

NATIONAL QUALITY FORUM

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

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WEDNESDAY

MARCH 5, 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, Intralignt*
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
EUGENE NELSON, DSc, MPH, Dartmouth Institute
For Health Policy and Clinical
Practice*
JANIS ORLOWSKI, MD, MACP, Association of
American Medical Colleges
CAROLYN PARE, Minnesota Health Action Group
JOHN RATLIFF, MD, FACS, FAANS, American
Association of Neurological Surgeons*
ANDREW RYAN, PhD, Weill Cornell Medical
College
JOSEPH STEPHANSKY, PhD, Michigan Health &
Hospital Association*
THOMAS TSANG, MD, FACP, Merck
LINA WALKER, PhD, AARP - 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
ANN PHILLIPS, Project Analyst
ASHLIE WILBON, RN, MPH Managing Director,
Performance Measurement
EVAN WILLIAMSON, MPH, MS, Project Manager,
Performance Measurement

ALSO PRESENT:

BENJAMIN N. HAMLIN, MPH, NCQA
BOB REHM, MBA, NCQA
ROBERT SAUNDERS, PhD, NCQA

* Present by teleconference

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

(9:02 a.m.)

MR. WILLIAMSON: Good morning, everyone, and welcome to Day 2 of the Cost and Resource Use Standing Committee meeting. I want to thank everybody for joining for us today and thank everybody for their participation yesterday. I think we had a productive day with some strategic discussions as well as measure evaluation.

At this time we'll turn it over to our co-chairs, Brent and Lisa, and we'll take care of a few disclosures this morning and then do a quick recap of yesterday and then dive right in.

DR. ASPLIN: Very good. Thank you, Evan. Good morning, everyone. I'd like to welcome Tom Tsang, good to see you. And I wonder if you could introduce yourself to the committee, and if you have any conflicts disclose those for us.

DR. TSANG: Yes, this is Tom

1 Tsang, executive director at the Merck Medical
2 Information and Innovations Group, but no
3 disclosures.

4 DR. ASPLIN: Great. And everyone
5 else was here yesterday, I believe. Are there
6 any committee members that are attending by
7 phone that did not have an opportunity
8 yesterday to declare any potential conflicts
9 or disclosures?

10 MR. NELSON: Gene Nelson is on the
11 phone, and I was not able to attend yesterday.

12 DR. ASPLIN: Welcome Gene. Do you
13 have any disclosures for the committee?

14 MR. NELSON: Let's see, yes. I'm
15 at Dartmouth, at the Dartmouth Institute, and
16 we do a great deal of research on costs and
17 the value of care. I am a founder of a
18 quality measurement company which sometimes
19 includes value assessments and reporting
20 that's called Quality Data Management. And I
21 think those are the major potential conflicts.

22 DR. ASPLIN: Thank you Gene, I

1 appreciate that. Has that company done any
2 evaluation on any of the NCQA measures or
3 specifically the measure that we will be
4 discussing this morning?

5 MR. NELSON: No.

6 DR. ASPLIN: Great. Any questions
7 from committee members for Gene or Tom? Any
8 updates or announcements this morning before
9 we get started?

10 From a housekeeping standpoint,
11 Evan, one question I had was has the dates for
12 the next in-person, have those been
13 communicated?

14 MR. WILLIAMSON: Yes, we will be
15 discussing the next steps and committee
16 timeline at the end of the meeting today, but
17 all the dates for Phase II and Phase III have
18 been set. So we'll go over those and make
19 sure everybody's aware of the responsibilities
20 for the committee.

21 DR. ASPLIN: Very good. Sounds
22 good. With that we are going to move forward

1 this morning with a quick overview of the day.
2 I think we've completed our recap. We have
3 the NCQA measure in front of us, have time for
4 public and member comment following our
5 consideration of the third measure, and then
6 this afternoon we'll have kind of a
7 continuation of the dialogue we began
8 yesterday morning around the future direction
9 for cost measurement and what Phase III for
10 the project will look like.

11 Again have opportunity for member
12 comment and public comment and discuss the
13 timeline before adjourning. So that's the
14 outline for the day, and let's get started.

15 So with that we have Measure 1558,
16 the Relative Resource Use for People with
17 Cardiovascular Conditions from NCQA. This is
18 an endorsed NQF measure that is up for
19 reconsideration by the committee.

20 On the phone with us today from
21 NCQA we have Ben Hamlin. Ben, welcome.

22 MR. HAMLIN: Thank you.

1 DR. ASPLIN: Great. Are there
2 other representatives that would like to take
3 a seat at the table here? Introduce
4 yourselves.

5 MR. WILLIAMSON: Ben, this is
6 Evan. Has the phone line issue been resolved?

7 MR. HAMLIN: Yes, I think it was
8 just some feedback from one of the other
9 members. It's fine now.

10 MR. WILLIAMSON: Okay, great.
11 Yes, just let me know if at any point the line
12 goes out or you can't hear us.

13 MR. HAMLIN: Okay, thank you.

14 DR. ASPLIN: Evan, could you look
15 at the list of committee members that are
16 online for everyone so we know who all is
17 online?

18 MR. WILLIAMSON: Absolutely.
19 Right now, logged into the webinar we have
20 Ariel Bayewitz, Gene Nelson, Joe Stephansky,
21 John Ratliff, Larry Becker, and Mary Ann
22 Clark.

1 So Gene, I know you weren't on
2 yesterday, so we'll go over a bit of a process
3 step here. There is a chat feature associated
4 with the webinar that we are using kind of as
5 a virtual placard raising if you would like to
6 speak. So just send the leaders a message at
7 any point you want to make a comment and we'll
8 let you know that you're in the queue. So
9 that's how we'll handle the remote
10 participation.

11 MR. NELSON: Sure.

12 MR. WILLIAMSON: We also have
13 voting set up through the webinar, and I'll
14 discuss that before the first vote just to
15 make sure we go over that again. I know we
16 have some new members in the room here as well
17 as on the webinar. So we'll make sure that
18 everybody's clear as to what the voting
19 process is. So thanks for that. We'll turn
20 it back over to Brent.

21 DR. ASPLIN: Great. And so for
22 this measure, first we'll have an opportunity,

1 Ben, for you to introduce yourself and
2 colleagues here that are with us in the room.
3 We'd ask for a brief introduction, an overview
4 of the measure, and if we could keep that
5 introduction at a high level and less than
6 five minutes that would be great.

7 We then have two lead discussants
8 from the committee, Andy Ryan and John
9 Ratliff, who will give their assessment of the
10 comments that the committee submitted online
11 prior to the meeting, highlighting areas of
12 both agreement and potential disagreement.

13 For Andy and John, we're going to
14 do that by category. So we'll start with
15 importance to measure, then move through
16 scientific acceptability, feasibility and
17 usability. And then of course Bill will again
18 represent us from the TEP.

19 And with just the sheer discipline
20 that we demonstrated yesterday of keeping our
21 comments to the section that we're voting on
22 we'll move through the rest of the sections

1 this morning.

2 Good. Very good. So Ben, my
3 understanding is that you'll be taking the
4 lead, so if you could take a moment to
5 introduce yourself and then we'll have your
6 colleagues in the room do the same.

7 MR. HAMLIN: Sure. I am Ben
8 Hamlin and I am the director of Performance
9 Measurement at NCQA and I'm also the project
10 director for the Relative Resource Use Measure
11 Domain and Efficiency Measures at NCQA.

12 MR. REHM: Hi, my name is Bob
13 Rehm. I'm Assistant Vice President for
14 Performance Measurement at NCQA.

15 MR. SAUNDERS: I'm Robert
16 Saunders. I'm Assistant Vice President for
17 Research and Analysis at NCQA as well.

18 DR. ASPLIN: Great. Welcome, and
19 I'll turn it over to Ben. Great, thank you.

20 MR. HAMLIN: Okay. So our
21 Relative Resource Use for People with
22 Cardiovascular Conditions measures how

1 intensively health plans use resources in
2 managing their members with a specific list of
3 cardiovascular conditions identified through
4 claims.

5 This measure uses standardized
6 prices that are published by NCQA, actively
7 creating a process by which health plans can
8 compare their total annual resource use to
9 their own peers in a meaningful manner.

10 NCQA receives aggregate data
11 submitted by plans which is verified by NCQA
12 certified auditors, and then NCQA uses all
13 plan submissions to calculate national and
14 regional benchmarks for all plans in addition
15 to individual specific plan benchmarks for
16 each of the service categories that are
17 displayed for the RRU measure.

18 This enables health plans to
19 understand how their own resource use for
20 their members with chronic disease compares
21 both to their peers and also to others across
22 the U.S.

1 NCQA presents the observed
2 resource use data along the calculated
3 benchmarks for each service category for each
4 plan, and that again allows them to compare
5 their observed resource use to the calculated
6 benchmarks.

7 The national and regional results
8 for each plan are presented alongside a HEDIS
9 quality composite in order to create a value
10 equation that the plan provides to their
11 members with chronic disease.

12 We found these measures are of
13 increasing interest to consumers and employers
14 and government programs, helping them identify
15 the best value and the high quality care
16 that's delivered most efficiently and cost
17 effectively.

18 So I'd be happy to answer any questions
19 that the committee may have.

20 DR. ASPLIN: Thank you, Ben.
21 Appreciate that. I think we will have plenty
22 of questions as we move through, so unless

1 there are any quick, high level issues I'd
2 like to hear probably first from Andy.

3 And Andy, if you could focus on
4 the Importance to Measure section that would
5 be great.

6 MR. RYAN: Sure. So the committee
7 -- I think there was wide agreement that this
8 is a high priority area. It's important to
9 measure with respect to opportunity for --

10 DR. ASPLIN: Andy, could you move
11 your mic just a little closer, please? I'm
12 sorry. Thank you.

13 MR. RYAN: Sure. With respect to
14 opportunity for improvement, I think there was
15 general agreement that the developers'
16 explanation was okay. There was some question
17 about there not being evidence about variation
18 in performance across plans.

19 There was a couple points made
20 that there wasn't data from the point at which
21 the measure had originally been endorsed a
22 couple years ago. All the data shown were

1 quite old.

2 And then there were other
3 questions about the fact that the measure is
4 intended to be at the plan level and having
5 some, this was throughout the comments, but
6 raising some question as to whether, you know,
7 assessment at the provider level would provide
8 greater potential for improvement. That had
9 been mentioned.

10 And then also there wasn't
11 information on disparities shown from the
12 developers. Those were points that were made
13 with respect to importance, but these -- my
14 read wasn't that these were huge problems,
15 just kind of requests for more information
16 from the developer.

17 DR. ASPLIN: Very good. Thank
18 you.

19 John, do you have comments around
20 the Importance to Measure, Measure Intent, the
21 first category?

22 DR. RATLIFF: I think that

1 summation was very good. At least from our
2 comments there was uniform support for the
3 priority of the measure.

4 With regards to the opportunity
5 for improvements, one of the commenters did
6 note that using unit of analysis in the health
7 plan might be suboptimal and using that
8 information with regards to assessing
9 providers would be kind of getting one step
10 away from the level of measurement that you
11 desire with regards to the intent.

12 And both with regards to the
13 intent and other aspects, there were multiple
14 commenters that brought up data and how this
15 plan has been used over the two years that
16 it's been endorsed, what's been learned from
17 using the measure or what kind of improvements
18 have been engendered because of the measure.
19 That was brought up in multiple sections of
20 the commentary from the standing committee.

21 DR. ASPLIN: Thank you, John.

22 Bill, do you have an overview from

1 the TEP's perspective?

2 DR. WEINTRAUB: I do. And once
3 again I think the best thing to do would be to
4 display the document that shows the TEP
5 summary and that response. And I probably
6 went through it a little too fast yesterday so
7 I'm going to slow down just a little bit.

8 The very last portion of it really
9 gets to validation and we come back to the TEP
10 at that time. In each, where there was a
11 question, there was also a developer response
12 which I can either summarize or it might be
13 better to have the developer comment as you'll
14 see it before you. Page 4, middle of Page 4,
15 there we go. Okay.

16 So the first one, based on stated
17 intent to what extent is the measure
18 appropriate? And there the TEP quite simply
19 felt that the measure was clinically
20 appropriate.

21 MR. HAMLIN: I'm sorry, could you
22 repeat that? Your words got garbled.

1 DR. WEINTRAUB: Okay. Sorry, I'll
2 try again. Can you hear me okay now?

3 MR. HAMLIN: Yes, just the last
4 sentence.

5 DR. WEINTRAUB: Okay. The TEP
6 agreed that the measure population was
7 clinically appropriate.

8 MR. HAMLIN: Okay, thank you.

9 DR. WEINTRAUB: Okay, next. Next,
10 to what extent will the definitions to
11 identify the population clinically consistent
12 with the intent? The TEP was concerned that
13 not all applicable diagnosis codes identifying
14 the population intended were included. And
15 you can see the developer response.

16 Do you want to comment or shall I
17 summarize? Want me to summarize? Oh, go
18 ahead.

19 MR. REHM: Ben, do you want to, do
20 you have any summary on the diagnosis
21 question? I think we supplied the value sets.

22 DR. ASPLIN: Ben, this is Brent.

1 If we could just have Bill finish the whole
2 TEP summary, and then I'd like to vote on the
3 importance and then we're going to walk
4 through.

5 Like most measures, I think, we're
6 going to spend most of our time in the case,
7 probably, with the reliability and section of
8 scientific acceptability along with validity,
9 and so we can have a lot more back and forth
10 in that section.

11 DR. WEINTRAUB: Would you rather
12 then that I summarize the TEP response just to
13 move this along?

14 DR. ASPLIN: Yes, why don't you
15 finish the TEP responsibility and then we can
16 move forward.

17 DR. WEINTRAUB: I mean the
18 developer response to the TEP points, so for
19 the second one, the developer response
20 adoption of ICD-10 codes and updates would
21 address this and the TEP agreed.

22 Okay. The third one, to what

1 extent does the measure accurately describe
2 the evidence, and the TEP agreed with the
3 developer's logic and grouping claims. They
4 felt that the exclusion of cardiovascular
5 patients with HIV or cancer was of some
6 concern.

7 The developer's response that the
8 exclusion was based on disproportionate
9 resource use and a plan with a larger number
10 of cancer patients will have results capped
11 out, and overall that the TEP was satisfied
12 with the response.

13 Okay, fourth question. Given the
14 condition being measured, describe the
15 alignment of the length of episode. The TEP
16 felt that that was appropriate. Fifth
17 question. Describe the clinical relevancy of
18 exclusions. TEP was satisfied with that. Do
19 the exclusions represent a large number of
20 patients? The TEP requested more detail, and
21 the developers said they will present
22 distribution data to the committee. So I

1 trust that we will see that today.

2 To what extent is the rationale
3 for clinical exclusions adequately described?
4 There was some concern that the measure of
5 patients excluded from the measure that we're
6 still using resources and a plan that refuses
7 to pay for those resources could appear to be
8 performing better but it was beyond the scope
9 of the evaluation.

10 The developer responded that this
11 issue is being handled through NCQA
12 accreditation standards, and so I'll just
13 leave it at that.

14 To what extent are relevant
15 conditions represented in the codes? The TEP
16 was concerned that not all applicable codes
17 were included, and the developer's response
18 was to reevaluate on an ongoing basis.

19 The next one, to what extent are
20 covariates included? And that really gets to
21 validation. Why don't we come back to the TEP
22 at the time? That's much longer.

1 DR. ASPLIN: Thank you very much,
2 Bill. I appreciate that. And we're just
3 going to move forward with the first four
4 votes in our evaluation of the measure, and
5 then likely get to the heart of our discussion
6 here.

7 So the first question, importance
8 to measure and report. You see the question
9 in front of you. And this section relative to
10 this measure is open for discussion. Dolores?

11 MS. YANAGIHARA: I'm not exactly
12 sure when to bring this up, but I just have a
13 question for NCQA. You know, many people
14 commented on the value of bringing this
15 measure together with the quality measures,
16 but because of the change, the recent change
17 in the LDL guidelines and the recommendation
18 by NCQA that's out for public comment to
19 remove the LDL screening and control measures,
20 I'm just wondering what your thoughts are and
21 what the quality measure would be that would
22 be paired with the resource use measure.

1 MR. HAMLIN: So the quality
2 composite is comprised of all current HEDIS
3 cardiovascular measures that are eligible for
4 public reporting. And so any modifications to
5 the LDL measure or other quality measures
6 would be reflected in this quality composite
7 should they be approved by our committee on
8 Performance Measurement.

9 So it should be up to date as of
10 the next publication of the HEDIS measures if
11 those changes are approved.

12 DR. ASPLIN: Ariel, is your
13 question relative to importance to measure and
14 report?

15 MR. BAYEWITZ: Yes.

16 DR. ASPLIN: Great.

17 MR. BAYEWITZ: So my question, so
18 I don't debate that the relative resource use
19 for people with cardiovascular conditions is
20 high priority. What I just wonder about is
21 how important is it to evaluate this at a plan
22 level? And so when I see a lot of evaluating

1 plans I think about, you know, so quality
2 makes sense because the intent there is that
3 you think the plan themselves can do something
4 about it, you know, be it in their selection
5 of their network or in terms of their actual
6 engagement directly with the member or they're
7 setting up certain value based purchasing
8 programs with providers to manage that
9 quality.

10 When I see that resource use
11 though, I was just thinking so what do we
12 expect the plans to do about it? Assuming
13 that we say it's reliable and valid, do we
14 expect them to change medical policy around
15 certain resources so that we can limit
16 resources for people with these conditions?
17 I mean is that the intent of this?

18 Are we saying that we think that
19 they should help manage, you know, in terms of
20 the selection of their providers they should
21 have a more narrow network or kick some
22 providers out? And if it's the latter, if we

1 believe that it's the providers that control
2 more of the resource variability, then I would
3 think that we would really need the ability to
4 drill down one layer below this and to be able
5 to evaluate providers.

6 It doesn't have to be physicians,
7 but even relatively mid-size organizations.
8 And it just seems from reading through the
9 documents that that was not in the scope here,
10 that wasn't really possible.

11 So I guess my question again, it's
12 not that relative resource use for
13 cardiovascular conditions is not meaningful,
14 but I do question how meaningful it is for a
15 purchaser or a consumer to see this.

16 And just even, you know, and one
17 step beyond that for a purchaser, when a
18 purchaser is looking at plan quality that's
19 one piece. When they're thinking about the
20 next piece, I think from a purchaser
21 standpoint they're really interested in cost,
22 right? What's it going to cost me? Again, I

1 don't know if they're thinking medical policy
2 or provider network there around the resource
3 use side.

4 MR. HAMLIN: So I mean, I think
5 the reason these measures have come into play,
6 I mean these measures have been in development
7 for some time, was the fact that up to the
8 point of where these measures were available
9 the only thing the purchaser had was, you
10 know, the cost of the benefit they were
11 purchasing. There really was no additional
12 information that they had about the value the
13 plan was offering for that cost.

14 You know, the reason that we use
15 standardized prices in these measures is
16 because there's so much market variation and
17 there's so much variation to cross contracts
18 within each plan, in order to try and create
19 a plan-to-plan comparison metric you do need
20 to address a little bit of that without
21 overdoing it.

22 And this was the approach that we

1 have found provides a way for plans to compare
2 themselves to their peers both on resource use
3 and on quality through the use of these
4 metrics.

5 We don't, through this approach,
6 I'd hate to say judge, but we don't judge
7 plans who have higher resource use in certain
8 categories, necessarily. You know, we just
9 basically present their data compared to their
10 peers in as detailed a fashion as conceivably
11 possible without being able to dive down into
12 some contractually prohibitive data that
13 creates issues for the plans.

14 And again, you know, given that
15 this is a national comparison strategy, we
16 wanted to be as relevant as possible given the
17 limitations of the measurement approach based
18 on the data available.

19 So we do not expect that plans
20 will be limiting resources based on their
21 results from this measure. What we do expect
22 plans to do is compare their resource use at

1 multiple levels to their peers and then drill
2 back down into their own data looking for
3 opportunities and cost opportunities to
4 improve, you know, based on the value that
5 they're seeing from these measure results.

6 These measure results are fairly
7 high level, I admit that, even though there
8 is a fair amount of detail in them. But
9 again, you know, this is a national plan-to-
10 plan comparison strategy that allows states
11 and employers to sort of understand how plans
12 perform against each other.

13 The plans themselves will have to
14 do the really heavy lift in drilling down into
15 their data to look for those opportunities
16 specifically.

17 DR. ASPLIN: Ariel, this is Brent.
18 I would just make a comment from the Twin
19 Cities market that the plans there have taken
20 architecture of this and similar measures and
21 gone to the next level and are reflecting back
22 to delivery systems, both the relative

1 resource index and also the pricing.

2 So that's happening in that
3 market. It's not the exact measure that's in
4 front of the committee today, but it's the
5 same architecture of that committee and that
6 has been very helpful feedback as a delivery
7 system leader in that market.

8 So I have Jack, then Andrea,
9 Carolyn and Dolores.

10 DR. NAESSENS: Brent, that comment
11 spoke directly to the question I wanted to ask
12 the developers which is clearly NCQA is geared
13 to comparing and providing information at the
14 plan level. That's the rationale for the
15 organization and its contribution in this
16 space, or at least one of its contributions in
17 this space.

18 But is the coding data, is the
19 methodology available to the plans to do
20 comparable analysis down to the group level,
21 the market level, the physician level so that
22 they can have the opportunity to do the kind

1 of drill-down we're talking about to make it
2 usable within the plan? Because you've
3 discussed that as one of the goals for the
4 plans in having the data available.

5 And to what extent do you know
6 whether they have been doing that?

7 MR. HAMLIN: So all of the
8 methodology that we use for the measure
9 calculation is available to the plans. We
10 provide them back as we mentioned, individual
11 benchmarks for each plan is calculated from
12 the data received so we try and provide them
13 as much information as possible.

14 I mean we do expect that the plans
15 would, because they have to map all of their
16 resources to the standard pricing they can
17 actually, effectively, use that same
18 methodology and plug in actual cost to do
19 their opportunity-cost calculations, and I
20 would expect plans to do that.

21 And we do hear stories, as I think
22 Brent just gave you, about different systems

1 that are sort of using this framework to, you
2 know, provide additional information. We try
3 not to be too prescriptive in how they should
4 be going about doing that.

5 We do try and offer some
6 suggestions and some stories that we hear back
7 and forth, and again we make our methodology
8 transparent and we publish, you know, again
9 all of our standard pricing tables and the
10 measure of methodology and all of that to try
11 and provide the systems as much information as
12 they possibly need.

13 There are several demonstration
14 projects where this has been applied to the
15 provider group level, you know, we do hear
16 some success. Because of the complexity of
17 the calculation it does require sort of an
18 organizational level, like NCQA approach, but
19 I do think that it is valuable if you drill
20 down.

21 And as we move forward we will
22 continue to investigate, you know, taking it

1 down to the next level if it is, in fact,
2 possible.

3 DR. ASPLIN: In fact, it might be
4 less valuable if we force them to take it down
5 to the provider system level, because doing so
6 we'd have to use the standardized pricing.
7 And one of the most powerful aspects of having
8 the conversation within the market is that
9 once they go below the level of the
10 standardized pricing they can use actual
11 pricing without disclosing what those prices
12 are, and that's actually very powerful in
13 those conversations.

14 Let's see. Andrea?

15 DR. GELZER: Thank you. We do
16 Medicaid-managed care and we're in about 14
17 states, and we're also, if the dual demo
18 projects ever start we'll be doing those as
19 well. So this measure, not so important in
20 the Medicaid population but hugely important
21 in the dual-eligible space.

22 And when I first, you know, was

1 reviewing it, and we don't use it a lot in
2 Medicaid, but when I was first reviewing it
3 for this committee I was thinking, well,
4 you're not going to see variation in a market.
5 You're going to see it market to market. So
6 I was trying to determine, well, is this
7 really even valuable?

8 But I think as, you know, we're
9 growing rapidly and a national company now.
10 And I think it's valuable to go into a market
11 when you have disparity from market to market,
12 this is, if I have this information, it's
13 valuable for me to go in then and have the
14 discussions with the systems and the provider
15 groups in the higher markets. So I do see
16 value to this measure.

17 DR. ASPLIN: Thank you. Carolyn?

18 MS. PARE: I think it's
19 particularly important to note that some of
20 the discussions we had yesterday around who is
21 your audience and who do these measures serve
22 right now, if you look at -- and I'll just

1 speak to the employers as purchasers.

2 There's not a whole lot of
3 transparency quality information for them, and
4 employers are always challenged with the fact
5 that they buy based on price and access and
6 never quality. And so NCQA's attempt to
7 somehow convey quality at whatever level they
8 can back to the purchasers allows the
9 purchasers to buy on some indication of
10 quality.

11 Now that's a point in time sort of
12 thing. If at some point we are directly
13 dealing with provider information and it's
14 transparent and clear for people, Brent talks
15 about the fact, and we talked about this
16 yesterday too. All the contracts are
17 proprietary and so plans and providers can't
18 disclose this information.

19 Until we have full disclosure of
20 the price and quality, we're going to have to
21 use some kind of proxy for these and that's
22 why this particular measure is so very

1 important because it allows right now the
2 purchasers to see quality at some level.

3 DR. ASPLIN: Thank you. John, did
4 you have a question?

5 DR. RATLIFF: Just a couple quick
6 questions for the developer following up on
7 the comments. The measure's going to be used
8 or is eligible for use with Medicare Advantage
9 plans in their Five-Star system for ratings?

10 MR. REHM: This is Bob.

11 MR. HAMLIN: Am I next?

12 MR. REHM: Ben, if you want to, go
13 ahead. But the RRU measure currently is not
14 in the Stars program.

15 (Off the record comments.)

16 DR. RATLIFF: Sorry, I'm off mute.
17 Sorry about that. I think the crackling was
18 me. So this isn't being used in Medicare
19 Advantage?

20 MR. REHM: We evaluate Medicare
21 Advantage plans in the RRU. We evaluate
22 commercial plans, Medicaid plans and Medicare

1 Advantage. But CMS decides what measures go
2 into the Stars rating and that is not one of
3 them yet.

4 DR. ASPLIN: Thank you. Ariel had
5 a follow-up question regarding the minimum
6 number of members per condition for the
7 measure to be meaningful, and specific with
8 the Twin Cities I don't recall whether the
9 number of members with each condition was
10 discussed.

11 We had enough attributed members
12 that it wouldn't have been a problem with this
13 one. Maybe some of the other diagnoses, I'm
14 not sure we met that threshold. But perhaps
15 the developer, we'd have to ask the plan, so
16 I'm not really sure how you would respond to
17 that.

18 MR. HAMLIN: So our minimum number
19 for this measure is 250 members. And for this
20 measure we had fewer problems with small
21 sample sizes than we do with some of the other
22 RRU measures, certainly.

1 MR. BAYEWITZ: What was the 2,000
2 measure reference that I saw?

3 MR. HAMLIN: I'm sorry, I don't
4 know what you're referring to.

5 MR. BAYEWITZ: In one of the
6 documents I thought it talked about -- I'll
7 take a look. I thought there was a mention of
8 a 2,000-member requirement, but I could just
9 be misremembering.

10 So it's basically saying you need
11 250 members per condition, and then based on
12 the prevalence of that condition you'd back
13 into what would be the necessary size of the
14 organization for you to evaluate them on this
15 particular measure. So yes?

16 MR. HAMLIN: Right. So we
17 validated the risk adjustment for this
18 specific measurement approach, you know, to
19 require to our level of comfort that the
20 organization have at least 250 members in the
21 eligible population in order to report the
22 measure, and that holds.

1 DR. ASPLIN: Thank you. Dolores,
2 do you have a follow-up?

3 MS. YANAGIHARA: Yes, I just
4 wanted to share that we have actually tested
5 this very measure at the physician
6 organization level in California and it does
7 work. Not all of the physician organizations
8 got results because they didn't have a large
9 enough population, but a majority of them did.

10 We ultimately didn't end up using
11 the measure in our program because we had
12 other utilization and cost measures that we
13 could use, but it definitely was of interest
14 to the plans to try to get to the next level
15 and, you know, our committees felt like it had
16 valuable information.

17 Like I said, we just had other
18 measures that we could use that gave more
19 information, but it does work at the physician
20 organization level.

21 DR. ASPLIN: Thank you. I would
22 like to call the question then on importance

1 to measure report 1(a), high priority. The
2 options are in front of you. High, moderate,
3 low, and insufficient evidence. And those of
4 you online, we'll set up the online voting,
5 and Evan, could you let us know when you're
6 ready?

7 MR. WILLIAMSON: So as a refresher
8 you have a vote-snap device. Please direct to
9 the laptop. It's a line-of-sight feature.
10 The numbers correspond to the responses. For
11 the webinar online you will see four options
12 appear when I change the slide. Please select
13 the appropriate response.

14 I will now vote on high priority.
15 This is subcriteria 1(a) for importance to
16 measure and report. You have four options.
17 You may begin voting now.

18 I believe we're still waiting for
19 one response in the room. If everybody could
20 please point their device again. One of these
21 days we'll get this right. Yes, there we go.

22 We have all the votes. And it

1 looks like we have an issue with our screen in
2 the room. So I believe we have 20 high and
3 two moderate.

4 DR. ASPLIN: For those of you
5 online we just have a little issue with the
6 screen resolution here. It's not a question
7 of whether we passed that.

8 All right, we're going to move to
9 1(b), opportunity for improvement.
10 Demonstration of resource use for cost
11 problems and opportunity for improvement.
12 It's the data demonstrating variation in
13 delivery of care across providers or
14 population groups. So open for comment.

15 Cheryl?

16 MS. DAMBERG: Yes, I was
17 struggling a bit in the documentation provided
18 because of the normalization that's done each
19 year. You noted that you can't actually trend
20 the information. So I was trying to figure
21 out how do you gauge whether a plan has
22 improved over time?

1 MR. HAMLIN: So the issues with
2 these measures are that we utilize all plan
3 submissions to calculate our benchmarks every
4 year. Also the standardized prices are
5 updated every year, and so those benchmarks
6 are basically dependent upon the plans that
7 submit and, you know, the prices.

8 And so in order for us to actually
9 track a single plan's improvement over time we
10 would have to hold a number of things
11 artificially constant in order to do that.

12 So again, this is a relative
13 snapshot of a plan's comparison in that year
14 to its peers and, you know, there are some
15 limitations to sort of tracking improvement
16 specifically at NCQA's level, but that doesn't
17 again prohibit a plan from going down to the
18 next level on their own and tracking their own
19 improvement in the services categories.

20 You know, there are some values,
21 you know, in the frequency of services
22 category that perhaps plans can watch numbers

1 change, but again whether they assess that as
2 a positive or a negative factor depending upon
3 how the rest of the designs that have links
4 together, that really is up to them to
5 determine.

6 MS. DAMBERG: So I'm just curious.
7 Has NCQA, I realize there are a lot of moving
8 pieces so it's hard to compare year-to-year,
9 but do you track whether plans actually do
10 shift positions? So, you know, maybe they're
11 above 1 for two years running and then they
12 shift below? I'm just kind of curious.

13 MR. HAMLIN: We do look at the
14 quadrant shifts for plans, you know, in annual
15 analysis and we sort of do a plan stability
16 analysis to, you know, to see. Around the
17 mean though, you know, it's difficult, because
18 shifting around the mean can be not really all
19 that relative. It's more of the larger
20 shifts.

21 DR. ASPLIN: Thank you. I have
22 Taroon, then Bill, then Lisa.

1 MR. AMIN: I just wanted to point
2 out based on Andy's comments yesterday about
3 the differences between maintenance measures
4 and new measures submitted. So opportunity
5 for improvement would be one of the areas
6 where we would expect to see data on the
7 opportunity for improvement with the measure
8 as specified.

9 And also I'll just point out for
10 reference that additionally the criteria for
11 around usability and use we would expect to
12 have some information about the measure in
13 use.

14 DR. ASPLIN: Thank you. Bill?

15 DR. WEINTRAUB: So this is pretty
16 tricky. Clearly we're spending too much money
17 in cardiovascular care. There are places that
18 we're doing things that we shouldn't be doing.
19 We also have tremendous healthcare
20 disparities, so some places we're spending too
21 little on healthcare.

22 And so what are our goals here?

1 Our goal is to spend less? Is the goal to
2 reduce variation between plans? Is our goal
3 to decrease disparities in care? And if we
4 reduce what we spend overall, how do we do
5 that without sacrificing quality, and yet we
6 had our discussion yesterday showing there's
7 not a very good relationship between what we
8 spend and quality. So I think there's
9 opportunity for improvement, but getting at
10 that, you know, and you have a good metric for
11 success, I don't think is a small task.

12 DR. ASPLIN: Thank you. Lisa?

13 DR. LATTIS: So my comments are
14 similar to Bill's. My issue with this measure
15 is always that I don't know what opportunity
16 for improvement means. Other than being
17 clustered around 1, I don't know if as a
18 health plan I want to be high or low.

19 As an employer maybe you say,
20 well, I want you to be low on this measure,
21 but as a patient I want you to be spending all
22 your resources on me if I need them. So it's

1 really far less about cost than
2 appropriateness.

3 So that's just, you know, I think
4 this is important. I think it's a piece of
5 the puzzle but, and again this goes back to my
6 comment from yesterday. We talked about cost
7 and quality. The third leg of the stool is
8 appropriateness, and we just don't know.

9 DR. ASPLIN: Thank you. Seeing no
10 other requests -- oh, are you good? All
11 right, I'd like to move ahead with voting on
12 Criterion 1(b), opportunity for improvement.
13 Evan, go ahead when you're ready.

14 MR. WILLIAMSON: We will now vote
15 on Criteria 1(b). I'd like to point out we
16 now have seven voting members on the web, so
17 the numbers will now be out of 23. You can
18 begin the voting now. And we have all the
19 votes. Okay, so we have seven high, 14
20 moderate, two low, and zero insufficient.

21 DR. ASPLIN: Thank you.

22 Next we have Criterion 1(c),

1 measure intent. Intent of the resource use
2 measure and measure construct are clearly
3 described. Any comments or questions? Seeing
4 none, let's go ahead with voting.

5 MR. WILLIAMSON: We will now vote
6 on Subcriteria 1(c), measure intent. You have
7 four options. You will begin voting now. And
8 we have all the votes. And we have 17 high
9 and six moderate.

10 DR. ASPLIN: And overall
11 importance to measure and report considering
12 all three of the votes we just took, Evan, go
13 ahead.

14 MR. WILLIAMSON: We will now vote
15 on overall importance to measure and report.
16 You have four options, high, moderate, low, or
17 insufficient, and you will begin voting now.
18 And we have all the votes.

19 DR. ASPLIN: We have some mystery
20 numbers for those of you on the web that
21 you're not seeing, but the bottom line is it's
22 a strong majority that have voted either high

1 or moderate. So we are going to move on to
2 the next category while we work through our
3 technical details here.

4 MR. WILLIAMSON: We'll pull the
5 numbers during the break and update the
6 record.

7 DR. ASPLIN: I think it's 21, or
8 22, excuse me, between high and moderate and
9 then one rated it as low. So it passes on
10 importance to measure and report. We'll get
11 those subcategories for you.

12 Next we're going to move forward
13 with scientific acceptability considering
14 both, the two votes, one on reliability, one
15 on validity. And we'll again turn to our lead
16 discussants. Andy, go ahead.

17 MR. RYAN: Okay. I would like to
18 verify that the documents submitted by NCQA,
19 the only one that has bearing on this question
20 is called SA Reliability, underscore -

21 MALE PARTICIPANT: Can you speak
22 up please?

1 MR. RYAN: -- from 2005. Is that
2 the only document that NCQA submitted with
3 respect to the reliability and validity of the
4 measure, the SA, underscore, reliabilities
5 and, underscore, validity from 2005?

6 DR. ASPLIN: That was a
7 supplemental -- go ahead, Ben.

8 MR. HAMLIN: Yes, that was a
9 supplement to the measure testing form
10 information that was included as part of that,
11 the 23 or 24-page document that was submitted
12 as part of the measure.

13 MR. RYAN: Okay, thanks.

14 All right, so to just give an
15 overview. I think the committee with respect
16 to specifications raised some questions about
17 risk adjustment and how this RRU-HCC risk
18 model differ from the CMS-HCC model in terms
19 of the comorbidities included.

20 There were, I think, it may be one
21 or two points raised about the specifications
22 with respect to the clinical diagnoses that

1 identified cardiovascular disease.

2 I think the largest issues were
3 about reliability and validity testing. I
4 think the kind of methods that the committee
5 is used to seeing that's documented in, say,
6 Algorithm 2 with a signal-to-noise ratio or
7 split-half correlation, the committee wasn't
8 satisfied with what was presented that it
9 showed reliability.

10 All I could see were standard
11 errors that were shown. And so I think
12 there's just a lack of information about what
13 they did to test for reliability. I think the
14 same thing with validity that there weren't
15 comparisons with other measures to show that,
16 or some, you know, external validation that
17 show -- resource use.

18 I think, you know, people thought
19 it makes sense. It has some face validity,
20 but in the extent of testing, I think, was
21 lacking. So that's how I would just quickly
22 summarize the comments of the committee.

1 DR. ASPLIN: Thank you. John, do
2 you have further comments for the committee
3 from your perspective?

4 DR. RATLIFF: I think that summary
5 of the committee's comments is extremely good.
6 I mean multiple different contributors borrow
7 from the fact that there was insufficient data
8 presented to develop an opinion as to the
9 reliability or validity of the measure. And
10 that was something that echoed through
11 multiple different commenters.

12 DR. ASPLIN: Very good. So we're
13 going to open up beginning with Bill. Do you
14 have comments, please?

15 DR. WEINTRAUB: From the TEP, if
16 you could pull up Page 5. That would help.
17 Okay, so our comments were very similar to
18 Andrew's, remarkably.

19 So there was concerns about both
20 reliability and validity. There was no R-
21 squared that we could find in the materials
22 that we were given. There was concern about

1 the risk adjustment models applied but not
2 validated.

3 The response beginning on Page 5
4 and going on to Page 6 is long and I don't
5 think I should try and summarize the
6 developer's response here. They should.

7 DR. ASPLIN: Very good. So
8 perhaps we could start with a comment and
9 response from the developers just in this
10 whole space about the lack of specific testing
11 and the concerns raised by the TEP and the
12 committee, and then we'll open it up for
13 dialogue.

14 MR. HAMLIN: Okay. So the
15 original testing for validity of the measure
16 was primarily, principally, outlined in the
17 document of 2005 and that's when the measure
18 was first, you know, tested for
19 appropriateness in this space.

20 The 2008 document that was
21 provided in the testing form, the information
22 there was when we did the validation of the

1 HCC model applicability and appropriateness
2 for the RRU. And that information, I believe,
3 was provided in the NERC measure testing.

4 These measures are tested
5 annually, so again our continued reliability
6 testing principally is around the
7 identification of outliers over the almost
8 1,000 plans that submit these measures to
9 NCQA.

10 And, you know, we look for
11 outliers. We look for errors in the
12 submissions through our audit process. And
13 we, you know, compare the results using fairly
14 extensive correlations, looking at the
15 different service categories to try and
16 identify any areas where the measures, you
17 know, don't conform to what we're seeing.

18 Unfortunately the limitations of
19 the amount of information we can provide
20 through the actual measure testing form, I
21 think, was scattered, and hence the number of
22 different, rather extensive attachments.

1 So again we can't do an individual
2 R-squared, our response, I guess, on the data
3 submitted to NCQA annually because we only
4 receive aggregate data from the plans that is
5 verified by the auditors. However, we don't
6 get patient level data submitted by the plans.
7 So, you know, it's because the individual
8 members are already included in the cohorts.

9 So again, we did test the
10 appropriateness of the HCC model at the
11 patient level using many simulations of
12 patient level data and that was, I believe it
13 was the 2008 document that was submitted. And
14 again, we utilized the HCC approach.

15 DR. ASPLIN: Cheryl?

16 MR. HAMLIN: It was developed by
17 CMS

18 DR. ASPLIN: Sorry.

19 MR. HAMLIN: -- the supplement
20 that was looking at the validation of the HCC
21 model to resource use measures.

22 DR. ASPLIN: Cheryl, before you

1 go, Robert?

2 MR. SAUNDERS: Sorry. Thanks.

3 The model, the testing that he's describing is
4 built off of the Optum data warehouse. And so
5 the underlying testing has information about
6 individual, has individual level performance
7 information, and so all the risk adjustment
8 testing has been done at that level.

9 So we will look through our
10 materials to see if that's available within
11 there to report out, but we've essentially
12 taken a model built off of that testing to
13 then apply across all the health plans that
14 submit to us.

15 DR. ASPLIN: Thank you. I have
16 Cheryl and then Lisa.

17 MS. DAMBERG: I was wondering if
18 the measure developer could comment on one of
19 the exclusion categories that you note. And
20 this was on Page 11 of your documentation. It
21 says the claim on the service was rejected
22 because it was missing information or was

1 invalid for some other reason.

2 And I wasn't sure that I saw in
3 your documentation what proportion of claims
4 fell into that category, because I could
5 imagine that could be quite large, and I have
6 some concern about setting aside those types
7 of claims.

8 MR. HAMLIN: So there is two parts
9 to that answer, I think. The first is the
10 HEDIS health plan accreditation standards
11 cover the processing of claims and the
12 approval of claims, and I'm not really the
13 person qualified to speak about the, in any
14 kind of detail about those.

15 However, all HEDIS reporting is
16 based only on claims that are in fact paid by
17 the plan, so that is the limitation that we
18 can work with as far as the submission. And
19 I would agree that perhaps there's some
20 additional information to be gained from those
21 others, but unfortunately those are not
22 accessible to us.

1 MS. DAMBERG: So you don't
2 actually know the proportion of claims that
3 fall into that category?

4 MR. HAMLIN: Actually we don't
5 have access to that information. It's only
6 available to the plan, because each plan's
7 different.

8 MS. DAMBERG: But do you know if
9 that varies across plans?

10 MR. HAMLIN: Specifically no. I
11 would expect over, nationally I would expect
12 they're similar enough, but I don't have the
13 data to make any kind of assertion in that
14 regard.

15 DR. ASPLIN: Thank you. Lisa and
16 then Nancy?

17 DR. LATTIS: So my question is
18 actually for NQF. Since this is a
19 recertification, do we, you know, so what's
20 sort of the expectation of the developers in
21 terms of testing?

22 Are they expected to do sort of

1 again de novo or can the committee accept what
2 was presented the first time around when it
3 was originally approved, or what's the sort of
4 expectation of the developer?

5 DR. BURSTIN: This has been an
6 issue we've talked about a lot. At this point
7 we have not required additional testing. We'd
8 love to see it, particularly when a measure's
9 out in use, but it's not something we can
10 really require. Especially when we recognize,
11 you know, three years sounds like a long time
12 to some of us, but in the world of actually
13 putting a measure into place, finding out
14 about its use, it's a lot quicker than we
15 think.

16 MR. AMIN: Well, I would just
17 clarify though we're not asking for updated
18 testing. We're just asking for, the level of
19 testing is exactly the same. So reliability
20 testing as we've seen should be consistent and
21 the same thing with validity testing.

22 You might expect that as the

1 measure becomes more mature additional
2 information will be available, but that's not
3 a requirement. But the level should be at the
4 absolute same, and this goes back to our
5 conversation yesterday. It should be the same
6 for maintenance measures and new measures
7 coming forward.

8 DR. ASPLIN: So, for
9 clarification, we should consider the whole of
10 the material that was submitted for the packet
11 that we reviewed along with the original
12 testing.

13 And if an individual on the
14 committee was going to determine that it does
15 not meet this criterion that would mean that
16 that person didn't feel like it crossed the
17 bar originally, correct? That's what I'm
18 interpreting your comments to mean.

19 MR. AMIN: Correct. However, the
20 requirement of the committee doesn't mean
21 that, there's no expectation the committee is
22 holding the same bar as the prior committee.

1 I just want to make that clear.

2 Just because the prior committee
3 may have felt that way doesn't mean that the
4 current committee needs to feel that way.
5 Everybody needs to evaluate what's in front of
6 you compared to the criteria that's in front
7 of you based on your own assessments of the
8 criteria. It's obviously an objective
9 evaluation, but there is some subjectivity to
10 how you weight these particular components.

11 So I'm not trying to sway the
12 committee in one direction or another,
13 absolutely in no way. But I just want to make
14 it clear that they should be held to the exact
15 same standard of the criteria regardless of
16 whether they're maintenance measures or not.

17 DR. LATTS: Was there other
18 testing then that was originally submitted, I
19 guess this is for NCQA, that was originally
20 submitted that was not submitted as part of
21 the resubmission?

22 MR. REHM: Ben, maybe you can

1 respond, but my recollection was that in the
2 original testing in 2005, which you have, was
3 the same testing we supplied two years ago
4 when all of our, we have four other RRU
5 measures that are NQF endorsed so that was the
6 same.

7 MR. HAMLIN: Yes, it was. I mean
8 the only additions were the reformatting to
9 the measure testing formally supplied. Some
10 of the additional analyses that we conducted
11 in more recent years based on the annual
12 submissions, but in a more limited fashion.

13 DR. ASPLIN: All right, we're
14 going to move to Nancy. Before that just to
15 follow-up to your question, Cheryl, from Ariel
16 online said, medical policy varies by plan so
17 the rejected claims volume could vary. I just
18 wanted to note that for your question.

19 Nancy?

20 MS. GARRETT: So a question for
21 NCQA about risk adjustment and socioeconomic
22 status and sociodemographic factors. So you

1 provide evidence in the documentation that
2 there are potentially disparities by race, by
3 gender. I don't see anything specifically
4 about socioeconomic factors, but I would
5 imagine that's possible as well.

6 So you're risk adjusting in the
7 models for gender, if I'm understanding this
8 correctly, and technically that's the current
9 position of NQF is that should be stratified
10 for rather than risk adjusted for, although
11 there's a committee looking at it right now
12 and that's probably going to change.

13 So can you just talk through that
14 a bit? It looks like also there is the
15 possibility of stratifying at the health plan
16 level by gender. That there's a way to report
17 it separately even though you're risk
18 adjusting for it. So can you talk about that
19 a little more?

20 MR. HAMLIN: Yes. So the current
21 measures are, the HCC risk adjustment approach
22 basically predicts utilization and that does

1 take gender into account. However, we do ask
2 the plans to -- I'm sorry. We do ask the
3 plans to submit the age and gender cohorts
4 because we do actually report out the
5 benchmarks by age and gender cohorts.

6 So effectively the age and gender
7 are taken into account in the risk adjustment
8 approach, but we also then, we do report them
9 out in a stratified fashion by risk cohort.

10 So I don't know if that answers your question
11 or not. We do not collect --

12 MS. GARRETT: So what does it mean
13 to report in a stratified fashion if you've
14 already adjusted for it?

15 MR. SAUNDERS: I'm sorry, Ben, let
16 me jump in. We report the strata back to the
17 plans, but when we're releasing information it
18 is all at the plan level for the performance.

19 So like you said, it wouldn't make
20 sense to have sort of the age group strata if
21 you're adjusting for age, but it's a part of
22 the math. We're still calculating all those

1 observed-to-expected at each of the cohort
2 levels just as part of the nature of the math
3 of working with the dataset, but is really
4 reported out is the health plan level
5 information.

6 MS. GARRETT: Okay. So I guess
7 the question for the committee is whether
8 people have any concerns about that. And then
9 kind of my follow-up question is around other
10 sociodemographic factors that are related to
11 resource use, so things like race, ethnicity,
12 language, education, income.

13 What are your thoughts on the
14 relationship of that to these outcomes and
15 whether the committee should consider
16 recommending that the results be stratified in
17 some way given that right now the NQF guidance
18 doesn't allow for the risk adjustment up
19 front?

20 So it's kind of a question -

21 MR. HAMLIN: We continually test
22 the request data from health plans about their

1 consistency and completeness of their
2 socioeconomic, SES, race and ethnicity
3 factors, and then unfortunately it's too
4 highly variable across plans right now for us
5 to require it.

6 We've heard from some plans that they're
7 actually actively not collecting that
8 information for legal reasons, and so
9 therefore there's problems there.

10 I agree that all of those factors
11 could affect, you know, and do affect,
12 probably, the resources used and the
13 opportunities for resources used. However,
14 there are limitations in the data for us to be
15 able to actually stratify these measures by
16 those factors at this time. And we are paying
17 close attention to the current SES and
18 sociodemographic risk group discussions.

19 DR. ASPLIN: Okay, I have Janis
20 and Andrea and then Cheryl.

21 DR. ORLOWSKI: So I have two
22 comments and I believe that they're both

1 directed at NQF. Since this is a re-up of
2 something that has already been approved, I
3 think it might be helpful for us to take a
4 look at what we would expect to hear about the
5 use of this during a three-year period of
6 time.

7 We might look into what questions
8 have been raised either to the developer or to
9 NQF during the period of the time, if there's
10 any evidence of its use within the medical
11 community, any concerns that have been raised
12 about the appropriateness.

13 So there's likely a way that we
14 can track this and then require some update
15 having to do with the use of the measure, the
16 concerns that are raised with the measure
17 during a period of time.

18 The second comment that I'd like
19 to make goes back to both the comments that
20 Bill and Lisa made regarding the goal. So
21 yesterday we spoke about whether or not it is
22 appropriate for us to make comments on should

1 the goal be higher, should the goal be low,
2 you know, where are you headed. And I thought
3 that those were very important comments
4 yesterday.

5 And so as you take a look at this
6 goal, and I recognize that we're not in the
7 position to do this so again it's a comment
8 for the committee to think about. As you come
9 up with a goal, I think that there's three
10 possibilities with this.

11 One is, you say there's no goal,
12 you know, it's unachievable and let the market
13 decide what happens. The second is to suggest
14 that there is some ideal utilization that is
15 appropriate, and I actually think that that
16 would be very difficult. I think it would be
17 very controversial, very difficult.

18 The third would be to take a
19 subset of cases that are within this goal and
20 then have an audited and peer reviewed
21 assessment of the appropriateness. And I
22 believe that you then begin to develop a group

1 of cases or an audited group within this that
2 becomes an ideal or, you know, at least
3 through what we currently believe is an ideal
4 management.

5 And so again, I don't know that
6 there's anything that we can do right now, but
7 I do believe that it is appropriate for us to
8 discuss how we would develop a goal and how we
9 would develop recommendations for the
10 appropriate use. Thanks.

11 DR. ASPLIN: Thank you. Andrea?

12 DR. GELZER: I just wanted to
13 respond maybe to Nancy that we, you know, as
14 a Medicaid managed care plan taking care of
15 all the vulnerable populations, I think most
16 Medicaid managed care plans do measure
17 individual level race and ethnicity data. And
18 I don't see why we couldn't do that with this
19 measure, and similarly use geocodings, surname
20 analysis to help fill in some of those gaps.

21 So I don't -- yes, go ahead.

22 MS. GARRETT: I think it's a great

1 point. And, you know, I don't think data
2 limitations should be a reason for us not to
3 make a recommendation, because making the
4 recommendation can help improve data -

5 DR. GELZER: Right.

6 MS. GARRETT: -- collection and
7 availability. And there are ways to do it on
8 an aggregate basis, especially for health
9 plan, using geographic analysis and things
10 like that.

11 DR. GELZER: Right. And certainly
12 if I'm submitting a measure, any measure, to
13 NCQA I would do that analysis to the best of
14 my ability, and I don't see why this would be
15 any different than any other one. That said,
16 I have a question to NCQA and the measure
17 developers.

18 So for those of us on this
19 committee who are struggling just a little bit
20 with statistical analysis and validity and
21 what is valid and what is not, why do you, I
22 mean you're hearing lots of discussion here.

1 I would just ask you guys to make
2 the case, why do you feel that this is valid?
3 Why does this meet the bar?

4 MR. HAMLIN: It's kind of a loaded
5 question.

6 DR. GELZER: I'm sorry. I'm sorry
7 but, you know, again I -

8 MR. REHM: And if I can just set
9 up, Ben, I'll let you roll with it, but great
10 question, Andrea. And I also want to come
11 back and talk, Nancy, about your question as
12 well. So should I do that first and then come
13 back to that?

14 You know, we developed a HEDIS
15 measure that was just approved a couple years
16 ago collecting race and ethnicity and language
17 from health plans that report to us as a first
18 step in achieving a future world, which is
19 exactly where I think we all want to go and
20 certainly where the IOM has told us we should
21 be going.

22 In the Medicaid and Medicare

1 population there are different challenges
2 around that data collection, but there are
3 less barriers there than there are in the
4 commercial population.

5 There are many regional barriers
6 about whether that is a cool thing to report
7 or not. Employers are very sensitive about
8 this. Both Lisa and Andrea were both very
9 involved in working on disparities reporting
10 with health plans back in the day, if you
11 will, and made great progress.

12 We're currently initiating a
13 project, I can't really speak too much about
14 it because it's not out there, but our
15 committee on Performance Measurement
16 identified this as one of the top cross-
17 cutting issues, getting to this, and
18 developing a plan around that.

19 And so I would just say we are
20 actively engaged in trying to take the next
21 step which is getting reporting. Would it
22 start with RRU? Probably not. It'll probably

1 start with something straightforward.

2 No measure's straightforward.

3 Breast cancer screening, cervical cancer,
4 something out there in the space that where
5 there's a quality gap and we want to
6 understand more about that.

7 One of the distinctions about NCQA
8 measures is that by and large we collect
9 things on Medicaid and we have to think about
10 that population and how we specify it. And we
11 do obviously Medicare Advantage plans and
12 commercial plans and divide commercial plans
13 into two types, for better or worse, HMO and
14 PPO.

15 So, you know, we are trying to
16 bring that level of the data down and we have
17 some tools available, and we think just
18 measuring race and ethnicity and language of
19 your membership even though it's not linked to
20 a measure is an important first step.

21 But I think we are very interested
22 in moving quickly towards the world that

1 you're trying to describe.

2 MS. GARRETT: And are you also
3 considering socioeconomic status in those
4 discussions?

5 MR. REHM: You know what, that is
6 a, I'm not going to say it's outside our pay
7 scale, it's that we really appreciate the work
8 that NQF is doing in bringing together folks
9 to take a look at that and come down with a
10 recommendation.

11 And if that recommendation, you know, is
12 X, then we're going to respond to that and
13 think through that and understand the
14 challenges and try to overcome them. That's
15 our lifestyle. We overcome measurement
16 barriers all the time.

17 Measures are not static. They're
18 constantly being refined. The very measure
19 we're looking at today doesn't even look
20 anything like it was when we had kind of
21 created it in 2005. It's changed a lot and it
22 will continue to change.

1 So back to Andrea's question, and
2 again I want to help set up Robert whose
3 analysis, and Ben who helped develop the
4 measure. If you take a look at the members on
5 our Efficiency Measurement advisory panel, I
6 think you'll see many of the people who are
7 really bringing cost and quality into the
8 national discussion.

9 I think just from a face validity
10 perspective and from the fact that every time
11 we put our measures out for change in the RRU,
12 measures changed enough in its life to have
13 gone through three or four public comments
14 through NCQA's 30-day public comment period,
15 we literally receive thousands of public
16 comments.

17 And so there's been a lot of
18 review. Even by the people who are burdened
19 with calculating the measure, this is not a
20 simple walk in the park. And they come back
21 to us and say, it's hard. It's a pain.
22 You've made it easier. You're providing us

1 valuable information back.

2 This is not a one-directional
3 measure. This is an interesting measure. We
4 shoot as much information back to the plans,
5 probably more than they're actually providing
6 to us because we can help interpret it and
7 give them national benchmarks back.

8 And so I think that from a
9 validity perspective, which is the question
10 you asked, Andrea, I think at one level, at a
11 fairly high altitude level, we believe this is
12 living in the true marketplace. If the
13 marketplace didn't like it, didn't find it
14 valid, they would have rejected it.

15 But that's just the high - Ben,
16 do you want to pick up on that?

17 MR. HAMLIN: I just wanted to add
18 to the fact that, you know, I mean, these
19 measures again were sort of initially
20 conceptualized in 2005 to address a very
21 specific need, and that was the fact that
22 there really was not a lot of information

1 about value.

2 I mean, I know that healthcare
3 costs continue to be in the national
4 discourse, and again we've heard about the
5 limitations about being able to do that.
6 These measures are constantly evolving. They
7 were not even publicly accorded or the
8 information was not available back in the
9 public sphere for several years.

10 I believe it was 2009 was when
11 this measure was first available for public
12 reporting, so it was, you know, a number of
13 years of development and then a number of
14 years of refinement. So even as a result of
15 the first evaluation by NQF for this measure
16 we made a number of fairly significant changes
17 based on that feedback.

18 So the biggest one was in our list
19 of inclusions where the committees, I don't
20 remember which level of committee, the
21 steering committee made a number of comments
22 about their concern that we were excluding at

1 that time ESRD patients who they felt were --
2 or, I'm sorry, patients in this cohort who
3 were identified with ESRD, and they felt, you
4 know, for the diabetes and cardiovascular
5 measure that was actually a pretty critical
6 component to be included.

7 And so we did go back and do some
8 additional testing and some research in our
9 large stock and database and determined that,
10 you know, that was, in fact, correct. And so
11 therefore we worked out a way to include that
12 in the iteration of the measure.

13 We are constantly looking to
14 include additional services. You know, we
15 have to ensure that the services that are
16 being priced and are being included in the
17 measure through our standard pricing tables
18 are, in fact, relatively reliably priced and
19 fair, if you will, to assign a price to that
20 service at the code level.

21 And we have been able to in the
22 last few years to add additional service

1 categories, the diagnostic laboratory and
2 diagnostic imaging, after some additional
3 testing that was, you know, found that we
4 could, in fact, price out the vast majority.
5 I don't want to say all of those services.

6 So again, you know, in receiving
7 feedback we are constantly making updates to
8 the measure to make them more relevant to the
9 audience that they are intended for which is
10 both the health plans to help them identify
11 their performance, if you will, against their
12 peers and presenting to the consumers, and
13 including consumers, employers and government
14 entities such as the state officials who are
15 interested in the report cards, and others
16 that, you know, they have the level of detail
17 that they need.

18 And so, you know, again we're
19 constantly revising, we're constantly re-
20 looking at the measures and looking at the
21 data that comes in to make sure, that is, the
22 measures still work for that specific

1 environment for which they were developed.

2 DR. ASPLIN: Thank you, Ben. Tom?

3 DR. TSANG: I have two questions
4 for the NCQA. Number one is, can you
5 elaborate a little bit more about the
6 conversion of ICD-9 to ICD-10 and the impact?
7 I know there's one statement here in the TEP
8 about annual updates of the value set and
9 implementation of additional codes would
10 address this issue, but I'm just wondering,
11 you know, the expansion of the number of codes
12 from ICD-9 to ICD-10, it's hugely significant.
13 And I'm just wondering if any of these
14 validity testing will be impacted by this
15 conversion. That's the first thing.

16 And then the second question is
17 really refinement of this measure and the
18 improvement of this measure, I'm wondering if
19 there's any distinction or differentiation
20 between correlation of these measures with
21 claim space quality measures versus this
22 measure correlating with eMeasures, clinical

1 eMeasures, and have you seen any difference in
2 those types of associations?

3 MR. HAMLIN: So to answer your
4 first question, NCQA for all HEDIS measures
5 has published the ICD-10 codes that are mapped
6 from the ICD-9 codes currently in the measure.
7 So the first part of that was to sort of try
8 and do the mapping and review.

9 We have an expert coding panel
10 that looked at that and performed that and
11 those ICD-10 codes were published alongside
12 those. That being said, we do an annual
13 review of our code list that identify all
14 these conditions for these measures and that's
15 based on both public feedback, expert
16 feedback, new codes being available, old codes
17 being retired and so on and so forth.

18 And so there's a whole process for
19 that. I would expect that, you know, given
20 the comments from the clinical committee that,
21 you know, with the increased specificity of
22 ICD-10 and the additional things that might

1 perhaps be included under our definition of
2 cardiovascular conditions could be expanded,
3 I would agree.

4 And I think we're going to closely
5 look at that as our comment, you know, I think
6 in that response said that, you know, we're
7 very interested in making sure that we're
8 including the appropriate eligible population.

9 We do have several sort of small
10 projects with individual organizations looking
11 at dual coding right now. So some
12 organizations have already started dual
13 coding, you know, to prepare for October of
14 this year, and we're working closely with them
15 to try and understand the effect it will have
16 on HEDIS measures. Unfortunately only time
17 truly will tell what the actual effect will
18 be, but I believe it's going to affect the
19 vast majority of people. Well, I know it will
20 affect the vast majority of people.

21 You know, we're hoping that our
22 caution in including new codes or in watching

1 this transition will pay out and that it's not
2 going to completely undo everything we've
3 developed in our latest portfolio.

4 With regard to eMeasures, NCQA is
5 intimately involved with both the measure
6 development and many of the meaningful use
7 programs and contracts both on the software
8 vendor certification side and also in eMeasure
9 development.

10 Currently the eMeasure
11 specifications and reporting programs are not
12 mature enough for us to truly be comfortable
13 with the data that's coming in. You know,
14 again the issues of whether we're reflecting
15 national performance or whether it's a data
16 submission issue, again these measures are not
17 in a full reporting program that's audited and
18 validated. You know, the stream of data has
19 not been validated and audited yet.

20 So we are very intimately involved
21 in making sure that the eMeasure specification
22 process is adhering to our standards of

1 transparency and scientific acceptability and
2 measurement reliability. However, the results
3 from eMeasure reporting are not significantly
4 mature for us to be able to look at the
5 correlations between measures derived directly
6 from clinical data to resource use at this
7 time.

8 I am sure that some systems who
9 have much more access to internal data and
10 have much more mature EMR platforms perhaps
11 are looking at that. But at the NCQA level
12 for the national reporting program we're not
13 able to do that at this time.

14 MR. REHM: Paul, just to
15 supplement Ben's comments. Just like we do
16 for all of our measures, we took three years
17 to essentially transition all of our coding to
18 ICD-10.

19 So we have about 100 measures out
20 there and we split them into three little
21 groups and spent a year putting them out. And
22 at each different cycle we put all of those

1 new code sets out for public comment. So I
2 just wanted you to be aware of that process.

3 DR. ASPLIN: Good. I'm going to
4 go to Dolores and then we'll have Taroon and
5 Ashlie make comments, and then we're going to
6 discuss the algorithm reliability, provided we
7 don't have other questions.

8 MS. YANAGIHARA: It's a quick
9 question for NQF, actually. Did these
10 guidelines for reliability and validity
11 actually exist when we endorsed the measure a
12 couple of years ago or are these new since
13 then? I can't remember.

14 MR. AMIN: So the guidelines for
15 evaluating reliability and validity existed.
16 The criteria for testing hasn't changed.
17 What, this algorithm has been developed by our
18 lead methodologist at NQF to help committees
19 be more standardized in their application of
20 the criteria.

21 I will also say, as you remember,
22 that was the first sort of cost and resource

1 use effort so, you know, I don't know how
2 familiar everybody was with the criteria so
3 that might be another input to consider.

4 MS. WILBON: I was just going to
5 add one more thing to Tom's question about the
6 ICD-10 codes. We don't currently have any
7 requirements around testing of the measure for
8 ICD-10 yet because of the limitations of the
9 data available to actually run measures on
10 ICD-10 data for those organizations that do
11 have the ability to dual code, which is not
12 very many have the resources to do that.

13 A lot of people don't have access
14 to the data to actually do the testing, so
15 that is not a requirement that we have yet,
16 just for the ICD-9. We request that they
17 submit them, but the testing, we haven't yet
18 made that a requirement yet.

19 DR. ASPLIN: Taroon, can you make
20 your comment and then actually walk us through
21 the whole algorithm?

22 MR. AMIN: Yes, actually that was

1 kind of where I was going to go as well. And
2 actually I wanted to frame it a little bit as
3 a question for the committee because I know it
4 was subtly addressed a little bit through the
5 lead discussants, and I know Cheryl sort of
6 made some comments to this effect too, but I
7 just wanted to be really clear about this.

8 I guess the question I have for
9 the committee is really, I think, you know,
10 there's some questions about Number 1 here
11 that the TEP has raised. But even Number 2,
12 I guess, in particular, can we have a
13 discussion about to the extent to which there
14 is empirical reliability testing that was
15 submitted in the attachment?

16 I know many of you have reviewed
17 all of the attachments, not just the testing
18 attachment, but what I've heard from many
19 members of the committee is that this is sort
20 of, there's a lot of descriptive information
21 and process information.

22 But I'm trying to understand the

1 level of empirical reliability testing because
2 that will have a very clear impact to where we
3 land on the algorithm.

4 MR. HAMLIN: Taroon, I may make a
5 comment to NQF that if you would like a lot of
6 detail on testing you should not limit the
7 testing form to 20 pages.

8 MR. AMIN: I appreciate that
9 comment, Ben. Thank you.

10 DR. WEINTRAUB: Taroon, I think
11 you summarized it well. It's mostly
12 descriptive data but not a lot of real
13 reliability testing.

14 DR. ASPLIN: Lisa?

15 DR. LATTIS: So Ben, in response to
16 that comment, then are there other data that
17 you have that were not shared as part of the
18 packet?

19 MR. HAMLIN: Outside of the
20 attachments that we can provide, I mean, we do
21 have, like I said, we do an annual analysis
22 that I believe we used as our testing, as a

1 good part of our reliability testing
2 information for the original submission.

3 And those are fairly extensive
4 correlations of the different categories both
5 to each other and to the quality side and also
6 the outlier analyses and the plan quadrant
7 shifting analyses that we do.

8 DR. LATTIS: Thank you.

9 DR. ASPLIN: Is there more
10 specificity from the committee about what you
11 exactly would have liked to have seen either
12 from the original testing or the annual
13 testing of the measure's performance that Ben
14 just described? Yes, and kind of a
15 qualitative description of it.

16 So from the original patient level
17 data reliability testing done in 2005 or 2008
18 we got summary information, but if there's a
19 lack of satisfaction what specifically,
20 especially those that have the methodological
21 chops here, what are you looking for?

22 Cheryl?

1 MS. DAMBERG: So I'm looking at, I
2 guess it's Page 32 of the documentation and it
3 talks about, this is in the reliability
4 section. It says an indicator of plan
5 stability over time is quartile movement of
6 O/E ratios with significant shifts having
7 implications about plan performance in terms
8 of resource use.

9 And then it says, for comparative
10 purposes plans that move less than one
11 quartile are considered stable. So it's very
12 descriptive and it doesn't give us a sense of,
13 you know, when they've looked at the data how
14 much shifting around is there.

15 And I think a table here that
16 would help people see how much movement there
17 is since, you know, this is their primary
18 means of demonstrating they have reliability.
19 So I think it's more the quantitative piece
20 seems to be missing here.

21 MR. HAMLIN: Are you interested in
22 the number of plans shifting or the magnitude

1 of each plan's shift?

2 MS. DAMBERG: Both. Yes, I mean
3 it would be helpful to know, you know, maybe
4 this isn't the right analogy here, but this is
5 the type of work that I do.

6 When I'm looking at a performance
7 measure, I look to see how many rank positions
8 any given provider moves depending on what I'm
9 doing in the analysis. And so if I see big
10 shifts, you know, that's more troublesome than
11 if I see shifts of like one or two rank
12 positions.

13 MR. REHM: Ben, if you can help me
14 find in the annual report, we provide to the
15 committee on Performance Measurement an annual
16 report on RRU. The last annual report was
17 about 80 pages. I can just show you the
18 graphics here. This is the data that doesn't
19 fit into 20 pages.

20 But Ben, which table includes the
21 quartile shift that Cheryl was asking about?

22 MR. HAMLIN: Well, again we only

1 provide the number of plans that shifted, we
2 don't actually provide the magnitude. And I
3 think that was the first part of her question.

4 MR. REHM: Right. Actually do you
5 have access to this? Taroon, was this
6 included in the packet that we sent you?
7 Okay, well, I could try to read the table
8 here. It shows the percentage of plans here.
9 You can validate this, the percentage of plans
10 that shift.

11 I mean, clearly we can provide you
12 this voluminous information. I think what it
13 tells you, it may not tell you exactly what
14 you're looking for but it answers the
15 question, are we exploring the detail each
16 year of the performance on the measure.

17 Are we looking at, in this case,
18 quartile shifts? What percentage of plans by
19 each plan type are moving and what's the
20 extent of that movement? Yes, we can answer
21 that question.

22 MS. DAMBERG: That's great. That

1 would be really helpful. Because I think part
2 of what we're trying to judge is to what
3 extent, where plans get classified is purely
4 random based on sort of the signal that's in
5 the estimate. But I suspect it's not, and I
6 suspect there's some stability but we weren't
7 able to judge that.

8 DR. ASPLIN: Thank you. Andy?

9 MR. RYAN: So Brent, just to
10 respond to your question. I think in the last
11 several submissions we've seen, and of the
12 reliability coefficients we've seen this
13 split-half correlation yesterday, and we saw
14 kind of shifts in groupings over time that
15 Cheryl just described. So I think some
16 combination of those things to provide
17 evidence of reliability is what the committee
18 would be looking for.

19 DR. ASPLIN: All right. Yes, go
20 ahead, Bob.

21 MR. SAUNDERS: I think one element
22 of that, I mean, so we definitely have the

1 beta binomial information. The challenge we
2 sort of run into on that is that with the
3 risk-adjusted measures that once we take out
4 all of those explanatory factors of the risk
5 profile of the patient it sucks away the
6 variation, and so the reliability kind of
7 naturally suffers on that. And so we don't
8 think that the beta binomial is sort of the
9 right choice for that.

10 I think where we would lean
11 towards as sort of thinking of we definitely
12 have the information about the proportion of
13 plans that are moving and how stable is
14 performance and so I believe we can provide
15 those percentages.

16 I think the other way that we
17 think about this is sort of what is a
18 meaningful shift and the observed-to-expected
19 ratio and thinking about sort of a criterion
20 based approach to can you distinguish the
21 folks that are above or below some threshold
22 as a way of thinking about that. But I don't

1 believe that that is in the testing materials
2 supplemental.

3 MR. AMIN: Okay, so Brent, to your
4 issue around the algorithm, I think the basic
5 question that we need to be focused on here is
6 effectively 2 and 3 of this, essentially to
7 the level of empirical testing we believe
8 that's been submitted. And we can think about
9 it broadly, you know, to recognize the concern
10 around the 20-page limitation of the
11 information that was presented.

12 And in our actual NQF submission
13 form, the developers have provided their
14 technical appendix which I know at least, I
15 mean, I'm sure the committee has reviewed in
16 particularly, the methodology folks that have
17 spoken on this particular issue as well have
18 certainly thoroughly reviewed.

19 So that's the complete information
20 that we've gotten from the developer. So as
21 you're making this decision you really should
22 be assessing essentially that question at this

1 point for reliability.

2 MR. SAUNDERS: Just real quickly,
3 they were able to pull up out of the table it
4 is between 89 and 94 percent depending on
5 which metric in the cost categories are in the
6 same quartile or move one quartile up or down.
7 There's not folks moving from the best group
8 to the worst group and vice versa.

9 DR. ASPLIN: Very good. Jack?

10 MR. NEEDLEMAN: I'm trying to
11 think about the issue and the challenge of
12 testing reliability in the NCQA context. And,
13 you know, what the reliability measure is
14 fundamentally about is about the stability of
15 the rankings in the face of data jitters.

16 And you do a lot of testing out of
17 your data warehouse at the patient level and
18 that'll tell you something about the stability
19 of the measure around, you know, how much
20 variance you get once you begin pulling
21 subsamples from that.

22 But at the plan level you don't

1 have the patient level data so you can't sort
2 of redo the plan. So I'm just wondering, you
3 know, thinking down the road, thinking about
4 going back to your data warehouse and creating
5 some synthetic plans out of that and then
6 playing around with subset analysis,
7 reliability testing around your synthetic
8 plans and seeing how much the relative
9 rankings shift and how much the score shift
10 might provide the kinds of information that
11 people here are asking for.

12 The year-to-year variations are
13 affected not only by the changes in the
14 patients, which is what we're trying to
15 capture with the reliability, but also by the
16 changes that the plans are doing in trying to
17 improve and we can't separate that.

18 Some stability is expected because
19 we expect plans to move slowly, and basically
20 the numbers you just gave us suggested that
21 that's what we're seeing. Small movements
22 consistent with change taking place slowly.

1 So it's comforting but doesn't
2 quite feel sufficient to really meet what's in
3 this rubric here that's on the screen. But I
4 think that's one of the challenges that we
5 have as a committee thinking about the
6 limitations and the way NCQA is collecting its
7 data and doing its analysis at the plan level.

8 MR. HAMLIN: One of the other
9 limitations to address that very point is I
10 don't think we would expect every plan, you
11 know, our assessment of quartile shift is at
12 a role of level of all individual data.

13 I mean, I would expect that plans
14 would not focus on each, so we provide
15 information back to the plans at each of the
16 individual service category levels and their
17 comparison to their peers on each of those
18 service categories.

19 And I would expect a plan to
20 probably focus on certain areas and not be
21 able to do everything at once overall because
22 that would just be unrealistic and probably,

1 you know, cost prohibitive.

2 So I do expect that plans are,
3 year-to-year-to-year, looking at each of these
4 service categories and comparing themselves to
5 their plans and seeing how they compare, you
6 know, to both their immediate peers and to the
7 mean, if you will, how far away they are from,
8 you know, that standardized mean.

9 But again, I think that's the
10 detail at which the plans then take this
11 template and go back to the, you know, to do
12 their own internal analyses, whether -- but
13 that's again beyond the level of what we can
14 actually do because of the level of
15 information that we receive.

16 So our plan database does actually
17 include actual plan data, so the database is
18 updated with, I believe it's about 60 or 70
19 health plans at the moment that gets, you
20 know, occasionally updated using the actual
21 plan data.

22 So we could theoretically retest all of

1 the assumptions we did in the initial testing
2 for appropriateness and validity for, you
3 know, things like risk adjustment to this
4 approach, however, that also is extremely
5 costly and given a lack of any other reason to
6 do so, you know, at this time, I think, again
7 with ICD-10 rollout we will definitely want to
8 go back and do that.

9 But I think until that data and
10 that experience from ICD-10 is mature enough
11 for us to be able to do that and in order for
12 our database to be populated with that
13 information it would be probably against our
14 own best interests to do so.

15 DR. ASPLIN: Bob?

16 MR. REHM: Thanks. Jack,
17 appreciate your comments. In some ways you're
18 asking the question, is this measure
19 different? And algorithm aside it could be
20 that it is different. But I do want to
21 provide the committee kind of a trajectory.

22 Out for public comment as we speak

1 are new standards, new measures for
2 accreditation in programs. We accredit a
3 thousand health plans around the country. And
4 in that discussion where we're really
5 revitalizing that measure matrix, but part of
6 that discussion was thinking about RRU.

7 And I think the challenge that we
8 faced as currently as reported and how we're
9 handling the data, the ability to -- oh, just
10 so you know, that when we accredit plans using
11 measures it's 50 percent of their
12 accreditation score and there's thresholds, 90
13 percentile, 10th percentile, 75th, mean,
14 median and all that stuff.

15 And we created benchmarks to apply
16 appropriate credit for better performance or
17 lower performance, and a key criteria for that
18 is being able to differentiate the very
19 performance you're asking us to prove to you
20 that we can differentiate.

21 And so I think that, now those
22 measures aren't in that public comment

1 because, one, we felt at a measurement level
2 that we need to let the ICD-10 stuff sort out
3 first. We don't want to be testing stuff
4 before that gets played out because that's
5 important.

6 Second, we feel that there's
7 techniques that we can apply, and whether it's
8 a virtual or a synthetic health plan
9 conglomeration where we can redo this stuff,
10 which is something we thought of and that the
11 trajectory again is to get to this ability to
12 benchmark, when we get to the ability to
13 benchmark, satisfying the algorithm or any
14 other kind of criterion is not going to be
15 hard at all because we'll have had to prove to
16 the field that we can differentiate that.

17 I think in so many ways this
18 measure is a -- speaking of signal-to-noise,
19 this is a measure that we're trying to signal
20 that value matters. We were early in the
21 field on this. The NCQA investment on this
22 measure, not that that matters, was over \$1

1 million. That's our own money, not anybody
2 else's. It's not a profit center.

3 So, you know, we're trying to
4 refine the measure all the time is why we do
5 this exhaustive annual report. Look at
6 correlations, try to uncover if there's
7 anything interesting going on that we can
8 latch onto that help us make it even a better
9 measure.

10 So I do think that if the measure
11 were to pass or go through and we're back in
12 three years that you would probably be seeing
13 something more refined than the measure you
14 saw two years ago. So I guess what I'm
15 talking about is there's a trend here and
16 we're interested in proving the measure and
17 proving to you what you would like to know.
18 And I appreciate the challenge.

19 DR. ASPLIN: Thank you. Janis?

20 DR. ORLOWSKI: So I understand
21 that this is a relative measure. My concern
22 is that the entire market could have dropped,

1 I know it hasn't, but could have dropped by 50
2 percent of actual dollars. And what we would
3 be looking at in this measure is the plans
4 would still look at each other in comparison
5 to are they spending less than other plans.

6 So it tells us where the plans are
7 relative to each other, but gives us no
8 information about a relative shift within the
9 market.

10 MR. REHM: So to the extent that
11 we're trapped, if you will, by standardized
12 pricing to the extent that this is driven by
13 RBSS or whatever, those things may be dipping
14 but they're probably dipping slower than the
15 actual market may be dipping in a particular
16 area around cost.

17 You're correct. In terms of the
18 health plan taking those data and then
19 basically tossing in their own cost data, then
20 that's meaningful. This is about a measure
21 that's not operating just in this space.

22 It's a measure that's operating in

1 this space and then moving down as Dolores was
2 talking about, their review of using the
3 measure at the provider level or, you know,
4 obviously ACOs are an area of great interest
5 and I would imagine would be working on that
6 as well.

7 So I think the U.S. knows that the
8 cost trend has been slowed. You know, we know
9 enough about the macroeconomics of this to
10 appreciate that. Some markets have great
11 transparency about what's going on. Others
12 don't. So it's a varied issue there.

13 So I mean, I think your point is
14 well taken that the storyline from almost a
15 policy level maybe the measure doesn't tell
16 you as much as you'd like to know, but at a
17 micro level it's probably more informative.

18 DR. ORLOWSKI: So during the last
19 three years, PCIs have gone to outpatient
20 almost, you know, 90 percent of them. Chest
21 pain, the first 24 hours is an observation
22 status. So there has been a dramatic shift in

1 what is paid for cardiovascular services.

2 And again, I think it's just a
3 point that what we're seeing is plans relative
4 to each other, but you don't see this shift
5 that has occurred because you're not taking
6 it. So I bring this up because again I think
7 the measure is what it is.

8 We understand that it's a relative
9 measure. It doesn't give us information about
10 a change in the market which has occurred in
11 cardiovascular disease, and again I think it
12 raises the issue of what the goal is.

13 MR. HAMLIN: So I think I would
14 like to make one point there. I think you
15 would -- so the standard pricing tables
16 actually are reflective of whether the service
17 was offered in an inpatient or outpatient
18 basis, and so there's an adjustment based on
19 the coding practices of that, you know, that
20 outpatient and inpatient services would be
21 effectively fairly priced if in a standard
22 manner.

1 The measure itself also is broken
2 down by inpatient and outpatient, so a plan
3 would see a reflection of shift in the market
4 from inpatient to outpatient services for very
5 specific areas, but certainly in procedures,
6 evaluation and management and so on and so
7 forth.

8 Those are individually reported
9 service categories within the RE measure. If
10 the entire market shifted in that regard, yes,
11 you probably would not see that shift in the
12 measure itself. However, you know, on a
13 national or even on an HHS regional basis, I
14 think that shift may have been a bit staggered
15 or a little bit longer, and I believe the
16 measures would probably pick those up
17 especially at the plan level. So I just
18 wanted to offer that additional information.

19 Also I think on the policy
20 context, you know, I think over the last few
21 years the fact that an increasing number of
22 plans choose to collect and report the RRU to

1 NCQA is significant in the idea that these
2 measures are, in fact, valuable to somebody.

3 DR. ASPLIN: Thank you. Lisa, I'm
4 going to give you the last word before we move
5 forward with a vote in reliability.

6 MR. WILLIAMSON: So two comments.
7 One is sort of in response to Janis's
8 question. I'm just a little confused by it
9 because it's not, what your question was
10 getting to, to my mind, is not what this
11 measure is at all designed to do.

12 And, in fact, we have lots and
13 lots of things that do what you were asking,
14 not the least of which is premiums which are
15 based on overall cost of healthcare, and now
16 especially in a post-ACA world we're limited
17 to an MLR of 85 percent. So we know exactly
18 what's going on with the overall healthcare
19 cost.

20 So to my mind, what this measure
21 is actually designed to do is something
22 totally different. We have actually a far

1 better handle on overall healthcare cost from
2 many, many perspectives than we do on relative
3 resources. So your question actually confuses
4 me a bit.

5 My question, my original question
6 actually was more towards NQF again. If this
7 committee were to say it's not passing
8 reliability and based on the testing
9 essentially that was done before the original
10 measure, does that reflect at all on the
11 original process?

12 And would it, I guess, and I'm
13 sure there's a more diplomatic way to put
14 this, but would it call into question the
15 inter-rater reliability, essentially, of the
16 process?

17 DR. BURSTIN: It's an excellent
18 question. There's no way for us to always
19 have a sense of our own inter-rater
20 reliability of course. I do think, you know,
21 the timing of the original report, and I know
22 the original work was done after our testing

1 task force was put into place where we had a
2 new report, we had raised the bar. It was not
3 very long after it.

4 So I think some of this is, you
5 know, based on guidance from many of you we
6 have continued to raise the bar. I think, you
7 know, as I mentioned yesterday is that we
8 recognize it as a real challenge for measure
9 developers to continue to test measures in
10 use.

11 And I think you've heard, you
12 know, from NCQA, there's a fair amount of on-
13 the-line surveillance in evaluation of the
14 measure. But I think I would more so just
15 focus in on sort of where we are right now.

16 I don't know whether there's
17 additional information that could be brought
18 to bear from NCQA that might influence that
19 decision, but certainly we afforded that
20 opportunity.

21 MS. WILBON: I would just add,
22 Lisa, that it was a different group of people,

1 and considering that there are many new
2 members on this committee and this is their
3 first time seeing the measure that I'm not
4 sure if you can really compare, because it's
5 not the same rater rating it twice. And so to
6 that extent is one of the reasons why we're
7 implementing standing committees so that over
8 time we have that consistency.

9 So I would rather us, you know,
10 not, I wouldn't worry about the previous
11 committee at this point. Let's just consider
12 this kind of ground zero going forward. If
13 this measure were to come back it would be the
14 same. You guys would still be the standing
15 committee.

16 So from that point I think we have
17 a better idea of whether or not this, you
18 know, the measures we're implementing to try
19 to maintain consistency are really working.
20 So I'll just add that.

21 DR. LATTIS: Yes, it's hard for the
22 developers, because, you know, from their

1 perspective, oh, this is what worked when we
2 brought it before the committee the last time.
3 And so it would seem to be a challenge from a
4 developer perspective to know what to bring
5 forth to the committee to meet the committee's
6 needs, sort of a priority.

7 DR. BURSTIN: And that's been the
8 work behind now having a measure developer
9 guidebook, trying to put these algorithms into
10 place. It's, you know, I will acknowledge
11 that it's certainly a work in progress for all
12 of us.

13 DR. ASPLIN: Nancy?

14 MS. GARRETT: So earlier I made
15 this proposal that we might want to consider
16 making a recommendation that this measure be
17 stratified by sociodemographic
18 characteristics. It sounded like Andrea had
19 some interest in that, but I'd like to know
20 what the committee thinks about it, and then
21 is this the right section to be talking about
22 that or is that in another place? Is that

1 under usability or --

2 DR. ASPLIN: It feels like a
3 usability issue. You know, recommendations on
4 how the measure be used, I think that would be
5 the section for that discussion.

6 Okay, there's only one way to find
7 out what's going to happen, because I can't
8 read what's going to happen. So let's move
9 ahead with the vote.

10 MR. WILLIAMSON: We will now vote
11 on subcriteria 2a for reliability. We have
12 four options, high, moderate, low or
13 insufficient, and you may -

14 We have all the votes. Yes, so we
15 changed the interim view so we could see all
16 the votes. It looks like we have 12, not 12,
17 18 moderate, we have two low and three
18 insufficient. The measure passes reliability.

19 DR. ASPLIN: And we are going to
20 take a break. We'll resume at 11:00. I'm not
21 going to say another word.

22 (Whereupon, the foregoing matter

1 went off the record at 10:48 a.m. and went
2 back on the record at 11:03 a.m.)

3 MR. WILLIAMSON: Before we get
4 started I'm going to read off the votes just
5 to make sure we're all clear. Hi everyone.
6 Before we get started again I want to make
7 sure that we read off the tallies that we've
8 voted so far just to make sure we combat those
9 technical issues we had earlier.

10 So 1a high priority we had 20
11 high, two moderate, zero low and zero
12 insufficient. For opportunity for improvement
13 we had seven high, 13 moderate, two low and
14 one insufficient. For 1c for measure intent
15 we had 17 high, six moderate, zero low and
16 zero insufficient.

17 For overall importance we had 12
18 high, ten moderate, one low and zero
19 insufficient. And for reliability we had zero
20 high, 18 moderate, two low and three
21 insufficient.

22 DR. ASPLIN: Very good. And then

1 before we move on to validity, I guess to Ben
2 and the developers, one question I would have
3 is since similar measures are coming this
4 committee's way and the same questions would
5 come up, a clarifying question. Would we
6 expect new testing prior to ICD-10 being in
7 place? I believe the answer to that question
8 was no.

9 And a related question would be if
10 the answer is no could we get a more complete
11 submission of the original testing and detail
12 that goes beyond the 20-page limit so that we
13 could dive into that prior to the subsequent
14 measures being discussed at future meetings?

15 MR. HAMLIN: I think the answer to
16 your first question is comprehensive testing
17 prior to ICD-10 would be no. And then the
18 answer to your second question is we are
19 certainly happy to provide additional
20 documentation that would fill in the back
21 story if you would like to request it.

22 DR. LATTIS: This is Lisa. Could

1 we also get that documentation for this
2 measure to this committee? Just the report
3 that you were reading off of.

4 MR. REHM: Sure. We can provide
5 you the annual report, and I think you
6 probably already have the original field test.

7 You know, I think you raise a good
8 point. Some of this is packaging. In many
9 ways this measure is context-driven and I
10 think you've captured that and appreciated and
11 understood that the submission form, the way
12 it's broken out it's hard to tell a story.

13 And we can certainly go back and
14 ask ourselves, okay, it's not exactly what we
15 thought would fit there but let's go ahead and
16 drop in the stability data, or we did
17 assessment of some of the risk adjustment
18 models, et cetera.

19 And so we'll do our best to
20 package that a little bit better for you to
21 make it easier. We do have three more
22 measures coming up in this space, so happy to

1 do that.

2 MS. WILBON: Also I would just
3 suggest we do offer technical assistance to
4 all developers, and it would be really great
5 to have an opportunity to, we do offer to help
6 developers kind of help package that material.
7 And so we would offer NCQA the opportunity to
8 meet before hand to make sure that we have the
9 most succinct information in there for the
10 committee before it's submitted.

11 DR. ASPLIN: Nancy, do you have a
12 comment on reliability or are you just ready
13 to roll on validity? Okay, good. So, you
14 know, there's always danger in interpreting
15 votes because there's probably 23
16 interpretations, well, there are going to be
17 23 interpretations of the vote. We're not
18 going to go around the room and describe them.

19 But so my takeaway from the last
20 vote is not that there's a great enthusiasm,
21 but rather that there's some degree of trust
22 that some of the testing had been done, and

1 also trust in the original committee's
2 decision looking in more detail at some of the
3 reports.

4 And so I guess my read from that
5 is that since some very similar measures are
6 coming our way that we would request that NCQA
7 not take the vote as a sign that we can have
8 the same discussion three or four more times,
9 and hopefully we could get more information on
10 the table so we can have a greater degree of
11 comfort.

12 So it's just an editorial comment.
13 Let's move forward with validity, and I'd like
14 to start first to see --

15 MR. AMIN: Brent, do you mind if I
16 make a few comments on that? So a few
17 additional comments that I'll make to the
18 committee. The first is as we put these votes
19 out to public and member comments, as we're
20 thinking about internal consistency between
21 this group and the prior, be very mindful of
22 the internal consistency between this measure

1 and the measures we reviewed yesterday. So
2 that's the first point I would just make.

3 The second is I would like to have
4 a conversation about the empirical testing.
5 If we go back to the algorithm, the only way
6 that this measure could have been rated
7 moderate is if the committee felt that there
8 was empirical testing.

9 The measure developers did present
10 this information. It would be an expectation
11 at least during the comment call that we'll
12 review this information again in terms of
13 actually having committee looking at this
14 empirical testing. Because based on our prior
15 conversation it didn't appear that there was
16 empirical testing that the committee reviewed.

17 So I'm assuming that the committee
18 was basing the empirical testing requirement
19 based on what was given verbally by the
20 developers by what's in their annual report.

21 The third thing which was sort of
22 highlighted and I'm just going to raise it

1 just to keep in mind is, you know, the
2 requirements that NQF puts together in terms
3 of the submission form limits, in terms of
4 page numbers, the format that NQF puts this in
5 is to ease the interpretability for the
6 committee to ensure that there's
7 standardization for the committee's time and
8 ensure that there's consistency across measure
9 developers.

10 So when we have conversation,
11 first of all, it's not within the committee's
12 sort of authority to allow for additional, you
13 know, more than 20 pages, but it is to have
14 the information in a succinct way for
15 interpretation and evaluation by the
16 committee.

17 So we could take back the
18 recommendations of the committee if they feel
19 that there was not information or not enough
20 space for developers to put this information
21 in.

22 But the way that we've set up the

1 submission form is standardized across all of
2 our measures and for our measure developers,
3 so we want to be respectful of sort of if
4 we're changing the requirements those
5 requirements have to be rolled out, and those
6 are understood and agreed upon by all measure
7 developers in terms of the submission form and
8 our criteria.

9 And this will be part of our
10 larger discussion, but since it's clearly
11 related to our prior conversation I just want
12 to make this really clear. A few members came
13 up to me during the break with the concern
14 that are we really, actually using this
15 algorithm in our decision making and, you
16 know, are people extrapolating their own
17 opinions about what needs to be done or the
18 importance of some of these components?

19 And I think, you know, that's a
20 reasonable consideration that the committee
21 should discuss amongst themselves, and if
22 there's a concern about any of the level of

1 the criteria also remember that those criteria
2 are applied across all measures, not just
3 measures across this committee but also across
4 NQF.

5 Clearly each person will make
6 their decision about how well these criteria
7 are met based on their own expert judgment,
8 however, particularly in this section of the
9 evaluation it's intended to be much more
10 objective.

11 So I would like to put all those
12 topics on the table before we get to validity,
13 and this is not just a conversation limited to
14 this measure by any means or this measure
15 developer by any means. But our role,
16 increasing role of staff is to make sure that
17 there's consistency and that we sort of have
18 this break period to say, okay, are we
19 comfortable with where we are particularly
20 when members of the committee are not
21 necessarily comfortable with where we landed.

22 And I think you should have that

1 opportunity to have a discussion with each
2 other about that topic.

3 DR. ASPLIN: Lisa and then Andy
4 and then Cheryl.

5 DR. LATTS: I want to comment on
6 Taroon's -- yes.

7 DR. ASPLIN: Yes, I guess we're
8 having another conversation first.

9 DR. LATTS: So I guess my question
10 based on that, Taroon, is that we've seen
11 three measures in front of the committee for
12 this phase, none of which had the empirical
13 reliability testing that the algorithm asked
14 for.

15 So I guess my question is either
16 there's a disconnect between what the
17 developers are being asked for and what we're
18 being asked to evaluate on, or what we're
19 asking for is not -- and I guess, I don't
20 know. Maybe we should ask Yale and NCQA to
21 comment on this, but why are we not getting
22 them what is being asked for? Because what

1 are we supposed to do as a committee?

2 I mean based on the algorithm
3 then, none of the three measures that we've
4 seen are, quote, unquote, high quality good
5 measures, and then what are we all wasting our
6 time here for, I guess, is my question.

7 MR. AMIN: Okay, so there's a few
8 different components there, and I think, you
9 know, the concern about high and moderate, I
10 think, is a level of interpretation.

11 But there's a particular
12 methodology, I think, and I don't know that,
13 I mean I can't speak to the committee, but
14 there were differences of opinion about how
15 much reliability testing was done between the
16 two measures. So I mean that would be
17 difficult for me to say.

18 But I will say that to the extent
19 there should be consistency around what we're
20 requiring in terms of methodology, and the
21 reason why that is is because we don't want to
22 set a bar in which some measure developers are

1 spending a tremendous amount of resources.

2 Again, this is not describing
3 anyone in particular, I'm just saying we don't
4 want to set a bar which some measure
5 developers are spending significant amount of
6 resources in terms of methodology and
7 statistical support and then others are not,
8 and there's, you know, irregular sort of
9 application of criteria.

10 Now if there's a concern about the
11 criteria, meaning that, look, reliability
12 testing is just not able to be done in cost
13 and resource use measures using administrative
14 claims data and we believe that that may be
15 the case or the current state of affairs in
16 this measurement domain, I think we need to
17 state that and apply that consistently across
18 all the measures that we're seeing here in
19 this project and going forward.

20 And try to, I mean obviously that
21 would raise another level of concern that we
22 should say, well, what are we going to do to

1 address that globally, and maybe we need to
2 put together a panel to give guidance around
3 this whole topic or reliability testing,
4 working with our developer colleagues to
5 understand the current state and the
6 challenges that there are of achieving the
7 actual criteria.

8 But those are two different
9 realities, and we just need to be really clear
10 and transparent about what we're doing.
11 Because what will end up happening through
12 this process is that you go through public
13 comment period and developers will feel that,
14 you know, if it's not applied consistently the
15 committee will have to address that through
16 the comment period.

17 And it's much more difficult to do
18 that once you have numeric values here that
19 we're supposedly using the criteria and the
20 algorithm to decide how we're making our
21 decisions. So if it really is the issue that
22 the criteria is too high of a bar then let's

1 have that conversation, not now but in our
2 afternoon session, and understand what to do
3 about it.

4 And we're totally open to that.
5 We can remove criteria if we feel it's too
6 high of a bar to, it's reducing innovation in
7 the field or it's redundant with other measure
8 developer processes or things of that nature.
9 We're certainly open to that conversation.

10 DR. ASPLIN: Very good. I might
11 not have gotten the order exactly correct, but
12 I've got everybody names that's got the card
13 up.

14 Janis?

15 DR. ORLOWSKI: So I recognize that
16 we had an opportunity to speak with the
17 developers on telephone conversations earlier
18 in the process, but what I would say is that
19 the conversations that we had yesterday and
20 today have been very rich conversations with
21 the developers. And they have influenced in
22 several ways how you view the data that has

1 been provided.

2 And I wonder if there wouldn't be
3 a more appropriate place for this discussion
4 rather than five minutes before the vote. And
5 so what I would say is that part of the
6 discussions and part of the votes yesterday
7 and today, I think, in a large part were
8 affected by information that was presented
9 immediately before the vote.

10 MR. AMIN: I know we're taking up
11 a little bit of time but this is really
12 important for our, this is broadly important.
13 Because one of the questions that we're still
14 struggling through with NQF is that our
15 typical approach prior to this phase of work
16 and our improvement work that, you know, many
17 of the folks here at the table and just
18 broadly have helped us think through is that
19 the submission form is what you're evaluating.
20 And that is what goes out to the public,
21 that's what the public has reviewed prior to
22 this deliberation.

1 And as you go forward, you know,
2 the information that's presented what we've
3 tried to capture and make sure that that gets
4 distributed as well, but it's obviously
5 challenging for the members to make comments
6 about the measures if all the information's
7 not in the submission form.

8 And so what we'll need to think
9 through is the fact that the process that we
10 have set up right now is supposed to be an
11 objective evaluation of the information that's
12 submitted in the actual submission form.

13 Now to the extent that there are
14 additional questions and there's additional
15 data that the committee wants to see that
16 could be addressed, obviously we're not
17 saying, you know, use blinders and that's not
18 relevant here.

19 But also I just want you to be
20 aware that the committee's deliberations are
21 part of a larger conversation that the
22 membership and public is part of, and to the

1 extent that we can that information needs to
2 be transparent and the main transparency
3 vehicle we have is the submission forms.

4 And that's why we ask the measure
5 developers, that's why we ask you to make it
6 very clear how the decisions are being made.

7 DR. BURSTIN: Just to build on
8 that one second, just -- sorry.

9 MS. WALKER: I asked a direct
10 question to that effect yesterday and you had
11 indicated that we are supposed to use all the
12 available information, which I did and I
13 assume everybody did.

14 Now I would say that on that
15 particular question during the webinar call,
16 I and others on the phone had explicitly asked
17 the developer to provide that information
18 because we felt that we needed it to assess
19 that particular question.

20 And having received that
21 information, you know, it made the measure
22 look a lot more favorable. And without that

1 data, the vote, at least my vote, would have
2 gone a different way.

3 Now I think it also behooves the
4 committee, I mean if we can incorporate these
5 additional data, I think it behooves the
6 committee to ask for that additional
7 information at these webinar calls. Because
8 it sounds like there are data that the
9 committee would have liked to see, and it
10 sounds like the developer has some, maybe not
11 all but some of that information, and if that
12 had been conveyed earlier in the process I
13 think that that would have been more helpful
14 to this conversation.

15 So that was my first comment. Can
16 I make my second comment? So my second
17 comment has to do with using the algorithm and
18 in responding to what you were saying. Now
19 I'm not a data statistical heavyweight, but
20 listening to the conversation it sounded like
21 what would be acceptable to a reliability test
22 would be if there was more stability in the

1 rank ordering from year to year.

2 And the developer described what
3 they had done which is didn't provide the
4 actual values from that data. So in reading
5 this algorithm, when you say answer no if it's
6 only descriptive statistics, that to me is not
7 descriptive statistics. That's more than
8 descriptive statistics. They actually did the
9 analysis. They just described the results
10 rather than presented the results.

11 So I think it's important for us
12 to understand that distinction and at least
13 that explains how I voted.

14 DR. ASPLIN: All right, I have
15 Cheryl, Andy, Nancy and Jack.

16 MS. DAMBERG: I think this is a
17 helpful discussion and I would say I have to
18 confess. I haven't looked at the measure
19 submission form and all the instructions in
20 detail, but it strikes me that given that this
21 seems to be an ongoing challenge for the
22 committee to review the materials of the

1 measure developers.

2 Maybe there's an opportunity to
3 here to provide them some examples of what a
4 good reliability and validity, you know,
5 written section would look like. And I think
6 largely what's missing in that section are
7 results, you know, data so that people can
8 judge.

9 And so I think you could dummy up
10 some examples or maybe draw from some better
11 submissions where people have produced that
12 kind of information, because I'm sort of
13 reminded of when people put together methods
14 papers for scientific journals around measure
15 testing they are essentially writing these two
16 sections of the measure submission form and
17 they're doing it in a very digested way
18 because the journals have, you know, word
19 count limits.

20 So I think if they can work toward
21 that kind of model I think that might be
22 helpful.

1 MS. WILBON: So we actually do
2 have that, Cheryl. We call it the "What Good
3 Looks Like" document. And we did actually,
4 for those of you that remember, we went
5 through that document with you guys on one of
6 our calls, it was last year probably sometime,
7 and we have that on our website.

8 And so we have been trying to make
9 all the developers aware of that and there are
10 several examples in there for different types
11 of tests, inter-rater reliability, face
12 validity of how to display the information in
13 the submission form, the types of information
14 we're looking for.

15 So it's out there and, you know,
16 the degree to which developers are applying
17 that in their practice and putting the
18 submission form together, I agree there's
19 still a disconnect there and we're doing what
20 we can to try to work with developers again
21 before the submission to make sure that, you
22 know, they're doing that.

1 Unfortunately at the time of the
2 submission we have a very short turnaround
3 time frame, and if we don't have that
4 opportunity before we don't always have time
5 to do a lot of back and forth after the
6 submission deadline to make sure that their
7 submission is kind of as tight as it could be.
8 So I think that's the challenge that we're
9 facing.

10 MS. DAMBERG: So does NQF, I mean
11 I'm not necessarily trying to put more power
12 in your hands, but do you have the ability to
13 reject a submission if it doesn't have that
14 kind of information? You know, it's kind of
15 like an incomplete college application, like
16 you didn't do the college essay, so, you know.

17 DR. BURSTIN: Yes. This has been
18 an interesting issue of when we feel
19 comfortable having staff make an assessment of
20 completeness versus, you know, if boxes are
21 left out, sure.

22 But if there's information in there and

1 it requires a real qualitative assessment,
2 we've been increasingly doing more of that in-
3 house but we haven't at least allowed that
4 information to flow to the committees to
5 ensure that you have a chance to review it as
6 well.

7 So we look at completeness but not
8 necessarily responsiveness.

9 MS. WILBON: We don't look at
10 appropriateness, I would say. We do look at
11 whether or not they responded to the question,
12 but in terms of the appropriateness and
13 whether or not they put exactly or worded it
14 in the way that we would like the committee to
15 see, we generally leave that to the committee
16 so that there's not a, well, why did you stop
17 this? Because we've had the, we've heard that
18 on the other side as well that we want to see
19 what comes in. So I mean it's a balancing act
20 then.

21 MS. DAMBERG: Yes. No, I
22 understand that the committee wants to see it.

1 But I'm also wondering, you know, maybe
2 there's sort of a middle ground here where
3 there's a subset of the standing committee
4 that does a quick review at the front end and
5 sort of signals quickly back to the measure
6 developers that it's not going to be
7 sufficient to kind of make its way through the
8 process in a seamless way. Because I think
9 that there's a lot of time and energy spent
10 here that maybe could have been sort of short
11 cut at the front end.

12 DR. ASPLIN: Right. So I want to
13 get feedback on the committee because I think
14 this is a good discussion for the long run for
15 how we approach this, and I'd also ask us to
16 be parsimonious.

17 So Andy?

18 MR. RYAN: Okay, so just a couple
19 quick points. Number one, I think the
20 algorithm is quite good and reasonable and
21 with respect to the measure we evaluated
22 yesterday, you know, they did do reliability

1 testing.

2 There was a section in the
3 appendix called reliability testing. They
4 gave us some numbers that we can evaluate and
5 we checked that. And with respect to validity
6 testing, according to this we don't need
7 validity testing for it to pass. It just
8 needs to pass face validity.

9 So, you know, I think the measure
10 yesterday didn't, even people didn't think it
11 past that second hurdle, but I think what they
12 provided was enough and it was responsive to
13 what NQF was looking for.

14 I also want to make the point that
15 with respect to the 20-page limit, I mean it
16 seems irrelevant to me because the
17 supplemental material can be how ever long the
18 developers put in, and with the Yale
19 application yesterday the section on
20 reliability testing was one paragraph.

21 And, you know, maybe I would have
22 liked to see more but that was enough. So

1 it's not like we need 100 pages. We just need
2 a couple things that we're looking for. And
3 so, you know, I don't think that's an undue
4 burden for developers.

5 DR. ASPLIN: Thank you. Nancy?

6 MS. GARRETT: So I understand the
7 attention here with the standard submission
8 and wanting to have everything fit there. I
9 found the visuals yesterday to be extremely
10 helpful because of these complex measures, you
11 know, that are measured over time.

12 And so I would just encourage you
13 to think about if there's some way to build
14 that into the standard form so that there's
15 actually, if it makes sense there's a picture
16 that you can actually look at of how it works.
17 I thought that was really helpful to see.

18 DR. ASPLIN: Thank you. Jack?

19 MR. NEEDLEMAN: I really
20 appreciate Taroon's frustration. And I share
21 it a little bit, and I think it raises some
22 questions about thinking through the process.

1 So we're here face to face. We've
2 got this rule which says if we reject on one
3 of these must-pass criteria we stop
4 consideration. We get another round of
5 voting. We've talked about what additional
6 information we want.

7 I was not quite prepared to stop
8 the discussion of this measure yet, which is
9 why I gave the developers the benefit of the
10 doubt on reliability in terms of testing. So
11 that's one element here, to think about the
12 process and how these votes influence that and
13 therefore how it influences voting behavior.
14 So that's one issue.

15 The second issue that I think is
16 raised by this conversation is also do we
17 believe the measure is reliable versus has the
18 reliability been demonstrated? And we've seen
19 enough of these other measures and I know how
20 it's been constructed, and one of the reasons
21 why these measures get to be not reliable is
22 you've got outliers that sort of pull things

1 around and really change the rankings, but
2 they eliminate that by capping the price per
3 patient.

4 So I fundamentally believe this
5 measure is going to be reliable in the sense
6 of you do the split sample, you do the other
7 stuff, you're going to get consistent results
8 that would demonstrate reliability.

9 Have we seen all that yet? No, we
10 haven't. But we've asked for more information
11 that would provide that. Given that, given my
12 gut feel that the measure probably is
13 reliable, given what we've seen about
14 reliability testing of similar kinds of data,
15 I said let's get past the reliability and deal
16 with the other issues on the measure, but I do
17 that knowing that we've got another vote
18 available to reconsider all this.

19 And that all entered into my
20 decision to give the benefit of the doubt to
21 the measure on reliability on this round of
22 voting. But we need to think about how the

1 stop affects the decision to vote in a given
2 way, and we need to think about this issue of
3 demonstrating reliability versus believing the
4 measure reliable at the committee level.

5 And the third thing is, with the
6 development of these algorithms I'd like to
7 see, you know, in some sense the algorithm
8 incorporated into the guidance for the
9 developers on here's how you're going to be
10 tested, here's what you need to be providing.

11 So that's a third element in terms
12 of looking down the road to future submissions
13 and how these the algorithm can play in. And
14 that was -

15 DR. ASPLIN: Thank you. That's
16 very helpful. Gene, could you make your
17 comment?

18 MR. NELSON: Hi, yes. Gene Nelson
19 here. It's been a great discussion and a
20 complex one. The suggestion was that in
21 future that we ask the staff when they do
22 their review and the TEP when they do their

1 review to actually use the algorithm for
2 reliability and a similar algorithm for
3 validity, and make their notes on the
4 algorithm so that you can trace through the
5 thinking and the conclusions of staff and TEP
6 in advance of a discussion like this that
7 we're having with people's, you know, various
8 backgrounds and understandings about some of
9 these technical issues.

10 And to treat it as a guideline
11 would be treated at Intermountain Healthcare
12 where the decisions are made but variances
13 from the guideline are noted. and that allows
14 improveability of the guideline for
15 specificity and future use.

16 DR. ASPLIN: Thank you. Carolyn?

17 MS. PARE: I just wanted to go on
18 record. I think I've mentioned to some of the
19 staff that I think their support in this
20 process this time around was particularly
21 helpful.

22 In their comments, when we got the

1 staff comments though, they weren't
2 necessarily giving us an assessment. They
3 were clearly moving us in a direction for what
4 to look for. I also found the TEP comments to
5 be extremely helpful. I did, because I'm not
6 an expert or a genius in this area I have a
7 lot of paper that I look at and one is the
8 very helpful document, that is, "What Does
9 Good Look Like?" And we got that last year.

10 There was a lot of very helpful
11 documentation that we all had access to and
12 again in the calls could have raised questions
13 where there was missing data because I think
14 we knew that in advance. I don't know how you
15 resolve that.

16 We all have only X amount of time
17 to dedicate to this work, and I think that
18 will always be a challenge. But I do, like I
19 said, want to go on record in complimenting
20 the staff and NQF for giving us the necessary
21 information in advance of our meeting.

22 DR. ASPLIN: All right, thank you

1 for that conversation. So let's transition to
2 validity and I'd first ask if either Andy or
3 John had additional comments that I thought
4 you had referenced most of the scientific
5 acceptability comments. However, if you have
6 additional comments on the validity section,
7 Andy would welcome you to share them now.

8 MR. RYAN: My only comment would
9 be that I'm not aware of any empirical
10 validity testing that was done through this
11 application. I didn't see any. And, you
12 know, with the other application there was
13 some formal process just that was face
14 validity. I didn't see that in this
15 application as well. Those are my only
16 additional comments.

17 DR. ASPLIN: Thank you. John, do
18 you have additional comments?

19 DR. RATLIFF: Yes, I don't have
20 anything else to add from the comments. I
21 think they've been covered.

22 DR. ASPLIN: Thank you. Bill,

1 from the TEP perspective do you have any
2 additional focused comments on validity that
3 you'd like to share?

4 DR. WEINTRAUB: Yes. So I'll
5 comment from the TEP and my own thoughts as
6 well. The TEP basically is an agreement with
7 what Andy said that we really don't see much
8 in the way of validity testing. So I think
9 that the problem here with validity is if you
10 don't know where you're going it's hard to get
11 there.

12 So I have trouble even with face
13 validity. When I looked at this and seen the
14 data and I said, well, I don't know what that
15 means. Is that good or is it bad? So I think
16 that what is the goal? Is the goal here to
17 reduce variation? Is it a goal to reduce
18 resource use? If you want to reduce resource
19 use when do you know when you get there, when
20 have you gone too far? How much variation is
21 acceptable? I think it's very hard to know.

22 Yesterday we suggested

1 opportunities for external validation. It's
2 not clear to me that for a measure like this
3 that there are the same opportunities for
4 external validation. So this is not really a
5 criticism of the developers. I think they're
6 sort of trapped in the situation. It's not
7 clear how with a measure like this you can
8 know when you really have validity.

9 DR. ASPLIN: I think it's a good
10 point. I would just add in direct follow-up
11 to your comment that the market-specific
12 conversations at least as they were
13 constructed and took place with various plans
14 in the Twin Cities market, and again going
15 down to the next level from their plan level
16 data with not standardized pricing but real
17 information, it gave more context as far as
18 where you stood locally.

19 It didn't answer the
20 appropriateness question that's been raised in
21 part of our discussions but helped you sort
22 out both the resource use and then of course

1 you had indirect information about your
2 pricing position that seemed to be at least a
3 locally referenced valid approach to your
4 relative standing. And I don't know if that's
5 helpful or not, just reflecting on how the
6 conversations go.

7 Jennifer, you have a comment on
8 validity?

9 MS. HUFF: Actually my comment was
10 pertaining to the last conversation, so I'll
11 just hold off.

12 DR. ASPLIN: Okay, and unless
13 there are not a lot of cards in the room -- I
14 shouldn't have said that out loud. But why
15 don't you go ahead and make the comment? I
16 think that's okay. We'd like to hear from
17 you.

18 Jennifer? Jennifer, you may be on
19 mute.

20 MS. HUFF: Sorry about that. So
21 are you saying it's okay for me to make the
22 comment now even though it's not about

1 validity?

2 DR. ASPLIN: Yes, go ahead,
3 please.

4 MS. HUFF: Okay. Sorry the timing
5 with putting, when I had a comment didn't
6 work. First of all, I just want to say I am
7 really appreciative of all the work that both
8 NQF has done and that the developers have
9 done. I found the conversation very rich,
10 deep and has really helped me, bring me closer
11 to a better understanding of the measures.

12 I can say I think the process has
13 improved significantly, so I think we're
14 moving in right direction of getting to a
15 better place of how to review these measures
16 and assess them. I do think they'll always be
17 a challenge because there is a lot of
18 information to sift through and it's a lot of
19 technical information. And that just is
20 something that I think is inherent as a part
21 of measure evaluation process.

22 For me, one of the things that I

1 was thinking about when I was evaluating these
2 measures was our earlier discussion where we
3 talked about how cost and resource use is
4 still in its early development. It's more
5 nascent than quality measures.

6 So considering that this is an
7 evolution, and some of that played in my mind
8 when I was reviewing the measures and I hadn't
9 heard anybody else say that so I wanted to
10 sort of make sure that was brought forward.

11 And then I'll just finally say I
12 think the work of having the developers have
13 a conversation with the committee before we
14 met in person was really helpful. And I think
15 no matter how hard you try to get the perfect
16 form and try to have everything on the form,
17 conversations really help and they really help
18 in understanding.

19 So maybe there's more up-front
20 work that still needs to be done before we get
21 together in person so we're less surprised by
22 some of the directions the committee is going.

1 Thank you.

2 DR. ASPLIN: Thank you, Jennifer.
3 Jack?

4 DR. NAESSENS: Since no one else
5 seems to want to be jumping in on the validity
6 issue, I appreciate the TEP's comments and
7 some of the challenges of dealing with this
8 measure.

9 So let me kind of step back and
10 talk about how I think about validity which
11 relates a little bit to the usability. And to
12 me, when I'm thinking about the validity of
13 these measures separate and apart from all the
14 specific testing, there are three or four key
15 considerations and concerns that I have. And
16 having sat on these committees for awhile,
17 those concerns are somewhat tempered.

18 One is, how complete is the
19 measure of resources that are relevant to the
20 illnesses, the diseases, the patients that are
21 being reflected? And I always feel the need
22 to say billed services are not necessarily the

1 most accurate measure of resources that are
2 being used, but that's what we have in these
3 measures consistently so I live with that.

4 But it's important to recognize
5 what we're missing when we only look at billed
6 services in terms of understanding what
7 resources are being provided to deliver care.
8 And so are the resources as they're being
9 reported complete?

10 And the NCQA tells us repeatedly
11 that, and we see the list of things that are
12 being measured. They are complete. They've
13 got drugs in there. They've got the
14 behavioral health services in there.

15 So to the extent that we're
16 talking about billed services we've got a
17 reasonably complete set of billed services
18 here, and that is sort of one of the first
19 things that I think about when I'm, is this
20 measuring resources? Well, within the limits
21 of billed services it's measuring resources.

22 The second issue is the pricing

1 issue, and here we're using standardized
2 pricing. And that has pluses and minuses, the
3 limitations of standardized pricing in terms
4 of understanding what resources individual
5 health plans or individual medical groups or
6 individual physicians actually have to
7 organize and deliver care differ from what the
8 standardized prices are.

9 Places that are heavily Medicaid
10 that may have lower actual revenues per
11 patient than places that are privately insured
12 are going to have different resources even
13 though the standardized pricing makes it look
14 like those resource differences are smaller.
15 That again is an inherent limitation of the
16 measure.

17 And in thinking about standardized
18 pricing I recognize that limitation but it
19 hasn't been a bar to approving measures. It's
20 just one of those limitations that I need to
21 recognize and take into account when I'm
22 thinking about what we've measured and what we

1 haven't.

2 So the standardized pricing
3 methodology feels acceptable to me in terms of
4 validity with all those limitations. The
5 third is what we're trying to do here is
6 differentiate between variations in resource
7 use, service use that are not driven by the
8 patient characteristics but are rather driven
9 by differences in provider care practices.

10 So the third consideration is
11 whether the risk adjustment or the model
12 adequately differentiates between the patients
13 that may need high levels of resources versus
14 low, and that turns directly to the risk
15 adjustment model.

16 And as I've looked the HC model
17 for doing risk adjustment, it seems to me that
18 based upon the report to CMS and some of the
19 data that we've seen it is doing an adequate
20 job of differentiating patients that need more
21 resources from less.

22 So in general I find measures that

1 have used that methodology acceptable and have
2 been okay with it. The way I would
3 distinguish this measure from the ones we
4 discussed yesterday is the HC method as its
5 been presented and discussed in the
6 documentation seems to do a better job of
7 differentiating patients that need different
8 levels of service than the way we saw the risk
9 adjustment yesterday do that.

10 So again to me this measure rises
11 to the level of adequate risk adjustment and
12 differentiation of patients. The fourth issue
13 is the interpretability of, you know, how do
14 we interpret high, how do we interpret low?
15 That to me falls into the usability issue and
16 not the validity issue.

17 And we've been struggling with how
18 to think about how to interpret resource use
19 measures and recognized all the way from the
20 beginning of this process with NQF that at
21 some point we're going to have to link them to
22 quality measures to get some sense of value,

1 but we can't do that if we don't have the
2 building blocks.

3 So I've treated the incompleteness
4 of these measures in terms of interpretability
5 of how much is being spent as an inherent
6 limitation at this point in the process, but
7 I still want the measures for building block.

8 So I tend to discount that problem
9 when I'm evaluating the validity of the
10 measure. It's measuring something, how to
11 interpret what it's measuring is a usability
12 issue not a validity issue for me.

13 So that's how I have approached,
14 to me, the key criteria here and why I find
15 this measure meets the threshold of validity.
16 The risk adjustment seems to be good enough.
17 The scope of the services that are being
18 priced are appropriate.

19 The standardized pricing, while
20 I'm not always thrilled with it, I know how to
21 interpret that and I understand the
22 limitations of it in terms of thinking about

1 what's measured and what's not.

2 DR. ASPLIN: Thank you, Jack.
3 Very helpful. Lisa?

4 DR. LATTS: First of all, it
5 occurs to me that when we were doing
6 disclosure of interest I probably should have
7 disclosed that I was on the CPM way, way back
8 when, when this was originally approved by
9 NCQA. So just to get that out there.

10 Second, it is so much easier to be
11 on these committees that are reviewing the
12 condition-specific measures, because this is
13 just so much harder. And it's different, and
14 I really think that probably these aren't as
15 helpful here as there.

16 That said, I agree with Jennifer's
17 comment and Jack's comment, not only what he
18 said just now which is far smarter than I
19 could ever have something to say, but his
20 previous comment about this being a work in
21 progress and a building block especially.

22 DR. ASPLIN: Taroon?

1 MR. AMIN: I wanted to make a note
2 about the introductory comments that Andy
3 made. I just wanted to note that the
4 requirement for validity, particularly face
5 validity, is that it's systematically
6 assessed.

7 So the face validity, it's not
8 necessarily that we're looking to this
9 committee to make a judgment about face
10 validity and say, you know, it looks right or
11 up or down, it's that the developer is
12 submitting information that demonstrates that
13 they've done that on their end and that's
14 systemically assessed.

15 I just wanted to kind of point
16 that out and make sure that we're sort of
17 using that bar in terms of the face validity
18 requirement.

19 DR. ASPLIN: Thank you, Taroon.

20 Lina?

21 MS. WALKER: This is a question
22 for the developer. I was just referring to

1 your submission on what are the statistical
2 results from the validity testing. You had a
3 series of questions which you answered. And
4 my read on that was that pretty much the
5 results that you got were reasonable, that
6 there wasn't anything kind of out of whack.

7 And so that was confirmation that
8 this was a valid measure. I'd just like to
9 give you the opportunity to say more about
10 that, if there are other interpretations we
11 should be gathering those sets of questions
12 and results.

13 MR. REHM: I'll let Ben follow up,
14 but just as a -- you know, it's interesting,
15 and may expand your question a little bit. We
16 built this measure for use in the real world,
17 and I can't tell you how many times it failed
18 because we didn't have the ingredients right,
19 we didn't have the mix right, we didn't have
20 approach right.

21 I was on the CPM as liaison at the
22 time this measure first came out, and every

1 year we'd say, you know, close but no cigar.

2 And then the next time it was, oh, well,

3 that's interesting. That's a new wrinkle.

4 And I remember because one of the
5 ways we were able to evaluate the measure each
6 year as it came back one more time, one more
7 time, was the stability. Because the early
8 ones, it was really unstable. Plans were
9 moving all over the place, and that became
10 kind of our metric, if you will.

11 And so I think one of the, and
12 maybe it's a problem we have. This is a
13 measure we implement in the true space. When
14 you read the submission form, in many ways
15 really what you're reading is our story of
16 implementation.

17 And the hard work of doing that
18 and getting it right and getting it so that
19 employers, plans purchasers, and, to some
20 extent, because we do visual displays of the
21 quality and resource use so that people could
22 see grids, high-low, you know, things like

1 that for the consumer, you know, information.

2 So when we look at the data and
3 bring in this annual report to the seat
4 committee on Performance Measurement that
5 reviews it every year that's the story of
6 telling them we've tweaked this, this is what
7 we saw this year. We modified this, we've
8 changed the number of entity, number of
9 members that need to be in the measure looking
10 at standard error and we have that data in
11 there.

12 And so I guess with a measure this
13 complex over such a period of time kind of its
14 arc of life, I don't know whether to call it
15 an adolescent or a, you know, an unruly teen,
16 but it's certainly getting closer.

17 And I think the feedback we've
18 received from you, and we received maybe parts
19 of this feedback in the earlier round in 2012,
20 I mean I think it's been very, very valuable.
21 You, just like our users, just like the people
22 who respond to the public comment that I

1 referenced on three different occasions, are
2 giving us information that helps us rethink.

3 I think in many ways we've been a
4 little entrapped by implementation in thinking
5 about that so much. We did not create the
6 measure for NQF. I think you appreciate that.
7 The user of the measure is not NQF. NQF has
8 a terrific service to the quality environment
9 and that's why we're here.

10 And that's why we're going to come
11 back and we're going to try to come back with
12 more information that's more helpful and does
13 get at kind of like, what does good look like
14 for a relative resource use measure?

15 Is that what the NQF provided us?
16 No. It provides us, what does good look like
17 on a kind of generic measure. And this is
18 just a particularly difficult thing sometimes
19 to translate. Sometimes we wonder if it's too
20 hard to translate. It sounds like we're
21 getting better at it and we need to improve
22 and we've heard that message.

1 So I guess in answer to your
2 question, yes, I think that there's so much
3 looking at the results of this measure over
4 time, but the lens that we look at it through
5 is for, to speak to Brent's point, the
6 usability and how it performs in the
7 marketplace and is it telling a better story
8 so that we can leverage it for other things.
9 And the things we want to leverage this
10 obviously for is to get at value.

11 Ben, did you want to add anything?

12 MR. HAMLIN: No, I don't have
13 anything else to add.

14 MS. WALKER: Just to be clear and
15 understand your response. So you were saying
16 that you submitted this information as part of
17 your validity testing, and so what you're
18 saying is that the answers to those questions
19 you asked kind of met the smell test.

20 So it was reasonable, in line with
21 expectations of how plans should be performing
22 on those various dimensions.

1 MR. REHM: Yes, I guess I was
2 being so AHRQ-oriented, what I was trying to
3 say is that different points in time that the
4 story of its early failures really tells the
5 story of its current status and that it did
6 pass that test.

7 And each time we'd take it back to our
8 committee on Performance Management and our
9 Evaluation Measurement advisory panel, and
10 they're listed in your submission form,
11 they've said good work, keep it up, don't
12 stop, keep improving it. And what we see here
13 does not make us nervous or concerned about
14 the validity of the measure.

15 DR. ASPLIN: We have two online
16 and then Bill. Joe? Joe, did you have a
17 comment?

18 MR. STEPHANSKY: I'm sorry. Who
19 did you, do you want Bill first or me first?

20 DR. ASPLIN: Joe, go ahead.

21 MR. STEPHANSKY: Okay. I realized
22 today that I have been around Jack long enough

1 to have been corrupted by him after serving on
2 a couple of committees with him. I really
3 like the way he laid out his four points, and
4 I very much agree with him on that.

5 I look at the measure in the same
6 way as him and think that the way he expressed
7 that really belongs in our committee report as
8 an example of how we have to deal with these
9 kind of messy measures and where our
10 limitations are.

11 Second, and I expressed this in an email
12 earlier last night to some of the NQF staff.
13 There's a Kaizen process that NQF went
14 through, and one of the things that stood out
15 to me in that was the necessity of measure
16 developers telling more of the story. And
17 that's actually what we were starting to hear
18 from you in your last comments, for example.

19 And I just want to emphasize again
20 to the NQF staff that that story is important
21 to me and I think to some of the other members
22 in terms of our final evaluation of the

1 measures and that we need to find a different
2 way to get that story to the committee
3 members. Thank you.

4 DR. ASPLIN: Thank you, Joe.
5 Gene?

6 MR. NELSON: Yes, two comments.
7 One is, I think building on what was just said
8 that the comments from the spokesperson for
9 the TEP and then from Jack both indicated that
10 for an expert in measurement to weigh in on
11 validity and reliability there needs to be
12 some sense of an operational definition
13 specific to the case of cost or resource use.
14 And that the specifications that Jack gave is
15 an example, I think, of contextualizing what
16 validity means in the context of this kind of
17 measure. And it's very helpful.

18 And again going back to the
19 algorithm, if the algorithm could have,
20 reflecting the kind of operational definitions
21 that are context-specific it might be helpful.

22 And then the second comment is

1 that towards the purpose of measuring value,
2 costs in relationship to quality, point in
3 time and over time, it would helpful if NCQA
4 in its use could actually provide information.

5 And over the past four years, for
6 example, how many plans made a substantial
7 decrease in costs, where their costs were
8 higher, and had quality hold equal or improve?
9 Because value improves if a cost in this case
10 were to decrease if you start at a higher
11 position and if quality improves or stays the
12 same.

13 So actually getting experience
14 from the field in the plans on moving the
15 parts of the value equation, what's the
16 experience been going to the point of
17 usability.

18 DR. ASPLIN: Thank you, Gene.

19 Bill, you might get the last word
20 here before we go through the algorithm.

21 DR. WEINTRAUB: Okay. Well, I was
22 going to sum up, so I think I might do just

1 that. I want to reflect on the comments I
2 made and the comments Jack made because
3 they're not in conflict, actually.

4 Jack talked mostly about construct
5 validity and I think he's right. What I was
6 talking about, sort of the overview of what
7 does this mean, and that at the end of the day
8 is a rub. But you've got to have something
9 that makes sense as you build it up and Jack's
10 right about that.

11 So Joe's comment and Gene's both
12 related to construct a good measure, and then
13 if you're not sure what all this means then
14 look at it over time and see what's happening
15 and tell that story, which is what we're
16 beginning to get from the developer.

17 And when you put all that together
18 this is probably as good as we can
19 realistically get with this right now.

20 DR. ASPLIN: Thank you. Andy?

21 MR. RYAN: Just a quick point. So
22 Jack took us through his criteria for face

1 validity which I think a lot of us think are
2 quite reasonable. I think the question and
3 the issue is that it seems like the developer
4 should have gotten people like Jack in a room
5 and asked the questions that Jack posed and
6 then gotten their responses and then said
7 people agreed with those things.

8 And then we would say that was a
9 systematic assessment of face validity, and
10 then we could say, okay, look, they did this
11 and everyone thinks it's valid so we sign off
12 on that. But, you know, absent that our
13 committee is kind of making these judgments.

14 And so I think we're an expert
15 committee and we are, I think, qualified to
16 make this assessment, but it seems like NQF is
17 calling for an additional level of testing to
18 have been presented by the developer prior to
19 that. So I think that's kind of maybe what
20 some of us are struggling with.

21 DR. ASPLIN: All right, thank you.

22 So let's move through the

1 algorithm and the guidance from NQF for
2 evaluating validity, and Taroon, I'd invite
3 you to walk us through.

4 MR. AMIN: Okay, I will attempt to
5 do that. I think one of the challenges I have
6 just as a note, the conversation that we're
7 having here is not the same tenor of the
8 information that was presented in the
9 documents by the TEP and by the preliminary
10 evaluations.

11 So I'm going to try to summarize.
12 I think I'll just walk us through this to say
13 that, you know, number one, looking to see
14 that the specifications are consistent with
15 the evidence in support of the measure, I
16 think generally the committee's okay with
17 that.

18 I think we're all, I think now I
19 don't have a clear sense of where the
20 committee is based on the conversation and the
21 information that was submitted in the
22 preliminary evaluations at this point, so I'll

1 look for further clarification or not. You
2 could just decide to vote.

3 But the potential threats to
4 validity were empirically assessed,
5 empirically assessed for exclusions, the risk
6 adjustment, and then those are probably the
7 two biggest ones. And the ability to
8 statistically significant meanings to
9 difference in performance may be less of an
10 issue, but the first two appear to still be
11 in. I don't see any question.

12 So depending on how you feel about
13 those things that if you feel no that would go
14 to insufficient. If you felt that that was
15 addressed that would be yes.

16 And now we're getting to empirical
17 validity testing, and again I think what I'm
18 hearing from the -- again it's very difficult
19 to assess this because there's differences of
20 opinion, I believe.

21 But what I heard from the lead
22 discussants is that there's some degree of

1 face validity, now the question would be
2 whether it's the opinion of the group about
3 whether it's systematically assessed. And
4 again that is a requirement.

5 Andy's characterization of what's
6 required in terms of NQF endorsement is a
7 systematic assessment of face validity. This
8 group isn't assessing the validity, the face
9 validity of the work. It should be
10 systematically assessed by the developer.

11 I don't know if that's sufficient,
12 but --

13 DR. ASPLIN: Bill?

14 DR. WEINTRAUB: Well, I'm just
15 wondering if the algorithm here isn't working
16 very well, were all potential threats to
17 validity that are relevant to the measure
18 empirically assessed, the answer is no, then
19 we'd have to write it as insufficient.

20 But it's too much to ask along the
21 lines of our previous discussion. So I'm not
22 sure that the algorithm's really helping us

1 here adequately.

2 MR. AMIN: So Bill, I think
3 that's, I mean I think we're cutting to the
4 heart of where there's a challenge here.

5 And I think we need to make a
6 decision about this measure and maybe we'll
7 move on, but we're coming back to that
8 conversation after lunch. Because if we don't
9 agree with the criteria then let's have that
10 conversation and let's identify which criteria
11 are either too high of a bar or not relevant
12 to cost and resource use measures. Because we
13 need to implement that consistently, and
14 that's all I'm asking.

15 I'm not trying to say that this
16 measure should go up or down, I don't have an
17 interest or I don't, particularly, you know,
18 the committee can make that decision. But my
19 only interest in this equation is that we're
20 consistent and that we're sending a clear
21 signal. Now if we don't -- and so I'll just
22 leave it there, and I want to come back to

1 that conversation though. I'll just say that,
2 for the sake of discussion.

3 DR. ASPLIN: Lina?

4 MS. WALKER: This is a question
5 for Andy just to get a sense of how the other
6 committees viewed this. I did not see any
7 systematic assessment of face validity, and I
8 don't know if I'm missing anything.

9 But Taroon summarized what you
10 said is that there was some disagreement, so
11 was there some systematic assessment of this
12 validity that I'm missing in here?

13 MR. RYAN: I can say I didn't see
14 any assessment of face validity, and I didn't,
15 I mean there was some committee member
16 comments saying, you know, we think the
17 measure is valid, but I don't recall seeing a
18 comment saying, yes, the systematic assessment
19 of face validity was sufficient or was done or
20 whatever.

21 MR. REHM: And I'm sure we want to
22 bring this to a close here pretty quickly. So

1 we're culpable in one area. This is a measure
2 that is so, despite the seeming absence of
3 data, you know, I can hold up this is our
4 total data package, if you will.

5 And not that pages mean anything,
6 but the due diligence is there. In a measure
7 that was so complex and so difficult to
8 develop in many ways reflects its complexity.
9 We normally put in a two-page thorough ad
10 nauseum description of our validity, face
11 validity process, as Taroon comments, and it
12 is systematic.

13 I've tried to touch on that during
14 some of my comments, but if you don't mind and
15 you have all the members of the eMeasure
16 advisory panel, I think we may have failed to
17 include our committee on Performance
18 Measurement.

19 Most of you folks know many
20 members on that committee, but we're glad to
21 share that with you. Sorry it did not get
22 into the submission form. I think we were so

1 taken with all the data that we kind of forgot
2 that face validity might be kind of where we
3 needed to be.

4 But just to do a short version,
5 every measure that NCQA develops goes through
6 a measurement advisory panel. You can take a
7 look at the list. It's in this main
8 submission form right at the end.

9 And I think you can appreciate
10 this is the group that literally developed the
11 measure along with staff. This isn't staff
12 going and developing a measure then coming
13 back and saying, oh, will you approve this.
14 No, this was much intertwined because many of
15 the people on that group have special skills,
16 special talent and special motivation, if you
17 will, to try to get a measure like this into
18 the field.

19 So every year that I told you we
20 brought this back to the committee on
21 Performance Measurement which votes on the
22 recommendations, and it takes two votes. One

1 vote to get the measure into public comment
2 which goes to a 30-day public comment period,
3 and again to vote it for inclusion, in this
4 case an AHRQ/HEDIS fine for the year.

5 And then the first year measure's
6 in play. It's actually in hold status. We
7 don't publicly report that data. And then we
8 bring it back for first-year analysis. And
9 then that goes to the Measurement Advisory
10 Panel again and then that goes to the
11 committee on Performance Measurement and then
12 that's the cycle.

13 This measure, because it's changed
14 when we changed the risk adjustment approach
15 to HCC so it went the first time around then
16 it went for the HCC change, and then last year
17 we took it because we lowered the number of
18 people permitted in the measure, so to lower
19 it and looking at the standard error,
20 maintaining the same.

21 And then we also looked at the
22 exclusions where we eliminated two of the

1 exclusions that are tested and are included in
2 our materials. So in terms of that I wanted
3 to make sure you were aware of that.

4 So this is, I think, then three
5 cycles where it's been through the panel,
6 public comment, committee on Performance
7 Measurement. So in some ways I would say, and
8 with votes by that and then of course votes by
9 our board of directors.

10 So that's the full governance of
11 NCQA. That's how we operate. That's where
12 this measure went through just as every other
13 measure we've presented to you has gone
14 through that has the HEDIS imprint.

15 So I apologize that we did not
16 include that boilerplate, if you will, but
17 that's the process and I'm happy to answer any
18 questions you might have about that.

19 DR. ASPLIN: Any questions from
20 committee members about that process? Jack?
21 Or other comments?

22 MR. NEEDLEMAN: Yes, so the face

1 validity in terms of the testing, I mean the
2 committee members you've got are really good
3 people.

4 But the two things that sort of,
5 the three things that drive the results, you
6 know, clearly the exclusions, and I'm
7 reasonably comfortable with those and didn't
8 recall the TEP complaining too much about the
9 exclusions, per se. But it's going to be the
10 decision to cap the maximum amount per patient
11 so that pulls the variation in a lot.

12 And the second is the risk
13 adjustment because the risk adjustment is
14 where we distinguish between the variations
15 due to practice and the variations due to
16 patients.

17 So can you just speak a little bit
18 to what kinds of analysis and what your
19 conclusions were as you looked at the decision
20 to use the HHC methodology, and then your
21 experience using it in terms of how well you
22 think it's doing right now in distinguishing

1 between variations in practice and variations
2 in patients, and what the consequences are of
3 capping at \$100,000 and where that number came
4 from?

5 MR. HAMLIN: So I can address some
6 of those certainly. So, you know, as Bob
7 mentioned every component of this measure had
8 to go through a multi-committee process and
9 that included the development.

10 The measures were initially
11 developed in 2005. We didn't get to public
12 reporting status until 2009, which meant there
13 was about 14 rounds of development that went
14 through this multi-faceted review before it
15 was even deemed to be valid enough to go
16 through HEDIS and the public reporting.

17 The initial cost caps were
18 developed again using our research database
19 where we looked at, you know, if you will,
20 sort of faux calculations of the RRU in
21 different scenarios and, you know, running
22 different bootstrapping analysis in different

1 scenarios to determine what the appropriate
2 cutoff would be based on the submissions that
3 were there.

4 And I believe we revalidated that
5 as still a appropriate cutoff in 2011 when we
6 were also, you know, again we'd updated the
7 database and refreshed it and then done some
8 additional analyses for the exclusions for the
9 eligible population size.

10 So every time we make what I would
11 call major change that we're reducing eligible
12 population size, removing exclusions, either
13 we do a fairly thorough analysis and we
14 basically, we take the entire measure back to
15 these different committees to look at the
16 change in the entire context of the
17 measurement approach.

18 And so again when it was pointed
19 out to us that, you know, these specific
20 exclusions are very relevant to the condition,
21 we looked at the effect on removing those
22 exclusions across the entire measure, across

1 a number of different plans to see if there
2 were unintended consequences elsewhere, and
3 then those entire results were sort of
4 represented back through the efficiency
5 measurement panel, the CPM, the board, public
6 comment, et cetera, et cetera.

7 So it's not just a matter of
8 taking the individual adjustment to the board.
9 It's kind of like we make an adjustment and
10 then we take the entire measurement approach
11 back up to these committees.

12 With regard to the HCCs, we
13 actually initiated a testing of four different
14 risk adjustment approaches to the RRU to kind
15 of see which was the most appropriate or the
16 most relevant to this type of model.

17 Two dropped off very early, and
18 then so basically what we ended up doing a
19 more thorough analysis on was the initial
20 approach which is sort of a age, gender,
21 comorbid, yes or no to the HCC, and it was
22 found that the HCC was much more sensitive and

1 much more specific to this population using
2 this at a plan level and it reduced the error
3 ratios down to a level, you know, again to
4 where we felt we could reduce the eligible
5 population size. It didn't change those very
6 much.

7 And again this was then taken back
8 through this entire process in the context of
9 the entire measure, what is this going to do,
10 how is this going to affect populations,
11 what's the effect on reporting.

12 The HCC was even bigger because it
13 actually increased the amount of data required
14 from the plans rather significantly because
15 they were reporting in multiple cohorts. And
16 so that was actually performed over a two-year
17 period through multiple reviews.

18 And so that's sort of the way we
19 approach each of these. It's not just a
20 matter of tackling a change, it's a matter of,
21 you know, the change in context of the entire
22 measurement approach.

1 And we do retest and we sort of
2 revalidate, if you will, taking it through all
3 these different processes to make sure that
4 aren't overreaching, unintended consequences
5 that are resulting from that change.

6 DR. ASPLIN: Bob, did you have
7 another comment? Okay.

8 So I'm comfortable with us moving
9 ahead with the vote here. I think using the
10 algorithm, the question before the committee
11 really is whether the materials plus the
12 subsequent discussion today would move us to
13 a point of being comfortable with the measure
14 having a systematic approach to face validity
15 beyond empiric testing. So let's find out
16 where we stand.

17 Evan?

18 MR. WILLIAMSON: We'll now vote on
19 subcriteria 2b, validity. You have four
20 options, high, moderate, low or insufficient.
21 You may begin voting now.

22 And we have all the votes. We

1 have zero high. We have 17 moderate. We have
2 one low and we have five insufficient. The
3 measure passes validity.

4 DR. ASPLIN: Thank you. We're
5 going to move ahead to feasibility, and again
6 I would ask, beginning with Andy and then
7 John, if they have any additional comments
8 based on the committee's preliminary
9 recommendations.

10 MR. RYAN: I don't have any
11 additional comments. I guess I would say that
12 as specified, you know, this is designed to be
13 at the plan level so there's drugs that are in
14 there.

15 You know, there were some, so for
16 instance this kind of measure might not make
17 sense for the Medicare population but that's
18 not really the intention. I think that the
19 overall comments were that the measure is
20 feasible.

21 DR. ASPLIN: Thank you, Andy.
22 John?

1 DR. RATLIFF: The comments that
2 were posted seemed to attest that for the plan
3 level data, which is where the measure
4 directed, it seems feasible and the data
5 appears to be available and feasibility
6 appears good, again at a plan level, that
7 caveat offered.

8 DR. ASPLIN: Very good. Any
9 additional comments from committee members or
10 questions for the developers? Seeing none,
11 let's move ahead with a vote on feasibility.
12 Evan?

13 MR. WILLIAMSON: We will now vote
14 on Criteria 3 feasibility. You have four
15 options, high, moderate, low or insufficient.
16 Begin voting now.

17 And we have all the votes. And we
18 have 20 high and three moderate.

19 DR. ASPLIN: Thank you. Let's
20 move on to usability. And again I would first
21 turn to Andy and John to see if they have any
22 additional comments on usability and use.

1 MR. RYAN: I think I would just,
2 the overall, I think that people liked how the
3 data were presented in the sample. The sample
4 score sheet, that that was important for
5 plans, the purchasers. It's helpful to have
6 this information and there's a role for this.

7 I think there were some comments
8 again about this measure, this level of
9 analysis and whether and how actionable it was
10 for the health delivery system, but if we're
11 just kind of taking that as given this is a
12 plan level, then I would say that it was a
13 pretty widespread idea that this had high
14 usability and potential use.

15 DR. ASPLIN: Thank you. John,
16 anything to add?

17 DR. RATLIFF: I would agree with
18 those comments. Comments from the committee
19 seemed to focus on this being usable at a
20 health plan level. I think if questions arise
21 on terms it would be applied to a facility or
22 individual physician level. I personally

1 would like to see more data or more testing
2 with regard to that.

3 But nonetheless, comments of the
4 committee were favorable with regards to
5 usability of the measure.

6 DR. ASPLIN: Thank you, John.

7 Ariel, we're going to scroll back
8 to a comment that we said we'd come back to.
9 In your written comment earlier was can
10 someone be more specific about what a health
11 plan does with the measure? What do they find
12 of value if no one can say high is good or
13 bad? That was your written comment, and maybe
14 you can expand upon that if you choose right
15 now.

16 MR. BAYEWITZ: Yes. I mean it
17 just seems like, you know, from the comments
18 that people have been saying that no one has
19 affirmed that directionally we know what do
20 with the number, right?

21 I mean we are saying it's clear
22 that it's saying something, I think, but we're

1 not sure exactly what that something is,
2 right, so which gets back to Jack's comment.
3 So I just want to understand. Because one of
4 the earlier comments was, well, health plans
5 have found it to be of value.

6 If someone could just walk me
7 through sort of end to end, you know, the plan
8 gets the number, the data that they see, again
9 if the number directionally doesn't say
10 something specific, what are they doing with
11 it? How are they finding it meaningful?

12 DR. ASPLIN: Thank you. Ben?

13 MR. HAMLIN: Well, you know, again
14 I think the measure results have a broader
15 application than just the plans. So, you
16 know, we've offered guidance on applications
17 to identify cost opportunities to improve the
18 numbers again, but we don't actually make any
19 kind of recommendations that high is generally
20 bad, especially for subservice category
21 levels.

22 So, you know, we hear oftentimes

1 through the experience of going to these NQF
2 committees about specific members who've used
3 the measure structure for specific use and
4 we've had a very informative.

5 We have not systematically
6 addressed or, you know, systematically tested
7 specific best practices or pilots that people
8 have undergone based on their results from
9 this measure.

10 MR. SAUNDERS: Ben, if I can jump
11 in to add. But I think what we do know or we
12 think that the measure provides tools to be
13 able to assess the reality of the spending at
14 the specific plan.

15 So we have in the whole suite of
16 measures we're looking at that total medical
17 spending for cardiovascular and we also have
18 it broken out by the specific component
19 categories, whether it's for inpatient
20 facility charges or for the inpatient or
21 outpatient components of E&M or procedure in
22 surgery. We now have the lab in imaging.

1 So we have a broad spectrum of the
2 components of cost, and so we feel like that
3 by providing that information in the
4 subcategories that we've set up an
5 infrastructure for the health plans to be able
6 to look at how their mix of services, what
7 their observed spending is, and granted it's
8 standardized but they're able to impute their
9 own pricing to know what they've actually
10 spent.

11 But they're in the position to
12 have both pieces of information and they're
13 the ultimate arbiters of the usability of
14 this. But they have the component information
15 to be able to say this is how much is expected
16 of my spending for my population given how
17 everybody else, all the other health plans
18 across the nation that are submitting this
19 measure are spending for similar populations.
20 So we feel like the risk adjustment model
21 provides a benchmark of sorts that is specific
22 to each individual plan.

1 And so while on an individual
2 measure, an individual metric, it may not be
3 clear whether you should be up or down. In
4 some of our papers we've found that greater
5 spending on having a higher observed-to-
6 expected is associated with higher quality
7 performance on cardiovascular care and for
8 diabetes care.

9 Think, well, gee, shouldn't we be
10 encouraging people to spend less? But the
11 benchmark there is perhaps as a mix of
12 services that is being spent that we're
13 underspending on a particular component where
14 HEDIS is sort of a multidimensional service
15 system that's contributing to the quality.

16 And so we think that by the plans
17 looking at the components of services, looking
18 at their own paired quality measures which are
19 for the exact same defined eligible population
20 that they're able to make those determinations
21 for themselves of what actions to take either
22 in terms of quality improvement or in terms of

1 how they choose to treat these populations.

2 So it's do we, you know, I think
3 at sort of a basic level is you could spend
4 less by doing bariatric surgeries or those
5 types of things or you could spend less
6 through exercise. That we see a variety of
7 patterns of utilization that are consistent
8 with high quality and we think that the health
9 plans are in the position to evaluate in terms
10 of their contracting and who they work with to
11 make those decisions.

12 DR. ASPLIN: Thank you. Cheryl,
13 then Andrea, then Tom.

14 MS. DAMBERG: I was looking at
15 your documentation, in particular the sample
16 report as well as what was in the table about
17 the planned use for regulatory and
18 accreditation programs, and I'm hoping you can
19 comment a bit more on that particular
20 application.

21 But when I look at the sample
22 report you have that quadrant graphic where

1 you're pairing -- and utilization. And is
2 that the type of feedback that you're
3 providing on this, and as you move towards use
4 for accreditation purposes, you know, is there
5 going to be some signaling that if they do
6 poorly on this they're going to receive a
7 lower accreditation rating, or how does that
8 play out?

9 MR. REHM: If I can just -- Ben,
10 follow up on this. But so the graphic
11 represents, you know, low cost/low quality,
12 high cost/high quality, low cost/high quality,
13 all variations on a theme.

14 And the intent for that was really
15 to help both the consumer and the employer
16 market, purchaser market, be able to
17 understand, first, the variation around the
18 cost and resource use, resource use and
19 quality, to give it essentially an image that
20 they could react to.

21 We held an employer forum around
22 measurement a couple of years ago with many

1 top 200 Fortune plans, I mean companies, and
2 I've got to tell you we were two days there
3 talking about measurement. The RRU measure
4 was the one measure that in our readmission
5 measure at the plan level that just really
6 caught their attention because it was trying
7 to do this thing.

8 So in terms of, I mentioned before, the
9 ability to take this into the accreditation
10 program, which it's not currently in, is going
11 to really be dependent on whether we can prove
12 the point which you had asked previously which
13 is can you demonstrate a true differentiation
14 here, because that's what we require in order
15 to benchmark and essentially rank plans on
16 that dimension.

17 So that's the goal, if you will.
18 Are we there yet? Not completely.

19 DR. ASPLIN: All right, so I'd
20 like to take the last two comments here and
21 then push through the vote so we don't miss
22 our posted public comment time on our public

1 agenda, because that was at 12:15. So believe
2 it was Andrea and then Tom.

3 DR. GELZER: Thank you. Just from
4 a plan perspective, dependent upon the
5 population, the plan population, I mean
6 obviously it's going to vary dependent upon
7 how much cardiovascular disease you have in
8 the population. But that said, from a
9 transparency perspective this is a valuable
10 and usable measure to have in the
11 armamentarium.

12 DR. TSANG: There's about 12 or 13
13 states that have legislated the use of all
14 payer claims databases right now, so I'm just
15 wondering whether this measure will be somehow
16 connected to those efforts. Because, I mean
17 that process also by the states are doing, not
18 doing this, but they are doing similar
19 comparisons between Plan A-Plan B.

20 So I just want to understand that
21 usability of this measure in the context of
22 what the states are doing and if there's

1 redundancy or there's any parallel efforts.

2 MR. REHM: I can't speak to our
3 policy department. I have a hard enough time
4 doing measure development. But, you know, we
5 certainly observe that first thing that the
6 all payer claims database holds a lot of
7 promise. Absolutely they do.

8 In the context of a cost and
9 resource use measure, many of the states,
10 depending on which ones they are, have
11 distinctive limitations on the use of that
12 data. I think in our own minds we would love
13 to have real costs, you know, imputed into
14 this so that it's more proximal to
15 HealthPartners Total Cost of Care measure and,
16 yet, conveying the quality dimension as well.

17 So I think that it is a better
18 thing to have all payer claims databases out
19 there, and it would be great if they could
20 loosen up the restrictions on some of the use
21 of that data from a policy perspective.
22 That's not a measure development thing. We

1 would be promoting that and advocating for
2 that for the purposes of true transparency.

3 DR. ASPLIN: Thank you. Let's
4 move forward with our consideration of
5 usability and use. You have the options in
6 front of you. We'll move to the voting, and
7 Evan, let us know when you are ready.

8 MR. WILLIAMSON: We'll now vote on
9 usability and use. You have four options,
10 high, moderate, low or insufficient. Begin
11 voting now.

12 Okay, we're still missing one
13 vote. Is everybody still in the room? Yes.

14 And we have all the votes. We
15 have eight high, 14 moderate, one low and zero
16 insufficient. The measure passes usability
17 and use.

18 DR. ASPLIN: Thank you. And we'll
19 move to our final overall suitability for
20 endorsement, yes/no. Does the measure meet
21 NQF criteria for endorsement? Evan?

22 Excuse me, comments. Nancy?

1 MS. GARRETT: I think this was the
2 section where I was supposed to bring up the
3 stratification issue. I apologize. Can we
4 talk about that now, or is this the wrong
5 time?

6 DR. ASPLIN: You know, let's -- I
7 don't think that's going to affect this vote.
8 Let's do the vote, let's see if there are
9 public comments, and then you can make that
10 comment after that if that's okay with you.

11 MR. WILLIAMSON: We'll now vote on
12 the overall suitability for endorsement. You
13 have two options, yes and no. You can begin
14 voting now.

15 (Off the record comments.)

16 MR. WILLIAMSON: So we're still
17 waiting on one vote in the room. If everybody
18 could please try one more time.

19 And we have all the votes. And we
20 have 20 yes and two no. The measure passes.

21 DR. ASPLIN: Thank you. Nancy?
22 Or excuse me. Are there any public comments?

1 Let's move to that first. Thank you.

2 MR. WILLIAMSON: Do we have any
3 public comments in the room? Operator, could
4 you please open the lines for public and
5 member comment?

6 OPERATOR: Yes, sir. To make a
7 comment please press star then the number 1.
8 There are no public comments at this time.

9 MR. WILLIAMSON: Thank you.

10 DR. ASPLIN: Nancy?

11 MS. GARRETT: So my proposal is
12 that I want to see if the committee would be
13 interested in making a recommendation that
14 this measure be stratified by sociodemographic
15 characteristics.

16 So the developers presented
17 evidence that there are associations between
18 race, ethnicity and gender and utilization on
19 this kind of general concept of heart disease
20 care. And right now again this risk
21 adjustment committee is making a
22 recommendation in June and that will possibly

1 change the current policy that NQF has which
2 is that those factors can't be used in actual
3 risk adjustment.

4 But the current policy does allow
5 for the committee to recommend stratification
6 by those factors which means basically
7 reporting by particular groups. So I wanted
8 to get feedback on whether people think that's
9 something we should comment on.

10 DR. ASPLIN: Committee comments?
11 Jack?

12 MR. NEEDLEMAN: Yes. I think the
13 policy context for thinking about this is
14 critical. We're seeing a major expansion of
15 Medicaid managed care. We're seeing major
16 expansion of insurance with many people going
17 into limited, you know, into HMOs or exclusive
18 panel plans where issues of adequacy of the
19 networks have been relevant and where adequacy
20 of non-physician services in the community
21 have been critical for thinking about the
22 consequences for both health status and both

1 outcomes and use of other kinds of things like
2 readmission.

3 We heard Andrea yesterday talk
4 about Zip Code as being the critical
5 determinant of whether you got readmitted and
6 -- I'm sorry, was that Janis? Okay. Well,
7 you're both on that side of the table.

8 So, you know, to the extent that
9 the kind of data are supposed to serve a
10 reporting purpose to understand the challenges
11 facing different plans and also the public
12 policy purpose to understand what the
13 challenges for committed providers to deliver
14 care in different communities or to different
15 populations, I would encourage more analysis
16 and more presentation of data that allows us
17 to understand the SES factors associated with
18 the ability to get needed care and get
19 appropriate services.

20 DR. ASPLIN: Ben, related to Nancy
21 and Jack's comments, could you clarify a
22 comment you made earlier around from the

1 feasibility using existing data whether plans
2 could stratify? And I thought you made a
3 comment that some of them are not collecting
4 the required data to do it systematically, or
5 did I miss that?

6 MR. HAMLIN: No, that's correct.
7 I mean that last assessment, which I think was
8 two years ago, there was still far too much
9 variability in the plan data for us to require
10 reporting, where we're trying to make strides
11 in that direction as Bob alluded to and we are
12 certainly open to recommendations from this
13 committee about, you know, future ways to
14 present the results.

15 So we're certainly happy to look
16 into it, and like I said we are currently
17 waiting very patiently for the SES and
18 sociodemographic factor recommendations to be
19 coming out.

20 DR. ASPLIN: Bob?

21 MR. REHM: Nancy, we were just
22 talking about it during the break. I think if

1 we were to venture forth in looking at these
2 new data elements in forming a measure and its
3 interpretation we would probably start simple.

4 I would not want to, I'm not sure
5 I'd throw it into this particular measure
6 first. I think there's a lot of learning
7 curve on how to do this and do this well. And
8 it could very well be we might start with some
9 of the component quality measures that link to
10 the cost and resource use just to get a start.

11 But I mean, this is a big lift, a
12 big lift downstream, and we're all aware of it
13 and we want to do it right. This will not be
14 a tomorrow thing. It'll be maybe a few weeks
15 after tomorrow.

16 MS. GARRETT: I mean I would just
17 respond quickly. I mean this is the measure
18 before us so we can't comment on your other
19 measures right now, but I think that the
20 conversation that's happening nationally and
21 locally about this issue is really different
22 than it was even a year ago, and I think that

1 we might want to consider actually making a
2 statement about it.

3 Now what that really means if we
4 were to make such a recommendation, you know,
5 I don't know. But I think as a committee we
6 certainly could choose to do that.

7 DR. ASPLIN: Yes, certainly,
8 without really settling the question of
9 appropriateness that's been raised during this
10 morning's conversation, and also might begin
11 to inform some of the questions about whether
12 higher is better or lower is better, et
13 cetera, and that dialogue.

14 Larry, you have a question or
15 comment?

16 MR. BECKER: Yes, I do. This is
17 Larry Becker. So I agree with all the
18 comments that were just made, and I think, you
19 know, not for this measure, but I do think
20 that it's an important thing to begin to look
21 at in maybe in terms of subsequent measures.
22 Because it seems to me that we need to

1 approach care in a more patient-centric way to
2 provide different, maybe it's an opportunity
3 to provide different groups with approaches
4 that we can do and that they're able to do.

5 And so maybe it provides us an
6 opportunity to get some leverage into care
7 that can actually be followed.

8 DR. ASPLIN: Very good. And Jack?

9 MR. NEEDLEMAN: One more thought
10 on this issue. I talked about the policy
11 context and the community context. But the
12 other issue that occurs to me is you're using
13 standardized pricing, and I understand why and
14 I think there's a lot of value in seeing
15 standardized rates.

16 But I also noted that in the
17 discussions about standardized pricing in
18 other settings we've raised the issue that it
19 hides things including real differences in the
20 resources that different plans have available
21 depending up on who's contracting with them
22 and at what rates.

1 So you're not, you know, for all
2 kinds of proprietary reasons you say you're
3 not getting that data from the plans and I
4 understand that. But some kind of SES
5 stratification either by the Medicaid versus
6 others or other kinds of SES stratification
7 may help us understand where implicitly some
8 of the differences in resources exist and make
9 more apples-to-apples comparisons of plans
10 with comparable levels of resources available
11 to them in terms of their performance, not
12 only on the quality measures but on the
13 resource use measures.

14 DR. ASPLIN: Janis?

15 DR. ORLOWSKI: Just a quick
16 comment to tag onto what Jack's saying. I'm
17 surprised that a first step wouldn't just be
18 Zip Code data. And I'm sure the plans have
19 that. And, you know, that would be an initial
20 foray into taking a look at some
21 stratification.

22 MR. REHM: You know, I'm familiar

1 with Zip Code for assigning race and ethnicity
2 status and even language, and I know there's
3 been a lot of work done by RAND and others.
4 Cheryl probably could comment on it.

5 But, you know, Zip Codes are
6 interesting. Zip Code home, Zip Code point of
7 service, Zip Code hospital, you know, it does
8 get what sounds so simple when you peel it
9 back. But I mean, I think that as a starting
10 point --

11 DR. ORLOWSKI: We're not talking
12 about the hospital --

13 MR. REHM: Right.

14 DR. ORLOWSKI: -- being
15 socioeconomic. We're talking about patients.

16 MR. REHM: Right.

17 DR. ORLOWSKI: And I think that
18 what we're talking about is comparing services
19 that are provided to the patients.

20 MR. REHM: Yes. No, I

21 DR. ASPLIN: I'd like to thank the
22 committee for the conversation throughout the

1 morning, and a special thank you to the
2 developers. Thank you, Ben, for joining us.
3 Bob, Robert, for participating with us in this
4 conversation.

5 I hope that some of the takeaways
6 for it enable the similarly constructed
7 relative resource measures in other clinical
8 conditions hopefully will go even more
9 smoothly. We'll see.

10 So with that we're going to break
11 for lunch and reconvene at 10 after 1:00. We
12 do have some give in the remaining elements of
13 our agenda so we should be able to get out on
14 time so everybody can get to their travel
15 plans. So we'll reconvene at 10 after 1:00.
16 Thank you.

17 (Whereupon, the foregoing matter
18 went off the record at 12:42 p.m. and went
19 back on the record at 1:18 p.m.)

20

21

22

1 MR. AMIN: And then can I just
2 jump in real quick? Oh, well, you're going to
3 --

4 MR. WILLIAMSON: Yes. So most
5 immediately we have Phase III, and I know that
6 you think Phase II has just started but Phase
7 III is starting up now too. The measure
8 submission deadline for Phase III is April
9 18th, so these are staggered but they're kind
10 of overlapping.

11 We have another orientation call
12 scheduled for the 23rd. Again we're going to
13 think about how we're going to use that as far
14 as a standing committee goes to make sure
15 we're not repeating information that we just
16 went through, but really try to use it to make
17 sure that we cover some of the issues that we
18 have identified during this phase as far as
19 measure evaluation and moving forward.

20 We'll do the same thing. We'll be
21 convening a TEP, a pulmonary TEP, still
22 thinking about how we're going to consider the

1 dental measure, but we definitely need to
2 convene a pulmonary TEP to provide input to
3 the full committee.

4 We've gotten a lot of great
5 feedback from Bill about how the TEP went for
6 the cardiovascular process, so we'll be
7 considering that and making sure that we've
8 got some good input to the committee from the
9 Technical Expert Panel.

10 Of most import is the in-person
11 meeting. That's June 25th and 26th. That's
12 all been scheduled. The dates are posted on
13 the SharePoint site. We'll be sending out the
14 calendar invites for all the Phase III just to
15 make sure it's all on your calendars.

16 I think all these dates have been
17 sent out in some form or another over the past
18 few months, but we really want to make sure
19 that we, we can get on this early and make
20 sure it's on everybody's calendar and
21 everybody knows what's going on. So we'll
22 make sure that these dates are on there.

1 So again this will be wrapped up
2 by the start of 2015, so again this is a quick
3 trip through cost and resource use measure and
4 for these projects, and as far as future
5 phases we don't have anything concrete yet but
6 we're definitely going to utilize the
7 expertise of this group going forward through
8 your terms.

9 Are there any questions about
10 Phase III? I want to make sure, you know,
11 it's crept up on everybody so we'll make sure
12 that we get it on everybody's calendar.

13 All right, so during lunch I
14 distributed a survey, and I also sent out an
15 email with a link to the survey. In case you
16 don't want to fill it out on paper you can
17 type in into a SurveyMonkey, but we will
18 accept the paper survey. We've already gotten
19 a few of those.

20 And really looking to, you know,
21 we've made some big changes, some subtle
22 changes and we're really looking for feedback

1 on that. We want to make sure that we take
2 into account the committee perspective, and we
3 also have an analogous survey that we've given
4 to the measure developers.

5 We really want to get all
6 perspectives on this, all the stakeholders,
7 everybody we're bringing to the table to make
8 sure that we get their feedback on how things
9 are going.

10 And so among the items on the
11 survey we have how we handle orientation, the
12 workgroup, or for this committee it was Q&A
13 calls as far as the measure documentation. I
14 know that this phase was a little different
15 than last time as far as the way you receive
16 documents, the type of documents you received
17 and how it was distributed through SharePoint.

18 We did a lot of work on
19 redesigning those project pages, but again we
20 really want your feedback. You guys are the
21 ones, you ultimately have to use the material.
22 We want to make sure that we're making it as

1 easy as possible for you guys to participate
2 with this.

3 We really appreciate all the volunteer
4 hours you guys put in and we want to make sure
5 it's as easy as possible and that, you know,
6 we're not wasting your time or doing anything
7 that doesn't, you know, we're not introducing
8 any waste, I guess, going back to some Lean
9 principles.

10 So in that regard we want to go
11 over the staff reviews. So what we definitely
12 meant at this time that was different was
13 providing some staff input on how we think the
14 developer addressed the questions, and really
15 just more identifying things to look for, not
16 necessarily directing you any direction but
17 making sure that there are, you know, we can
18 really focus you in on certain key issues for
19 the measure documentation.

20 And how we handled the TEP review,
21 we really wanted to see were those questions
22 appropriate? Did you feel that those

1 questions led you to a good answer? That it
2 led the TEP to useful information for you as
3 far as getting input on the clinical
4 specifications that you might not necessarily
5 be as familiar with?

6 And then how we handled the
7 preliminary evaluations. You might have
8 noticed this time rather than submit the high,
9 moderate, low ratings before the meeting, we
10 got rid of that. We just wanted general
11 comments. We felt that the high, moderate,
12 low that were submitted before necessarily
13 didn't, they didn't correlate with what ended
14 up happening at the meeting and we really
15 didn't think it was that valuable of an
16 exercise to go through that.

17 We just really wanted to make sure
18 you guys started thinking about the measure
19 and going through, so we really want feedback
20 on that. That's something that was very
21 important.

22 So I'm teasing us up right now. I want

1 to open it up for discussion. I just want to
2 go over some of the slides and then we'll open
3 it for anything that's on here as far as some
4 verbal feedback.

5 Okay, and finally is the meeting
6 facilitation. That's something we really put
7 a lot of work into as well. I know you might
8 have noticed that we designated two seats for
9 the measure developers. We really think this
10 was more of a conversation with the developer
11 than in the past where they've kind of been,
12 you know, off in a corner and only called upon
13 at certain times. So we want to get feedback
14 on that as well.

15 We've got a lot of feedback from
16 developers as far as their interactions with
17 the steering committee, so a lot of this as a
18 result of that feedback through our Kaizen
19 process and other feedback we received from
20 developers, we're really trying to engage
21 them. You know, make sure that this process
22 is valuable for them and that they want to

1 continue to participate with NQF.

2 So I guess I covered a lot there.
3 So I want to open it up for general comments.
4 Again we definitely want the survey feedback
5 as well, but if there are general comments
6 right now about kind of the changes you've
7 noticed.

8 We have some new members. If
9 there are things that you all want to address
10 with us while we're going through this, we
11 definitely want to hear that now. So we'll go
12 ahead and start. Nancy?

13 MS. GARRETT: Well, this is some
14 minor comment, but I really did like having
15 the measure developers kind of sitting at the
16 table with us, talking to us. And it would be
17 nice for them to have a name card because
18 after they introduced themselves it was hard
19 for me to remember who they were.

20 MR. WILLIAMSON: All right. I
21 posted the names of the developers on our
22 SharePoint site just so that in the future

1 we'll make sure that we do that just so
2 everybody knows which of the developers.

3 That information is listed on the
4 measure information form, but again is buried
5 and sometimes you don't necessarily know if
6 the person who filled out the form is the
7 person who's presenting in person.

8 I think those are kind of a last-
9 minute thing to make sure that those two seats
10 were saved. I think we usually have placards,
11 but again with our offices being closed on
12 Monday we were kind of scrambling yesterday
13 morning to get everything printed.

14 But that's definitely a great
15 point. We will make sure that we do a better
16 job of that. Cheryl?

17 MS. DAMBERG: First of all, I want
18 to thank all the NQF staff for putting
19 everything together. I know how much work
20 this is to put together these packets, and I
21 think you have been working really hard to
22 make it easier on committee members and we

1 greatly appreciate that.

2 I want to second Nancy's comment
3 about having the measure developers here. I
4 think that was really important. I
5 particularly liked the pre-call where we got
6 to ask them questions.

7 My suggestion that I made to you at
8 lunch time was possibly thinking about making
9 that a mandatory call for the committee so
10 that people can voice a lot of the issues in
11 advance of us coming together. Because I
12 think there was a lot of time spent here that
13 maybe could have been dealt with earlier in
14 that call to try to move things along faster.

15 MR. WILLIAMSON: Great. Thank
16 you. Brent?

17 DR. ASPLIN: I want to compliment
18 staff on the changes to the measurement
19 packet, the measure packet that we received.
20 I think it really helped clarify and
21 prioritize the area to focus on and I found it
22 helpful both, plus in the interaction between

1 the TEP and the staff comments, you know, I
2 kind of, it really helped zero in on what I
3 should be looking at and offering an opinion
4 on.

5 And in the setting in particularly
6 of large, complex measures, and maybe they're
7 all going to be large, complex measures, I
8 don't know, that was helpful to me. I think
9 that's a significant step forward.

10 MR. WILLIAMSON: And actually I'll
11 push that a little further. So one of the
12 things that we did was try to make it an
13 evolving document, and we understand that has
14 some challenges as well. So I want to raise
15 that where we started with the staff review,
16 and then when we got the TEP feedback we added
17 that to the document and then when we got the
18 preliminary evaluations we added that to the
19 document.

20 And we know we've gotten feedback
21 that some people like to print out the
22 documents and then they don't know which

1 version they've had, so I just wanted to get
2 some feedback on the best way to be able to
3 share new information as it's added. So I
4 don't know if anybody has any thoughts on
5 that.

6 MS. WALKER: I didn't have any
7 problems with the way that you had shared the
8 information. I think it's pretty clear. It's
9 all dated on the SharePoint site so it's clear
10 when you loaded it and it was clearly labeled
11 so you know what the document is and you can
12 get to it fairly easily.

13 You were also again, once again to
14 join everybody else who's already said this,
15 but I think staff has been outstanding.
16 Really, the review for the three measures were
17 very, very helpful. The questions that you
18 posed, you weren't trying to influence our
19 decisions but you were trying to provide a
20 frame for us to think about these measures.
21 I thought that was terrific.

22 I like that you constantly, and

1 you were great in constantly reminding us of
2 various meetings. That's very helpful. I
3 know everybody else is as busy as I am so it's
4 nice to get those gentle reminders. I really
5 appreciate it. I don't think it's
6 overwhelming. Keep doing it. So I nothing
7 but good things to say about the staff.

8 MR. WILLIAMSON: Great. Thank you
9 very much. I know we have John on the phone
10 and then we'll get to Janis here in the room.

11 DR. RATLIFF: Yes, just briefly.
12 I was a bit reluctant to use the SharePoint
13 initially, but you guys did a great job of
14 organizing the files, keeping them updated,
15 clearly showing the timeline of when the files
16 were being generated and posted. And I found
17 that portion of the process to be extremely
18 helpful.

19 And again, I hate to echo the
20 crowd, but I really commend the NQF staff for
21 what a smooth and diligent job you've done
22 with organizing the standing committee.

1 You're to be congratulated for it.

2 MR. WILLIAMSON: Great. Thank
3 you. That's very helpful. Janis?

4 DR. ORLOWSKI: I would consider
5 this a very minor comment because I found,
6 being a new person and looking at the material
7 for the first time, I thought it was highly
8 organized. And the SharePoint worked fine
9 and, you know, very, very organized for me to
10 be able to figure out and use the guidebook
11 that you gave us and stuff like that.

12 So I thought it was probably one
13 of the first times that I've been on a
14 committee where you really don't learn what
15 the committee does eight meetings later. I
16 mean you actually gave all the instructions to
17 me.

18 So to my minor point, I was on the
19 first call and there was a lot of discussion,
20 a lot of stuff that was going on. And so I
21 went back to the SharePoint site afterwards
22 and looked at the transcript and I would say

1 it's nearly impossible to get any information
2 because it is literally a transcript, and so
3 you get all the ahs and ums and everyone going
4 through.

5 And I was looking for two pieces
6 of data regarding a conversation that I
7 recalled and had trouble finding it. So what
8 you have on here is both the transcript and
9 the recording and I don't know that we need
10 both of them. But what would be great would
11 be, you know, sort of summary points.

12 And again that's work for the
13 staff and I apologize for that but that's my,
14 and as I said those are minor comments but the
15 SharePoint was terrific.

16 MS. WILBON: So I have a question.
17 This group has been a little bit different, I
18 will say, from our clinical committees because
19 they have significantly more measures, so 20
20 to 25 measures per committee generally for our
21 clinical areas.

22 And the unique aspect about this

1 group is that we've had less measures but they
2 tend to be a lot more complex and so, you
3 know, we spend more time on each measure than
4 our clinical committees would.

5 They have a process because they
6 have more measures where they divide their
7 committee up into workgroups and have a series
8 of calls before the in-person meeting to
9 really kind of figure out what those key
10 issues are, and then the work of the
11 workgroup, if you will, comes to the in-person
12 meeting and so they spend less time.

13 Again they're reviewing 20 to 25
14 measures so it's much more of this is what the
15 workgroup highlighted, and then the committee
16 as a whole really spends time focusing on what
17 the issues that the workgroup teased out.

18 We haven't used that process as
19 much because we have less measures. It's a
20 lot harder to figure out how we would divide
21 people up into workgroups, you know, only
22 having three measures. And so we've somewhat

1 repurposed those pre-calls, but just wanted to
2 get your input on whether or not you think
3 that workgroup process would be useful.

4 And seeing that we only have three
5 measures, you know, the in-person meeting time
6 might be, you know, would we need a whole two
7 days to do an in-person meeting if we had
8 those pre-workgroup calls since we are kind of
9 working through those issues at the meeting as
10 opposed to on the phone?

11 So I think these are some of the
12 things we've been trying to balance out
13 because this group is a little bit different.
14 So just your thoughts on that will be useful
15 and we can potentially implement that for the
16 next, you know, phase of work that we have.

17 MR. NEEDLEMAN: I do think the
18 work of this committee may be a little bit
19 different, but it's also because we're in a
20 very different stage in terms of the
21 experience with measure development here.

22 So a lot of the discussion has

1 been around core issues of how the measures
2 are done. We were talking at lunch about, you
3 know, risk adjustment. There are three or
4 four standard ways of doing it and a bunch of
5 other ad hoc ways to do it.

6 As we all get more familiar with
7 the standard risk adjustment methods and their
8 strengths and limitations, the adequacy of
9 risk adjustment conversation will go faster.
10 On the other hand we probably want to think
11 about ways to capture or memorialize some of
12 the background discussion of things like risk
13 adjustment, things like exclusion rules, so
14 that new members of the committee will get a
15 chance to learn from the experience so they
16 can get up to speed faster, and we get a
17 little bit more chance to reflect on what
18 we've said about things in the past so we can
19 be bringing a little bit more consistency to
20 our evaluation of the measures.

21 So I'm not quite sure where that
22 gets done or who or how that gets done, but we

1 ought to be thinking about some of the
2 consistent issues that we have spent a half
3 hour or 45 minutes discussing and how to
4 capture some of the issues that have been
5 raised and the points, the decisions, seem to
6 turn on so people have a framework for looking
7 at new measures using the knowledge about how
8 we've evaluated things in the past.

9 MS. WILBON: We had a discussion
10 with Janis earlier and it seems like you guys
11 had a similar thing about the transfers and,
12 you know, how do we handle transfers. Who
13 gets credit? Which hospital gets credit for
14 the transfers, and is there kind of a general
15 principle that we, you know, as a committee so
16 that next time we see a measure that uses
17 exclusions or inclusions related to transfers,
18 is there a way that in general the committee
19 feels that that should be handled for resource
20 use measures?

21 And I think it's something to
22 think about related to the other issues you

1 were discussing as well, Jack, of whether or
2 not we have a way for you guys to set up some
3 principles or something about these kind of
4 overarching issues and the way that we should
5 be kind of framing our discussions around the
6 measures that come forward so there's a
7 consistent approach.

8 MR. NEEDLEMAN: Right. But the
9 other thing we were also seeing is sometimes
10 after discussion we've reached some consensus
11 and sometimes after discussion we haven't. So
12 the attribution rules on all the per member
13 per month measures were contentious. They
14 remain contentious. I'm not sure very many
15 people's views on whether they were
16 appropriate or not changed very much.

17 So those are the areas where we
18 know it's going to be contentious but we don't
19 have to, you know, we've had the discussions
20 over and over again. So it's a matter of, you
21 know, understanding how they've dealt with it
22 here, so we need to think about -- but no, now

1 I've wandered all over my tongue here. Let me
2 try this again.

3 In some cases we have real
4 disagreements about what the appropriate
5 standards are to apply, and the documentation
6 of where we've been and what kinds of rules
7 we've used should reflect that. And in other
8 cases we've developed a little bit more
9 consensus about these issues and we can
10 probably, you know, revisit them periodically
11 rather than routinely.

12 DR. ASPLIN: At risk of reopening
13 the whole conversation that we had right after
14 our vote on reliability, I guess -- let's
15 reopen it. We didn't really want to go home
16 today. No.

17 To the extent that it is going to
18 be an iterative process between developer and
19 committee, and to the extent that we would
20 take Cheryl's recommendation that the call
21 with the developer would be a key step prior
22 to the in-person meeting, then I think we need

1 clarity on what levels of information we
2 include in our voting. Because I've gotten,
3 and I'm just trying to put it out on the table
4 if you want to improve the process.

5 I still don't know if we're trying
6 to stick to what's in black and white or if
7 we're supposed to include additional
8 information, and if so, what levels of
9 information are deemed appropriate. And then
10 at the end of the day how do we stay
11 consistent in how we approach those questions?

12 Taroon? Yes, that would be great.

13 MR. AMIN: There was one thing
14 that I wanted to add that I think is a good
15 bridge from where we were and where you're
16 going. And I just want to provide the
17 committee with kind of a macro context of why
18 we think that this process needs some
19 improvement and what sort of the intention of
20 this work is.

21 So it's generally, this is a very
22 intentional process. So as many of you may or

1 may not know, the majority of these consensus
2 development projects are supported through our
3 federal colleagues who are, you know, these
4 projects are generally run through contract
5 and the timelines and the funding, the
6 majority of it's supported by our federal
7 colleagues with an understanding that we're
8 able to bring together you as members and
9 experts on these topics to come together.

10 However, the reality around the
11 fiscal environment and the pressure to do
12 things faster and more efficiently is
13 certainly present. However, particularly in
14 this area of measurement and I think those of
15 you that have, I mean it's broadly an issue,
16 but it's particularly acute in this area of
17 measurement, cost and resource use and
18 particularly in readmissions, the process of
19 getting toward consensus is it takes time.

20 So one of the questions that we
21 were working through as an organization is how
22 do you make sure that you have good voice in

1 the process from the membership, the
2 developers, the steering committees in
3 particular, but also have a sense of
4 efficiency in the process? So that's one
5 macro objective.

6 The second macro objective is that
7 we recognize that just an up or down decision
8 on measures is not very satisfying for the
9 committees and it's not very satisfying for
10 developers, and most importantly it may not be
11 getting us the rapid amount of change that
12 we're going to see in the next few years in
13 where we need measurement to be, and
14 particularly it may not have the effect that
15 we need it to have.

16 And so one of the principles that
17 we've employed through our Lean Kaizen efforts
18 is that, you know, we make some of these
19 recommendations but these recommendations may
20 be so far past the development of the measure.

21 So, you know, do we really expect
22 that the measure developer is going to have a

1 fully-specified measure after as Bob mentioned,
2 you know, spending a million dollars on
3 development and then we're going to convene a
4 committee that's going to say, you know, this
5 part of it needs to change and expect that the
6 whole cycle is going to start over again?

7 Realistically that's not the best
8 optimal use of time, but there should be much
9 more upstream guidance or upstream input from
10 a multi-stakeholder group on, you know, what
11 are the development priorities, where do we
12 want to see measures, and have a much more
13 long-range view of development in various
14 different spaces.

15 What's really unique in this particular
16 area of measurement is that we are very new in
17 the sense of the number of measures that are
18 in the cost and resource use domain, so it
19 gives us the unique opportunity to start off
20 on the right foot so that we're not sort of
21 retroactively saying, well, how do we clean up
22 the portfolio and are these really all the

1 measures that we need? And a huge amount of
2 development dollars have gone into building an
3 infrastructure for measurement and we're not
4 really sure that it's actually resulted in any
5 improvement.

6 So very thoughtfully we're asking
7 the question about how do we build
8 infrastructure up front to make sure that we
9 are giving guidance to HHS around where they
10 should be investing their development dollars
11 in terms of gaps and priorities, and also sort
12 of setting a strategic vision around the
13 complex measurement issues that may arise so
14 that we don't have all these dollars spent on
15 the back end in terms of trying to implement
16 components that can't be implemented, whether
17 it's because of concern around attribution or
18 the fact that, you know, that's an easy one to
19 pick on, but you can imagine there's other
20 sort of complex measurement issues that need
21 to be addressed.

22 So as we're moving forward, the

1 important thing is to sort of think about,
2 yes, we're doing the up and down on measures,
3 still, and this goes directly to your point,
4 Brent, which is, you know, well, how do we
5 think about the information that's in front of
6 us? Because ultimately the committee does
7 still have responsibility to make an up or
8 down decision.

9 And right now the answer is we don't
10 really know because we're trying to transition
11 our process to a place where we can be more
12 iterative with an understanding that we're
13 trying to effect a much more upstream process.

14 And so we're looking for guidance
15 about how best to do that and we're also
16 looking for developers to play a different
17 role with us and be open to that type of
18 relationship which we haven't really
19 deliberately, you know, spent time building in
20 the past.

21 DR. ASPLIN: If I could just,
22 quick follow-up to that then. A

1 recommendation. I think there's power in
2 using an iterative process. I think you get
3 to a better place by going back and forth and
4 using an iterative process.

5 So my recommendation would be to
6 expand the list of potential data sources that
7 committees will be making decisions on. I
8 think the key will be how do you make that
9 transparent and so that people who aren't
10 involved in the process can understand what
11 data were made available that were not in the
12 original submission. How did the committee
13 move down this path to get to where they got
14 so that it doesn't seem like a black box and
15 it doesn't seem random.

16 So I would say if we can figure
17 out a way to capture the power of an iterative
18 process while making it transparent, so that
19 if there are questions about the process not
20 just the decision those can be raised, I think
21 that would be the sweet spot. I'm not saying
22 it's easy to do.

1 MR. WONG: So Taroon, I appreciate
2 your broader view and I could tell that staff
3 took a lot of time developing both the
4 guidance documents. And you can see that, you
5 know, it's been very thoughtful about the
6 whole process.

7 I think that one of the things I
8 think that caught probably the membership here
9 by surprise was, in fact, that document
10 existed. So if it was in some of the books
11 already then I totally missed that. And so
12 when we were going through the process of
13 looking at reliability and validity, you know,
14 we're paying a little bit more attention to
15 the guidelines there.

16 And I think that that's where part
17 of the conversation kind of emerged about,
18 well, if we do this what will happen to the
19 measure. Because we don't want to quite, you
20 have some concerns but you don't want the
21 measures taken totally off the table.

22 And so as Jack kind of mentioned,

1 it was kind of a strategic loading situation
2 especially for today given our experience
3 yesterday. So that's a broad comment. And I
4 totally understand the need for, as you put
5 it, consistency of how we do things, so I
6 think that we do need to be mindful about how
7 to best deploy this particular document. So
8 that's one point.

9 My second point is that for today's
10 measurements, you know, you mentioned before
11 and this is one thing I wanted to ask, but I
12 think that staff kind of alluded to this that
13 for the measure developers there is
14 information there about what the threshold is.
15 And for this particular measurement I kind of
16 wonder whether or not they kind of missed
17 something in terms of that, because clearly
18 there was not enough information in terms of
19 the reliability and validity. It seemed to be
20 missing.

21 And, you know, I sit here
22 thinking, well, they've been doing this for a

1 long time. It passed the first level. But we
2 were just missing that other set of
3 information and it was really hard for us to
4 make that call on it because we know from
5 experience they have been doing this. So
6 there has to be something there but we didn't
7 have that information.

8 And so I kind of wonder how much
9 of it was really on them for not paying enough
10 attention to that sort of thing in delivering
11 all that information versus us trying to tease
12 that out and try to come to that other place.

13 So it might be a process issue
14 where, you know, going back to the developers,
15 some comments may be even from staff that, you
16 know, from sitting on a lot of these
17 committees I'm pretty sure that this
18 particular issue is going to merge, so stand
19 ready.

20 And, you know, part of my comment
21 here is kind of, if you think about the
22 federal grant process and if you have a good

1 grant officer that is looking at applications
2 coming back, you know, the grant officer goes
3 to all those study section meetings and
4 they're sitting in the background and they're
5 listening to all the issues that kind of come
6 up.

7 And in some way there's this
8 little role that, you know, I've been through
9 this a lot, you know, you might want to pay
10 attention to these sort of things, right. And
11 again it's up to either the applicant to kind
12 of make that decision to take that advice or
13 not. So just a very broad comment about how
14 we can potentially fix that process.

15 MR. WILLIAMSON: Great. Thanks,
16 Herb. Tom?

17 DR. TSANG: Two comments. I echo
18 everyone's comments about the thoughtfulness
19 of staff in preparing the guidance documents,
20 so thank you very much. I guess this is more
21 about kind of like the life cycle of the
22 measure.

1 And, you know, Taroon, you really
2 talked about the Kaizen process, and I'm just
3 kind of invoking my conflict of interest here
4 maybe. You know, in the pharma world we
5 constantly do post-market surveillance and
6 look at adverse events of drugs in the real
7 world.

8 So I'm just wondering, you know,
9 I'm sitting here listening to the measure
10 developer saying, well, you know, this
11 measure's gone through puberty and it's like
12 reaching adolescence now, but it would be nice
13 to actually think about either the unintended
14 consequences of this measure and have a little
15 bit of that data, I think some of us would
16 actually benefit from that.

17 And if he can present the almost
18 like a growth chart of this adolescent and
19 tell us, you know, where has the measure
20 pivoted in terms of its specifications and
21 also, you know, what were the consequences or
22 the impact whether positive or negative, so

1 that I could learn whether, you know, it's
2 been useful the last three years. This has
3 gone through a re-endorsement process and I
4 think that type of information would be
5 helpful.

6 And then the whole process about
7 looking at adverse events is whether a measure
8 developer would want to take that, you know,
9 I know resources are constrained and funding's
10 lacking, but to look at the post-endorsement
11 process a year from now and collect that data
12 about the measure.

13 So it's about really trying to
14 refine the measure process and refine the
15 measure development process as well as the
16 improvement process of a measure. So I'm
17 looking at this from a standpoint of like drug
18 development as well.

19 So, and then I guess, you know,
20 this is totally aspirational in terms of the
21 technology platform to capture this data. I
22 know SharePoint's a little bit clunky, but at

1 some point, I guess, if you have the resources
2 to create a technology platform where you can
3 actually combine all the different data points
4 into the worksheet.

5 MR. WILLIAMSON: That's a great
6 point. So my list, right now I have Lisa,
7 Bill, Nancy, Cheryl, Andrea, and then Larry.
8 So we'll go with Lisa.

9 DR. LATTI: Thanks. So some of
10 our meeting over the past couple days reminds
11 me of those old AQA meetings we used to have
12 about seven or eight years ago, and some of
13 you were there with me. And we used to have
14 our knock-down, drag-out, yelling fights about
15 how to evaluate these clinical quality
16 measures.

17 And those just don't exist anymore
18 because we've come so far in measure
19 development on the clinical side that we know
20 how to evaluate clinical measures. I don't
21 think we know how to evaluate these measures
22 yet, and I don't think we can apply the same

1 criteria in what we've learned on the clinical
2 side to these measures.

3 So I think the criteria need to be
4 different, and I don't know what that is
5 exactly. I don't know if it's just that we
6 loosen some things up, and I especially don't
7 know how to do it and still provide the
8 consistency that we're looking for. So that's
9 what I'm struggling with.

10 But I think we need to somehow
11 recognize that these measures are different
12 and we don't have the same level of, that we
13 can't do the same level of testing and it's
14 not nearly as straightforward, even though I
15 know that it's still not straightforward on
16 the clinical side, it's even less
17 straightforward on this side. Number one.

18 Number two, I thought, Tom, your
19 comments were excellent, and I wonder if again
20 especially for these measures there needs to
21 be a special set of questions that are asked
22 for the recert measures. So it doesn't just

1 go through the normal process, but there's,
2 you know, maybe there's some things we take
3 off.

4 You know, we don't do the
5 importance to measure, but maybe we just do is
6 this, still, you know, is this measure still
7 relevant? And then we do, you know, what's
8 happened since you implemented this? Who's
9 using it? How are they using it? What are
10 the results? What are the problems?

11 And so we remove some of the stuff
12 that's clear in a recent measure because it
13 was approved the first time and we add some
14 stuff that allows for some of that in-depth
15 evaluation.

16 MR. WILLIAMSON: That's great.
17 Thanks a lot, Lisa.

18 So Larry, I know that your point
19 was to that. I don't want to go out of order,
20 but do you want to add anything about the
21 different criteria? I think it's something
22 we'll have to bring back and go in-depth at a

1 later point, but Larry, do you want to add
2 anything to that?

3 MR. BECKER: Yes, I just wanted to
4 lay the idea on the table that for, you know,
5 most of the history of NQF we've used these
6 endorsement criteria around clinical measures.

7 And as we pivot towards, you know,
8 cost and resource asking the question of
9 whether or not these are still, all of these
10 are still the appropriate criteria and are
11 there other criteria we should be thinking
12 about as we pivot to these kinds of measures.

13 MR. WILLIAMSON: Okay. That's
14 great feedback. We'll definitely have more
15 work on this. We'll definitely talk with you
16 guys about this. So we'll move on to Bill.

17 DR. WEINTRAUB: So I'll reflect on
18 the last several comments. While the measures
19 we use in resource may turn out to be somewhat
20 different, there are still principles of
21 looking at reliability and validity that will
22 pertain and we will have to do those things.

1 And I think we're going to have to help the
2 developers develop a tool kit to be able to
3 respond looking at reliability and validity.

4 For the measure we heard about
5 this morning, the comments all started off
6 with, well, they didn't look at reliability or
7 validity. And they really didn't. Jack put
8 it together for them. He put together their
9 face validity and their construct validity for
10 them.

11 Would have helped a lot if they
12 had done that, and they could have if we had
13 a good framework for them. But there are
14 other criteria for validity to think about,
15 the criteria of validity and consequential
16 validity, and there's a formalism to it that
17 people should go to.

18 They should respond to each of
19 those even if very briefly, saying, you know,
20 we don't know what the consequences of this
21 are going to be, even if that's all they've
22 got. But at least let's help them develop a

1 framework that then would help us. I think we
2 could do a better job.

3 MR. WILLIAMSON: Thanks Bill.
4 We'll go to Nancy.

5 MS. GARRETT: So also building on
6 some of the other comments, and Taroon in
7 particular, your comment that in some ways
8 we're giving input kind of too late, I wonder
9 if the standing committee provides an
10 opportunity to look at this a little bit
11 differently and do something a little more
12 creative around an iterative process.

13 So it would be really nice if all
14 of us really became experts on cost and
15 resource use measures knowing what's out there
16 in the community, what's being used, what's
17 being developed, what's in the pipeline. The
18 things that we've looked at in the committee,
19 how are they being used.

20 I mean, could there be a monthly
21 newsletter with some information so that we
22 understand what's going on and could there be

1 some more regular check-ins, rather than once
2 every three years this really deep dive and
3 then we don't look at it again?

4 And it's the same thing that came
5 up in the episode grouper criteria discussion,
6 which is if you endorse a software product
7 that needs to change every week what does that
8 even mean? And so we don't want these
9 measures to become static. So is there a way
10 we can somehow change the process to be more
11 iterative in response to that?

12 MR. WILLIAMSON: I think that's a
13 great point. Next, we have Cheryl.

14 MS. DAMBERG: So I agree with
15 everything that's been said so far, but I want
16 to turn to kind of another issue. So at the
17 beginning of the meeting you had presented a
18 slide that looked like the boxes within the
19 box to go from resource use to, what was it,
20 efficiency to value or something like that?

21 And then you had another table
22 that showed us a set of measures but it didn't

1 include all of the overuse measures that you
2 have evaluated on the quality side. And I
3 think it's hard for this group to kind of keep
4 track of all the moving pieces that hit this
5 space and sort of what boxes we have actually
6 filled versus where are these gaps such that
7 when a new measure comes forward we can say,
8 oh, you know, this is a resource use measure
9 for hospitals and, you know, that's a space
10 that we don't have anything in.

11 So I think just being able to get
12 our heads around that in a more systematic way
13 would help the committee think more clearly
14 about, you know, what is it that we're trying
15 to accomplish here and where is this going.

16 And I think that this has been the
17 challenge that the MAP has faced because, you
18 know, we want to be doing this at all levels
19 of the system and we want it to cover these
20 six dimensions and, you know, it gets hard to
21 think about.

22 But I was really struck by, I

1 think, Jack's repeated use of the word
2 building blocks. And so if partly what we're
3 reviewing here is a building block to even get
4 us out of that first box, I think that's
5 something we have to acknowledge and say is
6 that sort of the basis on which we're
7 reviewing this measure? That we're really in
8 the alpha stage of development rather than
9 beta into scalability.

10 MR. WILLIAMSON: Taroon, did you
11 want to respond directly to that or should we
12 go to Andrea?

13 DR. GELZER: I guess a question
14 and a comment. And the question is, how many
15 cost and resource use measures -- the
16 portfolio's very small. What is the pipeline
17 and how are we soliciting folks to develop
18 these measures?

19 MS. WILBON: That's what we were
20 asking you. No, we're -- and Taroon talked
21 about this, I think, a little on the first
22 day, but right now our process has been very

1 reactive in that --

2 DR. GELZER: So how can we become
3 proactive, I guess, is what -

4 MS. WILBON: Right. Working with
5 you guys to figure out what are the gaps, what
6 are the high priority areas that we should, to
7 help us, you know, work with developers and
8 some of the people that we know are giving the
9 development dollars to tell them this is what
10 you should be spending your money on. Because
11 otherwise our work will continue to be
12 reactive to what's already out there as
13 opposed to -

14 DR. GELZER: Well, so maybe you
15 should formally solicit, or formally send that
16 out to the committee so that we can each tell
17 you what we think.

18 MR. AMIN: Right. So maybe I'll
19 just piggyback on where Ashlie was going which
20 is that these are sort of the enhanced
21 functions of the standing committee that we
22 see. We're sort of putting them out for

1 reaction, but we're certainly not trying to
2 answer all these questions now.

3 So one of them is in its domain
4 which is, you know, what are the high impact
5 areas of cost and resource use measures that
6 we would want to see by care setting or how
7 would we start to look at the clinical areas,
8 how do we start to address these?

9 We won't be able to get -- how do
10 we start to prioritize the clinical areas
11 where we want episode-based measures? How do
12 we start to think about episode first per
13 capita measures and which cases would one be
14 more appropriate than the other?

15 And so we're just sort of putting
16 these out there as questions that need to be
17 answered, and we need to think through on our
18 back end, which is how do we start to create
19 this as part of our work going forward?

20 And part of our conversation now
21 is to create an expectation with this group
22 that this is where we see this group moving

1 to. Not just up or down on measures but, you
2 know, we've been doing some of this work.

3 I shouldn't say, you know,
4 definitely this group has not been just up or
5 down, certainly, but again because it's been
6 such a new area and there's been a lot of
7 conceptual building, conceptual model building
8 that we've done from the beginning.

9 But we're going to have to go
10 through that exercise, Andrea, in a much more
11 systematic way.

12 DR. GELZER: Okay. That's great.
13 And then my comment, really, I think that we
14 can't -- the way the process is set up now
15 it's probably too prescriptive for this area.
16 I agree with what Lisa said that this is a new
17 area. We have to consider these measures a
18 little differently than the quality metrics
19 and then evolve and iterate how we do the
20 evaluation.

21 And I would just say in a past
22 life when health plans were first starting to

1 talk about efficiency measures and I had to go
2 out on the circuit and go to specialty
3 societies and talk about our plans, you know,
4 new high efficiency network and how we were
5 measuring physicians on efficiency, we have to
6 make sure that we are able to use the same
7 vernacular or the same terminology as folks
8 out in the community. Because all I remember
9 is, well, tell me what's the confidence
10 interval? What's your confidence interval?

11 I mean, I think, you know, we need
12 to be speaking the same language that they
13 will be speaking. And that's just an example.

14 MR. WILLIAMSON: Thanks, Andrea.

15 So I have Janis, Bill and then Matthew.

16 DR. ORLOWSKI: So what I would say
17 is that I view this as a spectrum of
18 healthcare from physicians to hospitals to,
19 you know, the ambulatory to the healthcare
20 plans. And I think what we have to do is, if
21 you're saying where shall we go, I think the
22 answer is that you have to take a look at that

1 continuum and be strategic where you believe,
2 based on the experience of the group that we
3 have, where you believe it would be critical
4 for evaluation of cost and resource.

5 And I'll give a example. Large
6 hospitals have a lot of experience looking at
7 cost and resource use in order to improve
8 efficiency. And what they have learned over
9 time is that sometimes you go to, you know,
10 you go immediately this is a high cost item or
11 whatever.

12 And then as you look at the continuum
13 what you understand is that there are times
14 that you spend a certain amount of money and
15 it improves everything downstream. It
16 improves your costs. It improves your
17 resource utilization, your length of stay, and
18 it improves your outcome.

19 And so what I would say is that if
20 you want to say where you can make an
21 important contribution, take that example from
22 within the hospital and use it on, you know,

1 as sort of a broader look at healthcare.

2 And I think that there are areas
3 that can be pinpointed to question cost and
4 resource use and it can be coupled with
5 quality. I will also say that there are areas
6 along the spectrum of healthcare resource
7 usage where there's clearly an underspend by
8 folks.

9 And I think that it would be very
10 interesting to not only take a look at areas
11 where we believe that there's high cost and
12 high resource utilization, but it would be
13 very interesting to take a look at places
14 where there's likely low resource use,
15 inappropriately low resource use. And I think
16 that you can look at the spectrum and you can
17 begin to target that.

18 And so, but that is a strategic
19 discussion over, you know, a couple of days
20 where you take a look and then say where is it
21 likely, where are you likely to be able to
22 make a difference?

1 And I think that there are people
2 both on this committee and others that you
3 could add that would have a lot of experience
4 in looking at and evaluating strategically
5 resource utilization.

6 DR. WEINTRAUB: So I'm going to
7 build on what Janis just very wisely talked
8 about. We're just barely beginning to sort of
9 scratch the surface here and we're doing it
10 without a framework to plug that into.

11 So the three measures we discussed
12 these two days to me didn't fit into any kind
13 of framework, they were just individual
14 measures. And to develop that framework, that
15 strategic plan to do that and to think about
16 how we're going to serve society best in
17 looking at cost and resource use we're going
18 to have to have a framework. Because there's
19 so many different things that you can look at.
20 We've sort of, in a sort of standard way
21 looking at providers and episode of care in
22 the hospital in 30 days, or a health plan

1 looking at cardiovascular resource use.

2 But Janis just brought up the
3 whole issue of healthcare disparities and how
4 shall we address the issue of cost and
5 resource use when socioeconomic factors and
6 healthcare disparities are so tremendously
7 important in our society?

8 Where's the balance between acute
9 care focused on largely an older population
10 and preventive care for children and young
11 mothers? How do we as a society come to a
12 balance in looking at resource use and that?
13 How can the measures we would develop here
14 help address those kinds of issues in our
15 society?

16 So I think it's just going to take
17 time and we're going to have to have time
18 where we step back from individual measures to
19 consider just what we're doing and how we can
20 most efficiently use the limited resources we
21 actually have here.

22 MR. WILLIAMSON: Thank you.

1 Matthew?

2 MR. MCHUGH: So very much, I
3 think, in this same vein, I think in order for
4 us to identify gaps we need to have a
5 landscape to really look at it, and it just
6 can't be we have this measure, that measure
7 and this measure.

8 It needs some kind of organizing
9 structure in order to say, okay, well, this is
10 what we're covering here and how we're
11 covering it, you know, but there's this whole
12 other kind of black hole that we're not really
13 approaching.

14 So whether it's a framework or starting
15 out, I think, as Cheryl kind of talked about
16 in at least mapping things on to that kind of
17 very general kind of orientation of building
18 blocks towards value would be a good place to
19 start and would help us get the most value out
20 of our collective thinking.

21 MR. WILLIAMSON: All right, I have
22 Tom, Brent and then Dolores.

1 DR. TSANG: Two more comments. I
2 was pretty disappointed in the measure
3 developer's response to my question about the
4 states' APCD initiatives because his response
5 was we're only measure developers, I don't
6 touch policy.

7 Well, I think that's the wrong
8 attitude to have because obviously this is a
9 huge impact on policy and it's inextricably
10 linked to policy. So when he's telling me
11 he's spending a million dollars on this
12 measure development and yet this whole huge
13 initiative is going on, so I'd like to
14 understand why they haven't really, you know,
15 coordinated activities.

16 So I don't know if that's within
17 your scope, but I think that's one issue. And
18 then the second issue is really coming from
19 NQF's conference a couple weeks ago about
20 patient-centeredness.

21 And so far, you know, this is the
22 second committee I've sat on, but so far these

1 measures are either payer-facing or provider-
2 facing, and we've been giving lip service
3 about measures that would be patient-facing.

4 And so some of you may know about
5 Castlight. It's a new company that's, it's
6 not so new anymore, but I think they're
7 thinking about going on IPO and they're
8 presenting quality data along with cost data
9 to all these employees about plans on the
10 state exchange.

11 So I mean, how is that, you know,
12 how are they doing it in such a way that could
13 actually synergize and coordinate on these
14 types of measures that are looking at cost and
15 present it in such a way that's going to be
16 consumer friendly?

17 As I think we all know that high
18 deductible plans are becoming the majorities
19 on these benefit plans now these days and that
20 data is important, that information is
21 important to consumers, so how is this measure
22 going to be kind of like patient and consumer

1 friendly?

2 MR. WILLIAMSON: That's great.

3 Thank you.

4 MALE PARTICIPANT: Great point.

5 MR. WILLIAMSON: Brent?

6 DR. ASPLIN: Yes, the conversation
7 is sort of drifting naturally to the other
8 broad question I was going to ask, which is
9 what are the, you know, practical and best
10 guesses as to what the next steps might be to
11 the conversation we had just before lunch
12 yesterday?

13 And it really kind of echoes in
14 several of the recent comments around the need
15 for a strategy in this area. And I know there
16 are funding questions, yet who's being held
17 accountable?

18 How will we actually hold medical
19 groups to accountability or some combination
20 of medical groups and hospitals, not just
21 hospitals or plans? The two-tailed question
22 of not just over, but to Janis's point, under

1 use of resources, and some of the other
2 questions that have been raised that really
3 lend themselves to more of a strategy process.

4 So will that, you know, and I know
5 you might not have the final answer today, but
6 what's the likelihood and who are the
7 potential sources to fund that type of effort?
8 It almost seems like a collaborative effort
9 between a standing committee and the MAP,
10 potentially.

11 MR. AMIN: Can I just add to that
12 list real quick? Because I think that just as
13 we talk about strategic issues, I think this
14 criteria issue is on that list too. And then
15 related is this whole issue of the fact that
16 there's no directionality.

17 It's not clear whether higher or
18 lower is better and how do we, you know, and
19 that obviously has a link to the whole quality
20 aspect. So those are at least, I agree with
21 that strategic list.

22 MS. YANAGIHARA: Yes, that was

1 actually my point. This is actually a
2 combined point for Cheryl and I, but Cheryl
3 had to leave. So, you know, she pointed out
4 that with clinical quality, I mean all the
5 measure development really was focused on
6 clinical evidence, and where was their clear
7 evidence and let's make measures around that.

8 But there's not that with the
9 resource use measure. Which is better? We
10 had that conversation many times over the last
11 two days, right, like what number is the right
12 number? Is higher better, is lower better?
13 It might depend on who you are so as to answer
14 that question.

15 So what I actually think is that
16 in a way resource use makes the most sense
17 when it's paired with quality, and so if you
18 look at the key quality areas, and I think
19 yesterday that list that was up there was
20 pretty good and it was really kind of played
21 out in our own data those were the top areas.

22 It's really like finding resource

1 use measures that can then be paired with the
2 quality measures. And I think someone else
3 brought up there are already some kind of
4 resource use measures that are considered
5 quality measures like C-section rate, right?
6 That is considered a quality measure, but
7 really is also a resource use measure. It's
8 not cost but it's resources.

9 So anyway I think that if you
10 focus on those areas that clinically are
11 important, then there's context for
12 understanding the resource use and what is
13 kind of better or worse because you have it to
14 pair with the quality.

15 MR. WILLIAMSON: Thanks a lot,
16 Dolores. We have Jack next.

17 MR. NEEDLEMAN: Not going to be my
18 most clearly formed thoughts, and which given
19 some of the thoughts I've had it's a very low
20 bar. I was struck by Janis' comment about, in
21 essence, value stream mapping which is what I
22 took from what you were saying.

1 We've got usability as our
2 criterion and we've going over it rather
3 quickly. But in terms of setting priorities
4 for what we need to look at, what's useful to
5 look at, both the resource use measures and
6 the quality measures are fairly high level
7 endpoints of what in terms of summaries of how
8 well the organizations are doing or the
9 individual clinicians are doing.

10 But to make sense of them and to
11 think about feasibility we need to think about
12 we're trying to tie both of them back to what
13 happens in clinical practice and
14 administrative practice.

15 What's the value stream map that
16 allows a hospital to efficiently produce care?
17 What are the linkages to the post-acute
18 services that makes sure those services are
19 delivered appropriately to the patients that
20 are coming out of the hospital?

21 You know, if we think about it in
22 terms of treatment things like cardiac, we've

1 got the issue of what's the care map? What's
2 the care map look like for an optimal
3 treatment of this patient given the
4 uncertainties, you know, and the probabilistic
5 things that happen to patients?

6 And the usability of these
7 measures are a way of testing whether you're
8 on those paths at a very high level and
9 whether they give you signals about where in
10 that path you should be looking to improve
11 yourself.

12 So at some point I think, and
13 doing that linkage I don't think is in the NQF
14 space, but in terms of setting priorities and
15 thinking about the value of these measures, we
16 need to spend a little bit more time thinking
17 about the usability and the uses and how the
18 measures relate to the uses.

19 And then the reliability and the
20 validity come into do they give you accurate
21 information? But so those who are making use
22 of the measures should be part of the

1 conversation about what the priorities are,
2 and what the shape of the measures are, and
3 what kinds of information gets distributed,
4 along with the summary statistics from the
5 measures in terms of helping shape what a good
6 measure is and what a good set of analyses
7 are.

8 MR. AMIN: So Jack, one of the
9 questions that we're thinking through
10 internally is, does the use case for the
11 measure change the criteria or does it just
12 change the way you would potentially weight
13 the criteria?

14 MR. NEEDLEMAN: There are two
15 issues here. One is you've asked us where the
16 priorities should be. How can we be more
17 proactive? And I think the areas of priority
18 and proactivity depend upon use. Who needs a
19 measure to help them make improvements in
20 care? So that goes beyond the evaluation of
21 the individual measure.

22 The second question is, you know,

1 we've looked at some of these reports, that we
2 saw it with respect to the NCQA report. We
3 saw it in some of the stuff that CMS was
4 thinking about distributing. We saw it with
5 the CMS per member per month measure that was
6 evaluated earlier, where the report becomes
7 part of the usability assessment but also
8 provides some insight into what the measure
9 has to accomplish.

10 So maybe we ought to be
11 reweighting the evaluation of the measures
12 between, are they valid and reliable which is
13 where the core activity, and if we allocated
14 our time the last time few days where we spent
15 most of our time, and the usability measure.
16 What's the value of this measure in use to
17 clinicians, to administrators, to plan
18 administrators in terms of enabling them to
19 make improvements in care?

20 As we get more measures and we
21 come to that issue of, you know, the relative
22 value of different measures which is down the

1 road, I don't think we've hit it here yet, but
2 it's one of the criteria in the NQF list, I
3 think this issue of relative usability and
4 value to user is going to rise higher in our
5 decision making and maybe we can figure out
6 ways to anticipate that and send some signals
7 of that to the measure developers as something
8 that they also need to be spending time
9 worrying about rather than simply is it
10 reliable or valid.

11 MR. WILLIAMSON: Thanks Jack. So
12 we have Nancy, Lisa and then Janis.

13 MS. GARRETT: So two comments.
14 One is on the -- Tom reminded me of something
15 when he brought up Castlight which is, I
16 wonder if that's a stakeholder group that we
17 don't have represented that we should which is
18 analytic vendors who are really doing some
19 very creative things in this space and might
20 be able to inform some of our conversation.
21 So that's just something to think about.

22 I know on the episode grouper

1 committee we do have quite a bit of
2 representation from that kind of stakeholder
3 group. But it's almost like an emerging group
4 that's doing a lot of innovation in the
5 measure of costs and resource use
6 measurements. So it's just something to think
7 about.

8 And then on Brent's question of
9 what would it look like to get the resources
10 to put together a strategic plan for cost and
11 resource use measurement, I'm just wondering
12 the NQF staff reaction to that.

13 So do we need additional
14 resources? Could we do that without an in-
15 person meeting, for example, through kind of
16 working together virtually? What are thoughts
17 on next steps for that?

18 DR. LATTIS: So I just wanted to
19 add to this schema that we're building of sort
20 of the things we would like to see as part of
21 this committee, and I know I've reiterated it
22 multiple times.

1 But I think depending on the
2 measure and the type of measure that you're
3 looking at, I don't think cost and quality are
4 enough. I think we need that measure of
5 appropriateness or a measure of utilization as
6 that third leg of the stool.

7 And so, you know, again for global
8 measures it's less important, but when you
9 start to parse it out into particular pieces
10 I think it does get to be really important.
11 And, you know, I know that Daniel Wilson, who
12 was on the first, or the last phase of this
13 committee, whatever phase that was, and who
14 leads the Choosing Wisely initiative, always
15 says that this is not about measurement it's
16 about professionalism.

17 But I think those are, you know,
18 his list is a good place for us to start. And
19 we've got to start having measures of
20 appropriateness in terms of what's being
21 ordered.

22 MR. WILLIAMSON: Thanks Lisa.

1 We'll go to Janis.

2 DR. ORLOWSKI: So, Jack, I feel
3 like you were reading my mind, and so just to
4 continue my discussion. So I want to use,
5 hopefully this is helpful and not starts a
6 whole other part of the conversation, but when
7 I take a look at the measures that we have
8 before us in the last two days and we take a
9 look at total cardiovascular spend, I see
10 issues with that. You know, like anyone I
11 could be critical. I could see it.

12 But as far as usability, I think
13 that it has some, I think that it can be
14 directly usable to plans, to hospitals, to
15 large physician groups. I see a lot of
16 applicable use for that.

17 When I take a look at heart
18 failure, even though I agree that it's the
19 number one diagnosis in hospitals and it is
20 absolutely a critical issue that we have to
21 address, the pressure point for heart failure
22 is not the acute hospitalization.

1 The pressure point for heart
2 failure is the ambulatory care of a patient
3 with heart failure. And so it's right horse,
4 wrong rider is what I would say. Should we
5 talking about heart failure? Absolutely.
6 Should we be looking at measures on heart
7 failure? Probably one of the most critical
8 measures that we should be dealing with.

9 If you take a look, and again we
10 could be wrong, if you take a look at the
11 pressure point for making changes in
12 expenditure in heart failure it is not the
13 acute hospital admission and 30 days post. It
14 just isn't.

15 And so at some point for those of
16 us in the field, you've got to, you know, you
17 bring 25 years of experience to an
18 understanding of how to utilize this data.
19 And in my opinion that's how I look at these
20 two measures. One is a little fuzzy but
21 usable, the other is more discrete but is at
22 the wrong usability point.

1 And so I think that Jack, you're
2 right. That we're talking about value mapping
3 and we're talking about clinical care mapping
4 and then where do those become usable and
5 where do we have the ability to influence our
6 use of resources wisely.

7 MR. WILLIAMSON: Thanks, Janis.
8 So we're going to Lisa, Lina, Dolores, and
9 then we're --

10 DR. LATTS: I just wanted to push
11 back on that a little bit. CMS paid for Yale
12 to do that measure because CMS is the one
13 paying for the inpatient hospitalizations. So
14 what's their point of leverage? So I 100
15 percent agree with you that it's change in the
16 primary -- or the cardiologist's office,
17 whoever's caring for it, it's an outpatient
18 change that needs to occur.

19 But who's going to make that
20 change happen? All of the stuff that's
21 happened up until now has not made that change
22 occur in the outpatient arena, whereas holding

1 hospitals accountable will cause them to push
2 it downstream so that that change happens.

3 DR. ORLOWSKI: CMS pays doctors.

4 DR. LATTI: They don't pay them
5 enough. And it's the leverage.

6 DR. ORLOWSKI: Well, that's
7 another issue.

8 DR. LATTI: But no, no, no. But
9 it's the leverage. They pay them so little,
10 frankly, that they don't have the leverage.

11 DR. ORLOWSKI: So Lisa, I
12 completely disagree with you. Putting the
13 pressure on the hospital to be the deep
14 pockets to affect change in the ambulatory
15 space or the provider space or the plan space
16 is interesting. It works to a certain point.

17 But it's, you know, it's not where
18 the pressure should be put. CHF is an
19 ambulatory sensitive resource use. Now if you
20 say hospitals are beginning to own more
21 doctors then, yes, you know. But again it's
22 a physician-specific point that is sensitive

1 here.

2 MR. AMIN: There's a lot of
3 disagreement on this topic. Let's just maybe
4 move. Maybe we could just move around. I
5 mean, I'm just trying to be respectful of
6 people's time to be able to get out, just so
7 that we can get through the list, Evan.

8 MR. WILLIAMSON: Okay, we'll take
9 one or two last comments on it and then we
10 can, or we'll give Lina the last word on this
11 and then -

12 MS. WALKER: Well, I'm not
13 actually going to speak specifically to the
14 heart failure issue, but I think Janis raises
15 a broader point that I wanted to mention which
16 I mentioned yesterday.

17 I think part of the issue with the
18 heart failure measure was because the
19 developer was trying to align it with the
20 previously available quality measure. And so
21 sort of backward engineering and measure so
22 that it would complement something they

1 already have, I think, is a wrong approach to
2 building a cost and resource use measure.

3 So once again I'd like to, you
4 know, we really need to step back and ask what
5 is the problem we're trying to solve for and
6 think about what is the quality utilization
7 measure and what is the complementary quality
8 measure needed to address that problem?

9 And I actually do agree with your
10 point about heart failure but I'm not going to
11 go into that. But I think it highlights that
12 problem that we're facing now is that they
13 base it on whatever they have on the quality
14 side and that's really not the right approach.

15 MR. WILLIAMSON: Yes, so we'll get
16 Dolores and then Andrea, and then we'll call
17 it.

18 MS. YANAGIHARA: So Taroon, you
19 asked about whether the criteria should be
20 different based on use case or whether just
21 the weighting. I think the criteria have to
22 be the criteria. I don't think that those

1 should change.

2 But the way that they're applied
3 in terms of how much you value each thing or
4 what is the rationale for a certain exclusion
5 might be different based on different use
6 cases. But I think the criteria need to be
7 consistent, I mean just from a -- yes.

8 And then just a note on Choosing
9 Wisely measures, Lisa, I agree. Actually
10 they're not measures yet, that's the problem.
11 There's a lot of great concepts but there's no
12 measures yet on choosing wisely. So I think
13 it's great. That would be a great area to
14 focus on.

15 My concern is that they might be
16 too narrow to get really robust measurement
17 because usually they're very specific to a
18 very small population of people. But I think
19 it's still worth pursuing, because I think
20 those are really important areas that getting
21 to that appropriateness area.

22 And then just a note. When you

1 get into utilization measures and cost
2 measures, it's tricky because if it's not
3 paired with value-based purchasing what doing
4 the right thing may be meaning losing money.

5 So for example, reducing C-section
6 rates might be the best thing for the mother
7 and the baby and it might be the best thing
8 for overall total cost, but the hospital and
9 the doctor are going to lose money on that,
10 right?

11 So until incentives are aligned, it's
12 hard. There's just conflicting signals that
13 we're providing in the market. And so it's
14 just something that just makes it, you know,
15 the resource use measures that much more
16 tricky.

17 MR. WILLIAMSON: Thanks, Dolores.
18 All right, Andrea.

19 DR. GELZER: Okay, one more point.
20 We had the discussion at dinner a little bit
21 about who the driver is, and I agree with Lisa
22 that the hospital in this day and age is the

1 driver.

2 And there's way too much
3 fragmentation in the system and so costs may
4 be, you know, what we're trying to accomplish
5 here is rationalize the cost equation and to
6 rationalize that we've got to reduce
7 variation, but we've also got to reduce
8 fragmentation.

9 So I think that, you know, for
10 congestive heart failure, by god, the hospital
11 is still the biggest cost center and they are
12 still the biggest driver and we've got to use
13 that. Thank you.

14 MR. WILLIAMSON: All right,
15 thanks, Andrea. So we don't want to stunt the
16 discussion. We invite you to send us emails
17 or maybe we could find out some way to use the
18 SharePoint. That we could implement a
19 discussion board on there so maybe we could
20 start seeding some ideas on there and really
21 get some good discussion. You guys have a lot
22 of opinions and aren't afraid to share them.

1 So we want to make sure that we give you guys
2 a forum to do so and we can really start
3 moving forward.

4 So the last thing we want to go
5 over, just the next steps, we'll do public and
6 member comment right before we close, but here
7 are some next steps for Phase II and Phase
8 III. So we plan to have a draft report posted
9 by April 21st. Our post-comment call will be
10 June 4th, so that's the next time we'll all be
11 together is June 4th on that call for Phase
12 II.

13 For Phase III we have an
14 orientation call on April 23rd. Again as I
15 mentioned earlier, we'll figure out really a
16 high leverage way to use that. We don't want
17 to just reiterate the same information that we
18 have before.

19 We have Q&A calls scheduled May
20 28th and June 11th, and again, you know, maybe
21 some of the feedback we got today might
22 influence how we use those, whether it's a

1 workgroup call or true Q&A call. Question?

2 MS. WALKER: Now this phase, the
3 first Q&A call happened before the technical
4 expert panel convened. Is it possible to have
5 both calls after?

6 MR. WILLIAMSON: Actually the
7 first Q&A call happened after the TEP met.
8 There were things we had to stagger that
9 moved, you know, we were starting all these
10 processes. We had the first TEP call and then
11 we had the first Q&A call, then we actually
12 had a second TEP call scheduled that we
13 cancelled.

14 But in order to turn around the
15 information from the TEP we didn't have it
16 available in time for the first Q&A call.

17 MS. WALKER: Oh, I see.

18 MR. WILLIAMSON: So we can do our
19 best to make sure that it's available, but
20 again we're going to rethink how to use these.
21 These are the times we have scheduled.
22 They're on the books. And we'll think about

1 how we can use them to make sure that we get
2 the TEP information to you in a timely manner.
3 But again this is all, these are compressed
4 timelines.

5 MS. YANAGIHARA: Do you have the
6 times for these meetings yet? Because I'm
7 like, I don't have them on my calendar or -

8 MR. WILLIAMSON: Yes, we'll send
9 out -- the Phase III calendar invites will go
10 out. They're also all listed on the
11 SharePoint page. I'll just show you where
12 they are here. We have the committee
13 calendar. And so all the times are listed
14 here, so I think they're all noon Eastern.
15 All those calls are noon Eastern.

16 And see, they're separated by
17 phase here. But we'll make sure we send out
18 the calendar invites, but we want to make sure
19 we get it on the calendar. And then our in-
20 person meeting is June 25th and 26th.

21 So those are the next steps.
22 Again we realize this is a compressed timeline

1 and we're kind of starting Phase III while
2 Phase II is still going on, but that's just
3 how the timeline lays out. So are there any
4 final questions or feedback on that? We want
5 to give you guys some time to get to the
6 airport or get on your train.

7 So we'll close with public
8 comment. Do we have any comments in the room?
9 Okay, do we have -- operator, could you please
10 open the lines for public and member comment.

11 OPERATOR: If you'd like to make a
12 comment please press star and the number 1.
13 At this time there are no comments.

14 MR. WILLIAMSON: Great. Thank
15 you. Well, we really appreciate everybody
16 coming to Washington and braving the weather
17 and working with us over the last two days.
18 We really, I think we got a lot of work done.
19 A lot of questions to answer going forward,
20 but we know we're all up to the task. So
21 thanks again, and I want to thank our co-
22 chairs.

1 DR. BURSTIN: And also thanks to
2 those on the phone. I mean, for most of us
3 who can't handle more than two hours on a
4 conference call, the idea that they've hung
5 with us for two days is really above and
6 beyond the call. So thank you.

7 DR. ASPLIN: That was the comment
8 I was going to make. They did a much better
9 job than I could have possibly done hanging in
10 there on the phone. So I really appreciate
11 that. And one last thank you to the staff
12 here for coordinating everything. Thank you.

13 (Whereupon, the foregoing matter
14 went off the record at 2:35 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Cost and Resource Use Phase II

Before: National Quality Forum

Date: Wednesday, March 5, 2014

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