring -- have been
8 identified, sorry, measure specification
9 scoring analyses allow for identification of
10 disparities through stratification.

11 Go ahead and vote.

12 Two moderates and six lows.

13 So moving towards usability which
14 -- I don't know, should we stop?

15 MS. TURBYVILLE: Yes, I think we
16 should stop.

17 CO-CHAIR CURTIS: Okay.

18 MS. TURBYVILLE: Because of the
19 two moderates and six lows for stratification
20 for disparities, we may want to either after
21 we get through this measure, come back and see
22 if this is going to be an issue throughout all

1 the measures. And as I think it was mentioned
2 before, whether or not it's really applicable
3 to resource use measures. So you know, maybe
4 we can move through the rest of this measure
5 and then go back to this, because my sense is
6 it's going to be a recurring issue.

7 CO-CHAIR CURTIS: Okay.

8 MS. TURBYVILLE: All right, so
9 let's open it for public comment quickly,
10 right?

11 Operator, if you could please open
12 the line for any public input or questions at
13 this time, we would appreciate it.

14 OPERATOR: Thank you. If you have
15 a comment or a question at this time, please
16 press star-one for an open line. Again,
17 that's star-one if you have a question or a
18 comment at this time and we'll pause for just
19 a moment to give everyone a chance to.

20 (No response.)

21 OPERATOR: And just as a reminder,
22 it's star-one if you have a question or a

1 comment at this time.

2 (No response.)

3 OPERATOR: And it appears we have
4 no public questions or comments at this time.

5 MS. TURBYVILLE: Thank you. We're
6 going to break for lunch now.

7 CO-CHAIR CURTIS: So it's 12:52
8 now. Should we reconvene at 1:20? Helen says
9 1:30.

10 (Whereupon, the above-entitled
11 matter went off the record at
12 12:53 p.m., and resumed at 1:22
13 p.m.)

1 A F T E R N O O N S E S S I O N

2 (1:22 p.m.)

3 CO-CHAIR CURTIS: So I think we're
4 going to get started again. I hope everyone's
5 fed and slightly rested. We're still on the
6 first measure, but we are in the home stretch.

7 And just to orient people who may
8 be on the phone as well as the measure
9 developers, we're not going to -- we're going
10 to deviate from the current agenda, based on
11 a family emergency from one of the TAP
12 members, and so we're not going to consider
13 the -- what number was that, Sally?

14 MS. TURBYVILLE: 1558 will not be
15 done this morning.

16 CO-CHAIR CURTIS: So we'll
17 probably -- we moved it up and now we're
18 moving it back probably to tomorrow at the
19 earliest, if not later. Instead we're going
20 to move up to 1593 which is the ETG-AMI
21 resource use by Ingenix. But first we need to
22 close on the first ABMS measure.

1 So we were moving along with the
2 voting, and we were at the level of usability
3 when we broke. Which we didn't necessarily
4 review in great detail, but it could be
5 reviewed quickly.

6 As the measure developers note
7 that there is currently no -- it's not in
8 current use, I believe -- on 38, yes, 38 of
9 the measure specifications. And it is
10 basically the measure developers have said in
11 all these criteria that they are in the
12 process of assessing the usability of the
13 measures and have funding to do that, but have
14 not as yet completed that.

15 So I think we can -- in the
16 absence -- there's not much to discuss, but if
17 people feel comfortable voting, otherwise if
18 you want to discuss any aspect of it, I don't
19 know what the direction or guidance would be
20 from NQF as to that. I would assume that you
21 would have to vote low, at least that was my
22 interpretation, if there was no evidence to

1 support it, but I don't --

2 CO-CHAIR ROSENZWEIG: Or

3 insufficient.

4 CO-CHAIR CURTIS: Or insufficient?

5 Okay.

6 MS. TURBYVILLE: Insufficient is a
7 little bit more in line with them not having
8 submitted anything or acknowledging that it
9 hasn't been done yet.

10 CO-CHAIR CURTIS: Okay. So why
11 don't we then move on usability and the
12 individual criteria are almost irrelevant,
13 since we're going to do insufficient. But
14 measure performance results are reported to
15 the public at large in national community
16 reporting programs by the time of endorsement
17 maintenance review. Exceptions considered if
18 there is evidence that the measure performance
19 results are available for public reporting and
20 that the use of the measure has benefited the
21 public.

22 So go ahead and vote on that. And

1 again, insufficient is four, not applicable is
2 five.

3 And similarly, so eight
4 insufficient.

5 CO-CHAIR ROSENZWEIG: Everybody's
6 paying attention.

7 CO-CHAIR CURTIS: And hit the
8 right button.

9 3.B, performance results are
10 considered meaningful, understandable and
11 useful.

12 Again, go ahead and vote.

13 I think we can do the next one in
14 under ten seconds.

15 3.C -- I'm sorry, so one low and
16 seven insufficient.

17 For 3.C, data and result details
18 are maintained such that the resource use
19 measure, including the clinical instruction
20 logic, for a defined unit of measurement can
21 be decomposed to facilitate transparency and
22 understanding.

1 So two moderates, one low, and
2 five insufficient.

3 And 3.D, the measure
4 specifications are harmonized with other
5 measures or differences in specifications are
6 evaluated to be justified. And I think this
7 should be a not applicable or we shouldn't
8 vote on it.

9 MS. TURBYVILLE: At this point, it
10 would be not applicable. We recently
11 instructed the measure developers that they
12 did not have to try and harmonize with
13 currently endorsed measures. As we examine
14 other measures in the future within this
15 project, then we may ask them to harmonize.
16 So at this point, this is not applicable.

17 CO-CHAIR CURTIS: I would just hit
18 -- yes, I would vote. We have 35 seconds.

19 Okay. So under feasibility,
20 again, I think we have touched on all the
21 criteria that would be used to vote on this.
22 If I can open it up, I think the fact that all

1 the data elements are encaptured by electronic
2 claims submissions is fairly straightforward.

3 They do, in section F3 at page 40
4 of the PDF discuss some of the susceptibility
5 to inaccuracies, errors and unintended
6 consequences, which I do think we've discussed
7 in the previous session. I would say that
8 they didn't really explore unintended
9 consequences in the application, but I think
10 we've identified some instances where that
11 could happen.

12 DR. WEINTRAUB: You know, another
13 thing is that really you have to worry about
14 in claims cases is misclassification. So I
15 think that would -- I'm sorry.

16 The other things we should think
17 about in analysis of claims is
18 misclassification. And we really haven't
19 discussed that here, but I think in terms of
20 feasibility, it would probably be a part of
21 it.

22 CO-CHAIR CURTIS: And then the

1 final section, 4.D of F.4 is the data
2 collection strategy. And you know, they
3 included some information, sort of like
4 lessons learned in the process, but it's a
5 little hard to gauge this. The specific
6 criteria is data collection and measurement
7 strategy can be implemented as demonstrated by
8 operational use in external reporting
9 programs, or attesting to not identify
10 barriers to operational use.

11 And I think this -- outside of the
12 scientific acceptability, from purely a
13 feasibility standpoint, at least using the
14 claims data and assuming they fix the ICD-9-
15 CPT codes, I think it is certainly feasible to
16 apply this.

17 Open that up for discussion?

18 (No response.)

19 CO-CHAIR CURTIS: Okay. So why
20 don't we go ahead and vote on the elements of
21 feasibility, 4.A. So for clinical measures,
22 the required data elements are routinely

1 generated and used during the care delivery.

2 I voted high on that, as it's all electronic
3 claims submission.

4 Five high, three moderate.

5 4.B, the required data elements
6 are available in electronic health records or
7 other electronic sources, which I think is
8 fairly straightforward. I voted high on that
9 as well.

10 Five high, three moderate.

11 4.C, susceptibility to
12 inaccuracies, errors or unattended
13 consequences related to the measurement or
14 judged to be inconsequential or can be
15 minimized through proper actions, or can be
16 monitored and detected.

17 And I felt like this was low,
18 based on my interpretation of it.

19 Go ahead and vote.

20 One high, two moderate and five
21 low.

22 Finally, 4.D, data collection and

1 measurement strategy can be implemented as
2 demonstrated by operational use and external
3 reporting programs, or did not identify
4 barriers.

5 I voted that as moderate, but that
6 was for lack of a more informed choice.

7 Go ahead and vote.

8 So five moderate and three low.

9 So with that, our voting is
10 completed on the first measure.

11 (Applause.)

12 CO-CHAIR CURTIS: Thirteen to go.

13 (Laughter.)

14 CO-CHAIR CURTIS: So as I noted,
15 we're going to go to the Ingenix measure of
16 AMI. And so that's 1593, and Dr. Marwick is,
17 I think, going to be the primary lead, and I'm
18 the co-lead on that, or co-reviewer.

19 DR. MARWICK: So this is a measure
20 that's labeled as being for acute MI, but I,
21 I must say, struggled with it a little bit as
22 to whether these all were going to be acute

1 infarcts. In particular, some of the
2 description of the physicians looking after
3 the patients included primary care physicians,
4 which seemed inconsistent.

5 So I guess in the interest of
6 time, we should go through it.

7 CO-CHAIR CURTIS: Let me interrupt
8 there. I think we're going to start with a
9 presentation by Ingenix, is that correct?

10 DR. MARWICK: Okay.

11 MS. TURBYVILLE: Yes. So we would
12 like to allow Ingenix about three to five
13 minutes or so to reintroduce the approaches in
14 this measure, if you like, Tom. It's up to
15 you.

16 DR. MARWICK: That's fine.

17 DR. LYNN: Thank you.

18 I'd just take a few minutes to
19 talk about the rules in general, this rule and
20 ones coming forward.

21 First I'd like to thank NQF and
22 the technical advisory panel for taking time

1 to review the measures submitted by Ingenix,
2 and we appreciate your thoughtful evaluation
3 and feedback.

4 The measures submitted by Ingenix
5 and under review today are based on our
6 episode treatment group methodology. This
7 methodology consumes administrative claims and
8 creates case mix and risk adjusted units of
9 analysis around diseases and conditions. The
10 methodology is table driven, which allows for
11 easy maintenance and change to the clinical
12 content leveraged by the method.

13 Although the features of episode
14 treatment groups related to the diseases today
15 have been extracted for evaluation, the
16 methodology groups claims to all diseases and
17 conditions.

18 In most cases, a measurement is
19 accomplished by aggregating actual utilization
20 of episodes in the numerator of the measure
21 and case mix and risk adjusted expected
22 utilization the denominator, whether the

1 measure of utilization is dollars or something
2 like emergency visits.

3 And that's really all I have to
4 say.

5 MS. TURBYVILLE: Great, thank you.

6 DR. MARWICK: Thank you. So we'll
7 proceed going through the format.

8 The first section relates to the
9 items about whether the post-infarct
10 population is worth of this kind of measure,
11 and I think the case is made very strongly for
12 that.

13 The second relates to the
14 performance gap, and there is a performance
15 gap, I think, but what I struggled with was in
16 the documentation. That wasn't put as
17 forcefully as I guess it could have, and there
18 were quite a number of sort of generic
19 statements about that.

20 I would say parenthetically that I
21 think it's very challenging to do this kind of
22 work from this data set. You know, the kind

1 of things you might be more interested in
2 would be, for example, door-to-needle time and
3 so on, which obviously aren't available. But
4 possibly could be configured if we think about
5 some of the alternatives that were presented
6 earlier for gathering data.

7 Just in relation to that as well,
8 there is a statement there about CAD episodes,
9 there's a distinction between subendocardial
10 and Q wave infarction and STEMI, but not
11 further detail. And I think that's something
12 we could discuss a little bit later.

13 Then in relation to the purpose, I
14 think the purpose is pretty clear. But the
15 resource use category information I thought
16 was somewhat limited here. There were
17 reference, for example, to ambulatory care
18 sensitive conditions, which again was
19 irrelevant to this.

20 So really, to summarize the first
21 component of this, about the importance, I
22 think the statements that were made about it

1 being important condition were well made. The
2 rest of the information I think we all know
3 from our background knowledge is relevant.
4 But the defense of this in the actual document
5 was not so good, in my opinion.

6 So in terms of scoring, I gave
7 this a high for impact, and medium for
8 performance gap and purpose, and for resource
9 use scale category, I felt that that
10 information was limited.

11 MS. TURBYVILLE: Any questions or
12 input from the other panel members?

13 CO-CHAIR CURTIS: I just want to
14 say, I did appreciate the fact that they put
15 in the empiric evidence of variation in costs
16 derived from the data in this section. I just
17 thought that was useful to have it on hand.

18 DR. MARWICK: Yes. So are we
19 going to vote on this?

20 MS. TURBYVILLE: We can. If there
21 are no more questions or input, we can go
22 ahead and vote on this, these subcriteria.

1 MS. CLARK: I guess I have a
2 question, because I didn't get a chance to
3 read this one.

4 But I'm just curious, how does
5 this differ from some of the other AMI
6 measures? I mean, what's the definition of an
7 episode?

8 DR. MARWICK: Well, that's what I
9 alluded to in the beginning.

10 MS. CLARK: Oh, okay.

11 DR. MARWICK: We'll get on to
12 talking about that later.

13 I really struggled with that, as
14 to whether that was an acute presentation with
15 infarction or whether that was somebody with
16 a history of infarction presenting to outside
17 of a hospital stay. And in particular, I was
18 confused by the involvement of the primary
19 care physicians in that process as well. And
20 it wasn't clear to me. I don't know, maybe
21 the developers could help us with that?

22 DR. LYNN: I think we can help.

1 Well, the -- in a lot of these processes,
2 we're trying to avoid looking at utilization
3 and having utilization drive severity or drive
4 certain case. But I think -- and so that's
5 why you see AMI being defined, but not
6 necessarily an admission.

7 DR. MARWICK: Yes, I think this is
8 probably pertinent to the next component, but
9 we may as well discuss it now because, to me,
10 this was the fundamental problem with this.
11 That if we're talking about acute infarction,
12 then particularly in relation to the costs
13 that are incurred, the defining it at the time
14 of presentation is critical.

15 If somebody has had, you know, an
16 infarct last year or an infarct while they
17 were being looked after by a previous carrier,
18 and then their first -- your first knowledge
19 of their infarction comes from somebody coding
20 it, you know in a non-acute setting, I think
21 they're two completely different scenarios.
22 And I think that plays out enormously into how

1 you judge cost.

2 CO-CHAIR CURTIS: Let me, before
3 we get too into that, I think maybe we should
4 just close on importance, because this is
5 really the heart of this particular measure,
6 is how you're defining the episode. So I
7 would just start -- let's table that for just
8 a few minutes --

9 DR. MARWICK: Okay.

10 CO-CHAIR CURTIS: -- and get that
11 one vote out of the way quickly, and then we
12 can spend some more time on that.

13 So let me just, everyone grab
14 their keychains, unless there's more
15 discussion as to the importance.

16 So for the 1.A, the measure
17 focuses on national health goal and priority.
18 And Tom, your preliminary was --

19 DR. MARWICK: My preliminary was a
20 high for that.

21 CO-CHAIR CURTIS: Go ahead and
22 vote.

1 So that's eight highs.

2 For 1.B, the demonstration of
3 resource use for cost problems and opportunity
4 for improvement.

5 DR. MARWICK: So my preliminary
6 was a moderate for this, based on the
7 information presented rather than background
8 knowledge.

9 CO-CHAIR CURTIS: Go ahead and
10 vote. Sorry, I don't know if you're waiting
11 for me to say that or not.

12 So for 1.C, the purpose or
13 objective for the resource use measure and
14 construct for resource using costs are clearly
15 described. I don't know if we've discussed in
16 sufficient detail to vote on that.

17 DR. MARWICK: So what I struggled
18 with here was the interaction with exactly who
19 we were describing, and that's the reason I
20 thought that discussion was pertinent to this
21 part. You know, if this is about judging the
22 costs of an acute episode, then as configured,

1 this is not appropriately set up.

2 If it's for judging people who
3 have had an MI in the past, then it's also
4 ambiguous because I think it would include
5 people presenting acutely. So I really
6 struggled with this, and I gave this a low.

7 MS. TURBYVILLE: So just to add
8 for context purposes, so in the importance,
9 you can think of it as they describe this, if
10 you recall, later on in the validity section,
11 there's a question about whether or not the
12 specifications match the intent of the measure
13 as they've described it.

14 DR. LYNN: I don't want us all to
15 torture ourselves and each other over this.
16 I mean, it's very clear to me, this is better
17 as an event -- as considered by the TAP, is
18 evaluated better as an event. And it's not
19 how we did it.

20 And you know, we can go through
21 the voting, but it sounds like we're on the
22 wrong track here.

1 CO-CHAIR CURTIS: Well, let's
2 finish up the importance. And then as we go
3 through the scientific acceptability, if we
4 kind of reach an impasse, you know, as the co-
5 developer, I shared the exact same concern
6 about the definition of the episode.

7 But I think for measure intent,
8 what I think we should go by is really just
9 what's written on IM3, which is, you know, the
10 intent of the measure and its components is to
11 support the understanding of opportunities to
12 improve the efficiency of healthcare, in
13 particular for patients with selected
14 conditions, and reducing unwanted variation.

15 And then secondarily, as a step
16 towards the estimation of value delivered by
17 individual providers. So I think that's the
18 intent of the measure that we're voting on.
19 And then come back to that later and say, "Did
20 they achieve that based on the specifications
21 of the measure?"

22 So did you want to revise that to

1 --

2 DR. MARWICK: Okay, I'll revise
3 that to a moderate. Thank you.

4 CO-CHAIR CURTIS: Go ahead and
5 vote on that, unless there's more discussion.

6 One high, six moderate and one
7 low.

8 And then for 1.D, the resource use
9 categories that are included in the resource
10 use measure are consistent with and
11 representative of the conceptual construct
12 represented by the measure. Whether or not
13 the resource use measure development begins
14 with a conceptual construct or set of resource
15 service categories, the service categories
16 included must be conceptually coherent and
17 consistent with the purpose.

18 And I think then I would allow the
19 -- your estimation of the measure. And again,
20 we said up front that we might come back to
21 this down the road. But --

22 DR. MARWICK: So I gave this a

1 low.

2 CO-CHAIR CURTIS: Does anyone have
3 any questions about how to vote? I mean, it's
4 sort of a tricky thing. If you're looking
5 into the future to what you might do. I'm
6 still not sure about the placement of this
7 particular voting category.

8 DR. HWONG: Is this more of like,
9 you know, the categories of data and the way
10 they classify them, you know, as listed,
11 versus the -- you know, versus like when they
12 dig down into the actual codes, which it
13 sounds like individuals are having, you know,
14 some concern with.

15 But you know, in terms of the
16 general categories of resource use, we should
17 be voting on, you know, what's sort of listed
18 on a high level, is that right?

19 MS. TURBYVILLE: That's right. So
20 this isn't about the detail. Again, the
21 entire importance section is not about the
22 specifications as written, it's about the area

1 focus, the type of categories of resource use
2 that they are proposing to measure. To the
3 extent that it might be informed, again, later
4 one, we can understand that. But it really is
5 have they listed a comprehensive set.

6 As I said, it's really a check
7 box, but we also allow for others, presumably
8 there could have been opportunity for other
9 resource categories to be presented that just
10 didn't really jive with the intent of the
11 measure. So I'm trying to think of an absurd
12 example, but let's say the intent of the
13 measure was to look at diabetes. And in the
14 other category -- resources for diabetes in
15 other category, they mentioned capturing
16 something completely off the wall, I think
17 they would potentially -- or are missing very
18 key components that I think would change their
19 rating results.

20 CO-CHAIR CURTIS: So why don't we
21 go ahead and vote on that, then.

22 That's one high, three moderate

1 and four low.

2 And that closes us on -- unless do
3 we need to define what we would say back to
4 the measure developer?

5 MS. TURBYVILLE: I think it would
6 be helpful, especially with so many lows on
7 the last one. If there is some kind of
8 justification or rationale.

9 DR. MARWICK: Well, I think it's
10 very difficult to define resource measures
11 unless you hook it into specifically what
12 you're seeking to study. And I find that
13 ambiguous at the moment.

14 CO-CHAIR CURTIS: Any other
15 feedback?

16 DR. HWONG: I mean, I guess the
17 only thing from my perspective -- again, I
18 think it's interpreting the question and, you
19 know, how you want to look at it. But when I
20 looked at the categories of, you know,
21 inpatient services, ambulatory, which you want
22 to capture, I thought the broad -- you know,

1 pharmacy, E&M, procedures, surgery, I think
2 the categories seem comprehensive. Again,
3 we'll probably get more into detail about the
4 definition in there. But I didn't think that
5 there was some actual like place of service or
6 category that was, you know, obviously
7 lacking.

8 CO-CHAIR CURTIS: I agree. I
9 think we probably don't need additional
10 feedback to the developer because I think it
11 will come in the next section.

12 So why don't we move on to
13 scientific acceptability?

14 DR. MARWICK: So this is really
15 the fundamental area, I think, which I
16 struggled with.

17 So first of all is the definition
18 of exactly what is being studied. And then
19 secondarily, if this is an acute episode, then
20 there are a bunch of things that you would
21 want to have in the description of risk that
22 I think are limited at the moment. In fact,

1 I think the only risk verification is really
2 between STEMI and non-STEMI.

3 So I would imagine, for example,
4 that previous infarct, valve disease and so on
5 would be important modulators of risk.

6 I'm not sure I completely
7 understood the pharmacy benefits, but I would
8 -- there's a mention that the incorporating
9 pharmacy benefits has been avoided. And I
10 think that's potentially problematic.

11 So my other comments there are
12 really related to lack of sophistication and
13 understanding risk. There are no means to
14 allow an episode to shift to another episode
15 treatment group, which I think might be
16 pertinent for some subgroups, particularly
17 ones that are infrequent and cause major
18 increments of cost. For example, the post-
19 infarct complications and stuff like that,
20 cardiogenic shock.

21 I thought the attribution
22 approach, which was based on primary care

1 physicians, was not well suited to infarction,
2 which was hospital based. Defining a single
3 responsible physician I thought was very
4 challenging, particularly relating to high
5 cost items in the cath lab that may have
6 nothing to do with the primary provider. And
7 we had the discussion about that for the last
8 example.

9 So I found that it was very hard
10 to produce favorable scores on any of these
11 components because the risk piece was missing,
12 and the exact nature of the patient group that
13 we were studying was ambiguous.

14 I could go through them in detail
15 individually, but I think there's a generic
16 problem here.

17 CO-CHAIR CURTIS: I think just
18 because most people haven't had the chance to
19 review this type, although many people have
20 reviewed another Ingenix measure, it might be
21 worth just going through your specific
22 concerns about the characterization of the

1 episode, and what's making you concerned.

2 DR. MARWICK: Well, in the
3 characterization of the episode, for example,
4 there's a statement about looking at observed
5 and expected costs for CAD and infarction. So
6 we know that that's a heterogeneous group of
7 episodes. It varies from somebody presenting
8 with an acute infarct, transmural infarct
9 requiring attendance to the cath lab, to a
10 non-STEMI, potential medical care in hospital,
11 to complications of all those things ranging
12 all the way down to presentation to a primary
13 care physician.

14 So this doesn't include just the
15 description of acute MI. It says, "episode
16 results were not readily available for AMI
17 episodes to support a specific analysis of
18 this condition. However, results for CAD and
19 AMI can provide some insight."

20 So just in the beginning, about
21 the definition of that, I find that very, very
22 broad.

1 CO-CHAIR CURTIS: Maybe if the
2 developer could comment on that limitation or
3 -- was there a reason you couldn't break out
4 AMI? And this was confusing in my review as
5 well, was is this embedded within the ischemic
6 heart disease measure or is it thought to be
7 distinct? And some of the sample reports that
8 you showed, I couldn't even find AMI in there.

9 DR. LYNN: It's embedded in
10 ischemic heart disease or coronary artery
11 disease. And with diagnostic-only markers of
12 myocardial infarction.

13 CO-CHAIR CURTIS: So it's part of
14 a measure that would be recorded but not the
15 entire measure?

16 DR. LYNN: It's a coronary artery
17 disease reported measure that includes
18 diagnostic evidence of acute myocardial
19 infarction.

20 CO-CHAIR CURTIS: But what about -
21 - so no patients without that evidence of
22 having experienced an AMI would be included in

1 this?

2 DR. LYNN: That's correct.

3 CO-CHAIR ROSENZWEIG: Is that an
4 acute myocardial infarction in the recent past
5 or ever in the patient's history, or --

6 DR. LYNN: Well, the diagnosis
7 indicates that it's acute, but --

8 CO-CHAIR CURTIS: So maybe we
9 could actually go to that.

10 DR. LYNN: Again, I think this
11 clearly should be -- you know, there's a
12 feeling here that should be event oriented.
13 You know, I think that's a reasonable --

14 CO-CHAIR CURTIS: Well, did you
15 consider not, you know, doing this a more
16 traditional episode of admission for MI with
17 post -- you know, as a start of the episode?

18 DR. LYNN: We were asked to
19 provide -- I think we would do it that way.
20 I think we would do it that way, as an event.
21 But that's not --

22 CO-CHAIR CURTIS: So just to

1 broaden the discussion and include the other
2 members, if you look at -- if you bring up the
3 spreadsheet that shows the diagnostic category
4 codes, I think it's workbook S-5 something-
5 something, and sheet 4 within it.

6 CO-CHAIR ROSENZWEIG: Do you know
7 exactly which one would have it?

8 DR. LYNN: Oh, it should be S-5.

9 CO-CHAIR CURTIS: So while they're
10 bringing that up, so you know, as the ABMS
11 measure specified in acute admission for an
12 MI, so the 4.10.x1 implies admission for that
13 procedure. This measure, if you scroll down,
14 includes those -- sorry, no, where would it
15 be? Primary diagnosis code, the worksheet,
16 the fourth worksheet in? Yes, I think.

17 So this is how they're
18 characterizing the codes that are included in
19 the population. And so it's 4.10, and -- but
20 not specified to dot-x1. It doesn't specify
21 an acute episode. So they could be more in
22 the chronic phase, they could be at the acute

1 phase. So it's a heterogeneous population
2 from that standpoint.

3 And if you scroll down, do you
4 make the -- they try to account for
5 subendocardial infarction using the specific
6 codes of 410.7x. And then there's the
7 inclusion of the 429.5, 429.6, which is very
8 different than how we traditionally
9 characterize MI patient populations, or acute
10 MI patient populations.

11 So I think this is probably what
12 you were reacting to. And is -- it's a very
13 different measure. But I --

14 DR. HWONG: If I could get some
15 clarity around this, especially with the
16 measure developer here. So I guess what the
17 concern is, you know, with these 410 codes
18 which -- or actually not all of them are 410,
19 right, but with acute myocardial infarction,
20 so this could be present on any -- you know,
21 as a primary diagnosis on whether it's a
22 hospital stay or an E&M visit. I see, so

1 either one could actually be the anchor to
2 start the episode then?

3 CO-CHAIR CURTIS: As long as it
4 had excluded the clean period, which is think
5 is 30 days here.

6 DR. LYNN: Yes.

7 CO-CHAIR CURTIS: So in that case,
8 I think you could have a 30-day clean period,
9 have someone come in to your cohort as a
10 outpatient visit --

11 DR. HWONG: Yes.

12 CO-CHAIR CURTIS: -- the code is a
13 4.10.x2. And they're in your cohort. And
14 that's very different than with very different
15 resource use expectations when someone's not.

16 DR. HWONG: Got you.

17 CO-CHAIR CURTIS: So I would --
18 right, and I think it's two weeks -- two or
19 four weeks after, is how it -- anyway, it's
20 certainly more than the acute admission.

21 So I think in the -- maybe if I'm
22 hearing the measure developer correctly, that

1 based on this feedback, would you want to
2 reconsider our consideration of this measure
3 or would you -- I don't know if you --

4 DR. LYNN: We would have to --

5 CO-CHAIR CURTIS: -- can do it
6 during this timeframe.

7 DR. LYNN: Yes, we would have to
8 wholesale change it, which, you know, we'd
9 love the opportunity to do. But I think we've
10 -- well, anyway.

11 I am -- I think it's reasonable
12 for us to withdraw the measure at this point.

13 CO-CHAIR ROSENZWEIG: In practice,
14 how -- to what extent are cardiologists and
15 primary care doctors using the granularity of
16 these various individual subcategories --

17 DR. LYNN: Let me --

18 CO-CHAIR ROSENZWEIG: -- in
19 cardiology?

20 DR. LYNN: Yes, in general, we
21 were trying to fit a little bit of a square
22 peg in a round hole here for us. And I -- and

1 the unit of analysis that's used is the
2 episode of coronary artery disease. It's not
3 used as an episode with AMI in isolation at
4 all, as far as I know. I mean, we tried -- we
5 could test it and we could run it through our
6 data, but the methodology is meant to create
7 an episode of coronary artery disease and mark
8 that there's evidence of acute myocardial
9 infarction as a severity adjustment. And we
10 tried to, you know, configure that to make
11 that meet the call for measures. And I think
12 it was totally unsuccessful.

13 MS. TURBYVILLE: Just to provide
14 some context, this particular effort, as well
15 as the other NQF efforts, are looking at
16 evaluating measures independently. And as you
17 know, the ETG system -- and Tom, I don't want
18 to speak for you, but it's a system of
19 measures that work together.

20 And so you know, the -- but we did
21 need to -- we're not evaluating a group, or
22 we're not looking at systems of measures in

1 this particular effort. We really are
2 evaluating discrete measures. So that's --
3 you know, they're -- I think that's in
4 response to you trying to fit the square hole
5 in the round --

6 DR. LYNN: That's correct.

7 MS. TURBYVILLE: Yes, yes. So to
8 really provide, it was NQF who insisted that
9 these be independent measures and be evaluated
10 independently of each other.

11 CO-CHAIR CURTIS: So again, I'm
12 not terribly sure how to proceed, this is sort
13 of unprecedented in my experience.

14 DR. HWONG: I do have a question,
15 just for us to be able to understand the
16 context for the rest of the Ingenix measures,
17 right? But I think there is an Ingenix
18 measure for coronary artery disease, I mean,
19 you know, if I'm not mistaken.

20 So if this one is sort of
21 modified, like how should we be looking at the
22 next one, right, like in terms of the context?

1 Like how different --

2 DR. LYNN: Well, the next one is
3 looking at a disease, a coronary artery
4 disease that occurred for one year, period.
5 It's not event-driven.

6 DR. MARWICK: Yes, I agree. I
7 think the problem here is that the label here
8 is acute MI. And you know, there we're
9 talking about coronary disease. We do have a
10 little bit of a mirror image problem of
11 capturing the acutes as well. But this is a
12 particular problem, that this is a label of
13 acutes that's being contaminated by other
14 entities.

15 MS. TURBYVILLE: Yes, I mean it
16 sounds like based on that, that Ingenix, the
17 measure developer, would like to withdraw the
18 measure, at which time we don't have to
19 continue rating the measure and put, you know,
20 the rating through that whole process, as well
21 as the developer.

22 DR. LYNN: That's correct.

1 MS. TURBYVILLE: Okay, great.

2 CO-CHAIR CURTIS: So then we were
3 going to -- right. So in the interest of
4 reviewing one measure from every measure
5 developer while we have Carlos here, for a
6 limited time longer, we were going to go over
7 -- tell me again, Sally?

8 MS. TURBYVILLE: We're going to
9 jump to the NCQA 1557, the diabetes NCQA
10 measure. Yes, 1557.

11 CO-CHAIR ROSENZWEIG: You, being
12 the primary reviewer --

13 DR. HWONG: Yes, I guess so.

14 MS. TURBYVILLE: Let's give Ben
15 Hamlin from NCQA a few minutes to introduce
16 the measure, and any other approaches that you
17 want to reiterate.

18 MR. HAMLIN: Thank you very much,
19 Sally.

20 Is this on? I can't tell. Okay.

21 Thank you very much. NCQA
22 currently has five condition-based -- the big

1 five chronics, if you will, total annual
2 measures. So these are a little different
3 from the one you're evaluating right now. So
4 we're looking at total annual cost or resource
5 use for anyone identified with one of these
6 chronic conditions, diabetes being one of the
7 factors.

8 The measure-eligible populations
9 are aligned with the HEDIS chronic disease
10 manager. So for the diabetes population, the
11 base eligible population looks at a very
12 similar population to that, but is defined in
13 the NQF-endorsed diabetes set, if you will --
14 I think it's 00623, 0068 or something like
15 that -- instead of NQF-endorsed quality
16 measures.

17 We only used the RU measure
18 results along with the quality measures, so we
19 felt it was very important to align those two
20 things together. And again, I'll be here to
21 answer any questions you may have about the
22 methodology, but that's really the high-level

1 overview.

2 DR. HWONG: Okay. Well, I guess I
3 will start to drive.

4 In terms of the first area, sort
5 of the measure focus and sort of the
6 importance. So you know, does this address --
7 sort of 1.A, does this address a national
8 health goal as defined by DHHS or National
9 Priorities Partnership? And I actually rated
10 this as high, I said it seemed to align with
11 National Priorities Partnership for affordable
12 care, elimination of overuse. Also that it
13 again, you know, affects large numbers,
14 there's high resource use, and that there are
15 a lot of societal consequences to poor quality
16 management for diabetes.

17 So I'll pause there and see if
18 anybody has any other comments in that regard?

19 (No response.)

20 DR. HWONG: Okay. Should I move -
21 - should we vote or move on to 1.B? Maybe
22 just go through the importance --

1 CO-CHAIR ROSENZWEIG: Why don't we
2 go on to the importance one first.

3 DR. HWONG: I agree. Sure.

4 CO-CHAIR ROSENZWEIG: Oh, yeah.
5 Why don't we just continue going through the
6 importance ones first --

7 DR. HWONG: Okay.

8 CO-CHAIR ROSENZWEIG: -- and then
9 vote on them as a group.

10 DR. HWONG: Sure. So
11 demonstration -- so 1.B, demonstration of
12 resource costs -- resource user costs,
13 problems and opportunities for improvement.

14 So what I found here was that NCQA
15 was able to sort of look at their own history
16 in their annual analysis that they've been
17 doing over the last four years in identifying
18 sort of varying resource use or variation in
19 the sort of health services related to
20 diabetes management.

21 And as such, you know, with that
22 sort of variation, it did seem to imply that

1 there is opportunity -- you know, opportunity
2 for improvement or modification in that
3 regard.

4 CO-CHAIR ROSENZWEIG: It should be
5 noted that they're talking about opportunities
6 for improvement in quality of care, mostly --

7 DR. HWONG: Okay.

8 CO-CHAIR ROSENZWEIG: -- from
9 their HEDIS measures, as opposed to
10 opportunities of improvement in cost of care
11 or in resource -- specifically resource use.
12 But I think there's a lot of data certainly in
13 there to suggest that resource use --

14 DR. HWONG: Oh, yeah, I guess it
15 looked like -- it says, "demonstrates
16 substantial variation in health plan resource
17 use for an overall perspective."

18 So perhaps more of the evidence
19 that's listed is really on quality. But I
20 think it did make mention that, you know, the
21 resource use measures themselves have shown,
22 you know, variability that way.

1 MR. HAMLIN: One of the things
2 that we had noticed in our annual analysis is
3 that there is a -- they had a variation in
4 resource use between plans achieving the same
5 level of quality, and vice versa. So there's
6 a flaw in the variation on the quality side,
7 aligned with the resource use, and we really
8 have not been able to address specific
9 correlations between those two. So I think
10 there's room for improvements in both areas.

11 CO-CHAIR ROSENZWEIG: To a certain
12 extent, resource use, I mean a lot of the
13 HEDIS measures are actually performance
14 measures. So for instance, getting an eye
15 exam is a resource use that's a benefit, okay,
16 to the patient, okay? But it also costs a
17 certain amount of money. So there's an
18 overlap -- so a lot of the things you're
19 actually measuring are in that category.

20 MR. HAMLIN: And we're not
21 specifying that improvement is necessarily
22 lower in resource use. We actually noticed

1 that there are a few correlations between high
2 resource use and high quality. So we're not
3 saying higher is better and lower is better,
4 we're saying it is what it is.

5 DR. HWONG: That there is --

6 CO-CHAIR ROSENZWEIG: Exactly,
7 yeah.

8 DR. HWONG: Okay, good. So why
9 don't we move on? If there's no further
10 discussion on that, we can go on to 1.C.

11 I think the purpose of this
12 objective is resource use measure is -- you
13 know, the intent of this is clearly described.
14 You know, I found this was high. I think it
15 described the intents well, the unit analysis
16 is at this regional health plan level. You
17 know, it adjusts the case mix for health plan
18 members and the goal was simply to compare
19 sort of regional health plans versus sort of
20 other peer health plans, it seems like. So I
21 felt like the intent was fairly
22 straightforward and clear. So I would -- I

1 ranked that as high.

2 Any comments from the group?

3 (No response.)

4 DR. HWONG: Okay. So are we ready
5 -- is this the voting time now?

6 MS. TURBYVILLE: You have 1.D --

7 DR. HWONG: Oh, 1.D left, okay.

8 So the resource use service
9 categories consistent with measure construct.
10 And again, so I looked at this, I felt like,
11 again, sort of the resource use areas, the
12 categories that were listed in terms of, you
13 know, ED visits, hospitalization, procedures,
14 surgeries, you know, pharmacy, et cetera, I
15 felt again that this was fairly comprehensive
16 in terms of the -- you know, the costs that
17 would be generated in terms of management of
18 members with diabetes.

19 CO-CHAIR ROSENZWEIG: Okay, any
20 questions or comments?

21 DR. HWONG: I think they'll be up
22 -- oh, sorry.

1 And the only thing I would mention
2 is, I think there will be time to kind of dive
3 down into a little bit more of the details of
4 what was actually specified. But again, the
5 categories, the broad categories are what you
6 were looking at in terms of generating cost I
7 felt were appropriate.

8 CO-CHAIR ROSENZWEIG: All right?
9 Any additional comments?

10 (No response.)

11 CO-CHAIR ROSENZWEIG: Does the
12 measure developer have any comments they want
13 to add?

14 MR. HAMLIN: Not so far.

15 CO-CHAIR ROSENZWEIG: Okay, good.

16 So why don't we vote on these
17 categories first. Okay, the first one is
18 clearly the -- whether or not it addresses a
19 national goal or priority. And I believe you
20 said it did, it was high?

21 DR. HWONG: I ranked this as high.

22 CO-CHAIR ROSENZWEIG: Okay. And

1 then the second category was opportunity for
2 improvement.

3 DR. HWONG: Yeah, and I ranked
4 this as high. But like there was demonstrated
5 variation and whatnot, so --

6 CO-CHAIR ROSENZWEIG: Okay, very
7 good. And then the third category is, the
8 purpose of the objective is -- of the resource
9 measure are clearly described.

10 Okay. And then the fourth
11 category is that the service categories are
12 included in the research measure consistent
13 with and representative of the conceptual
14 construct represented by the measure, so that
15 it's conceptually coherent.

16 Someone hasn't voted. Try voting
17 again, maybe you can get counted twice.

18 Okay, thank you.

19 All right, so why don't we move on
20 to the scientific acceptability of the
21 measure.

22 DR. HWONG: Okay. So I guess

1 we'll spend this portion sort of talking
2 about, you know, again how the measure is
3 constructed.

4 So I'll talk about sort of a
5 general approach. So in terms of a couple
6 things, sort of the data requirements, they --
7 you know, NCQA sort of specified that we need
8 demographic data, at least two years of the
9 data. Eligibility, you know, file data. And
10 essentially how it starts off, in terms of
11 this measure, the population -- the
12 denominator population is really individuals
13 who are identified as diabetics, and this can
14 be based on any claim that is paid or unpaid.
15 And there are certain criteria for this.

16 So when I looked at this, again I
17 think this matches up with sort of NCQA's
18 diabetes quality effectiveness of care
19 measures, so there's this nice synchronization
20 that way. But you know, members can be part
21 of the denominator if they show evidence of,
22 you know, diabetes medications, oral hypo --

1 you know, hypoglycemic, you know, agents,
2 either in the measurement year or in the
3 previous year. Or alternatively can show two
4 face-to-face meetings, sort of E&M codes in an
5 outpatient setting with any diagnosis of
6 diabetes in any position or category.

7 So I think -- you know, from there
8 it seems like, again, it lines up with the
9 effectiveness of care measures. It has a way
10 to identify individuals who, you know, have
11 diabetes. You have to show evidence of it in
12 the last year or the current year. And then
13 we can probably move to some exclusions maybe
14 for next, for the conversation.

15 CO-CHAIR CURTIS: I just want to
16 ask --

17 DR. HWONG: Yeah, go ahead.

18 CO-CHAIR CURTIS: -- so on the
19 identification of diabetic on a non-paid claim
20 or a denied claim --

21 DR. HWONG: Yes, I --

22 CO-CHAIR CURTIS: -- is that

1 unusual or is that the standard?

2 DR. HWONG: It's interesting, you
3 know. I looked at that, and I thought -- so
4 in terms of being -- later on in terms of the
5 calculation, that will be only on paid claims.
6 But I got the -- you know, maybe we can talk
7 to the measure developer, too. But I got the
8 sense that they were trying to essentially
9 scan the entire data set for evidence of this
10 diagnosis code or this usage. You know, uses
11 of medication, put this diagnosis code on a
12 claim, and sort of take that as an individual
13 in the denominator.

14 MR. HAMLIN: Yes, that is correct.
15 Whenever we were looking for the
16 identification population, we're looking for
17 the diagnosis codes, not necessarily paid
18 claim codes.

19 And then you're also correct, when
20 we get to the pricing of services on these
21 services, it's only on paid claims or claims
22 that are expected to be paid.

1 DR. HWONG: Right. So I think if
2 -- you know, I guess that's the idea of trying
3 to be very sensitive, right, out there? If
4 there's any member that has any evidence of
5 some sort of diabetes, you know, diagnosis
6 code, you know, the measure developer has
7 opted to try and include them.

8 But then for later on, if the
9 costs, you know, in terms of, you know, their
10 costs, if it's all, you know, denied claims,
11 et cetera, then that person would be -- that
12 individual would be excluded. But we can go
13 through sort of the exclusion criteria which
14 might help.

15 DR. MARWICK: So how did you deal
16 with the person who changes their diagnostic
17 status, the post-operative diabetic who is no
18 longer then a diabetic, or the metabolic
19 syndrome who loses weight and then is no
20 longer a diabetic?

21 DR. HWONG: I did not see in the
22 specs handling of that. I think it simply

1 said, you know, if there was evidence of two
2 separate diabetes diagnoses in outpatient
3 setting, for example, you know, those two, if
4 they change -- if clinicians change their mind
5 about the diagnosis and that diagnosis didn't
6 show up for the second half of the measurement
7 year, hypothetically, that person would still
8 be considered diabetic.

9 I think it's very hard to be able
10 to capture that kind of change. I think this
11 is, you know, just trying to look for some
12 kind of evidence of -- you know, of at least
13 two episodes of coding, you know, in an E&M
14 basis.

15 CO-CHAIR ROSENZWEIG: I think the
16 general convention is that you don't lose the
17 diagnosis of diabetes. I mean, even with the
18 bariatric surgery or -- as opposed to the
19 metabolic syndrome or the so-called pre-
20 diabetes category, which has other terms
21 attached to it now.

22 You don't revert to normal,

1 necessarily, if your glycemc control
2 improves. You're still considered to have
3 diabetes. Now it may be that, later on, a
4 physician might have -- a patient might have
5 a -- a physician at some later time may not
6 include diabetes among the diagnoses, when the
7 physician sees the patient. But in general,
8 it's a matter of basically controlled
9 diabetes.

10 Now that's different from
11 secondary diabetes, which -- and there are a
12 whole series of codes associated with
13 secondary diabetes. The 249 codes, okay,
14 whereas if a person was like on
15 glucocorticoids or -- and of course,
16 gestational diabetes can revert to normal as
17 well.

18 But type II and type I diabetes,
19 in general, kind of stick to you.

20 DR. HWONG: And as you've
21 mentioned, those are actually explicit
22 exclusion criteria, so individuals who -- and

1 I'll go through some of the specific exclusion
2 criteria. But PCOS, as well as steroid-
3 induced diabetes, if those are coded without
4 evidence of a follow-up -- without evidence of
5 any E&M visit with the concurrent diagnosis of
6 diabetes, then those individuals would be
7 excluded.

8 So I think there's some -- some
9 thought to, you know, essentially exclude
10 individuals who are being treated for
11 gestational diabetes, exclude individuals who
12 are temporarily being treated for steroid-
13 induced diabetes.

14 But just to be complete in terms
15 of their exclusion criteria, you know, and
16 this was something that was echoed earlier in
17 the ABMS, you know, measure, I think. But
18 essentially excluding individuals who have any
19 evidence of active cancer, ESRD, organ
20 transplant, HIV-AIDS. I think -- and again,
21 with those special criteria for the
22 gestational diabetes and the steroid-induced

1 diabetes.

2 CO-CHAIR ROSENZWEIG: There may be
3 some changes as well. I don't know if you
4 addressed this in the measure, I don't
5 remember if I saw it. But the -- in the past,
6 you know, even if a person did not have a
7 diagnostic -- a diabetes-related diagnostic
8 ICD-9 code, they would be considered to have
9 diabetes as a group if they were on
10 medications for treatment of diabetes.

11 That's changed, largely because
12 people are using metformin and other agents.
13 A certain percentage of physicians are using
14 them in the pre-diabetes state, as well as for
15 PCOS. So it becomes a little more
16 complicated.

17 DR. HWONG: Okay, good.

18 Sorry if I'm jumping around with
19 this. I'm trying to wade through some of
20 these notes here.

21 But okay, so the only other aspect
22 is to back up a little bit. You know, I

1 talked about how you would identify these
2 members, how you would exclude certain
3 members. If we just sort of jump back a
4 little bit in terms of the data and sort of
5 what the measure developer has submitted in
6 terms of, you know, what do you do -- you
7 know, what you want to do ensures sort of the
8 integrity of the data that -- I'm trying to
9 think here.

10 Yes, so I mean, I think there's
11 some mention here that there's no desire to
12 impute or -- you know, with missing -- with
13 any sorts of missing data. Let me see.

14 Oh, yes, I'm sorry. So -- and
15 again, any of -- as we talked about, the
16 denominator can be defined by anybody whether
17 it's paid or unpaid claims. But the service,
18 in order to be considered for this resource
19 measure, would have to be paid at least in
20 part -- you know, in full or in part by the
21 plan, or that the member absorbed the cost
22 entirely, right. And that this is a service

1 that's covered under sort of a PMPM payment by
2 a health plan.

3 So again, just trying to define,
4 you know, if there was some kind of payment or
5 if the health plan is responsible for that
6 cost, that cost would be included in terms of
7 the calculation. So I just wanted to back up
8 on that and sort of cover that topic. Okay.

9 CO-CHAIR CURTIS: It would be
10 helpful to just sort of refer to what part of
11 the PDF you're in, too, what page number.

12 DR. HWONG: Oh, sorry.

13 MS. TURBYVILLE: It's page 9 of
14 the PDF.

15 DR. HWONG: Thank you.

16 And let me scroll back here.

17 Okay, so -- right, and we talked
18 about the exclusions, et cetera, so maybe we
19 can go towards -- yes, and the only other
20 thing in terms of that clinical framework,
21 they do provide a detailed listing in terms of
22 the types of medications that would be used in

1 that criteria, as well as the specific lists
2 of what qualifies as an E&M visit with the
3 specific CPT codes or, you know, revenue
4 codes.

5 Okay, so maybe we can scroll down
6 to -- I guess in the printed out version, it's
7 page 13, because I think that takes us to that
8 point. And talk about the sort of comorbid --
9 comorbid and interactions, you know, in terms
10 of how are we identifying individuals with,
11 you know, certain comorbid conditions.

12 So the resource -- you know,
13 relative resource use measure is using the HCC
14 relative resource use risk categories. And
15 from what I understand, you know, in looking
16 at this -- looking at this explanation, right,
17 you know, understanding that this is an
18 externally sort of validated risk adjustment
19 method for costs.

20 Essentially, based on sort of the
21 diagnoses codes, individuals get grouped to
22 one of 184 sort of clinical condition

1 categories, which ultimately can get rolled up
2 into the HCC, you know, relative resource use
3 categorization, which ultimately has a
4 ranking, right. So a member will be
5 classified, you know, among those. And then
6 the highest ranked -- I guess that's the
7 lowest number, you know, in terms of the
8 system, essentially gets assigned to that
9 patient.

10 So you know, I think I sort of
11 described that on a high level, and I want to
12 see if the measure developer has any further
13 comment in terms of how this HCCR, you know,
14 relative resource use, you know,
15 categorization is used. My understanding is,
16 based on these codes, you get rolled up and
17 then essentially you get assigned to the most
18 significant -- significant category, unless --
19 oh, and then unless there's some other code,
20 you know, that is as known interaction which
21 would increase your risk adjustment.

22 MR. HAMLIN: Right. So you're

1 exactly right. And there is some interaction
2 with combination code -- HCC codes.

3 Effectively what happens is, once
4 these categories are assigned, they're also
5 assigned a weight from this. And then an
6 additional demographic and -- so basically
7 age, gender, weight is also assigned. And so
8 effectively what you do is you add up the
9 weight of that member and assign a risk
10 category -- a risk grouping, if you will.

11 DR. HWONG: Okay.

12 MR. HAMLIN: So we have 13 risk
13 groupings for each measure.

14 DR. HWONG: Right.

15 MR. HAMLIN: So if you take the CC
16 to HCC, if there's multiple HCC's, you take
17 each of those weights. You add the
18 demographic weight, and that's the total
19 weight is what that member is weighted, as
20 their risk overall for comorbidities,
21 demographics, and sort of everything in one
22 bucket.

1 DR. HWONG: Great.

2 CO-CHAIR CURTIS: And that's
3 assessed in the 12-month period, or what
4 period upstream?

5 DR. HWONG: Yes. It seems like
6 that, if I'm not mistaken, it's sort of prior
7 to, you know, not the measurement year, but
8 the year prior to the measurement year?

9 MR. HAMLIN: No, it can be done in
10 the measurement year or the year prior. So it
11 --

12 DR. HWONG: Oh, so it's the two
13 years?

14 MR. HAMLIN: Right.

15 DR. HWONG: I'm sorry. Okay, so
16 within the two-year period.

17 CO-CHAIR ROSENZWEIG: Are you
18 using entirely coding data to be able to
19 identify these comorbidities?

20 MR. HAMLIN: Yes. The --
21 primarily ICD-9 diagnosis.

22 CO-CHAIR ROSENZWEIG: All right.

1 The one potential problem with this that
2 always occurs, and actually I was alluding to
3 it when we were talking about the
4 cardiovascular -- one of the cardiovascular
5 protocols is that there's a notorious lack of
6 use of the complications codes, as well as the
7 -- you know, the 250.xx, there's a notorious
8 lack of use of the codes defining the various
9 complications as well as the codes that
10 identify whether or not the patient has or
11 does not have -- is or is not in good control.

12 MR. HAMLIN: Right.

13 CO-CHAIR ROSENZWEIG: So
14 especially among the primary care population.
15 So it becomes a -- it becomes a difficulty in
16 truly identifying the full spectrum of
17 diabetes complications.

18 MR. HAMLIN: Yes. And we actually
19 -- when we create the HCC tables, which we do,
20 but we don't use every single HCC that CMS
21 publishes, obviously. We try and select -- we
22 go through a process of selecting the ones

1 that are most relevant to the chronic disease
2 population. But I will agree, there is
3 probably some variation in the area of the use
4 of the codes, where they're not all there.
5 And so therefore, some of the rankings might
6 be -- might have some gaps.

7 However, in doing this whole idea
8 of identifying at least as many comorbidities
9 as we can, or at least we feel putting them in
10 the right risk groups, which is the one to
11 thirteen, as opposed to just identifying them
12 with a comorbid or no, which is the previous
13 approach that we used, which we feel kind of
14 doesn't really give you that exact same case
15 mix for these patients who have multiple
16 comorbidities, and some are more serious than
17 others. So it's a step in the right
18 direction, it's still not the perfect
19 approach, I don't think.

20 CO-CHAIR ROSENZWEIG: Yeah, I'm
21 not disagreeing with that. I was just saying
22 that there is a problem with the use of those

1 codes, which hopefully in the future,
2 physicians will adhere to better, because
3 they'll get paid more.

4 MR. HAMLIN: ICD10 is going to fix
5 everything. That's my story.

6 (Laughter.)

7 CO-CHAIR ROSENZWEIG: But the HCC
8 process has been validated with respect to
9 costs, hasn't it?

10 MR. HAMLIN: Yes.

11 CO-CHAIR ROSENZWEIG: Yes.

12 MR. HAMLIN: Yes, it has.

13 CO-CHAIR CURTIS: I just want to
14 follow up on that. So if you're using the
15 comorbidities for risk adjustment and you're
16 assessing it in the measurement year, isn't
17 that potentially explaining away some of the
18 differences or the variation that you're
19 seeing?

20 It's different than what we do for
21 sort of the outcomes measures?

22 MR. HAMLIN: So when these get

1 reported then, we actually back up a bit and
2 then report them out by the risk group, and
3 also by age and gender categories. So while
4 we roll them -- we take these things into
5 account in the risk adjustment, in order to do
6 calculations. The reporting out then is done
7 in these member cohorts, which are the age,
8 gender. So for example, in diabetes, one of
9 our member cohorts would be males 18 to 44,
10 HCC category 1; males 18 to 44, HCC category
11 2 would be the second one.

12 So they get rolled up into groups
13 with the calculation process. But then when
14 they're reported out, we actually do report
15 them out in sort of an expanded set in these
16 different cohorts. So we do -- while some of
17 it's adjusted away, we then do try and
18 identify them in the reports specifically by
19 these member cohorts, which we feel are most
20 applicable to this condition.

21 It's a little confusing, I fully
22 understand, but it's --

1 DR. HWONG: So just - I'm sorry, I
2 want to understand your concerns so that,
3 like, in contrast, previously the risk
4 adjustment was done on data prior to the
5 measurement, right, like that one other
6 example? So you're concerned -- and I want to
7 understand your concern, but that if there is
8 data taken to understand their comorbid status
9 during the measurement year, is that a problem
10 or --

11 CO-CHAIR CURTIS: I'm trying to
12 unravel it in my head, but it just seems like
13 it's not intuitive or it's just, again,
14 different, setting a red flag. And maybe
15 that's appropriate for costing, I don't know.

16 But for instance, if you have
17 increased resource utilization with increased
18 use of the diabetes complications codes,
19 because you're seeing the patients more
20 frequently, then you're adjusting that away
21 because they have more diabetes complications
22 coded.

1 DR. HWONG: Right.

2 CO-CHAIR CURTIS: It just seems
3 like it's circular.

4 DR. HWONG: Yes.

5 MR. HAMLIN: I should clarify too
6 that the weights are actually calculated on
7 the previous year's data, because that's how
8 we do -- we do the calculation of weights
9 based on prior year. The identification of
10 each person for the HCC is --

11 DR. HWONG: Yeah, that helps.

12 MR. HAMLIN: -- done in the
13 measurement year itself. So there is a one-
14 year lag. But they're updated every year, so
15 we are using hopefully the -- you know, the
16 most current available data for the
17 calculation of risk adjustment.

18 DR. MARWICK: What does the risk
19 adjustment predict?

20 MR. HAMLIN: Well, I'm not sure
21 what it really predicts, but I think what it
22 does is it really balances out some of the

1 factors that allow us to not create comparable
2 populations for the plan. I mean, we end up
3 ranking plans, and so the idea is to create
4 comparable populations for our approach.

5 So what we do is try and adjust
6 away the mitigating factors that would really
7 skew the plan-specific populations one
8 direction or the other. Beyond that, I'd have
9 to probably get someone who is more technical
10 in explaining the specifics of that.

11 CO-CHAIR ROSENZWEIG: But was it
12 designed for severity of illness or was it
13 designed to predict costs?

14 MR. HAMLIN: Well, a little bit of
15 both. It really was more on the -- the ones
16 we selected were the ones that were most
17 predictive of costs for this population. And
18 again, we're looking sort of commercial,
19 Medicare, Medicaid plan populations. And we
20 take those factors into account when selecting
21 and designing the HCC-RRU tables that we used
22 to do the risk adjustment. So they're the

1 ones that are the most predictive of cost.

2 MS. CLARK: They were designed by
3 -- it was for Medicare. It's in use right now
4 by Medicare for paying managed care plans,
5 their monthly capitation rates or risk
6 adjusted capitation rates. So they're looking
7 at, you know, the patients that these managed
8 care plans are getting enrolled, and how
9 predicting their costs. So it is for
10 predicting costs.

11 I think the scores that are
12 generated, you know, if you have a value of
13 one, if some -- if a patient has a value of
14 three, then they're three times more costly
15 than the average.

16 CO-CHAIR ROSENZWEIG: Yeah, I know
17 it was used for the Medicare health support
18 program, when they put that together.

19 DR. HWONG: Great. So sort of
20 moving along. We figured out, you know, who's
21 going to be in this measure, right? And in
22 terms of the cost, we know the resource

1 categories. And so I think maybe here we can,
2 you know, start to introduce what is going on
3 in terms of the cost data, right?

4 Here is where the measure
5 developers introduce sort of the standardized
6 price tables. So this is not going to be
7 reflective of any health plans, actual
8 contracted, you know, contracted fees and
9 rates. It's not about charges or costs, this
10 is just really sort of normalized -- or
11 standardized, rather, to -- you know, across
12 all, you know, health plans or across the data
13 in terms of the standardized pricing tables.

14 So every service that is
15 associated with these members gets mapped to,
16 you know, this table, right, in terms of the
17 prices there or the costs there, excuse me.

18 So the advantage of that, in terms
19 of trying to make, you know, sort of
20 comparisons across health plans, you know,
21 that sort of essentially, you know, with
22 everybody in terms of the same sort of E&M

1 code or whatever, would just get mapped to
2 sort of the same costs. And so I think it
3 allows for a greater comparability or
4 comparability between health plans,
5 ultimately, which is kind of the intent of
6 this measure.

7 So the one thing, when I was
8 thinking about this, right, where this is not
9 so much about sort of the costs of care
10 regarded to an episode or truly the
11 management, per se, of diabetes or of diabetes
12 patients. I got the sense that any type of
13 inpatient admission, any type -- I mean, if
14 someone, God forbid, had a horrible motor
15 vehicle accident and, you know, was laid up in
16 the ICU, those costs would actually still be
17 associated with, you know, these members who
18 have diabetes.

19 So it's really -- you know, I
20 mean, and I'd love to hear from -- I'm just
21 looking at the measure developer here, but
22 yeah, it's interesting that, you know, in some

1 ways you're very specific about who these
2 people are, these diabetics, but there's --
3 you're really sort of taking this global cost
4 of, you know, sort of cost of care for this
5 diabetic regardless. I mean, I know there's
6 some risk adjustment, regardless of, you know,
7 what the management might be, which could
8 be completely unrelated.

9 MR. HAMLIN: Well, it is and it
10 isn't. I mean, yes, you're right. This is a
11 great annual snapshot of the utilization of a
12 member with diabetes. And that really is
13 truly what the measure is designed to do.

14 But my best example I can give,
15 you know, is how do you know the person didn't
16 fall over and break their arm because they had
17 a severe hypoglycemic episode?

18 So again, we don't want to do that
19 identification of specific episodes to the
20 chronic condition itself, we want to give them
21 a total resource use snapshot, broken down by,
22 you know, 21 service categories for that

1 member and what that member or that population
2 might look like, given that perspective.

3 So we don't make any associations
4 between specific things. We do exclude, as
5 you mentioned earlier, the sort of high cost
6 conditions, HIV, active cancer,
7 transplantation, because we feel that those --
8 you know, a small percentage of the population
9 might skew the costing approach too much for
10 a specific plan.

11 But we really feel that it is
12 important to capture all service utilization
13 for that member with diabetes over the year,
14 whether that's directly attributable or not to
15 the diabetes itself.

16 DR. HWONG: And so another
17 question that I had, when I was thinking about
18 this measure, was you know, so if we're
19 capturing global costs, right? I mean, I'll
20 just say global for now, but like, you know,
21 for these diabetics.

22 And then they have these

1 comorbidities and they sort of happen to fall
2 into the heart failure category, et cetera,
3 you know, how do you sort of distinguish for
4 a member -- you know, so the member
5 essentially gets double, triple counted, you
6 know. When you roll it up in terms of a
7 health plan, how do you sort of separate that
8 out where -- because it's not like specific
9 services, you know, are attributed to the
10 episode.

11 It's just globally the cost of
12 someone who has -- you know, a member who has
13 these multiple comorbidities end up -- you
14 know, end up sort of showing up in terms of
15 costs that are used for a health plan multiple
16 times?

17 MR. HAMLIN: So I should also
18 probably qualify it. We actually only are
19 able to price around 82 percent of the actual
20 costs. So we have tested each one of these,
21 the coding structures in a variety of health
22 plans. We have a large research database, is

1 what we call it, that helps us to pilot some
2 of these costing structures through this.

3 We have to look for the
4 reliability of the paid claims, and have to be
5 sort of not -- you know, we have to look for
6 duplicate claims and things like that. And
7 there are certain services we just can't price
8 because they're just too unreliable.

9 So we're about 82 percent right
10 now with those, and so we're only pricing
11 select services, but again it's about 80 to 82
12 percent of those associated costs. But once
13 a person's been identified with diabetes, any
14 of their utilization that they incur over that
15 measurement year is attributable to that
16 person sort of being rolled up in these
17 categories.

18 If there -- if the service -- if
19 the code is in the standard pricing tables, it
20 should be counted towards that member for that
21 year.

22 DR. HWONG: Okay.

1 MR. HAMLIN: That's basically the
2 way we look at it.

3 DR. WEINTRAUB: So this is the
4 opposite choice that we saw from the -- from
5 this morning, from the acute MI, where there
6 was a detailed attempt to figure out which
7 codes to attribute to the MI versus everything
8 you see. This is actually -- this is a
9 simpler approach. And you're not trapped into
10 trying to figure out what's in and what's out
11 and you don't have to -- the problems about
12 updating, you just count them all up and
13 multiply.

14 So it's simple. I like it better.
15 That's what people usually do in cost
16 effectiveness analysis. Its downside is also
17 obvious, that you introduce some noise that
18 may make it more difficult to really
19 distinguish between providers.

20 But again, I think you've got the
21 point exactly right here. Someone falls down
22 and breaks their arm, does it have nothing to

1 do with diabetes? You really can't say.

2 CO-CHAIR ROSENZWEIG: The data
3 also indicates that with almost -- with a wide
4 variety of surgical procedures and
5 hospitalizations that are unrelated to
6 diabetes, if you're in the hospital, you tend
7 to be in the hospital for at least a day
8 longer if you have diabetes. So length of
9 stays are -- tend to be for almost any
10 condition, cholecystectomy, for example,
11 approximately one day longer, on average.

12 DR. HWONG: And I was thinking
13 like this rolled-up method, right, where it's
14 not really about the whole episode of
15 management, you know, of the diabetic patient,
16 per se. But this is, you know, probably okay
17 in terms of useful and aggregate on a plan
18 level, I think this would be more problematic,
19 you know, going down to that individual, you
20 know, physician attribution level.

21 Again, where you know -- you know,
22 I come from the perspective where we have had

1 to actually implement measures in terms of
2 quality profiling, et cetera, and I guarantee
3 you, as some of the things that, you know,
4 physicians would come back with which is, you
5 know, this is unrelated, you know, I have --
6 you know, my patients happen to be X
7 profession -- you know, whatever, and these
8 sorts of issues.

9 So I think, you know, that sort of
10 global concept I think does, actually in
11 general, fit better for a larger sort of unit
12 of analysis.

13 MR. HAMLIN: The approach works in
14 the health plan in large physician group
15 level. It does not really work at the
16 individual provider level. You have to have
17 a sample size of at least 400 or so patients
18 with the disease, which I think is unavailable
19 to many physician groups.

20 DR. HWONG: Yeah.

21 MR. HAMLIN: It works in those
22 scenarios and ACO's, and whatever else you

1 want to call them. But I mean, it's got to
2 have a fairly decent-sized population in order
3 to use with the data that encompasses all the
4 different systems.

5 CO-CHAIR CURTIS: Just remind me
6 then, where is this plan to be attributed to?
7 What level?

8 MS. TURBYVILLE: That's 11.3, page
9 26 of the PDF is where you'll find what the
10 measure developer selected as the --

11 CO-CHAIR CURTIS: We'll get there.
12 We haven't passed it yet. Okay.

13 DR. HWONG: Yeah, but it looks
14 like it's broken out by product -- I'm sorry,
15 yeah, product line. So it will be on health
16 plan, but they'll segment the populations like
17 Medicaid, Medicare, commercial.

18 And then I think you're mentioning
19 that it would be large provider groups. But
20 I didn't actually see -- maybe I didn't see
21 that.

22 MR. HAMLIN: It's been tested and

1 used in that environment. We don't actually
2 maintain that group, we're using different
3 health plans right now. So it's --

4 DR. HWONG: And so I had sort of
5 assumed that this whole thing was about
6 essentially on the health plan level. But
7 perhaps segmented by line of business.

8 MR. HAMLIN: Right.

9 DR. HWONG: Right.

10 MR. HAMLIN: It's commercial,
11 Medicare, Medicaid and we divide them by HMO,
12 PPO and further. And so it's --

13 DR. HWONG: Okay, great.

14 MS. CLARK: I just had one
15 question, in terms of the standardized cost
16 calculation. And so that, again, is based on
17 the claims data? You're calculating
18 standardized -

19 MR. HAMLIN: Primarily the
20 Medicare fee schedule and there's a lot of
21 adjustment for the commercial data that is
22 maintained in our data system. I think they

1 use an RBBS to adjust the Medicare fee
2 schedule primarily, but we use the national
3 Medicare fee schedule, I think, as the base
4 for the standardized costing. Because there's
5 so much variation across the country in prices
6 actually paid, contract by contract, and we
7 don't really want to dive into getting each
8 individual contract price and trying to make
9 some kind of adjustment for it.

10 DR. HWONG: Right. And I think
11 also for the pharmacy costs then, you're sort
12 of using sort of the -- was it average
13 warehouse -- you know, the AWP pricing, right?

14 MR. HAMLIN: Right.

15 DR. HWONG: Which -- I mean, which
16 may not in reality sort of reflect again
17 contracting with PBM's and sort of how certain
18 things will become different tiers in terms of
19 cost. But you just sort of use this standard
20 AWP, which you know, can over-estimate, I
21 think, you know, some of the costs there.

22 All right. So the one other thing

1 I thought was interesting was, in terms of the
2 cost calculations, they actually -- the
3 measure developer spent some time to pull out
4 the hierarchy in terms of cardiac
5 catheterization procedures, coupled with CABG
6 and how to sort of separate that out. Where
7 everything else -- everything else in terms of
8 this whole thing you just throw into the
9 bucket, right? But for -- specifically for
10 like cath or invasive -- like there's this
11 strict hierarchy where you'll sort of throw
12 out some of this and sort of take -- it seems
13 like to take the most invasive, you know, cost
14 and sort of -- and use that alone. So if
15 someone has, you know, a cath go in, you'd
16 understand or whatever. Then a CABG, it looks
17 like, you know, you just --

18 MR. HAMLIN: So those are actually
19 included in the cost component as well.

20 DR. HWONG: Okay.

21 MR. HAMLIN: The service frequency
22 component is an additional component of sort

1 of what we call select procedures that are
2 relevant to that condition. It's primarily in
3 diabetes and cardiovascular, which are the two
4 measures under evaluation.

5 So we look at frequent procedures
6 that are attributable to populations so that
7 you can look at the standardized cost. We
8 have the surgery and procedures both in
9 inpatient and outpatient level, but then you
10 can also see on a per unit per year basis, the
11 frequency of the procedures performed in this
12 population. So you're looking at the
13 frequency of CABG's in the diabetic population
14 for this measurement year.

15 So there's a frequency number and
16 there's a cost category. And actually the
17 CABG's are included in the cost component of
18 the total roll-up. So you can sort of cross
19 compare those two things, and hopefully that
20 will give you more information.

21 DR. WEINTRAUB: Just to clarify,
22 you're not using different methodology to

1 cost?

2 MR. HAMLIN: No.

3 DR. WEINTRAUB: Okay, thanks.

4 MR. HAMLIN: No. It's -- since
5 you're counting the year, you're mapping it
6 for the costs, you also put a checkmark on the
7 frequency category, effectively.

8 CO-CHAIR CURTIS: How did you
9 define the procedures that were relevant?
10 Obviously cath, PCI, CABG makes sense. But
11 why not amputations or progression end state
12 renal disease or other diabetic-relevant
13 complications?

14 MR. HAMLIN: Many were a
15 derivative of a past HEDIS measure that was
16 frequency of selected procedures. This went
17 through several expert panel reviews, and they
18 sort of decided this was a good list to look
19 at the procedures that perhaps were either in
20 the appropriateness over-use category, as
21 future thought into measurement in those
22 arenas.

1 They were also felt to be relevant
2 to this population so it would be of interest
3 to -- you know, specifically of interest to
4 plans who were trying to identify
5 opportunities to improve in certain areas,
6 primarily with procedures that are frequently
7 performed.

8 And they can look at -- and again,
9 you can -- when the plans compare each other
10 to their peer group, they can look at these
11 frequencies and compare themselves to other
12 frequencies that are displayed by other plans,
13 to see how they compare, again, across these
14 different categories.

15 CO-CHAIR ROSENZWEIG: I didn't see
16 pregnancy list in the cost calculations. Are
17 you -- you're not excluding women with
18 diabetes of child-bearing age, are you?

19 MR. HAMLIN: Well, gestational
20 diabetes is an exclusion from --

21 CO-CHAIR ROSENZWEIG: No, I'm
22 talking about people with diabetes who become

1 pregnant.

2 MR. HAMLIN: On maternity, I
3 believe there's a series of maternity codes in
4 the cost calculation tables. I couldn't tell
5 you which ones exactly. There are some that
6 are not included, however, and I don't know
7 exactly -- I have to get more information on
8 that for you. I know that maternity is one of
9 those difficult areas we're struggling with
10 right now in identifying what should count and
11 what should not count.

12 Certain maternity codes are in the
13 82 percent that I mentioned, but there's also
14 a series that are kind of in that gray area
15 that they're not consistent -- not consistent
16 enough so that we can't price them accurately,
17 if that makes sense.

18 CO-CHAIR ROSENZWEIG: Okay. But
19 they do represent a very significant cost
20 component?

21 MR. HAMLIN: Yes. And I know a
22 number of them are included, I just couldn't

1 tell you what percentage of them -- you know,
2 which codes and what percentage of the
3 services are included in the current 80 versus
4 the 20 percent of services that are captured
5 and priced.

6 CO-CHAIR ROSENZWEIG: Okay, thank
7 you.

8 DR. HWONG: All right. So I think
9 we have moved through sort of -- what is it,
10 9.7. I think we're sort of moving on if
11 people are following along in the sheets,
12 let's move to sort of page 19, all right. And
13 we'll go through a couple of these other
14 categories then.

15 So care setting provides
16 information in which care setting is
17 encompassed. So again, since this is the
18 whole kitchen sink in many aspects, not in a,
19 you know, direct -- not to be negative, but
20 basically a lot of these areas, you know, it
21 is covering some ambulatory care, inpatient
22 care, laboratory, pharmacy, you know. It is

1 covered, you know, within this measure.

2 Going to sort of item 10.1, sort
3 of the risk adjustment method, I think we've
4 spent, you know, some time already sort of
5 discussing the details of that. And sort of
6 how that is organized. I think in the end it
7 sounds like, you know, when you're comparing
8 health plans, you're sort of able to stratify,
9 you know, in terms of your reporting in terms
10 of along these. So in these particular
11 cohorts, or are these like categories?

12 MR. HAMLIN: We're actually doing
13 a comparison, we actually do the roll-up and
14 then do the comparison. But then the data is
15 available, if you keep clicking down through
16 the published reports of -- by these
17 individual member cohorts to the strata.

18 DR. HWONG: Okay. That's great.
19 I'll pause --

20 CO-CHAIR ROSENZWEIG: Is your data
21 -- you need 400 patients, distinct patients
22 with diabetes to compare two different groups.

1 Is that with the risk adjustment included?

2 MR. HAMLIN: Yes. You have to
3 have a minimum population of 400 diabetics in
4 your plan, and then everything else gets --
5 it's not an age cohort, it's totally
6 population. In diabetes, the populations in
7 reality are much, much larger than that. So
8 it's -- we rarely exclude any plans because
9 the minimum population is such a size.

10 CO-CHAIR ROSENZWEIG: But for
11 physician groups and for individual
12 physicians, it becomes a real problem then?

13 MR. HAMLIN: Physician groups it
14 does. We're actually seriously considering
15 dropping that minimum sample size down to
16 probably about 250, which may become more
17 attainable for physician groups. I think
18 individual physicians still probably may be a
19 problem because of the -- this HCC methodology
20 has shown that it actually has the same level
21 of specificity at the lower population sample
22 size.

1 We just -- we're staying with the
2 400 because it's been tested, it's been run
3 over several years, we're very comfortable
4 with that. Right now the plans seem able to
5 meet that goal, there are very few that are
6 limited from diabetes. So we're sort of
7 holding to something that's constant and, you
8 know, updating other things at the time
9 because they're very complex measures, we
10 don't want to overload the plans with a whole
11 series of changes every year. So we're
12 sticking with the larger populations because
13 it seems to work in the plans.

14 As we think about -- as we work
15 with groups like IHA to test these with
16 physician groups, and with ACO's coming out,
17 we'll be reevaluating those criteria and
18 retesting different samples, minimum sample
19 sizes. But for now, like I said, it -- the
20 400 seems to be perfectly appropriate for the
21 health plan population, because almost every
22 plan can achieve that for diabetes.

1 DR. HWONG: Good. It's perfect.

2 So I'm trying to keep us on the items here.

3 So any other questions in terms of
4 the risk adjustment methodology? I think
5 we're on -- sort of moving down to sort of
6 10.2. Long list, we're almost there.

7 The stratification method, we
8 talked a little bit about, again, sort of
9 health plan and product line. The other thing
10 to mention here is that it seems that you have
11 sort of the resource use categories like you
12 actually will break it out so you can compare
13 across health plans. Sort of inpatient
14 utilization and ambulatory, pharmacy, et
15 cetera, so you can kind of break out and see
16 sort of which areas, you know, may be -- you
17 know, the plans are sort of variable. So I
18 thought that was, you know, again a nice --
19 nice way to be able to slice it up in terms of
20 stratifying this group and their reporting.

21 Anybody have questions further on
22 stratification?

1 (No response.)

2 DR. HWONG: Okay. All right, and
3 I think we've spent some time on the costing
4 method, again, with these standardized pricing
5 tables. There is a large -- you know, there's
6 a lot of detail here in terms of how to do
7 this for sort of inpatient facility, you know,
8 services, you know, length of days, et cetera.

9 You know, I -- maybe what I could
10 do, if the measure developer -- you know, if
11 it would be helpful for the group also on, you
12 know, maybe if you want to go on sort of maybe
13 on a high level? I know it's hard, because
14 there's multiple sort of categories --

15 MR. HAMLIN: Right.

16 MR. HAMLIN: -- and there is,
17 again, you know, I look at this and, you know,
18 was trying to remember sort of a length of
19 stay, take a length of stay and then you
20 multiply this. And so I mean, I wonder if
21 there is some way to kind of capture this, if
22 you could, you know, for just the group?

1 MR. HAMLIN: Well I mean, again,
2 it effectively -- you sort of capture the
3 appropriate level services, and then you map
4 those individual codes to -- you know, to the
5 standard price for the inpatient. I mean, the
6 reason we provide specific steps for the
7 different categories is because with
8 inpatient, obviously you have length of stay
9 and issues that we -- a per diem multiplier
10 that we use for length of stay. Again, for
11 the category, it's longer lengths of stay.

12 You know, the outpatient are
13 generally fairly easy, it's kind of an ICD-9
14 code and map -- or CPT map for services, but
15 very specific pricing. So again, we sort of
16 provide individual steps for each service
17 category because then the mapping is slightly
18 different, but there are certain
19 considerations, primarily on the inpatient
20 side. And that's the high level, I don't know
21 how much detail you want me to go into.

22 It's very long and extensive, but

1 again, to create consistent comparable
2 populations, we want to make sure each plan is
3 doing it absolutely correctly, each -- and
4 absolutely the same each time.

5 DR. HWONG: Right. And one other
6 thing, and I was trying to understand this,
7 and maybe I have missed this in the details.
8 But in terms of the outlier, potential outlier
9 cost, when you're doing the costing and then,
10 of course, the services, and when you look,
11 you know, overall for any given number, what
12 is the -- you know, I know some of the other
13 measures have used Winsorization technique,
14 you know, to just chop off the ends at the
15 99th percentile, you know, and out.

16 But what is the technique for
17 this?

18 MR. HAMLIN: So we -- all plans
19 that report their data to NCQA, their observed
20 data to NCQA --

21 DR. HWONG: Right.

22 MR. HAMLIN: -- goes into a bucket

1 and gets calculated. We calculate expecteds.
2 We report out any plan that is between .3 and
3 3.0, so we -- if I could just back up a little
4 bit.

5 DR. HWONG: Okay.

6 MR. HAMLIN: We calculate an
7 observed to expected ratio for each plan,
8 specific to that plan. We then do a
9 normalization process where we then take all
10 the plans and normalize their means to one in
11 order to create comparable plan populations.

12 So then we have this nice sort of
13 mean of one, there are some plans above and
14 some plans below. Plans that fall outside of
15 the .3 to 3.0 range are considered outliers,
16 and are not included in those calculations.
17 So we don't -- we sort of narrow the field a
18 little bit there.

19 We do actually Winsorize because
20 we actually Winsorize -- when we display these
21 results, we actually do Winsorize any outlying
22 plans down to about -- what is it .5 and 1.5

1 because they don't fit in the display graph.
2 So there is sort of a two-step of the
3 calculations. Anyone who falls outside of the
4 .3 or 3.0 gets eliminated from the
5 calculations because they're considered to be
6 an outlier.

7 DR. HWONG: Okay.

8 MR. HAMLIN: It's a very small
9 percentage right now, less than one percent --
10 less than .1 percent, I'm sorry, of plans
11 reporting.

12 And then again, for the display
13 purposes, for reporting these measures, we
14 actually Winsorize any plan between, you know,
15 .3 and .5 to the .5 ratio. We have a little
16 special designated symbol that they get so
17 they show up as a Winsorized plan versus dots
18 on our graph. I provided you a sample display
19 of that.

20 DR. HWONG: Okay. Great to know
21 that, that's helpful.

22 Go ahead, yes. No?

1 Anybody have any other questions?

2 MR. HAMLIN: Feel free to correct
3 me, Sally, if I'm --

4 CO-CHAIR CURTIS: Just one
5 clarification, I'd like -- if it's within a
6 calendar year, let's say someone gets
7 hospitalized on December 28th and they're in
8 the hospital. Do you only account for those
9 days within the calendar year?

10 MR. HAMLIN: Within the calendar
11 year, yes.

12 CO-CHAIR ROSENZWEIG: Are you able
13 to collect any socioeconomic data?

14 MR. HAMLIN: Right now we only get
15 aggregate plan level information. We have
16 continually tested member level data in the
17 health plans and the things that are highly
18 inconsistent are race and the socioeconomic
19 status. Gender is fairly reliable, age is
20 fairly reliable when everything else is across
21 the board from two percent to 98 percent.

22 Some plans are actually not

1 collecting that data now, purposefully,
2 because they feel it's a liability. So we're
3 not able to do any kind of reporting out of
4 that, by those stratuses, at least, which is
5 why we restrict it to age and gender. The
6 data's just not in the plan systems, and they
7 won't give it to us, even if it was.

8 CO-CHAIR ROSENZWEIG: What about
9 duration of diabetes?

10 MR. HAMLIN: That would actually
11 be really interesting. I think that would be
12 something that would be really interesting for
13 us to try and look at. But I don't -- we
14 don't currently collect that. So again, we
15 just receive aggregate level population data
16 from the plan of all their observed. We don't
17 get any individual level member data. It's
18 very hard to report.

19 CO-CHAIR ROSENZWEIG: I'm not
20 suggesting you add it.

21 MR. HAMLIN: You know, always open
22 for suggestions.

1 (Laughter.)

2 CO-CHAIR ROSENZWEIG: Thank you.

3 DR. HWONG: Okay we're making
4 progress here.

5 So if we move on to, again, the --
6 let's move down to 11.5 -- we're almost there.
7 So subset requirements, I think it's already
8 been stated that, you know, you need have to
9 have a population of at least 400 observations
10 for you to be, you know, included in the
11 measure, which seems to make sense.

12 Especially, you know, essentially they've done
13 sort of an analyses on this, you know, in
14 terms of their observed to expected ratios.

15 Okay. Benchmarking, right, so
16 11.6. So again, you know, from what we've
17 heard so far, essentially, you know, this
18 would get again normalized versus sort of the
19 average in there would be sort of one. So
20 you'll calculate sort of these ratios. And I
21 think you can then, with that, sort of, you
22 know, see how far, you know, any given health

1 plan sort of deviates from that in sort of a
2 positive, more resource use intensive versus
3 less resource use intensive, you know, greater
4 than one, less than one, and sort of see, you
5 know, how many standard deviations, you know,
6 a health plan is out. So there's a way to
7 kind of, you know, take a look at that.

8 MR. HAMLIN: And we do this
9 annually, so there's no way right now we could
10 trim the data. We don't have the capacity
11 data-wise, because the number of data points
12 required for each of these measures to do
13 that. We're hoping to do that in the future,
14 but right now it's an annual snapshot, and you
15 can, in fact, see for that year how far away
16 you were from the mean, so to speak. But
17 that's really about the best we can do at this
18 point.

19 DR. HWONG: Okay. All right, any
20 more thoughts on that?

21 (No response.)

22 DR. HWONG: Okay. So why don't we

1 -- actually, I think we can -- should we pause
2 here? Because I think next we'll dive into
3 sort of reliability testing and validity.

4 CO-CHAIR ROSENZWEIG: Why don't we
5 vote on these --

6 DR. HWONG: Yeah, I didn't know if
7 we wanted to, yes, since we spent all that
8 time on 2.A.1 or shall we do that all in --

9 MS. TURBYVILLE: If you want to
10 vote on 2.A.1 now, you can. And then you can
11 move into reliability and validity.

12 DR. HWONG: Yeah, why don't we
13 sort of have a sense of progress, right, you
14 know, before all of that sort of discussion
15 and detail.

16 So let's see -- so for 2.A.1, I
17 mean, given -- so having gone through all this
18 sort of sub-subcriteria, you know, I felt like
19 this measure was, you know, very well defined,
20 very precise. And so you know, in general, I
21 looked at this and I thought, you know,
22 there's been, you know, a lot of consideration

1 for different scenarios and factors and sort
2 of I felt like this was -- you know, I ranked
3 this as high, in terms of the 2.A.1. But
4 let's see how the voting turns out.

5 Any other comments then, before we
6 go to --

7 CO-CHAIR ROSENZWEIG: Just the one
8 comment that I had already mentioned, is that
9 the traditional way of identifying patients
10 with diabetes by medication is going to become
11 more and more of a problem in the future. So
12 I don't disagree with what they have been
13 using in the traditional method. But the fact
14 is that you're going to be seeing more and
15 more patients on certain medications that were
16 used for diabetes that don't have diabetes.

17 DR. HWONG: Right. And I think I
18 saw it --

19 CO-CHAIR ROSENZWEIG: It's
20 probably not statistically an important issue,
21 but it probably will be in the future.

22 DR. HWONG: Right. And I did see

1 that they had already taken -- taken that into
2 account to some extent. I mean, I think
3 they're going to have to continue in the
4 future, but you know, for example, metformin
5 alone cannot be used as one of the
6 medications, I think, to identify someone as
7 being diabetic. It has to be sort of a
8 combination with another class of diabetic
9 drugs because metformin can be used in --
10 again, for these other applications like PCOS
11 and whatnot, right? If I'm not mistaken?

12 CO-CHAIR ROSENZWEIG: That's
13 right. But there was a paper that came out
14 showing that the alpha-glucosides inhibitors
15 can also prevent diabetes. So --

16 DR. HWONG: Right, yeah, so this -
17 - I think that's a point well taken.

18 MR. HAMLIN: Metformin is a
19 constant thorn in the side of our diabetes
20 measures, both on the EOC side and on the RE
21 side. So there's other things we're looking
22 at. I mean, again, we sort of deferred to the

1 endorsed diabetic tested and approved
2 identification algorithm we've used for a
3 number of years in the HEDIS population, I
4 think, to keep this population. But I agree
5 there may be some adjustments. I mean, we
6 analyze the medications and the codes annually
7 for inclusion in the measure, and any
8 reflection on the diabetes side will be
9 reflected in the RE measure as well.

10 CO-CHAIR ROSENZWEIG: Yeah, I'm
11 not disagreeing with you, it's just the fact
12 that it has to, in fact, for your
13 harmonization purposes, you have to have the
14 same methods for identifying patients with
15 diabetes for your quality measures, if you
16 want to coordinate them with your cost -- with
17 your -- excuse me, resource use measure.

18 DR. HWONG: Okay, great. So why
19 don't we open it up for voting right now?

20 CO-CHAIR ROSENZWEIG: Yes. So for
21 2.A?

22 DR. HWONG: Yes, 2.A.

1 CO-CHAIR ROSENZWEIG: 2.A.1.

2 DR. HWONG: So again, you know, is
3 this measure well defined, precisely specified
4 so that this could be implemented across and
5 used -- you know, have results that allow for
6 a good comparability?

7 CO-CHAIR ROSENZWEIG: All right.

8 DR. HWONG: All right.

9 CO-CHAIR ROSENZWEIG: And 2.B.1?

10 DR. HWONG: Yes. So 2.B.1, all
11 right, measure specs are consistent, you know,
12 with evidence presented to support the focus
13 of measurement.

14 You know, so this one was a -- you
15 know, in terms of my other comments about, you
16 know, is this really episode -- you know,
17 diabetes management? I think this kind of
18 comment comes in to this category, right? You
19 know in terms of the target population. I
20 think this is where, you know, I felt like
21 again it's large sort of global resource use,
22 and that it would be very interesting to be

1 able to sort of narrow that down with
2 additional thought. Like some of the other
3 measure developers have gone through that step
4 to say, you know, what is actually really
5 associated, you know, with diabetes
6 management.

7 So you know, I can kind of see how
8 that could be, you know, useful in that
9 regard, you know. I understand there is that
10 concept of, you know, if someone has a
11 hypoglycemic event and injures their arm, you
12 know, but I do still see how there's a lot
13 that, you know, it may be telling you more
14 about sort of the, again, services as opposed
15 to, you know, broader, as opposed to something
16 that's really sort of diabetes management
17 focused.

18 So I felt that it was actually
19 more of a moderate for myself.

20 CO-CHAIR ROSENZWEIG: Any other
21 comments?

22 (No response.)

1 DR. HWONG: Okay. So why don't we
2 move on to -- I think we're going to get into
3 sort of validity -- validity testing, right?

4 CO-CHAIR ROSENZWEIG: Correct.

5 DR. HWONG: And I would love to
6 take advantage of having Carlos here at the
7 table here. But so when I looked at, again,
8 sort of validity testing demonstrated that the
9 measure data elements are correct and the
10 scores reflect -- you know, correctly reflect
11 the cost of care for resources provided. I
12 know there was this sort of large document
13 included about this 2005 study that, you know,
14 tested a lot of it on sort of face validity,
15 right, you know, looking at it and having
16 these extra panelists take a look and say, you
17 know, member costs are actually high.

18 You know, with this calculation we
19 see that, you know, costs are higher for AMI
20 patients, you know, heart failure patients,
21 lowest for asthma. I mean, there was sort of
22 this iterative process where, you know,

1 clinician group or advisory group got to look
2 at that.

3 I think where I was trying to
4 figure out, in terms of the validity testing
5 was, you know, again like, you know, we're
6 using this sort of standardized pricing table,
7 which I think has some advantages, it will
8 allow for comparability. I just didn't know
9 in terms of, you know, how valid that might be
10 for, you know, some, whether it's plans or
11 groups that have got some sort of things set
12 up in terms of their, you know, how you would
13 actually calculate their costs. I didn't know
14 if that was, you know, something that could be
15 looked at, you know, in terms of this pricing
16 table versus if you were to actually use, you
17 know, costs, you know, per actual service.

18 But maybe I could also turn it
19 over to Carlos, you know, if you have any
20 comments like here at all. Not to put you on
21 the spot, Carlos.

22 MR. ALZOLA: I don't have any real

1 specific comments as to compare standard costs
2 versus actual costs. Clearly you are getting
3 the variability, a lot of the variability out
4 of the calculations when you're using standard
5 costs. But if the point here is to compare
6 plans, and you seem -- it seems to me that
7 using standard costs is helpful because
8 everything -- all those regional variations
9 that could occur because of -- or because of
10 difference in contracting are not really
11 reflecting of quality or efficiency of care.
12 It's more the ability to negotiate a contract
13 than you see done there than a reflection of
14 real costs.

15 So I think using standard costs is
16 a good approach.

17 DR. HWONG: All right.

18 MR. HAMLIN: One of the things
19 that we actually really focused on, now that
20 we have a really well defined methodology, it
21 gave the risk adjustment in the service
22 category that we're comfortable with.

1 And the things that we're working
2 on now, just FYI, is that we're looking at
3 perhaps a measure of here's your standard cost
4 and here's sort of a delta measure. The
5 difference between irrational cost and
6 standard cost. Actual costs are just a
7 political hot button. They will not give us
8 actual costs. So we were trying to -- and
9 total expenditures is another one we're
10 looking at.

11 Using, again, same methodology for
12 the same population, but you know, can you
13 give us the difference, if you will, in
14 somehow using that. But those are -- we had
15 to stay away from the actual costs and use the
16 standard costs. Not only that, but we could
17 do that on a national scale. But there is a
18 lot of aggregate variation. So there is some
19 weakness in certain areas, probably, where
20 these costs may not be reflective of actual
21 costs paid in that market.

22 DR. HWONG: Sure.

1 DR. WEINTRAUB: These standardized
2 costs are payments, is that right?

3 MR. HAMLIN: Yeah, it's based on
4 the Medicare fee schedule and it's sort of --
5 yeah. And it's a national average so, you
6 know, there's some adjustment. But --

7 DR. WEINTRAUB: Because the
8 Medicare fee schedule, there are both fees and
9 payments.

10 MR. HAMLIN: Right.

11 DR. WEINTRAUB: So which is it you
12 can use? The fees are regionally based,
13 rather than national as I understand it.

14 MR. HAMLIN: They are. But we
15 usually use it on national level.

16 DR. WEINTRAUB: So you do some
17 sort of averaging of the fees, just come up
18 with a national --

19 MR. HAMLIN: We don't have a
20 national standard pricing tables. I mean, we
21 don't have regional standard pricing tables,
22 we have just the national standard pricing

1 tables. So it's kind of a -- it's basically
2 an averaging of the fees for each of these
3 individual service units, or whatever you want
4 to call them.

5 DR. WEINTRAUB: So again, there is
6 societal costs is a construct, but not
7 something you actually ever get, right? So we
8 -- you know, you pick your poison and hope you
9 can live with it.

10 CO-CHAIR ROSENZWEIG: I assume you
11 can't take into account the costs of co-pays
12 or whether or not a particular service is
13 covered?

14 MR. HAMLIN: We think that some of
15 the utilization patterns are very reflective
16 of benefit design, but we can't capture those
17 things at this point in this methodology.
18 It's just too difficult. Again, there's
19 already 10,000 data elements per measure, you
20 know, so expanding that out to capture
21 additional ones, it would just be
22 overwhelming.

1 DR. HWONG: Okay. Maybe we can
2 move on then to -- let's take a look here. So
3 it looks like we're down to -- oh yes, this
4 item, 3.1, sort of describe the impact of
5 exclusions, transparent in criteria. Am I
6 moving along appropriately? Am I missing
7 something here?

8 MR. AMIN: Quick process question.
9 Did the group decide not to vote after 2.B?
10 Maybe we should vote at 2.B.1 and then 2.B.2
11 before we get too far down?

12 DR. HWONG: No, I think that's
13 good. I'm sorry, yeah.

14 CO-CHAIR ROSENZWEIG: We did vote
15 at 2.B.1, didn't we?

16 DR. HWONG: We did 2.B.1, but the
17 2.B.2 --

18 MR. AMIN: Oh sorry, 2.A.2,
19 correct. So it's 2.A.2.

20 MS. TURBYVILLE: 2.A.2 was skipped
21 inadvertently.

22 DR. HWONG: I'm sorry, 2.A.2.

1 Sorry. There you go. Okay.

2 MS. TURBYVILLE: I was waiting for
3 a natural break in the conversation.

4 MR. AMIN: There's 2.A.1 and
5 2.B.1. Where's 2.A.2?

6 DR. HWONG: Reliability testing.

7 MS. TURBYVILLE: Page 29.

8 MR. AMIN: Page 29?

9 MS. TURBYVILLE: Yes.

10 MR. AMIN: So it is, but it was
11 further down on the list. Okay. Yeah, it's
12 ten pages later.

13 DR. HWONG: All right.

14 MR. AMIN: So it's not my fault.

15 (Laughter.)

16 DR. HWONG: All right, so maybe I
17 can try and address -- yeah, I'm trying to
18 like it. Hard for me to keep track of this,
19 too.

20 So okay.

21 MR. AMIN: Okay.

22 DR. HWONG: So if I can address a

1 little bit on this, the reliability testing,
2 when I looked at this.

3 And so again, this is sort of
4 saying, are the results repeatable, producing
5 the same results a hyper portion of the time?
6 And again, so the advantage here for the NCQA,
7 this measure's been in use for the last like
8 four years or more.

9 And then -- and so that, you know,
10 annually -- again, you can't -- it sounds like
11 it's not -- I think you made the caveat
12 earlier, it's not sort of a trending, you
13 know, not used for trending purposes, right,
14 but in general that the plan measurements
15 appear sort of stable over time, over these
16 four years, right? That nearly 90 percent of
17 the plans shifted, at most, sort of one
18 quartile within their ranking? And that you
19 know, there was a significant number that --
20 I'm not going to go down and look at the exact
21 statistic, but did not actually change
22 quartiles at all, so that there is this sort

1 of stability from year to year measurement.
2 Which I think is very -- I mean, you know,
3 obviously this is a criteria that's important,
4 right?

5 There's nothing more frustrating
6 for, I think, whether it's physicians being
7 graded or health plans, et cetera, that, you
8 know, one year you're top 25, next year you're
9 bottom 25, right. Then you sort of flip flop
10 back and forth.

11 So the fact that -- you know, the
12 advantage of this is having sort of this
13 experience over the last four years, showing
14 that again, you know, the vast majority do not
15 move sort of significantly from top to bottom,
16 back and forth, I think is comforting.

17 CO-CHAIR ROSENZWEIG: Is there
18 anything in your methodology that you're
19 proposing here that's different from what
20 you're currently reporting?

21 MR. HAMLIN: No. The only thing
22 that's going to be -- every year we expand the

1 service category. So the data we received
2 last year had I think two fewer service
3 categories. This year I'll have those in
4 there, and then next year I'll have even more.
5 So it's just, again, you know, annual
6 expansion. But the methodology is identical.

7 CO-CHAIR ROSENZWEIG: And you
8 actually are reporting this on 88 percent, I
9 read in there?

10 MR. HAMLIN: Yes. It's a high
11 percentage, yes.

12 CO-CHAIR ROSENZWEIG: Okay.

13 DR. HWONG: Good. So do we need
14 to do some voting now, or are we like --
15 should we keep moving?

16 CO-CHAIR ROSENZWEIG: We've still
17 got 2.B.2, so why don't we vote?

18 DR. HWONG: Did we do the validity
19 testing?

20 MS. TURBYVILLE: Typically what we
21 had done earlier was get through the
22 scientific acceptability section and then go

1 back and vote on the subcriteria. However, I
2 think because 2.A.1 incorporated so many
3 components that we wanted to take a break
4 there and vote. But then you're more than
5 welcome to get through 2.A.2, B.1, B.2 and
6 then go back and vote.

7 CO-CHAIR ROSENZWEIG: Yes, I think
8 we should -- let's finish --

9 DR. HWONG: Do you want to keep the
10 momentum?

11 CO-CHAIR ROSENZWEIG: Yes.

12 DR. HWONG: Okay.

13 CO-CHAIR ROSENZWEIG: At least
14 until usability, okay?

15 DR. HWONG: Okay. That's fine,
16 yes, I think we're almost there then.

17 So you know, I wanted to say sort
18 of, I think we had this discussion a little
19 earlier, sort of a little bit, you know, in
20 terms of validity testing and I was sort of
21 commenting on how there was a lot of face
22 validity opportunities, you know, back and

1 forth in terms of modification of this, you
2 know, with their clinician groups.

3 There wasn't -- you know, like I
4 said, my only concern has simply that, again,
5 using this sort of standardized pricing, how
6 that actually, you know compares with the
7 actual, you know, contractor grade, was it
8 costs, et cetera. I think, you know, would be
9 something of use. But that's all kind of I
10 had, as far as comments go, in terms of
11 validity testing. I didn't know if anybody
12 else had anything else they'd like to
13 contribute in that regard, or even anything
14 from the measure developer in that regard?

15 (No response.)

16 DR. HWONG: Okay. So let's go
17 back.

18 But let's go to 2.B.3 then. So
19 that would be exclusions supported by clinical
20 evidence or otherwise. And we've already
21 talked a little bit about this. Those key
22 categories that I think we mentioned earlier.

1 And the only thing that when I looked at this,
2 and I said, sure, you know, you look at this
3 and these are expensive categories: cancer,
4 ESRD, et cetera.

5 But I wondered if there's a way to
6 kind of continue to update that, right, in
7 terms of -- you know, I sort of look at that
8 and I think it could be set in stone and ends
9 up sitting there for ten years, right? But is
10 there something else that's much more of a
11 sort of empiric kind of way to say, hey, you
12 know, when we look at historically and look at
13 patients who have these X, Y, Z conditions,
14 they actually constitute the top, you know,
15 one percent of costs, et cetera? Or this is
16 -- you know, these become, you know -- that
17 are unrelated to these conditions, but these
18 other entities, and we'll reassess that
19 periodically, every five years or every, you
20 know, several years?

21 So it's just one of those things,
22 when I look at this, and I think it gets kind

1 of codified, right, as like, okay, great,
2 these are sort of expensive, you know, areas,
3 but doesn't necessarily -- I don't sort of see
4 how that gets sort of readdressed and what
5 sort of empiric criteria was applied to say,
6 you know, these are the conditions, you know.
7 Again, sort of -- you know, start off being
8 sort of unrelated to the condition at hand,
9 right? The diabetes. But you know, are
10 actually significant contributors to cost?

11 MR. HAMLIN: Yes. These measures
12 undergo effectively almost an annual analysis.
13 The standard prices get updated every three
14 years, and so we do do some analysis as to
15 sort of conditions and costs and sort of
16 reliability and validity of the data, albeit
17 it's not really a deep dive into it. But we
18 do look at these things.

19 I mean, these conditions were
20 really effectively selected at the get-go.
21 They were shown to be the ones that had the
22 greatest effect. We haven't done updating

1 since then other than to the codes associated
2 with those conditions. Those get updated,
3 again, every year. You know, perhaps we could
4 take another sort of deeper dive into the
5 exclusion criteria and think about, you know
6 are there other conditions or could one of
7 these conditions maybe be modified to only
8 include stage four ESRD or something like
9 that.

10 DR. HWONG: Right. And maybe some
11 cancers that maybe are fairly benign and with
12 some treatment are actually -- you know, would
13 not be an actual high, you know, cost outlier,
14 et cetera.

15 But I just was, you know, for me I
16 thought, it would be nice to hear about some
17 way that you can kind of continually update
18 that and sort of have a little more of an
19 empiric basis to say, you know, why you think
20 these are high cost drivers, right, as opposed
21 to --

22 MR. HAMLIN: We actually have a

1 public comment system where we -- sort of
2 every day of the year we actually get comments
3 on codes and conditions from the general
4 public, and their positions or plans or
5 whatever. And they actually do an annual
6 recycle. So they do it again, they get
7 updated every year. We just haven't -- those
8 four have been kind of the, you know, the
9 stone fort, I don't have any other way to --

10 CO-CHAIR ROSENZWEIG: Which four?

11 MR. HAMLIN: HIV, organ
12 transplantation, ESRD and -- I did them out of
13 order so I forget --

14 DR. HWONG: Cancer?

15 MR. HAMLIN: Active cancer, thank
16 you.

17 CO-CHAIR ROSENZWEIG: Now, the
18 interesting thing is that two out of those
19 four are clearly related to diabetes. I mean,
20 about 50 percent of kidney transplants have
21 diabetes nationally --

22 MR. HAMLIN: Yes.

1 CO-CHAIR ROSENZWEIG: -- and a
2 significant number -- and almost all of
3 pancreas transplants currently have diabetes.

4 MR. HAMLIN: Yes.

5 CO-CHAIR ROSENZWEIG: And the
6 other one you mentioned was ESRD.

7 MR. HAMLIN: ESRD, yes.

8 CO-CHAIR ROSENZWEIG: About 50
9 percent of the people on dialysis in the
10 country have diabetes, so -- 60 percent,
11 probably closer to 60 percent. So they're not
12 unrelated. And now there is more and more
13 data showing various cancers being associated
14 with diabetes.

15 MR. HAMLIN: Well, I think, too --
16 I mean, again, these apply across all five of
17 our chronic conditions, and that's the way it
18 was designed to have steady methodology. But
19 I think, again, there may be a logic behind,
20 you know, making them required for certain
21 measures where they're less applicable versus
22 diabetes, where, yes, I would agree, ESRD

1 definitely, and organ transplantation may, at
2 least, in some, you know, maybe in kidney
3 transplantation should be in there whereas
4 others should not be. Yes, I agree with you.

5 DR. PALESTRANT: This is David
6 Palestrant. How is the age criteria defined
7 for --

8 DR. HWONG: Sorry, I think we're
9 having a hard time hearing you. Could you get
10 closer to your telephone?

11 DR. PALESTRANT: Can you hear me
12 now?

13 DR. HWONG: Yes, better, thank
14 you.

15 DR. PALESTRANT: The problem I
16 have is with the age criteria. And it
17 applies, like you said, in your other chronic
18 disease categories, but after 75 years of age,
19 all these diseases increase in prevalence, and
20 also this is where most of the costs come,
21 especially for Medicare.

22 DR. HWONG: Yes, I'm sorry, we're

1 still having a problem -- I apologize. Maybe
2 try again right now?

3 DR. PALESTRANT: All right, can
4 you hear me now?

5 DR. HWONG: Maybe a little slower,
6 too, would be helpful, too.

7 DR. PALESTRANT: I have an issue
8 with the age criteria. And this is not just
9 applicable to this -- to diabetes, but to your
10 other chronic diseases as well.

11 After age 75, as you know, all of
12 these diseases increase in prevalence and
13 that's also where the majority of cost is,
14 especially for Medicare, which is one of the
15 areas that you're looking at. So it seems
16 sort of strange to me that 75 is your cut-off.

17 DR. HWONG: So to summarize, your
18 concern is that 75, you know, may be too low
19 a cut-off in terms of the upper age limit?

20 DR. PALESTRANT: Right. You know,
21 as people get -- you know, the average life
22 expectancy for a male in this country is

1 somewhere around 75. So half the patients
2 basically are going to be above that age where
3 they die, and it's also going to be where the
4 highest use of health care resources is within
5 the last three months of life.

6 So if we don't include those
7 patients, I don't think we're getting a true -
8 - you know, it's consistent, I agree. But I
9 would think we'd want to measure the time when
10 the utilization is going to be most costly and
11 most resource intensive.

12 MR. HAMLIN: Yes, that's a comment
13 we frequently hear. Again, this is an issue
14 of the criteria being a derivative of our
15 HEDIS product. The original justification for
16 the 18 to 75 under HEDIS effectively was the
17 care side was that management of diabetes over
18 the age of 75, when these measures were
19 developed, became much more complex. And so
20 we didn't want to be attributing much more
21 complex management of people with chronic
22 diseases to levels that were maybe more

1 appropriate for some of the younger
2 population.

3 And again, there would be relative
4 resource use measures reflect that, again
5 those HEDIS definitions.

6 The current HEDIS effectiveness of
7 care diabetes group is looking at age criteria
8 as now diabetics are becoming older and older
9 and not having as many comorbidities or
10 complications, and so therefore they're
11 examining the upper age thresholds. Should
12 that happen on a diabetes HEDIS side, it will
13 definitely be reflected in the RRU side and
14 we'll probably increasingly be incorporating
15 geriatric and the older populations in our
16 measurement strategy.

17 But for now, again, we're just --
18 we're in line with the current HEDIS and cost
19 approaches.

20 DR. HWONG: Yes. Personally I
21 think there are some advantages to be able to
22 kind of line that up with the quality. I

1 mean, this is the whole concept, right,
2 tagging the quality measure with the actual,
3 you know, resource use measure. So I see sort
4 of the advantage of that.

5 The interesting thing, and you
6 know, I also agree sort of maybe later on if
7 there are sort of opportunities to do sort of
8 different -- again, some of these categories,
9 break it out, but sort of for specifically,
10 like if you're reporting on the Medicare line
11 of business, you know, doing only the 65 to
12 75, you know, you could potentially expand
13 that. And especially for, you know, health
14 plan indications or sort of the Medicaid rates
15 or the SSB kind of state sponsored business
16 population. You know, a pediatric, you know,
17 version maybe, you know, of interest,
18 especially, you know, in terms of the growing
19 incidence of diabetes.

20 So you know, some interesting
21 things that kind of come out of thinking, you
22 know, about the age sort of criteria that --

1 MR. HAMLIN: Yes, there's actually
2 a pediatricians' group right now working on
3 that. And gain, if those were developed for
4 HEDIS, we would immediately include that as
5 perhaps an age strata in the diabetes, like we
6 do for asthma.

7 DR. HWONG: Excellent, thank you.

8 MR. HAMLIN: So they're working
9 hard.

10 CO-CHAIR ROSENZWEIG: After age
11 75, a lot of the non-diabetes related medical
12 issues swamp out the diabetes-related medical
13 issues. So you're dealing with end of life
14 care, a lot of very expensive kinds of issues
15 with Alzheimer's disease, a whole variety of
16 conditions that come up that consume a large
17 part of the health care dollar that can be
18 less specifically diabetes related.

19 MR. HAMLIN: And again, after that
20 age it became too hard to sort of -- to parse
21 out the ones that were non-diabetes related
22 and the ones that were. And you know, we

1 don't like too much complexity in our
2 measurements, so we want to keep things as
3 clean as possible.

4 DR. HWONG: Okay. Good, all
5 right. So --

6 MS. TURBYVILLE: Can I add just
7 one --

8 DR. HWONG: Yes, go ahead.

9 MS. TURBYVILLE: Just as a
10 reminder, we did hand out today, as well as
11 emailed earlier, your -- in addition to the
12 lead discussant's comments, your other
13 colleague's discussions. So feel free to look
14 at them and provide your input or whether or
15 not your input is in here as well during the
16 conversation.

17 I just wanted to encourage
18 everyone to do that if it feels right.

19 DR. HWONG: Okay. Great, so why
20 don't we move on to -- I guess we're on 2.B.4
21 then, right?

22 So evidence-based risk adjustment

1 strategy. I think we spent actually a fair
2 amount of time talking about the use of the
3 HCC categorization and how that's assessed and
4 sort of ultimately reported out. So I don't
5 know if we need to go over that any further,
6 unless anybody has another comment?

7 (No response.)

8 DR. HWONG: Okay. So I'm going to
9 move this along.

10 Let's go to 2.B.5, all right,
11 which is methods for scoring allowed for
12 identification of statistically significant or
13 meaningful differences, right. And again, I
14 think there was some good thought put into
15 this. You know, there's sort of a standard
16 sample size, you know, that's required of
17 greater than 400 member cases. You know,
18 you're sort of calculating through observed to
19 expected ratios. And then, you know, in
20 essence sort of the larger numbers you have is
21 sort of standard of error that you'll probably
22 have.

1 So I think you -- as far as when I
2 looked at this, there was a way to actually
3 statistically show, you know, whether someone
4 is an outlier or not, you know, in terms of
5 this. And so there's a very large sort of
6 sample size, you know, requirement there.

7 CO-CHAIR CURTIS: Can I ask a
8 question? Is there any vulnerability to
9 gaming in this type of measure if the payers
10 are submitting their claims to you? How do
11 you know it's a complete set?

12 MR. HAMLIN: Every data submission
13 to NCQA has to go through a very rigorous
14 audit process before they can actually submit
15 the data to NCQA. And so that it's a very
16 well mapped and each auditor has to be
17 certified by NCQA before they can even market
18 themselves as an auditor for this data.

19 So we have fairly high confidence
20 in the data that's being submitted is -- I'm
21 sure there probably are some opportunities for
22 gaming, but it's minimized by the fact that we

1 have this very detailed audit process for
2 submission of data to NCQA before we even use
3 the results.

4 That's it. I'm not going to add
5 anything more, Sally. You were a former
6 auditor, so you know.

7 DR. HWONG: No, no, no, I think
8 that's a very interesting aspect of this
9 measure, that, that's in place, right.
10 Because in terms of the validity or just from
11 the data integrity from these other measure
12 developers or whatever, I don't -- you know,
13 the fact that there is this threat of the
14 audit -- and I know that health plans are
15 always thinking about this, right, but --
16 every year, right?

17 But you know, I think that's an
18 interesting way to kind of, you know, make
19 sure about the integrity about the claims that
20 are submitted.

21 Okay. Yes, any other comments on
22 that area?

1 (No response.)

2 DR. HWONG: And I want to try to
3 move us on to -- if not, let's move on to
4 2.B.6, which I think actually is not
5 applicable. This is the if multiple data
6 sources are specified to demonstrate that, you
7 know, we're producing sort of comparable
8 results. Again, it looks like administrative
9 claims data is the only source of data at this
10 time for this?

11 MR. HAMLIN: Yes.

12 DR. HWONG: Okay.

13 MR. HAMLIN: And anyone using
14 proprietary coding systems has to map to the -
15 -

16 DR. HWONG: Has to translate that?

17 MR. HAMLIN: -- administrative
18 code. So even for EHRs you have to have a
19 specific code for mapping to the diagnosis
20 codes.

21 DR. HWONG: All right. So moving
22 on to 2.C, right. Disparities in care. You

1 know, if they are -- have been identified, you
2 know, measure specs allow for this
3 identification through stratification of
4 results. So I know that when we looked at this
5 in terms of the reporting, there's a way to
6 stratify against age and gender, which is
7 coupled into the HCC categorization.

8 But -- and I think maybe this was
9 that whole broader topic about how good are
10 resource measures in terms of these units of
11 analysis to kind of get at sort of disparities
12 or very -- you know, disparities of care in
13 terms of like ethnicity, socioeconomic, you
14 know, background, et cetera.

15 So you know, I think the best you
16 can say for this one is, you know, age and
17 gender. But it may not get at, you know, some
18 of these other important aspects. But I
19 didn't actually see any other measure
20 developers have a better solution to that,
21 either.

22 MS. TURBYVILLE: Yes, I didn't as

1 well. And to -- no, in reviewing the
2 measures. No.

3 DR. HWONG: Good. So I think
4 we've made it down to three. So if I'm not
5 mistaken, we've gone through all the twos?

6 MS. TURBYVILLE: Are you ready to
7 vote on all these subcriteria from A.2 on.

8 CO-CHAIR ROSENZWEIG: Okay. So
9 now we're going back to 2.A.2.

10 DR. HWONG: 2.A.2.

11 CO-CHAIR ROSENZWEIG: All right.
12 So 2.A.2 is -- all right, so 2.A.2 on the
13 bottom of page 2. All right, the reliability
14 testing, showing that the results were
15 repeatable. And same -- repeatable and also
16 reproducible.

17 DR. HWONG: I rank that as high.
18 Again, so I decided the fact that have we have
19 multiple years of measurement, 90 percent of
20 the plans stayed within the, you know, one
21 quartile. Most did not actually have, you
22 know, a shift, you know, within quartiles at

1 all. So I felt like there was good evidence
2 of this.

3 MS. TURBYVILLE: Okay.

4 CO-CHAIR ROSENZWEIG: Okay. So we
5 already did 2.B.1, I believe, so we're going
6 to go to 2.B.2, validity testing demonstrates
7 that the data elements are correct and they
8 reflect the cost of care or resources provided
9 adequately, distinguishing higher and low cost
10 resource use.

11 DR. HWONG: Sure. So I -- again
12 summarizing, I thought this was sort of
13 moderate. There was a lot of face validity
14 testing in terms of, you know, the
15 modifications of this, looking at sort of
16 conditions you think would be more expensive
17 than others. But again, I just sort of have
18 this, again, from standardized pricing, you
19 know, kind of perspective. You know, I wonder
20 if there is some kind of way to get -- be able
21 to capture that a little bit, you know,
22 further or whatever. So I gave it a moderate

1 rating.

2 CO-CHAIR ROSENZWEIG: Did our
3 statistician have anything else he wanted to
4 say about it or -- oh, he's busy.

5 DR. WEINTRAUB: I don't quite
6 understand your criticism.

7 DR. HWONG: Sure, yes.

8 DR. WEINTRAUB: I guess your
9 criticism reflects your -- I'm sorry.

10 I don't understand your criticism,
11 why you're rating this moderate. I seem to be
12 on the higher end of criticism around here.
13 But I'm not sure what else they could
14 realistically do. You have to make some
15 choices about standardized pricing, or
16 something much, much more difficult. And
17 perhaps less generalizable. So I'm not quite
18 -

19 DR. HWONG: Yes, no, no. I mean,
20 I'm not -- I think there are advantages of
21 using the standardized pricing tables and sort
22 of the technique as being presented. I think

1 it was much more about the validity testing to
2 say, you know, have you analyzed -- you know,
3 and maybe I'm, you know, this is completely
4 irrelevant. But I was thinking like, you
5 know, it would be interesting to see how this
6 looks if we were to compare this to just
7 actual costs, you know, for a particular plan.

8 DR. WEINTRAUB: But there is no
9 such thing.

10 DR. HWONG: Okay.

11 DR. WEINTRAUB: I mean --

12 DR. HWONG: Maybe that's where I -
13 - you know --

14 DR. WEINTRAUB: Unless you're
15 thinking of a large sample, you can do
16 microcosting. Well you know, very, very hard
17 to do.

18 DR. HWONG: Yes. So that was my
19 only reason that I thought, you know, perhaps
20 there could have been some more discussion or
21 evidence of that, and that's the only reason
22 I ranked it as moderate.

1 CO-CHAIR ROSENZWEIG: But there
2 are a lot of -- I mean, with respect to
3 coding, there are a lot of errors that are
4 made, that they have to kind of take into
5 account, as a part of what they're doing. I
6 mean, is that --

7 DR. WEINTRAUB: That's another
8 story entirely. Misclassification coding
9 errors where you're using claims data here,
10 it's -- is you know, it's pretty -- we all
11 know it's pretty dirty stuff.

12 DR. HWONG: Right. I guess -- and
13 again, I was just sort of thinking from
14 validity, right, like how valid is this
15 assessment, and it gets down to kind of the
16 data elements and the costs, right. And then
17 do the costs truly reflect kind of the
18 resource utilization that's happening in a
19 given system based on their contracted fees
20 and, you know -- you know, I think that was
21 sort of what I was trying to get at.

22 But again, I'm sure everybody has

1 the opportunity to vote. So okay, so maybe we
2 can move on on that.

3 CO-CHAIR ROSENZWEIG: Okay.

4 DR. HWONG: So go ahead. Okay.

5 CO-CHAIR ROSENZWEIG: People I
6 guess took your point of view in mind.

7 (Laughter.)

8 CO-CHAIR ROSENZWEIG: All right.
9 So let's go to 2.B.3. The issues of
10 exclusions, that they're supported by the
11 clinical evidence, and you went through the
12 exclusions to a certain extent. And that the
13 scoring include computing exclusions so that
14 the effect on the measure is transparent.

15 DR. HWONG: Right. So I was kind
16 of borderline moderate/high, but I think I've
17 gone to high, given some of the, you know,
18 explanation and reasoning. But again, my
19 whole concept was just to make sure that
20 nothing got sort of codified in stone and why
21 these and, you know, what was making these
22 particular, you know, four entities, you know,

1 kind of highlighted, and that there was an
2 empiric method.

3 So you know, given that there is
4 sort of this annual process, whatever, I felt
5 more comfortable with this review process.
6 And so I've, you know, put my ranking as high
7 on this one.

8 MS. TURBYVILLE: Waiting for one
9 vote.

10 DR. HWONG: There you go.

11 CO-CHAIR ROSENZWEIG: Okay. And
12 2.B.4, which is --

13 DR. HWONG: Evidence based, yes.

14 CO-CHAIR ROSENZWEIG: -- evidence
15 based, yes.

16 DR. HWONG: This is just some
17 strategy.

18 So I ranked this as high, given
19 our extensive discussion in terms of the HCC
20 categorization and how that would be applied
21 and also used in reporting, stratifying on
22 those -- in those groups so that you can

1 compare.

2 MS. TURBYVILLE: Someone's vote
3 didn't register.

4 CO-CHAIR ROSENZWEIG: Got to press
5 harder.

6 MS. TURBYVILLE: Yes. There you
7 go.

8 CO-CHAIR ROSENZWEIG: I'm
9 surprised there aren't cars that are -- you
10 know, haven't had their alarms going off.

11 (Laughter.)

12 DR. HWONG: Or unlocking ones as
13 we speak, right?

14 (Laughter.)

15 CO-CHAIR ROSENZWEIG: All right,
16 2.B.6 --

17 DR. HWONG: I think 2.B.5.

18 CO-CHAIR ROSENZWEIG: 2.B.5, you
19 know see, I'm just trying to get ahead of
20 myself here.

21 All right, okay, scoring analysis
22 allowed for identification of statistically

1 meaningful -- significant and practically
2 clinically meaningful differences in
3 performance.

4 DR. HWONG: Right. So I mean, I
5 ranked this as high. Again, the unit of
6 analysis on the health plan level, you have
7 over 400 observations. You know, in terms of
8 individual member observations in order to
9 even qualify for the measurement. And you
10 know, again, so given this sort of vast amount
11 of data, I think you're able to sort of
12 calculate, you know, when health plans are
13 sort of statistical outliers or not.

14 DR. WEINTRAUB: Do you have
15 examples of that in the literature from the
16 developer?

17 MS. TURBYVILLE: There's a sample
18 report that they submitted, if you want I'll
19 quickly pull that up.

20 CO-CHAIR ROSENZWEIG: Which one is
21 it?

22 DR. HWONG: Right, and maybe --

1 CO-CHAIR ROSENZWEIG: S-A-D-D?

2 No.

3 DR. HWONG: It's in the -- yes.

4 The measure developer has --

5 CO-CHAIR ROSENZWEIG: No, that's
6 not it.

7 DR. HWONG: -- anywhere in terms
8 of the focus of that, I'm not sure which one
9 would be the best descriptor. I was sort of more
10 -- sort of summarizing conceptually kind of
11 what I was reading.

12 MR. HAMLIN: Right, and I think we
13 gave you two in our sample reports. One was
14 the chart of the plan by plan comparison of
15 sort of the total medical ratios, if you will,
16 of everything -- our revenue of one, which is
17 what you're seeing there. That's an
18 individual plan detail.

19 So this would be one plan. So
20 each of those different service categories
21 that you're looking at -- this is an older
22 report, I just pulled this example from an

1 older report. So you're looking at --

2 CO-CHAIR ROSENZWEIG: This is real
3 data, this isn't just a mock-up?

4 MR. HAMLIN: Exactly. I think
5 it's like 2008 data or something. This is,
6 like I said, older data to identify the plan.

7 So each plan gets a detailed
8 report, which is national and regional
9 results. The ratios you're seeing there are
10 the total medical ratios, so you can see sort
11 of -- the numbers are so small I can't really
12 see it from back here. But effectively, a one
13 is the normalized mean. And then the, you
14 know, plans for each of those categories that
15 are below one have lower resource use, that
16 are above one have higher resource use.

17 So the quality composite is the
18 HEDIS measures that we use that are relevant
19 to diabetes. There are ten measures that were
20 used for this one out of basically the entire
21 diabetes composite. That creates the quality
22 composite, and then the total medical is

1 actually the resource use ratio. And then the
2 pharmacy is, again, the resource use ratio.
3 And then below that are all the subcategory
4 components of the total medical. So you can
5 see the inpatient/outpatient breakdown.

6 CO-CHAIR ROSENZWEIG: This is one
7 plan solely?

8 MR. HAMLIN: One plan.

9 CO-CHAIR ROSENZWEIG: No, no, go
10 further down, there's another --

11 MR. HAMLIN: So also included in
12 these results are the scatterflies, where you
13 see -- so this is where you see for each plan,
14 the research use map with quality, and the
15 dotted lines are the -- are the mean of one.
16 So that's where you see the variation in the
17 resource use and the quality. And this is
18 what shows up, like, you would see commercial
19 HMO's for diabetes would be what this would --
20 would probably this would be included.

21 And the plan, can you see the red
22 -- yes, the red plan would be the one plan

1 that was selected, when you selected a scatter
2 plot. And like I said, any plan that falls
3 above the 1.5 or below .5 would be Winsorized,
4 and it would show as a little diamond on the
5 edge of the graph where it was Winsorized to.
6 But any plan that was less than .3 or greater
7 than 3 would not show on this graph at all
8 because those would be considered outliers.

9 CO-CHAIR ROSENZWEIG: And how many
10 of your HEDIS measures did you use for the
11 quality composite?

12 MR. HAMLIN: The diabetes quality
13 composite, I believe the most is ten. Just
14 here it's nine because we just converted the
15 blood pressure measure to first-year measure
16 status. But it's the greatest number of
17 quality measures, yes. We use the whole
18 diabetes quality composite, so we have the
19 best -- this has the best variation in the
20 quality component because it has so many
21 indicators in it. Asthma and hypertension as
22 one, so there -- you don't see as much in the

1 quality variation. But even so, you still see
2 broad resource use, interestingly enough.

3 CO-CHAIR ROSENZWEIG: That's very
4 impressive.

5 DR. HWONG: Yes. Okay. So I rank
6 that as high for this meaningful -- you know,
7 find meaningful differences and representing
8 that as such.

9 CO-CHAIR ROSENZWEIG: Okay. And
10 2.B.6 --

11 DR. HWONG: I think we said that
12 doesn't apply.

13 CO-CHAIR ROSENZWEIG: That doesn't
14 apply, right?

15 DR. HWONG: Yes, multiple data
16 sources is not applicable.

17 And then I think 2.C -- I don't
18 know what we've been voting on, again -- sort
19 of across again. That's just sort of this age
20 and gender and we're not able to take into
21 other considerations given the sort of
22 administrative claims data limitations.

1 So I mean, I sort of -- I sort of
2 previously just ranked it as moderate because
3 you can only do age and gender, but that may
4 be the same for all measure developers.

5 CO-CHAIR ROSENZWEIG: And region,
6 yes.

7 DR. HWONG: And I guess region,
8 yes.

9 MS. TURBYVILLE: We'll be sure to
10 capture that rationale in the report, too.

11 DR. HWONG: Sure.

12 Okay. All right, so I think we're
13 ready to move on to items three and four,
14 collectively, right?

15 CO-CHAIR ROSENZWEIG: Correct.

16 DR. HWONG: Which hopefully we can
17 get through fairly quickly.

18 So let's see what I have in here.
19 So we start on like 3.A, right? Let's see,
20 measure performance results are reported to
21 public at large and national community
22 reporting. I rank this as high. You know,

1 these relative resource use measures are
2 reported in "Quality Compass" and "Annual
3 State of Quality Health Care" reports, so
4 they're visible. They have had sort of an
5 audience and, you know, they're -- yes, I mean
6 I think they have high visibility and they are
7 reported to the public in these publications.

8 I'm sorry, so let me move through
9 the rest of 3. So results are meaningful,
10 understandable. You know again, sort of
11 representation of the results are done sort of
12 in a very clear way.

13 And then NCQA mentioned in the
14 documentation that they have a series of
15 webinars, resource documents, they frequently
16 go back for stakeholder feedback, et cetera,
17 to inform -- you know, inform how this
18 information is ultimately presented. So I
19 thought that -- I ranked that as high as well.

20 Transparency, I said was high as
21 well. They're very clear regarding their
22 specs and process. I appreciated the detail

1 that they went into, you know, both in the
2 standardized pricing tables as well as the
3 HCC, you know, methodology. So I thought --
4 you know, so what was represented here would
5 allow for, you know, physicians and health
6 plans or large groups to kind of understand
7 how the score was ultimately generated. So I
8 ranked that as high.

9 I think 3.D is not applicable
10 right now because that's harmonization.

11 Again, part of these advantages I
12 think is simply because they have been in use
13 for like the last four years now. So they're
14 visible, you know, there's been opportunities
15 to have that kind of feedback to make those
16 results more understandable.

17 Okay, shall we vote?

18 CO-CHAIR ROSENZWEIG: Yes, I think
19 -- okay, so let's go to 3.A. We're talking
20 about current use and --

21 DR. HWONG: That these are
22 reported in public at large, right?

1 CO-CHAIR ROSENZWEIG: Yes.

2 DR. HWONG: And I ranked this
3 high, you know, for the publications that
4 these are reported in.

5 Great.

6 CO-CHAIR ROSENZWEIG: Finished?

7 MS. TURBYVILLE: Yes.

8 CO-CHAIR ROSENZWEIG: And then the
9 -- are the results meaningful, understandable,
10 useful for the intended audience for both the
11 public reporting and performing quality
12 improvement.

13 DR. HWONG: I ranked this high.
14 So you know, again, webinars, resource
15 documents, stakeholder, you know, feedback.

16 MS. TURBYVILLE: Seven high, one
17 moderate, right?

18 CO-CHAIR ROSENZWEIG: Okay. So
19 the third one is that the data results detail
20 are maintained so that the measure and the
21 logic for defined unit of measure can be
22 decomposed to facilitate transparency. So

1 it's -- and it can also be taken down to its
2 specific components.

3 DR. HWONG: Yes. So yes, I ranked
4 that as high, you know, given some of the
5 detail of the specs. And again, I try and
6 view it from, you know, if you're a practicing
7 physician or a health plan, you know, within
8 a group, you know, how do you get to this
9 score? And I think it is -- well, there is a
10 lot of work involved, I think it is fairly
11 transparent.

12 DR. WEINTRAUB: Well, an
13 individual physician interpreting this would
14 do it within the context of a plan, since
15 they're already proposing that --

16 DR. HWONG: Yes, right. Within
17 the -- exactly. This is at a plan -- yes,
18 right, at a plan level.

19 CO-CHAIR ROSENZWEIG: And we also
20 saw a copy of the reports.

21 DR. HWONG: Yes. Great.

22 CO-CHAIR ROSENZWEIG: And then --

1 DR. HWONG: Okay, so then --

2 CO-CHAIR ROSENZWEIG: You said we
3 did not need to --

4 DR. HWONG: 3.D is not applicable,
5 harmonization, at this time. So I think we
6 can get through 4 very quickly; 3 and 4 are
7 sort of -- kind of run through that.

8 So feasibility -- 4.A is
9 feasibility, is the data generated as a
10 byproduct of the care process? And indeed, it
11 is. This is administrative claims and
12 billing. So that I ranked as high.

13 Is this an electronic source? It
14 is, because it is administrative claims. So
15 that is high as well.

16 Susceptibility to inaccuracies,
17 errors are minimized. And this is where I
18 sort of noted that the fact that NCQA conducts
19 these audits is well known, people have to
20 prep for that. That I think in terms of like,
21 you know, whether its willful or just
22 neglectful kind of errors in terms of the

1 data, I think there's just a lot of
2 apparatuses in place at health plans to
3 actually, you know, make sure about data
4 integrity and what's sort of submitted.

5 So I ranked that as high, simply
6 because there is this auditing arm.

7 DR. WEINTRAUB: Well, you know,
8 you do have a problem with quality of -- with
9 it being administrative claims data. So I
10 mean, it isn't --

11 DR. HWONG: The susceptibility is
12 to inaccuracies.

13 DR. WEINTRAUB: -- I mean, forever
14 -- you know, I mean, you're forever limited by
15 the inaccuracy of that. So what we say about
16 that, I don't know.

17 DR. HWONG: I would say --

18 DR. WEINTRAUB: I would move you
19 to moderate rather than high.

20 DR. HWONG: Right. I would say
21 given the other -- you know, again, all the
22 other measures that we're considering, they

1 were all administrative claims data so they
2 would all be subject to the similar sort of
3 that, you know, versus electronic medical
4 record, et cetera. So you know --

5 DR. WEINTRAUB: Or clinical
6 databases.

7 DR. HWONG: Right. Oh, yes,
8 right. Yes. Registries or something, right?

9 Yes, I mean, I still ranked it
10 high. Again, I thought it's great, you've got
11 this auditing arm. Again, it's well known
12 among health plans to sort of anticipate that
13 there are resources sort of -- you know,
14 devoted to that.

15 So are we voting? Oh, I have to
16 go through -- sorry.

17 And then the one more, just one
18 more. Okay.

19 So 4.D, data collection
20 measurement strategy can be implemented as
21 demonstrated. And you know, I think the proof
22 is in the fact that they are currently being

1 implemented and have been, you know, as such
2 for like the last, you know, four years.

3 So all high for me, in terms of
4 the four subcategories for this -- for number
5 4.

6 CO-CHAIR ROSENZWEIG: Okay. So
7 let's vote.

8 So 4.A is required data is
9 routinely generated and used during care
10 delivery.

11 Okay, 4.B, electronic sources.

12 Okay, 4.C, susceptibility to
13 inaccuracies, errors, unintended consequences.

14 Okay, and then implementability -
15 if that's a real word.

16 Feasibility, that's the proper
17 word.

18 All right, thank you very much.

19 DR. HWONG: Thank you.

20 MS. TURBYVILLE: Should we take a
21 break and then come back in 10, 15 minutes?
22 I don't know, are breaks usually 15 minutes?

1 In 15 minutes, and then we'll pick up another
2 measure.

3 CO-CHAIR ROSENZWEIG: Which one?

4 MS. TURBYVILLE: I'm trying to
5 remember what we agreed to before lunch.

6 CO-CHAIR CURTIS: We've changed
7 since then, so I think we should probably just
8 go back to the -- we'll discuss it.

9 (Whereupon, the above-entitled
10 matter went off the record at 3:45 p.m. and
11 resumed at 4:02 p.m.)

12 CO-CHAIR CURTIS: So we're going
13 to get started. We're going to mix it up one
14 more time, sorry Ashlie. We've lost the team.

15 We're going to go ahead and move
16 to the other ABMS-REF measure, which is the --
17 so 1573, episode of care for management of CAD
18 post-revascularization. And Bill Weintraub's
19 going to lead and I'm the co-discussant.

20 DR. WEINTRAUB: Okay. This one is
21 episode of care, management of coronary artery
22 post-revascularization. This also comes from

1 the American Board of Medical Specialties
2 Research Education Foundation. So this is
3 very similar to the measure that Jeptha
4 presented in such detail this morning.

5 So I'm going to repeat it in
6 exactly the same level of detail and we'll be
7 here until 9:00 o'clock tonight.

8 (Laughter.)

9 DR. WEINTRAUB: No, actually I
10 think because it's so similar, they go about
11 things so similarly that we do not need nearly
12 the level of discussion and detail.

13 Once difference is, unless I'm
14 missing something -- I'm probably missing a
15 lot -- is this is post-revascularization,
16 after the discharge rather than the 30 days to
17 a year. I think that's really okay. They
18 have inpatient and ambulatory facilities under
19 resource use categories. Looks pretty
20 reasonable.

21 This is also, by the way, entirely
22 based on claims data and it's constructed in,

1 as far as I can tell, exactly the same way as
2 the AMI measure. So to identify patients
3 post-revascularization, count their resources.
4 And then the costing approach is going to be
5 also exactly the same.

6 So the testing and reliability are
7 not yet done since this is -- they just made
8 this up. And so I think it is actually a very
9 important issue, important measure of
10 considerable societal interest. We spend a
11 lot on revascularization. We know that there
12 is some variation in care, after people go
13 home after revascularization. For instance
14 there's variation in use of imaging, it's all
15 very uncertain how to go about that. We know
16 a fair amount about disparities of people
17 coming into revascularization, we don't really
18 have much in the way of descriptive data about
19 variations in disparities after.

20 We know about regional variations
21 in use of revascularization, I don't know much
22 about -- I don't know if there's much

1 literature on variation use after. But we
2 know there is at least uncertainty as to what
3 things we should be doing with people post-
4 revascularization.

5 So that's sort of where this is.
6 So I guess we can go through all the first-
7 level measures. So I think that this measure
8 is a measure that makes sense and I think it
9 will be of some value once they're done.

10 DR. MARWICK: Do they include both
11 surgical and post-surgical?

12 DR. WEINTRAUB: Yes. So it's
13 essentially two measures. They're stratified
14 by that, but they're so different that they're
15 really quite different.

16 CO-CHAIR CURTIS: So I just want
17 to make sure so people -- it is different in
18 that this is not -- it's more of a stable CAD
19 population. They've excluded patients with an
20 AMI in the preceding year, I believe -- I've
21 got to look that up again.

22 DR. WEINTRAUB: No, it's true.

1 CO-CHAIR CURTIS: And so they
2 identified that, in this case, the index is
3 not an AMI admission but rather the
4 performance of some revascularization
5 procedure, CABG or PCI. And then the follow-up
6 period is -- you know, starts, I guess, at
7 discharge, although it gets a little unclear
8 to me.

9 DR. WEINTRAUB: That's a little
10 weird, but that's certainly my take.

11 And then the other thing --
12 certainly the category patients with this
13 would be described as stable ischemic heart
14 disease, is what's become a popular term these
15 days.

16 MS. CLARK: And CABG and PCI are
17 combined together?

18 DR. WEINTRAUB: No.

19 MS. CLARK: There's two separate -
20 -

21 DR. WEINTRAUB: Essentially it's
22 two separate -- doing essentially the same

1 thing.

2 CO-CHAIR CURTIS: I thought they
3 were specifying it as one, but including both
4 populations. I didn't think they got so they
5 were going to stratify it.

6 DR. WEINTRAUB: Yes? Well, all
7 right, it may be just my take.

8 DR. REEDER: What's the level of
9 analysis?

10 DR. WEINTRAUB: What do you mean,
11 what's the level? Do you mean is it --

12 CO-CHAIR CURTIS: Provider?

13 DR. WEINTRAUB: Oh, I see,
14 provider. They are unclear.

15 DR. REEDER: It says per episode
16 of care.

17 DR. WEINTRAUB: They say anywhere
18 from the individual practitioner to the health
19 plan level. They're unclear about that.

20 DR. REEDER: Okay.

21 DR. WEINTRAUB: Similar to this
22 morning's discussion with the AMI measure.

1 MS. TURBYVILLE: I just want to
2 say that they're clear that they believe this
3 measure could be used at a individual provider
4 level. It could be used rolled up to a health
5 plan as specified. So what is up to you is,
6 as specified, can it be implemented and does
7 it make sense, et cetera. So yes, right.

8 DR. WEINTRAUB: Right. So this is
9 my discussion this morning about, as Jeptha
10 was presenting it, it's the same. That they
11 say they can do it, yes, from the level of the
12 provider through the health plan. And I think
13 it seems unlikely to me.

14 DR. REEDER: Thank you.

15 DR. WEINTRAUB: So it seems to me

16 --

17 CO-CHAIR CURTIS: I think we took
18 the overview, and take a step back to go to
19 importance, which I think you --

20 DR. WEINTRAUB: So do we want to
21 discuss this more? Or both?

22 CO-CHAIR CURTIS: It's probably --

1 I don't know. I don't know if people are
2 clear on how they specified the importance of
3 it. But I think it does overlap with the
4 previously discussed measure, in that this is
5 a CAD high-impact area. So that's easy. The
6 disparities, yes. So to stick to your bottom
7 line, I think we can use the same criteria and
8 the same discussion from this morning to vote
9 on importance. But I want to make sure it's
10 clear in everybody's head, exactly where we're
11 at.

12 DR. WEINTRAUB: And I rated the
13 importance of this as high.

14 CO-CHAIR ROSENZWEIG: Timeframe
15 for revascularization?

16 DR. WEINTRAUB: One year.

17 CO-CHAIR ROSENZWEIG: Thirty days
18 to one year or just --

19 DR. WEINTRAUB: Not entirely
20 clear, but it looks like it's discharge to one
21 year.

22 CO-CHAIR ROSENZWEIG: Discharge to

1 one year?

2 DR. WEINTRAUB: Yes.

3 CO-CHAIR ROSENZWEIG: Okay.

4 DR. WEINTRAUB: That's not
5 unreasonable.

6 MS. TURBYVILLE: I think Tom has a
7 question, too.

8 DR. MARWICK: Yes. And just in
9 terms of their description of the impact, they
10 don't actually talk about a post revas group,
11 they talk about chronic CAD.

12 DR. WEINTRAUB: Well, these are
13 all patients that have had revascularization.

14 DR. MARWICK: No, no, I agree.
15 But if -- it goes back to our discussion this
16 morning as to what we're scoring. Are we
17 scoring what we consider to be the importance
18 of the topic, or how they are portraying the
19 topic? And my understanding is that we're
20 scoring how they're portraying the importance
21 of the topic. And their description of the
22 topic is actually talking about chronic CAD,

1 not about the numbers of people that get
2 revascularized and how they're followed up and
3 whether they're managed inappropriately, or
4 whatever.

5 CO-CHAIR ROSENZWEIG: That's a
6 good point.

7 DR. REEDER: It says on page 5
8 this measure can be used to identify, and if
9 necessary address unwarranted variability in
10 the resources used to treat CAD patients post-
11 revascularization annually. So it is the
12 treatment of patients who have CAD, but who
13 also have been revascularized from discharge
14 up to 12 months.

15 DR. WEINTRAUB: Well, I think our
16 -- I have a feeling we're dancing on the head
17 of a pin here. These are patients who, with
18 chronic stable ischemic heart disease - really
19 I think they did pretty well, actually, which
20 is okay. These are patients with stable
21 ischemic heart disease who are revascularized.
22 And then from that point forward, we are

1 looking at resource use.

2 DR. MARWICK: I understand, we're
3 completely on the same page about what this is
4 about.

5 My observation is about, if we're
6 giving the imprimatur to how this is put
7 together, then the background information that
8 they've provided is not about a post-
9 revascularization population, it's about
10 chronic CAD. So if we're scoring the
11 importance of it based on how they're spinning
12 the importance here, they haven't actually
13 done a very good job.

14 CO-CHAIR CURTIS: But I would
15 argue, I agree, but I would argue that this is
16 another one of these semi-paired measures
17 where there is a CAD without revascularization
18 or some other cohort that's similar, I
19 believe, that we're going to review tomorrow.
20 Am I correct in that? I believe so.

21 MS. TURBYVILLE: 1572, I believe
22 is --

1 CO-CHAIR CURTIS: Right. So I
2 think they're probably just using a generic
3 discussion for the overall stable CAD
4 population, and not specifying. They do cite
5 one paper that focuses on differences in
6 utilization post-VCI.

7 DR. STROUPE: This is the MS
8 measurement developer, I'm Kevin Stroupe.

9 That's exactly right, there are
10 two separate measures. One regarding CHF
11 which -- chronic CAD, which was looking at a
12 stable chronic management period for a year
13 period of time, and then there was also the
14 post-revascularization measurement period,
15 which is also trying to look at -- that would
16 be a similar type of population, but following
17 post-discharge for revascularization.

18 DR. WEINTRAUB: All right. So let
19 me just ask you a simpler question. The
20 period here is from discharge to one year, is
21 that correct?

22 DR. STROUPE: That's correct.

1 CO-CHAIR CURTIS: All right, so
2 I'm ready to vote on importance, if everybody
3 else is, before we degenerate.

4 So getting back onto the specific
5 criteria which I now -- so in terms of the
6 importance, 1.A, the impact, grab your
7 keychains. I think we can agree that this is
8 a high-impact area or disease.

9 Go ahead and vote.

10 And then for 1.B, is there a
11 performance gap demonstrated in the data?
12 Bill, how did you vote that for preliminary
13 review?

14 DR. WEINTRAUB: I voted it high,
15 but I was probably being generous.

16 CO-CHAIR CURTIS: Okay. So it's -
17 -

18 DR. WEINTRAUB: But I think it
19 probably is, but I'm not sure they've
20 demonstrated it perfectly. I'm not sure the
21 literature would support it. But I think
22 there is that.

1 All right, we're on the same page
2 here.

3 CO-CHAIR CURTIS: Let's go ahead
4 and vote on that.

5 MS. TURBYVILLE: One vote hasn't
6 come through yet.

7 CO-CHAIR ROSENZWEIG: Do you have
8 any sense as to how much of the results are
9 affected by the quality of care after the
10 revascularization or the actual quality of the
11 revascularization procedure?

12 DR. WEINTRAUB: Gosh, that's a
13 great question for research. If you can come
14 up with some good ways of studying that, that
15 would be good.

16 CO-CHAIR ROSENZWEIG: I don't want
17 to get all --

18 CO-CHAIR CURTIS: I would assume
19 it's much more about the system of health care
20 in which the care is delivered as opposed to
21 the quality of the PCI itself.

22 DR. WEINTRAUB: You know, resource

1 utilization is going to be -- you know, it
2 will be driven by -- but I think that
3 selection of patients for vascularization is
4 very difficult. But the quality of
5 revascularization today has almost been
6 commoditized. It's not that -- I don't think
7 it's that variable.

8 CO-CHAIR CURTIS: So one high, six
9 moderate and one insufficient.

10 And moving on to 1.C, the intent
11 of the measure.

12 DR. WEINTRAUB: So the purpose,
13 objective of the resource use measure -- I'll
14 get it right yet, I promise.

15 The purpose of the resource use
16 measure, including its components, and the
17 construct for resource use costs are clearly
18 described.

19 It's not perfect, but I think it's
20 high.

21 (Laughter.)

22 DR. WEINTRAUB: Am I missing

1 something?

2 CO-CHAIR CURTIS: He was trying to
3 vote with his BlackBerry.

4 (Laughter.)

5 CO-CHAIR CURTIS: Let's go ahead
6 and vote on --

7 DR. WEINTRAUB: What? I came to
8 the wrong meeting.

9 MS. TURBYVILLE: I do love you
10 all. You're very different than the surgeons
11 last week. They just sat there. You all put
12 it down and then pick it back up. The
13 surgeons were like aiming at it.

14 DR. WEINTRAUB: Maybe they thought
15 it was a scalpel.

16 CO-CHAIR CURTIS: And finally, the
17 resource use category, whether or not this is
18 -- the appropriate categories are being
19 assessed and consistent with the measure
20 intent, to recap it.

21 So it's our usual issue. Bill, do
22 you have a suggestion on this?

1 DR. WEINTRAUB: Yes, I voted
2 moderate. I don't think they explained this
3 as well as they might have. But you can -- I
4 don't know, it's somewhere between moderate
5 and high.

6 DR. WEINTRAUB: Okay. So we're
7 ready to plunge into the measure. Jephtha took
8 us through in two and a half hours, I'm going
9 to take us through in 15 minutes.

10 CO-CHAIR CURTIS: You're a better
11 man.

12 DR. WEINTRAUB: Probably not.

13 Okay. So their general approach,
14 you've heard for the using claims data to look
15 at resource use in this target population. So
16 as we already heard -- so the patients have to
17 be enrolled for 24 months, similar to what we
18 heard this morning. Describe the data
19 cleaning steps, most of it's fairly
20 straightforward.

21 CO-CHAIR ROSENZWEIG: Bill if you
22 can give us an idea of where you are on the

1 PDF?

2 DR. WEINTRAUB: Okay, sorry. I'm
3 on page 9, looking at the PDF data exclusion
4 category criteria.

5 CO-CHAIR CURTIS: Let me make a
6 suggestion. Perhaps aside from the population
7 definition, if the measure developer could
8 point out how this methodology is different,
9 if at all, from the previously discussed
10 measure on utilization post-AMI? Because as
11 far as I can tell, as Bill's alluded to, data
12 cleaning, data specifications, cost
13 methodology, everything was identical.

14 And so in the absence of a
15 significant difference, as I think Bill is
16 suggesting, we can really just use the --
17 unless there's been a change of opinion, use
18 the same feedback to the measure developer.

19 So let me open that up to the
20 measure developer.

21 DR. WEINTRAUB: Good point.

22 DR. STROUPE: The data cleaning

1 and that, this was similar to the approach
2 before. The difference is just around the
3 particular fact that, for this measure, there
4 again was the same requirement for the
5 continuous coverage and for this period,
6 though, there were -- for this measure, the
7 exclusions that there had to be, there
8 couldn't have been an AMI between 14 and 365
9 days, as far as specific criteria.

10 But then there were the other or a
11 prior revascularization, and then the other
12 sort of standard excluding criteria, the end-
13 state renal disease and cancer and so forth.
14 So basically set for some particular issues
15 around the procedure, prior revascularization
16 or the clinical conditions.

17 And what was looked at as far as
18 revascularization being the triggering event,
19 otherwise the data source that was used for
20 that, the measurement testing and the other
21 data cleaning and so forth were similar to the
22 other measures that have been described.

1 DR. WEINTRAUB: All right. So
2 once again, they do not recommend imputing for
3 missing data, that's 6.4 on page 9.

4 Help me, what am I supposed to do?

5 CO-CHAIR CURTIS: So I think if
6 the only difference is really the inclusion
7 population, I think there are some areas that
8 are worth reviewing on that, and specifically
9 that one that you mentioned. The exclusion of
10 patients with an MI 14 to 365 days before the
11 index revascularization. So I'm not sure
12 where that is in the --

13 DR. WEINTRAUB: Yes, how did you
14 pick that? What's your rationale? Why 14
15 days?

16 DR. STROUPE: The --

17 CO-CHAIR CURTIS: This is page 10
18 of the PDF.

19 DR. STROUPE: The measurement was
20 -- these criteria were worked through in
21 conjunction with a clinical advisory group.
22 And the rationale regarding that was that an

1 AMI -- if we excluded AMIs closer to the
2 triggering event, that the -- there might be
3 some AMI that might be associated with the
4 revascularization that we were wanting to
5 capture to be the triggering event of the
6 episode.

7 DR. WEINTRAUB: So I'm sorry, I'm
8 not following. Are patients included if they
9 have a revascularization within 14 days after
10 an MI?

11 DR. STROUPE: Yes.

12 DR. WEINTRAUB: All right, so this
13 is not -- so what I said was wrong, it's not
14 about stable ischemic heart disease, it's a
15 mix?

16 DR. STROUPE: Well, in that
17 there's that time window when the AMI could
18 have occurred, then leading to the triggering
19 revascularization event.

20 DR. WEINTRAUB: Yes. So then it's
21 a mix of patients with stable ischemic heart
22 disease and patients with -- who have had a

1 recent acute MI?

2 DR. STROUPE: Recent in the -- at
3 least within a two-week period. But prior to
4 that two-week period, they would be excluded.

5 DR. WEINTRAUB: Right.

6 DR. MARWICK: Could I seek some
7 clarification as to whether the identifier is
8 the process of getting the revascularization?
9 Because on page 10 in the clinical framework,
10 the first step is to identify patients,
11 episode inclusion criteria of one ambulatory
12 visit for CAD-related care. That sounds like
13 a chronic CAD descriptor rather than a post-
14 revascularization descriptor.

15 DR. STROUPE: For the patient and
16 the chronic -- in the revascularization
17 measure, the triggering event would be the
18 existence of a -- would be the existence of
19 the revascularization event. That's -- that
20 was the indication that was -- we were looking
21 for to trigger the revascularization measure.

22 DR. MARWICK: Yes, I get that.

1 It's just in the framework it doesn't seem to
2 read like that. Or maybe I've misunderstood
3 it. But it seems to -- in the framework, it
4 seems to read like chronic CAD.

5 CO-CHAIR CURTIS: I think the top
6 level is patients who had a revascularization,
7 either type technique, and in the subsequent
8 12 months they had to have at least one CAD-
9 related resource use to be included in the
10 measure, is the way I interpreted that. So
11 that if for some reason unknown to man, they
12 went back to France or wherever they were
13 from, and they were never heard from again,
14 that they wouldn't be included in this
15 measure. But that might be an assumption on
16 my part?

17 DR. WEINTRAUB: Is that correct?
18 They have to have some evidence of resource
19 use in the year after their revascularization?

20 DR. STROUPE: That right there,
21 there does have to be -- in order to so that
22 we'll be able to capture there, they have to

1 have some use, right. That's correct.

2 DR. MARWICK: That's a source of
3 bias, isn't it? Because if your question is
4 about the costs of management in the year
5 after revascularization, then you don't want
6 to limit it to people that have actually -- to
7 only people that have incurred some cost. I
8 mean, there might be some people that haven't
9 incurred any cost.

10 DR. WEINTRAUB: That would be
11 pretty unusual, to have no resource use at
12 all, unless you're dead or have left the
13 planet, have no resource use at all would be
14 most unusual.

15 DR. STROUPE: There would be a
16 concern with having zero costs that there
17 might be some data missing issues for those
18 particular --

19 DR. WEINTRAUB: I agree, and I'm
20 not that troubled by it. I mean, you don't --
21 they're not asking for very much, they just
22 want to know you haven't disappeared from the

1 planet.

2 So all right. So these are
3 patients 18 years and older. The one this
4 morning I think excluded people over the age
5 of 85. But this one does not. And here we
6 see acute myocardial infarction 14 days to 365
7 days as exclusion, and I missed that.

8 And then they identify patients
9 by, what is it, CPT codes?

10 CO-CHAIR CURTIS: Sorry, I just
11 want to sort of build on that. I don't
12 understand that exclusion of sub-acute
13 infarcts or within the one year prior to or
14 not the 14 days prior to. It just doesn't
15 make sense to me. Either this is a
16 revascularization population or it's not.
17 Right now you kind of have the highest-risk
18 patients, the MIs, the acute MIs, you've got
19 the lower risk ones without any MI, but you're
20 missing that middle of the sandwich, which is
21 the remote MI.

22 DR. WEINTRAUB: Yes, I agree.

1 That's peculiar. Are they going to make a
2 case for no prior MIs, it's purely stable
3 ischemic heart disease, or you could make a
4 case for including anyone with a prior MI.
5 But then of course, someone with really remote
6 MI is included. So it's peculiar, the 14 days
7 to 365 days.

8 DR. STROUPE: That two-week window
9 is that, again, with discussion from our
10 clinical advisory panel, there was concern
11 that by eliminating patients with that
12 diagnosis within that two-week period, that
13 you might be excluding a larger number of
14 patients than we would want, patients where
15 the MI then was related to the
16 revascularization just prior to the trigger.

17 DR. WEINTRAUB: Yes. So I
18 understand. The real question is, why exclude
19 the patients 14 to 365?

20 DR. STROUPE: Oh, why not exclude
21 the patients 14 to --

22 DR. WEINTRAUB: Why exclude them?

1 DR. STROUPE: Oh, why exclude
2 them. The -- from the 14 to the 365, that was
3 to -- so that the population would be, again,
4 one -- trying to get a population that would
5 be more in a stabler or more management phase
6 of the condition.

7 DR. WEINTRAUB: Then you would
8 want to exclude the zero to 14. I mean, you
9 sort of --

10 CO-CHAIR CURTIS: You can't have
11 it both ways, I think is what you're getting
12 at.

13 DR. WEINTRAUB: You can't have it
14 both ways. This is one failure here.

15 CO-CHAIR CURTIS: So I think, you
16 know, we've heard your response. If in the
17 course of matters you want to respond to this
18 more, this would be part of the feedback that
19 we provide to you, but obviously there's a
20 difference of opinion with the members of the
21 TAP.

22 DR. WEINTRAUB: Fair enough, why

1 don't we move on.

2 CO-CHAIR ROSENZWEIG: Are you
3 excluding patients who have had a
4 revascularization in that period of time? A
5 prior revascularization?

6 DR. STROUPE: We -- yes, a prior
7 revascularization. A revascularization is the
8 -- that's that the triggering event is then
9 post-discharge on one year of the patients
10 that we followed in this measure.

11 CO-CHAIR ROSENZWEIG: I don't
12 understand.

13 DR. WEINTRAUB: So consider the
14 timeframe. Someone is within the timeframe of
15 the measure, they have a revascularization.
16 They're not going to enter again for -- at
17 least for the next year. But suppose it's not
18 within the timeframe of the measure. Can
19 someone enter twice? Can someone be in the
20 measure in year one, have a revascularization,
21 year two they come back and have another
22 revascularization? Can they enter the measure

1 again?

2 DR. STROUPE: Within the close
3 revascularization measurement, if someone
4 would have the -- a revascularization within
5 that year -- within that one-year period, that
6 the multiple revascularizations were -- would
7 be allowed in the measure.

8 DR. WEINTRAUB: That's not the
9 question. So that would be additional
10 resource use for the year, the next year. So
11 year one's over, and now they come back in
12 year two. And three months into year two,
13 they have another revascularization. So in
14 year one they have a PCI and 15 months later,
15 when their first year is over, they have CABG,
16 and they enter again as a new
17 revascularization, would then be followed up
18 for yet another year?

19 DR. STROUPE: Oh, would that be --
20 okay.

21 CO-CHAIR CURTIS: Let me just skip
22 to the chase. The answer is yes, because they

1 are screening -- you are screening for other
2 revascularization procedures in the preceding
3 12 months, and that's one of your exclusion
4 criteria. So I think that's pretty clear,
5 that you can enter in a subsequent month more
6 than 12 months set apart.

7 DR. WEINTRAUB: So that's actually
8 very similar to the MI measurement this
9 morning.

10 DR. STROUPE: That would be
11 correct. Within that one-year period you can
12 have the subsequent revascularization, but in
13 the following time period, then if you were
14 starting to measure the first one from that
15 triggering event, and looking prior -- for a
16 prior one-year period, then as noted, that
17 revascularization in year one would be picked
18 up as part of -- during the screening process.

19 DR. WEINTRAUB: But would that
20 kick them out of year two?

21 DR. STROUPE: Could you repeat
22 that, please?

1 DR. WEINTRAUB: So if it's not
2 within 12 months but it was in year one, it
3 still could enter in year two?

4 DR. STROUPE: Within the second
5 year, there's a triggering event in year two
6 and you look back 12 months and there hasn't
7 been a triggering revascularization from year
8 one was more than 12 months before the
9 revascularization in year two --

10 DR. WEINTRAUB: Okay.

11 DR. STROUPE: -- then that could
12 be picked up again.

13 DR. WEINTRAUB: Okay. Everyone
14 got it? Good.

15 All right. So I'm on page 11. So
16 they identify the patients, and then they look
17 for these exclusion criteria in detail. Then
18 they identify the measure population in step
19 four.

20 CO-CHAIR ROSENZWEIG: Why would
21 insertion of a cervical dilator be considered?

22 DR. HWONG: Is that categorized

1 like under a pregnancy-related --

2 CO-CHAIR ROSENZWEIG: It's an
3 exclusion criteria.

4 DR. REEDER: There are a lot of
5 OB/GYN procedures that are in here, and I
6 would ask the same thing.

7 CO-CHAIR ROSENZWEIG: But someone
8 has a Pap smear, I mean, are -- or a -- why
9 would that exclude them? Or someone has a
10 DNC? If someone has a DNC, that shouldn't
11 exclude them from -- am I mistaken?

12 DR. HWONG: I got the sense that
13 the exclusion here, at least for all these
14 codes here, was trying to be -- you know,
15 whether or not it's successful this way, but
16 trying to be related to pregnancy. Because
17 pregnancy, in terms of resource utilization,
18 is you know -- can contribute to costs. So I
19 don't know if it's --

20 CO-CHAIR ROSENZWEIG: Oh, that's
21 all pregnancy related?

22 DR. HWONG: I don't know, like

1 we'd have to have a code, or someone who's
2 very adept at these codes to kind of say,
3 like, how often these codes ever associated
4 with pregnancy. I'm assuming --

5 CO-CHAIR ROSENZWEIG: You're
6 assuming, okay.

7 DR. HWONG: You know, I would
8 assume that, you know, we could kind of look
9 into that. But if the overall concept here is
10 to exclude, you know, patients who have been
11 pregnant at any point, you know, during this
12 measurement period, then maybe -- I get a
13 sense that they're trying to capture that.

14 CO-CHAIR ROSENZWEIG: So DNC --

15 DR. HWONG: Your question is a
16 good one.

17 CO-CHAIR ROSENZWEIG: So a DNC not
18 related to pregnancy shouldn't exclude you?

19 DR. HWONG: Right. So we'd have -
20 - so maybe the comment to go back and just to
21 make sure that these are very specific about
22 pregnancy, right?

1 DR. REEDER: I think it has the V
2 code, the overall general V code for pregnancy
3 in here. So they are trying to get
4 everything.

5 CO-CHAIR ROSENZWEIG: Okay, all
6 right. Sorry.

7 DR. WEINTRAUB: So the exclusion
8 just discussed is very nicely highlighted.
9 The rest is very nicely highlighted here,
10 cancer, end-stage renal disease, organ
11 transplant, HIV/AIDS and things related to
12 pregnancy, largely. It's the kind of things
13 we've actually seen before.

14 They identify their population --
15 I'm on page 11. And then they look at these
16 various events. And again, this is the kind
17 of framework we saw this morning. Rather than
18 trying to capture everything, we're looking at
19 specific areas of resource use.

20 CO-CHAIR CURTIS: And it looks
21 like it's completely identical to that used in
22 the earlier measure.

1 DR. WEINTRAUB: So we have to
2 worry that Mary Ann found coding errors this
3 morning, and they would have to go through
4 this again and make sure, if they're going to
5 do it this way, that they don't have similar
6 errors.

7 So now I'm up to page 12. They're
8 taking out patients less than 18, they justify
9 that.

10 Let's talk about their exclusions
11 again, this is really repetitious of what they
12 have above, and they justify their specific
13 codes on page 13.

14 DR. HWONG: So one thing I was --
15 on page 13, there is this mention about "to be
16 included in the measure, an individual must
17 have an inpatient admission for heart failure
18 or congestive heart failure."

19 Oh, I'm sorry, this is on page --
20 I moved ahead a little bit -- on 12, sliding
21 between 11 and 12 here.

22 So I just wanted to -- I'm trying

1 to recall, but this sort of stratification
2 between you have heart failure, you don't have
3 heart failure, was that in the ABMS version or
4 was that in the --

5 CO-CHAIR CURTIS: We should ask
6 the measure developer for help on this.

7 DR. WEINTRAUB: Yes.

8 CO-CHAIR CURTIS: But it's not
9 specified elsewhere, and I assume that that
10 was a typo or an oversight --

11 DR. HWONG: Yes.

12 CO-CHAIR CURTIS: -- where they
13 were trying to put seven applications in in a
14 very short time.

15 DR. HWONG: Sure, yes. So yes, if
16 that's something we can sort of disregard,
17 that's good to know, right?

18 DR. WEINTRAUB: So let's ask the
19 developer?

20 DR. STROUPE: That was probably a
21 typo.

22 DR. HWONG: Okay, good. So

1 there's no -- nothing about having to have
2 heart failure to be included in the measure?

3 DR. STROUPE: No.

4 DR. WEINTRAUB: That would make no
5 sense.

6 DR. HWONG: I just wanted to make
7 sure. Okay.

8 DR. WEINTRAUB: So they go through
9 a lot of their logic on page 13 and into 14.
10 They do not -- they're not specifying severity
11 levels.

12 CO-CHAIR CURTIS: Which I think is
13 in contrast to the other measure, where they
14 stratified by heart failure.

15 DR. WEINTRAUB: They said, we
16 attempt to create a relatively homogeneous
17 population through our inclusion/exclusion
18 criteria. Well, lots of luck. The
19 variability of patients undergoing a
20 revascularization is extreme, and right now
21 they've got both patients who are recently
22 post-acute MI and patients with stable

1 ischemic heart disease.

2 MS. TURBYVILLE: It seemed like
3 they would want to look at stratification
4 based on diabetes status, right? Those are
5 usually --

6 DR. WEINTRAUB: So you know, I
7 think that, do you want to stratify on it or
8 do you want to be able to examine it as a
9 subgroup? I mean, they really -- I would
10 stratify on type of revascularization, because
11 they're so very different, percutaneous and
12 CABG.

13 For other things, diabetes, non-
14 diabetes, heart failure, no heart failure,
15 severity of coronary disease, age and gender,
16 those can really be examined in subgroups
17 rather than stratify. That's how I would
18 handle it.

19 The idea that they're a
20 homogeneous population doesn't make sense.

21 DR. MARWICK: You would also want
22 to stratify on acute and chronic.

1 DR. WEINTRAUB: Yes, if they're
2 going to do it that way. Revascularization
3 setting of a recent acute myocardial
4 infarction and stable ischemic heart disease
5 are pretty different.

6 That being said, I've just gone
7 through this recently about stratifying versus
8 all within one analysis for ischemic -- first,
9 stable versus acute and there's no perfect
10 answer to it.

11 (Off mic comment.)

12 DR. WEINTRAUB: No, that was --
13 it's not in this.

14 MS. TURBYVILLE: Typo.

15 DR. WEINTRAUB: That was a typo.
16 Actually, they said it was an inclusion
17 criteria, but that was a typo.

18 CO-CHAIR ROSENZWEIG: So it's an
19 exclusion?

20 DR. WEINTRAUB: No.

21 CO-CHAIR CURTIS: It's just --

22 CO-CHAIR ROSENZWEIG: So shouldn't

1 there be some stratification based upon CHF?

2 DR. WEINTRAUB: So do you want to
3 stratify all these different things, or are
4 they really co-variants or subgroups? I think
5 to stratify on all of the different things
6 doesn't make sense. I mean, stratification
7 means you're only analyzing within the group.
8 So I would say diabetes, heart failure,
9 severity of disease, left ventricular
10 function, age and gender are subgroups without
11 stratifying variables. But I think that
12 logically, type of revascularization is.

13 And you could argue acute versus
14 non-acute.

15 CO-CHAIR CURTIS: And so just let
16 me ask the measure developer that question.
17 Is since you are including two very types of
18 procedures, and certainly resource use would -
19 - in the following year would be expected
20 based on clinical trials, to vary by that
21 procedure, did you consider again stratifying
22 your subgroup reporting by procedure? I

1 didn't see that in the application, but maybe
2 I missed it.

3 DR. STROUPE: Yes, the
4 stratification that was -- had been so far was
5 stratifying regarding whether the patient had
6 a subsequent or only one revascularization.
7 But that's certainly another group.

8 DR. WEINTRAUB: I don't follow
9 that. That doesn't quite make sense.

10 DR. STROUPE: The stratification
11 that was -- that is originally proposed in the
12 measure is to stratify individuals based on
13 following the trigger event, whether they had
14 no subsequent revascularization or whether
15 they did have a subsequent --

16 DR. WEINTRAUB: That's an outcome,
17 that's not a stratification variable.

18 CO-CHAIR ROSENZWEIG: Maybe he's
19 thinking prior --

20 DR. WEINTRAUB: Maybe.

21 CO-CHAIR CURTIS: But it is -- as
22 currently specified, you guys have

1 demonstrated your intent to stratify by number
2 of revascularization procedures in the
3 following 365 days?

4 DR. STROUPE: Right.

5 DR. WEINTRAUB: Where does it say
6 that?

7 CO-CHAIR ROSENZWEIG: They say
8 they're not going to stratify --

9 CO-CHAIR CURTIS: No, they -- so
10 bottom of page 20 -- sorry, bottom of page 20,
11 section 10.2, the patients included in the
12 revascularization measure will be stratified
13 by whether patients did or did not have
14 multiple revascularizations during the 12-
15 month measure period.

16 DR. WEINTRAUB: That doesn't make
17 any sense.

18 CO-CHAIR CURTIS: Which I flagged
19 myself as being nonsensical.

20 DR. WEINTRAUB: That's
21 sufficiently nonsensical.

22 CO-CHAIR CURTIS: So do you want

1 to provide the rationale for that? Because I
2 think in most cases, that would be in your
3 outcome of resource use, would be subsequent
4 revascularization.

5 DR. STROUPE: That there are
6 patients requiring a multiple
7 revascularization, those might require the
8 higher resource use patient that could be
9 looked at separately from the ones that didn't
10 have a subsequent revascularization. For
11 keeping a more homogeneous population of
12 individuals for the analysis.

13 DR. WEINTRAUB: Well, the problem
14 is that you cannot -- if you're doing that, if
15 you stratify that way, then you can't use it
16 as an outcomes measure. So it doesn't -- it
17 really doesn't make sense. Once you
18 stratified, you can't go back and say, well,
19 now I want to unstratify. I mean, I just
20 don't think that that makes any sense. The
21 stratification variable is essentially always
22 a variable that you have in hand in the

1 beginning.

2 DR. MARWICK: I wonder for the
3 developer, if you could get a -- we could get
4 at your intent by stipulating the difference
5 between the people that have had a single and
6 multiple previous revascularizations, you
7 could say --

8 DR. WEINTRAUB: That's not what it
9 says.

10 DR. MARWICK: No, I know it's not
11 what it says. But I wonder if that's the
12 intent of the developer, in terms of people
13 that have had multiple previous episodes are
14 more likely to cost more?

15 DR. STROUPE: Well, with the prior
16 episodes, that would be the case. That they
17 would have been excluded from the measure.
18 Trying again to create a sample that would be
19 --

20 DR. WEINTRAUB: Within the 365
21 days?

22 DR. STROUPE: -- it would be more

1 homogeneous. This then, just looking at the
2 resource use pattern following the discharge,
3 that those individuals with the subsequent
4 revascularization might have other outcome --
5 other costs that would -- higher cost profile.
6 And just to keep the groups that would be more
7 similar for --

8 DR. WEINTRAUB: I think we need to
9 cut this off here or we'll be on it all day.
10 I think this is one of the feedback points we
11 have to give them, that we think there's
12 problems with the construction logic.

13 MS. CLARK: I wonder about multi-
14 vessel disease, whether that might be an
15 appropriate way to stratify?

16 CO-CHAIR CURTIS: That is what
17 this is really trying to capture, but it's
18 unacceptable.

19 DR. WEINTRAUB: Well, it doesn't -
20 - no, it doesn't get at that.

21 MS. CLARK: No, but they could.

22 DR. WEINTRAUB: They could, but I

1 wouldn't advise it. Again, I think that
2 that's a co-variant, or should be looked at as
3 a subgroup.

4 MS. CLARK: Well, in terms of --

5 DR. WEINTRAUB: Stratification
6 means that you think that these are really
7 different things and you want to analyze them
8 separately. Otherwise, there's little reason
9 to stratify. So I think you want to look at
10 resource use after PCI and after CABG, you
11 want to look at those separately.

12 Now you may want to compare
13 across, that's another story. But I don't
14 think that this is not a comparative
15 effectiveness study of different
16 revascularization strategies.

17 MS. TURBYVILLE: Just a question.
18 Is that the only purpose for restratification?
19 Or is it also -- or is it -- just to make sure
20 that -

21 DR. WEINTRAUB: Within a
22 randomized trial, the reason for

1 stratification is to impose balance between
2 groups. For reasons for -- you don't have to
3 stratify this at all. You can still look at
4 it as a subgroup. You could do that.

5 My reason I would think of these
6 as separate strata is the description of
7 resource use in a gamish that includes both
8 PCI and CABG, doesn't to me make a lot of
9 sense.

10 MS. TURBYVILLE: I just bring it
11 up because some of the approaches that I've
12 seen across developers is they'll estimate the
13 measures as a whole, but then encourage the
14 users to stratify to increase not -- to look
15 at the whole, but also to increase
16 actionability at a sub-population level. But
17 I'm not trying to disagree, I'm just trying to
18 think through --

19 CO-CHAIR CURTIS: But I think
20 Bill's point is that those are subgroups as
21 opposed to stratified analyses. Is that --

22 DR. WEINTRAUB: I mean, you should

1 always -- so how do you go about developing
2 subgroups? The idea of subgroups in any
3 analytic framework you want is for there to be
4 a small number, have a pathophysiologic basis
5 and specify in advance. I'm not hearing a lot
6 about proper development of subgroups in the
7 measures we're talking about here.

8 MS. TURBYVILLE: I just wonder how
9 much in -- that even NQF has indicated the
10 difference between a strata and a subgroup, in
11 thinking about how you propose users use the
12 measure, not in any way disagreeing with what
13 you're saying. I'm just wondering how much
14 guidance we've actually given on that.

15 CO-CHAIR CURTIS: I think this is
16 actually a minor point in the overall
17 evaluation. But it does indicate some concern
18 about the clinical sensibility approach, and
19 particularly if you're going to stratify based
20 on an outcome. This just doesn't make sense.

21 DR. WEINTRAUB: Yeah. Well,
22 certainly stratifying based on outcomes makes

1 no sense.

2 CO-CHAIR CURTIS: We'll put that
3 in the back parking lot and go on.

4 DR. WEINTRAUB: I mean, the whole
5 thing where strata and subgroups comes from
6 the clinical trial world, and you'd be
7 applying it here. But I think there -- you
8 know, there are reasons to think about that.
9 Because that would overlap in their logic for
10 reasons I raised.

11 Okay. So moving on. So then a
12 lot of this is just sort of mechanical, on
13 page 15, on how they're doing this.

14 And then they're using -- as I
15 understand it, they're using the same approach
16 to standardized pricing we heard about this
17 morning. I didn't really fully understand it
18 from their description here, but they
19 explained it this morning.

20 Is your approach to pricing in
21 this measure the same as in the AMI measure?

22 DR. STROUPE: Yes, it is. The

1 pricing approach is the same.

2 DR. WEINTRAUB: All right. I'm on
3 page 16. And again, here they do mention the
4 strata again here. Then we go to the next, is
5 also on page 16 --

6 DR. HWONG: Sorry, could you go
7 back? I know this morning when we talked
8 about the Ingenix measure, it kind of went by
9 a little fast.

10 DR. WEINTRAUB: Do you mean
11 Ingenix or do you mean ABMS?

12 DR. HWONG: The --

13 DR. WEINTRAUB: You mean this same
14 developer?

15 DR. HWONG: Yes. You know,
16 previously I think it was taken off the table.

17 DR. WEINTRAUB: That was the
18 Ingenix.

19 DR. HWONG: Right. Then me just
20 sort of catching up and understanding the
21 pricing again?

22 DR. WEINTRAUB: This is -- we

1 never even got a description of the pricing
2 from them.

3 DR. HWONG: Okay.

4 DR. WEINTRAUB: This was the
5 pricing from the MI measure we heard this
6 morning from --

7 DR. HWONG: Okay.

8 DR. WEINTRAUB: -- what's this
9 group, ABM.

10 DR. HWONG: ABMS, okay.

11 DR. WEINTRAUB: So they're using
12 the same standardized pricing, based on
13 payments.

14 You want to take -- very, very
15 briefly take us through the costing strategy
16 for the developer, very briefly?

17 DR. STROUPE: The costing
18 strategies, there were three different methods
19 for costing, depending on the type of
20 utilization that we were using.

21 The -- for inpatient events, for
22 inpatient and for -- for inpatient, there's

1 one for ambulatory, pharmacy, and then for all
2 other events.

3 For the inpatient, a DRG was
4 determined, and then using a pricing table for
5 a cost per DRG, the length of stay that the
6 patient incurred during the measurement
7 period. So if the hospitalization occurred
8 but then extended beyond the 12-month
9 measurement period, those length of stay days
10 weren't included. But for the length of stay
11 days that were in the measurement period, that
12 was multiplied by a cost for DRG to get the
13 inpatient amount.

14 CO-CHAIR CURTIS: And this is
15 overlapping or comparable to the NCQA
16 methodology for defining inpatient, correct?

17 DR. STROUPE: That's correct.

18 And then there's some -- another
19 coding in -- for situations without the DRG.
20 So that's sort of a cost per day approach, was
21 the approach that was used for the inpatient
22 cost.

1 For the medication cost, for the
2 data set that was available for the testing
3 purpose, we took -- determined the -- for each
4 NDC code, the base supply all the medication.
5 And in addition to that, the cost for -- so
6 for each NDC, the cost and the base supply.

7 And then determined for each NDC
8 what an average cost per day would be, for
9 each NDC code. And then for the data that --
10 for the patients that were in the measure, we
11 would have information on the NDC code for
12 their medication they received as well as the
13 days supplied. So for each NDC we would
14 multiply the days supplied by the cost per
15 days supplied for that NDC code.

16 For the other, the ambulatory
17 care, E&M, so forth, the -- a cost per the CPT
18 code and CPT code modifier combination was
19 determined for the entire data set. And then
20 that cost was used to estimate a cost for each
21 of the code events for the -- that occurred
22 during the measurement period for the

1 individuals in the -- that were identified for
2 the measure.

3 So those are the three approaches
4 that were used to estimate the cost of
5 inpatient, ambulatory, pharmacy and the other
6 health care.

7 MS. CLARK: And the cost for CPT
8 code modifier combination, that's coming from
9 the Thomson-Reuters database?

10 DR. STROUPE: That's correct.
11 That's by taking the data that were available
12 and then using that to generate those values.

13 MS. CLARK: And is that including
14 -- you know, if there was a facility component
15 and a professional component? So for example,
16 if somebody had a re-PCI and it was an
17 outpatient procedure, which about 25 percent
18 are outpatient, you're including the facility
19 cost as well as the physician cost at the CPT
20 modifier level?

21 DR. STROUPE: That would be for
22 the -- it would be the cost that was in the --

1 within the database. And so that would be
2 primarily for the facility component.

3 DR. WEINTRAUB: So how are you
4 handling professional costing?

5 DR. STROUPE: The cost for the
6 E&M, for things related to that. But
7 basically regarding the cost for the CPT codes
8 that were in the database.

9 DR. WEINTRAUB: All right. So you
10 know, I think we have to -- one of our
11 comments back to them that they'll have to
12 provide better clarification of their costing
13 strategies. I suspect that's true of the AMI
14 measure as well, we didn't go through it in
15 the detail we probably should have. Because
16 we didn't spend enough time on it this
17 morning.

18 (Laughter.)

19 DR. WEINTRAUB: All right. So I'm
20 on page 16 to 17 of resource use service
21 categories. And those are pretty good.
22 They've already said that above so it sort of

1 becomes repetitious. And then they go
2 identify this.

3 And then care settings, and that's
4 all in the bottom of 17, it's pretty
5 straightforward.

6 And then the risk adjustment
7 methodology, as far as I can tell, is exactly
8 the same as we heard this morning. So there's
9 no perfect way of doing this, but it's as
10 reasonable as any.

11 DR. STROUPE: That's correct. It
12 was the same, the risk adjustment approach was
13 the same as the other measure that was
14 discussed this morning.

15 CO-CHAIR CURTIS: And again, just
16 like that measure, I think there are some,
17 given the 48 different models that were
18 considered before deciding on which one was
19 optimal, we need just more information as to
20 the selection criteria for the final model, as
21 well as the results for that model.

22 DR. STROUPE: That certainly seems

1 reasonable, based on our information.

2 DR. WEINTRAUB: And they have a
3 model developed here, which is on page 19. So
4 it's very difficult to really look at it
5 critically and know, you can sort of specify
6 it. And you can accept it or not accept it.

7 All right. So I'm at the bottom
8 of 19 now, and they just take us through the
9 their -- how they develop a model in some
10 detail. So I would assume again it's
11 essentially the same as for the AMI.

12 And now I'm on to page 20, S.10.2,
13 stratification method. Again here we have
14 this problem of the stratification by
15 revascularization and follow-up.

16 Then we go through the costing
17 methodology again, which we've just really
18 discussed, going from page 20 to 21.

19 And I don't think we have to
20 discuss that in detail. We want a little more
21 -- a little better specificity from them.
22 It's in detail here, but it's still kind hard

1 to figure out what they did in handling
2 certain things, especially related to
3 professional costing.

4 Okay, I'm not to -- now I'm going
5 through all the costing. Ambulatory and
6 pharmacy is on page 23.

7 CO-CHAIR CURTIS: I think we've
8 covered pretty much everything up until the
9 hierarchy, which is 25 -- or the attribution,
10 sorry.

11 MR. AMIN: May I have a quick
12 clarifying question, Bill?

13 DR. WEINTRAUB: Yes.

14 MR. AMIN: Was more -- did you
15 need more robust information on pricing,
16 standardized pricing for all or just the
17 professional services?

18 DR. WEINTRAUB: So I didn't hear
19 about any other problems, other than that.
20 You know, the problems were sort of accepting
21 what they're doing without fully understanding
22 it, but I don't know what we could do about

1 that realistically.

2 MR. AMIN: Okay.

3 MS. TURBYVILLE: We could ask for
4 more detail.

5 DR. WEINTRAUB: They provide a lot
6 of detail. I think what we'd want is perhaps
7 a little more -- some clarity, so maybe some
8 overarching text of their approach to costing,
9 and a little bit more of the professional
10 component. Does that make sense?

11 All right, their approach to --
12 I'm going to keep going. Their approach to
13 attribution, as far as I can tell is also the
14 same as we heard with MI this morning. We're
15 going to have the same kinds of problems, so
16 I think that just at they need to address
17 problems with attribution for MI, they're
18 going to need to address problems with
19 attribution for this measure as well.

20 All right. So if we come down to
21 level of analysis, I think there's a problem.
22 They're proposing a level of analysis at

1 individual clinician. I don't believe that
2 that's going to be possible. I think measures
3 like this will work at the level of health
4 systems or health plans, but it would be very,
5 very difficult to make this meaningful at the
6 level of individual clinician.

7 So I think that should be part of
8 our feedback to them, that they should rethink
9 the level of analysis.

10 They're not providing
11 specifications and guidelines for sample size
12 requirements. That can be done, per the
13 discussion this morning of doing some
14 simulation work, of what it would take. It
15 would be a help if they had a sufficient level
16 of data to do that, but they don't right now.

17 So then this becomes more
18 mechanical again through page 27, and the
19 interpretation is it's standard O to E ratio
20 sort of thing.

21 And I'm on to page 28 -- we're
22 almost done, actually, with it. And will

1 provide reports along the lines we've heard,
2 on the bottom of page 28.

3 So they've done some testing. Do
4 we want to rate up to this point, and then we
5 can very briefly go over their slides on
6 testing? That will be faster than what we've
7 just been through.

8 MS. TURBYVILLE: So you want to
9 rate 2.A.1 and then after that move into the
10 reliability and validity testing?

11 DR. WEINTRAUB: Yeah, we can do
12 that. That's reasonable.

13 MS. TURBYVILLE: Okay.

14 CO-CHAIR CURTIS: So 2.A.1 and
15 2.B.1 I think are kind of like -- is that --
16 they're kind of there, right? Okay.

17 So regarding 2.A.1, the measure is
18 well defined and precisely specified so that
19 it can be implemented consistently within and
20 across organizations.

21 DR. WEINTRAUB: So I think I rated
22 it moderately, but we've come up with a lot of

1 problems. So I'm going to -- I'm actually
2 going to rate it low. I think that this can
3 be pulled up to snuff, but it will still
4 require some reworking. Right now it's not
5 ready.

6 But it's up to you.

7 CO-CHAIR CURTIS: I think -- I
8 mean, specifically the exclusion of the MI
9 population, I mean, to me that's strange and
10 worthy of low. I mean, it makes it almost --

11 DR. WEINTRAUB: I think so.

12 CO-CHAIR CURTIS: --
13 uninterpretable as a measure.

14 DR. WEINTRAUB: Right. Also
15 things like the stratification of something
16 that occurs and follow-up doesn't make any
17 sense. Their problems -- their costing
18 methodology needs to be cleaned up a bit.
19 There's a lot of problems here.

20 CO-CHAIR CURTIS: But the voting
21 is in your hands.

22 So then for 2.B.1, the measure

1 specifications are consistent with the
2 evidence presented to support the focus of
3 measurement under criteria 1.B. It's
4 specified to capture the most inclusive
5 population. Bill do you want to comment or --

6 DR. WEINTRAUB: So we see again
7 some of the problems in the population. I
8 haven't really defined the problem of the
9 target population properly and it needs a bit
10 of work. I mean it's very global, it
11 certainly can be fixable, but they're not
12 there. So I think I rated it moderate before,
13 but we've uncovered problems, and I'm going to
14 rate it low again.

15 CO-CHAIR CURTIS: Eight lows. So
16 I think this will require a lot of feedback,
17 but it -- and overlapping -- I think you've
18 captured it. Okay.

19 DR. WEINTRAUB: All right. So on
20 page 29, so again, they're using the Thomson-
21 Reuters market scan data set.

22 MS. CLARK: I wonder if we can

1 even rate these, the reliability and validity
2 testing is --

3 MS. TURBYVILLE: They -- well,
4 depending on the extent to it. But it is
5 acceptable to do reliability and viability
6 testing in a database.

7 MS. CLARK: No, but I mean if the
8 measure is not even --

9 MS. TURBYVILLE: Oh, that's right.

10 MS. CLARK: -- if the measure is
11 not even valid. We all rated it low, how can
12 we test -- oh, they did a good job of testing
13 it, but it's --

14 MS. TURBYVILLE: I think that's a
15 good question. But well, I think that's part
16 of how your rating will be impacted. So I
17 mean, you'll - you can't help but have that
18 influence it because that is a huge part of
19 it. So staff will just make sure it's
20 reflected in the notes that whatever rating
21 you give is, in part, based on that if you'd
22 like.

1 DR. WEINTRAUB: So they go to some
2 effort to just describe the market scan
3 database. And then they go into their
4 analytic methods. And then they have the
5 testing results. And that's on page 30.

6 The slides are actually helpful,
7 and they begin on -- the computer is very
8 colorful.

9 CO-CHAIR CURTIS: You can use the
10 paper copy if you need.

11 DR. WEINTRAUB: Well, keeping
12 everybody else on track, it will be helpful to
13 get the slides.

14 So Jeptha took you through the
15 slides before, and they're very similar. You
16 can go slide 4 shows how they defined the
17 population, and ultimately come down to 11,000
18 patients. And then they have their
19 stratification -- I don't have that blue
20 binding before, this is all over the place.

21 CO-CHAIR CURTIS: I will say that
22 it's interesting that only 3.9 percent of

1 population is excluded, based on having had
2 that MI between 14 and 365. I guess that's
3 believable. It seems a little on the low
4 side, but --

5 DR. WEINTRAUB: It seems low to
6 me. I don't believe it. Maybe that suggests
7 problems with the reliability of the data.

8 They go to, from there, it's slide
9 6. You see the same problem we saw this
10 morning with the distribution of the costs,
11 inpatient facility charges. The 75th
12 percentile was at zero, and the 95th
13 percentile was at 10,000. Very skewed data
14 making it rather difficult to work with. Not
15 impossible, but just the challenge needs to be
16 understood.

17 And then in slide 7, we have the
18 distribution of the costing. Slide 7 is the
19 top 20 CAD-related E&M post-revascularization
20 episodes. Just 14 percent of total episode
21 costs. So that's pretty low total, low
22 percentage.

1 And then they have a whole bunch
2 of non-CAD related costs. Then they have --
3 then on the top of 9, the CAD-related
4 procedures. And this is a big -- or a
5 relatively big percentage of costs. That's
6 pretty believable, actually.

7 CO-CHAIR CURTIS: Sorry, what
8 slide?

9 DR. WEINTRAUB: Slide 10 is common
10 non-related procedures. Well, you know, some
11 of this can be argued about whether they're
12 related or non-related. And this gets to the
13 whole problem, again, if you're going to even
14 try and go through this exercise of what's
15 related and what's not. Replacement of aortic
16 valve, cardiopulmonary bypass. Replacement of
17 the mitral valve in particular I would not say
18 is non-related with coronary disease.

19 CO-CHAIR CURTIS: And then
20 specifically, like what's that \$5.8 million of
21 anesthesia for procedures on the heart
22 pericardial sac and great vessels. That would

1 certainly seems to be relevant to the cost
2 methodology.

3 DR. WEINTRAUB: And then insertion
4 of a Swan-Genz catheter, well, your patients
5 with coronary disease develop heart failure.
6 That's why I think, you know, it becomes
7 extremely difficult, different people are
8 going to come up with different things they
9 think they are related or not.

10 And the next thing is --

11 DR. LEE: This is Todd Lee, I just
12 joined the call again. Can I clarify some of
13 the information here?

14 DR. WEINTRAUB: Sure.

15 DR. LEE: For related and non-
16 related information in that slide, for example
17 the Swan-Genz catheter placement, 93-503,
18 2,418 of the times that occurred in our data,
19 it was grouped to the episode. Only 13 times
20 was not grouped to the episode. So while the
21 primary grouping algorithm was by the
22 diagnostic code or the procedure code, these

1 procedure codes were not specific to this
2 episode.

3 And so the majority of these still
4 are being counted in the episodes. So those
5 \$800,000 are being counted in the total
6 episode costs here.

7 DR. WEINTRAUB: Oh, I see, 2,400
8 are related. Oh, you have it listed under
9 non-related, but you have those related and
10 not related all on the slide?

11 DR. LEE: Yeah, I apologize for
12 that confusion. It's what we do with the
13 intent of the slide was to say, look,
14 sometimes if these procedures are showing up
15 both as related and non-related, and we had
16 asked our work group if they felt there was
17 enough specificity with the procedure code
18 itself to group it to the episode. If not, we
19 still relied on the ICD-9 code.

20 And so this was our -- part of our
21 iterative process with each of our work
22 groups, to go through these codes. And they

1 would let us know, okay, yeah, now we're going
2 to take that Swan-Genz catheter CPT code and
3 group it to the episode, or no, we're
4 comfortable with the proportion that seem to
5 be grouping to the episode, let's just leave
6 it with ICD-9 approach.

7 DR. WEINTRAUB: So I don't
8 understand quite how you do that. If you put
9 in a Swan-Genz catheter, how could it be --
10 and it's within the year's timeframe, how
11 would you know it's not related?

12 DR. LEE: It was based on the ICD-
13 9 code that showed up on that claim. So if
14 the ICD-9 code that was with that specific CPT
15 code for that claim, was not one grouped to
16 the episode, it falls into this non-related
17 column.

18 DR. WEINTRAUB: Well, okay. I
19 think that's pretty hard to do, pretty hard to
20 do it in a way that will be uniform for
21 people.

22 CO-CHAIR ROSENZWEIG: Who does the

1 groupings? I'm not sure I understand who does
2 the grouping to the episode?

3 DR. LEE: What process did we use
4 for the grouping?

5 CO-CHAIR ROSENZWEIG: Yeah.

6 DR. LEE: This was -- each of our
7 clinical advisory work groups, which is again
8 principally made up of physicians, walked
9 through each of these outputs with us. They
10 generated an initial set of specifications
11 that said, these codes are related to CAD,
12 these codes should group to the episode.

13 And then as part of that, we would
14 go through this output with them and they
15 would identify additional codes that we would
16 add to the specification, or codes that we
17 might take away from the specification.

18 CO-CHAIR ROSENZWEIG: But with
19 respect to like anesthesia for the procedures
20 on the heart, how did they determine that
21 there were 24 episodes that were not related
22 to the event?

1 DR. LEE: There are 24 claims.
2 These are 24 unique claims that do not have an
3 ICD-9 code that is included in the ICD-9 code
4 list for this episode.

5 CO-CHAIR ROSENZWEIG: But that's
6 just a coding error.

7 DR. WEINTRAUB: Well, not
8 necessarily. I mean --

9 DR. LEE: Or it's a procedure
10 that's not related to their CAD. I mean,
11 that's the other alternative. We don't know
12 which direction -- we don't know if it's
13 accurate or if there is some degree of
14 misclassification. I mean, there is certainly
15 potential for some noise in these measures,
16 but this was part of the process that we
17 worked through our -- with our clinical work
18 groups.

19 CO-CHAIR ROSENZWEIG: Okay.

20 DR. WEINTRAUB: Well, I think this
21 is very hard to pull off in a way that's going
22 to be consistent and really believable. And

1 you're right, they may have come up with codes
2 where it doesn't make sense. They're putting
3 in a Swan-Genz catheter for patients in septic
4 shock, I suppose is a possibility. But
5 anesthesia for procedures of the heart,
6 pericardial sac and great vessel, very hard to
7 say that that's not related.

8 CO-CHAIR CURTIS: So maybe part of
9 the feedback to you, the measure developer,
10 would be that in trying to help us validate
11 this approach by doing a deeper dive on some
12 of these instances where there is uncertainty
13 as to whether or not it's an appropriate
14 classification. So digging in on those 24
15 claims for the cardiac anesthesia or what have
16 you, some of the ones that are even more
17 frequent, or the ones we identified earlier
18 today.

19 I just think it would be -- it
20 would go a long way to allaying sort of the
21 suspicions as to this approach, which I grant
22 you is reasonable and has some face validity

1 to it. But you know, it's just a matter of
2 getting us comfortable with it as well, and
3 maybe it's in all the outputs that the working
4 groups saw over time, over the three years of
5 the measure development. But it's just having
6 the -- I think it's just hitting the wrong
7 note with the group here, potentially.

8 DR. WEINTRAUB: I think you'll
9 have to think about that for the heart failure
10 measure we saw this morning as well. I mean,
11 you have others here that are related
12 sometimes where you'd think they'd probably
13 never be related, if you're taking this
14 approach.

15 Colonoscopy, flexible, proximal to
16 splenic flexure. Fifty-eight of them are
17 related. Cataract removal, 30 are related.
18 So I mean, I'm not -- I'm having a fair amount
19 of trouble here.

20 All right. So and then the next
21 thing is imaging, CAD-related, and then non-
22 related. And again, we have the same sort of

1 problem here on the imaging. Computed
2 tomography, pelvis with contrast material, 186
3 are related, 365 are not. So I guess it's
4 possible, you know, if they have a
5 retroperitoneal hematoma. Pretty tough to
6 pull off. You've got screening mammographies
7 related in 231.

8 And then they have the testing on
9 -- that's on slide 13. And then we have more
10 testing. You have lipid panels, on page -- on
11 slide 14, lipid panels, half are related and
12 half aren't related.

13 And they have, on slide 15, major
14 joint replacement, you have some of them that
15 are related. And non-related -- okay.

16 All right, I think that's enough
17 of this. I mean, I think there's some
18 problems on how you're attributing what's
19 related and not related. I think we've made
20 that clear.

21 So why don't we go back to page
22 29, which is where we were before we started

1 all this. Jephtha, how do I get there rapidly?

2 Everyone should have Jephtha
3 command their computer for them.

4 (Laughter.)

5 DR. WEINTRAUB: All right. So
6 really, we're on page 30 with validity
7 testing.

8 Okay. Are we ready to score then?

9 (Laughter.)

10 DR. WEINTRAUB: That was cute,
11 Mary Ann.

12 MS. CLARK: Well, I was told.

13 DR. WEINTRAUB: All right.

14 CO-CHAIR CURTIS: All right, so we
15 still have to do 2.A.2, reliability testing
16 demonstrates results are repeatable producing
17 the same results a high proportion of the time
18 when it's in the same population in the same
19 period.

20 Bill, what do you think?

21 CO-CHAIR ROSENZWEIG: Get your
22 microphone.

1 CO-CHAIR CURTIS: I'm sorry.

2 CO-CHAIR ROSENZWEIG: Yeah, it
3 wasn't me this time.

4 CO-CHAIR CURTIS: So to say it
5 again, reliability testing demonstrates the
6 results are repeatable producing the same
7 results a high proportion of the time in the
8 same population.

9 DR. WEINTRAUB: So we don't really
10 quite buy into what they're doing here, so I
11 don't think we have a -- they may measure at
12 the same time, but I really thing that they
13 have some real analytic problems here.

14 So I think I measured it as
15 moderate, but with the problems we've
16 uncovered, I'm going to rate this as low.

17 CO-CHAIR CURTIS: But I don't
18 think this has to do with the scientific
19 acceptability of it. This is a different
20 criteria, which is just, if they apply this
21 methodology in the same -- you know, how often
22 can they get the same results, irrespective of

1 whether or not they're the right results, we
2 know it's the same.

3 DR. WEINTRAUB: All right, so we'd
4 have to say we actually don't know. Then we
5 really have insufficient data. Because they
6 have -- they've done this once. They haven't
7 shown the kind of testing that it would seem -
8 - that we just saw in the previous measure
9 where it's been in use.

10 CO-CHAIR CURTIS: I think that's
11 fair, but then again, being alert to the
12 possibility of drift, and I think we're sort -
13 - for the earlier one using the same
14 methodology, I think I proposed at least a
15 moderate, based on the fact that I think that
16 they've gone through these codes in some
17 detail and have at least a way that they're
18 defining the costs the same way. And so I'll
19 push on that -- I'm going to vote a little
20 differently, but --

21 DR. REEDER: My light is on. They
22 can be consistent regardless of what the

1 validity, what we determine construct validity
2 to be. I think Dr. Curtis is correct in that
3 we're looking at that consistency component.
4 And it's a necessary component for the
5 establishment of validity, but not all-
6 inclusive or sufficient in and of itself.

7 So the consistency piece of it, I
8 agree, is quite high here. And to be
9 consistent across the measures or -- yeah,
10 measures that we've done today, I would have
11 to go with high.

12 DR. WEINTRAUB: High, that's
13 interesting.

14 So but look at what it says here.
15 Reliability testing demonstrates that the
16 measure results are repeatable. We don't have
17 a demonstration of that. It's been tested
18 once.

19 Producing the same results a high
20 proportion of the time. We don't know that.

21 CO-CHAIR CURTIS: I guess we don't
22 know that, but I guess --

1 DR. WEINTRAUB: I mean, it's
2 reasonable that it would. It looks like it
3 would do the same thing again. But you don't
4 know that.

5 MS. TURBYVILLE: But they did
6 numerous -- just as a reminder, they did do
7 numerous iterations of just removing 1-2
8 codes, and then -- so there was kind of
9 repeat, repeat within what they submitted, as
10 they submitted it.

11 CO-CHAIR CURTIS: So not to
12 belabor it, I'd propose we just vote on this.
13 So 2.A.2.

14 DR. WEINTRAUB: Wow, you can go
15 anywhere you want on this one.

16 CO-CHAIR CURTIS: So one high,
17 five moderate and two insufficient.

18 Regarding 2.B.2 which is validity
19 testing, which I think is getting more into
20 how it interplays with scientific
21 acceptability, demonstrating that the measure
22 data elements are correct and that the measure

1 score correctly cost of care or resources
2 provided adequately distinguishing higher or
3 lower costs for resource use.

4 Bill what --

5 DR. WEINTRAUB: I rated it
6 moderate before. I think here we have some
7 data. I'm going to rate it low.

8 CO-CHAIR CURTIS: Okay. So let's
9 put that to the vote then.

10 Eight low.

11 2.B.3, exclusions are supported by
12 the clinical evidence, otherwise they are
13 supported by evidence of sufficient frequency
14 of occurrence so that results are distorted
15 without -- with the exclusion. And the other
16 criteria. But I guess we're just focusing on
17 the reasonability of the exclusion criteria.

18 DR. WEINTRAUB: So here the thing
19 -- the problem is the MI's and how they handle
20 it. I mean, it's really quite fixable on what
21 they do, we'll have to do that.

22 CO-CHAIR CURTIS: So put that to

1 the vote.

2 I think we're getting better at
3 voting, or pressing.

4 Two moderate, five low and one
5 insufficient.

6 Criteria 2.B.4 we're at, correct?
7 For outcomes measures or resource use
8 measures, evidence-based risk adjustment
9 strategy as specified and based on clinical
10 factors influencing income -- or sorry,
11 outcome --

12 (Laughter.)

13 CO-CHAIR CURTIS: -- and are
14 present at the start of care.

15 And Bill, what did you think of
16 this?

17 DR. WEINTRAUB: I'm leaving it
18 here.

19 CO-CHAIR CURTIS: So I think it's
20 a risk adjustment approach. And that includes
21 the stratification.

22 DR. WEINTRAUB: Yeah, the

1 stratification makes no sense. And so --
2 otherwise, their approach for risk adjustment
3 is fairly standardized. So they need to do a
4 little bit of work here, clearly.

5 CO-CHAIR CURTIS: Okay. So let's
6 vote on that.

7 So five moderate and three low.

8 2.B.5, data analysis demonstrates
9 methods for scoring and analysis of the
10 specified measure, allowed for identification
11 of the statistically significant and
12 practically/clinically meaningful differences
13 in performance.

14 Bill?

15 DR. WEINTRAUB: So they haven't
16 really demonstrated this yet. It's liable to
17 work if they can fix their other problems.

18 CO-CHAIR CURTIS: Okay. Any other
19 comments?

20 DR. WEINTRAUB: So I mean, I think
21 right now, to me, it looks insufficient.

22 CO-CHAIR CURTIS: Okay, let's vote

1 on that.

2 One moderate, one low and six
3 insufficient.

4 DR. WEINTRAUB: Well, I don't have
5 that much influence with my family.

6 CO-CHAIR CURTIS: 2.B.6, multiple
7 data sources; I think this is not applicable,
8 so we won't vote on 2.B.6.

9 2.C, disparities have been
10 identified, I think we can forego voting on
11 that.

12 And that brings us to usability.

13 DR. WEINTRAUB: All right. So

14 CO-CHAIR CURTIS: Can you just
15 remind us generally how we voted on usability
16 for the related measure?

17 MS. WILBON: I'm actually trying
18 to create a table side by side of the
19 evaluations you did this morning on 1570 --
20 was it, no. 1571 and this measure so you can
21 kind of see. I can bring that up in a second,
22 but for now, let's see, for usability for the

1 measure this morning, right?

2 CO-CHAIR CURTIS: Right.

3 MS. WILBON: 3.A was rated eight
4 insufficient -- yeah, they were all
5 insufficient.

6 CO-CHAIR CURTIS: I just wanted to
7 remind people that -- in general for this.
8 And I think we can probably forego the review
9 of it since we kind of know what we're going
10 to say in this case, that they're similar.

11 So why don't we go ahead and vote
12 on 3.A.

13 DR. WEINTRAUB: So when I
14 originally rated these low throughout, but I
15 think insufficient is a better descriptor.

16 CO-CHAIR CURTIS: And 3.B -- I
17 guess it needs to tabulate, sorry.

18 So 3.B, meaningful results, go
19 ahead and vote on that.

20 DR. WEINTRAUB: They're not there
21 yet.

22 Waiting on one.

1 And 3.C, data results details.

2 DR. WEINTRAUB: Well, I want to
3 see the results here first.

4 CO-CHAIR CURTIS: Okay, eight
5 insufficient.

6 And moving to 3.C, whether or not
7 it can be decomposed to facility transparency
8 and understanding.

9 DR. WEINTRAUB: We can't tell
10 about it yet, so again I would vote
11 insufficient.

12 CO-CHAIR CURTIS: And 3.D we'll
13 forego.

14 And for feasibility, I don't think
15 we have the same insufficient --

16 DR. WEINTRAUB: No, yeah, I mean,
17 this is all electronic. This can be done,
18 that is routinely collected. So it is -- for
19 this one, it is feasible. That I can actually
20 rate high. Remember, not to say anything
21 about believable as it is, but that you can do
22 it.

1 CO-CHAIR CURTIS: So again,
2 susceptibility to inaccuracies, errors and
3 unintended consequences, is that the only one
4 that might be worth discussing?

5 DR. WEINTRAUB: That's not a
6 question, though.

7 CO-CHAIR CURTIS: Well, I know,
8 but I thought we'd go through all the
9 feasibility ones before going through the
10 vote.

11 DR. WEINTRAUB: Oh, all right.
12 Okay.

13 CO-CHAIR CURTIS: But I think the
14 first two, I think we can agree on without
15 much review. But 4.C, this morning I think we
16 voted that it was --

17 MS. WILBON: One high, two medium
18 and five low.

19 CO-CHAIR CURTIS: Yeah.

20 MS. WILBON: And then the last,
21 4.D was five moderate and three low.

22 CO-CHAIR CURTIS: Okay. So

1 starting the voting for 4.A, required data
2 elements are routinely generated.

3 Six high, two moderate.

4 4.B, data elements are available
5 in the electronic health record or other
6 electronic sources.

7 DR. WEINTRAUB: Well, we don't
8 know that.

9 CO-CHAIR CURTIS: That's
10 administrative data. I don't know if it's
11 different than any of the other measures that
12 we --

13 DR. WEINTRAUB: Well, but this is
14 -- I mean, what do the words say here? It
15 says, are available in electronic health
16 records or other data -- or other electronic
17 sources, okay.

18 CO-CHAIR CURTIS: 4.C,
19 susceptibility to -- I'm sorry. Six high, two
20 moderate.

21 Susceptibility to inaccuracies,
22 errors or unintended consequences.

1 DR. WEINTRAUB: All right. So
2 here they've really got some clear-cut
3 problems. So I'm going to vote low on this.

4 CO-CHAIR CURTIS: And 4.D, data
5 collection measurement strategy implemented as
6 demonstrated by operational use or testing do
7 not identify barriers to operational use.

8 DR. WEINTRAUB: Well, until they
9 do some more work, they've clearly got
10 barriers. Of course, it's overcomable, but
11 they've got some barriers as it is right now.
12 So I'm going to vote low.

13 CO-CHAIR CURTIS: One moderate,
14 five low and two insufficient.

15 And I think the feedback on this
16 would probably more in line with the problems
17 with identified or concerns we raised on
18 scientific acceptability being the major
19 barrier, probably in implementation and
20 feasibility.

21 DR. WEINTRAUB: I would agree.

22 CO-CHAIR CURTIS: Okay. So that

1 was fun.

2 Let's wrap up the day. Let's go
3 to Sally.

4 MS. TURBYVILLE: So before
5 everyone leaves and has a chance to forget
6 about today --

7 (Laughter.)

8 MS. TURBYVILLE: -- all of the
9 staff who are supporting this wanted to
10 quickly take -- it doesn't even have to be a
11 minute of your time. Is there any adjustments
12 we could make for tomorrow to make it go
13 smoother in your estimation? So we can think
14 about those adjustments ahead of time.
15 Anything come to mind immediately?

16 Not to put people on the spot, but
17 --

18 DR. MARWICK: I don't know about
19 tomorrow, but from the one that I presented,
20 I just wonder if there's -- we should consider
21 some process of selection of these before they
22 come to this meeting? Because there's some

1 that -- you know, that particular one was not
2 on target, and I think there's others that are
3 -- have got fundamental problems.

4 MS. TURBYVILLE: And I think
5 that's an excellent question, and I appreciate
6 you bringing it up.

7 We are relying on you as the
8 clinicians to tell us if they're not measuring
9 what's intended. Staff really tried to not --
10 while we looked for the submissions to be
11 complete and work with the developers to make
12 sure they're submitting things as much as we
13 can, where we asked, if we preemptively held
14 things back without getting your input, we
15 would be playing the role of, you know,
16 potentially biased.

17 DR. MARWICK: Okay.

18 MS. TURBYVILLE: So I think we do
19 try to make sure that incomplete ones, but we
20 don't want to make a clinical judgment without
21 your input and guidance, because you really
22 are the first stop in that assessment.

1 DR. MARWICK: I'm not suggesting
2 that at all. I'm just suggesting there should
3 be a process of culling ones -- after their
4 sent out to us, culling ones that --

5 CO-CHAIR CURTIS: You're talking
6 about maybe something analogous to fast-
7 tracking for grant submission?

8 MS. TURBYVILLE: Oh, I see. So
9 when we send it out. And hopefully in the
10 future we'll be sending them out in four
11 weeks' time for the TAP, they can -- there can
12 be an opportunity through preliminary
13 assessments to reconsider whether or not it
14 should be dealt with onsite in the in-person
15 meeting. Is that what you're -- yeah, I think
16 that's a good idea.

17 CO-CHAIR CURTIS: I think so. And
18 specific to that one, I mean, it took hours
19 and hours and hours for Tom and I to go
20 through that submission, and then ten minutes
21 into it, they withdrew. And so if we'd been
22 able to go through that earlier --

1 MS. TURBYVILLE: I still think we
2 need the clinical input of someone to go
3 through --

4 CO-CHAIR CURTIS: I think, yeah,
5 on the basis of the reviewer rather than
6 before, potentially --

7 MS. TURBYVILLE: Oh rather than
8 the primary? Yeah --

9 CO-CHAIR CURTIS: We can explore
10 different options.

11 MS. TURBYVILLE: It's a challenge,
12 but we can certainly think out of the box a
13 little bit.

14 DR. BURSTIN: There may be ways we
15 can explore it, because I think maybe it will
16 be a handful, I'm assuming. And maybe it's
17 work with the two chairs and make sure that if
18 you see -- if the member sees something like
19 that, we can have a conversation with the
20 developer and figure it out beforehand,
21 perhaps.

22 MS. TURBYVILLE: As much as

1 possible.

2 DR. MARWICK: I think we were
3 lucky that the developer took us off the hook,
4 really, because we could have ground on doing
5 something that we all knew was futile.

6 MS. TURBYVILLE: Point well taken.

7 DR. HWONG: And the only other
8 suggestion I would have, maybe for the future,
9 too, in terms of, you know, the 2.A section
10 that had this like -- you know, a large number
11 of the microcriteria, I remember sort of going
12 through it, I felt like some of those
13 criteria, you'd sort of talk about up front,
14 and yet it's sort of listed again.

15 Maybe if we could group them,
16 right, so that you can kind of -- so if it's
17 exclusion criteria or, you know, something --
18 I would have to go back and take a look at the
19 categories much more.

20 But I sort of felt like, yeah,
21 going through, sometimes you'd end up sort of
22 going back and you'd already covered it. And

1 I don't know how much of that is just, you
2 know, offshoots of conversations. But somehow
3 there might be a way to kind of group them a
4 little more tightly.

5 MS. TURBYVILLE: Absolutely.
6 We'll look at how we might do that. It is
7 very much right now a laundry list, so I think
8 we can put a little more thought, especially
9 having the benefit of listening to a full day
10 of review, how we might better group them.

11 CO-CHAIR CURTIS: The only other
12 thing, I think the table that Ashlie is
13 putting together, which will kind of remind us
14 within each developer, what our previous
15 assertions have been would be useful.

16 MS. CLARK: I just have one other
17 comment. I really liked the NCQA's measure in
18 terms of how they incorporated the quality
19 measures into it. I thought that was very
20 helpful. And what I'm wondering about,
21 though, is you know, comparing these different
22 ratios of costs to norms and things like that

1 is fine. But really, trying to focus more on
2 tying it to the outcomes, because you could
3 spend, you know, a certain amount of money and
4 get much better outcomes than, you know, maybe
5 somebody who's spending less money.

6 So I guess I'm just wondering if
7 we're going to make that -- or if anyone is
8 going to make that next leap to tying the cost
9 to outcomes.

10 CO-CHAIR CURTIS: We discussed
11 this at length at the steering committee, and
12 that we didn't want to have an unlevel playing
13 field such that those measure developers who
14 hadn't already pre-tied it to quality would be
15 looked on more favorably. Intuitively you
16 kind of feel that. But we thought that it
17 wouldn't necessarily be fair, or we didn't
18 want to suppress interest if they hadn't made
19 that connection already.

20 So I think that was the compromise
21 that we made.

22 DR. BURSTIN: We probably should -

1 - not that anyone is in the room, and I don't
2 know if anyone is on the phone, but we
3 probably should have public comment.

4 And then maybe start it out in the
5 morning and see if there's anyone, since I
6 have a feeling we've dropped off the --
7 Operator, can you see if there's anyone who
8 has any public comments?

9 Operator, are you there?

10 All right, so I guess we'll start
11 with public comment.

12 OPERATOR: Again, if you have a
13 comment, star-one.

14 MS. TURBYVILLE: Anything else,
15 Ashlie? Actually, let me make sure.

16 (This proceeding was concluded at
17 5:45 p.m.)

18

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This is to certify that the foregoing transcript

In the matter of: Technical Advisory Panel

Before: NQF

Date: 05-10-11

Place: Washington, DC

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