NATIONAL QUALITY FORUM

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COST AND RESOURCE USE PHASE II: CARDIOVASCULAR CONDITION-SPECIFIC STANDING COMMITTEE MEETING

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TUESDAY

MARCH 4, 2014

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Brent Asplin and Lisa Latts, Co-Chairs, presiding.

PRESENT:
BRENT ASPLIN, MD, MPH (Committee Co-Chair), Fairview Health Services
LISA LATTS, MD, MSPH, MBA, FACP (Committee Co-Chair), WellPoint
ARIEL BAYEWITZ, WellPoint*
LAWRENCE BECKER, Xerox Corporation*
MARY ANN CLARK, MPH, Intralign*
CHERYL DAMBERG, PhD, MPH, RAND Corporation
JENNIFER EAMES HUFF, MPH, Pacific Business Group on Health*
NANCY GARRETT, PhD, Hennepin County Medical Center
ANDREA GELZER, MD, MS, FACP, AmeriHealth Mercy Family of Companies
MATTHEW MCHUGH, PhD, JD, MPH, RN, CRNP, FAAN, University of Pennsylvania
JAMES NAESSENS, ScD, MPH, Mayo Clinic
JACK NEEDLEMAN, PhD, UCLA Fielding School of Public Health
JANIS M. ORLOWSKI, MD, MACP, Association of American Medical Colleges
CAROLYN PARE, Minnesota Health Action Group
JOHN KEVIN RATLIFF, MD, FACS, Stanford University Medical Center
ANDREW RYAN, PhD, Weill Cornell Medical College
JOSEPH STEPHANSKY, PhD, Michigan Health & Hospital Association*
LINA WALKER, PhD, AARP's Public Policy Institute
WILLIAM WEINTRAUB, MD, FACC, Christiana Care Health System
HERBERT WONG, PhD, Agency for Healthcare Research and Quality
DOLORES YANAGIHARA, MPH, Integrated Healthcare Association

NQF STAFF:
HELEN BURSTIN, MD, MPH, Senior Vice President, Performance Measurement
TAROON AMIN, MA, MPH, Senior Director, Performance Measurement
ERIN O'ROURKE, Project Manager, Strategic

Partnerships
ANN PHILLIPS, Project Analyst
ASHLIE WILBON, RN, MPH Managing Director, Performance Measurement
EVAN WILLIAMSON, MPH, MS, Project Manager, Performance Measurement

ALSO PRESENT:

SUSANNAH BERNHEIM, MD, Yale School of Medicine - CORE

NANCY KIM, MD, PhD, Yale School of Medicine - CORE

HARLAN M KRUMHOLZ, MD, Yale School of Medicine - CORE*

* present by teleconference

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9:04 a.m.

MR. WILLIAMSON: Good morning, everyone and welcome to the Cost and Resource Use Phase II Standing Committee meeting.

We really appreciate everybody joining us today. We understand there were a lot of weather and travel difficulties so everybody who's in the room, they braved those challenges and made it here.

And I know we have a lot of people participating on the phone line so we'll try to manage that as best as we can throughout this two-day meeting. We'll make sure that we get everybody involved and keep everyone involved throughout the course of the meeting.

We have a lot to cover, a packed agenda involving both strategic discussions and measure evaluation.

So, with that we'll go into our first agenda item which is a welcome and kind of an agenda review and ground rules.

So for those here in the room we have restrooms available. It's the exit past the main elevators. They're on your right.

We'll be taking several breaks today. We're going to try to stick to the posted time. We have Brent and Lisa here who are our co-chairs who are task masters. They're going to make sure we stay on time and stay on topic.

So we're intending to break at 10:45. We'll have a lunch at 12:30. And then again at 3:15 there's another break. Those breaks will be preceded by public and member comment as indicated on the agenda.

And again, for those public participating on the phone line we'll make sure we try to stick to those so that we can get that covered and make sure you can provide input to the meeting.

Again, for those in the room a little process step. In order to speak, I know many of you have been at an NQF meeting before. We

use these little table tents. If you just turn it on edge that will indicate that you would like to speak and the co-chairs will call on you.

For those on the line, the committee members participating, we will use the chat feature available through the webinar platform. We have it up here in the room. So that if you would like to speak just send a chat to the leaders. It'll show up on the screen and then we'll call on you.

Again, we need a little more formal process than we usually do for people on the phone just because I think we have up to six or seven people participating on the line. We want to make sure that we include you in the discussion so we hope that that will be a sufficient workaround for that.

So we have our NQF project staff here in the room. Again, my name's Evan Williamson. I'm the project manager.

Ashlie Wilbon ran into some Metro

issues this morning on the Red Line. They should call it the delay line, I don't know, the stopped line. But she'll be here hopefully soon.

Ann Phillips is our project analyst. Again, I know many of you were on the project last time. She's new to the project so we'll welcome her.

And then we have -- there's Ashlie. And then we have Taroon Amin who's the senior director on the project.

We're also joined by Helen Burstin. She's the senior vice president for performance measurement. She'll actually be running through the disclosure process this morning instead of Ann Hammersmith. So we're glad to have Helen here.

A quick rundown of the agenda. We're doing the review of the agenda right now. We'll move into a disclosure of interest process followed by some really strategic discussions this morning.

Again, you might have realized that we're using new terminology now. We kind of covered this on our orientation call. Instead of a steering committee we're now a standing committee and so that brings with it some new responsibilities and roles. More of an ownership over our portfolio for cost and resource use. And really provide us with some direction, some really far-reaching direction.

So we're really excited about that. We're going to spend most of the morning going over that role, how it fits into NQF's other affordability work going on.

We'll go over the measurement portfolio as well as some input to our Measure Applications Partnership.

After that we'll go over the evaluation process. We'll go over an overview. A few things might have changed since last time. We've been doing a lot of improvement work on our process. And so actually a lot of it came out of our last

phase of work. Some of the considerations with close votes and how we really handle reaching consensus on this work.

And so we'll go over that evaluation process before lunch. Again, we'll have a public and member comment and then move into lunch.

In the afternoon we're going to consider candidate measures. Today we'll be going over the two Yale/CMS measures. So those are two new measures to the NQF process. And so we'll spend all afternoon going over those two measures.

Tonight we have an optional dinner. We made a reservation just down K Street at McCormick & Schmicks. And so at lunch we'll be taking a final headcount for that so I can update the restaurant. And we hope you'll join us.

Again, completely optional. We find it's a good time to catch up with your fellow committee members, meet some of the new ones

and just have a little wind-down at the end of the day.

Great, at this time we'll move into our disclosure of interest process and I'll turn it over to Helen.

DR. BURSTIN: Great. Thanks, Evan, and good morning, everybody.

Some of you have been on our committees before but we usually at the beginning of each of our processes do a round of asking each committee member to offer any disclosures of interest they may have.

We've all seen your CVs. They are very, very impressive. We do not want you to recite your CV. We really just want you to share with the committee anything you think would be important for the others in this room to know as well as the public to know about your role in measure development, about your role potentially in any areas that might be associated with the ultimate implementation of these measures.

We recognize many of you are experts. That's why you're here at the table, or end users. So anything you can share with the group that you think would be relevant please go ahead.

At the end of this process I will ask each of you if you have any questions of each other, just to give you a chance to fully flesh that out.

So perhaps we'll begin with our chairs. Lisa, would you like to do your disclosures?

DR. LATTS: Hi, I'm Lisa Latts, currently consulting with LML Health Solutions. And I have no disclosures, no conflicts. I work for some clients that might use measurement at some point, but nothing currently.

DR. ASPLIN: Good morning. My name's Brent Asplin. I'm currently chief clinical officer for Catholic Health Partners based in Cincinnati, Ohio.

And I was a prior chair of the Quality and Performance Committee for the American College of Emergency Physicians which does have some NQF-endorsed measures for which it is the measure developer. But I'm not currently in the chair role and I do not have any conflicts to report.

MR. WILLIAMSON: At this time we'll continue with members in the room and then we'll handle members on the phone.

DR. WONG: I'm Herb Wong. I'm a senior economist with the Agency for Healthcare Research and Quality. And I have nothing to disclose.

MS. PARE: I'm Carolyn Pare with the Minnesota Health Action Group. I sit on the NCQA Standards Committee but I have no conflicts to disclose.

DR. WALKER: I'm Lina Walker. I'm with AARP and I have nothing to disclose. No conflicts to disclose.

DR. WEINTRAUB: Good morning, I'm

Bill Weintraub, chair of cardiology at Christiana Care in Delaware, professor of medicine at Thomas Jefferson University, the president of the Great Rivers Affiliate of the American Heart Association. And I'm very involved as well with the American College of Cardiology. So there are potentially interested parties about measurement.

I also do some low-level consulting for the pharmaceutical industry which I do not think are really relevant to these measures.

MR. RYAN: Hi, I'm Andrew Ryan from Weill Cornell Medical College and I have nothing to disclose.

MS. YANAGIHARA: Good morning, I'm Dolores Yanagihara with the Integrated Healthcare Association in California. And we do contract with NCQA. I sit on the Overuse Measure Advisory Panel for NCQA, but no conflicts.

MS. DAMBERG: Cheryl Damberg from the RAND Corporation. I don't have any conflicts.

My area of work tends to focus on the evaluation of organizations' use of performance measures.

And I previously had several contracts that were looking to develop efficiency measure concepts that could be translated into performance measures, but those contracts have ended.

DR. ORLOWSKI: Good morning. I'm Dr. Janis Orlowski. I am the senior director at the Association of American Medical Colleges. I have no conflicts to disclose.

DR. GELZER: Hi, I'm Andrea Gelzer and I'm chief medical officer for AmeriHealth Caritas. And I have no conflicts to disclose.

DR. NAESSENS: Good morning, I'm Jim Naessens, a health services researcher at Mayo Clinic. And I've used various measures but have no conflicts to disclose either.

DR. BURSTIN: And Evan, can you run the list of who we think is on the telephone?

MR. WILLIAMSON: Yes. So we have a

list here. So we'll start with Larry Becker?

MR. BECKER: Hi, this is Larry Becker. I work for Xerox. I'm on the board of NQF and of PCORI and I've recently as a consumer engaged in the Yale Core group in looking at some measures more as a learning experience for me to see how measures are developed at the other end. But, so I don't think I have any conflicts.

MR. WILLIAMSON: Great. Thanks, Larry. Next we go to Mary Ann Clark.

MS. CLARK: Hi, Mary Ann Clark, senior vice president at Intralign. We are a company that helps hospitals improve the cost and quality associated with orthopedic procedures.

I've been involved with past NQF technical expert panels on cardiovascular work. At my current company we don't develop measures but we do use them in a lot of our work in our consulting work.

MR. WILLIAMSON: Great. Thanks a

lot, Mary Ann. Joe Stephansky?

MR. STEPHANSKY: I am with the Michigan Health and Hospital Association and I have nothing to disclose.

MR. WILLIAMSON: Great. Ariel Bayewitz?

MR. BAYEWITZ: Hey, Ariel Bayewitz from WellPoint. I have accountability for WellPoint's shared savings and risk models. And we use performance measures to evaluate provider performance in the models. But I don't believe I have any conflict.

MR. WILLIAMSON: Great, thank you. Jennifer Eames Huff?

MS. HUFF: Hi, good morning, Jennifer Eames Huff. I'm director of advancing policy for the Pacific Business Group on Health. I have no conflicts to disclose.

MR. WILLIAMSON: Great, thank you. And John Ratliff.

DR. RATLIFF: Good morning, John Ratliff from Stanford. I'm the chair of the

Quality Improvement Workgroup for the AANS.

I've done some work with Yale on their readmissions projects but otherwise I don't have any conflicts relevant to today's discussions.

MR. WILLIAMSON: Great. Do we have any other committee members on the line?

(No response)

MR. WILLIAMSON: Great.

DR. BURSTIN: Thanks, Evan. This is Helen again.

So, just one quick question for Larry. Larry Becker, was any of your engagement with PCORI around the measures before the committee today?

MR. BECKER: No, these are CMS measures that are currently being thought through.

DR. BURSTIN: Excellent. Thank you, Larry, appreciate that. Any questions of anybody on the panel for each other? Pretty minimal conflicts from this group. Heavy

health services/researcher/methodology types.

Just one last comment then. And thank you for all those disclosures. At any point during this process if you have any concerns please feel free to come forward to the chairs, myself, or anybody else.

We really would like to find out about any concerns about potential bias or conflicts in realtime. It's often difficult to navigate those post hoc. So, anything you can let us know we're perfectly happy to help engage and see if we can sort through those issues in realtime as they happen.

With that I'll turn it back over to our chairs.

MR. WILLIAMSON: Thanks a lot, Helen. And thank you everybody on the committee for providing your disclosures.

We're now going to move into the role of the standing committee. So again, as I mentioned earlier this is a new process for NQF. It's something we really think is going

to provide great value as far as overseeing the full portfolio of measures in this area. And we're really excited about it so we'll move right into it.

And so again, we really see this as an overseeing of the NQF portfolio and providing strategic direction for future measure development as well as addressing gaps. So we're going to have a gaps discussion to make sure that we provide direction for where we really think measure development in this area should go.

We also hope this will lead to increased developer involvement in the measure evaluation process. Where we have a committee that's really well versed in the evaluation process, will have been through it a number of times and are really able to engage the developers.

MS. WILBON: One of the other things that really kind of brought this whole standing committee transition on is to really

help consistency across the evaluation process.

So, a lot of -- or many of the people on the committee have actually been participating with us for some time.

And it's really -- I think our committee has been somewhat of an example of what it can be like when you have a group of people that have meshed over time, that are used to reviewing the same type of measures and that we're getting to a point where we're being more consistent with our evaluations of these types of measures.

So that's one of the main benefits we're looking to see with having the standing committee process in place, and also having a group of people that over time are familiar with the measures in the portfolio, what's going on in the field and to be able to give us that input instead of kind of seating a new group of people every year who are kind of just learning the process by the time they

roll off.

So in terms of consistency I think that's one thing that is really a major goal of the standing committee process. So I just wanted to add that in.

MR. WILLIAMSON: Great. Thank you, Ashlie.

On the next slide here we have a full listing of the responsibilities we see for the standing committee.

And so for this we'll have you provide input on relevant measurement frameworks. And so, again, we won't be addressing any frameworks today but as they arise throughout the term on the standing committee we'll have you provide input.

We'll task you with knowing which measures are included in the portfolio and understanding their importance in the portfolio. We'll be listing those out as we move through this presentation.

We want you to consider issues of

measure standardization and parsimony when addressing the portfolio. So again, as we get new measures we want to see how they fit with the other measures in the portfolio, how we can align and provide harmonization to reduce burden in the field.

It's very important as far as overseeing a full portfolio, seeing it as a whole as opposed to just the individual measures that are coming in front of the committee.

We'll have you identify measurement gaps in the portfolio. And we want you to be aware of other NQF measurement activities from the topic areas. That's something that we are really starting here in the affordability area.

We have a number of other projects going on. So we'll really address how this work fits in with the other affordability work going on, how we can provide input to the other groups, how they can provide input to

this group.

Again, we have a lot of expertise that we're drawing on for these groups and we want to make sure that we're not duplicating work or really redoing work. It's very important in this area here.

We also want to be open to external input on the portfolio. So again, as we've been through in the past in phase I we all saw the public and member comment we got on our report. And we're really seeking that public and member comment on the full portfolio, on the work we're doing here. And so we want this group to be open to that input and to really consider it as we move forward.

So we'll have you provide feedback on how the portfolio should evolve. So again, not where we are right now, but where we want to be next year, we want to be five years from now, where we really see this work going. We think it's very important. Trying to figure out who we should engage in this work, who are

really the key players that can make things happen in this area.

And again, as we've all been -- or most of the people here have been through the measure evaluation process. We have a few new members. We'll hope to bring them along as we go through this.

But really to consider the portfolio when evaluating individual measures. So, moving beyond just the properties of that individual measure, but really how it fits into the whole portfolio.

So, at this point I'll open up to any questions. We have a full list of responsibilities here. There are some new things that we'll be covering here as a standing committee, things that we think are very important here at NQF.

And so I want to open it up for any questions, any clarifications. If there are things that are unclear or other things that you think the standing committee might be

responsible for I want to open that up for discussion right now.

DR. WEINTRAUB: So, always glad to start things off. So, this has been a very good process and I think moving to a standing committee is really a good idea because it will give us deeper insight and an overview over the whole portfolio of cost and resource measures.

You know, you come in and you see a little slice of NQF, maybe engage for a day or two, but you don't really have the sense of it that you do when you're involved in the committee over a period of time and you see the full portfolio.

I mean, the danger of course is that you become too inbred and you don't have enough external input. So obviously there needs to be rotation over time. But still, I think the process is a very good one.

MS. WILBON: One of the things we're going to do a little bit later is draw terms.

What we'll do is we'll stagger you guys for the first set of rotation.

We'll rotate off half the committee every -- well, the first rotation will be in two years. And then we'll bring in a new -- we'll do a new call for nominations and bring in another fresh half of the group. To address your point, Bill, about kind of keeping -- making sure we're keeping fresh perspective in the mix as well. So that's to come.

DR. LATTS: Brent?

DR. ASPLIN: One question I have for staff is how you anticipate managing common themes or common issues across a portfolio of measures given the fact that at any given meeting any standing committee in its current configuration is only going to have a limited portion of the portfolio in front of it for actual comment or recommendation for endorsement.

When there may be a broad-based

systematic or methodological approach issue that comes up that you'd like to apply consistently to the whole portfolio but yet you don't have the whole portfolio in front of you.

How do you want to manage that issue over time? Given the fact that the committee is not a developer yet if there's going to be consistency for the community out there about how we approach cost and resource use we want to try to apply the same principles consistently to the measures.

MR. AMIN: So there's at least two -- let me start with that. There's at least two different issues that you've raised, Brent. And I'll sort of use one as an illustrative example of what we've started to do.

So, across committees one of the main issues that we started to recognize coming out of this group and then actually the group that you were on last year with the readmissions panel was around the issue of risk adjustment,

adjustments for SES broadly, the issues of hierarchical modeling and the effect of -- what that does for small hospital performance. And that issue came up in multiple different committees.

And so what we're really trying to understand from these discussions across the different panels is to characterize the nature of the problem. Which there was an unanswered question around -- or it was an existing guidance that was out there that NQF sort of was standing behind. And then there was general concern or an ask for revisiting that guidance.

And so what we did was we sort of worked across the different, you know, what we will do as staff is work across our various different projects and say at the end of the day this has become a major issue for all projects, or at least projects that relate to outcome measures.

So we need to seek funding to convene

panels to discuss this issue across the different workgroups.

And obviously Nancy was our -- and others I think maybe, but at least Nancy in particular was our representative on that panel that was recently convened to address this issue.

And the goal of that work will be to inform, once there's actually a final recommendation from that group it will obviously be informing all of the different efforts in terms of what would be affected by that work.

And what we'd like to do with a standing committee is keep you informed of what that work is and then make sure that we're bringing it back to you in a more discussion-oriented -- obviously there will be a final report which we'll share with you. But we'll also have a discussion on the implications of those issues. So that's at least the one issue.

The second -- I actually lost it. But maybe Helen's got it.

(Laughter)

DR. BURSTIN: I don't know what Taroon's second issue is, but my first comment is -- thank you for that -- is that one of the other things we've done is we've tried to group the measures together in a way that always tries to put like measures together.

So we've actually worked with the developers so that they recognize that some measures, for example, might come up slightly sooner than they thought they would. Or even potentially later than they thought they would in terms of maintenance.

So that we're going to prioritize putting measures that need harmonization issues or alike measures together to exactly get at those concepts. Because we do want to make sure that we're logically kind of going in the same direction and not having measures that are really kind of coming off course in

terms of some broad principles.

MR. AMIN: Thanks, Helen. You jogged my memory.

So the issue that you brought up, Brent, was around, you know, this group is not a measure developer. But as you're reviewing measures there are sort of methodological issues that arise that warrant some kind of, you know, certainly some discussion.

And what we found, that there was a lot of discomfort with measure developers in terms of the Kaizen work that we did last year with the fact that steering committees wanted to make changes to the measures sort of on the fly.

And a lot of that is understandable considering that in the previous model this was the only opportunity you had with that measure, and this might have been your only opportunity to be on a panel that was discussing this issue.

So the goal of what we were trying to

do with this more longitudinal time, having a more longitudinal view of the portfolio and having members be on the panels with us over time is to say, okay, we're cataloguing these issues that are present with some of these measures, or some future guidance that you have.

And we can better apply them over time and give the actual measure developers time to make some of these changes and have an interactive experience with the panel so that they can come back, provide some updates on what's happened and the committee feels a little more comfortable that there's some actual movement and progress with the recommendations that have come up.

So that we get out of this -- hopefully that improves the experience of measure developers and also makes the committee time much more productive. So hopefully that sort of addresses the two issues that you brought up, Brent.

DR. LATTS: So, this is Lisa. I'm going to call on myself.

And just a reminder to those of you on the phone. We know that you're going to be very tempted to multi-task and how hard it is going to be to be on a two-day webinar. So, please participate and raise your hand or your placard virtually through the webinar.

My question is if we come up to a measure or a set of measures that are similar but better than a previously approved measure, does that mean this committee would say we want to nuke the previous measure in favor of this one? And what does that mean for the measure developers and all the people that are currently using that measure?

MR. AMIN: So, one of the things that we're really working on with our sort of harmonization and competing measures discussion that we're having globally is that we are trying to identify like measures even when the measures are not necessarily up for

review.

So you'll notice that in our last effort when we convened we invited our colleagues from HealthPartners who had developed a non-condition specific per-member per-month measure.

And similarly there was a measure that was developed for the Medicare population that was a PMPM measure.

But we asked our colleagues from HealthPartners to come up and describe how the measure was similar or not to the new measure that was in the portfolio. So, the goal would be to have sort of more, again, with the idea of having much more of an iterative interaction with the committee with these issues so they're not sort of new issues and the developers of the prior endorsed measures aren't taken by surprise when we're having these discussions.

I will say this obviously increases the burden of the standing committee. I mean,

the discussions are not simply going to be around individual measures.

And it also increases the burden for developers who need to participate in our process much more than the three-year cycle that we've had in the past. But, the idea here is if we have much more sort of constant communication we can have much more reasonable time-lines for turnaround for our developer colleagues and also the standing committee can have much more of an informed understanding of the field of where we are with endorsed cost and resources measures.

Obviously this includes more than just cost and resources measures, but particularly for this group.

DR. LATTS: Andrew?

MR. RYAN: Could NQF please describe what the iterative process is going to be with these measures that we're evaluating this time? In terms of how we feed back to the developers and how they respond to our

comments.

So for the last time with the total per capita spending and Medicare spending per beneficiary we met, we had comments. And then a couple of months later we had another kind of formal process where the developers kind of got back to us with changes. And then there was another vote.

Is there an expectation that there could be a similar process with these measures? I know that seemed to be kind of unusual. That was my first panel so I don't have a lot of context there.

But I think knowing what we can expect in terms of whether it's just an up or down vote, or whether we can expect some tweaks that would make the panel kind of more comfortable with approving this measure. Whether there's an expectation that that could happen would help kind of inform the deliberations of the committee.

MR. AMIN: So, Andrew, that's sort of

a difficult question in some ways.

So, the -- what we're trying to balance -- let's put it this way. What we're trying to balance is that the developers are coming here for essentially an evaluation of what's in front of them.

So it is not intended to be a process that sort of has an iterative, the committee will approve this based on some changes because some of those changes might require additional testing. It might require changes.

Quite frankly, a lot of the measures that we see are under federal -- they're under contract for development and the contract for development has expired. I mean, they're just coming here to kind of present their final deliverable if you will.

So there really isn't either the time, that's the first issue, or the resources to actually make the types of changes that the committee is requesting.

So that's one end of it. So the

process is currently structured to be essentially an up or down.

With that being said, however, nobody wants to see a measure voted down because of some small changes that could be made in the measure and that the developer is willing to make.

So one of the key changes that we're trying to introduce here is that unlike sort of if you will a dissertation defense we don't want the developers to feel like we're just evaluating them and they're not part of the conversation.

So, you know, one of the key things you'll see if we've changed the format of the meeting a bit here so the developers will be joining us at the table.

And these are questions that we can sort of ask the developer to understand what is the nature of these -- if we have these recommended changes how long would it take. Is this reasonable to make in a certain period

of time. Could you do this by your annual update. Can you commit to doing that by your annual update.

And then at that annual update process we could then expect to see an updated measure or -- again, with the idea of having a continual conversation with them to say you're always annually updating your measure. That might be a good time to update this. So, the goal of this is to have more of a conversation with them.

What is the boundaries? I think we should sort of think about this exercise as an up or down exercise. But if there are changes that will really affect your -- if you're really going to vote a measure down and there are some changes that you think would make the change I think we should have that conversation. And have that conversation with the developer in terms of timing.

But you should be aware that this process, our process with constrained time

periods and the ability for developers to make the changes within the time period is extremely limited.

But our goal is not to -- again, with the caveat being the goal is not to take down a measure for some small changes in age ranges, or exceptions, or things of that nature that might be easily made in terms of the specifications.

So that's not a direct answer but we'll kind of -- we'll have to learn with that. I don't think there can be a complete standardization of that across every panel.

DR. LATTS: Jennifer on the phone?

MS. HUFF: Yes. Jennifer Eames Huff with PBGH. I have a question about the role of the committee in identifying measurement gaps.

I was wondering if that could be talked about a little bit more in terms of what that looks like. And then what would happen with that information once gaps are

identified.

MR. AMIN: So, we'll be starting this conversation actually right after this session in terms of overall roles and responsibilities.

But essentially the goal of what we're trying to do here is to say -- and some of you have been with us since the first cost and resource use panel that we just even characterized what a resource use measure was and where we are right now.

So, particularly in this area since it's a smaller area with a smaller number of measures, although it's generally more technical and much more complex than some of our other areas of measurement.

What we're really trying to understand is what's the game plan here. What kind of measures do we really need to move the needle in terms of overall spending for the country. And more importantly, to make the health system more efficient in terms of cost

and quality.

And so we've started down this path with some measures in the portfolio in terms of total cost measures. And we're starting down this path with some episode of care measures.

But as somebody noted during our orientation call, it might be Andrew but I can't recall off the top of my head actually, is like we're doing these cardiovascular measures. Then we're going to pulmonary. What's the game plan here.

Well, that's the question that we're actually going to be asking the group. Like, where are we going. What are the real high-impact episode measures that we need? Do we really need episode measures versus per capita measures?

And if we could really define in a much more -- put some more structure around what our five-year plan, one-year or five-year plan we can work with our federal colleagues

and help to structure future measure development contracts and other, if there are other sort of measurement science issues that exist in the field.

Which as we'll describe later on today there were that we identified during the first panel around linking cost and quality measures which Andy and Chris and others are working on with us. Or these -- like how do we define affordability from the consumer perspective.

We can then put together more -- we can put together additional panels and additional steering committees or concept papers to address some of these more methodological issues that may still be in the field.

So, our effort is to -- is multi-fold which is that we want to define where we want to get to and then put into place actual projects and committee work that we might pull subsets of the group to work on. We might

convene additional panels. We might actually get a white paper authored by some folks in the field and start to address the sort of bigger, technical, methodological issues that are in the field.

So, in particular related to the issue of gaps what we'd like to do is take the issue of gaps where we think we need to go and that will define our future call for measures and even more upstream inform our colleagues at HHS about how they should be structuring future -- or make some recommendations about how there should be future measurement development contracts.

Obviously we're not doing that but we obviously have a role with advising HHS in that function with our work on the Hill, with our Stand for Quality effort. So, which involves measurement dollars and how they're allocated.

DR. LATTS: Andrea.

DR. GELZER: Thanks, Lisa. Cost

tensions, I want to applaud NQF and I want to thank NQF because this is all very positive and this is the direction we need to be moving in.

But I also think that cost tensions over the next few years are just going to exponentially rise. And I think that historically we've done so much work with traditional quality measures.

But the cost area is still really nascent and we've got a lot of work to do. So, I applaud the fact that we have a standing committee but I worry if we're going to be rotating off.

If you want to get consistency, if you really want to get a jumpstart to this work at this point I think that we do, as you have said, Taroon, we need to have subcommittees. We need to be working at this more than two in-person meetings, or one in-person meeting a year to get that consistency and get that drive.

DR. BURSTIN: One more point about the standing committees. That's a great point, Andrea.

We'll be giving each of you today the option of, you know, you'll basically pull out of a hat a two-year or a three-year term just so we could stagger the first iteration of this. But you're all eligible for a second term as well.

So I think at least in sort of the five-year focus which I think is probably when this activity is going to be the most intense I suspect we'll have a lot of the same players around the table.

And again, our hope is, as Taroon mentioned, to really be able to come back to this committee off-cycle as an issue comes out.

So it's not just the in-person meetings, but it's very powerful to at least have the chance to see each other, understand where people come from so that when you're on

conference calls and webinars for the next several years you'll just feel much more comfortable I think having that dialogue that's really open.

DR. LATTS: Bill.

DR. WEINTRAUB: This is the start of really great discussion. Certainly this effort still has that sort of nascent, just getting started feel to it.

And so you raise the idea of a white paper. I think that's a great idea. But maybe what we need even beyond that is a true strategic plan of how we're going to address the issues of cost and resource use.

And developing a strategic plan like that, that's a process. Many of us in our organizations where we work every day have been through that process a number of times.

Developing a really good strategic plan is probably a one-year process in and of itself. Maybe it's something we should consider.

DR. LATTS: Larry on the phone.

MR. BECKER: Hi, yes, this is Larry Becker. So I agree with what was just said. I think having a strategic plan is really important.

My question is what is our capability to actually go out to the field and do surveys. Surveys of, for example, what do patients want in this area, what do clinicians want in this area. People that are treating people every day, the kinds of things that they come up against in their practice every day.

I mean, do we have that capability to go out and get information from various stakeholder groups?

MR. AMIN: So, Larry, that's a great, great point. And I think we heard you and Jennifer I believe in particular and Lina to a certain extent as well during our last committee meeting about the importance of that issue.

And what we've done in response, again, and I think this is what we mean in particular. As we get into this morning's discussion we'll describe this in much more detail.

But what we've done with that goal of trying to really understand what the priorities are from various different stakeholders' perspectives is that we've gone out to the Robert Wood Johnson Foundation and they funded a project to do precisely what you've just described, Larry, which Lina will be sort of our liaison to that group to really characterize affordability from the consumer's perspective in particular.

But it will also be we have a consumer panel, about eight consumers that we have convened across the country. But we've also -- it will also be a multi-stakeholder group that Liz Mort from Mass General that's going to be sort of characterizing what affordability means from the consumer

perspective and how we can start to get better measurement concepts, information and information systems in terms of social media and other potential opportunities for how do we really start to understand what affordability and cost and resource use means from the consumer perspective. But broadly from the multi-stakeholder perspective.

I should also say that this work also will interact very directly with the work of the Measure Applications Partnership which we'll talk about later on today.

So, meaning in particular how measures are used in federal programs. So, it has a very longitudinal across all of our work what are the important areas that we need to be focused on.

And that will very clearly translate to projects that we go out to seek funding for and then ask you to participate with us on, or take leadership roles in.

And you already start to see some of

that work. Like I described, the linking cost and quality work is a direct result of this committee. The affordability work which we'll describe in a little more detail is a direct result of that work.

And there will be an interactive relationship between this group and the Measure Applications Partnership in terms of advising -- or I should say this group is not charged with advising HHS, but participating in that process and being much more informed about the needs of the measures as they're used for federal programs.

MR. BECKER: Thank you.

DR. LATTS: Andrew, did you have another question? Okay, you're up.

MR. RYAN: So, one of the -- in terms of the committee being more active. And Taroon mentioned us, the committee forming calls for measures.

I want to ask NQF how successful prior calls have been in generating measure

submissions. Because if we think about what this committee has seen, the last two measures were driven by CMS contracts and priorities. And the Yale one seems similar to that. The other one we're looking at is just a refresh.

So I wonder what kind of ability you think we have to really get good submissions from calls for submissions as opposed to something that's a policy priority and is occurring under contract from someone like CMS.

MR. AMIN: I'm writing down my thoughts so I don't forget them.

All right, so I think we need to think about this more longitudinally than we have.

So, our typical call for measure submissions happens within a few months of the committee meeting. So, you know, you're not really going to see the type of measures that you want to see during the next cycle.

Which makes some sense, right? I

mean, nobody's going to start to develop a measure once the call for measures is actually put out there.

Which is why one of the things that we've been really trying to work on over the last year is to develop much more of an upstream relationship with our federal partners to say that we're convening these groups, they have a lot of -- they're bringing some of these sort of methodological issues and measurement issues forward. Let's play a more active role in informing your upstream development dollars and you can consider that as you're starting to put these dollars into play.

Now, obviously that has one to two years of lag time. I mean, our colleagues are doing the best they can with the government but they have their own time periods. So it's going to take some time.

But parts of the organization, parts of NQF is specifically tasked with the role of

advising HHS around gaps which has a very clear impact to how HHS decides to invest their dollars.

Now, clearly this group's not, you know, NQF in particular doesn't have any direct responsibility for the distribution of those dollars. So it's more of an advising function I would say rather than anything.

CMS can do whatever they want, quite frankly. But ultimately the role of this group is to represent our multi-stakeholder perspective on where we need to go as a field. And CMS takes that very seriously.

So we don't necessarily see it from the -- and that's why this whole longitudinal relationship for the committee vis-a-vis the work that we're doing needs to be much more longer-term viewing, that we need to really work with our federal partners. We need to understand the issues, characterize the problems and then work with our federal colleagues to understand how we can start to

address them.

But that might be on a one- to two-year lag period. And that might just need to be where it's at given the way the dollars and structure of contracts work.

DR. BURSTIN: And just wanting to build on that. A couple of other things we've been working on, one of which is in one of our current projects we've got what we're calling more of an open pipeline.

For example, to our endocrine project we've negotiated a pilot with CMS where every six months that committee will have measures come forward. So we don't have to wait years.

We're trying to see how many measures come in through each of those different calls. And that might be an option certainly in a field like this where there are going to be measures coming up every six months or a year. We wouldn't want to wait three years.

It's very dependent for us on federal funding of course to be able to do that.

The second piece of this is we're increasingly trying to think about where we can find measures already in use. So not everything has to be the start of a de novo measure development cycle. The developers in the room know it can take years.

And I think one thing that would be really helpful for this group to help us with is where are there measures that people are actually using, that they're finding very useful and potentially help us bring those into the process.

Now, we often find those people don't feel comfortable serving as measure developers, measure stewards to submit to NQF. So we're also trying to develop some of you have been calling a measure incubator where we can do sort of a bit of matchmaking between those who might have the expertise with those who have the sort of more technical skills around submitting measures, risk adjustment issues, potentially funders as well as those

who have data to be able to test it.

So those are all strategies I think of thinking about what's out there, bringing in measures already in use. Because frankly so much more optimal to know what the experience has been with a measure rather than a brand new measure coming to the process where we have no background or experience.

Then lastly, how we could actually help facilitate that process of matchmaking essentially, of where there is a good measure can we tie them to more technical folks who might be able to bring it forward and then work to make it a national standard.

DR. LATTS: Lina and then Ariel you'll be next after Lina.

DR. WALKER: Lina Walker. This is a question about whether or not NQF has any plans to integrate the cost and resource in the quality measures. And maybe you'll talk about that when you talk about the linking cost and quality.

But this came up in our last committee and I suspect it will come up again in this committee. Where a lot of these measures, maybe all of these measures, cost and resource use measures are developed with the intent of being used with a complementary quality measure.

But, you know, and when we assess the use and feasibility of these measures we are supposed to speak only to the cost and resource use measure and not so much consider it in the broader context in its application which is our instructions.

But it's hard to separate the two, particularly because many of these measures don't make sense on their own. You know, when it's applied in the field it has to be linked with a complementary quality measure.

And right now the process is that we review these measures in silos. And I wonder if there are any plans to integrate the two processes so that the two measures are more

meaningful when they're used together.

MS. WILBON: So, we do actually have a project going on now that actually Andy is very integrally involved in where we are trying to think through those issues.

And I think the barrier up to now has been if we do require in the submission in some way that people, the developers describe that link, what exactly are we looking for, is there -- technically and methodologically are there ways in which it is better to link, or better to report the cost and quality signal together.

And so without having that guidance we've been less forceful about making that link, making it a requirement up to this point.

But I do think that after this piece of work which we'll talk about in a little bit more detail that we'll have the guidance that we need to kind of -- to update our submission process such that cost measures or quality

measures that come forward that do have a link to a quality measure, that they would be able to describe that in the submission and those would be evaluated together, the actual link as well as potentially the individual measures similar potentially to a composite or some other type of reporting functionality.

So it is coming. I think we've just been waiting for this piece of work which has kind of been our missing link so to speak to figure out what does that mean. If we ask for it, what exactly are we asking for. And so, I don't know if you have anything to add, Taroon?

MR. AMIN: Yes, I do. Let me just also add a little bit of just my own thinking on this.

So, Lina, one of the other things that I just want to sort of -- especially with this group. We started with a lot of assumptions with the cost and resource use work.

And staff sort of is an administrative arm of the will of this group in some ways, especially more directly as we use -- you become a standing committee.

So, I want to be clear that some of the guidance that we have, if we strongly disagree with the way the guidance is constructed there are mechanisms to start to adjust that.

So, one of the assumptions that we had going into this, and particularly related to your comment, is that in order to start getting towards measures of efficiency, we have the quality measures. But we needed cost measures that met our criteria, meaning that they were important, scientifically acceptable, usable and feasible. And they needed to be constructed in their own right in order to start moving toward measures of efficiency.

And there are some tradeoffs. I think there are some folks around the table,

especially over the phone as well, that may argue, particularly I'm referring to our purchaser community, that have felt very strongly that the measures of cost in their own right are important to collect and report. While we're still trying to get toward measures of efficiency or signals of efficiency I should say more broadly. Maybe not measures in particular as Ashlie described but more signals of efficiency.

So, our current construct is that, yes, let's look at the cost and resource use measures and look at them across the four criteria. And then make endorsement decisions on them, recognizing that there are some people in the field, some of our -- some stakeholders that feel strongly that those measures are needed in their own right. And then let's work on the science to get toward signals of efficiency.

Now, if we think that there needs to be a different approach, or a conceptual

thinking about how that works, or how we're going to get there in five years let's have that discussion. And let's be, especially if we're seeing potential unintended consequences in the field of just measuring cost which may potentially be a concern for other stakeholders.

So, as we're thinking about these strategic conversations all of these topics are open for discussion. So I want the committee as we're sort of stepping into this role of being a standing committee these sort of larger conceptual issues that may be present I would encourage us to characterize them.

We may not be able to answer them right away, it may take some time to answer them, but let's characterize them in a way that we can communicate that to at least the membership and then potentially start to address them over time.

DR. LATTS: So we've got four in the

queue right now. We're going to take these four comments and then move on to the next section so we can keep on time. First Ariel on the phone and then Nancy, you're next.

MR. BAYEWITZ: Thanks. So, probably a fairly basic question.

So, just generally speaking when we're selecting and prioritizing measures, and just thinking specifically about usability.

So number one, who is the primary audience? You know, I'm thinking just looking even at the three that we have over here there's the customer, there's a purchaser, there's the plan.

And also, who's I guess primarily when we're prioritizing, who are we looking to evaluate? Is it the plan? Is it provider in the context of provider hospital versus practices or more accountable care kind of organizations which don't necessarily need to revolve around hospital?

Just thinking from a plan perspective

I'd love to see more measures that we can use to evaluate provider performance beyond the context of a hospital.

And just even here with the three that we're looking at. You know, again, one is more plan-focused and the other two are more hospital-focused.

Is there a plan to include more measures around that capacity? We have a lot that we use on the quality side but not much on resource use.

And especially now with there's so much design around accountable care models, both in terms of ACOs but even within patient-centered medical homes. It would be great to have more measures that we could use there that would measure cost and resource use.

DR. LATTS: Anybody want to comment?

MR. AMIN: Absolutely. I think the conversation that we're going to have when we characterize the current measures in the portfolio, part of the gaps discussion will be

around what additional areas of measurement, in particular levels of analysis if you will do we need to be focused on and potentially what are some of the measurement issues with being able to measure down to the individual providers or groups or ACOs. And whether we know exactly what that construct is right now is still open for discussion.

But certainly those are the types of things that we want to characterize and be able to capture as we go forward.

DR. LATTS: All right, Nancy, then Janis, then Mary Ann and then we'll move on.

MS. GARRETT: Thanks. This is Nancy Garrett.

So, in thinking about gaps, and I'm not sure if we have another point in the agenda where we're going to focus on that, but I think one place that I see a really big gap right now is around price.

So, a lot of the measures that we're looking at focus on the resource use part, but

cost is a function of price and resource use.

There's just been so much developing noise in the community and in the press about price transparency. And I feel that NQF could really have a leadership position to help us figure out how to move forward on that.

And it's a little bit tricky because price transparency, you know, there's a measurement component but also there's kind of this business component.

I mean, it could be as simple as making a fee schedule public. But is that really meaningful to a consumer who's experiencing episodes of care that involve lots of different services together, and that combination of price and resource use.

So, the HealthPartners' per-member per-month measure, there is one that does include both price and resource use. But a lot of times we're looking at just the resource use side. So, I feel that price is something that we really have a gap in.

DR. LATTS: And hold that thought for two discussions from now. Janis.

DR. ORLOWSKI: As a new member of the committee I have two questions.

First is as you talk about the individuals who are involved in the measures, in the development, the one group that I didn't hear about was the professional organizations, professional medical organizations.

I was just wondering what our relationship or interaction with the professional organizations. I'm a nephrologist and the American Society of Nephrology has extensive work done on value and quality and resource utilization within that field. And so I was wondering how we engage that community.

And the second question, before joining the AAMC, about four months ago I was the COO/CMO of a 950-bed hospital. And I would tell you that on a weekly basis I

received metrics having to do with resource utilization. And I call it data from the trenches I guess.

I would tell you that COOs and CMOs can probably give you pretty good information for drivers for resource utilization. And I wonder what our ability is to tap into that. Or to tap into a number of organizations which we see as leaders in quality and efficiency within their organization.

So for example, I had a metric in cardiac resource utilization. The hospital that I was at was considered one of the top 20 within the nation. And I could tell you specifically two drivers for resource utilization that we were able to watch, that we were able to measure.

And the question that I always had is whether those drivers within that 950-bed hospital were the same drivers in others.

But I think that there's some value at looking at what I call in-the-trench data.

And I would think that most senior executives at hospitals have similar resource measurement and similar dashboards to use.

DR. BURSTIN: Those are all good questions and we're glad to have you on the committee so thank you. It was good to bring that experience from the trenches to the table. Running hospitals as we know is not an easy task.

So, in terms of the specialty societies we are actually very engaged with most of the major professional organizations. They're probably one of the major sources of particularly the clinically-oriented measures submitted to NQF. In fact --

DR. ORLOWSKI: Can I ask you where do I see them in the measures we're looking at today?

DR. BURSTIN: Yes, I don't know that they're part of the measures being looked at today. Again, I think that's a fair question to ask the developers, for example, about

their degree of clinical input. I think they oftentimes will have clinical groups who advise them.

But I think that in general we do a fair number of the clinical measures. And some of the overuse measures increasingly.

For example, in the last couple of years ACC has submitted numerous measures on imaging overuse, for example, in the cardiology space. But I think that's still coming along.

We have not seen measures specifically in the cost and resource use space from the clinical community yet. I think what we're beginning to see is a lot of partnerships being forged between the clinical community and those developing these kinds of measures.

In terms of your second part of the question we are also trying to do more work in terms of these action teams that we've formed through a sort of newer iteration of the

National Priorities Partnership called National Quality Partners.

These action teams are trying to bring together people from the front line to find out what are you using, what's working. And also not just about the measures, but what are the right levers to pull.

To your point, I mean if you're able to use those cardiac resource utilization measures in your hospital how are you using them. I think we've heard a lot over the years that simply throwing measures over the transom and hoping they kind of work isn't enough. And I think we're increasingly trying to think about what our role is with our partners to say how do you actually push measures out there with some real implementation guidance, with some real thoughts about how they could be most useful.

DR. LATTS: All right, Mary Ann, close us up.

MS. CLARK: Yes, hi. I just wanted

to echo what Nancy Garrett said and agree with her.

I have serious concerns about the use of these standardized pricing in the use of these measures and how that's actually going to impact -- effect a change.

Because I agree it may help with utilization and resource use control, but not necessarily the actual cost control. And with our shifting payment mechanisms towards more risk-based payment and bundled payment we don't really have any good information on what the prices really are.

And that's really where the negotiation is going to take place both for providers and for payers on trying to take on that additional risk and be able to manage the cost better. And then also make it more apparent and transparent to the patients as well.

So I just wanted to say that I do have an issue with the way these measures are

using standardized pricing and their ability to actually change cost in a significant way.

DR. LATTS: Thank you. Great comment. Okay, we are now going to choose our terms. So in lieu of a hat we're going to use a cup. Evan.

MR. WILLIAMSON: Yes. The traditional pick from a cup. So I'll walk around. We'll have you each grab a sheet of paper here. It has a number two or a number three on it. We'll have you hold it and then we'll go around the room and have you read off your term. We'll write it down.

And then for the people on the phone we will pick your term for you. So a little less control there but hopefully you trust us to be objective and random. So I'll walk around right now.

DR. LATTS: While he's doing that a couple of folks snuck in after the disclosure of interest. Do you guys want to introduce yourselves and any disclosures?

MS. GARRETT: Hi, everyone, I'm Nancy Garrett. I'm the chief analytics officer at Hennepin County Medical Center. So we're a care system in Minneapolis, a safety net care system and a teaching hospital. So, I lead analytics and IT there.

And I am, as I think Taroon mentioned I'm on the committee that's looking at the issue of risk adjustment and socioeconomic status which is currently in process with a final report due in June.

So lots of really robust discussion. I'm sure some of the issues will come up here as well and I'll try and share some of what we talked about in that group.

As well as the group on evaluating episode groupers. And Jim is on that as well. So we'll share more about that.

DR. LATTS: Anybody else we missed? Anybody else on the phone that we missed? Okay, then hang out while we are picking our numbers. Yes, Bill.

DR. WEINTRAUB: One more comment. So --

DR. LATTS: As long as you pick while you're talking.

DR. WEINTRAUB: So, I -- in listening to the discussion I worry a little bit about that the number of measures we could come up with would be essentially endless.

And obviously we can't do that because all our resources are going to be constrained. We know about resource constraints after all. So I think developing measures within an overall framework is really going to be essential to making this operate efficiently.

MR. AMIN: On that note since we maybe have a few minutes. The overarching framework that we're still using and we'll talk about to a little bit more detail is still the patient-centered episode of care framework that sort of characterizes the three different domains of time periods in which

patients may be seeking care and then measuring resource consumption over those three different areas.

And so I think part of the question, or part of the framing that we'll use in this next phase of our discussion is to think about the measures that we have in the portfolio across these three different domains and understand exactly how these map and effectively making sure that we're not just sort of listing off multiple different measurement concepts without really thinking about how they map to our sort of conceptual map about what we need to measure.

So we'll get into that a little bit more, Bill. But we're still working from the patient-centered episode of care framework.

MR. WILLIAMSON: Great. At this time we're going to read off our terms. And so Ann is going to read down the roster. If you're here in person you can go ahead and read off your number. If you're on the phone I will

pick the number for you and you will be stuck with whatever I give you. So, Ann.

MS. PHILLIPS: Brent Asplin.

DR. ASPLIN: Three.

MS. PHILLIPS: Lisa Latts.

DR. LATTS: Two.

MS. PHILLIPS: Ariel Bayewitz.

MR. WILLIAMSON: Two.

MS. PHILLIPS: Larry Becker.

MR. WILLIAMSON: Two.

MS. PHILLIPS: Mary Ann Clark.

MR. WILLIAMSON: Three.

MS. PHILLIPS: Cheryl Damberg.

MS. DAMBERG: Three.

MS. PHILLIPS: Jennifer Eames Huff.

MR. WILLIAMSON: Three.

MS. PHILLIPS: Nancy Garrett.

MS. GARRETT: Two.

MS. PHILLIPS: Andrea Gelzer.

DR. GELZER: Two.

MS. PHILLIPS: Stanley Hochberg.

MR. WILLIAMSON: Three.

MS. PHILLIPS: Martin Marciniak.
MR. WILLIAMSON: Two.
MS. PHILLIPS: Matthew McHugh.
MR. WILLIAMSON: Three.
MS. PHILLIPS: James Naessens.
DR. NAESSENS: Two.
MS. PHILLIPS: Jack Needleman.
MR. WILLIAMSON: Three.
MS. PHILLIPS: Eugene Nelson.
MR. WILLIAMSON: Three.
MS. PHILLIPS: Janis Orlowski.
DR. ORLOWSKI: Three.
MS. PHILLIPS: Carolyn Pare.
MS. PARE: Two.
MS. PHILLIPS: John Ratliff.
MR. WILLIAMSON: Three.
MS. PHILLIPS: Andrew Ryan.
MR. RYAN: Three.
MS. PHILLIPS: Joe Stephansky.
MR. WILLIAMSON: Two.
MS. PHILLIPS: Thomas Tsang.
MR. WILLIAMSON: Two.

MS. PHILLIPS: Lina Walker.

DR. WALKER: Two.

MS. PHILLIPS: Bill Weintraub.

DR. WEINTRAUB: Two.

MS. PHILLIPS: Herbert Wong.

DR. WONG: Two.

MS. PHILLIPS: Dolores Yanagihara.

MS. YANAGIHARA: Two.

MR. WILLIAMSON: Great. So now we'll move into NQF's other cost and resource use and affordability work.

There are a few more slides here but we'll skip over them. Just the general roles of the standing committee that we've been over during orientation.

So we'll turn it over now to Ashlie and Taroon.

MS. WILBON: So, you guys have seen this slide before. It's somewhat of a precursor. We're actually going to go into detail into each of those purple boxes today.

And we'll tap a few of the committee

members here today and potentially some on the phone that are actually sitting on some of those committees as well to provide some color to the discussion in terms of the discussions that have gone on so far with those different bodies.

So, again, those purple boxes are an overlay to our conceptual framework for how we have been conceptualizing I guess how resource use, cost, quality and value all kind of fit together.

So, and each of these different purple boxes in terms of the projects are addressing those different areas. So the measuring affordability for consumers is somewhat in the value realm. The linking cost and quality project is in the efficiency realm.

The MAP affordability family of measures kind of crosses all those domains. So we'll have Erin O'Rourke from the MAP team come and talk a little bit about the work

they've done so far.

And then we also have in terms of the cost measurement space work around the episode grouper evaluation criteria. And then the work of this committee today. So that's what we'll talk about next.

MR. AMIN: Actually, could we go back to that for a second? I just want to spend a little bit of time here. And just, I know you quickly just walked through it but I want to just point out specifically how this works for some of the newer members if that's okay. Can I go into a little bit more detail on this?

MS. WILBON: Okay, sure.

MR. AMIN: So, one of the key things that Ashlie pointed out but I'm just going to highlight it again just so that we're kind of all on the same page. Again, because I want to make sure that we're all starting from the same conceptual starting point.

So, the way that NQF -- and also there's a lot of language and terminology that

people -- this whole space is a lot of different terminology. What we mean by efficiency, what we mean by cost and price and all these various different terms. So I want to make sure that we're all starting from the same place.

So, on the bottom right, the darkest blue area is our previous conversation around what is resource use, what are costs that are absorbed in the system.

And so the work that we're doing, some of the primary work of this group is around endorsing, reviewing measures of cost and resource use.

And that will have conversations around what are the important measurement areas in terms of gaps, what are some of -- how do we start thinking about more high-impact measures.

Given that this is our newer measurement area for NQF we want to be really thoughtful about the process of how new

measures get endorsed and into the portfolio. And make sure we're being very strategic about that.

I mean, we don't want to -- I mean, I think we've done a lot of really good work on the quality side. What we want to make sure as we're introducing new measures into the field, that they're really high-impact. And we want to characterize how that is.

I mean, we certainly don't want to have 500 cost and resource use measures in the next 5 years. I don't think that is a marker of success. Maybe it is, maybe -- but it seems like at least we should have a much more strategic approach about how these measures are getting into the portfolio.

In particular, there's this whole issue about episode groupers. In the first cost and resource use project that we did we had Ingenix measures that were -- and Ingenix is just obviously one of many episode groupers that are developed in the field -- that were

sort of measures that were a result of an episode grouper.

And the work that we've undertaken, and I think there's -- as Nancy I think is again our sort of representative here from the episode grouper group, to describe and characterize what an episode grouper is and how one would evaluate an episode grouper.

And Nancy will give a high-level about what an episode grouper is. But effectively you take all these claims and you understand the cost for an episode of care.

So, at a very specific level what we're looking at in that bottom right box is how to characterize cost and resource utilization.

But clearly if you're trying to understand the efficiency of the healthcare system you can't just look at cost. Because that could just drive us toward reducing quality and ultimately we want to be able to find efficiencies, really ensuring that we

have cost-effectiveness, good utilization of cost and resource utilization, but at a good level of quality, so that you have a good specified level of quality.

And so how do these concepts relate to one another is really what we're doing in the linking cost and quality work which we've, again, as a direct result of this group we then took this issue and talked to our colleagues at the Robert Wood Johnson Foundation, got some funding. And Andy will walk through that I believe later on, exactly what we're doing in that domain.

And then finally when we think about how does efficiency relate to value, value is really driven by stakeholder preferences and values. Well, I shouldn't use the word to describe itself.

But like, if the concept of affordability and value is really up to an individual perspective. And the two pieces of work that we're doing, one most directly, the

Robert Wood Johnson work around measuring affordability for consumers is really trying to understand how consumers think about the concept of affordability, how affordability relates to these other three concepts that we have in front of us.

But more directly, what are the important measurement concepts from a consumer perspective, what are the types of information and then how can we best deliver that information. What are the channels, meaning, whether it's websites or social media platforms, things of that nature that we could start to think about how to get that information to consumers.

But there's also the work around the Measure Applications Partnership which is tasked by HHS to advise on selection of measures for federal programs. Which is also looking at the question of affordability from multiple stakeholders' perspectives. And also coming up with a framework for effectively how

you select cost and resource use measures for particular programs.

So, on that last point I also want to just point out the linking cost and quality work is really approaching the question of how you link cost and quality from two different aspects.

The first is looking at it from the measurement aspect of how do you put these two signals together to understand efficiency.

But also from the Measure Applications Partnership perspective taking an actual use case, for example, one could be value-based purchasing, and thinking about how you take the cost and quality signal to actually get a signal that you would use for the purposes of assessing provider performance.

And that again is a whole different area in terms of use. And that's a little bit outside of the measurement, like the actual measures, but much more around the signal of

how you start to put these two signals together for the purposes of profiling.

So, that's, again, I don't think I've said anything --

MS. WILBON: We're going to get into a lot of detail on these in just a second.

MR. AMIN: Yes, right, absolutely. I just wanted to make sure that we were conceptually.

And again, all of this is up for discussion and debate if we feel like the conceptual framing of how we're approaching this work needs to be adjusted or have other considerations.

As you're thinking through and as we're talking through in more detail each of these pieces let's also bring in some of the conceptual pieces about areas that we might be missing, or alignment of these terms to other terms that are being used in the field.

So, that's all I wanted to add. Thanks, Ashlie.

DR. LATTS: All right. Andrea.

DR. GELZER: So, can you go back to that slide? So, when I look at the resource use episode grouper evaluation criteria cost and resource use measure endorsement.

The episode grouper group, are they just considering the traditional Ingenix type of grouper? Or are they looking at 3M products? Population-based groupers?

I mean, we've decided not to even use an episode grouper right now. We are more comfortable with other products. So, I think we're missing a whole category there.

MR. AMIN: Maybe Nancy can also jump in here from her perspective from the group.

But the episode grouper work is intended to characterize what we even mean by an episode grouper. There doesn't seem to be general agreement in the field. Meaning that each of the different products is designed to do something different.

DR. GELZER: Agree.

MR. AMIN: And they all call themselves episode groupers. And, well, that could be debated. But let's, just for the sake of discussion I think that they're in the domain of episode groupers.

And the question that we were trying to understand is, and I guess this is really what Nancy is going to get into in a little more detail so maybe I'll just either let Nancy go on this topic right now or --

DR. GELZER: She may be able to answer my question.

MR. AMIN: Yes.

DR. GELZER: Great, thank you.

MS. GARRETT: So, really what we're doing is there's a definition here of what episode groupers are. But I can tell you we spent quite a while talking about that definition and trying to get agreement. It's not easy.

So, it might be helpful just to understand a bit of the catalyst for this.

And I mean, Taroon, you can correct me if I'm wrong but I think there's a couple of things.

One is this committee I believe has been asked to review episode-specific measures some of which we're looking at today but in the past as well. And if that measure is calculated from a proprietary episode grouper then how does the committee know whether the algorithms built into that grouper would meet any standards for endorsement.

So, I think that that was one of the reasons why there was a desire to try and figure out if we should actually be endorsing the episode grouper itself so that then measures that are developed off of it could have a more natural path to endorsement.

I think that was one of the catalysts. Whether or not that's achievable is another question.

And then the other thing is that in the Affordable Care Act there's a stipulation that CMS needs to create a publicly available

episode grouper that has to be endorsed by a national organization. Something like that, right?

MR. AMIN: That is endorsed by a national consensus body. A multi-stakeholder consensus body, which is effectively the National Quality Forum.

MS. GARRETT: Codename for NQF, yes. So that's the other catalyst for actually convening the committee.

So with those two drivers we've been really wrestling with what's really achievable, what can we do. If you go to the next slide.

There's a wide range of purposes and functions as Taroon mentioned. And really, one of the things we talked about is the fact that episode groupers is really a piece of software. And it's always changing, and there's so much complexity in it. So it's really different than looking at one individual measure.

And so what does it even mean to endorse it? If you endorse it does that mean it's frozen in time and you can't continue developing and improving on the algorithms? So what does that mean, and how do you even approach that?

We almost talked about the idea of is it kind of like getting certified, like certifying that the software does what we think it does and having a regular process of review. So, those are some of the things we wrestled with.

So Jim, I don't know if you want to add anything?

DR. NAESSENS: Well, I will say we also spent a lot of time looking at what criteria would we use to actually determine this. Can we follow the NQF criteria we're using for measures? Do we have to add additional ones? Do some things not fit? How do you determine that it's valid?

Looking at episodes we have at least

three main aspects for every episode grouper. What sort of clinical group of patients are included? What sort of time frame are we looking at? What type of services get included?

So, do you assess validity and reliability on every one of those for every one of their groups? Or do you do something that's kind of a global assessment?

And I know I missed the last couple of hours of the meeting so I'm not quite sure what we concluded. I haven't had time to go through the transcripts. But it's a big challenge and it clearly wasn't definitively decided at that first meeting.

MS. GARRETT: To answer your question, Andrea, the panel has a lot of really great perspectives and a lot of the major episode groupers are represented. So it's not at all software-specific.

DR. ORLOWSKI: So, I would say that this is very critical work. I understand at

this point that there are many software packages out there.

But in the end I think that we need to have a public definition and understanding of an episode. And that right now it's being driven by proprietary software. And what we need to do is to find definitions and publicize those and have comments about definitions that in the end the entire community can buy into.

And I think we're being driven by software and we need to be driven by -- I won't, I'll stop using the word "trenches" but we have to be driven by what is reality. And so I think that's the important work that you will be doing in this group.

MS. GARRETT: So, do you mean, Janis, in particular the publicly available episode grouper that CMS is working on, that that is really critical? As compared to commercial ones.

DR. ORLOWSKI: I was being more

global in my comment.

DR. LATTS: Larry, did you have a question?

MR. BECKER: So, a couple of things. I think you answered my question about the information on the private groupers being proprietary.

I recall several years ago when we had competing measures. I think it was Leapfrog's measure and STS' measure. One of the values of NQF is that we need to have this stuff out in the public domain. And so a lot of really good work was done to make that happen so that we didn't have these competing measures.

It seems to me that we ought to bias ourselves on the public's side and leverage those who have these proprietary tools to put them out in the open so people can understand what the results are that they're getting and being able to evaluate each against the other so that there's understanding.

And if they're not willing to do that then I think we ought to bias ourselves on the side of having a public tool that people can use and can base their decisions off of that until such time as somebody wants to come forward with a better methodology.

MS. GARRETT: Yes, I think that's a great point, Larry. This is Nancy Garrett again. And that's definitely something we talked about.

Among some of the software vendors that were represented some of them really have taken a step towards more transparency. Like the Optum Symmetry products. You can register for their website and get detailed access to a lot of the algorithms that they use. So, that is definitely something that we talked about.

But we also talked about what would be the value for a private company to get NQF-endorsed. I mean, this is such a different kind of space.

And so it may be that this is really a process that CMS is going to use and that other companies wouldn't come through. It's really -- we'll have to see what happens. It's kind of a different animal.

MR. BECKER: Though it would seem to me that if everybody started to use the public tool there would be a lot of pressure on the private ones.

DR. LATTS: Great. Okay. Do you want to go to the next committee? Herb, you're up.

DR. WONG: Okay, so it looks like I'm up.

So, several of us on this particular committee are also on another committee that is seeking to really link the concept of cost and quality together.

And the concept is that we recognize that there's this space out there that has not been well covered. There's talk about trying to get to this notion of value and other

elements there, but it hasn't been done well.

And in many dimensions there is this committee that is working on a white paper with the sole purpose of at least setting the baseline or conceptual framework for us to begin thinking and talking about this particular space.

It's really designed to talk about the things that are happening out there in the field in terms of composite measures and things of that nature, but also highlight the challenges as well.

So, the committee met twice. I think one was an introduction meeting and then a very long two-hour meeting where like any NQF committee there's no shortage of opinions I would say.

And many of the same themes that emerged out of that conversation I think that there are some elements that folks have heard here.

And I would characterize it into

really four very broad buckets.

The big thing that I kind of heard through our conversation was the concept or the notion that we need to be very clear in terms of our definition.

So as you all know, when we talk about resource use and things of that nature the concept of charges, cost, payment, price, they all emerge.

And it became clear that in terms of writing this white paper that the concepts that sits behind all of these terms have to be absolutely clear.

One of the key things that is directly related to the definitional aspect of it is the notion of perspective. And that is once we kind of got into this a little bit obviously a critical question is who's the audience and who's the main user of a potential product that comes out of that.

So, is it the consumer? Is the payer? Is it the provider? All of those

elements kind of emerge.

Obviously there's some work that has already been done in this field. Comments about looking at the AHRQ/RAND report that kind of got at this. This notion of efficiency kind of emerged there.

But there was a clear recognition that we really need to make sure we cover those bases.

We had a good conversation about the difficult challenges that emerge there. And I think that the challenges are I think multifold. And I'll put it into two larger buckets. And folks that sit on this particular committee, also on that one as well may also chime in on it.

The way I kind of saw the biggest challenges emerging are, one, in terms of the methods. So, there's comments about, well, if you go to a composite measure where you're trying to blend these sort of things what are some of the technical aspects? Do you get

false positives, things of that nature? So there are challenges that kind of emerge there.

The other component that folks talked about were really what I would say data challenges. And that is in many ways there's known sets of data out there. Oftentimes it's administrative claims data and things of that nature. And you wonder whether or not there is enough information to do some of the things that you want to do there.

And there was some good conversation about, well, should the committee be limited to where the peer recognition of the data challenges and only move down one pathway.

So, some examples were these concepts of efficiency. And in the economics world there are these different methods that look like SFA and all these sort of things. But they rely heavily on what they call input prices. And those are hard to get. So should we be limited there.

And I think that, I'm not sure exactly where we ended up on that, but there was at least a group of folks on that committee that basically made the following comment which I think I agree on.

And that is if this white paper is designed to be a conceptual framework to move the field ahead let's be honest of all the limitations out there.

Here's the field that we need to make headway on, here are the concepts that sits behind it, here are the limitations and challenges. Because maybe that will motivate the field to collect more data and things of that nature. So that's the third component.

And I think the fourth component that I had a takeaway on is the notion of actionability. As we think about these measures that emerge we should give serious consideration that the measures will give the field, the players out there some information that they can in fact act on.

So, I will say that's kind of my high-level perspective of the conversation there. And as I said before, I think there are other committee members here that also participated on that call and they can add their two bits too.

MR. STEPHANSKY: This is Joe Stephansky. I'm on that workgroup.

And I think the main takeaway that I had was that if you wanted to guarantee a lack of consensus just put 20 economists together.

(Laughter)

MR. STEPHANSKY: I'm going to leave my comments out about the particular discussions that we had.

But I think it's important to note that that group is not likely to produce a lot of useful guidance to us as we consider the possibilities of, say, this AMI resource use measure being combined with the AMI mortality measure and the AMI readmissions measure into some potential measure of value.

We're not going to get a lot of guidance out of that committee in the short run. That's more of a long-run output of the committee. Thank you.

MR. RYAN: Hi. So, I'm involved with writing that white paper. And I would echo the comments by Herbert and Joe.

It was a very I thought an excellent discussion. Very high-level. It's an excellent panel.

And there's a lot of complexity here. It's I think getting people to have the same mental model about what we're talking about is a real challenge. And I think it will be part of the goal of the paper is to get people the same mental model of these issues.

Just a couple of things I would add are that with respect to what Herb said about the data issues. I would also say there was some question about the economic notion of efficiency and that it's considered from the kind of firm or provider perspective.

That one way to think about it is how do you get the maximum level of output for a given set of inputs. Whereas in this discussion we were really thinking about it from, not from an internal resource use perspective but more from a payer or system perspective of what is a given payer getting for a price that they're giving for a service. What kind of level really of quality are they getting for it. So that's one thing I wanted to note.

And I think moving forward we kind of want to bracket that in saying there is this notion of economic efficiency, but we're thinking about this from really kind of a different perspective, number one.

I think there's a real interesting controversy about the kind of quality measures that should be considered when we talk about efficiency. Such as opening that up. You could see that there really wasn't any consensus about using process measures, really

focusing on outcomes, how you can have a kind of blended quality signal using process and outcomes. So I think that's something we want to try to bring out more in the paper.

And I think what we'd like to do, this is really the prerogative of NQF, is to try to help developers in providing guidance when they think about bringing up measures for NQF endorsement around efficiency.

And to provide some high-level issues about what we're looking for in terms of harmonizing data elements for cost and quality, and providing some larger framing to help NQF think about this but also measure developers when they're trying to bring forward ways to measure efficiency.

MS. GARRETT: I had a question for the group. Did you do any kind of literature review about what we know about the relationship between cost and quality empirically?

Just in my own professional

experience what I've looked at suggests that there isn't necessarily much of a correlation with our current measures which is kind of interesting. You might have a hypothesis either way.

But what do we know about that? Are you looking at that at all?

DR. WONG: I think in general there is a small literature that looks at different dimensions on that. So, there's a couple of papers I know that a colleague of mine had worked on that looked at costs in a relationship to quality.

But it's costs from the perspective of the hospital. That is the cost of producing those services.

And he found some positive -- negative relationship. No, let me think about this. I have to go back on it. But it wasn't overwhelming.

I would say that in general that the literature is probably mixed on that at this

point because of the different dimensions of quality that one may be measuring.

And if you think about quality dimensions potentially that measures different dimensions. And so potentially that could have an impact on those sort of things in a different way.

DR. LATTS: Cheryl.

MS. DAMBERG: So, Herb, I agree. I think there's probably less in the literature than actually people have been finding on the ground. Because I'm sitting next to someone who's been looking at that. And I know some work that we've done at RAND.

And I think what's confusing in this space is that -- not so much that it's a mixed signal, but the signal's very weak. And so that doesn't tell us whether it's positively related or negatively related.

And I don't know whether your paper is going to also cover what I'm going to call the implications for signaling this

relationship to consumers. And kind of that consumer reporting space of how they think about this information. And so I'd be curious to know about that.

DR. LATTS: Janis and then I'll move on to Lina's committee next.

DR. ORLOWSKI: Just a quick comment. I had the opportunity to talk to the VA this past Friday. We were talking about big data. And it was around this discussion.

We were talking about the engineering term "signal to noise ratio." And the solution to a signal to noise ratio is not volume, it's trying to define.

And I think that's the issue that we have right now. We really have a significant amount of noise around this which is why the papers that we see are so weak.

DR. LATTS: One quick comment before we go onto the next.

DR. WEINTRAUB: Yes. So, this is very complicated, the relationship between

cost and quality. It depends, I think the problems of measurement that Janis is getting at.

There are also problems of perspective and scope. So, we know worldwide that the relationship between cost and quality doesn't look very good for the United States. We all know those data. So, a lot depends on the question that you're asking. Terribly, terribly complicated.

DR. LATTS: Okay, so this is our third subcommittee of relevance. Lina.

DR. WALKER: This is Lina Walker. I am on a panel looking at affordability from the perspective of a consumer. And I think that this is really important work and I applaud NQF and the Robert Wood Johnson Foundation for supporting this effort.

There's a lot of interest in asking consumers to play a more active role in healthcare decisions. And they need the tools in order to make these appropriate decisions.

And what's lacking right now are these measures that could support and empower them to make good decisions about their healthcare and about their choices. So this is the first step towards that end.

Now, this is no doubt going to be quite challenging. As Taroon alluded to earlier part of this reflects preferences of the individuals. And part of it also reflects the individual circumstances. You know, affordability is tied to their own ability to pay.

And so thinking about that broadly and being able to come up with some kind of recommendation in the end I think is a hard lift but a very necessary -- it's very necessary for us to look into it and attempt it.

Now, what's a really important part of the conversation would be thinking about what is currently out there, what are useful

measures for consumers, how do you construct them and what information does it convey to the consumer.

Now, I think this is where the issue of price comes in. And Nancy and Mary Ann alluded to it earlier today.

So, there are different components to prices of course. There's the price of the service but that may not necessarily be something that's important to a consumer as they're making their decision.

So the price that the consumer faces is probably more important. But there are many, many components that go into that. The type of health insurance coverage they have, the benefit structure, et cetera, et cetera.

So, thinking through these issues will be part of our discussion. We've had an orientation call and there are some consumer members on this committee. And a few of them expressed some observations around the concept of affordability.

And I think what's really interesting from those conversations was that there is a really very broad spectrum of how people regard affordability in the context of healthcare decision-making.

So for instance, there was one comment where the consumer said that in making her particular healthcare decision, it was a very personal decision, cost was of no consideration.

And then there was of course the opposite perspective where cost was one of the most important considerations. A lot of it again is coming from differences in perspective and differences in the ability to pay.

So we haven't moved forward in the discussion yet but I expect that there will be a lot when we get together for the two-day meeting.

DR. LATTS: Andrea.

DR. GELZER: I think it's hugely

important, especially obviously in the commercial population.

And when you talk about deductibles, first dollar coverage, copays, coinsurance. I mean, how a consumer can come to that meeting and even understand the decision that they will have to make, all of those things impact care.

So I hope that the committee gets to that stuff. It is, it's so important to every consumer.

DR. WALKER: Yes, I completely agree with you. And I hope we do discuss all that at our two-day meeting.

Just to continue on your thought, in the commercial space there's actually a movement towards these private exchanges and high-deductible health plans. And this is a space where it becomes really critical to have good cost and quality information that is usable and understandable for the consumer. So, a lot of this work hopefully will support

a lot of the broader changes that's going on in our healthcare system.

DR. LATTS: And this is Lisa. I'll just pipe up. I'm on this committee as well.

And I think there's a fairly vocal group of consumers. So I think that will definitely come up.

But I think it's a very -- the complexities are so multilayered that you end up having the perspective of whatever segment you come from.

So, it's almost a nomenclature and a language problem trying to combine the different perspectives of the different segments. So it's a challenge. Brent?

DR. ASPLIN: So, this sounds like a very interesting conversation.

My question is around -- clearly you're focusing from a consumer perspective about engaging them as customers of the healthcare system at one level and that would be kind of critical.

To what extent is the conversation also overlapping into accountability? We talk about accountability for hospitals, for providers, for health plans, but especially as you move into preference-sensitive conditions in areas where not personal resources but shared resources are being used, to what extent is this conversation also asking the question of the consumers how can we hold each other accountable in a partnership.

And there's lots of conversations in that space, some more politically charged than others. You could get into the end of life conversation. You could get into a whole different series of conversations

And I just, as critical as the engagement as consumers is, I just hope there's also some interest and ability to move into what's the accountability questions that consumers need to face.

MS. WILBON: So, this is Ashlie. I'll just try to respond to Brent's comment

quickly.

That's actually a good point. We've struggled with, because the issue is so complex and there's so many different avenues you could go down.

The shared decision-making issue has come up quite a bit. We've done some research on some of the drivers of utilization for consumers.

So, you know, the commercials that are out there, having more informed consumers that are online coming to their doctor, asking for specific medications or specific tests and how that influences utilization and cost.

And so that's definitely going to be a part -- this is actually going to be a paper as well. So the committee will be providing input in terms of the structure and the formulation of that paper.

But that's definitely something that's been -- that will be addressed. We won't be able to go down the whole path of

shared decision-making which as you know can blow up. But it's definitely on the radar.

DR. LATTS: Great. Nancy?

MS. GARRETT: I was just wondering if the committee is looking at the question of how consumers might think of cost as a marker for quality.

So, the idea being if I'm looking for a healthcare service I might not want the cheapest one because I would assume that that had less features, was lower quality. I mean, just like if you go out and buy a computer you might want to pick the middle model instead of the really fancy expensive one or the cheap one.

So for consumers that sort of psychology that price and cost is a marker for quality seems an important consideration. So just wondering if you're talking about that.

DR. LATTS: Well, and from a consumer perspective it's all messed up, right? Because you don't know if high cost or low

cost is better. Often it's the wrong way around.

DR. WALKER: I think Nancy that we will definitely touch on that point. There wasn't an explicit conversation about it during the orientation call, but there was an underlying tone. And I think it will definitely come up.

DR. LATTS: All right, we've got Larry and then Joe on the phone, and then we'll take a break.

MR. BECKER: This is Larry. So I think at the outset for talking about this, sometimes we make it more complicated and put so many things into it.

It seems to me that we ought to do what we can do. And one of those things is to be able to provide to a consumer, to a patient at the point of service the cost that they will pay.

And much like the drug, you know, you go to a pharmacy, much like in the dental

arena or the Lasik arena people know what it's going to cost them.

And I think there's a shared partnership here. Because what I hear in the field here is that doctors and hospitals, their accounts receivable, their bad debt's going through the roof.

And part of that is because when the patient is in front of them, when they can actually collect the money they can't tell them how much it is. And so your ability to actually collect the funds goes down. And your billing costs go up, and everything else around it goes up.

And so I think the first thing, and we don't have to invent anything new, is to be able to provide to patients and consumers the cost of many of the things, not all of the things, but many of the things in the heath arena such as tests and basic office visits and physical therapy costs and all of those things.

And let's start in a place where we don't have to invent anything new.

DR. LATTS: This is Lisa. I think that's a great start. The problem is it's just not that simple, as you know Larry. Just because you start getting into the insurance product itself and it's like well, this costs $30 if you've met your deductible. If you haven't met your deductible it's going to be $45.

MR. BECKER: Lisa? Lisa? I can do that with my drugs. I can walk up to a pharmacy and there's an intermediary that understands where I am on my deductible, on my high-deductible health plan instantaneously. So it's not something we have to reinvent.

DR. LATTS: Well, except we'd have to then extend that -- well, we don't need to get into this here, but we need to extend that system to how many thousands and thousands of providers that they have in the pharmacy.

So, but point taken, absolutely.

Joe?

MR. STEPHANSKY: Yes. I'm going to bring up one other area of cost since I haven't heard Jack Needleman talk and I want to emphasize one of his pet peeves about costs that we are not including.

When I look at cost to consumers we tend to think about what they're actually going to pay out of pocket. And we're kind of ignoring the costs that they pay out of pocket just to get to a healthcare provider. And at the costs of family members who may need to be looking after an elderly parent, say, in the hospital.

We have areas in Michigan, we have 17 counties where there's no OB services at hospitals. We've got multiple counties with not a single OB/GYN practitioner in them. There's costs to consumers that we're not considering at this point. Just as a background idea.

DR. LATTS: That's a great point,

great point. Okay, Carolyn, last word.

MS. PARE: My comment is somewhat in response to Larry's but probably speaks to a bigger issue of a lot of the things that we've already discussed this morning.

And it really has to do with something that Herbert said. And maybe some of the others around the table have said this as well and I haven't picked up on it quite as clearly.

But who is the audience ultimately? I don't think NQF is in a position to resolve all quality and cost transparency issues for everybody that's out there needing to know.

I think that it is important that we start somewhere. And from my perspective in the work that I've done consumers don't even recognize that there's variation in care which is why they can't understand and connect cost with quality because we haven't really been particularly transparent with them about that variation in quality and explain to them why

that exists.

I think you first have to focus on the variation in quality and then maybe bring the cost component in for the consumer. But that's a different audience and that audience probably unfortunately and painfully again from my perspective can't be brought in until providers are really open and understanding of what that transparency provides them in terms of quality improvement and accountability to the people they treat.

So I really think we need to -- this always gets so hard because we get into the quality issues, the cost issues, and then we start kind of looking at and whose fault is it. And I say that we are all culpable in the system that exists.

What's important for us is to identify which part of that can we influence. And I don't think NQF can really go beyond -- this isn't a criticism but even in the work that we've done so far on these measures, they

don't mean anything to consumers. But then I don't think that's the point right now.

DR. WALKER: Carolyn, I would respectfully disagree. Because I really think that a lot of the -- I mean, in the end we want all participants to actively engage. And you can't improve the system without having consumers actively participate as well.

And I would rephrase a little bit what you said about consumers and whether or not they're able to assess quality.

I think they know that there is variation in quality. We see them make these decisions based on their perceived notion of differences in quality.

I think the issue is that they're not able to assess the signal so they don't have the ability to assess the -- they understand that there's variation but they can't identify the variation in a way that -- in all circumstances.

So, they're misinterpreting the

signals. Maybe they're using prices instead. Or they're not able to understand the measures that are available to them.

So, more so then we need to think about how we can present this information so that they can use it and make those decisions appropriately.

DR. LATTS: Great, terrific. Well, thank you everybody for a very, very fruitful morning I think so far.

We're going to take a break now so we'll truncate it just a little bit since we're a few minutes behind. So if everybody could come back at 10 minutes after the hour we'll see you in a few.

(Whereupon, the foregoing matter went off the record at 10:58 a.m. and went back on the record at 11:11 a.m.)

MR. WILLIAMSON: All right, everybody. Welcome back from the break. At this time we'll be going over the cost and resource use measurement portfolio as well as

input to the Measure Applications Partnership.

We are joined right now by Erin O'Rourke who is project manager for the Measure Applications Partnership as well as several of the Robert Wood Johnson projects that we just discussed in the last segment.

So at this time I'll turn it over to her as well as Brent and Lisa who will be running this portion.

MR. AMIN: Actually, I think Ashlie is going to get started on the first slide which is a review of the portfolio before we get into the input sections.

MR. WILLIAMSON: Then I will turn it over to Ashlie at this time and she will start this section.

MS. WILBON: So, we've been talking a lot about kind of the role of the standing committee in terms of looking at the overall portfolio.

So this is somewhat of a new exercise for us in trying to present the measures to

you in a way that we can kind of conceptually look across how all the measures map to the episode of care framework.

So, we'll go through several slides here to try to walk you through the process and then we'll take input along the way and see where we end up.

MR. AMIN: Actually, Evan, before you move on that slide, can I just --

MS. WILBON: Go ahead.

MR. AMIN: So, for some of the new people who are new to the committee who haven't reviewed some of these measures I'm just going to give a two-second overview about what these are and conceptually how we categorize them.

So, the way that we sort of think about these cost of care measures is that we have per capita measures where the measurement period is one year.

And then we have episode measures where the measurement period has a defined

what we call trigger and end which is a start and end period that's usually not a year.

The easiest way to conceptualize that is sort of an acute episode. Your hospitalization starts the episode and then your discharge ends the episode, or 30 days post discharge ends the episode. So, we have per capita measures and then we have per episode measures.

And then we have those that are measuring resource use which is essentially using standardized pricing. Where really the dollar amount is only a signal as a weighting mechanism effectively but they don't represent true dollars spent by the system. It's resource utilization monetized.

And then we have actual prices paid. Meaning usually by the health plan, prices paid by the health plan. So that's our pricing model. Those are the measures that use price. So we have per capita, per episode and then we have those using standardized

prices, resource use measures. And then we have cost measures that use actual prices paid.

So, when you're looking at the measures that are currently in the portfolio we have two, 1598 is your -- using standardized prices. So it uses a standardized pricing table weighting utilization. That's a PMPM per capita measure by HealthPartners.

And as Nancy pointed out before the second one, the 1604, the total cost population-based PMPM measure is a per capita that uses actual prices paid. So those are sort of paired but they give two different pieces of information.

The two NCQA measures, actually the four NCQA measures, I'll just describe them broadly. They're PMPM measures but condition-specific. So you identify a patient with diabetes, but for the measurement year you catalogue all the measures that are related --

just you're cataloguing all the measures of the patient regardless if they're specifically related to the diabetes.

MS. WILBON: All the costs, Taroon.

MR. AMIN: Oh, sorry. All of the costs. I don't know what I said but that's what it meant. So that categorizes the four NCQA measures broadly.

And then the two ETG-based measures are measures that are a result of an episode grouper. So, they used the Ingenix episode grouper and then they have the two ETGs for hip and knee and then for pneumonia.

And then finally we have also, we generally consider this an episode measure as well but it's non-condition specific. It looks at the total spending per beneficiary during a hospitalization and 30 days post discharge. So that's what we have currently in the portfolio.

MS. GARRETT: Taroon, do the ETG measures include price?

MR. AMIN: They --

MS. WILBON: Yes, they're actual prices paid.

MR. AMIN: Actual prices paid. Thank you. For some reason I couldn't remember that off the top of my head. But yes, that's right.

DR. LATTS: Why do we only have one of the four endorsed in January of 2012 for review now?

MR. AMIN: This one, the way that this phase was constructed was to look at cardiovascular conditions. So, this measure fell into that clinical domain. However, that is -- I'll just flag that as a conversation that we'll have at a later time during this meeting which is around do we want to continue to have sort of condition-specific resource use. You know, is that a proper way to categorize future work, or should we be thinking about it in a different construct.

So you may not have opinions about

that but we're thinking about that in terms of how to structure this work of the committee going forward.

So, I'll turn it back to Ashlie in terms of how that fits. Or do you want to just go to the next slide and talk about the episode of care? Okay.

So, as we look at the -- this model is the patient-centered episode of care framework that we described. This was a piece of work that we had done about four years ago in which we described essentially how we would like to look at the question of efficiency, particularly looking at cost and quality.

And really there is categorization of three different components of the patient episode. One meaning the population at risk where you're looking at general patients without any acute condition.

You have your sort of phase II which is your acute condition, flare-up of a condition. And then your follow-up care which

is involving post-acute services broadly.

So, really the purpose is to think longitudinally about the care that we're providing to the patients, to patients broadly.

And as we think about the construct of what we have in the portfolio. Actually this is pretty much the characterization I provided earlier which is per capita non-condition specific, per capita condition-specific, and then per episode non-condition specific and then per capita condition-specific. I know that's a mouthful.

But as you can see from the categorization of what we have in the current portfolio we have a number of measures that sort of span all three phases which is effectively measurement period being one year.

And then we have a few measures that are sort of in the phase II domain, non-condition specific. And then we have sort of three condition-specific. One that's up for

evaluation in phase III of this project which we'll look at later on this year.

Effectively the question that we need to consider as we move forward with this work is what really is the mechanism for prioritizing. What are the condition-specific measures that we need to be looking -- actually, that's a typo, I apologize. That should be per episode condition-specific. Apologize for that.

But how are we really prioritizing what conditions we should be looking at from an episode perspective. What conditions and what is the mechanism for prioritizing that.

Because right now one of the things that you can just effectively say is how do we only have hip and knee and pneumonia. And then potentially others that are currently up for review during this meeting.

But what's the logic here. What are we trying to get into the portfolio and what do we have. And what types of measures are

more appropriately looked at from an episode framework, and what conditions might be more appropriate to look at from a per capita paragraph.

One thing that we've discussed in the past is that more acute conditions might be more appropriate to look at from an episode approach. More chronic conditions might be appropriate to look at from a per capita approach.

That could be one framework that we use. But the more that we can sort of define that strategy the better that we can give some guidance to the field.

So anyway, that's a sense of where we are right now. We'll have more of a discussion about where we want to go with this work at the end of this discussion.

Because the MAP actually provided some additional guidance about where they would like to see the measure portfolio evolve to and provided some guidance to this group

about what they're seeing in terms of the programs and the limitation of the programs in terms of what measures are currently available.

And then maybe I'll turn it back to Ashlie in terms of the future work. And then we can go into the MAP work from Erin's perspective.

MS. WILBON: So, this slide just summarizes what we're looking at in the next phase. Initially it was focused primarily on pulmonary. But we did learn of another measure from the American Dental Association that they do have a dental cost measure that will be ready around the time of phase III.

So while it was initially focused on pulmonary we're going to accept this measure as well given the somewhat limited opportunities we have now to submit measures. And we'll go ahead and include that in the review.

The next time we meet, I believe in

June or July it will be to discuss these five measures, two of which as Taroon mentioned are -- I'm sorry, three of which are maintenance measures, two from NCQA that will be very similar to the measure you will review today for the cardiovascular conditions, and then one of the ETG-based pneumonia measures from Ingenix that will be kind of a re-review if you will in terms of maintenance review. And then two new measures.

MS. O'ROURKE: Hi, everyone. As Evan said I am Erin O'Rourke. I am the project manager for the Measure Applications Partnership affordability family of measures project. And thank you very much for letting me attend this meeting today and take advantage of the expertise of this committee.

MAP is a more policy-focused group so we wanted to take advantage of the technical expertise that this group has up front of our in-person meeting to get some input on our high-leverage opportunities and measure gaps.

To give you a little bit of background about the MAP, the statutory authority for this work is in the Affordable Care Act requiring HHS to contract with a consensus-based entity to convene multi-stakeholder groups to provide input on the selection of measures for public reporting, payment and other programs.

In pursuit of the National Quality Strategy our goal is to inform the selection of measures to achieve improvement, transparency and value for all.

The main way that MAP does this work is through our annual pre-rulemaking work where we receive a list of measures under consideration by HHS for the various federal programs that go through the rulemaking process. And MAP provides upstream multi-stakeholder input on each measure, whether we would support the addition of that measure to the program, conditionally support it, or not support it.

MAP operates through a two-tiered structure. There are four standing advisory workgroups. Three are based on settings. The last is based on population to provide specific input on dual eligible beneficiaries.

We also convene a series of time-limited task forces to primarily do the work of developing measure families which are one tool that we use to inform our selection of measures for programs during the pre-rulemaking cycle.

The four advisory workgroups provide input to the MAP Coordinating Committee which makes the ultimate recommendations to HHS.

I did want to point out that Dolores is a member of both the Cost and Resource Use standing Committee and the MAP Affordability Task Force, hopefully providing some continuity and a link between both groups.

The specific charge of the Affordability Task Force is to advise the Coordinating Committee on an affordability

family of measures including recommendations for specific measures that should be in the family, identification of any gaps and recommendations for a pathway for filling those gaps, as well as an analysis of the barriers that could exist to actually using these measures in the family.

This task force is time-limited. It consists of current members from the Coordinating Committee and all four workgroups.

MR. AMIN: Before Erin gets into the next slide here I just wanted to point out that -- actually, if you can go to the next slide, Evan.

I just wanted to point out that what we're looking for from the Cost and Resource Use Standing Committee from a content perspective is actually very similar to the task of this time-limited affordability family workgroup.

But the construction of the groups is

fundamentally different. So this group is much more -- both groups are constructed to be multi-stakeholder obviously, but this group is much more methodologically oriented. And the group that is in the MAP is much more policy-oriented. And Dolores can obviously speak to that.

But as you look to these goals, the reason why we want to have this conversation collectively in terms of the goals that the affordability family has been discussing and some of their preliminary recommendations, we want to have that discussion along with what does the standing committee think are the high-leverage opportunities in terms of gaps that we need to be focused on in the context of the current portfolio.

So this is serving as an input in terms of that general broader strategic conversation that we're having, that we'll be having later on at the end of this session.

But effectively this is sort of an

input to that discussion. And given the nature of our conversation we'll provide the input from this group back to the affordability group.

So these groups sort of interact very strategically in the sense that they're addressing essentially the same concepts, but they're constructed differently which is why we're sort of having both groups inform each other.

MS. O'ROURKE: Thanks, Taroon. So as Taroon was saying, our goals for the family of measures, we're hoping to promote alignment across settings and the public and private sectors.

We want to create a comprehensive picture of affordability considering multi-stakeholder perspectives, including measures related to cost drivers and other key components of cost, and really use these cost drivers to identify the highest-leverage opportunities and available measures to

hopefully reduce costs across the system.

We'll be building on existing measures primarily from the NQF portfolio and laying out a path to build on these initial measures and consider what barriers might exist to actually using them in programs.

Just to define some of the terms that you'll see on the coming slides. Families of measures are related available measures and measure gaps for specific topics that span programs, care settings, levels of analysis and populations.

And a core measure set is available measures and gaps drawn from the families that can be applied to a specific program setting, level of analysis or population.

So, to illustrate for you how the families of measures work. If you look at the bubble surrounding the multicolored boxes that would be an NQF priority or a high-impact condition.

Each of those rows would represent a

subtopic of measurement. Say if this was a safety family of measures that first row might represent healthcare-associated infections.

And then each of those multicolored boxes in the row is a different measure. So those measures would then be organized to create the core measure set for each of the settings, whether it's hospital, clinician, or post-acute long-term care.

So then to play out how we would use these for informing the selection of measures for programs. You'd see the measures come together to create the clinician core measure set.

We would then use those measures when the MAP is doing its pre-rulemaking deliberations. And if a measure is in a family it would be given higher weighting for supporting that for the various programs.

So, for the clinician setting that might be the Physician Quality Reporting setting, the value-based payment modifier, or

the Meaningful Use Program.

To develop the affordability family of work we are taking a five-step approach. Our first step was to develop a consensus-based definition of affordability.

The task force chose to really define affordability from the consumer's perspective, representing that they are ultimately the ones to bear most of the costs of healthcare. Next slide.

Our next step that we accomplished at our February web meeting was to identify and prioritize high-leverage opportunities for measurement.

At this point we are kind of flipping how we're approaching this. We recognize that affordability needed to be defined from the consumer perspective. But they ultimately can't be held accountable for the affordability of healthcare.

So at this point we wanted to take a look at the system and identify what are the

high-leverage opportunities where there's excess costs that perhaps measurement could contribute to reducing those costs and promoting the affordability of healthcare.

Our next step will be to do a scan of available and pipeline measures that address the high-leverage opportunities. We'll be looking to the endorsed portfolio of measures, measures that are in use in federal programs and available private sector efforts.

We'll then be defining the affordability family which would consist of available measures as well as measure gaps. We'll be doing this at our May 7 and 8 in-person meeting.

And then finally we'll be playing out some of the principles that will be developed in the RWJ-funded work that Taroon and Ashlie presented to you earlier today, and considering how those principles might impact the use of effectively measures in federal programs.

So we identified four high-leverage opportunities related to cost and resource use, total costs. Where measurement areas might be total cost of care, disparities between the prices charged for the same services, and then pricing information and price transparency. Cost by episode with some high-leverage measurement areas including heart disease, cancer, mental disorder, pulmonary conditions, orthopedics, obstetrics and gynecological conditions, GI conditions, end-organ failure with functional impairment, cognitive impairment as well as multi-morbidity functional and cognitive impairment.

Utilization including total resource use, spending per beneficiary and relative resource use as well as taking a look at cost to the patient including premiums, deductible, out-of-pockets and pricing information from the patient perspective.

So with that we wanted to take our high-leverage opportunities to this group and

take advantage of your technical expertise to see if it seemed like this was -- if we are on the right track and if there's additional gaps that we might have missed in this work.

Specifically, MAP noted a need for an environment of greater price transparency. So, we wanted to see if the standing committee agreed with this approach, and if so, how measurement can support that objective.

If there is advice that this committee might have on additional episode-based measures which would be the key conditions that we don't currently have episode-based measures for. And are there additional gaps that should be addressed in the family of measures.

MR. AMIN: So, before we start with that, I mean there's a series of questions here. Actually I'll just go to the next slide as well because I just want to lay out the field of topics here.

And this is all part of our strategic

conversation broadly. So while these are sort of inputs that the MAP is looking for from this group I'll also just note that what we're trying to understand as well -- and we'll have this conversation at the end of day two as well as we've looked at the measures. And we might have some more specific ideas about some of these topics.

But what really are the high-impact measures of cost and resource use that we need in the portfolio in the context of the measures that we currently have.

How should we prioritize the clinical areas for the episode-based measures for future work? What's our construct for selecting these?

I think Erin sort of pointed out a list of episode-based measures that were identified as high-impact by the MAP. What we're asking is more of a broad question. It's how do we really prioritize them so it doesn't appear to be just a list of

conditions, but what is the mechanism that we're going to be using going forward.

And then broadly one of the questions that we're still interested in understanding is what are the additional areas that NQF should think about in terms of future project work to advance cost and resource use measurement science broadly.

And there are some just general topics that have been raised in the past and still continue to be issues around integration of potential clinical data and other data sources since we don't really see many of those types of data sources in the current measures right now.

How do we advance the goal of price transparency broadly. I think that was another that Nancy brought up in the beginning of our effort. So how do we really think about that in terms of the future work that we need to be doing, whether that's through the measures or broadly, like additional guidance

work that may need to be done about how we think about pricing data.

The impact of the use case. Currently, and this is just a broad conversation. I know Dolores has thought about this considerably in terms of the challenges in having a national standard for a measure, but also the fact that the use case might change the actual construction of the measure itself.

So, currently NQF guidance has -- essentially thinks about -- we're use agnostic effectively. Whether the measure is used -- we want measures to be used for public reporting and accountability applications both.

Now, the question inherently is if the measure is used for accountability applications, particularly for payment applications is there a difference in the way we would essentially look at these measures. Is there a construct that would justify a

difference of approaching this.

And this is obviously not just limited to cost and resource use measures, but a broad question that we're considering internally, strategically.

And then further, just as we're thinking about other types of cost measures, you know, obviously there's a lot of work that people have talked about around really what we should be measuring is more activities-based costing approaches and much more production cost. But how would that really be done in the current data environment that we have.

So, the span of sort of strategic questions is broad. And so we want to spend a little bit of this session, so I'll turn it over to the co-chairs, to just walk through some of the strategic conversations that the MAP has laid out for us, and then some of the other strategic questions that we've laid out here as a starter to lay out a path forward for how we think about making recommendations

for future measure development, and additionally, how we think about some of these other measurement science issues.

Before we get to that I just want to provide one additional piece of context which is that the reason why we've asked Erin to be here and to describe the MAP component in particular is that this work around families and selecting measures for programs in most of the other areas is really a sorting exercise of the myriad of measures that we have in the portfolio.

So, looking at a diabetes family, you're trying to take all these diabetes measures and understand which are appropriate for which application.

In the area of cost and resource use measurement there's not a lot of measures to choose from. And so it became much more of a conceptual exercise around defining terms and much more defining priorities.

And so, again, this is where the

overlap between what this workgroup is doing which it's charged with which is essentially defining the priorities and the path forward for cost and resource use measures. And so that's really where these two processes interact.

And this is particularly a unique use case because the affordability family is not really doing the sorting that they would be doing for the other clinical areas, but much more conceptual which is sort of where we relate with this group.

So, as a bit of context that's why this MAP conversation is included here as well. And obviously it interacts with other pieces of work like the linking cost and quality work around playing out an example in an actual federal program, for example, value-based purchasing as Erin described.

So, those are how these two domains interact. However, strategically we're asking very similar questions. So, I'll leave it

there, turn it back over to the chairs.

DR. LATTS: All right, well we have placards up fast and furiously. So I have Janis, Cheryl, Lina up.

DR. ORLOWSKI: Taroon, in the last part of your conversation I think that you hit on the comment that I was going to make.

I think that one of the most critical things that need to be done is first, definitions. And I think that we need to understand the definitions.

And I see in the slides the use of the word "cost," the use of the word "price." And I think that we have to understand what it is that we're talking about.

I believe that looking at the chargemaster unless you understand historically what the chargemaster was and how it was derived it provides little public information. And I think that what we have to understand is charge or expected revenue. And so again, I believe that definition is

important.

I think that what we have to do is that we have to be able to define these terms from several different perspectives. From the payer, from the payee, from the hospital or physician and from the patient and from the employer.

I think that we need to be able to look at all of these different areas and say what is the cost of the actual episode of care to these individual groups. Or what is the receipt of revenue.

And finally, what I believe that we need to do is when you're talking about the federal programs we have to carefully define what is in the cost basket and what is out.

And by that what I mean is that there has to be a robust discussion about graduate medical education and IME and whether those and how those costs are identified and separated from the underlying cost structure of academic medical centers.

So I think it's a long-winded statement that definitions is where you have to start.

DR. LATTS: Cheryl.

MS. DAMBERG: So I had three issues I wanted to raise.

I was kind of surprised in terms of describing this landscape that there was no mention of overuse. And I was kind of curious where that language had gotten lost.

Because I think the ability to advance measures that are very targeted have the potential in the near term to yield some very direct gains and to do direct signaling to providers. So I didn't see that.

And I know that to the extent that you do environmental scans and try to pick up what's going on on the ground. So this bottom-up that Janis and I have been talking about in our sidebar conversations, you know, really I think is focused around looking at areas of variation and trying to identify

potential areas of overuse. And I would hope we're not leaving that behind in some way.

Second issue. You teed up price transparency. And I'm a big proponent of that. And I this that that should be a core focus, whether it's of NQF that I just think in this country we need to move forward on that quickly.

And I think that I sit here as a researcher but I think more importantly we all sit here as consumers. And I cannot tell you the struggles I have faced in the healthcare system personally trying to get anybody to tell me the cost of anything, particularly when they make me sign forms that say I'm liable for whatever my insurer doesn't pay for. So I say, okay, what am I on the hook for and they can't tell me. So, I definitely think anything to advance that.

But I think above and beyond trying to figure out what those metrics look like, I think there's a lot of work that needs to be

done to try to understand what I call the regulatory legal space and all of these gag clauses that are in effect that prohibit the industry from stepping forth and disclosing information.

And I don't know whether that's some sort of legal analysis that NQF might help sponsor, but I think really trying to get a handle around all of those issues that are going to permit transparency of price information really need to be fully looked at.

And my third issue, and I've sort of sensed this not just from this meeting but the previous committee work. It's very easy to get pulled in lots of different directions. And I worry about scope creep.

And I think we have a hard enough time staying focused on we're here to look at three measures and to look at them in terms of their intended use in specific applications.

And I think we have a danger of being in too many places to thinly. And so I would

encourage NQF and the MAP in particular to try to figure out how best to leverage the expertise and the resources to make progress on a narrower set of fronts to demonstrate success.

Does anybody want to comment on any of this?

MR. AMIN: Yes, I think I would agree on almost all those. I think the question that we're trying to understand, actually, and we can go into a little bit more detail. But you know obviously we can't get into a complete analysis strategically about how to prioritize really the high-leverage opportunities that Erin sort of played out.

We can walk back through them a little bit. But one of the specific asks for the committee is to reflect on those high-leverage opportunities. And maybe not suggest one versus the other, but how one would even think about which are really the high-leverage opportunities.

Particularly on the cost by episode, effectively conditions. How one would really think about the approach there. Are we looking at high-dollar amounts by condition? Are we looking at total spend by the country on these conditions? Are we looking at sort of prevalence of these conditions?

I mean, those are three that anyone could throw out. But how are we really prioritizing these so we don't end up trying to develop condition-specific measures for all of these. Or is that really the approach that we want to take.

So, reflections on it. That's broad, not just to Cheryl. But how do we start to really have a framework to start really addressing how we spend our measurement dollars on these topics.

DR. LATTS: Lina.

DR. WALKER: We're just at the beginning stages of thinking about cost and resource and maybe pricing measures. And I

think that this is a good opportunity for us to think about what we are trying to solve for.

It's particularly important for these kinds of measures because how you construct these measures affect how you can interpret them and how you can use them.

This is where I see that being use-agnostic is really quite difficult. If the purpose of the measure is just to collect information on resource use then you can understand that being use-agnostic -- just that information then, that's fine.

But the fact is that these measures would be used to drive improvements in X or Y and Z.

And then I think then it becomes imperative to ask, well, what is it that we are trying to improve.

And I have to say that I had a lot of problems with the episode-based measures that we evaluated because it's not clear to me that

the resource value carried a lot of meaning in the context of what it is that you're trying to achieve, what it is that you're trying to improve.

So I think it's really imperative that we consider the broader question of how you want to use it, what is it you're trying to improve. And I'm glad that we have this opportunity to discuss these issues.

DR. LATTS: Okay, so next on my list I have Lisa, then Brent, Andrew and Bill. And just wanted to comment that those of you on the phone are being very quiet. So re-engage and put your virtual placards up so we can hear you.

So I just wanted to comment on the grouping. I actually think condition-based grouping is far less important than the type of measure and what's being measured.

I think a lot of the condition clinical stuff is probably interchangeable for a lot of these measures. It's far more

important, is it a global measure, is it a hospital-based episode measure. I think that's what is the more salient way to think of these. And that's how I would prefer to see them grouped.

And I think that will start to show us the gaps far more appropriately than thinking of them by condition.

I mean, to some degree you just plop in a particular condition's particular codes and you could just switch out the methodologies as really very similar I think.

DR. ASPLIN: Lisa just made one of the points I was going to make. I think of it kind of in a framework of questions around who are we trying to hold accountable, questions around what we're trying to do, and then some questions around how we would approach it.

And on the who I think we have the accountability for payers and hospitals figured out. And I don't think we have the accountability for medical groups figured out.

And I think that played itself out in spades at our last meeting.

The value-based modifier program is moving forward. The measure that we did not endorse is moving forward at a total per capita cost.

But how we hold medical groups or patient-centered medical homes accountable and at what level we decide to do that I think is a key question that we have to at least signal to the community how we would like to approach.

Because if we don't get that figured out we're going to have a very difficult time with the global measures of cost and resource use.

And then I made my comments a moment ago about consumers. And I think it's not just engagement. I actually think they can be held accountable in certain areas over time. And they need to be -- because it's us, right? It's not them, it's us.

So, that's the who question with the biggest question being how do we hold medical groups accountable methodologically.

On the what it's really, it's a mix of episode versus global. And Taroon made the comment earlier. I actually do think that the chronic conditions, trying to muscle those into episode measures just conceptually doesn't make a lot of sense to me.

In the spirit of all models are wrong, some models are useful, I would in general favor the global toward primary care and payers, and the episode-based events more towards specialists and hospitals across that phrase of who.

There will be exceptions. It wouldn't be a hard and fast rule, but in general signal that let's figure out how to do global measures of resource use over chronic -- or annual periods of time for primary care and -- because that's really how plans and primary care need to be judged because that's

how consumers' costs will be determined, right?

And then in that context, nested in it, episodes are really driven by what happens with discrete events. And that's where specialists and hospitals really come into play.

And just saying that out loud, you can all think of a dozen different exceptions to what I just said. But all models are wrong, some models are useful, right?

And then the third category is how. And that's where we kind of need to tackle some of these crosscutting issues. Like SES, how to use SES. And several of them have come up today. Price transparency. Standardized pricing, for Nancy's point.

Part and parcel is solving for the medical group which I think is the core of why we could not -- and I respect the process, but couldn't quite get our arms around the total per capita fee-for-service Medicare measure

last time is how we do attribution at the medical group level.

And I think that's another area that is important enough that it probably deserves its own crosscutting group to wrestle with the issues around attribution.

And then of course we've had countless discussions about risk adjustment which will continue well beyond our careers fade off into the sunset, I'm sure.

So, who, what, how. Those are my comments.

DR. LATTS: Andrew.

MR. RYAN: Thanks, Lisa. I want to agree with the point that Lisa just made. I think understanding the relationship between non-condition specific and the condition-specific measures is really key.

And thinking about what's the default. Because if we could just work off of the measure we just approved, Medicare spending per beneficiary, then we could say if

you have an index admission for cardiovascular conditions, or AMI CHF, well then we already approved that. So that measure is approved.

Do we need to go through and approve every single measure for each set of admissions?

And maybe the default should be that everything kind of underneath that big measure that we approved is NQF-approved unless otherwise specified. If there's some reason to think some set of admission codes are, you know, give the wrong resource signal or are incorrect then maybe that should be singled out and there should be some different process.

But having kind of new measures come in with somewhat different specifications than the larger measure, it doesn't seem to me like that's -- I think that might be a net minus rather than a net plus in trying to have some simplicity and understand the whole framework here.

DR. LATTS: All right. Next up is Bill with Andrea and Nancy on tap.

DR. WEINTRAUB: Twenty-five years ago when I first started getting into healthcare economics I remember a discussion with the head of the economics department at Emory.

He said to me in a mixed product environment you can't tell what anything costs. And that's something that every time I do a study in healthcare economics that conversation reverberates in my mind because it's absolutely true.

One of the problems with the hospitals is they don't know what their products cost. I work with the accountants in our hospital all the time. They don't know what anything costs.

You might think transfers of money, payments does it, but economists have told me it doesn't tell you anything about cost because it's just transfers of dollars. It doesn't tell you anything about resource use.

So, how do we deal with this chaos? Because it can be dealt with. Obviously it has to be dealt with.

And I first knew I was going to make this comment when I heard Janis' comments about we have to be very careful about definitions. And that's where we better start. We better be very careful about what we're saying about costs in any measure that we're dealing with.

And then from there we go to Lina's comment which I think is very important. What's the question that's being asked? Because the question will drive the perspective that you're going to use.

And then you consider Brent, who, what and how. Have I got that right? Who, what and how. And that will help you drive it which will allow you to cut through the thicket of the chaos and make good choices.

But in our work here we better be very clear about the definitions when we're

talking about cost. Just what do we mean, what's the perspective that we're using for any one measure.

DR. LATTS: Andrea.

DR. GELZER: These are all -- I agree with everything that's been said. But I'm sitting here struggling and thinking, okay, so we're going to consider now cardiovascular measures. And if I'm a consumer, if I'm a patient and I have a cardiac event.

So you talked about, Brent, for hospitals we should be talking about groupers and specialty. But I'm thinking about, okay, where do I want to go. And I want to go to the hospital, the academic center that has the best person to do my bypass surgery, or the best technician electrophysiologist if I have an arrhythmia. I mean, those specialists command very high salaries and as well they should.

But somehow we have to get to, okay, specialists commanding these high salaries,

and so unit cost at these institutions is going up. Which of these institutions are really delivering the best value from an outcomes perspective.

So we have to make sure that we marry I guess these cost measures with the outcomes and quality metrics. We just can't consider them separately.

DR. LATTS: All right. Next is Nancy with Mary Ann and Larry on tap.

MS. GARRETT: So, I wanted to second what Brent said about we really need to also be considering sociodemographic factors and their impact on cost and resource use.

So the committee that's looking at that issue is likely to make a recommendation that NQF does take a different approach to that. And the final recommendation isn't out yet, but we'll be looking to that guidance for the future.

But I think if we don't include that we're really missing the real costs that are

included in taking care of vulnerable populations. So I think that's really important.

Second, on price transparency I really like, Cheryl, the points that you were making. And I wonder if the price transparency issue, if we need to have a different framework.

Rather than thinking about individual measures is price transparency something where we need to have a whole different approach? Like there's a systematic way in which NQF could get the right people around the table to decide on the policy issues that we need to work through, and the ways in which we might start to make price more available.

I'm not sure that the way it's captured on this list is quite right. Having total cost and then a separate category for utilization. So then there's not a separate category for price. And so I just think that maybe there's a whole different approach that

we need to take for that price issue.

And then the third thing is the last point here about what kind of costs we are measuring. And should we be considering production costs.

I'll tell you that in my healthcare system every time I talk about these national cost measures I spend the first half hour explaining what cost means, and it's not actually cost to us, it's reimbursement.

So, I do worry that if we only focus on reimbursement that increasingly those measures will become less relevant. Because as providers take on more risk and are doing more population management and moving to more capitation type models there's a lot of costs that aren't going to be captured in the traditional reimbursement sense.

So, we have an ACO program called Hennepin Health and it's capitated as we receive a payment to manage the population. And if we can take care of the population for

less than that payment then we can use that extra, the difference between what we're being paid and what the costs are to do some reinvestment.

And so we're doing things like transitional housing for patients who don't have a place to go, to move them out of the expensive hospital setting. A sobering center for people who show up in our ED and are inebriated and need a place to go but they don't have to be in an expensive ED setting.

And so those things are real costs to society but they're not captured in the reimbursement model.

So I don't have an answer, but I just think it's really important to be thinking about and be strategic about where healthcare is going on that issue.

DR. LATTS: All right. Mary Ann, you're next.

MS. CLARK: Yes. So, I don't know if I'm going to say anything new because I agree

with a lot of what's been said already.

But in terms of definitions, definitely agree that we need to make sure we're all talking about the same thing. And I've run into this many times when -- well everybody does.

You run into the Wall Street Journal article that says Medicare just published all this cost data on how much hospital services cost. Well, it's not really cost, it's charges. So you know, we're all aware of that.

In terms of the production costs, and someone mentioned time-driven activity-based costing or micro-costing, whatever you want to call it, I mean that's probably the best way to get at what a service or an episode will cost.

But I don't know that that's necessarily our responsibility. I see that I guess more of a provider, a hospital, they need to be able to understand their costs to

be able to manage a global budget, or manage what a -- determine what to contract, what kind of prices to contract with.

I mean, while ultimately we would like to understand that level of costing I don't know, that seems like such a much, much larger effort to undertake to determine what the true cost of a service or an episode is.

In terms of the slide that you have up now I totally agree with. These costs by episode are really more I think looking at chronic conditions. And I think we need to look at those more on a population basis.

In terms of trying to prioritize I think that was one of the questions here is how do we actually prioritize which measures we're going to look at.

And I guess we in a sense already have some of the key things we would want to look at in order to prioritize already in place. For example, when the measure developers need to submit an application for

creating a measure they're supposed to demonstrate that it's a high-need, a high-cost area, affects a large population. And then that there's an ability to impact the area.

So it seems like there are criteria that we can use to sort of rank-order some of these different disease areas, whether they be chronic disease areas or acute episode areas.

So, it seems like we have some of that in place. I'm not sure, maybe we just need to formalize the process of looking at that for ranking and prioritizing some of these measures.

DR. LATTS: Great, thank you. Larry. Larry, are you on mute? You still with us? All right, then we're going to -- Larry, if you get with us please break in. Janis, Dolores, Bill.

DR. ORLOWSKI: The comment, and you know in some respects the conversation is headed towards how do we have world peace. And so I recognize where we're headed. But

it's always good to have these conversations and then you get down to working on something specific.

I think that one of the things that you should also be responsible for discussing, if you, as you get into further discussion of cost is that there are community resources that are borne by an institution that will not be borne by an institution if we move towards a commodity-based pricing structure.

And an example of it, I think for anyone who's run a burn unit is the burn unit. So, if with transparency of cost we, and I think there's consequences. It will drive everyone to a commodity pricing for cost, that there will be certain community services that cannot be borne by a single institution. And what do you do about that.

And whether it's the poison control, whether it's the burn center, whether it's the trauma center, that there are consequences to driving this discussion on cost per unit

service without taking into account the fact that there are certain institutions that bear for the community the cost of these services that right now are not supported by anyone else.

DR. LATTS: Thank you. Dolores, you're up.

MS. YANAGIHARA: All right. Several just comments. And this is kind of the in the trenches, where the rubber meets the road kind of comments.

One, on price transparency the question I think -- yes, definitely, there needs to be more transparency around is it price, is it cost. I mean, I think that's the question.

There's so much politics around it and it comes on both sides. Almost all of the contracts in California for hospitals and physician groups have gag clauses in them. And so without the hospitals' or physician groups' permission they cannot, the health

plan cannot share any kind of pricing information. So until that is addressed it's just probably not going to happen.

On the flip side, the health plans are quick to point fingers at that. But when we've talked about actually dividing total cost of care information to the physician groups based on buckets of care. For example, professional services which in California are capitated. Pharmacy, the inpatient facility and then other.

The health plans are saying oh no, that's too much information. They'll use it against us in negotiation. So, really, I mean there's politics on both sides.

And what ends up happening is that the purchasers and consumers end up losing out because of all these politics going on between payers and providers.

What we've actually done is gone to total cost of care because that's not the pricing of any one provider, it's total cost.

And that's been very powerful for us.

We haven't publicly reported it yet, but it's going to both health plans and physician groups. And especially the high-cost physician groups are paying a lot of attention to it and trying to understand what's driving their costs. Underneath that total number what's really driving their costs and trying to get that under control.

So we've found that to be very powerful. Even though it's not very transparent it's directional. So I think that that's something to really keep in mind.

In terms of prioritizing I do think that total spend for a particular condition or area is important. But you also from a measurement perspective really need to look at the frequency of the condition or the situation.

Because you can have something that's really high-cost but happens so infrequently you're not going to be able to really get good

measurement for accountability and public reporting purposes. So, frequency really does need to be taken into consideration.

Looking at these different categories that are here and based on some data we've done around episodes I think that all of the ones that we found were high-cost and frequent are here with the exception of diabetes which is kind of there via heart disease and end-organ failure, but not specifically there.

But otherwise I think these areas are all really important and what we found were both high-cost and high-frequency.

Then, let's see. In terms of the whole question on use case it's really tricky because use case is so entwined in a measure and how you construct a measure.

And when you look at the use of a measure for public reporting it may be different than a use of a measure for payment. Both of those are kind of accountability. But it could lead to different methodologies.

I'll just give one quick example. The HealthPartners measure that's for total cost of care that's endorsed has -- it's between ages 1 and 64. So it excludes under 1 and 65 and over.

Our measure doesn't. So we were looking at, okay, so should we exclude that. You get a more reliable measure that way because there's more variation in cost in the first year of life and later in life.

But it excludes like 20 percent of the costs for a group. And so we thought if we're trying to hold groups accountable for total cost and we're excluding 20 percent of the cost that's on top of excluding 8 or 9 percent of the cost that comes from truncating at $100,000 per member per year.

So it just, you know, the use case is really entwined in how the measure is constructed. And so I don't know how you can separate the two. Unfortunately I don't have any good guidance. But I think it's just the

use case is really key to the measure construct.

And then just one note on data. There was a mention of trying to integrate more clinical data. I'm all for that.

The problem is the clinical data resides with the providers. And most of the measurement is happening by the payers. And so until you have a way to get the clinical data in a consistent way to the payers it's really hard to actually incorporate that into the measurement and have specifications that include that when the payers don't have that data.

And so it's this conundrum. And we've been working a lot on trying to get data-sharing in place. And there's all kinds of issues and challenges with that.

But really the clinical data are just not available to the people doing the measurement right now.

DR. LATTS: Great, thank you. All

right, John Ratliff, you're up, followed by Jennifer. And then, Cheryl, we'll let you have the last word.

DR. RATLIFF: Thank you very much. Initially I was very worried with bringing up this topic. The scope of it is just so broad that you get lost in the weeds. But this has been just an actually fantastic discussion. I've learned a lot just from listening to the points being raised.

I think with regards to episodes of care, procedural or not, we run into so many different potential to get tripped up, as we get into nested episodes, as you look at a patient who had a total hip arthroplasty and then developed some post-operative pneumonia and suddenly is involved in perhaps three different episodes of care that are running concurrently.

How are you going to do attribution within that system? How are you going to make sense out of the complexity of this patient's

care?

And yet we're faced by this at present. I mean, we've had this, I guess, 45-minute long discussion now about this topic and yet we're presently using value-based payment modifiers.

My members are coming to me asking me what their quality resource use reports mean and how they came up with these numbers.

And I want to also echo the point brought up earlier about the additional benefit that healthcare facilities provide to their communities.

At least at Stanford we do a lot of things that are extremely inefficient, like training people and having nursing students, medical students, residents, things that really decrease our efficiency of care yet provide hopefully something to the community.

And the yield there as we move into a commodified environment may be lost. And hopefully we won't lose touch or lose sight of

the other benefits that some of our healthcare facilities are providing.

But nonetheless, this has been an absolutely fantastic conversation and many great comments.

DR. LATTS: Thank you. Jennifer?

MS. HUFF: Hi. So, I have to weigh in a little bit on the pricing transparency issue. And instead of repeating what people have said obviously it's important in general. There are a couple of additional points I'd like to make on it.

So, in addition to it being important to consumers I think we have to look at also purchasers as well as those, whoever is paying for healthcare.

I think people readily know that it's very opaque to consumers in terms of what is the price. I think people don't necessarily know that there are places where it's opaque to purchasers as well.

So in decisions about paying for

healthcare I think we need price transparency at multiple levels, particularly for those that are paying for it.

I think one of the other issues, not just for the importance of knowing how much things cost, but also looking at the waste or the affordability that's in the system.

We haven't talked about the role of what market power plays in terms of prices. And in some regions the really outrageously inflated prices that are going on. And the importance of transparence and how that will help in addressing affordability of healthcare.

When we talk about market power some of that is actually -- what's driving it is the need to better coordinate care and have more coordination across providers. So there's also some positive aspects going on in terms of that level.

I think when we're looking at sort of the development of measures or the priorities

of what we're talking about I think it would be really helpful for us to not think of the healthcare system as it is today, but think of it more as it will be in the future since there is a lot of change that's been going on because of the healthcare reform.

And it takes awhile to develop measures, and it takes awhile to get to a place. So if we could be more forward-thinking and think two steps ahead it would give us -- maybe we'd catch up instead of it being such a nascent area in terms of providing this information.

I also just want to thank everyone else who is serving on other committees related to this topic, or who are working on it and shared the information today.

It was really helpful for me to really start putting together the pieces. It's been a little confusing seeing all these different committees that NQF is working on related to cost and resource use and

affordability.

And what I'd hope is that you'll continue to foster that discussion as we continue to have our deliberations down the road, that you'll bring back what is happening at the other workgroups so we can make sure to not duplicate work. And we can be really efficient in what we're doing since there is a lot of resource and energy going into the topic in general.

DR. LATTS: Great, thank you. Cheryl, then Jim and then Ariel, we will indeed let you have the last word.

MS. DAMBERG: Thanks. I am also struck by another conceptual issue that I think we as a committee and NQF has to deal with.

You know, as I'm looking through the list of measures and also the one that I talked about a little bit earlier in terms of overuse of services. I think there's this tension between are we operating at the macro

level.

Like Dolores just mentioned in terms of this total cost of care measure we're more at the micro level.

And I think this is particularly important as we're trying to think about combining quality measures with cost measure. Because most everything we've measured in quality is at this more micro level. And so I think we're kind of -- until we get some clarity on that.

And I think again it points back to Dolores' comment about who are the actors and who's making use of this information.

And it may be that these more global, macro type measures work because what they ultimately do is they free up the organization to have to go back and think hard about what are all the various inputs that are driving our overall costs.

And they can look on the ground to see where they can make changes. So maybe

that's sufficient.

But if that's the case I think we have to rethink how we're measuring quality if we intend to pair them.

DR. LATTS: Great point. Jim.

DR. NAESSENS: I wanted to reinforce some of what Brent had said in terms of thinking about it even from a consumer perspective, that we really have kind of three groups of measures, or subjects, or topics.

We have kind of the per capita perspective for the population, for the ACOs, for plans.

We have episode-based information for surgical procedures, for short kind of acute events, and around the hospital and things.

But we also have this relatively small percentage of patients who are very complex, who would include burns and transplant patients, might include multi-morbid chronic disease patients, patients who aren't really going to be necessarily getting

the best care within narrow networks that don't include various options that might give them better choices.

And so we might need separate measures and some separate activity around that.

Then in terms of prioritization we of course want to look at total spend. We want to look at volume. But we also want to look at some leverage possibilities.

And the leverage possibilities would include variability. So those areas where there is a lot of variability across markets, across the nation should be higher ranked because there might be things that can be done to kind of address those things.

Also, when we look at episode bases we should also include that idea that we're getting more and more into shared decision-making opportunities. We should be looking at appropriateness measures.

And those should be incorporated in

some fashion to be able to determine what is an appropriate cost. And clearly if we have different attitudes in California than we do in Minnesota in terms of our values then we're going to see variability in costs whether we look at episodes or we look at per capita bases depending on those shared decision-making decisions.

DR. LATTS: Ariel.

MR. BAYEWITZ: Yes, I just wanted to -- first of all, I agree with what everyone is saying so I'm not going to restate.

The only piece that I just wanted to clarify. There was one comment around payers not being willing to share information around, you know, episodic information or procedural information that was more global, that wasn't specific.

You know, CP-4 code, for example, that may be a little bit more global like the overall cost of getting a colonoscopy.

And just from that respect I'll talk

from like a Blue Cross perspective. We definitely do share that.

My impression is a lot of other -- and it may not be all plans in this space, but there are definitely other plans, many other big plans in this space that are beginning to share a lot of that information.

We think it's very important for the consumer, the member, to be able to compare certainly at that rolled-up procedural level.

But I think even now when you're talking about value-based models the provider is a consumer of this information as well. So when they're trying to make decisions about who to refer certain procedures to they need to be able to differentiate between providers.

The last piece that I just wanted to throw out there also -- oh, just to back it up.

With regard to total cost I think that's important, very important also. Where that gets tricky of course is in risk

adjustment and dealing with different populations.

It also isn't always actionable. So it may be helpful to be able to differentiate between one organization and another, one plan and another by talking about their total cost, but then take it down a few levels and say, okay, well now, how do I drive change, or how do I identify within that total cost what is the differentiating factor that's making one cost more than the other.

That gets a little bit complicated. And that's why I think both of those pieces really are very important, even from a payer perspective.

Just the last piece on the who, what and how. The how, where I think it gets a little tricky and I think it's very important is how can we give -- how can we turn the how into actionable information.

So, beyond us saying this provider or this plan is not as good in this area as

another, to get to a how to give information that you can actually put in a report or a dashboard at a provider level. To have a measure that can get into that would be very powerful. We have a lot of that in the quality but not again as much on the resource side.

DR. LATTS: Great. Bill, did you have a quick comment?

DR. WEINTRAUB: I believe in transparency but I think it's very challenging. From the point of view of providers consider charges, cost and payments.

Payments is fairly transparent. What CMS pays us is publicly reported and available.

Costs, well, per my previous comment we don't know what anything costs. We don't know what coronary surgery costs at our institution. We have models, but at the end of the day we don't know.

And then there's charges, or price.

It's the least meaningful number and essentially no one pays it. You could say well, the people without insurance, they get charged and they have to pay it. But, in point of fact very few of them pay it because they don't have the resources to pay it so the institutions write it off.

So, I absolutely believe in transparency. Maybe from the point of view of the plans it's a little easier. But we have to be careful here. Transparent about what? And it's not always so easy to do.

DR. LATTS: Terrific. Well, thank you, everybody. I think that was a really fantastic discussion and hopefully it gave you guys the information to move onto the next steps.

So, we're running a little bit late. So we're actually going to move onto public comment next, take our lunch break, and then come back and get the overview of the evaluation process while we dig into our first

measure.

MR. WILLIAMSON: That's great. Thanks a lot, Lisa.

Operator, at this time can we please open up for public and member comment? And I'll ask if there are any public and member comments in the room.

OPERATOR: At this time if you would like to ask a question please press * then the number 1 on your telephone keypad. At this time there are no questions.

MR. WILLIAMSON: Great, thanks a lot. So we'll now break for lunch. We'll now break for lunch.

In order to get through our afternoon agenda I'll ask that we reconvene maybe 10 minutes early. So we'll reconvene at 10 to 1 and we'll get started with the overview of the evaluation process.

Because several members weren't able to make it we can offer lunch to everybody in the room. So, bonus, right? And so, we'll

now break for lunch and we'll reconvene at 10 to 1.

(Whereupon, the foregoing matter went off the record at 12:25 p.m. and went back on the record at 12:56 p.m.)

MR. WILLIAMSON: So now we're moving in. We're going to quickly cover the section we were going to cover right before lunch which just goes over the measure evaluation overview.

We've all been through this on the orientation call. And again, the members of the committee who have been on the committee before, this shouldn't be anything new.

The only thing that will be new is at the end when we discuss some of the close vote procedures, kind of our lack of consensus range that actually came out of the last phase of this work.

So, we'll go ahead and I'll turn it over to Taroon here. He's going to go over the quick measure evaluation overview and then

I'll go over the voting process.

MR. AMIN: Okay, great, Evan. So, I'm going to go through this relatively briefly, assuming that the majority of the committee has gone through this.

However, I want to just stress that as part of our improvement efforts ongoing, you know, we've had a lot of conversation with developers broadly, not related to this committee in particular, about standardizing the way that we're approaching the evaluation process and ensuring that the discussion and the voting is really clear in the criteria, and that we're giving feedback that's sort of indexed back to the criteria in a very clear way.

So, as you all may remember we have five principal criteria that we evaluate: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and the harmonization and best in class.

On the next slide you'll see that there's two must-pass criteria. I should note that the criteria follows a hierarchical model. So, importance to measure is the most important criteria, it's a must-pass criteria, followed by scientific acceptability of measure properties. Which includes, and I'll go into this in a little more detail, two components in particular, the reliability and validity. And then feasibility and usability.

If we have two measures that are similar we will go through a harmonization process which is not relevant for the two measures that we'll be discussing this afternoon.

So, on the next slide as we talked about there are two must-pass criteria. Generally for cost and resource use measures we don't really spend that much time on importance to measure and report. Generally these are high-cost areas with a high number of patients within them.

The subcriteria, we really like to sort of follow the approach where we have, particularly within scientific acceptability, follow a systematic conversation along the subcriteria to ensure that the major criteria are met.

So, these criteria are developed to follow best practices. They require evidence and expert judgment. And the assessment generally follows a matter of degree rather than an all-or-nothing approach.

Again, it's up to -- it's the burden of the committee to justify their votes, to talk about why they're voting in certain ways so that the process is transparent.

If we see the conversation in the committee generally sort of positive and then there's a large number of low votes we're going to query the committee to understand exactly what's going on, to provide more transparency around the nature of those decisions.

That obviously provides some transparency to developers. Equally importantly it helps to provide some clarity to our members who will be providing comments on your report and your evaluation. And also the Consensus Standards Approval Committee which your recommendations go to.

So, moving onto importance. Again, I won't go into much detail here, but we're looking to make sure that this topic is important to measure, that there is variation or overall lack of -- or there's overall poor performance.

And as we look to the scientific acceptability we're looking at two major subcriteria here. We're looking to understand the extent to which the measure produces consistent, reliable results and that there's empirical testing of the measure.

For validity we're looking to ensure that the specifications are consistent with the measure intent, that if you're measuring

asthma care that you are including all the appropriate cost types and including the appropriate codes.

There's empirical validity testing. That there is testing of the exclusions. That you're not excluding large numbers of patients, a large number of the dollars that you're intending to test.

There's an evidence-based risk adjustment strategy. And there's actually some statistical results about the goodness of fit of the risk adjustment model with adequate discrimination and calibration.

And that you're actually producing statistically significant and clinically meaningful differences in performance.

And if it's -- this is not the case, but generally -- this is not the case for these measures, but if there's multiple different methods that are specified in the measure, i.e., there's two different risk adjustment models which is -- they should

demonstrate comparable results if they're within the same measure.

When we're looking at feasibility we're looking to understand the data is readily available and it can be captured with undue burden.

And typically since these measures are using administrative claims data it's generally not a major topic of discussion.

And then usability and use. The purpose of this criteria is that we want to ensure that measures that are -- on the next slide -- that we want to ensure that measures that are endorsed have a plan for use. There's a plan for use within three years.

And those that are currently endorsed are being used in the field. To ensure that we understand what the limitations for getting the measure in use are.

And finally, I'll just point out the last subcriteria here that's sort of unique to -- actually, if you can go back, Evan. Sorry.

The last subcriteria which is unique to cost and resource use measures, that the measure can be deconstructed to facilitate transparency and understanding.

And then finally, I'll just sort of just talk broadly about related and competing measures on the next slide.

We're looking to understand -- for cost and resource use measures it's not only the measure focus, but you're also using the same measure type. I.e., you're looking at per-episode measures and you're measuring it in the same way using actual costs or resource use. Using a standardized pricing table.

So, broadly, that's what we're going to be evaluating when we look at these two measures today and then a third one tomorrow.

The two measures in front of you today are new measures that are submitted. The one that's tomorrow is a maintenance measure.

And with maintenance measures the

criteria is the same, although we expect slightly different submission information, meaning that we should see performance results from the measure being implemented.

So, are there any questions that anybody has about the criteria or how we are going to go about the process of evaluating the measures in front of you?

I know many of you are very familiar with this process so you're probably able to answer it for anyone who has got any questions. Any questions at all? Straightforward. Okay.

MR. WILLIAMSON: Thanks, Taroon.

MR. AMIN: Evan, we have one. Andy.

MR. RYAN: Sorry, Evan. I have a question.

MR. WILLIAMSON: Oh, sorry.

MR. RYAN: So, Taroon, is it fair to say that the criteria for endorsement for a maintenance measure and our decision-making process should be identical to that for a new

measure? Or should we be -- would it be less stringent? Or kind of just given that it already passed once.

Is there any additional guidance for how we would consider endorsing a maintenance measure?

MR. AMIN: So, you should not assume that because it passed once that the measure should continue to -- that it meets the criteria. You shouldn't assume that.

The second issue is that there are certain components of the measure evaluation, meaning the performance results, the amount of the performance score variation that you see in the measure. There are some specific submission elements that we actually expect to be at a higher bar for measures that are coming in through maintenance.

They should be able to show in some way that there's been an improvement in the performance of the -- by the measure being in use.

So, from a submission element perspective the bar is actually a little bit higher. That they should be -- and we can walk through that tomorrow as we go through the actual, that measure.

I can point out exactly what submission elements need to be slightly different for a maintenance measure.

But as far as the criteria goes, how you evaluate the measure, the criteria is the same. But don't feel that you need to continue to move the measure forward, or any measure forward based on the evaluation of the prior committee.

Again, all the criteria are a matter of judgment. And so the judgment of the committee may be different than prior committees. However, you want to make that clear about what the issues are and understand what has changed. And be really transparent about that.

DR. BURSTIN: Just one additional

comment on the question about usability and use. Again, it's not often completely within the control of the measure developer that a measure gets picked up for use.

Some of the measures that are brought to you were developed with CMS dollars for the express purpose of being put into a CMS program.

There are others developed more in a private sector way like NCQA, for example, where you wouldn't necessarily be able to look and say, well, that's been picked up by this federal program since they didn't necessarily support it at the outset.

So I think we usually don't have quite as strict a rule, Taroon, of expecting to see that within one cycle you will have seen an impact in terms of improvement. That would be the goal.

But again, some of this is really how much has it even been taken up in that short period of time.

MR. NEEDLEMAN: Jack Needleman. Nothing to disclose. And I apologize for not being here in the morning. So perhaps this got discussed during the morning session.

But the issue of measures that are in use, the earlier incarnations of this committee confronted that. So, and I'm just wondering if there was any discussion about whether the endorsement bar is lower, higher, or the same for a measure that is in use or clearly intended to be in use.

Because this came up with some of the other CMS measures as we were discussing it. So I'm just wondering if there has been any conversation about that.

DR. BURSTIN: It's a great question, Jack, and it's one we've really been struggling with, of whether we should move away from a binary yes/no endorsement and move towards endorsement that's more fit for purpose.

So, for example, does this measure

meet the bar of fill in the blank, pay-for-performance at the individual physician level, something along those lines.

We're not there yet. So certainly at this point we would still maintain that equivalency. Because we don't, again, often know how measures will ultimately be used and in what fashion.

MR. WILLIAMSON: Great. If there are no further questions we'll move into the voting guidance and process.

So this will be new for everybody on the committee. We have kind of identified a range where there's a lack of consensus. And so we've defined that as a range between 40 and 60 percent. So, on any of the criteria we'll be voting on if we reach 60 percent approval which is either high or moderate then it passes. Subsequently, if it reaches below 40 percent, or if it's below 40 percent it won't pass.

So we've identified this range

between 40 and 60 percent where we want to get more information. And so in that regard if it reaches between 40 and 60 percent we'll put it out for public and member comment.

And so we identify that on the next slide here. Where we have a lack of consensus we'll put it out to get comment and voting. Then we'll re-vote on the -- we'll re-vote on the measure after we've received that public and member comment.

And if after that we reach greater than 60 percent the measure will pass. And again, if we still fall between 40 and 60 percent we'll put it out for NQF member voting, to try to continue to get more information.

MS. WILBON: I'll just clarify the 40 to 60 percent threshold is really for the first two criteria. So for importance to measure and scientific acceptability. It's not for necessarily feasibility and usability and use.

So, as long as we get that 60 percent, reach that 60 percent threshold on those first two criteria we will continue to evaluate the remainder criteria for each measure.

MR. AMIN: I also add maybe, I don't know if this is on the next slide, Evan. I'm sorry if I'm jumping ahead.

But the reason why this occurred was for a number of different measures, but one of which was the one that we looked at last time.

So, the -- and Larry was on the panel that made this recommendation. But the issue has gone all the way to the board and the issue around -- we used to have a hard stop. If it didn't meet 50 percent it stopped in the process. The membership had no opportunity to provide any input to the committee.

And what ended up happening in some committees, they would just move the measure forward to understand what the membership felt about some of these issues.

So, the general idea here is defining the gray zone. So, I mean it's just that there might be somebody in the room or not. So that's why we have new quorum requirements and things of that nature.

But the purpose of this is to get more membership understanding of the issue if we're sort of in the gray zone.

And we'll do all the calculations in the background. It's not, you know, you don't really need to worry about that. But the purpose of this is to define the gray zone and then for us to have a process, i.e., have some conversations, send this to the membership and then provide that feedback back to the group to understand what we do when there's not real consensus on some of these more controversial or high-stakes or whatever measures you want to describe.

MR. WILLIAMSON: Great. Thanks for that clarification. So, in order to do this we'll be voting in the room and also on the

webinar today because we've had a lot of members who aren't able to join us. So it will be a little more fragmented than we'd hoped, but we'll be adding numbers together from the webinar and our in-the-room voting process here.

So Ann should have passed out a Vote Snap device to you. Just make sure you have one. We took down the numbers so if you want to take one home as a souvenir, please don't.

(Laughter)

MR. WILLIAMSON: We'll know who you are. Just make sure that we get them all back at the end of the day. We'll collect them tonight and pass them out again tomorrow.

For those on the webinar we have voting slides set up. And so when the voting is open a series of choices will appear on a slide. Please select your corresponding vote and we'll make sure it gets recorded.

Now, one thing I want to point out. On these Vote Snap devices it will only record

your last input. So if you vote and want to change your input, just press the next button. You don't need to do any clearing out or anything, just press the next button. Whatever you press last will be recorded.

It also works on a line of sight feature. So you can see this computer here, this laptop in front of Ann will be running the voting. There's a little USB dongle off the edge of it. So you'll need to point at that when you're voting.

It's very scientific. Somehow it sees it. I won't go into it. But make sure you're pointing at it.

Throughout this process sometimes we register 14 out of 15 votes so we'll ask everybody to vote again to make sure that your vote's captured. Just press it again, point it at the computer and we should be good to go.

We give 60 seconds for the voting. We usually don't need all that time. We might

need more time this time just to make sure that we get all the voting on the webinar and in person. So again, please work with us as we go through this. This is going to be kind of new for us.

So, I think that's it as far as Vote Snap. We'll be going through it the first time and we'll work on it. Ann will be reading off the voting prompts and starting and closing the voting. So we'll leave that to her. And I'll be running the webinar voting so we'll have to add all that together to determine our percentages and everything. But we think we can handle it.

I'll now read through a script that we put together as part of our CDP improvement work. This describes some of the changes. We'll invite the measure developers to come get seated at the two spots we have available at the table.

So NQF is working to improve committee meetings based on input from a

variety of stakeholders. We've made a few changes to our meeting process.

We recognize that we are fortunate to have the measure developers present and we'll be asking them to briefly introduce their measure as they come up for discussion.

Selected committee members will then begin the discussion of the measure in relation to the measure evaluation criteria. So those are the lead discussant assignments that we sent out.

We have also provided a designated place for the developers at the main table during the introduction and discussion of their measures. Here they may more easily respond to questions from the committee and correct any misunderstandings about their measures during our discussion.

As is the case with the committee members, developers may put their cards up to indicate when they wish to respond to questions raised, or correct any statements

about their measures.

During measure evaluation committee members often offer suggestions for improvements to the measures. These suggestions could be considered by the developer for future improvements. However, the committee is expected to evaluate and make recommendations on the measures for the submitted specifications and testing.

Committee members act as a proxy for NQF's membership. As such, this multi-stakeholder group brings varied perspectives, values and priorities to the discussion. Respect for differences of opinion and collegial interactions among committee members and measure developers are expected.

The Q&A call and full committee meeting agendas are typically quite full. All committee members, co-chairs, developers and staff are responsible for ensuring that the work of the meeting is completed during the time allotted.

So as we put up on the slide here we expect committee members to be prepared having reviewed the measures beforehand. That they base their evaluation and recommendations on the measure evaluation criteria and guidance. They remain engaged in the discussion without distractions. Attend the meeting at all times, except during breaks.

Keep comments concise and focused, and avoid dominating a discussion and allow others to contribute. And finally, indicate agreement without repeating what has already been said.

So, in order for the process for this, we have a list here. We'll start with the developer introduction. We've given them a few minutes to introduce their measure. I'll be loading their slides here in just a second.

We'll then turn it over to the assigned lead discussants. We'll summarize the key issues for committee discussion. We

distributed the committee evaluation summary which has both the TEP evaluation as well as the preliminary evaluation submitted by committee members over the last few weeks.

We want to note any areas of disagreement based on those reviews. Then again we'll turn it over for the TEP summary to Bill Weintraub. He served as the TEP chair, so he was able to utilize his experience to really be a crossover on that, so we're excited about that.

We'll then turn it over to committee discussion. So again, we really want to emphasize that we're evaluating the measure as is in front of us.

We'll then vote on each subcriteria and measure criteria. So the votes on recommendation for endorsements for measures that pass the must-pass criteria. So we'll go on an overall recommendation at the end if we pass. So, at this time we'll load up some slides.

DR. ASPLIN: While Evan is loading the slides Matt McHugh has joined us, a committee member. Welcome, Matt. And I will ask you if you have any conflicts to disclose before we move ahead.

MR. MCHUGH: No conflicts. Thank you for kind of letting me just sneak in here, grab a little --

DR. ASPLIN: Sorry, I had to call that out.

(Laughter)

DR. ASPLIN: Are there any members of the committee who have joined us by phone who were not on this morning? Very good.

And with that we'll try to get into a cadence here with the developer followed by Bill as our TEP representative. And then the brief overview from the key discussants from the committee. And then we'll get into the process. So, welcome our measure developers.

DR. KIM: Good afternoon, everybody. My name is Nancy Kim. I'm a general internist

and served as the clinical lead of this measure. I'm accompanied by --

DR. BERNHEIM: Hi, I'm Susannah Bernheim. I'm our project director at the Yale CORE site.

DR. KIM: Okay, so I think we're going to begin with our slides. And I just want to emphasize that when we began developing this measure we knew that we had to get to value. That's the biggest, one of the biggest discussions in healthcare right now.

There are many, many and value is really payments and quality, or cost and quality. And there are a lot of great quality measures out there. Many of them are NQF-endorsed. But there was really very little in the cost space.

So we took a CMS perspective to try to answer this call to get at measuring cost -- from our perspective it's Medicare payments -- to try to fill in that void so we can take one step closer to getting toward value.

So this is our measure overview. The goal is really to measure hospital-level payments for an episode of care that begins with an AMI. I guess this part is all about AMI. Hospitalization ends 30 days post admission.

We wanted to create a relative measure that reflects both differences in inpatient and post-discharge care. So we removed payment adjustments that were unrelated to clinical care that are indicated by CMS policy such as geographic factors in policy adjustments like indirect medical education and disproportionate share payments. We took those out of the equation.

We wanted to risk-adjust for patient case mix to level the playing field across all hospitals.

And we really wanted to align with our publicly reported outcome quality measures because we were trying to get toward value, although we're discussing the development of

a payment measure in isolation today.

So, in order to do this we used the Chronic Condition Data Warehouse data. We used their Medicare fee-for-service administrative claims data. They include 100 percent of patients with a primary discharge diagnosis of AMI.

We included payments for the index admission and up to seven other post-discharge settings. And they're listed here. So the inpatient including any readmissions, including inpatient psych, including LTACHs and other inpatient settings, skilled nursing facilities, outpatient which is really outpatient hospital, any physician-type visits, home health agency claims, hospice claims, non-institutional providers such as physicians and independent labs, those kind of claims that you'd find are there. And any claims for durable medical equipment. We didn't include Part D.

So, our cohort again was aligned with

our AMI mortality cohort. We did include a few other exclusion criteria. We excluded admissions without 30 days post-admission enrollment and fee-for-service Parts A and B because we simply can't calculate a payment outcome on these folks.

We excluded any inpatient transfer bundles that were associated with the VA or other federal hospital because we cannot calculate payments on those VA or federal hospital claims.

We also excluded patients with no DRG during their index admission. Our index payment portion of the total payment calculation is heavily based on the DRG so if there's no DRG we can't calculate that portion.

And we excluded -- well, this is for heart failure patients who received transplant LVAD during the episode of care for heart failure. We did not exclude those for AMI. I know we're talking about AMI right now.

There was no LVAD exclusion for AMI.

For inpatient transfer patients we define the start date of our episode of care payments as the date of the index admission. Conceptually this creates a standardized payment window for anybody that comes into our AMI cohort, whether you're involved in transfer or not.

We totaled all of the inpatient payments for payments made for that initial index admission to hospital A and the transfer to hospital B. So that's one index payment. And calculated all of the other payments for the rest of the post-acute care. And then we passed that back to hospital A because they started the episode window on the date of index admission.

Our payment calculation. We removed payment adjustments. We call that standardizing or stripping. And what we did was we isolated difference in payments that reflect practice patterns by estimating CMS

payments by stripping, which is just completely omitting the geographic adjustments and the policy adjustments that I mentioned before.

So, geographic adjustments are wage, index and cost of living, and the policy adjustments are mainly indirect medical education. But there are other smaller policy adjustments as well.

When we couldn't fully omit them because of the way the claims are based we had to standardize. So we averaged geographic differences when geographic adjustments couldn't be removed.

So for durable medical equipment every state pays a set price for an insulin syringe. It's different across all states. So we would average that price for the insulin syringe across all 50 states and assign that average price any time that insulin syringe came up in the claims data.

This is our actual payment

calculation example. It's a little lengthy. This is the way the inpatient hospital payments are included. It's a long -- this is all CMS policies from CMS websites.

And what we do is we take out the geographic factors like wage, index and COLA in the top row and we remove indirect medical education payment disproportionate share in the bottom row.

And then we also take out the wage index from DRG outlier payments and capital outlier payments shown in red in the last two boxes in the bottom row.

This is the payment calculation example that I just told you about. When we cannot omit or strip we standardize. And this is all the HCPCS codes for all sorts of different items that you can find in the claims. Sterile water saline 10ml is the first line in that row. And you can see across the different states they have a slightly different unit price, $.43 in

Alabama, $.45 in Arkansas, et cetera. We average it and then assign that unit price to that claim across the board.

We also prorated payments that began during the measurement window but ended after the measurement window.

So, in the example here, moving from left to right you see the index admission going onto day 30 and beyond. In this example in the green. Again, it's a heart failure example. I apologize, pretend it's AMI then they're discharged to SNF.

And then they have home health payments that span that 30-day cutoff window. We only include those payments that would fall in that 30-day payment window shown in green there. The orange which is also the home health payment goes beyond our measurement window so we don't include them in our total payment calculation.

Regarding our model selection, the payment is positive and continuous. So it's

a bit different than other quality metrics that have come before this board.

It's heavily right-skewed as can be seen in that first histogram which is the distribution of unadjusted patient-level payments for an AMI 30-day episode of care. The N is about 130,000-plus patients.

And next to it is the distribution of unadjusted patient-level payments for heart failure. So again, disregard I guess.

When we were selecting the right model to use in calculating our risk standardized payment outcomes we had to look at the distribution of our payment outcome and make a model choice based on empiric data.

So, based on Manning & Mullahy which is an algorithm used to guide model choice for payments in econometrics in the health economics literature we chose for AMI a generalized linear model with a log link and inverse Gaussian distribution. We tested about five models and this one was chosen

because it had very, very good performance and was easier to interpret.

Moving onto our risk adjustment.

DR. ASPLIN: Nancy, one thing we might want to do, since this is a little bit longer than what we had --

DR. KIM: Oh, sorry.

DR. ASPLIN: That's okay. Just cover both measures. Because there's so much symmetry.

DR. KIM: There is.

DR. ASPLIN: And let's not do an overview.

DR. KIM: Okay.

DR. ASPLIN: So just, if there's a salient comment for the heart failure let's make it here and then not do it again when we get into the heart failure.

DR. KIM: That's terrific. Thank you for that leeway.

And yes, so for heart failure we chose a generalized linear model with a log

link and gamma distribution. But again, it is the same approach.

The next slide is our risk adjustment. And this cartoon is really a conceptual model of how we approach risk adjustment.

The dashed line you see is time zero, the date of index admission. So we risk-adjust for the things that happen before that shown in purple to the left.

We risk-adjust for patient characteristics that the hospital has no control over. We adjust for AMI relevant prior procedures like PCI and CABG because they've been directly tied to your total payment outcome and it's not -- the hospital has no control over whether you had a PCI or CABG before you walked through their doors.

We adjust for relevant comorbid conditions.

And you come away with a diagnosis. In this case let's just talk about AMI. Although there are 20 ICD-9 codes for AMI you

come in with an AMI.

What we don't risk-adjust for is on the right side in the blue. We don't risk-adjust for -- let's take that, one of the complications shown in the middle in blue.

Because we feel that the complications that happen in the hospital may be attributable to the hospital. So we don't want to adjust away for the things that happen in the hospital.

We also don't adjust for procedures that the hospital chooses to do during that index hospitalization.

And the care setting here in the leftmost blue box is just there to represent the fact that we include not only the inpatient setting but also post-acute care settings, whatever they may be.

So, in the AMI model we adjusted for age, diagnoses that were relevant that were present 12 months prior to the admission date and during the index admission that did not

represent complications of care. We have a whole list of things that are adjudicated as complications of care.

We also adjusted for history of PCI and CABG for the AMI model. We did not adjust for complications as I mentioned, SES, gender, race and ethnicity as I'm sure we'll talk about it, hospital characteristics and admission source such as whether you came from an LTACH, a SNF, et cetera.

Our risk standardization. The way we present the risk standardized payment is a ratio of the predicted hospital-specific payment over the expected hospital average payment. And then we multiply it by the national mean payment to get it back to dollars so it's a bit more understandable.

MR. WILLIAMSON: Nancy, can you move the microphone closer, please?

DR. KIM: And then if we move on these are our results in the next slide. These are unadjusted AMI results. And this is

the distribution of the AMI episode of care unadjusted payment.

Although we include all hospitals with any AMI patients in the calculation of our total payment outcome we don't report on those hospitals with fewer than 25 AMI admissions in a year.

So here you can just see that the minimum unadjusted payment was $11,000, the maximum was $42,000 and the median is about $20,000. These are reported in all hospitals with a minimum of 25 AMI cases.

I think it's about 4,000-plus hospitals. Two and three thousand. But it's thousands.

Looking at the next slide, the risk standardized AMI results. So after risk adjustment and standardization here is the distribution of our AMI episode of care risk standardized payment. That's what RSP stands for. Again, reporting only on those hospitals with a minimum of 25 AMI cases, but including

all hospitals in the calculation of the measure.

And then you see the minimum risk standardized payment is about $14,000, the maximum is about $29,000 and the median is about $21,000.

For heart failure, these are our heart failure results. This is the unadjusted heart failure results similarly. Every hospital included in the calculation. Reporting only on those hospitals with 25 or more heart failure index admissions.

Maybe as you'd expect a minimum for heart failure is about $7,000, the maximum is about $27,000, the unadjusted, and the median is about $13,000. So cheaper than AMI.

And then if you look at the next slide which is the risk standardized heart failure results the minimum is now about $9,600, the max about almost $21,000 and the median is about $13,700. So also cheaper than AMI.

These are our episode of care payment results, the same ones you saw presented in table format. I know I'm going over so I'm trying to move quickly.

And this is our distribution of payments for both measures by the portion of total national patient-level payments by either index or post-acute care.

So the blue represents your index payments. On the lefthand side is AMI. On the right-hand side is heart failure. So, looking at that first pie chart on the top left, that's AMI.

Seventy-seven percent of total episode payments were for the index admission, and 23 percent were for post-acute care.

The breakdown in the row below is just the proportion of total national post-acute payments by care setting. So looking down from that little wedge piece for AMI the red is their readmission. So, 35 percent of post-acute payments were for readmission, 30

percent for SNF and 13 percent for non-acute inpatient.

Heart failure, 61 percent were for index and 39 percent were for post-acute payments. But interestingly for heart failure when you look at the post-acute payments 35 percent were also for readmission, 33 percent for SNF and 7 percent for non-acute inpatient, things like inpatient rehab, inpatient psych.

And that's it. Sorry I went over. Thank you.

DR. ASPLIN: Very good. I believe, Larry, you had a quick clarifying question. And I don't know if we have to dive all the way back into the slides. I don't want to get into an open Q&A about why certain approaches were taken but if there is a quick clarifying question, go for it.

MR. BECKER: Yes. So, I have about four or five slides back you had the continuum. And there was a box called diagnosis that you were adjusting out. Was

that the diagnosis that they were being brought into the hospital for? Or was that other conditions the patient had?

DR. KIM: Yes, so this is the cartoon. The diagnosis box should probably be over the dashed line. We don't adjust it.

Because our measures are condition-specific, everybody in the AMI measure had an AMI, we don't adjust away for that diagnosis. In the cartoon it represents the fact that the diagnosis is something the patient had when they walked in the door. Does that answer your question?

MR. BECKER: Thank you.

DR. ASPLIN: Very good. So next we're going to hear from Bill. Or do you want to do the lead discussants first? Lead discussants, okay. Cheryl and Ariel. Cheryl, do you want to go ahead?

MS. DAMBERG: Okay, thank you. So, if I understand my charge I'm supposed to highlight the areas of agreement and point out

some of the areas of disagreement. And I'll start in order of the four criteria.

In terms of the importance of the measure to both measure and report I think there was general agreement that this is a high-priority area for measurement because AMI is a common condition. So I didn't see much disagreement among the committee members on that.

I did see in terms of opportunity for improvement a question about sort of the amount of variation. And once you risk-adjust that inner quartile range gets very narrow. And so the question is what behavior are we trying to alter, and are we trying to bring that upper right tail more closely in, and how much of that can actually be brought in versus an issue related to risk adjustment.

So, I think the question that was raised here was what kinds of steps or actionable activities are there for improvement.

However, noting from your PowerPoint presentation it was helpful because one of the questions that emerged was how much of this is related specifically to what the hospital does versus happens once the person is in that 30-day window outside the hospital. So it was interesting to see that breakdown.

In terms of the specifications I think generally people felt that the details were clearly defined. And there were only a few questions that kind of emerge. And they fall into this methodologic space.

DR. ASPLIN: Cheryl?

MS. DAMBERG: Yes.

DR. ASPLIN: Can I just interrupt you for a moment?

MS. DAMBERG: Sure.

DR. ASPLIN: Because we're going to get into a rhythm here. And there was a suggestion that perhaps what we could do to tie the comments from you and Ariel as well as Bill to the sections that we're going to be

voting on, let's go section by section. So, sorry, you just did exactly what I asked you to do and then I interrupted you.

MS. DAMBERG: No, that's fine.

DR. ASPLIN: There we go. So, what I would like to do is ask Ariel if there are comments about importance. And then I'd ask the same question of Bill from the TEP perspective. And then let's have our committee discussion and vote on those questions. And then we'll move onto the next section. Ariel?

MR. BAYEWITZ: So I'm very embarrassed right now because I actually missed the email that I was presenting. So I'm not prepared to speak. I mean, I could pull my responses up from what I submitted but I wasn't prepared to speak right now.

DR. ASPLIN: That's okay. Bill, from the TEP perspective on importance?

DR. WEINTRAUB: All right. So, the TEP questions were phrased differently than

the standard NQF questions. So I can summarize or we can look at -- what I would suggest to do is at least put on the screen so people can look at it what the TEP suggestions were.

And they were essentially the same on both. But to summarize then I think clearly the TEP felt that this was an important question. So if you go to the evaluation measures you'll see how the TEP responded.

DR. ASPLIN: Very good.

DR. WEINTRAUB: So those are the questions. But actually you have the document with the comments as well.

While he's doing that I could go through it very rapidly.

DR. ASPLIN: So we've all had a chance to read through the measure -- to respond to --

DR. WEINTRAUB: I think it's on page 4 where TEP begins. Yes, there we go.

DR. ASPLIN: Great. So comments on

that, Bill? Or have you already summarized what you felt --

DR. WEINTRAUB: It's phrased somewhat differently. I mean, I could go through it very rapidly. It might -- within two minutes I could go through these. It might be worth it, Brent. Whatever you want me to do.

DR. ASPLIN: Great.

DR. WEINTRAUB: Okay. So, the first one was clinically appropriate, clearly was felt to be clinically appropriate. Was it clinically consistent with the intent? Clearly so.

The next one was where there was problems. The evidence to support the logic.

There was concern about the attribution of the first facility, of the transfers to the second facility. The developers had what I thought were really pretty good answers to that. While there was concern no one felt at the end of the day that they should be excluded.

Alignment of length of stay, the episode. This overstates it a little bit here, saying that there was concern. It was discussed. I think people felt that the 30 days at the end of the day was really appropriate and it harmonizes with the clinical measure.

Consistency and relevancy of the population, clearly so.

Excluding patients. There was some concern with excluding same-day discharges. I think that the response from the developers was really very -- quite adequate here.

The real concern was in model adjustment. The R-squared for AMI was only 0.05 and for heart failure 0.03. So we're only explaining a very small amount of the variation.

Now, of course the developers and what they did, they excluded anything in the hospital and that's appropriate. But the problem is it leaves a tremendous amount of

variability and how much of that really represents variation in the hospital. And how much has it led to things that we're just not adequately accounting for. And we were really very troubled by that.

Also, as we all know socioeconomic status was not included. As Nancy discussed this morning this is an area that's up for discussion right now. But that is currently NQF policy and the measures can't be held accountable for that.

In general the TEP thought that the developers did a great job, that technically they did a good here, a very good discussion about it. But again, our biggest concern was the small size of the R squares.

DR. ASPLIN: Very good, thank you. So, let's loop back to the importance section for the voting.

I think at a high level -- I'm an ER doc, right? So this measure needs a disposition by 3:15 this afternoon.

(Laughter)

DR. ASPLIN: I just think simply. So, we want to make sure that we're focusing on the most important things that we can leverage the expertise of this group for.

So with that said is there discussion on the question of importance to measure and report? Nancy?

MS. GARRETT: So, I have a question for the developers about the trigger being the date, the time of admission. So I'm just wondering if you've done some analysis of the effect of length of stay on the results of the measure.

So, just thinking through what this could mean, it could be that hospitals that have longer length of stay are going to look better on this measure which is kind of weird because if you look at cost to society that's actually a really expensive place to be keeping people. But from a reimbursement perspective that could be a way to look good

on this measure. So, could you talk about that a little bit?

DR. KIM: Thanks so much. We did look at length of stay. The median length of stay is about four to five days for AMI. Of course there's wide variation but most of the folks are falling well within that four- or five-day area.

It's tough to know what length of stay does. You're right, the way we calculate is on DRGs. So unless you're there for a complication which would get accounted for in your DRG, but it would bump you up, that would be reflected in the DRG.

But sometimes some hospitals are keeping you longer and you're doing more stuff and that wouldn't necessarily be seen in our measure because you're paid on the DRG. So, it's really difficult to know what the length of stay is going to do in terms of bumping you up, real complications and stuff like that, or if they're just going to truncate your window

and advantage you for no good reason. That's what your concern is.

But when we looked again we weren't so concerned about the variation in the length of stay for the majority of the hospitals. Does that answer your question?

MS. GARRETT: It helps, yes.

DR. BERNHEIM: I'll just add to that. We had a lot of discussions about this because there's a very high priority on having the full measurement period be a standard period so that it's fair across hospitals.

Because the other way you could do this is to have whatever the length of stay was plus 30 days. But then when you have a longer length of stay you're stuck with some hospitals being evaluated on payments over 45 days and others on 35 days. So there wasn't an ideal solution.

I think we will do some more looking to see whether that decision would change results. We did some very early looking as

Nancy said just to make sure that there wasn't hospitals that were wild outliers on length of stay when you aggregate all their patients in there. It didn't seem to be there.

DR. ASPLIN: So, I'm going to ask us to focus on importance to measure. Because the problem will be when do you cut off the conversation because there will be important follow-up comments and questions if something is raised. And I hate to cut off conversation.

So let's narrow this to importance to measure. Are there any other comments on importance to measure? Sure.

MS. GARRETT: So the other thing I'm thinking about is harmonization. And so, Medicare spending per beneficiary does it the opposite way where the 30 days post discharge starts after discharge by definition.

So, I mean that's another thing as we get more of this portfolio of cost measures, that we're doing it differently in different

measures. And it just kind of creates more confusion for people to try and understand what we're doing. So, I think that's another thing to think about.

DR. BERNHEIM: We were also trying to harmonize with the AMI mortality measures so that when we were comparing hospitals on cost and quality we would be looking at a standard period.

We actually do have further analyses on this. I think for your benefit we'll pause, but Leslie can talk a little bit more about a little bit more work we did on the length of stay issue if people are interested later.

DR. ASPLIN: All right. Seeing no other cards in the room or comments from those on the phone I'd like to move ahead and vote on importance to measure criterion.

And how are we going to move forward with this?

MR. WILLIAMSON: All right, so we'll

start the voting online and in the room at the same time. So we'll go ahead -- to make sure you have your Vote Snap. This will be our first run of this during this meeting.

And so what we'll do is I'll move this slide here for online voting. So in a few seconds online you will see four options. Please select it online and please point your Vote Snap at this laptop here and we'll go ahead and get started.

So we're voting on high priority. You have four options: high, moderate, low, or insufficient. You may begin voting now.

If it blinks red that means it's communicating with the laptop. It looks like we have all 15 responses in the room and we have 6 on the webinar so we are good to go. Ann, if you'd close the voting.

And so our totals. We have 20 high, 1 moderate, zero low and zero insufficient. It passes the high-priority subcriteria. Good job, everyone.

DR. ASPLIN: Moving on. Opportunity for improvement. And this is in the first category of importance to measure and report. So I think we can move ahead and ask if there are any comments around what you see in front of us, the opportunity for improvement. Janis?

DR. ORLOWSKI: So my question has to do with a concern about attributing the post-acute expenses to the hospital.

And as with many of these measures they drive behavior. And I am concerned that that might drive behavior that would have consequences, poor consequences.

And so I would like to know what the rationale is for attributing the SNF and hospice and other attributes to the hospital.

DR. BERNHEIM: I'll say just a couple of quick things. I think the most important one is that we feel like if you only look at hospital costs you're really missing the picture on payments.

And right now our system is set up to sort of incentivize pushing those payments out into the post-discharge time period. So it's really critical to capture those.

And then the question is who do you attribute them to. We are moving in a direction where there's going to be systems where, like ACOs where there's an entity that feels responsible for both the inpatient and outpatient. But it just doesn't exist right now.

What we have found with other hospital-based measures is that hospitals are incredible catalysts in their communities for improving care and improving decision-making. We've had people talk to us about sort of choosing the SNF that provides the better care.

So they have -- a lot of the post-discharge costs are related to things that hospitals have some control over which SNF people go to, whether they go to SNF, whether

they go to readmission.

So I think our thinking was it's critical to include these costs and the hospital was the most appropriate player who could take some responsibility for reacting to those costs.

DR. ORLOWSKI: My concern is that since this will likely drive behavior that you may actually have hospitals that reduce the amount of post-discharge care that they have influence over.

DR. BERNHEIM: Right. Sorry, I realize that was part of your question and I didn't get to that piece.

I would say that's really among so many other things why the outcome measures had to come first.

So, I would never use this measure by itself because lower isn't always better. And so it's only meaningful if a hospital is appropriately reducing post-discharge care as in getting terrific outcomes for their

patients.

And that's why it's so critical that this be paired with the outcome measures. Because as a stand-alone you could incentivize the wrong thing. But we don't think it's going to get used -- our understanding is it's not intended to be used as a stand-alone.

DR. ASPLIN: Very good. So I have Jack, then Lina and then Bill.

MR. NEEDLEMAN: Thank you. I have no doubt that there are substantial amounts of variation in treatment and cost that are unrelated to value to the patient that could be removed here.

What I'm concerned about is I'm not sure I know how much. That very low risk adjustment R-square makes me wonder whether we're adequately controlling for things that are not under the control of the providers but which are driving some of the care costs. So I've got a couple of questions to try to get clarification there.

The description of the -- who's included were ICD-9 codes. And I'm just wondering how many different DRGs are there actually lumped together in this measure?

DR. KIM: In our TEP report we show the top eight. But there are a number of DRGs, both medical and surgical.

MR. NEEDLEMAN: Okay. So I understand that medical/surgical might represent a treatment choice that you might want to incorporate and pool together.

But I'm just wondering if this patient heterogeneity here. You know, some patients are going to walk in with an AMI, walk out in two days and not need anything else. And some patients are going to be there for a week.

And that the diagnostic information captures some of that. And you're basically lumping it all together and ignoring that information about how much care the patient needs. So, that's one question that I have.

And then I've got this question about all the post-acute care and the variation there. But if you can respond first to the decision to simply lump without any acknowledgment of patient severity that's indicated by diagnosis or what the DRG of the patient.

DR. ASPLIN: Could you respond to that, and then I want to have rich discussions in each section. And the challenge becomes we have two more votes on importance. So if we don't finish that we get into methodology and then we get down a roadway.

Because it's a great question. I just want to make sure we have space for a robust discussion in the section we're in. So why don't you respond and then let's try to tailor the rest and get our other importance votes.

MR. NEEDLEMAN: I'm happy to throw all this to the scientific validity section.

DR. KIM: I'm going to respond

because I've been asked to respond. Thanks for that question.

So, regarding the clinical severity we are limited to administrative claims data. So the kinds of stuff I think that most clinicians including myself would love to see, blood pressure, whatever, vitals, are just not in there.

So we are limited to claims data. So we won't really ever have the clinical severity that would be sufficient to satisfy the clinical side of this piece.

Regarding the R-squared which is related but different we have a backup slide that we can show.

MR. NEEDLEMAN: Forget the R-squared.

DR. KIM: Okay.

MR. NEEDLEMAN: I'm more concerned about the heterogeneity that's not measured in your R-squared.

DR. KIM: So, when we looked at the top DRGs across a quintile. So when we

separate hospitals by quintiles of RSP. So you've got the highest, most expensive, all these payments, not costs, payments. You have the highest payment hospitals in quintile 5, the lowest in quintile 1, 2, 3, 4 in the middle there. And they're quintiles so they're separated by the distribution.

When we looked at the top 70 percent of DRGs, the top 70 percent of the DRGs were the same. They weren't exactly the same. There were three or four that made up the top 70 percent of DRGs, but they were the same throughout all quintiles.

Some had similar proportions, not exactly the same proportions, suggesting to us that the patients and the coding practices are not different. Something is responsible for the variation for sure but it doesn't seem to be the coding practices. We'll never be able to answer your question directly because we don't have those clinical markers.

MR. NEEDLEMAN: So, each DRG has a

weight.

DR. KIM: Yes.

MR. NEEDLEMAN: So did you look at the -- within the DRGs relevant to these patients construct the average DRG weight for each quintile? And how similar are those?

DR. KIM: We didn't do that exact analysis. We just looked to see proportionately were these coding practices, were these such different patients that you're going to code them differently.

And is it all about the coding variation rather than actual clinical care variation. And we, when we did our analysis that I shared with you we were satisfied that it really wasn't a coding practice reflecting a difference in patient clinical severity. But we didn't do the --

DR. KRUMHOLZ: Nancy?

DR. KIM: Yes?

DR. KRUMHOLZ: Real quick. So I think it's a really good question. And I

think it has to be looked at in the context of our past experience which has shown that at least, for example, with mortality and readmission that in the absence of having the clinical variables at the level of the hospital you can create a measure that creates an outcome that is a good proxy for an outcome that you would receive using the clinical variables.

In this case what we want to avoid is, you know, the DRGs are put in kind of retrospectively. And that there's probably a lot of judgment and variation in it. And there's a concern that using them as a severity adjuster here would be endogenous and influenced by factors that really don't -- that sort of obscure this quality signal more than bring it out.

And so there is a bit of a leap of faith because we don't quite have the same data we had when we did the mortality measures. That again, while at the patient

level you fail to predict well that the aggregate technological level, at the hospital level actually represents it pretty well, and can serve as a reasonable surrogate for the severity issues.

That there's not such broad severity differences that aren't captured by the other information we have here at the hospital level, the aggregate hospital level that they would lead you to a different conclusion.

And that's -- you have to decide whether or not you believe that or not. But it's what allowed us to do the other outcome measures was that we actually were able to prove that these were very good surrogates for the measures that you would get if you had the data that you wished you had, which is blood pressure, pulse and a lot of the other things that we think are traditional around that.

And that the things that are really fueling these differences aren't differences in case mix.

DR. ASPLIN: Thank you. Lina?

DR. WALKER: I just want to get a little bit more clarity on how you are presenting the measure and how that could be used for improvement.

So as I understand it you're not presenting a continuous value, you're presenting three categories. So about average, above average, below average. And so there's a lot of variation even within each of those categories.

And so when it is being used you -- I'm glad to hear you say that you won't expect less is better, but then I guess I'm trying to understand, and I'm hoping you can help me understand how it could be used for improvement if the corresponding or complementary measure is the risk standardized mortality rate.

There's a lot of things you can -- things that can go wrong before you actually die. So, you could cut back a lot on your

resources and not affect your mortality rate.

So, you could see potentially hospitals moving towards the lower category and still not affect their rate, but you could also see hospitals moving towards the higher category. And again, the same result with the mortality rate.

So, how exactly do you envision this could be used for improvement?

DR. KIM: Harlan, did you want to say something? It sounded like you wanted to say something. If not, I can respond to that.

DR. KRUMHOLZ: I think it's a good question. You always prefer to have more granularity to the kinds of things that you want to pick up, more sensitivity. For unintended consequences doing things like trying to improve efficiency of care.

I can tell you that, for example, we're working in efforts with the Premier hospitals and are trying to look at groups of hospitals as they perform with regard to both

of these dimensions, both their mortality and their cost.

And patterns are emerging that I think is leading them to think about where they stand. And there are higher-cost hospitals with higher mortality rates. And they've got to start thinking N. I mean, this doesn't tell you the Y but it starts to point you directionally in the question of whether or not the practices are leading to the best outcomes for patients.

There are also ones that are lower cost that are higher mortality and vice versa. I think that this begins to paint a picture about where people sit vis-a-vis their peers and begins to help them solve the question of what's driving them, what can they do to improve.

I know that it's always a little unsatisfying. When we have process measures we're worried that they're too narrow. When we have outcomes measures we worry that they

don't tell enough about underlying mechanisms. And probably in the end of the day it's going to require us to go in both directions.

And what we've felt is that it's up to the institutions to begin to diagnose what those opportunities are. And we do urge them to be sensitive to the other kinds of outcomes which may not be picked up by mortality. But our hope is that mortality at least is picking up the more outcomes and can provide them some impetus to directionally focus on both efficiency and outcomes that matter to patients.

And Nancy, you've thought a lot about this too.

DR. KIM: Yes. I just want to add to that. So, I think that's right.

I also interpret your question meaning how practically are hospitals going to use this information to help them improve.

We have an example of our hospital-specific report on that thumb drive that I

handed you. Is it possible to pull that up?

And I think Harlan's right. Right now if you ask an institution where their patients go I don't think they could tell you for AMI, or heart failure, or any other specific condition.

So, what this hopes to do is to make transparent something that's happening that's affecting our payments and our quality.

And it's a first pass, because otherwise this remains invisible. It gets discussion started and if we can see the hospital-specific report you can see the kinds of information we're feeding back to hospitals so they can make local changes where they see fit, where it's feasible for them.

So, this is the --

DR. BERNHEIM: Just for context, when the measure is reported on the public website -- this measure hasn't been reported yet, but the other measures like the mortality measure, you can see both the category, one of the

three categories.

You can also drill down, see what the actual number is so they can see where they are on the continuous range with the interval estimates which are like the confidence interval.

But hospitals are provided privately much more detailed information for each discharge that's included in that calculation. And so we've been working to try to make that as actionable as possible.

And the AMI payment measure went through a dry run last year. So we did a first iteration of the report that hospitals would get to accompany the public reporting aspect. And that's what Nancy's going to show you.

DR. KIM: Yes, I don't want to walk you through every single tab on this, but this is an example of what the hospitals receive for their dry run, the hospital-specific report.

You can see your hospital's payment category, et cetera, et cetera, et cetera, across the board.

If you look at the index -- in the post-acute tab. So this gives you a lot of information about your index stay, whether or not you were transferred moving from left to right, your total payments, how much of your payments were for the facility, how much went to physicians. Whether or not your particular admission in your hospital was eligible for post-acute care. So this is the kinds of data that we're providing to our hospitals.

And then if you look at Table 4, post-acute care, I just don't think they know any of this right now.

And this is a table of the post-acute care settings. You can look at the venue ID, the index date, the index discharge date. And the care setting and how many times your patient went to a SNF or rehab, how many days they spent there and what percentage that made

of your total episode payments.

So, I think that's the way that hospitals are going to use these data. I think hospitals will hopefully use these data in two ways, broadly, with a companion quality metric, and then more specifically locally to understand what the phenomena are, their own patterns are which they may not know right now. So in that way I think it will be useful and can be used to promote local improvements.

DR. ASPLIN: I'm happy to report even the dogs at Harlan's house know a lot about the breakdown in episode spending, so that's good.

Jack, do you have comment on this section?

DR. KRUMHOLZ: No dog at my house.

DR. ASPLIN: Oh okay, sorry. Somebody's house.

MR. NEEDLEMAN: It's the second half of the question I wanted to ask which is you reported the proportion of the costs in each

of the categories, how much was acute, how much was SNF, how much was readmission and so forth. It looked like readmission and SNF were the two big post-acute for both of these.

But I'm just wondering, we're talking about variation here. So, and what you didn't tell us is how much variation there was in those. So, can you give us a sense of -- of course the room for improvement is a function of how much variation there is in readmissions or SNF or the acute cost for that matter.

DR. KIM: That's a great question. We have it in our slide deck. It's the patient-level. It's slide number, I have it as number 36 in our slide deck. It's entitled "Patient-Level Post-Acute Payments by Care Setting" by quintiles of hospital for AMI, the risk-standardized payment.

So, on the slide, I'll just set it up for you while Evan's pulling that up. All the hospitals are stratified by the quintile of the total risk-standardized payments.

And what we have laid out in the left column are the different types of post-acute care, readmissions, SNFs, non-acute inpatient which is essentially inpatient psych, inpatient rehab, home health, other outpatient, et cetera.

And then what you get are the number, so you're looking for frequency counts really, the number of patients who were readmitted across quintiles. And then the readmission dollar amount per patient across quintiles. And that's teeny tiny. I know it's teeny tiny for me, probably for you too.

And what we've highlighted in red are qualitative big differences. So in red across that top row it's readmission. The columns are quintile 1, 2, 3, 4, 5 by RSP.

Under readmission, that first red is 14.1. So that says 14.1 percent of patients in the lowest quintile of risk-standardized payment were readmitted in that window. And it cost $9,905 per patient.

In quintile 5, 16.8 percent of patients were readmitted and per patient a cost -- the payment, it's not a cost, the payment was $11,409. So that could be a source of variation. Across the quintiles from top to lowest it looks like more folks are being readmitted and they're more, the payments are more expensive for those folks in that top quintile.

As you go down the other settings the story becomes a little more complicated. It's also accounting for fewer dollars of the post-acute care.

But it's not such a simple story which is I think why it's important to give hospitals local information so they can figure this out locally and try to mediate connections and relationships with other post-acute care providers in a way that makes sense for them locally.

DR. ASPLIN: Andrea, is this about this particular issue?

DR. GELZER: Yes, it's about this slide actually.

DR. ASPLIN: Okay.

DR. GELZER: So, the third line down, non-acute inpatient, is that an LTACH?

DR. KIM: It can be. The non-acute --

DR. GELZER: So, they hardly return if they're at an LTACH. Am I reading that right? No?

DR. KIM: This is where they went from index stay.

DR. GELZER: Oh, this is just the payment.

DR. KIM: These are post-acute care settings during their episode window. So they didn't come from LTACH. They went from their index AMI admission possibly to an LTACH.

I will say that non-acute inpatient is more than LTACH. It's inpatient psych, LTACH and inpatient rehab.

DR. BERNHEIM: Okay. So just to make

clear what that slide's showing for that, among hospitals -- among the patients who are at hospitals where the total episode payments are lowest, they're in the lowest quintile of total episode payments, a smaller percentage are going to LTACH during the post-discharge time in the quintile 1 hospitals.

Among patients who are at the highest payment quintile of hospitals we're seeing greater percentages of them going to LTACHs and on average the cost of that LTACH stay is higher at the patient level.

It starts to give you, you know, this doesn't answer the whole story at all, but this was in response to some questions that had come up in your earlier meetings. Are you learning anything about how the high- and low-cost providers differ.

So this was a first pass to say there's a lot more to learn but some things emerge in an aggregate way that could be valuable for providers and for improving

costs.

DR. ASPLIN: Okay, so checking on our time here, one of two things happening. Either we're getting some of the questions that were going to come up during the scientific acceptability answered which I'm hopeful that that's what's happening here.

Or we have no hope of being done by 3:15. So I'm just going to have Bill, Lina and on the line Joe. And then let's keep these quick. And then I'd like to call the question on criterion 1b. Bill.

DR. WEINTRAUB: So I think this gets at some of the problems that the TEP came up with. And to summarize what Jack said previously, there seems to be some area for improvement, although when you look at this it looks relatively modest and most of it's related to readmission when you get down to it.

But it crosses over into the validity because your ability to predict with the model

that you've got is so weak. So, some opportunity for improvement but limited scientific validity given your model.

DR. BERNHEIM: Just a quick thing on the ability to predict is so weak comment because I think it's really important to address. And this definitely crosses into your scientific acceptability section so I'll just acknowledge that.

This is a problem we run into all the time with these measures. And if we wanted to maximally predict your cost there are all kinds of things we could throw into this model. And we've played with that a little bit to prove it to ourselves.

So I can make our R-squared 10 times as high if I put in a risk adjustment for your DRG. But when I put in risk adjustment for your DRG I am risk-adjusting for your decision about procedures. I am risk-adjusting for the complications of a care that have occurred during -- those all feed into the DRG payment.

And I can predict how much your episode is going to cost, but I can't actually tell you nearly as much about how hospitals vary in terms of the decisions they're making that affect costs.

Now, I'm not saying we've got everything in there we need to, but I just want to make the point that a low R-squared in and of itself does not tell you whether we've got everything in there that we need to. There's lots of ways to increase R-squared that don't make you better at projecting what hospitals are doing.

I totally hear your point that there may be clinical factors that you wish were in there that we can't get but we have parsed apart the pieces that we think are present at the time zero that we can capture and lots of these kinds of measures similarly have very low R-squared.

Like the HCC model that's used for

Medicare Advantage, similarly low. I mean, this is what you find in this world. And we think that a lot of it has to do with a lot of decision-making about care that affects the payments.

And so it's just really important to remember that we're not trying to predict payment as best we can because we can do that much better than we're doing. We're trying to just level the playing field so that when there's differences among providers we're accounting for that and leaving the variation that's most likely to be due to the decision-making.

DR. WEINTRAUB: So let me respond to that because I think that we agree that your choices were good ones and you shouldn't include things after the administration. Actually, you could drive up the R-squared by including complications and your R-squared would be like 0.7. Or include length of stay and your R-squared is like 0.09. We know that

wouldn't mean a thing. So we agree with your decisions but that's not where the rub lies. The rub lies given the low R-squared what can you say after you've made the right decisions on what to include.

DR. BERNHEIM: I think this comes back to some of the earlier comments Harlan was making which is that there's lots of ways to interpret the earlier slides.

But we know, for instance, that decisions about SNF post-heart failure varies enormously across hospitals without having much difference and impact at the hospital level. We know there's lots of places where hospitals are making decisions.

There's nothing we can show you that tells you we've got everything in there we need to. Harlan referred to earlier studies we've done that we haven't had the opportunity to do with this that have shown if you use clinical data for risk adjustment or the claims data for risk adjustment you profile

hospitals very similarly which reassured us that the claims data adequately are a surrogate for the clinical severity in aggregate of a hospital.

But you're right, I mean it is -- it's a question we'll never be able to fully answer. So we've tried to think about the best approach given the data we have and to reassure ourselves that there's variation that we think is meaningful and that's sort of where the measure lies.

DR. ASPLIN: Lina?

DR. WALKER: This is actually a question for NQF as we consider this particular question.

So what we're learning today was not included in the packet of material. So, and I'm hearing that some of this information will be shared with the institution. All maybe? I don't know.

So I guess the question is what are the information we should use in evaluating

this question, what was submitted in the packet or everything? What they've presented today and any information they say that they would share with the institution. Okay, thank you.

DR. ASPLIN: The answer is everything, for those of you on the phone. Unless you could hear the heads nodding. Herb? Or Joe, I'm sorry. Joe, you're up next.

MR. STEPHANSKY: I'm sorry, I seem to have -- my call got dropped someplace along there when my dog started to bark. Sorry about that.

My comment is from a hospital standpoint. I was in a meeting last week with six of our largest hospitals and they make a great deal of use of the -- those hospital-specific reports that were being mentioned. They take them very seriously and we're hoping to get something similar from some of our commercial payers in Michigan.

They are useful once -- because if the only place we can see what happens post discharge, the actual types of care that are provided to the patients.

My comment is that now we are having a cost measure, a readmissions measure and a mortality measure where these hospital-specific reports are separate they need to be combined into a format that hospitals can use more easily.

I'll leave it at that for now but I'll have some suggestions later. Thank you.

DR. ASPLIN: Herb has the last word and then we're going to vote on 1B.

DR. WONG: So, my comment clearly falls into the scientific validity sort of thing and that's where this whole conversation has taken.

DR. ASPLIN: If it does can we just wait?

DR. WONG: But I think I just want to make one point because it was just two

conversations ago. And that is there was great conversation about the whole R-square issue.

And I think that the developers were, from my perspective there are ways to in fact increase your R-square. And the question is do we really want to do that to kind of tease out those sort of things.

The TEP members have made a point about the R-squared. So my general comment for the committee is that there is this balancing. So R-squared is one component but a high R-squared is not necessarily the best thing. So that's my general point for the committee to consider.

DR. ASPLIN: Very good. So, question 1B, opportunity for improvement, demonstration of resource use or cost problems and opportunity for improvement. The categories in front of you, high, moderate, low, or insufficient evidence. And Evan, let us know when you're ready for us to begin voting.

MR. WILLIAMSON: Great. We will now vote on opportunity for improvement. You may begin voting now.

And we have all the votes. And so we have 10 high, 10 moderate and 1 insufficient. It passes opportunity for improvement.

DR. ASPLIN: Move onto the next question. In the final one in the area of importance to measure and report, 1c, measure intent. So the intent of this resource use measure and construct are clearly described. Are there comments prior to voting from the committee? Or on the phone? On this particular question. Evan, let us know when we're ready to vote on 1C.

MR. WILLIAMSON: Great. We will now vote on the measure intent. Your options are high, moderate, low, or insufficient. You may begin voting now.

Looks like we're missing one vote in the room. There we go. And we now have all the votes. And we have 16 high and 5

moderate. It passes measure intent.

DR. ASPLIN: Very good. We're on a roll. We've only got six more vote slides to go. Let's just keep going.

(Laughter)

DR. ASPLIN: Just kidding. This is the overall -- for the importance to measure and report overall based on the three subcriteria, your summary recommendation relative to importance to measure and report.

Any questions prior to going ahead with the vote on the overall category? Evan, let us know when you're ready.

MR. WILLIAMSON: We will now vote on overall importance to measure and report. You have four options, high, moderate, low, or insufficient. You may begin voting now.

Great, we have all the votes. Looks like we had one additional member join us on the online webinar so we will now be at 22 votes. So we have 17 high and 5 moderate. The measure passes the overall importance to

measure and report.

DR. ASPLIN: That was Joe's dog that added a vote.

(Laughter)

DR. ASPLIN: Okay. So, could I ask -- to allocate our time my sense is the next category of scientific acceptability is where we're going to spend the bulk of our time.

Would there be concern among committee members if we left only 15 minutes for feasibility and usability? I'm seeing no concern in the room so I'd like us to try to have the scientific acceptability discussion over the next 40 minutes then. Sound good?

And we can move forward with 2a.1 construction logic. And we'll loop back and have Cheryl provide an overview of where there was agreement and disagreement. Thank you for reminding me.

MS. DAMBERG: Okay, I'll try to be quickly. So, there are multiple subcomponents to number 2.

So, generally people thought the specifications were clear but there were a few questions that were raised in terms of whether secondary diagnoses from the index hospitalization were considered for possible risk adjustment and was present upon admission, coding incorporated.

I'd say the bigger issues fell into reliability testing as well as validity. So, it was clear that the developer had done various tests related to the reproducibility of the measure, but there seemed to be no documentation of looking at sort of the signal-to-noise ratio in terms of the measure which was another measure of reliability.

And I think we've already talked about the R-squared issue so I'm going to skip over that.

And let's see. So let me move onto validity testing because I think this is where a lot of the issues surfaced.

There were questions about the

attribution of transfers and that that issue is always vexing. There were comments that the measure itself hadn't been validated although the data elements, the sort of building blocks had been. And that was an issue.

And then the big issues were around risk adjustment in terms of both severity as well as adjusting for socioeconomic status. Nancy had raised that earlier in the discussion. So I think those were the big issues that came up as well as why exclude patients with same-day discharge.

I think those were the major issues that were surfaced.

DR. ASPLIN: Very good. We have a number of categories where you'll be asked to have two votes in this large category of scientific acceptability and the first is on reliability. The second is on validity.

I would agree with your assessment, Cheryl, that on this particular measure more

of the questions from both the TEP and the online survey related to the validity questions, some of which we've started to discuss.

MR. WILLIAMSON: I will point out that for these two sections, for reliability and validity we placed algorithms on your desk. They're the colorful charts that we've posted on there. They're also available -- they were in the committee guidebook. But they serve as a good reference for these discussion as far as figuring out how to make your rating.

DR. ASPLIN: So let's open up for discussion of reliability questions. And you see the categories in front of you but we don't need to take all subcategories in order. I would just open up for questions or comments from the committee on reliability. Andy, go ahead.

MR. RYAN: So, one of the criticisms of the mortality measures that Yale developed

is that it basically cancels out any volume and outcome relationship that a lot of people think is really there in the aggregate. But once you do the shrinkage basically the low-volume people get shrunk back to the mean and then that kind of takes away the volume-outcome relationship.

And I was wondering if there was any analysis for this measure that -- to assess whether there was a volume and outcome relationship with respect to the cost and what kind of implications that could have for both the reliability and validity of the measure.

DR. BERNHEIM: So, I'll take that in two pieces. We have not directly looked at the relationship between the volume and outcome for this measure.

And in terms of the controversy around this issue in the modeling as you probably know the issue really relates to uncertainty. So, the lower the volume, the less certainty you have about your estimate

for mortality or cost or anything else.

We have a little more power here because we have a continuous outcome so it's a little bit easier, but in general there are different ways to handle that uncertainty.

The statistical guidance and people that we have worked with have always felt that it was more important to use the kinds of modeling we used as hierarchical modeling which does have some assumption that when you have too little volume to be sure of your estimate it brings those more towards the mean.

So part of when you look at our unadjusted cost distribution and the adjusted, some of that is related to the risk adjustment, accounting for differences in patient population, the shrinking of the width of the distribution, and some of that is related to volume.

If you're a provider who is a small-volume provider who has one expensive case and

we don't account for the fact that that could be random you're not going to be very happy that we assume that your number is your number.

It's better for the small-volume providers and many people think it's more fair but there is debate about this. But we have always used hierarchical modeling on the strong statistical advice of our consultants who feel that it's the fairest way to handle inherent uncertainty when you have small volumes.

MR. RYAN: So, the R-squared that's being talked about from the materials is based on a regression of observed cost to -- or observed or regressed on predicted cost.

And so that predicted number includes both the hospital random effect and all the risk adjustment stuff that's on the right-hand side.

So, can you -- did Yale do any analysis trying to identify whether the model

actually had a higher R-squared than without the hospital effect? Or if it was based only on the risk adjustment factors?

I'm just trying to understand kind of what's leading to that low R-squared. Is it just poor prediction from the risk adjusters, or is it also being contributed to by the hospital random effects?

DR. BERNHEIM: We have not done analyses to try to separate those issues.

DR. ASPLIN: Cheryl?

MS. DAMBERG: So, I wanted to get a little more clarification. So you've set your threshold at 25 cases per hospital. And I was trying to figure out did you do some tests to again look at the signal-to-noise ratio?

Because in essence you are classifying these hospitals into better than, worse than, or no different than. And you know, the sort of stronger the signal, the better you're going to be able to classify people correctly.

DR. KIM: So, all payments are included in the actual -- all hospitals are included in the payment calculation whether they have 1 or 26 hospitals.

The only thing about the 25 is the reporting. We only report on hospitals if they have 25 or greater cases because we were afraid that the uncertainty around the small-case hospital, not the small-volume hospital, is too much to report on and classify into a category of above- or below-average payment.

But no, we didn't look, we didn't do any analyses to look and see if the volume was related.

DR. BERNHEIM: The 25 threshold is from the original analyses done for the mortality and readmission measures where we did do some of that analysis.

One of the things that comes up is people use the word "reliability" to mean many different things. But some of our measure development for the AMI mortality measure

established 25 as a good threshold for that. And so we set it the same for this measure.

MS. DAMBERG: Yes, I guess my concern is that cost data tend to be a lot noisier. And so I think it would be helpful to get some sense of that type of reliability calculation for the measure.

DR. ASPLIN: Janis?

DR. ORLOWSKI: Could you review for me again the strategy for assigning the cost to the initial hospital? My concern is that -- two. One is that the hospital A, the presenting hospital is likely to have perhaps a couple of hours of interaction with the patient prior to transfer, most of it decisions in the emergency room.

And then the second is whether the assignment then to hospital A rather than the tertiary referral center, if that would not provide adequate data on large referral centers.

DR. KIM: Thanks for that question.

So, just to clarify, when we talk about transfers we're talking about inpatient admission to inpatient admission specifically for AMI. We're not talking about ER to inpatient admission.

DR. ORLOWSKI: So that goes to B.

DR. KIM: That goes to B because B looks like A. Because we start from the index admission. So, this is not the three hours in the ER, go to a hospital. The ER is not hospital A and the other hospital is not hospital B.

When we consider transfers, there's really only three ways to deal with transfers. You can exclude them. And for our AMI cohort that was about 7 to 8 percent of our AMIs, and that was too many.

And transfers are important to include because it tells you a lot about care coordination. So we didn't want to exclude them.

You can attribute to A as we have

done because they begin the episode of care so conceptually it provides the same standardized payment. Or you could attribute them to hospital B.

When we crunch the numbers for the A-B comparison, because again, we didn't want to exclude because we think it's an important piece of the AMI picture, we basically lost hospitals. We lost about 100 hospitals. So we would be reporting on 100 fewer hospitals.

And the hospital B, the accepting hospital, wasn't any more expensive than it looked like in the attribution to hospital A.

What did happen was hospital A got a lot cheaper. And in AMI you're really talking about PCI-capable and not-PCI capable hospitals. And we didn't want to disadvantage PCI-capable hospitals.

In fact, it doesn't disadvantage them. Their risk-standardized payment stayed about $15,000, so slightly higher than the risk-standardized payment for non-PCI

hospitals when we use the hospital A attribution approach.

When we use the hospital B attribution approach those transferring hospitals which are likely non-PCI hospitals are about $12,000.

So, when we use the hospital B approach we lose about 100 hospitals so we're reporting on fewer hospitals which we don't want to do. We want to include as many hospitals as possible.

It doesn't change the way we characterize the risk-standardized payments for PCI-capable, usually the accepting hospital. But it makes hospital A look cheaper.

When we do our approach which conceptually we like because it gives everybody a standardized payment window we found it doesn't have any negative effects on the risk-standardized payment. So for those reasons we chose to go with hospital A.

And lastly, it does mirror our quality metrics. So it harmonizes nicely with the quality metrics. But we did have a lot of discussion around transfers, particularly for AMI. Less so because for our heart failure cohorts 0.08 percent, so less than 1 percent of our heart failure patients are transfers so it's less of an issue.

DR. ASPLIN: Very good. Andy, do you have another comment or question? We're good? Okay.

Other questions on reliability? Don't see any on the phone or on the webinar. So let's move forward to the reliability vote.

So considering all these criteria the question that you're voting on is now in front of you. How well overall has the developer demonstrated the measure results are repeatable and can be implemented consistently?

Do we need to speak to the algorithm or not?

MS. WILBON: So, the algorithm that was at your seats and that we have subsequently passed out to some of you that we didn't get to is something new that we're implementing to try to more systematically and consistently rate the measures according to our criteria, specifically for reliability and validity.

So again, this is somewhat new and we've only implemented it I think with one committee so far. So, we'd like to walk you through this before we begin voting to make sure that to the best of our ability we're trying to apply the criteria the way that it was intended to be applied.

So, the first question is about whether or not the submitted specifications are precise, unambiguous and complete, and that they can be consistently implemented. And so depending on where the committee lies on that then we can go to another question.

So, I guess we can just ask now in

terms of the committee's general agreement on the specificity of the -- or the preciseness of the specifications. And if we feel like it was okay to advance. Okay, I feel like -- if anyone on the phone has any objections to that? Okay.

So I'm seeing nodding heads for the record that the answer to that question is yes.

So the next question is about whether or not empirical reliability testing was conducted using statistical tests with the measure as specified.

And so if the answer is yes, I'm looking for some indication from the committee on whether or not there's agreement that empirical reliability testing was conducted using statistical tests.

MS. DAMBERG: I think there's partial testing. So what do you do in split cases? Where they haven't sort of covered all the elements. So they've covered some of the

elements. So what do you do in that situation?

MS. WILBON: Okay. So, the next question would be for the reliability testing that was conducted was it done at the computed performance measure score level or at the data element level. Go ahead, Cheryl. I'm sorry.

MS. DAMBERG: So they did it at the measure level.

MS. WILBON: At the measure score level? Okay.

So the next question would be was the method that they described for testing the reliability, was it appropriate for testing the proportion of variability due to real differences among measured entities?

So again, was the testing that they did at the measure score level, was it appropriate for what we would be expecting to find.

MS. DAMBERG: I guess this was my earlier comment I made. So they did part of

this but not all of the different things under your "such as."

So, they did reproducibility in terms of the random split correlation type of test but they didn't look at signal-to-noise.

MS. WILBON: I'm sorry, I can barely hear you. I'm sorry.

MS. DAMBERG: Sorry. So they did some of these tests but not all of them. So they did not do the signal-to-noise analysis but they did do the random split test.

MS. WILBON: Okay, there's not necessarily a requirement that they do all of them. These are just examples that they could have done.

So, if the committee is satisfied with the appropriateness of the reliability testing that was done the next question would be number 6 which says based on the reliability statistic and scope of the testing, the number of measured entities and representativeness, there's a series of three

questions.

Is there a high certainty or confidence that the performance measure score is reliable? Is it moderate or is it low? And so that's really where your scoring should come out for the overall reliability score in terms of your confidence in the reliability based on the testing that they did.

So that's kind of the end of the algorithm and would tell us what your vote would be.

MR. RYAN: Ashlie, can I?

MS. WILBON: Sure, go ahead. Please.

MR. RYAN: So, with respect to whether the testing was done with the measure as specified. So as I understand this is supposed to be a hospital profiling it for a 12-month period is how the measure is specified.

And it appeared from their description of reliability testing that their split sample method used combined 2008 and

2009 data.

So, my question is whether the reliability testing that they did is consistent with the measure as specified.

MS. WILBON: Yes, I would ask a question of the developers, maybe a rationale for why that was done as opposed to one year. There may be a reason for that. And then I would defer to Taroon and Helen to see whether or not there's any --

DR. BERNHEIM: So, generally when we do the risk model development we do that in a single year of data. That's just been the approach we've taken for determining the modeling and the risk adjustment variables.

Our measures in the past have actually been reported on three years of data in order to get greater sample size. In this case we didn't yet have three years of data.

And we used the two-year split sample because if you use a single year and then you split it you're getting even smaller volumes,

so fewer and fewer hospitals we can use. So the two-year split sample gives you a sample size. For each of the split samples it's about a year's worth.

I don't think that that -- I mean, it's the same measure. I can't imagine why that would affect -- why that wouldn't meet the NQF criteria, but I'm welcome to hear if people have concerns.

MR. AMIN: I mean, I'm not going to speak to concerns. I'm not here to evaluate.

I think all I would say is that the measure should be tested as specified. So, if the measure -- is the measure specified for one year of data. The testing should demonstrate the reliability with the amount of data that you would have for one year.

DR. BERNHEIM: And in fact it's probably going to be implemented with three years of data, with more, just to get the sample size.

DR. ASPLIN: Ashlie, do you want to

go down? Or do you feel like you've gone through the algorithm?

MS. WILBON: Yes, we're -- I mean, I'm not sure. Maybe with Andy's question that may take us back to the algorithm. I don't know if, Taroon, did you have? Oh, okay.

So, I don't know if any other committee members have comments on Andy's question or whether or not we need to go back and revisit some of the earlier questions in the algorithm to determine whether or not we agree that it was actually tested as specified.

DR. ASPLIN: Cheryl?

MS. DAMBERG: So, could I just follow up on that last comment? I guess this was something I missed, that it's a three-year period.

So, can you help explain why it's a three-year period? Because how does that then factor in any improvements the hospital makes?

DR. BERNHEIM: This is a real

challenge with AMI in particular. Part of the things that people like about the hospital Y measure is that we then have enough patients at a large number of hospitals that you can report using a single year of data.

It's a balance between wanting to get adequate sample size to have reasonable estimates for a large number of hospitals and using the three years lets us do that.

But there's a remarkable number of hospitals in this country that don't have 25 AMI cases in a year.

DR. ASPLIN: All right. I'd like to move forward with the question on the vote on reliability. Bring that screen back up again. Overall they've demonstrated the results are repeatable and can be implemented consistently. And Evan, let us know when you're ready for us.

MR. WILLIAMSON: You will now vote on overall reliability. You have four options, high, moderate, low, or insufficient. You may

begin voting now.

And we have all the votes. We're back down to 21 votes now. One was a duplicate before. So, crisis averted. We have 3 high, 16 moderate and 2 low. It passes reliability.

DR. ASPLIN: All right. So we'll move onto questions of validity. And I think, Cheryl, you made your validity comments in your overview, correct? Okay.

So we'll open this up. And Jack, take it away.

MR. NEEDLEMAN: Okay. We've had a lot of conversation about the R-squared and the R-squared is not the right issue.

The right issue from my perspective is whether we're capturing variation in cost that's due to discretionary choices among the providers about what to provide.

As you said, you can bump the R-squared up by 50 percent by including DRGs. Now, some of the DRG choices accurately

reflect differences in the status of the patient walking in the door and some reflect choices.

To the extent that it reflects the status -- to the extent that the differences in patient status and therefore what's needed to effectively treat them vary we've got unaccounted-for variability in the cost.

Now, that's not relevant if every hospital faces the same distribution of patients. Because all that variability is equal. It's the equivalent of randomization, right? All that variability is equal and therefore the cost differences are driven by the care choices.

So we come back to whether or not the variability in the condition of the patients walking in the door are comparable enough across the different hospitals that it can be ignored. And if it is then we're fine I think in terms of that issue of the validity here. And if it can't be ignored then some -- then

it isn't quite ready for prime time. As difficult as that is to measure.

So, I'd like to hear about the TEP conversation on this issue, about how comparable these patients were in terms of the distribution of needs for care. Even if it's not fully captured in the way in which the -- I'd like to hear the TEP conversation on this and then the measure developer conversation on this to figure out how concerned about the variations due to differences in patient need are that are not accounted for in the measure.

DR. ASPLIN: Bill?

DR. WEINTRAUB: We didn't quite frame it that way, Jack. But I think then I can summarize the feelings of the TEP like this. That we could not adequately account for variation given what we've seen. That we basically agree with the choices of the developer on what to include and not to include. Given the choices that were made we could not adequately account for variation.

And as good a job as they did, and they were applauded wholly by everyone in the TEP to have done a very good job, that as you put it it may not just be ready for prime time because we can't adequately account for variation.

DR. ASPLIN: Response from the developer?

DR. BERNHEIM: So, I wonder, I'm just going to go back again to something we were able to do with our AMI measure. Because this is the question that comes up with the claims-based measures pretty consistently.

And quite honestly, if you talk to our team was the question in our team's mind when we started to depend these measures. How can the claims possibly account for patient severity.

And so, I'm just going to -- I'm repeating myself a little bit, but not all the members of this committee are going to be aware of this work and I think it's important.

When we depend the original mortality measure. So again, we're looking at the same population of patients, AMI patients. No question that your clinical status at arrival is going to have a huge impact, probably much more on mortality than on payment.

We didn't know whether the claims data was adequate for differentiating between hospitals and the case mix that they were facing. Not for individual patients but for the aggregate risk of the patients that are coming into hospital A compared to the aggregate risk for -- you want to interrupt me so I'm going to let you.

MR. NEEDLEMAN: Okay. You've made the point and I think it's quite appropriate. The claims data are as good for measuring severity as within the limits that you're looking at as the medical record data. That's not the issue that I'm raising.

The issue is whether the differences in severity across the different hospitals are

accounted for sufficiently in your measure when you've lumped all these DRGs together, when you've lumped all these diagnoses together and you're seeing big differences in not only the post-acute payments but the acute-level standardized payments because of the differences in case mix.

Whether you're adequately taking into account the legitimate differences in how much is being spent for these patients when you put together this many different diagnoses, this many different DRGs into a single measure labeled AMI or measured heart failure. That's my question.

DR. BERNHEIM: So I think the answer is the same. And forgive me if I'm misunderstanding something. What the validation work that we did early on said was you can differentiate between hospitals -- among hospitals in terms of the severity of the patient.

So, I think the concern is whether or

not we are adequately accounting for the severity of patients that might lead to higher procedure rates. And so our early validation work suggested that you can.

But somehow that's not answering your question so I'm missing something.

MR. NEEDLEMAN: Yes, because let's say all the ambulances are passing the hospitals that don't have PCI and bringing the most severe patients, or the ones most tractable to treatment to the PCI-based hospitals. We're going to have a real difference in case mix there.

DR. BERNHEIM: Absolutely.

MR. NEEDLEMAN: Real differences in how many people are going to survive the hospital, how much -- and therefore the cost.

Now, you've combined all those different -- not just the treatment choices, but the diagnostic categories that drive the treatment choices in the way that you've lumped together a whole bunch of things and

said all these are AMI patients. And we're not drawing any distinctions among all these different AMI patients. That's my question.

Now, if those distributions are the same across all the hospitals it doesn't matter. But if those distributions are really different across the hospitals then you're going to get cost variation which is not under the control of the hospital and yet you're attributing it to the hospital both in the acute stage and in the post-acute stage. That's my question. That's my concern.

DR. KIM: We do take into account all the diagnoses we can including the 12 months prior and on the index admission. So we do get a realtime look at anything that's coded on admission.

We don't count complications. So things that are coded as secondary diagnosis that we consider potential complications we don't include.

But we are getting realtime claims

data which is comorbidities. It's never going to be the blood pressure, the vital signs as we discussed earlier.

Would it -- for AMI a lot of this concern is PCI/non-PCI hospitals. And it turns out when we looked at the PCI v. non-PCI hospitals using hospital A for transfers the PCI hospitals are maybe a few hundred dollars to a thousand dollars on average, on average more expensive than non-PCI. So, it's not just about the volume of procedures, it's something else.

So I hear your concern. I think there are several components. The conceptual concern of not capturing clinical severity which we can never directly answer. If you don't like our chart review answer I'm not sure --

MR. NEEDLEMAN: Well, no, the chart review answer says that there are things in the claims that concern -- stand as surrogates for the charts.

And I'm happy to hear that. I use mostly administrative data in my research. So I'm happy to hear that.

No, the issue is whether you're using all that to accurately capture things that are going to drive differences in how much is spent on the patient, separate from the clinical discretion of the hospitals and the other folks, and the cardiologists and the surgeons that are treating the patient. That's my question.

DR. BERNHEIM: So let me just ask. So, if we had blood pressure STEMI or no STEMI, drive-by ambulance, in shock, all of the clinical variables you would want and we used our exact same measure for the same set of patients. And in one of the measures we used all of that clinical variable and we said hospital A is nine and hospital B is four.

And then I said, okay, I'm going to do the same measure, same patients, same outcomes, but I'm going to use just chart-

based data -- I mean, claims-based data. And I came up with the same answer, hospital A is nine and hospital B is four. Would that make you more comfortable? That somehow we're getting the same risk adjustment. With the claims-based -- because that's what we did.

What we did was we took the same patients and the same outcomes and we said if you run a model that has every clinical variable you want in it for risk adjustment do you get a different answer about that hospital's profile. This is for the mortality measure. We haven't redone it for the payment measure. Than you do --

MR. NEEDLEMAN: Yes, but except the measures that you're describing are things that have to do with the condition that I walked into the door with this time, the AMI.

So you've got my ejection fraction, you've got all that other stuff. Got my blood pressure. You know whether I came in awake. And you have all that having to do with right

now what do I look like.

That's different from knowing that I've got diabetes, that I've got --

DR. BERNHEIM: But that's what I'm trying to explain. Our validation -- that's what I really want to make clear. We did not do a validation that says if the claims say diabetes does the chart say diabetes. That's --

MR. NEEDLEMAN: No, no, no. But what I'm saying is the patient who walks in with a mild heart attack. And I have no -- I'm not a clinician. I have no idea what a mild heart attack means except that they're going to walk out of the hospital in two days and be referred to cardiac rehab.

And that's very different from somebody who comes in with a massive heart attack that's going to get all kinds of treatment, going to wind up getting stented and all kinds of other stuff going on.

And the question is is there anything

in your risk adjustment that lets us differentiate those two patients. Does the prior diagnostic information do that? Does something else you're using in your risk adjustment allow us to differentiate those payments when we're trying to predict patients, when we're trying to predict costs?

DR. BERNHEIM: So I really do think I understand your question and I am not sure why I'm being so ineffective at explaining what we did. But that's the question we answered.

It's not that oh, a history of diabetes correlates so well with severe heart attacks. It's that if you use all the information from the claims to understand the risk of a population coming in you come up with very similar understanding of risk as if you had all the information from the charts. They're not a 1:1 correlation but in aggregate they do a very similar job. So the claims in the mortality measure did a remarkably good job at acting as a surrogate for exactly the

information you wish we had.

MR. NEEDLEMAN: And have you done the same thing around the cross measures?

DR. BERNHEIM: So we haven't done the same thing with this measure at this point.

But the concept is similar. I mean, if you can do it for AMI patients for mortality I'm not sure what you would think would be so different for the --

MR. NEEDLEMAN: How highly does mortality correlate with cost?

DR. BERNHEIM: But the question isn't whether mortality and cost --

MR. NEEDLEMAN: Well, you're telling me your risk-adjusted correlates with mortality so now -- you haven't checked it with cost. How highly does mortality correlate with cost? That's the way I would do the comparison.

DR. BERNHEIM: But the question we were asking was is our ability to understand how severe this population is with the claims

measure similar to our ability to do that with cost.

MR. NEEDLEMAN: For purposes of predicting cost.

DR. BERNHEIM: For AMI, right?

MR. NEEDLEMAN: For purposes of predicting cost.

DR. BERNHEIM: Right. So I guess the question for the cardiologists is --

MR. NEEDLEMAN: Because we're now in a cost measure here, not a mortality measure.

DR. BERNHEIM: Absolutely, absolutely different measure. But I think the kinds of things clinicians are looking for are very similar. Maybe not identical but similar concern about sort of severity leading to higher costs and severity leading to higher mortality.

So I think there is some important information from that early validation study. It's not the same, but it's not about whether cost and mortality travel together. It's

whether risk for cost is similar to risk for mortality. And they're not identical but we show that they correlate.

I'm going to let it go, I'm sorry. I really am trying to address your question and not drive you crazy. But I want to make sure people understand what the validation studies were because they're really -- it's a really important underpinning of our belief in these claims-based measures.

MR. NEEDLEMAN: No, I mean you've answered my question --

DR. ASPLIN: Jack, I don't know --

MR. NEEDLEMAN: I'm done.

(Laughter)

DR. ASPLIN: The distribution across hospitals, I don't know if in the administrative data if the STEMIs are identifiable as a subset of all MIs or not. And Bill is saying no. Because I don't know how else to get at the distribution.

DR. WEINTRAUB: So, let me give you

an extreme example, all right? Can you distinguish the patient who comes in with a mild heart attack and goes home in two days from a patient who comes in in cardiogenic shock. They have all the same comorbidity. They look -- a day before they look exactly the same, but one has a mild heart attack and the other one comes in in cardiogenic shock.

DR. BERNHEIM: No, at a patient level no question I would never use the claims data to distinguish two patients.

Can I distinguish a hospital that gets a lot of one of those kinds of patients from a lot of the other? Yes, and that's what we're trying to do in this case.

DR. WEINTRAUB: The question is if the distribution in hospitals of who has shock and who has a mild MI is the same then that doesn't matter. But if that distribution is different then it matters.

DR. BERNHEIM: But in the aggregate the risk assessment works with the claim.

DR. WEINTRAUB: But you don't know. You don't know because your ability to predict is weak.

DR. ASPLIN: All right, so, this is who we've got. We have Mary Ann on the phone, then Nancy, Andrea, Janis and then John back on the phone.

MS. CLARK: Hi, I just had a comment. So, I mean I think that we all know that the claims data are limited in their ability to capture a lot of the clinical information. But you know, it's been demonstrated that it can be used, the comorbid conditions are a good predictor of risk and severity.

And I think they are using -- they're using the historical one-year claims data to identify patients who have comorbid conditions as well as the index event.

And the addition of the DRG code is not really going to change that except for procedures. Because the DRGs are based on diagnosis and procedure codes primarily. So

all of the diagnosis codes are being captured.

It's just really the procedure codes that they're not risk-adjusting for the procedure codes for the reasons that they mentioned which are they want to -- want the provider, the hospital to have I guess options for being able to treat them in different ways.

So, that's probably the main source of resource consumption that's going to be affected.

DR. ASPLIN: Nancy?

MS. GARRETT: So, I really like, Jack, the way you kind of outlined the two underlying causes here. There's the patient status and then there's the decisions that the provider is making.

At this point I'm not convinced that we're doing a good enough job of adjusting for severity given that they could be -- it could be different across hospitals.

And in terms of providers really

buying into this measure that's huge, to be able to have that kind of face validity that this is measuring what it's supposed to measure.

I almost feel like not adjusting for the DRG is going too far. Because then you have -- the DRG is a mixture of the things that are going on with that patient clinically and what needs to happen in the hospital.

And it's a mixture of that and the provider choices about the treatment. And it's hard to separate the two out. So I'm concerned about that.

DR. ASPLIN: Andrea and Janis, I'm presuming that your comment or question was addressed because I had you written down earlier. So I'm going to go to John on the phone.

DR. RATLIFF: Quick question for the developer.

DR. ASPLIN: Go ahead, John.

DR. RATLIFF: Excuse me?

DR. ASPLIN: Go ahead.

DR. RATLIFF: Sorry about that. Just a quick question for the developer with regards to the validation of your risk adjustment modeling. You use as your primary quality endpoint mortality. Was that you used for validation of modeling the severity of the AMI with regards to your validation strategy? Just the endpoint of 30-day mortality?

DR. BERNHEIM: So I was referring to a study that was done when the 30-day mortality measure was developed to just explain why we have gained confidence at the hospital level in the claims being able to differentiate between hospitals that have higher-risk patients and lower-risk patients even though the claims don't contain those individual variables.

So that was a study that we did when we developed the original AMI mortality measure.

DR. KIM: But we don't validate with

the mortality data. When we develop the payment measure we use a split sample. And we validate the risk adjustment model with a split sample of the payment data.

I want to make sure that's clear. We don't validate with mortality. This is all payment data. The model development, model validation done with payment data. Measure validation done with 2 years of payment data for a 30-day episode of AMI care.

So that's what we specified. I just want to make sure that's clear and not getting lost in the discussion.

DR. RATLIFF: That was my second question. You're validating administrative to administrative with regards to your risk adjustment strategy.

DR. KIM: Correct. We use one --

DR. RATLIFF: Or administrative data to administrative data.

DR. KIM: We use a split sample validation technique with administrative

claims data for the payment outcome calculation.

DR. BERNHEIM: Can I just say one thing about sort of how we thought about this DRG problem that Nancy raised? Because it's an issue and we talked about it a lot.

The DRG software is hard to break into, but there's basically four factors that go into determining your DRG. There are some clinical demographic age and gender. There is your principal discharge diagnosis. Did you come in for an AMI, did you come in for heart failure. And then there's whether you have complications or comorbidities. Both of them can bump up your DRG and there's procedures.

And so you'll remember our earlier slide. We really thought about the DRG and we really, again, did the best we could to say if we risk-adjust for the full DRG we're going to end up risk-adjusting a lot of important information about decisions made in the hospital.

And essentially sort of just account for your index stay. I mean, it sort of becomes a measure just of post-acute care. Because the DRG is so determinant of a varying patient payment.

But we wanted to capture the right thing. So again, just so people understand conceptually. We have age in there and we have your diagnosis in that we have lumped AMI.

Now, we don't differentiate between the ICD-9 codes within AMI. They're probably at this stage not worth doing that. I don't think anybody thinks they are right now.

And then we do comorbidities but not complications and procedures.

So conceptually we were trying to take the pieces of the DRG that we thought were valuable to risk-adjust for and not the ones that weren't. It's not a perfect model.

But just so people understand those really are the things that go into determining

your DRG. So we really tried to take the pieces that made sense and pieces that didn't.

DR. ASPLIN: All right. So, could we shorten as concise as possible our comments and questions? Janis and then Jim.

DR. ORLOWSKI: So, as I understand it this is the doctor's view of statistics I think. So, what you're saying is that you can predict based on morbidity prior to admission, you can risk-adjust. Meaning that those people who have diabetes and hypertension before are likely to have the more severe AMI. That's what I'm hearing.

The question that I have is -- and it has to do with the not risk-adjusting for anything that happens in the hospital. I would think -- did you look, rather than I would think, did you look at specific items that you could get data about?

For example, heart failure, complete heart block. Those things that likely are not attributed to either the physician's decision

or a complication within the hospital, but truly are associated with the severity of the MI that is occurring.

DR. KIM: We used the secondary diagnoses on the index admission. So, those are things that were coded on the index admission. So not historical 12 months prior.

And we did risk-adjust for those things that did not appear to be complications. A complication would be something like a UTI. We couldn't tell if you had it before or was it a complication of admission.

We didn't look at complete heart block or anything like that unless it was coded.

DR. ORLOWSKI: So on the index admission you are coding for not complications but comorbid events in the index admission.

DR. KIM: Correct.

DR. ORLOWSKI: I actually think that's -- my question.

DR. KIM: Can I just make one comment about what we're doing with the risk adjustment? The risk adjustment is really there to level the playing field across all hospitals I think we all agree.

It's not there to predict the payment. We want to see how much of the payment may be attributed to patient comorbidities. But it's -- we're not trying to predict payment based on that. We are measuring the payments as they are and we're trying to make sure that we give hospitals credit for the types of patients they have.

So, I know that's part and parcel of some of the questions. But the other confusing piece of the discussion has been how much does this predict.

Again, the reason the risk adjustment is there is not to predict accurately. It is to understand the contribution of the case mix across hospitals and their contribution to the payment outcome.

It's not so we get the prediction model. I just want to make sure that's clear.

DR. ASPLIN: Jim?

DR. NAESSENS: Following up on Jack's point with a specific example. In southern Minnesota we've had an attempt, and on of our mutual colleagues has kind of driven it, to get almost all of the STEMI MIs in the region treated at the hospital that has PCI capabilities.

The difference between looking at mortality outcomes and looking at cost is that almost every one of those STEMI MIs who come to the institution will get a PCI. Will get some sort of intervention.

Hopefully those interventions are effective. And you actually may get similar outcomes in terms of mortality for both groups. But you won't have the same level of resource use going into the patient who stays in the local hospital without the STEMI MI and the one that gets transferred in.

So, my guess is that even though the analysis might have been very effective looking at mortality outcomes it will be different when you look at cost outcomes.

DR. BERNHEIM: Would people feel better if that same analysis was redone for the cost outcomes? Because I wasn't sure if that actually was going to -- okay. So the people --

DR. ASPLIN: I'm going to ask Ashlie to walk through the algorithm that's on the screen here.

MS. WILBON: Actually, I'm going to defer to Taroon. We're going to try a different approach. Oh sorry, go ahead. Sorry.

DR. WEINTRAUB: So, everyone agrees that you're not trying to predict cost. And it's good that you're trying to give hospitals credit for the difference in their patients.

But I think that rather than the things you can measure, the big driver is

going to really be how sick the patient is when they present. And that's what you can't get at. That's the problem.

And again, if there's no variation between the hospitals it doesn't matter. But if there is it matters a lot potentially.

DR. BERNHEIM: Right. But you know, I mean, again in aggregate it actually does a pretty good job of telling how sick the patients are. I mean, that's just what we've found.

DR. RATLIFF: Did we lose you?

DR. LATTS: Sorry, this is Lisa. I'm trying to follow this because that's what she said it exactly does is it predicts exactly how sick they are. In the mortality measure it predicts how sick they are when they present.

So yes, it's not for the cost measure. But it predicts how sick they were and whether or not they were going to die. So, sicker people cost more. That's what

we're saying. So that's what it does is predict that sicker people are sicker.

DR. WEINTRAUB: Well, then the question is how well does it do that. And given what I've seen I have my doubts.

DR. ASPLIN: Okay.

MR. AMIN: Okay, are you ready?

DR. ASPLIN: Taroon, go.

MR. AMIN: Okay, so the issue of validity includes a number of different components. So, one of the components is around validity testing which is 2b.2.

And as you see by the list that's on the side screens it's only one segment of the validity question. It includes all the components around inclusion and exclusion criteria, this risk adjustment conversation.

But in particular, the question of how to interpret validity testing, what we want to do is assess whether or not the validity -- the exclusions, the need for risk adjustment, the multiple data sets and

specifications if that's -- well, that's not appropriate for this measure, has been assessed in which we know, yes.

And then effectively we're looking at whether there was empirical validity of the measure as specified. And so there appears to be some question about that that the group has raised.

And so then really the question becomes if there's face validity. Effectively you move onto 4 which is around the face validity and whether it was systematically assessed.

So, that's pretty much where we are here in terms of the algorithm. Yes, Andrew.

MR. RYAN: Based on what you just said I didn't see any empirical testing in the sheet, in the document that was sent. It alludes to testing that was done for -- there's face validity stuff in here, and then kind of how the mortality measures were validated, but nothing -- I don't see any

empirical testing with respect to the validity -- with respect to validity.

Is that where we are? Because if that's the case then we're just making a judgment based on face validity, right?

MR. AMIN: I think that there's an open question. I think there's differences of opinion about whether the empirical validity testing around the mortality measure, I believe that's what the developer has submitted in order to demonstrate empirical testing is the information about mortality.

Effectively we should look at empirical testing using the measure as specified. So, if you don't believe that that is the case then you should assess the face validity issue.

If you do believe it's specified, you do believe the empirical validity testing. I mean, it's still not as the measure is specified. I think, maybe I'll ask the developer if the empirical validity is as the

measure is specified.

DR. BERNHEIM: No, I think it's a useful -- I want to make sure that we're portraying what happened.

So, we are resting for the risk adjustment piece heavily on previous testing. We did not do empiric measure-level validity testing for this measure. We did internal model validity validation which some people call reliability, people call other things. We did face validity with our TEP. We rested on prior testing.

But I don't think we would say, and I don't think we did in our application that we had done empiric measure-level validity testing.

MR. AMIN: So, systematic assessments of face validity is an acceptable standard with current NQF testing guidance. So that would sort of lead us to 4 and the highest that could be rated is a moderate.

However, I want to make sure you keep

that in context with the fact that validity testing is only one segment of the validity testing components that you're going to evaluate now which includes all the other components of validity.

So, effectively though, the highest that it could be rated is a moderate given our testing guidance.

DR. WEINTRAUB: Very briefly. From clinical databases the number one predictor of mortality for PCI and acute myocardial infarction is cardiogenic shock. It accounts for almost all of the C-index.

DR. BERNHEIM: Again, totally understand this concern. At a patient level we don't have the data.

There's nothing -- I mean, I will say cardiogenic shock is actually a huge problematic variable because it's coded differently at every hospital. If you had chart data you still might not use cardiogenic shock because it means one thing at one place

and one thing at another. It's actually a tough risk adjustment variable.

DR. WEINTRAUB: So this has been done with clinical databases where the variable is clearly and carefully defined. Not from EHRs where it's not.

DR. ASPLIN: Okay. And Taroon, you're comfortable with the algorithm?

MR. AMIN: I'm comfortable.

DR. ASPLIN: I am if you're comfortable.

(Laughter)

MR. AMIN: Is the committee comfortable with the algorithm is maybe --

DR. ASPLIN: Okay, so let's -- having encompassed that entire discussion we're going to move ahead with a vote on validity. How well overall has the developer demonstrated this measure is valid? And Evan, let us know when you are ready.

MR. WILLIAMSON: We will now vote on overall validity. You have four options,

high, moderate, low, or insufficient. And you may begin voting now.

We're still missing one vote in the room so if everybody could please -- okay. So we have 20 votes. Okay, we have all the votes. And we have nine moderate, seven low and four insufficient.

This measure falls in the lack of consensus -- or the validity vote falls in the lack of consensus range. So we will note that and move forward.

DR. BERNHEIM: Can I ask one question about that vote? Just, committee members can think about this.

One of the other paths for validity testing for this measure is correlation with other performance measures. And we did a lot of thinking about sort of construct validity for this. We can show you that it correlates well with actual payments which won't surprise anybody.

But if people have thoughts about how

to -- you know, we're not trying to measure quality. We're trying to measure cost that can be modified by hospitals. And so I just want to say we would really welcome the expertise of this group to help us think about other paths to validity testing. Because we scratched our heads a lot.

And we would love to have your thoughts on that. It's measuring payments so it is measuring payments and it becomes hard to get your contract validity piece which is another pathway. So, something to think about.

DR. ASPLIN: All right. So we have -- we're moving forward based on the approach that this falls in the lack of consensus category.

We're going to take a stab at these last three questions. So questions on feasibility, usability and then there's an overall vote.

So, before moving ahead with the vote

here the question that you're going to be asked is in front of you. From a feasibility standpoint are there questions or comments from the committee members or those on the phone?

Seeing none, let's move ahead with the vote. Make a summary determination of the extent to which the criterion of feasibility has been met. Evan, go ahead when you're ready.

MR. WILLIAMSON: So we will now vote on the overall feasibility. You have four options, high, moderate, low, or insufficient. You may begin voting now.

And Nancy, would you like to vote? And we have all the responses. And we have 18 high, 3 moderate, zero low and zero insufficient.

DR. ASPLIN: Very good. The last category is usability and use. The criteria are listed and we'll have an overall vote based on those criteria.

And on this particular issue, Larry, you had raised a question earlier and we were going to capture it in the use and usability section. And you have the floor if you would like it.

MR. BECKER: I'm fine now.

DR. ASPLIN: Okay. Any other questions or -- one personal comment I had that I really was appreciative of the additional data that facilities received because the public reporting side of this is a little bit Lake Wobegon-ish in a way. You know, as far as we're all kind of average.

What percentage fall out of it? Is it literally the 95 percent on either side? As far as -- what's the breakout of those that are reported in the public data as average, above average, or below average?

DR. BERNHEIM: It's not a 95 percent confidence interval so it doesn't always end up being 5 percent that are outside because it's done with interval estimates.

We have those numbers.

DR. KIM: It's 7 percent -- this is for AMI, AMI only. Seven percent were low, 50 percent were high. So I guess 82 percent were average.

DR. ASPLIN: Seventy-eight. Yes, okay. Thank you.

So the additional detail data, particularly a breakdown of post-acute utilization spending, et cetera, and going back to the validity question, the face validity of how those data broke down actually made sense.

Other comments on use and usability? We have wore ourselves down. So let's move ahead with a vote on this question.

MR. WILLIAMSON: We'll now vote on overall use and usability. You have four options, high, moderate, low, or insufficient. And you may begin now.

I believe we're still waiting on one more vote in the room. If everybody could

please try again. There we go, we have all the votes.

And we have 12 high, 7 moderate, 2 low and zero insufficient.

DR. ASPLIN: All right, very good. So we have one more vote, overall suitability for endorsement. And this is a yes or no on suitability for endorsement.

Any comments or questions before we go ahead? Seeing none -- I'm sorry, go ahead.

MS. DAMBERG: We have a question down at the end of the table. So, if we rated validity as insufficient information how are we supposed to vote on this? It's not suitable at this point?

MR. AMIN: Scientific acceptability is a must-pass criteria. So, you -- if you weighted scientific acceptability as low or insufficient, you would probably not recommend the measure for endorsement.

However, you weight every criteria. Everybody has to weigh the criteria to their

own satisfaction. I mean, importance and scientific acceptability are must-pass criteria. But you know, the weighting, there's not a clear algorithm that says if you sort of -- I mean, you get the point here.

So I mean, there's no clear answer. But if it's a must-pass criteria and you voted it low then that would have an impact on what you should recommend it for endorsement.

DR. BURSTIN: Well, I think she's asking it slightly different. She's asking about whether there's insufficient evidence. Rather than rating it low.

She didn't say low so I just want to qualify that ever so much. Because I think when you looked at the listing of what was listed on that slide for validity it was only, what was it, 2b.2, that was validity testing.

So I think you need to then within your assessment look at all those different subcriteria and make your assessment and then decide how you think it fits for overall

suitability.

DR. ASPLIN: Okay. Are we good? All right. So Evan, let us know when you're ready.

MR. WILLIAMSON: We will now vote on overall suitability for endorsement. This is a yes/no question. You may begin voting now.

And we have all the votes. And we have 12 yes and 9 no. This again falls into our lack of consensus range. And we'll go out for -- yes. Yes, it does. So this will go out for the public comment and will be reconsidered again by the committee.

DR. ASPLIN: Let's start up again -- 15 minutes. And we'll commence with the heart failure.

(Whereupon, the foregoing matter went off the record at 3:23 p.m. and went back on the record at 3:45 p.m.)

DR. LATTS: All right, now that we've got one under our belt we only have two to go before we can all get on a plane and go home.

So, this measure stands between us and dinner. Nothing like incentive, that's right. And we've already probably said just about everything there is to be said.

So, as we're starting the heart failure measure we're going to start with asking the measure developers to discuss what's different in heart failure from AMI.

DR. KIM: So really what's different is the cohort, the heart failure cohort. So the ICD-9 codes that we used to identify our heart failure patients are different from the AMI. We don't have to go through all the slides again.

One thing I want to draw your attention to is for heart failure we do not adjust. We do adjust for age and comorbidities. We do not adjust for PCI or CABG but we do adjust for LVAD during the index stay or during the episode.

And that's really the only

difference. We strip and standardize our payment outcome as we did for AMI. We use the same risk adjustment approach as we did for AMI.

We selected a model. I already mentioned that we used a different model for AMI. We used a generalized linear model with a log link and inverse Gaussian distribution for heart failure. Those of you -- everybody cares.

We used a GLM with log link and gamma distribution based on our empiric analyses of five different models based on the Manning and Mullahy algorithm from the economics literature. And I think that's it.

I will say when we calculate these risk-standardized payment it is the predicted hospital-specific payment using their individual case mix over the expected hospital payment using an average hospital effect over that same specific hospital's case mix.

Then it's multiplied by the national

average. So, when we compare hospitals we're comparing hospital A to an average hospital with hospital A's case mix. So I hope that that can inform the discussion around the R-squared and the patient case mix and the risk adjustment. But that's really -- those are the big differences.

MR. NEEDLEMAN: It's the case mix within the set of conditions?

DR. KIM: Yes. So, you don't have to turn to the slide but the predicted is the hospital A times hospital A's case mix. The expected is average hospital performance times hospital A's case mix.

We multiply that by the national mean payment to get it back to dollars but this is a ratio. So I just, I don't know if that helps or hurts the discussion regarding risk adjustment. But it's not like we're comparing hospital A to B exactly. We're comparing them to the average.

DR. BERNHEIM: To an average -- and

how are you doing compared to an average hospital with the same case mix.

DR. LATTS: In case you missed that on the phone, how you're comparing that -- how the hospital is comparing to an average case mix.

DR. BERNHEIM: To an average hospital that had the same case mix as that hospital.

DR. LATTS: Yes, sorry. I misstated that. Slide 15.

Okay, any questions for the developers on that before we move to the summary?

MR. NEEDLEMAN: Again, I'm still --

DR. LATTS: Jack can't help himself.

MR. NEEDLEMAN: Yes, I'm still not clear. When you say case mix you're not talking about the whole -- the hospital case mix across all the conditions. You're talking about the hospital case mix for the heart failure cases, or for --

DR. KIM: Correct.

MR. NEEDLEMAN: Okay, thank you.

DR. LATTS: Janis.

DR. ORLOWSKI: Could I ask you to go to the slide where you talk about your risk adjustment? Where you have purple prior and then pink or something afterwards. Okay, great.

So, I just want to be sure that I understand the risk adjustment. And so I asked a question in the last setting and I think that we got an answer that different people heard different -- or I heard different answers to.

If a patient comes in with heart failure here and they have diabetes, and they're male, and they have whatever, I understand that all gets risk-adjusted.

But on the index admission if in addition to their heart failure they develop heart block. It's not a complication, it's not a UTI, it's not whatever. But it's something that they develop during that

hospital stay. Is that included in the risk adjustment?

DR. KIM: It is. We include in the risk adjustment 12 months prior plus index secondary diagnosis codes. We don't know if they developed it or not during the hospitalization but it's the first time we're seeing it so we're going to include it as a risk adjustment variable.

DR. ORLOWSKI: So then if that is your answer which is what I heard, then when we spoke about shock in AMI I did not understand, and I think we didn't understand if you come into the hospital with an AMI and you have cardiogenic shock based on the answer you just gave me it should be included in the risk adjustment.

DR. KIM: So, it is. So the quick answer is CC79 cardiorespiratory failure and shock is included in the risk adjustment for heart failure on page 57 of our technical report.

However, we don't deliberately -- I think your point is do you force it in, do you deliberately put it in.

DR. BERNHEIM: So I think -- let me just add a layer because I want to make sure it's clear.

So, we've said a bunch of times we risk-adjust for your past history and your secondary diagnoses unless they are complications of care.

There's not a terrifically reliable way right now to understand is there complications of care. We are optimistic the POA coding in these later years of data are going to soon help us with that. But right now we don't use the POA codes.

So when we see a secondary diagnosis we have an algorithm that is clinically vetted and imperfect that says is this more or less likely to have been a complication of care or not. Right? That's all you can do.

So, if you see acute renal failure

for the first time, they've never had a code in the past 12 months of renal failure, and you just see during their heart failure admission that they had acute renal failure we're not going to risk-adjust for that because it could easily have been that they were dried out too much and went into renal failure and we don't know. Right? Don't know.

If they have dialysis we're going to risk-adjust for that. That's not an acute complication. That's a patient who's got end-stage renal disease. We're going to risk-adjust for it whether it was seen in the prior 12 months or for the first time during the index stay.

So we risk-adjust for secondary diagnoses or things that show up for the first time during the index if they are according to our algorithm which Nancy laid out unlikely to have been a complication of care. That's the best way we had to differentiate it and it's

imperfect.

So, the answer about shock is unfortunately shock gets lumped with a bunch of other things. And so right now this measure considers shock a potential complication of care. So if you have a history of shock it counts, but if you have shock only for the first time during this admission because it's also with something else --

DR. ORLOWSKI: So you do risk-adjust for certain diagnoses that occur during the index care, but only if by your algorithm it is thought to be more likely to be a complication of the pathophysiology of the disease.

DR. BERNHEIM: Only if it's more likely that it was not caused by the care.

DR. ORLOWSKI: Right.

DR. BERNHEIM: Right.

DR. ORLOWSKI: Exactly. That it's the disease and not the care.

DR. BERNHEIM: Right. Exactly.

DR. ORLOWSKI: And so, okay. So then in the prior example I'm surprised by your choice.

DR. BERNHEIM: It has been very controversial.

DR. ORLOWSKI: Okay. I get you. So it -- so really as we look at this issue of risk adjustment and if you're looking at the same, if you're looking at apples to apples we need to understand what you consider a complication of care.

DR. BERNHEIM: Potentially a complication of care.

DR. ORLOWSKI: Okay.

DR. BERNHEIM: And it's listed. I think, again, I think in the future POA can help with this.

DR. WEINTRAUB: So, there is something we can look at. Because shock, ask me is shock in someone with AMI more likely to be related to patient-level factors or care-

level factors I would say far more likely to be related to patient-level factors.

DR. BERNHEIM: So, in fact we had a side discussion. James had made the same suggestion, that it might be helpful to look a little bit at some of these things looking at POA coding.

Because in the years that we were developing this measure there was basically no POA coding so we really couldn't do that. But we now have later years of data. So I think that one thing we can do is try to look a little bit at POA to differentiate exactly that question.

DR. LATTS: Okay, does anybody have any more clarifying questions before we get onto the summary? Is this -- are we revisiting --

DR. ASPLIN: It is on this comorbidity complication issue.

DR. LATTS: Can you hold that till when we get to scientific validity again?

DR. ASPLIN: It's directly applicable to the conversation we were just having.

(Laughter)

DR. ASPLIN: Which is it would be good to see what complications you've included. So that would be one thing.

I want to reinforce Jim's comment about looking at POA coding. We've done work -- I've done work on looking at POA coding and expert panel rules developed without it and the expert panels stink at figuring out what's present on admission and what's hospital-acquired. So, you really do need to start informing those decision rules if you're not going to use the POA coding with good POA-coded data to figure out what's going on.

DR. BERNHEIM: All right. We're just waiting for the good POA-coded data.

In our technical report Appendix 6 has for every risk adjustment CC whether or not it was only found during this index stay, whether we considered it a potential

complication.

And we use the word "potential." We know that sometimes it's not a complication of care. We're trying to be very careful not to risk-adjust for complications.

DR. LATTS: Terrific, thank you. Okay, so Mary Ann and Janet are lead discussants on this. Is somebody on the phone? Oh okay, Mary Ann. So, Mary Ann and Janis. Is Mary Ann taking the first pass?

So let's not maybe revisit all the -- let's really talk about if you would focus on sort of what's different from the comments and the review in the heart failure measure than the AMI if you could.

MR. AMIN: So maybe we can start with importance too.

DR. LATTS: Okay, yes, I'm sorry, we're doing -- yes, importance.

MR. AMIN: And Evan, maybe you can move the voting slide to the first subcriteria as well just so that we're aware.

Yes, if there are TEP comments related to importance as well they would be welcome here as well.

DR. LATTS: Okay, great. So, Mary Ann, if you could talk about importance, the summary around importance. And then Bill, you'll be up for TEP.

MS. CLARK: Sure, sure. So, this measure is very similar to the AMI measure we saw I think in terms of importance to measure and report. There was a lot of consistency in that it is definitely a high-priority area.

And there were some comments such as on the 30-day episode and whether -- it's unclear where the spending in that 30 days come from. But I guess given the fact that some of these additional reports are being provided to the hospitals we didn't have visibility to that. So, it sounds like that's available to understand what's driving the cost.

Let's see. There were additional

comments around not enough clarity around understanding the underlying clinical scenario to determine if there is wide variation in the resource use for the same type of case.

Let's see, what else do we have here. That again there were several comments on the 30-day episode and that the variation is likely to occur there and not necessarily within the -- I guess the acute index hospitalization episode.

Little discussion regarding how there could be opportunities for improvement in a way to, you know, related to the whole topic of severity of illness. And how if there's not a way to control for severity of illness that it may be difficult as well.

There were additional comments regarding the socioeconomic factors. You know, continuing to be a need to adjust for socioeconomic factors. There were several comments on that.

I think that is probably the summary

of the differences there. In general I think people thought that the intent was clear.

However, I had some questions myself on the intent. There were some places in the application where it was discussed or referred to as the typical heart failure patient. And I know that you discussed in your risk adjustment that you -- when you stated it just a little while ago you said you adjust for the LVAD cases.

But it appeared from the description of the inclusion/exclusion criteria that they were actually excluded from the development, not necessarily an adjustment.

So, I just had a question as what is kind of meant by the typical heart failure patient. Because I could see where it may be in this case a little difference from AMI in that a lot of these patients are more chronic patients and that their admission to a hospital is for an acute incidence of this disease.

And that there may not necessarily be surgical approaches I guess to treating the disease. Or there are definitely but they're not as -- probably these patients are more medically managed.

I know that the surgical procedures could affect the costs if they do have them. For example, I know that heart failure patients could have pacemakers or defibrillators implanted, or their valves replaced. And those patients I guess are included in this measure as well.

So how was it determined that patients with LVADs and transplants are excluded but yet patients with these other kind of major costly procedures are still included in the measure. So, that was an area of -- I'd like a little more clarity around that.

DR. LATTS: Okay, and maybe we'll hold that until we get to the scientific portion and stick with importance to measure.

So, great.

And Bill, could you give some TEP comments?

DR. WEINTRAUB: So, the TEP considered both of the measures together and really found the same in both. And certainly thought this was a measure of considerably importance.

DR. LATTS: Great, thank you. So, let's vote.

MR. WILLIAMSON: Before we vote, actually, I will point out one thing. There was a request to have the slides that were presented by the developer posted to the SharePoint site.

So if you're on your computer and you'd like to refer back to them during the discussion they are now posted under the meeting documents. So, just as a quick reference.

DR. LATTS: Brent.

DR. ASPLIN: So, I'm actually going

to make a case -- I'm not hung up on this, but this kind of loops back to something that Andy said earlier.

I have no qualms with the fact that heart failure is an incredibly important condition to be concerned about when it comes to total resource use and total cost.

I just think we've got the who and the what misplaced here. I mean, I think that system accountability for heart failure management should be with ambulatory providers.

And it should be over a longer period of time like annual resource use for those patients who don't have another dominant diagnosis. In other words, for those patients whose dominant diagnosis is heart failure what is the resource use over a period of a year? I think it would be a better global measure of how well a system's doing.

Because frankly, I'm hoping that over time for all of our patients diagnosed with

heart failure our hospitals become a less and less significant part of their overall care picture. They will always be part of it.

But I could make the case that the chronic disease was coronary artery disability and the acute event was an acute MI and therefore an episode-based measure was relevant.

It just seems to me like the chronic condition is heart failure. And yes, a hospitalization is an acute event but if you're doing it well they should have few of those events.

So, I'm not hung up on it, but I don't think this measure, if we had both in front of us I would say that this one is not as important.

DR. LATTS: Do you guys want to comment on that at all?

DR. KIM: Sure. Just a couple of clarifications. You're totally right, I misspoke. Heart transplant are LVAD are

exclusions, not risk adjustments. So they're excluded if they happen on the index or during the episode window. Both transplants and LVAD - exclusions.

And just, I appreciate your comment about the heart failure yet it remains one of the most common reasons for the elderly to be hospitalized. So it's still an important locus of leverage points. But I appreciate the comments you're making about it's a chronic disease.

But right now it's still a big, it's the most common reason the elderly get hospitalized. So that would be my response to that comment.

DR. LATTS: Great, thank you. And with that let's call the vote. Sorry, Nancy.

MS. GARRETT: I just wanted to make one response to Brent. I think it's a really good point.

One corollary of that is that if we're successful in moving more of these heart

failure cases out of the inpatient setting and into the ambulatory setting then this cost might be going up over time.

DR. LATTS: Those are sicker patients --

MS. GARRETT: -- become more severe. So again, sort of reinforces the idea that it's hard to say whether higher or lower is better for these cost measures. So anyway, interesting.

DR. BERNHEIM: And just to reiterate, we totally agree with that. And the hope would only be that if the patients consistently get sicker you're still doing a relative measure and so it may be that the average cost would go up. But your relative performance would --

DR. LATTS: Well, and it also speaks to the importance of partnership between the inpatient arena and the outpatient arena. Because if they're going to keep people out and keep their cost low in the 30-day window

which I agree is probably too short they're going to have to partner with their PCPs to keep them out. Or cardiologists.

John? John. John on the phone. And then Joe.

DR. RATLIFF: Hi, just a quick question which I think feeds into the high-priority discussion.

You handle readmissions for a given patient in a 12-month period by choosing one of the admits for your indicator. How do you think that harmonizes with Medicare and other institutions' push towards adamantly avoiding readmissions and putting lots of resources into outpatient management of these patients?

DR. KIM: So I think the question was about if a patient is admitted multiple times in one year the way we approach the measure is we randomly choose one of those heart failure admissions as their index admission.

And that is harmonized with the way the heart failure risk derived mortality

approach is also that approach. Is that the only question?

DR. RATLIFF: So, I guess my question would be is the facility penalized within this measure for having a high percentage of patients that have 30-day readmits.

DR. KIM: So, the way it works is if we choose one randomly and you're readmitted within a 30-day episode of care window that readmission would count towards your total payment episode. And because readmissions are costly it would likely elevate your total payment episode.

But there is no guarantee -- let's say you had multiple admissions in January, June and November. In that case we wouldn't see those quote unquote "readmissions" if you take January to be the index. Those would not appear. So there isn't a systematic bias toward including readmissions.

Obviously if you're readmitted within 30 days that would count towards your total

episode payment. I hope that answers the question.

DR. RATLIFF: If I'm following on one of the earlier comments was a move towards kind of ambulatory ICU management of these patients, putting lots of resources into avoiding those 30-day readmissions. Really treating this as an outpatient disease.

At least at our facility it seems like the patients sort of being admitted are the ones where that has failed. Or where they've had something really catastrophic happening.

I just worry that hospitals that are really -- hospitals and practices that are forced -- focusing a lot of resources on ambulatory management of CHF may look poor on this metric alone. They may be selecting out their sickest patients for admission.

DR. KIM: Yes, I think your point is a good one. Heart failure management is dynamic. It's changing really rapidly over

the years. And that's one thing that we are cognizant about.

And as we include more recent years in our heart failure measure we are looking at the difference in payments across years and across time. Because heart failure management is changing. So that is definitely one piece that we are thinking about.

And I understand your concern, that only the sick patients get admitted because everybody else is discharged the same day or goes somewhere else. It's an ambulatory setting.

And we definitely have to keep that in mind as we look toward the more recent years. Keep in mind this measure was developed in 2008-2009 data.

DR. LATTS: Well, and if I can take the leader's prerogative to make a comment as well. I mean, this goes back to a conversation that we've had for years is that cost and quality does not give you the full

picture of what's going on in a system. And this might be something, actually, Frank, you have to consider is really that utilization that's the third piece of the stool.

And this goes back to the days, and I don't know if you guys remember, it was a big -- I think it was the New York Times or maybe Time article about a cardiology group. And those of you cardiologists in the audience will remember this, that had very, very low-cost and very high quality for their cardiac cath rates. And it was because they cast one vessel at a time.

So every patient would have three or four casts. And so their utilization was incredibly high but their cost was very low per cath. And their quality was very high. So utilization is really that third leg of the stool that we're not capturing in either of these measures.

DR. BERNHEIM: Just a quick developer response which is just in certain ways this

measure is as much a utilization measure. I mean, if you think about what we're actually capturing it's sort of -- it's kind of every time you -- it's a cross. Every time you sort of touch Medicare in any setting it's going to get picked up. So higher utilization will also be reflected.

Of course if it's high utilization -- what you're saying is if it's high utilization of very low payment services that might not be visible.

I think in the days post heart failure admission sort of acuity and travel with payment. So an LTACH visit is a lot more expensive than an ED visit is a lot more expensive than an outpatient visit.

DR. LATTS: All right. Any other comments before we vote? All right. Call the vote.

MR. WILLIAMSON: We will now vote on high priority. It's importance to measure and report 1a. You have four choices, high,

moderate, low, or insufficient. You may begin voting now.

We're missing anyone in the room. If everybody could please try to vote one more time. There we go, we have all the votes. And we have 14 high, 4 moderate, 3 low and zero insufficient. It passes high priority.

DR. LATTS: Opportunities for improvement. Any comments? Janis.

DR. ORLOWSKI: So, it is not clear to me why 30 days was chosen. If I look at the pathophysiology of the disease 30 days makes no sense to me.

I could argue with AMI that most of the acute event is over within that period of time. There is some logic to it. But there's not logic to me other than we look at other things for 30 days. But there's no logic that I can see in a 30-day time interval for this measure.

DR. KIM: So we chose the 30 days because it's anchored around a

hospitalization. Most heart failure hospitalizations have a length of stay of between four and five days.

And we felt that a 30-day window was short enough where some of the post-acute care would be attributable to the hospital admission. Many times as you transition care from inpatient to the outpatient setting the inpatient team makes the outpatient appointments, makes the visits, maybe sends them to a SNF or to rehab or to LTACH. So they bear some responsibility for those decisions on transfer or on transition to the non-hospital setting.

And it is harmonized as you said earlier. Really we're trying to get to value. We understand payment is one dimension in and of itself. It provides transparency about variation of payments across hospitals.

But if we really are trying to get to value, so comparison, some comparison of payments with quality indicators such as our

heart failure mortality measure. So we did try deliberately to harmonize and that 30-day was used in those NQF -- heart failure quality measures.

DR. LATTS: Any other comments on opportunities? Anybody on the phone? Okay, call the question.

MR. WILLIAMSON: We will now vote on opportunity for improvement. This is importance to measure and report 1b. We have four options, high, moderate, low, or insufficient and you may begin voting now.

If everybody could please vote one more time. It didn't capture. All right, I guess we'll stick with -- I want to capture everybody's vote so let's try this. So, glitch in the software. But we have 11 high, 9 moderate, 1 low and zero insufficient.

DR. LATTS: All right. And measure intent. Any comments before we vote?

MS. CLARK: Again, I guess I would like to -- for the measure developer to

provide a little more clarity around the intent and the patient population that is expected to be captured here. So, if you could provide a little more clarity around that.

DR. KIM: So I think maybe this is referring to the typical heart failure patient again.

So, really when we wrote that we meant non-LVAD non-transplant heart failure patient, non-major surgical procedure that we know changes your payment outcome. We know LVADs are extremely expensive and that you stay expensive within the year post LVAD implant. And transplant similarly. We know they're sicker. So those are the reasons we excluded those two conditions.

As you mentioned there are other conditions that may not be quote unquote "common" but that are costly like AICDs and pacemakers that you mentioned. But we chose not to exclude those because we feel that many

more heart failure patients are eligible for those.

Now, that is changing and again heart failure -- therapy for heart failure is dynamic. But when we developed this in 08-09 we chose to exclude only LVADs and transplants.

And typical, by typical we were really referring to the non-LVAD non-transplant patient.

DR. BERNHEIM: I just want to make sure that addressed the question. I wasn't sure. I heard a different question than Nancy heard. So, can the caller just say whether that answered what you were looking for or restate your question?

MS. CLARK: Yes, this is Mary Ann. So yes, I think that answered the question.

One related question though. I mean it may be obvious, but this is for the Medicare fee-for-service patients, not for Medicare Advantage, correct? I'm just asking

the question because of the standardized pricing methodology, the ability to replicate that in any other organization outside of Medicare or a research organization.

DR. KIM: You're correct. It only includes Medicare fee-for-service. It does not include Advantage.

DR. LATTS: All right, any -- oh, Nancy.

MS. GARRETT: Well, I'm not quite sure if this is the right place to make this comment or not.

But we've talked a little bit about how it's hard to tell which direction is better for this measure. And also some of the concerns with risk adjustment. So, I feel uncomfortable with what I know about both of these measures or having them used for potentially like in the value-based purchasing program for actually rewarding or penalizing providers.

And so I wonder if we want as a

committee to make a recommendation about that, about the parameters in which we feel this would be appropriate to use the measure.

So this may be the wrong section to bring it up, I'm not sure.

DR. BERNHEIM: I would just say as the developer we would welcome that. We feel really strongly that what's valuable here is to be able to look at a hospital and start to learn what a hospital who has high costs and great outcomes looks like compared to a hospital that has low cost and low outcomes.

But I have no idea what to tell you if you tell me a hospital is high on this measure. I have no idea if they're doing a good job or not and I would never judge a hospital solely on that. So that has been our intent and we would welcome the committee to support that.

MS. GARRETT: It doesn't mean CMS won't. Or a private payer.

DR. LATTS: Let's put a parking lot

on that for usage. Bring it up in the usage section.

Any other comments? Anything on the phone? All right, then let's vote on measure intent.

MR. WILLIAMSON: We will now vote on subcriteria 1c measure intent. You have four options, high, moderate, low, or insufficient. And you may begin voting now.

And we have all the votes. We have 11 high, 9 moderate, 1 low and zero insufficient.

DR. LATTS: All right. So, overall importance to measure and report.

MR. WILLIAMSON: We will now vote on overall importance to measure and report. Again you have four options, high, moderate, low, or insufficient. And you may begin voting now.

And we have all the votes. And we have 8 high and 13 moderate.

DR. LATTS: All right, moving on.

Scientific acceptability. Mary Ann, are you on tap for this one as well?

MS. CLARK: I believe so. And feel free to comment because I know there's a lot of work that's already been done on the construction logic and clinical logic.

But I guess in terms of the clinical logic we're supposed to discuss inclusion/exclusion criteria, risk adjustment which we've already talked about a lot, cost methodologies and scoring.

So this again is very similar to the AMI measure as we all know. We've talked already about inclusion and exclusion criteria. And where I think the issues are very similar to the AMI measure.

And you heard about the additional exclusions here for heart failure which include the LVAD and the other transplants. All of the other exclusion criteria are I think pretty much the same.

For risk adjustment there are some

differences actually between this, the risk adjusters for this measure versus the AMI measure. And I was wondering if we could discuss that a little bit.

And also how they are comparable or not to the other measures for the mortality measure and the 30-day readmission measure. Because they do appear to be different from those in my review anyway and comparing the different adjustments.

For example, it doesn't look like diabetes is included, or cancer. I think those were the main ones.

And also it looks as if sex was included originally in some of the other measures but not in this one as well. So, I just wondered about the comparability there for that.

And the costing methodology, we already heard about. It's using the standardized pricing model that -- apply the CMS methodologies for pricing. And we heard

about the scoring as well, that it's comparing the predicted to the estimated. So, I think those are pretty similar in terms of the methodology.

Could we talk a little bit more about the specific risk adjustment that was done for the heart failure model?

DR. LATTS: Yes, I'll turn it over to Nancy.

DR. KIM: Sure. Thanks for the question. So, the risk adjustment for heart failure is done based on a 2009 sample of heart failure patients that we defined using the ICD-9s.

And we employ the same strategy. But it's not surprising that the risk adjustment variables are different because it's again based on the heart failure population, our cohort of the heart failure population.

Basically we look at all of the -- I think there's 189 candidate CCs. We ran bivariates with the CCs and the total payment

outcome. We look at those that are statistically significant and frequent. We then regroup those and then we run those again together in a multivariable model. And then we take half the sample to develop that model. And then we validate it in the other split half. So that's our approach to risk adjustment.

And that's why you may find differences across the different measures. Because again, they're regressed ultimately on the total payment outcome for that particular cohort and that particular condition.

Does that answer your question about why there may be differences?

MS. CLARK: Yes, it does. I guess I was just kind of surprised that some of those other disease areas didn't come up as significant.

I've done some work on a similar area and we always found that some of these other comorbid conditions did come up as significant

for cost or for payment. So, I'm just kind of surprised is all.

DR. LATTS: Yes, absolutely. All right, any other TEP comments you want to make?

DR. WEINTRAUB: We really discussed all the points in the TEP in the previous measure.

DR. LATTS: Great. All right. Any comments that we want to make? Okay, Nancy, I think you were first, then Matt.

MS. GARRETT: I was curious about gender, whether you looked at that as a stratification variable. I know you talked about race and payer status.

DR. KIM: We never put in gender into these models. It was a conceptual decision that gender should not affect the type of care you receive that would affect your payment outcome for AMI or heart failure.

So we never put gender into the model on a conceptual basis. But we never did

analyses to look at that.

DR. LATTS: Matt?

MR. MCHUGH: I have a question about the claims that are used. Specifically about the outpatient claims.

You go back and forth it seems in the description about sometimes using provider, sometimes using physician. Is it everything in the outpatient file? Is it only physician claims? Are there other providers excluded? Or is that just --

DR. BERNHEIM: Are you addressing specifically what's used to calculate the payment outcome, or what's used for identifying comorbidities for risk adjustment?

MR. MCHUGH: No, no, no, I'm not talking about risk adjustment. I'm talking about the calculation of the payment --

DR. BERNHEIM: Of the payment outcome.

MR. MCHUGH: Yes.

DR. BERNHEIM: Okay, great.

DR. KIM: Everything goes in there. The reason it's called provider, I believe when facilities are located it's a provider, but physicians are submitting Part B claims for physician fees off a fee it probably looks like a physician fee. I'm looking at our analyst to confirm that what I'm saying is correct. Everything is included except for --

MR. MCHUGH: So if it's in there it's included. So like nurse practitioners, that would --

DR. KIM: Yes, yes, it is.

MR. MCHUGH: And facilities.

DR. KIM: It's probably -- yes. I see your question now. Yes, it's all in there.

MR. MCHUGH: Okay. All right.

DR. LATTS: Great. Janis? You got your answer, okay. Other questions? Reliability?

MR. AMIN: Yes, I'll just quickly --

DR. LATTS: Oh, that's right. Yes,

okay.

MR. AMIN: I'll just quickly walk us through the algorithm in terms of the testing approach.

It looks like as we look at this they did do some empirical testing of reliability using a split halves approach. So we're on 5. So this is very similar to where we were during the last discussion. I'll let you guys just catch up with me.

And so basically we're looking to look at the reliability statistic and the scope of testing to -- and we'll assess whether that's high certainty, moderate certainty, or low certainty.

And I believe this is on page 22 of their overall submission which is in their testing attachment. Which I believe was 0.752 for the percent agreement between the independent assessments.

So, we can have a conversation around that if we need to or if that's sufficient.

I would just insert that into your overall assessment of reliability which includes multiple components, one of which is reliability testing.

DR. LATTS: All right. We ready to vote?

MR. WILLIAMSON: Waiting for Bill to get back to his seat. We will now vote on overall reliability. You may begin voting now.

And we have 6 high, 12 moderate, 2 low and 1 insufficient. The measure passes reliability.

DR. LATTS: Is there any more discussion on validity?

MR. AMIN: I'll just go through the algorithm just for the sake of completion.

So, again, I think based on the developer's description in the last -- the testing approach for validity is very similar.

I point out on page -- I think it says page 23 they've talked about the data

element approach is similar to the -- other claims, other measures that they've compared it to.

But the basic method here is again face validity. So again, the highest rating that we could have in terms of validity testing is moderate. So we're at four on this algorithm.

DR. LATTS: All right, vote.

MR. WILLIAMSON: We will now vote on overall validity. You have four options, high, moderate, low, or insufficient. You may begin now.

There it is. And we have all of them. And we have 6 moderate, 10 low and 5 insufficient. It falls in our lack of consensus and we'll move forward.

DR. LATTS: All right. Feasibility. Any discussion on feasibility we want to have? Seeing none. You know, he did a great job. He wiped you guys out.

MR. WILLIAMSON: Actually this is

again one of the concerns with having multiple voting. This actually fell below the 40 percent threshold. I'm trying to do all this in my head at the same time and I obviously failed. So we'll go back.

So, we had 6 moderate and then the combination of low and insufficient was 15. So again that falls below. So this measure does not pass validity.

DR. BERNHEIM: Can I ask a question? So, the voting was very different on this one than the last one. Without any discussion that suggested there was concerns.

I would have expected many of the concerns to be greater for AMI. It was my expectation. So I wonder if there's an opportunity just for us to understand what the shift was in greater concerns about validity for this measure than the other one.

DR. LATTS: Anybody who want to speak? You don't necessarily have to change your vote but if you have a difference of

opinion. Jim.

DR. NAESSENS: In terms of hospitalizations for heart failure there's more variability and severity than you probably see in MI at least in terms of cost and what the expected cost would be in the next 30 days.

DR. WEINTRAUB: I agree with Jim on that. I think there's potential, greater -- I agree with you. I think there's greater potential for variability.

DR. BERNHEIM: So, is it okay if I ask? I mean, it's valuable for us to understand.

So, variability per se. Can you say a little bit more?

DR. ASPLIN: You're saying variability in case mix that's not captured by the risk adjustment?

DR. WEINTRAUB: Yes. Potential for it. Just as a clinician taking care of patients like this for 30 years heart failure

is a very variable clinical entity while myocardial infarction, I have a stronger sense of sort of the bounds of it.

DR. LATTS: Janis?

DR. ORLOWSKI: Similar comments. I worry that hospitals that have gained a reputation for taking care of the extremes of heart failure where they have very robust ambulatory settings for heart failure and admit a more severe population that are closer to needing intervention, whether it's LVAD, whether it's work-up for a transplant. Recognizing the length of time that people sit on the transplant list.

I don't know that the risk adjustment will distinguish that group of patients from the chronic sort of moderate heart failure that's not well taken care of in the ambulatory setting. And so I don't see that that's risk-adjusted.

I also believe that hospitals that have large end-stage renal disease populations

have multiple admissions for renal failure -- I'm sorry, for heart failure which is truly an admission for non-compliance with fluid. And so it's a mixed bag.

It wasn't clear to me that the extremes of the heart failure group are well risk-adjusted.

DR. BERNHEIM: So, just to follow the string and make sure we are understanding. Because again, the conversation was same-same and then the vote was different. So it's really helpful to flesh out if there's really conceptual differences in these pieces.

To the extent that there's things like renal -- you know, if a hospital takes care of a greater number of patients with end-stage renal disease that's clearly accounted for in the measure.

We've had versions of this discussion with AMI and I won't rehash it all, but just to be clear that there are many clinical characteristics and comorbidities, and age

which obviously is not alone going to predict heart failure but is going to be related to it. So just to remind the group that there is a fair amount about these patients that is captured in this risk adjustment.

Harlan, you said you were on the phone. I don't know if you want to weigh in at all. And I don't know when you joined the conversation.

The concern of the group is that this issue of differences in severity of disease that might not be captured by the risk adjustment would be a greater issue for the heart failure measure than the AMI measure. And I'm also trying to think about how that relates to later costs. How much of the later costs are discretionary or not in this episode.

DR. KRUMHOLZ: First, let me say that our group deeply appreciates the service that the people on this panel are putting in and recognize the challenges of doing this kind of

work.

And you've already had a chance for deliberation so this, as Susannah is expressing, isn't an attempt to re-vote or re-convince you but to help provide our team with insight about the measure.

You know, as the healthcare system drives toward trying to create more value there is, as you know, increasing emphasis on trying to quantify the resources that are being provided and then the outputs that are being achieved.

There is natural imprecision in the codes and cohorts that are created, but that in the course of creating the outcomes measures there was a sense that they were coherent enough, and that at the hospital levels we were able to get sufficient risk adjustment at that aggregate level that would provide some meaningful signal about the quality that was being provided.

And in the same way we migrated those

methods over to payments where we actually felt it even would be better than we had for outcomes. Because instead of a binary outcome it's a continuous outcome and one that we felt directionally would be important.

And with all the emphasis on post-acute care we would be able to capture that as well and consider that -- even though attributed to the hospital there's kind of more of a community effect there.

Well, you've heard all this. So for us I think it's a question of, and it may come to a different group if we come back to NQF, but this group has worked so hard and so long to try to get this as good as it could be, as technically correct as possible given what's out there and available. So I just want to say this respectfully, we're not looking to change your mind, but more about any insight.

And the idea that it's just variable with heart failure, you know, almost sounds like well, is that saying it's a non-starter

in heart failure given what we've got, or that there's a need for greater something else for us to do? Or is this just the sense of the group that you couldn't do this in heart failure now given the quality of the data that you have? So I think that's where we are.

And again, I say this with deep respect recognizing you have the same goals we do and are trying to do the best job you can. So we're not trying to be critical or get you to re-vote, but more just get some insight.

Because, I mean this group's been working two years on this measure and it needs -- the group needs to know whether it just has failed or whether there is another path forward in providing the country with an ability to give hospitals some sense of the risk-standardized payments that are being generated as a result of this condition.

DR. LATTS: Does anybody want to comment on Harlan's question directly? Okay, just go in order. Jack.

MR. NEEDLEMAN: Okay. So, I'm thinking about what made this different. And I'm trying to integrate the whole conversation we've been having.

So, the issue of the greater variability in the patients comes back to the issue of how much of the cost variation across hospitals is really being driven by differences in the case mix of the patients who are there. And that remains an issue here. And if that were the only issue I think the vote would have been the same.

But in the course of the conversation I heard two other issues raised that go to the essence of is it a reasonable measure at all which is sort of what Harlan was asking.

One was, I think it was Janis' comment about why a 30-day window. This is an ongoing chronic illness.

And that also relates to I think it was Brent's comment about this is really about primary care management. So, both of those

raise the issue of whether the hospitalization truly represents an index event around which and from which one should be measuring cost. Or whether that's an inappropriate window for looking at heart failure patients and heart failure costs.

So if you want to come back with a heart failure index hospitalization measure I think partly what you've heard in the group here is you need to make a much stronger case that it makes sense to be thinking about cost in the context of the cost window starting with a hospitalization and continuing for a fixed period after that. That's what I've heard in the conversation that goes beyond the issue of the heterogeneity of the patients.

DR. LATTS: This is Lisa. I'm going to call on myself next.

I had a couple of comments. One is that you mentioned that this measure was developed initially in 2009 I think. And so is it being used and sort of what's the

implication if it's not approved here.

I actually think it is important. I want to differ with Jack. I think it is very important to have a heart failure measure because it's a huge cause of hospitalization.

And so it's all fine and good for us to say we should push it to the outpatient arena and we should hold the PCPs responsible.

I think it's an "and" as opposed to an "or" because people with congestive heart failure are getting admitted. And the things that happen to them in the hospital matter. And so I think it is important.

I don't know, frankly, what the right index of time is. Maybe 30 days is almost too long in the sense that it is a chronic disease and maybe -- the hospital window maybe is shorter than that given that it's a chronic disease. So I don't know if it's too long or too short.

I am disturbed at the idea that we wouldn't have a heart failure measure.

DR. GELZER: And I'm going to piggyback. This is Andrea, and I'm going to piggyback on Lisa.

I agree completely with what you said and I disagree with you, Jack, because -- inpatient hospitalizations and rehospitalizations for heart failure, you showed data. I mean it's 30 percent. It's 30 percent. And that's where all the costs are today. And we have to get costs out of the system. So I think it's kind of a travesty that this measure doesn't go forward at this point.

MR. NEEDLEMAN: Andrea, just to be clear I was trying to reflect on the whole set of conversations, not necessarily expressing my own opinion.

DR. GELZER: But now this measure has to go to the council.

DR. LATTS: Well no, I think now it's dead.

DR. GELZER: It doesn't even go

there? It's dead?

DR. LATTS: Yes. And I guess, so what --

DR. GELZER: I think we do a re-vote.

DR. LATTS: Well, that's what I'm wondering, is if there are any questions that anybody had that could be answered that would change your vote. If not then there's no point in a re-vote. But if there are any questions or clarifying points that could be made that would lead to a re-vote. But let's go to Brent's comment first.

DR. ASPLIN: My comment wasn't directed at the validity question or the scientific acceptability. It was really around portfolio management and the parsimony and if you had to pick one. And maybe we don't have to pick one, you know.

So, I'm not suggesting that heart failure admissions aren't important, just trying to get at the bigger picture of who should be held accountable. But we don't have

that alternative in front of us. So, between the two my vote was the same on this.

There was a question raised by the TEP that might crack open a little window here. It might not. Which was there was a larger distribution of codes that got you into the analysis.

And one of the TEP members raised the question of whether -- and if you already presented this and I missed it I apologize. But whether the distribution of those codes to get you qualified for the measure varied across hospitals or not.

And that would speak at least in part, but I don't think it would fully satisfy our questions about differences in case mix prior to the episode begins.

DR. KIM: I don't think we have those data. I'm not sure we looked at that for heart failure. I know we did for AMI. I'm not sure, I don't think so.

DR. KRUMHOLZ: I think our concern

there was that, you know, heart failure is squishy enough. And there's probably some vagaries in terms of which exact code they give.

And we also don't want to create an incentive for people to kind of move heart failure patients into a code that is acceptable for coding heart failure but wouldn't be considered in the measure. So we sought to be more inclusive than less inclusive.

And there's nothing we've done or the literature would suggest that there's that much heterogeneity with regard to the specificity of the diagnosis. It's sort of fungible among many of the codes.

Like hypertensive heart disease, whether they put that in heart disease or hypertensive heart disease, I mean heart failure is a little hard. So I'm not sure that's the window.

I just will say this one thing about

attribution. Again, just clarifying, that what we thought is that the hospital is the conductor of the community's healthcare right now. I mean they're the only major central organizing force in most communities.

On the attribution it's not really about blame, but it's about who's in the best position to orchestrate a response to whatever comes out of the quality measures in a period that's immediately connecting to the hospitalization and the post-hospitalization period.

I'm just reflecting back on the outcomes measures which is why we got to 30 days in the outcomes measures. Not because we thought something that happened on day 28 was the fault of the hospital, but that we thought that the hospital could play a central organizing role, be the center of gravity for efforts to reduce risk in this post-acute period. With a little less influence than it has within its own walls but that coordinating

function could be a responsibility of the hospital who's really generally the deeper pockets and the more influential organizing forces within communities, and increasingly part of healthcare systems and delivery networks.

And so -- and people are asking about 30 days. But also with this interest in bundling it also provided some opportunity for people to sort of see how this all fit together. And increasingly people are taking responsibility for longer periods.

So, again, I'm not trying to do anything but just give you perspective on. We talked about every combination and permutation, two weeks, four weeks, six weeks, eight weeks. Do we narrow the codes, do we expand the codes. Can we do anything with this to represent better for risk adjustment. So we've been through this and realize there's no single best way to do it.

And we recognize too that you guys

are hearing this as a single measure and reflecting on it. So we're just -- I mean this at this point is just kind of a conversation on perspective. But it is at least helpful again to know directionally whether -- because if the measure dies here then we've got to think, okay, what is the future of this and how do we go with it.

DR. LATTS: Great. Andy and then Janis.

MR. RYAN: So, I actually voted to approve both these measures and I think that they're good, they're important.

But I would say that more testing around validity really would have been good. And so one of the ideas I had was we've already approved Medicare spending per beneficiary, that already exists. Just to show a correlation between these two measures and Medicare spending per beneficiary either for the whole hospital or for these particular cohorts I think would have been pretty

straightforward and would have shown something we could have grabbed onto.

I think also with respect to this inpatient versus outpatient management for heart failure, seeing the correlation between the hospital costs for this heart failure measure and also maybe per capita costs or total annual costs for patients with heart failure to say, you know, is the hospital measure kind of consistent with what we see with this patient's expenditure over the entire year.

If they're not then it speaks to some kind of mismatch with maybe outpatient management and then what's happening in the post-hospitalization period. If they are matching up, well then maybe we have a central construct here. And we might not be as concerned about differences in what's happening -- kind of if we have a kind of selection issue of those heart patient -- heart failure patients that are hospitalized.

So anyway, so just some additional work around those kinds of issues with validity testing I think would -- you know, you didn't need to convince me any further but it might have helped with the rest of the committee.

DR. LATTS: Janis.

DR. ORLOWSKI: So, a couple of years ago the hospital that I was the chief medical officer at had a -- participated in a Robert Wood Johnson study of looking at whether there was discrimination in care in heart failure. And there were 10 urban hospitals that participated in this around the United States.

And I can tell you the data from the study and I can tell you the data from D.C. There's one and one thing only that determined whether you were going to have a recurrent admission to the hospital and that had to do with your zip code. And it was essentially socioeconomic status.

And so whether people had insurance

or not, whether they, you know, a whole list of factors. It had to do where in Washington, D.C. you lived. And if you lived that way you had no resources in the community. And if you live here and this way you had every resource in the community to keep you out of the hospital. And that's what we're talking about.

And these measures, like them or not, and I agree that heart failure is important and heart failure needs to be dealt with. It's an important measure for us.

But right now they are being used as a stick and they are again taking money out of the urban hospitals and throwing the money to community hospitals because we do not have an appropriate socioeconomic adjustment to these measures. And so we've got to face that.

And so if you say is this a valid measure of the hospital we have a very, you know, well-defined three-year study that shows that it's not the care within the hospital.

DR. BERNHEIM: Just so people know because we didn't get to this though I think it is in our NQF application. For this measure when we looked at socioeconomic status, and you can discuss as Nancy and I have had the opportunity to for many days what the right variable is. But we used Medicaid status which in Medicare patients is an important, although not the only and not a perfect marker of low-SES.

And we looked. The concern was that hospitals that had lots of lower-SES patients would come in with greater needs and would therefore generate more payments. And we looked at that. Well, you have to as part of your NQF application.

And for both of these measures we were really surprised that the hospitals that are -- and I'm not sure that this is good or bad. Because again, I don't think that lower is better.

But the hospitals with the greatest

number of low-SES patients on these measures have similar to slightly lower payments.

Now, again, I'm not saying that's good or bad. I'm saying they're certainly not going to look like high-cost -- I mean, to the extent that people are worried that they're going to get profiled as high-cost and that's going to hurt them this measure doesn't play out that way.

I'm not sure that that speaks well of again how we're spending resources. There's a million issues.

But just to note I don't think that the -- if we risk-adjusted for SES in these measures it would only make hospitals caring for low-SES providers look worse in this particular measure. So it's not what's playing out here. Just so people know that for this measure.

DR. LATTS: Okay, Jennifer, then Nancy. Go ahead, Jen.

MS. HUFF: Hi. So, being on the

phone it's a little bit more challenging to understand what's going on with the room, but I have to say I was really surprised to see the votes come out to the point of it tipped it so far that this measure doesn't go forward.

And based on the conversations that I wouldn't have sensed that just from listening to what people have said.

I do appreciate that this is a very deliberative process and NQF does a really good job of facilitating that.

I think one thing that I've noticed in serving on a variety of these committees is there tends to be a focus on all the challenges with the measures and that's what we keep bringing up and being critical. And I think that's part of our role.

But sometimes I think we tend to overlook what is done well, or what is capable of being done with a measure given the environment we're in.

So, I think I really question what level of bar we're using for this measure in terms of the good enough bar versus the perfection bar. And whether or not this measure is good enough to provide more benefit of having this in use than harm.

Admittedly there are some challenges with it that need to be adjusted, but measurement is an iterative and evolving process. We talked this morning about how in the cost and resource use arena, in this arena it's more nascent than quality, and more work needs to be done. And I think we see that.

I wouldn't want to stall work going on in this area or stall progress from things moving -- from being able to move forward. So I just, I really need to say on its face sort of supporting -- not supporting this measure and it not going forward just is really disconcerting.

DR. LATTS: So, on that note we've been discussing back here whether or not we

should re-vote on this factor. And we were going to vote on whether or not to re-vote, but I think in the interest of time let's just go ahead and re-vote.

And if it comes out the same we'll pick up this discussion exactly where it left off. Nancy, you want to do a quick comment?

MS. GARRETT: So I have a question which is what does it mean if we don't endorse this. So, people are talking about this measure is going to die and it will never be used. But the measure we didn't endorse last year is being used. So, it doesn't necessarily mean that CMS can't use this or anyone can't use it. It means it's not NQF-endorsed.

DR. LATTS: It dies from an NQF perspective, correct. Others can still use it. Although, you know, they try to use NQF.

MS. GARRETT: It may mean that it's less likely to be used for payment purposes like in value-based purchasing which -- it

doesn't mean that?

DR. LATTS: My understanding is that CMS could still use it if they wanted to for payment. I don't think it affects that likelihood.

DR. BURSTIN: It basically stops the discussion of this measure. It won't go out for comment. You won't get additional deliberations. I think that's I think what we're trying to emphasize, rather than it won't get used. It's a conversation stopper.

DR. BERNHEIM: Clarifying question. I'm struck by the fact that the no comes from a combination of lows where people had sort of absolute concerns and insufficients which it makes sense to count as it's not a moderate or high. I understand the counting.

But I wonder how we address the insufficients. You know, if -- because if somebody feels like there's insufficient evidence this discussion may have illuminated that but we haven't brought new evidence.

So I don't know. If you feel like there's insufficient evidence you're putting people in the position of sort of saying oh well, it's moderate actually. I mean I don't know.

I just am wondering from an NQF process sort of what happens with that sense that one-third of the committee has. I did the math wrong. Some people in the committee of insufficient.

DR. LATTS: Well, and I think that could potentially be sort of further expressed in the comments from this committee to you, in the comment period.

I guess my concern is that if it's no, it's no. Whereas if it's yes, but, the discussion can continue.

Okay. You guys have comments prior to our vote?

DR. WEINTRAUB: In that regard if the measure is voted down does that mean there can be no more discussion, that they can't come

back? Isn't it possible for them to reevaluate, say you know, we thought this through and there are other opportunities to do a better job. Can't they come back?

DR. BURSTIN: Come back in another cycle. Perhaps not in this cycle.

DR. LATTS: A couple of years.

DR. BURSTIN: Right. So just not --

DR. LATTS: It's years.

DR. BURSTIN: -- clear exactly when that would happen.

DR. WEINTRAUB: I don't think anyone would want to say we never want to hear about this again.

DR. LATTS: Right. It just means a couple of year delay. Yes. Carolyn and then --

DR. RATLIFF: That was my question as well. It's a two-year delay? If the developer wanted to take the suggestions from the panel and modify the measure it will be two years before they can get it back in the

queue for NQF endorsement?

MR. AMIN: So, we would have to wait until the next cost and resource use project.

So again, I just want to make it perfectly clear that NQF has no position on this. Just want to make it very clear that you can vote it down, you can vote it up. You should vote it on the criteria and that's how you should vote. We're not -- there's no pressure to go either way.

And I think before we vote it would be important for us to get through these comments just because, for the sake of completion. I don't want anyone to feel like they haven't been heard if we decide to go to a re-vote.

MS. WILBON: Taroon, I just have one thing to add. It might also be helpful using the algorithm because I feel like the algorithm kind of makes things a little bit more concrete in terms of where kind of the branching really happens, at what point.

I don't know if people who are willing to kind of share -- for those of you that voted no or low or insufficient where that decision happened. It would help us illustrate to others who weren't here in the report where that kind of breakdown happened and provide a little more specificity.

And if it's at different places for different people that's fine. But it might help give us a little more context for where the breakdown was.

MR. AMIN: So, with that Ashlie, though, I think the challenge is the algorithm only talks about the testing. So I will, you know, where we landed, and I'll try to understand for the sake of -- I'll try to characterize the nature of the concerns. I don't know if this is accurate or complete.

Is that the issues around -- well, for the sake of the algorithm we're at face validity testing. And effectively that puts us at a moderate or potentially low. But

that's where we kind of land from the testing perspective.

There were other issues around the heterogeneity of the cohort. And there's still this residual concern about the risk adjustment.

DR. LATTS: And then a quick question in follow-up. So, now that we are a standing committee does that mean it has to wait for another project, or could it be, you know, do these three things and bring it back in three months or six months? So is a standing committee different from the project committee?

MR. AMIN: So, I mean, our -- I don't know the answer to that question.

(Laughter)

MR. AMIN: So our current process is that we can't bring a completely new measure to a conference call for when we're reviewing comments. So we would have to have another phase of this work. And we have another

submission deadline that's for phase III already which is already funded. So, which is only in a few months.

MS. WILBON: Yes, we could potentially -- that could be potentially an opportunity to bring the measure back. We're accepting a dental measure during that even though it was initially spec'd for a pulmonary.

Because of the uncertainty in terms of when we're getting funding for different types of topic areas we are allowing others with measures ready to submit while we have an opportunity to do so. So I do think that could be something, could be an opportunity to do that.

In terms of the standing committee I think this is one example where our processes haven't yet caught up with our funding structure and funding models. So we are setting up our structure to be able to review measures on a more consistent basis but our

funding hasn't quite caught up with that. So while we do have a standing committee we don't yet have the structure to keep that work going on an ongoing basis.

So, we do have funding right now to have the committee continue to work for the next phase of work into probably early next year. But we're still kind of working out how that work will continue. So it's an evolving conversation. But just for those of you that have questions about the standing committee versus the project.

DR. LATTS: Okay. So Carolyn has been very patient. I have Carolyn, John, Matt, Cheryl and Mary Ann. So Carolyn's up.

MS. PARE: Well, Lisa, you asked a lot of the questions that I was going to ask. It feels to me that the NQF has been particularly nimble and adaptive around some of the things that we wanted changed to make this process better.

And I think that as evidenced today

in the discussion that we had I think there was some really rich conversation that helped inform our understanding and our perspectives on this.

I recognize that a lot of us are disappointed in terms of this moving forward, but I think we've learned a lot more about it.

And rather than go back and take a re-vote because we're disappointed in the outcome I would like to challenge NQF to see if there is some way that they could let the measure come back sooner rather than later. Three years feels, and I'm not a big process person, but three years feels a bit arbitrary to me. And perhaps because we are redefining how we work through this consensus process this can be something that we can redefine. And we have a great opportunity to do that right now.

I do think, personally I think the measure does need some work yet. But does it need to go away for three years? Probably

not.

MR. AMIN: Clarify. The three-year -- there's a three-year maintenance cycle which is why we kind of have these three-year cycles.

But this committee will be reconvened in a few months. So there will be another opportunity to submit.

Now, whether the developers will be ready at that point is a whole nother question. But NQF is ready to look at this measure in a few months.

So I just want to make that clear. We're not saying that we won't look at this measure again for three years. That's not -- we're not saying that. And in fact there's good reason to believe that this committee will meet much more frequently than that.

But again, as Ashlie described, we also have the limitation of our funding. And given where we are with funding in general it's challenging.

DR. LATTS: All right. John, did you still have a question or did you ask it earlier?

DR. RATLIFF: Just one other -- a couple of other issues. Some of the things that came up just for the developers.

I mean, the readmissions were brought up by multiple speakers as being a potential issue and that the measure does not seem to be capturing as it's presently stated the impact of readmissions in congestive heart failure care.

Also, that almost provides a perverse incentive to not provide high-quality outpatient care and to have very sick inpatients.

I'd also say, kind of echoing the last commenter, if the standing committees will allow the developer to bring back a modified version of this at our next in-person would that be acceptable to you, Evan, and to our NQF team?

DR. LATTS: Hang on, John, there's whispering.

DR. BERNHEIM: I think we have some understanding of where the concerns are around the measure. But I don't have a lot of -- I mean, people are talking about a modified measure. And I don't want this committee to have to become a measure developer, but aside from having clinical data which is a different measure completely and not feasible in any way for awhile it's not clear to me -- the question was could we come back in three months and the answer is it depends what people are asking for.

We can do additional analyses on this measure but it's not clear to me that we -- I mean we, again, we understand I think for the most part the concerns and we respect them. And we feel like it stands despite some limitations.

I haven't heard oh, if you just took care -- got rid of 428.03 we'd believe in

this. Like sure, we could come back in three months with that. So I don't know how to answer that question because I don't know really what this committee is looking for that we can do. Except test it further. Except respond to the insufficient evidence which we can try to do.

DR. LATTS: Matt.

MR. MCHUGH: So my question was about the insufficient component. And maybe, I think Andrea, maybe you brought this up as an example.

There are some things that could probably be done that wouldn't necessarily change the measure but would provide more certainty about -- move maybe some of those insufficients to a more definitive response. So I think that seems like it's kind of the flavor. It's a matter of what process allows for that.

DR. ASPLIN: Like what though, Matt, exactly? Would it be the type of additional

validity testing that was done on the mortality?

DR. LATTS: Okay, Cheryl, then Mary Ann, then Bill. Oh, comment. Evan.

MR. WILLIAMSON: I just want to make one process clarification as far as just clarifying that the measure doesn't die right now.

Basically we don't put out measures for public comment traditionally. We have another section called Measures Not Recommended. So this measure would be a measure not recommended which could still go out for public and member comment as part of the report.

And then as part of our committee process is following the public and member comment period the committee can reconsider any measure based on the comments received. And part of those public comments can be additional analyses by the developer, can be any comments from anybody.

And so I just want to make sure that that's clear, that this measure isn't going to go away from this project, that there's still opportunity based on the Measures Not Recommended comments.

DR. LATTS: So we could send it out for public comment? Because I thought we couldn't if it wasn't in the 40 percent.

DR. BURSTIN: All of it goes out for public comment, we just don't tend to get as much comment on things not recommended by the committee. That's all. But it is in a comment --

DR. LATTS: Why would people waste time on commenting --

DR. BURSTIN: It will be in the report saying not recommended. We could specifically draft the report to invite comment if there are, again, some specific issues you want the public to weigh in on.

DR. LATTS: Cheryl.

MS. DAMBERG: I think this is more of

a general comment because per your schematic here, rate as insufficient, it feels like that's sort of a deal-breaker no matter what when you're looking at any of these measures, when in fact I think it's the committee's desire to have more information to be able to fully evaluate a measure.

And so based on the scoring algorithm that sort of down-weights everything. So, it just feels peculiar as a process.

DR. LATTS: Mary Ann?

MS. CLARK: I guess -- I mean, I totally agree that this is important, heart failure, to measure.

I guess my issue is with the procedures, the patients that are getting procedures in their index event because those are obviously going to be more costly.

And it seems like in the case of heart failure that patients who may be candidates for some of these procedures may be different from patients who are more being

managed medically and they happen to have an acute admission for heart failure.

For example, again, the valve replacement patients are more typically in aortic stenosis. Maybe not your typical heart failure patient. And of course anyone who gets a procedure, especially those that have implantable devices are going to be much more costly. So facilities that are doing these procedures I would think would be -- have higher costs. So, those are not being accounted for in this measure, right?

DR. KIM: It's Nancy Kim. I think I can respond to that. Can I respond to that? Okay. Yes.

So, when we looked at things like cardiac defibrillator implant without cardiac cath, with and without major complication as well as permanent pacemakers, in our development and validation cohort they make up about 1 percent of our total cohort. They are expensive but they're relatively -- they're

very infrequent.

And that is something we would have to look again over time because heart failure management is changing over time.

And those aren't accounted for in the way I think that you're talking about in terms of risk adjustment. So you're correct in that.

But you know, in heart failure because it is so dynamic over time one thing internally we are discussing is whether or not we need to look at risk adjustment variables every year. Because if we find year-to-year differences that may be something we have to reevaluate.

So it's not something we're ignoring. We understand that procedures are increasing in heart failure patients over time. And for heart failure in particular compared to something like AMI. We are cognizant of the secular changes over time in average heart failure patient management.

So we know about the procedures, we know they're expensive and we are thinking a lot about how to manage those.

DR. LATTS: Okay, Bill, then Nancy -- I'm sorry, go ahead.

MS. CLARK: Just a follow-up. Sorry. So, the LVAD patient population then was larger than some of these other patient populations that got procedures and that's why they were excluded?

DR. KIM: They were not excluded on the basis of size. They were also small. I can give you that number in a moment. But they were excluded on the conceptual basis that they were extraordinarily expensive.

So yes, it was the TEP input for both transplant and LVAD. That came from our TEP, not this NQF TEP. As you know, in the course of development we have a technical expert panel as well and it was their suggestion that we exclude LVAD and transplant patients.

MS. CLARK: Okay.

DR. LATTS: All right. So, Bill, then Nancy. And then I think we are going to vote on whether to re-vote. So we'll go the democratic process.

DR. WEINTRAUB: So I'm going to address the question you pose about are there things you can do. And I think there are clearly things you can do.

Remember, you're also not home free on the AMI measure because that was in the indeterminate range. And so more work may be needed there along the lines of things that we've suggested like looking for cardiogenic shock, hemodynamic instability. You can do the same sort of thing with heart failure as well and I would urge you to do that.

The other things you can do is look for external databases to validate. In particular, for AMI there is a wonderful external database, the set of databases from the ACC, CathPCI and ACTION and your group has experience working with these databases.

So that's, you know, it's time-consuming, it'll be some expense, but it's a straightforward process to try and do some validation work.

I don't know heart failure, the guidelines databases as well as I do the NCR databases but I would look at that very carefully to see if it's going to help you in validation for your heart failure measure.

And we don't have to come up with everything you can do right now. As you think about it undoubtedly with the leisure of time you'll come up with other really good ideas of things you can do to try and validate what you've got and improve what you've got.

DR. BERNHEIM: Absolutely. I mean, the group has been tremendous at suggesting potential validation approaches. And we actually had under way trying to do a chart validation. As you said it takes time and money and so it's not done for the AMI measure.

I was speaking more to when people said bring the heart failure measure back differently. We've heard lots of suggestions for further validation. We hadn't heard as concrete suggestions of sort of changes to the measure itself. So I wanted to know if those were unspoken but obvious.

DR. WEINTRAUB: Well, so I actually like the idea of a heart failure -- admission plus 30 days. I think that that's relevant. It doesn't cover everything in heart failure. You can't with one measure. But I think the measure itself, the idea of the measure is a good one.

DR. LATTS: Nancy.

MS. GARRETT: So, in terms of kind of additional ways that this could be looked at one thing I want to throw out is this whole problem of accurately controlling for patient status and patient severity.

Going back to the DRG one way you could do that is to control for the DRG. That

changes the measure quite a bit conceptually.

But we have a prospective payment system for inpatient stays. And by all accounts it's reduced costs dramatically for hospital stays because hospitals are incented to be as efficient as they can.

That doesn't account for choices of procedures but it's so conflated with patient status is it really fair to not control for that. So, that's just another thing to consider.

DR. LATTS: All right. If there are no other comments then I think we will indeed vote on whether or not to re-vote.

So, again, if nothing we said has been convincing then, you know, and you're not intending to change your vote I think probably vote no. Matt. Yes. You're right. If you're going to change your vote one way or the other vote yes. Yes. Yes, exactly. Matt?

DR. RATLIFF: Can my dog vote?

(Laughter)

DR. LATTS: I think we'll just do a straight up and down yes/no.

MR. WILLIAMSON: Okay. We will now vote on whether or not to re-vote on validity.

DR. LATTS: So press yes if you would like to re-vote.

MR. WILLIAMSON: You have two options, yes or no. You may begin voting now.

And we have 11 yeses, 9 nos. So we will re-vote.

Okay, so we will now re-vote on validity. Okay, and now we will vote on validity. So this is subcriteria 2b. You have four options, high, moderate, low, or insufficient. And you may begin voting now.

And we have all the votes. And we have 9 moderate, 6 low and 5 insufficient. So actually we -- we now pass.

DR. LATTS: It's now in the 40 percent.

MR. WILLIAMSON: It now passes this

as lack of consensus.

DR. LATTS: So it's still -- a majority still vote no, but it continues on. There continues to be discussion. And it will go out for comment with a lack of consensus.

DR. BURSTIN: Only on validity. Just a reminder.

DR. LATTS: I don't know about you guys but I need a drink now.

MS. WILBON: We'll need to continue the discussion on usability and use and feasibility tomorrow. Because it now passed we continue to evaluate the remaining criteria.

DR. LATTS: We can just do it now.

MS. WILBON: Oh, I'm sorry. I forgot you guys are out of town. Yes, I guess we're digging in.

DR. LATTS: It's better to do it when people are tired and hungry. Does anybody have any more comments they want to make on feasibility? All right, call the question.

MR. WILLIAMSON: We will now vote on feasibility. You have four options, high, moderate, low, or insufficient. Begin voting now.

And we have all the votes. And we have 16 high and 3 moderate.

DR. LATTS: So usability and I think, Nancy, you had had a comment early on for usability. So if you want to re-raise that.

MS. GARRETT: So, my comment on usability is around using this for actually moving money around between providers. And I have concerns about that because of the fact that we don't all feel that the severity adjustment is substantial enough.

And really what's the right direction here. So if you're going to give it stars is higher better or worse?

And we talked about a scenario, for example, with heart failure with more -- if you're successful at doing this well in the outpatient setting your inpatient costs might

actually go up.

And so I have concerns about that. And I wonder as a committee if we would want to make a recommendation about how this is used, and that it's really used for exploratory analysis and conversation and not necessarily -- and actually not for pay-for-performance.

MS. DAMBERG: I would second that. I think we don't know enough about this measure to put it into widespread use.

And I think unfortunately we have sort of this large catalog of measures without a lot of guidance in terms of how it should be used or what kinds of cautionaries to put out there with the measure.

DR. LATTS: Lina.

DR. WALKER: I agree with both Cheryl and Nancy. I think it's too hard to say whether up or down is better. And the last thing we want is for providers to stint on care and make things worse because they're

graded on how much they're spending. And that may not be the right measure to be using. So I absolutely agree.

MS. GARRETT: So just a process question. Can we make such a recommendation?

DR. BURSTIN: It's a great question. It's really one of the cornerstones of what we're going to be working on this year is do we actually move towards having different levels of endorsement for different intended uses.

At this point we don't have that. We do have the capacity of committees to at least put forward implementation guidance as part of their recommendation. So, it could certainly come with that recommendation. Certainly as part of public comment that could be part of the dialogue.

MR. AMIN: Yes. And one of the other things that Ashlie's pointing out here is that this committee also can make some recommendations to the Measure Applications

Partnership that's specifically tasked with the work of recommending particular measures for particular applications.

And they reviewed this measure in their pre-rulemaking activities and -- they recommend pending endorsement. So they recommended it pending the decision of this group.

So Dolores can take it back to the MAP with the guidance that comes from this committee in terms of caution around -- or I don't know if this is in your workgroup or not, Dolores. But we will bring it back to the MAP in terms of the concern about using for payment purposes.

DR. LATTS: So Dolores, it's 100 percent your responsibility now.

(Laughter)

MS. YANAGIHARA: And I just want to be clear that I actually stepped down from the MAP. I did, sorry. So I'm not on the MAP anymore.

MS. GARRETT: Would it make sense to do a quick vote on this so we can just see where people are at? Because if we make a recommendation we want it to be that people feel comfortable with it.

MR. AMIN: What I'm hearing in terms of the recommendation is that we should get some experience with this measure. It should be paired with a measure of quality and there should be caution in using the measure for payment application. Is that correct?

MS. GARRETT: I was actually saying stronger, that we recommend it not be used for payment purposes.

So, I think it could be useful for understanding from a provider's perspective what care happens after the hospitalization, forming those community partnerships, understanding how to do things more efficiently. I think those kinds of -- even public reporting I can see.

But you're actually talking about

moving dollars around. Then there's a value for -- high or low has to be better or worse and that's where I think we get into trouble.

DR. LATTS: So, from a process perspective would this be something that would be part of the recommendation now before it goes out to comment? Or would that be something that would be part of a recommendation in sort of our final vote?

DR. BURSTIN: It's a little bit of process in flux. So I think you can do it however you would like. But keep in mind at least for this very moment we endorse measures for all intended uses.

You could certainly add that caution if that's the will of this group to use with caution for certain uses and that information can get transmitted back to the MAP.

We could put it out as part of the draft report for comment and get commentary from the broader member and public about their perceptions of intended uses of this measure

as we provide that feedback back to the MAP.

DR. WONG: I don't think there's anything dramatically different about this measure than any of the other ones in the portfolio around resource use that would lead me to say don't use this one for payment. But you can use these others.

I think it's the same cautionary tale across the portfolio and the need to pair them with good measures of quality and other measures of performance.

I mean, 40 percent of the variability on this is post-acute and a big driver of that is readmissions which we've already sort of collectively said, although there's debate on that too. Things that we hope to avoid.

So, I guess I wouldn't go as far. I don't agree with you, Nancy. I usually do but I don't this time. I would say it's a cautionary note. I wouldn't say don't do it though because we have to pair it with quality across the board.

DR. LATTS: So, here's what I would propose as we're getting pelted by stones over there. That is there a way to put it out for public comment, to put this particular thing out for public comment as well? That there's been some question about how this should be used and get comment. And then when it comes back to the committee it's considered.

Because frankly, if we're still a majority don't endorse it anyway. So, it might never even get to the we endorse it to even be having this discussion.

MR. WILLIAMSON: I will say that this entire discussion will be captured in the report and that all goes out in public comment. So this will be definitely reflected in the report.

DR. LATTS: Great. Okay, that said, any other comments before we go to vote on usability? People are hungry. All right, usability.

MR. WILLIAMSON: And so we have two

votes remaining, first for usability and use and then an overall recommendation. We will now vote on usability and use. You have four options, high, moderate, low, or insufficient. You may begin now.

And we have all the votes. And we have 4 high, 10 moderate, 6 low and 1 insufficient. It passes usability and use in the lack of consensus range.

We will now move on for -- or I guess we'll open it up.

DR. LATTS: All right. Any final comments before we go to an up or down vote? All right, overall suitability.

MR. WILLIAMSON: We will now vote on overall suitability for endorsement. You have two options, yes or no. Please begin now.

And we have all the votes. And we have 10 yes and 11 no. The measure -- we did not reach consensus on whether or not it reaches -- meets the overall suitability for endorsement so the measure will be indicated

as a lack of consensus.

The measure evaluation portion of the section. We will now open it up for public and member comment. We do have one comment in the chat.

And the question is is it within the standing committee's authority to make recommendations on use to the MAP. And this is from --

DR. BURSTIN: It's from CMS. Yes, this is Helen. I'm happy to take a crack at that.

Again, it's not so much a question of authority. I think it is more an issue of just this is the group assembled to make the scientific determination about a measure.

We have been routinely passing on that information as we did as part of the readmission discussion recently at the MAP, as well as other issues. When scientific issues come up at the MAP they do frequently defer it to the co-chairs of our committees as well as

the committees for their recommendation.

It is not certainly firm in stone that this is absolutely what this group is saying, but I think it is part of the implementation guidance that our endorsement side does frequently put out for measures like this. So thanks for the question.

MR. WILLIAMSON: Do we have any public or member comments in the room? Operator, could you please open it up for public and member comment on the phone?

OPERATOR: Thank you. At this time if you have a question or a comment please press * then the number 1 on your telephone keypad. And there is no public comment.

MR. WILLIAMSON: Great, thank you. Before we adjourn for dinner I would like to point out one document that we've posted onto SharePoint in advance of tomorrow's discussion of measure 1558.

As you know this is a maintenance measure. We did pull out the evaluation table

from the previous report, the previous technical report. That was posted before, but just to really call it out. And we added that to the measure document set.

So, just a little homework assignment overnight. If you would like to brush up on the last evaluation just in advance of tomorrow's evaluation. That is posted and available should you choose to have a look at it.

I believe that concludes the business of the committee for today. We have a reservation at McCormick & Schmicks which is just really right around the block from your hotel. And that is at 6 o'clock but feel free to head over there whenever you'd like to unwind from today's activities.

MS. WILBON: And I'd just like to thank the committee and the developers actually for being such troopers today. It was a really long day and you guys did a great job so thank you. And those of you that

stayed on the phone all day, goodness gracious. Thank you.

(Whereupon, the foregoing matter went off the record at 5:33 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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Before: National Quality Forum

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was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter