

NATIONAL QUALITY FORUM

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COST AND RESOURCE USE

STEERING COMMITTEE

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WEDNESDAY

MAY 8, 2013

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The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Eugene Nelson and David Penson, Co-Chairs, presiding.

PRESENT:

EUGENE NELSON, DSc, MPH, (Co-Chair),  
Dartmouth Institute for Health Policy and  
Clinical Practice

DAVID PENSON, MD, MPH, (Co-Chair),  
Vanderbilt University

BRENT ASPLIN, MD, MPH, Fairview Health  
Services

LAWRENCE BECKER, Xerox Corporation

MARY ANN CLARK, MHA, Interalign

CHERYL DAMBERG, PhD, 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

DAVID GIFFORD, MD, MPH, American Health Care  
Association

LISA LATTS, MD, MSPH, MBA, FACP, LML Health  
Solutions, LLC

MATTHEW MCHUGH, PhD, JD, MPH, RN, CRNP,  
FAAN, University of Pennsylvania

MARTIN MARCINIAK, MPP, PhD, GlaxoSmithKline  
JAMES NAESSENS, ScD, MPH, Mayo Clinic  
JACK NEEDLEMAN, PhD, UCLA Fielding School of  
Public Health  
CAROLYN PARE, Minnesota Health Action Group  
DAVID REDFEARN, PhD, WellPoint  
ANDREW RYAN, PhD, Weill Cornell Medical  
College  
JOSEPH STEPHANSKY, PhD, Michigan Health &  
Hospital Association  
THOMAS TSANG, MD, FACP, Harvard Medical  
School  
LINA WALKER, PhD, AARP - Public Policy  
Institute  
WILLIAM WEINTRAUB, MD, FACC, Christiana Care  
Health System  
DANIEL WOLFSON, MHSA, ABIM Foundation  
HERBERT WONG, PhD, Agency for Healthcare  
Research and Quality  
DOLORES YANAGIHARA, MPH, Integrated  
Healthcare Association

NQF STAFF:

HELEN BURSTIN, Senior Vice President,  
Performance Measures  
ANN HAMMERSMITH, General Counsel  
  
TAROON AMIN, Senior Director, Performance  
Measures  
LINDSEY TIGHE, Project Manager, Performance  
Measures  
ASHLIE WILBON, Senior Project Manager,  
Performance Measures  
EVAN WILLIAMSON, Project Analyst,  
  
Performance Measures  
CARLOS ALZOLA, NQF Statistical Consultant

ALSO PRESENT:

RICHARD BANKOWITZ, MD, MBA, Premier

Healthcare Alliance

JEFFREY BALLOU, Mathematica Policy Research

CRAIG CAPLAN, Centers for Medicare and

Medicaid Services

JAYNE HART CHAMBERS, Federation of America

Hospitals

GREG POPE, RTI International (by

teleconference)

EUGENE RICH, MD, Mathematic Policy Research

SHEILA ROMAN, MD, MPH, Centers for Medicare  
and Medicaid Services

JOHN SHAW, Next Wave

KIMBERLY SPALDING BUSH, Centers for Medicare  
& Medicaid Services

MARY WHEATLEY, Association of American  
Medical Colleges

SAJID ZAIDI, Acumen LLC

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Adjourn

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

8:42 a.m.

CO-CHAIR NELSON: Good morning.

We would like to welcome you today for the Cost and Resource Use Committee deliberations, and we are very pleased that everyone is here.

As we think about how to operationalize the three part aim and the National Quality Strategy and the Affordable Care, measures of cost and resource use are clearly important. And so, we appreciate you taking the time today to be here with us.

CO-CHAIR PENSON: Thank you very much for coming. I look around the table and there are faces I know and some I don't know. So, it is good to see you people we have worked with before.

(Participant asks him to use the microphone.)

CO-CHAIR PENSON: I am sorry, I am talking into the microphone. I will talk



1 louder. I am from New York originally, so it  
2 shouldn't be a problem.

3           Anyway, having done this process  
4 before, I think all of you know, for those of  
5 you who have done it before, you know it can  
6 be a little bit challenging. But, that being  
7 said, I think these measures, we only have  
8 two. So, that will at least make the workload  
9 a little easier. I look forward to good  
10 discussions.

11           Taroon, I don't know if you want  
12 to add some comment.

13           MR. AMIN: Yes, I would. Thank  
14 you, David.

15           Again, thank you all. I really  
16 appreciate all the hard work. There is  
17 obviously a lot of materials that we sent out.  
18 We understand that that is a lot of work that  
19 you are doing on volunteer time. So, again,  
20 we appreciate all that work.

21           This is, obviously, not the end of  
22 the work. We will be going through, as

1 Lindsey and Ashlie will be talking through,  
2 you know, a comment period and going to our  
3 CSAC and to the Board for approval.

4 I just wanted to highlight a few  
5 components as we go forward here. Clearly,  
6 this is one of the nation's and, clearly, one  
7 of NQF's most high-profile projects this year.  
8 Because of that, obviously, we want to just  
9 stress a few components as we kind of move  
10 forward here.

11 The first, as you noted, we had a  
12 number of public comments that fed into this  
13 Steering Committee meeting. The role of  
14 public comments is obviously very important in  
15 the Committee discussions because, obviously,  
16 we are maintaining sort of a multi-stakeholder  
17 perspective here and all of the perspectives  
18 that feed into this discussion should weigh  
19 into the Committee's discussions.

20 So, again, making sure that we are  
21 weighing the inputs of the public, not only  
22 here in terms of the pre-member input, but

1 also evaluating those public comments as they  
2 arise during the Committee discussions. So,  
3 we will have various points during the  
4 Committee deliberations where we will ask for  
5 public comments and facilitate that discussion  
6 as we go.

7 The final Committee preliminary  
8 recommendations on this measures will also go  
9 out for public comments, in which we will ask  
10 you to evaluate and to think about those  
11 comments in the spirit of your deliberations.

12 The second is thinking about the  
13 fact that, obviously, these measures are, in  
14 the grand scheme of NQF measure portfolio,  
15 very complex in terms of the risk adjustment  
16 and their construction, and, obviously, issues  
17 of use are important here as well.

18 So, these conversations are highly  
19 technical. In a lot of ways, we have seated  
20 this Committee because of your technical  
21 expertise in various different areas. But it  
22 is also important to maintain the fact that

1 this organization sort of prides itself on the  
2 fact that we are multi-stakeholder, and the  
3 work of this organization will sort of feed  
4 into various different sectors of the  
5 healthcare landscape.

6 In particular, we should make sure  
7 that these discussions, once we have sort of  
8 digested the technical discussion, we can  
9 translate that into sort of a level of  
10 discussion that could be easily digestible by  
11 all stakeholders. And again, that is one  
12 piece.

13 And then, the second is to make  
14 sure that we look across the table during our  
15 introductions, recognize that we have various  
16 different perspectives represented here, and  
17 all those perspectives are valued at this  
18 table, and not to necessarily move the  
19 conversation into a technical domain, in which  
20 not everybody can participate.

21 So, if you do raise technical  
22 concerns on the measures, which would be valid

1 and appropriate for our discussions, please  
2 make sure that you kind of translate those  
3 discussions into a position that is understood  
4 and able to be translated to all broad  
5 stakeholders. So, I think that was the second  
6 piece.

7 And I think that was all I had to  
8 say. So, again, thank you all for being here,  
9 for all of your work that you have already put  
10 into this effort, and for the work that you  
11 are going to be putting in in the future.

12 CO-CHAIR PENSON: Thanks.

13 So, looking at the agenda, the  
14 next thing is to do introductions and, then,  
15 do disclosures. So, I would propose we go  
16 around the table, introduce ourselves, maybe  
17 say a little bit about where you are from,  
18 what stakeholder you may represent. And then,  
19 we will do the disclosures.

20 MS. HAMMERSMITH: No, we will do  
21 the disclosures at the same time.

22 CO-CHAIR PENSON: Oh, at the same

1 time. Okay, great. Okay. Thanks. Sorry.

2 MS. HAMMERSMITH: Hi, everyone.

3 I am Ann Hammersmith. I am NQF's  
4 General Counsel.

5 As was just said, we are going to  
6 combine introductions with disclosures. I see  
7 some familiar faces, so I know you have heard  
8 me say this about a thousand times, but I will  
9 give you a few reminders before we go around  
10 the table and you disclose.

11 You should have received a form  
12 from us where we asked you a number of  
13 questions about your professional activities,  
14 including your current position, any  
15 consulting, and so on. We culled through  
16 those as we seated people on the Committee.  
17 For members who have been seated, we like to  
18 do an oral disclosure in open session in the  
19 spirit of openness and transparency.

20 When you disclose, please tell us  
21 who you are, who you are with, and if you have  
22 anything to disclose. Please do not disclose

1 your entire CV because that will take a very  
2 long time, indeed, and we want you to be able  
3 to get to the work you are supposed to be  
4 doing today.

5 So, what you should be disclosing  
6 are things that you believe are relevant to  
7 the subject matter of what the Committee is  
8 going to talk about today. We are  
9 particularly interested in your disclosure of  
10 relevant consulting arrangements, research, or  
11 grants.

12 I also want to remind you that you  
13 serve as an individual. Sometimes people,  
14 going around the table, meaning well, say, "I  
15 am So-and-So and I represent the American  
16 Academy of" fill in the blank. And actually,  
17 you don't. You sit as individuals. You are  
18 here because you are experts. So, you do not  
19 represent the interest of your employee or of  
20 any organization that may have nominated you  
21 for service on the Committee.

22 And finally, I also want to remind

1 you that, because of the unique nature of what  
2 we do here, you may have something to disclose  
3 that is not a financial disclosure. Some  
4 people will say, "I don't have any financial  
5 conflicts," which is great, but it is possible  
6 that you could have something else that you  
7 should disclose where no money changed hands.  
8 For example, service on a committee where the  
9 subject matter is relevant to what you are  
10 going to be doing today.

11 So, with that, I would ask you to  
12 go around the table, tell us who you are, who  
13 you are with, and if you have anything to  
14 disclose. And we will start with the Chairs.

15 So, start with you.

16 CO-CHAIR NELSON: Gene Nelson. I  
17 am on the faculty at Dartmouth Medical School  
18 in the Dartmouth Institute, where some of the  
19 research involves Accountable Care  
20 Organizations and value measurement, and we  
21 have research and contract in these areas.

22 I am on the faculty of IHI and



1 have been working with them over time around  
2 the triple aim idea and its measurement.

3 And I am a founder of a company  
4 called Quality Data Management that is  
5 involved in quality measurement.

6 CO-CHAIR PENSON: Thanks.

7 My name is David Penson. I am a  
8 urologist from Vanderbilt University in  
9 Nashville, Tennessee. I am also a health  
10 services researcher. And obviously, I receive  
11 a salary from Vanderbilt.

12 I also have a consulting  
13 arrangement with the American Neurological  
14 Association as their Health Policy Chair.

15 I do research and have funding  
16 from various federal institutions, including  
17 NCI, AHRQ, and now PCORI, thank God. And I  
18 also have industry relations in terms of  
19 research agreements with a company called  
20 Dendrion and Medivation and Estelles.

21 MEMBER MARCINIAK: Good morning.

22 I am Martin Marciniak. I am with

1 GlaxoSmithKline. I am a senior leader at  
2 GlaxoSmithKline, and I have an equity position  
3 there as well.

4 I am the leader of the U.S. Health  
5 Outcomes Organization. It is an organization  
6 that has work that spans from quality of life  
7 to economic endpoints, both in clinical  
8 trials, observational data, and quality and  
9 economic measures.

10 MEMBER EAMES-HUFF: Good morning.

11 My name is Jennifer Eames-Huff. I  
12 am with the Pacific Business Group on Health.  
13 I am the Director of Advancing Policy there.

14 I also hold a role, being Director  
15 of the Consumer-Purchaser Disclosure Project.

16 MEMBER BECKER: Good morning.

17 I am Larry Becker. I work for  
18 Xerox Corporation in benefits and other  
19 things. You should know that Xerox  
20 Corporation also owns Buck Consulting.

21 I am on the Board of the National  
22 Quality Forum, and I also serve on the Board

1 of Governors of PCORI, the Patient-Centered  
2 Outcomes Research Institute.

3 MEMBER DAMBERG: I am Cheryl  
4 Damberg. I am a health services researcher  
5 from the RAND Corporation.

6 I have a number of contracts and  
7 grants that are in the value-based purchasing  
8 space. I just recently finished a project for  
9 the Office of the National Coordinator on  
10 identifying candidate measure concepts around  
11 efficiency and resource use.

12 I also sit on the eQuality  
13 Measures Work Group for the Office of the  
14 National Coordinator, and they have been  
15 considering inclusion of efficiency measures.

16 And I am doing evaluation research  
17 around the impact of value-based purchasing,  
18 and some of those programs include efficiency  
19 measures embedded in them.

20 MEMBER NAESSENS: Good morning.

21 I am Jim Naessens. I am health  
22 services researcher at Mayo Clinic. I am also

1 involved with the Value Analysis Program  
2 within the Clinic.

3 Also, I have a subcontract  
4 research grant with Minnesota Hospital  
5 Association, an AHRQ grant, and also serve on  
6 some Minnesota Department of Health advisory  
7 committees in terms of value and cost  
8 measurement.

9 MEMBER CLARK: Hi. I am Mary Ann  
10 Clark. I am Senior Vice President with a  
11 brand-new company called Interalign. We help  
12 work with hospitals to improve costs and  
13 quality. I am doing a lot of work right now  
14 with looking at various cost and quality  
15 measures for hospitals.

16 MEMBER WONG: Hi. I am Herb Wong.  
17 I a Senior Economist with the Agency for  
18 Health Care Research and Quality. The agency  
19 is a federal agency that conducts and supports  
20 research on health services research. And I  
21 have nothing to disclose.

22 MEMBER STEPHANSKY: Hi. I am Joe

1       Stephansky. I am with the Michigan Health and  
2       Hospital Organization, a trade association as  
3       well as a lobbying advocacy organization.

4                       I have worked very hard to  
5       maintain plausible deniability in everything  
6       that I do. So, I have no association with any  
7       grants or other organizations.

8                       MEMBER REDFEARN: Good morning.

9                       I am David Redfearn. I work for  
10       WellPoint. The work I have done for WellPoint  
11       over the years has been focused on physician  
12       cost-efficiency profiling, risk adjustment,  
13       episode-of-care methodology. I have no  
14       conflicts to report.

15                      MEMBER GELZER: Good morning.

16                      I am Andrea Gelzer. I am  
17       Corporate Chief Medical Officer for the  
18       AmeriHealth Caritas family of companies. We  
19       do Medicaid-managed care and are also in the  
20       dual-eligible space.

21                      I am on the AHRQ National Advisory  
22       Council, and I am also on clinical leadership

1 committees at both AHIP and Medicaid Health  
2 Plans of America.

3 MR. WOLFSON: I am Danny Wolfson,  
4 Executive Vice President and Chief Operating  
5 Officer of the ABIM Foundation. We are an  
6 independent corporation from the American  
7 Board of Internal Medicine, but we have  
8 interlocking boards. I run the Choosing  
9 Wisely Campaign. We have a grant from the  
10 Robert Wood Johnson Foundation to spread the  
11 campaign across the country.

12 MEMBER LATTIS: Good morning.

13 I am Lisa Latts. I am a physician  
14 currently working as an independent consultant  
15 in the quality arena, formerly with WellPoint,  
16 where I would turn to David where I needed  
17 anything to do with smart physician  
18 efficiency.

19 My current clients include  
20 organizations such as the Colorado Health  
21 Exchange, where I am working on their quality  
22 strategy; pharmaceutical and biotech clients,

1 working on quality and payer integration, and  
2 the University of California.

3 MEMBER TSANG: Good morning.

4 Tom Tsang. I am Executive  
5 Director at Merck Pharmaceuticals. I work in  
6 the Office of the Chief Medical Informatics  
7 and Innovation Office, and I work on health IT  
8 partnerships and strategy for the company. I  
9 was formerly Medical Director for Meaningful  
10 Use at ONC.

11 MEMBER NEEDLEMAN: I am Jack  
12 Needleman. I am a professor of health policy  
13 and management at the UCLA Fielding School of  
14 Public Health. I am also the Associate  
15 Director of the UCLA Patient Safety Institute.

16 I occasionally sit on the Quality  
17 Committee for the American Academy of Nursing,  
18 and currently I am working with the UCLA  
19 Center for Health Policy Research and UC-  
20 Berkeley Labor Center on studying the  
21 implementation of the Affordable Care Act in  
22 California. And no other disclosures.

1                   MEMBER ASPLIN: Good morning.  
2                   My name is Brent Asplin. I am  
3 Chief Clinical Officer and President of the  
4 Fairview Medical Group, part of the Fairview  
5 Health Services, in Minneapolis. I am an  
6 emergency physician, Past Chair of the  
7 American College of Emergency Physicians'  
8 Quality and Performance Committee. Fairview  
9 is one of the pioneer AC organizations in the  
10 U.S. And I have nothing to disclose.

11                   MEMBER YANAGIHARA: Good morning.  
12                   I am Dolores Yanagihara with the  
13 Integrated Healthcare Association in  
14 California, where I lead the performance  
15 measurement and analytics area. We use  
16 efficiency measures.

17                   And the only thing I have to  
18 disclose is that I am on NCQA's Efficiency  
19 Measurement Advisory Panel.

20                   MEMBER GARRETT: Good morning.  
21                   I am Nancy Garrett from Hennepin  
22 County Medical Center, which is a safety-net



1 care system in Minneapolis. I lead analytics  
2 there.

3 And I have a background doing  
4 provider profiling at several health plans as  
5 well as working with Minnesota Community  
6 Measurement through the Board and some of our  
7 efforts in the community to measure both cost  
8 and quality.

9 And I don't have any disclosures.

10 MEMBER GIFFORD: Hi. My name is  
11 David Gifford. I am a geriatrician. I am the  
12 Senior VP for Quality and Regulatory Affairs  
13 at American Healthcare Association, which  
14 represents nursing homes and assisted living.  
15 I am also on the faculty at the School of  
16 Public Health at Brown.

17 My wife works for the Medicaid  
18 Program. She is the Medical Director in Rhode  
19 Island.

20 And I have a 401(k) that God knows  
21 what they invest in, probably things I don't  
22 support, and probably things I don't support

1 here, but something out there.

2 (Laughter.)

3 Other than that, no disclosures.

4 MEMBER MCHUGH: I am Matthew  
5 McHugh. I am faculty at the University of  
6 Pennsylvania School of Nursing, Center for  
7 Health Outcomes and Policy Research. I am a  
8 Senior Fellow at the Leonard Davis Institute  
9 for Health Economics.

10 I am a health services researcher.  
11 So, predicatively, I have funding from various  
12 federal and nonprofit agencies like the  
13 National Institute on Aging, the Robert Wood  
14 Johnson Foundation, the National Institute for  
15 Nursing Research. And some of that is  
16 associated with looking at value-based-  
17 purchasing-oriented outcomes.

18 MEMBER PARE: Hi. I am Carolyn  
19 Pare. I am President and CEO of the Minnesota  
20 Health Action Group. We used to be the Buyers  
21 Healthcare Action Group based in Minneapolis,  
22 Minnesota. It seems to be Minnesota is pretty

1 well-represented here.

2 I also do work, I sit on the  
3 Consensus Standards Approval Committee of the  
4 NQF. I sit on the Standards Committee for  
5 NCQA, and I am on the California Health  
6 Benefits Review Program as well. I have no  
7 conflicts.

8 MEMBER WEINTRAUB: Good morning.

9 I am Bill Weintraub. I am Chair  
10 of Cardiology at Christiana Care in Delaware  
11 and professor of medicine at Thomas Jefferson  
12 University. I am a cardiovascular  
13 epidemiologist and outcomes researcher.

14 I have grant funding from CMS and  
15 the National Institutes of Health, several  
16 different agencies.

17 I am the President of the Great  
18 Rivers Affiliate of the American Heart  
19 Association, incoming Chair of the Data  
20 Standards Task Force of the American College  
21 of Cardiology and American Heart Association.  
22 I am also on multiple American College of

1 Cardiology committees, including Informatics,  
2 Data Standards, and NCDR Board. I do  
3 consulting for Pfizer and Daiichi Sankyo.

4 MEMBER WALKER: Good morning.

5 I am Lina Walker. I direct the  
6 health policy team at the Public Policy  
7 Institute in AARP, and I lead the team's work  
8 on Medicare and Medicaid and coverage issues  
9 for the under-65 population. I have nothing  
10 to disclose.

11 MEMBER RYAN: Hi. Andy Ryan. I  
12 am assistant professor at Weill Cornell  
13 Medical College.

14 I have grants from AHRQ and RWJ to  
15 evaluate value-based purchasing and quality  
16 profiling in Medicare, and I have a consulting  
17 relationship with Ecometrica to evaluate  
18 Medicare's bundled payment demo.

19 Thanks.

20 MS. HAMMERSMITH: Thank you.

21 Are there any Committee members on  
22 the phone? Specifically, Stanley Hichberg?

1 (No response.)

2 No? Okay.

3 Thank you for those disclosures.

4 Do you have any questions of each other or of

5 me, based on the disclosures this morning,

6 anything you would like to discuss?

7 (No response.)

8 Okay. Thank you. Have a good

9 meeting.

10 DR. BURSTIN: I would add my

11 welcome as well.

12 I am Helen Burstin. I am the

13 Senior Vice President for Performance

14 Measurement at NQF.

15 Thank you to all of you for

16 coming. I know this was a pretty significant

17 lift, lots of materials, and I am looking

18 forward to a great discussion.

19 Thank you.

20 MS. TIGHE: Hi. I am Lindsey

21 Tighe. I am the Project Manager who has been

22 emailing you consistently.

1 (Laughter.)

2 I figured I would, first, just run  
3 through the papers that we printed out for you  
4 today and just let you know what you collected  
5 out there.

6 So, we have the agenda. We have  
7 got the rosters and bios for everybody on the  
8 Committee. We have got a handout of the  
9 Resource Use Measure Evaluation Criteria. We  
10 have a set of slides for each measure that the  
11 measure developers provided.

12 We will run out and grab them for  
13 you. They are on the table out there. Yes,  
14 we can bring some in and get them passed  
15 around to everyone.

16 They are reference materials.  
17 Most of them you already have except for the  
18 slides and memos that the measure developers  
19 have provided, which, when we actually are  
20 discussing their measures, they will walk  
21 through those with you. So, we have got one  
22 set of those from each measure developer.

1                   We have got a table that lays out  
2                   the HealthPartners measure that we sent out to  
3                   you, the total resource use PMPM measure with  
4                   the total cost measure from CMS. We will use  
5                   that later this afternoon when we have the  
6                   harmonization discussion of related measures.

7                   And then, we have got the compiled  
8                   preliminary evaluations for you all, so you  
9                   are able to reference that during our  
10                  discussions today.

11                  So, hopefully, those are helpful.  
12                  Most of them you already have, but we just  
13                  wanted to have handy references, as we have  
14                  our discussion.

15                  MS. WILBON: Just for the sake of  
16                  introduction, my name is Ashlie Wilbon. I  
17                  think I was able to speak to everyone this  
18                  morning. Some of you I know; most of you I  
19                  know.

20                  I just want to thank you guys  
21                  again for coming. It is great to have such an  
22                  amazing group of people around the table to

1 discuss these important measures.

2 Evan Williamson is our Project  
3 Analyst. He will be walking around the room  
4 helping us with various things today. So, he  
5 is an important team member I wanted to  
6 recognize.

7 And again, we are happy to have  
8 you guys here.

9 MS. TIGHE: Yes, my hesitation was  
10 Evan is actually running the slides.

11 Okay. So, I will just briefly run  
12 through a little bit of the meeting objectives  
13 and the project background. And then, Ashlie  
14 will give you all a refresher on the measure  
15 evaluation criteria.

16 So, our objectives for today are  
17 review both of the measures that were  
18 submitted against the measure evaluation  
19 criteria and, then, make a recommendation for  
20 endorsement.

21 This afternoon we will be  
22 discussing the two related measures, the



1 HealthPartners one and the CMS one, to  
2 determine whether or not they need to be  
3 harmonized and, if so, what elements should be  
4 harmonized.

5           And the third objective is broken  
6 into several pieces. This afternoon we will  
7 also just be asking you all to give some broad  
8 input to the Measures Application Partnership  
9 on recommendations for the measures. For  
10 those of you who are less familiar with the  
11 MAP, it is a group that we have NQF that makes  
12 recommendations for application of the  
13 measures into federal programs. And so, we  
14 will just be asking you all after you evaluate  
15 these measures to just give them some broad  
16 considerations, as they consider these  
17 measures for federal programs.

18           Tomorrow we are going to have a  
19 broad discussion of the implications for  
20 specifying and endorsing measures with  
21 multiple risk adjusters. We have a measure  
22 that is currently endorsed where we will be

1 looking at the possibility of adding on  
2 additional risk-adjustment models. And we are  
3 trying to really establish NQF policy going  
4 forward on how we handle that.

5 We will also be asking for your  
6 input on inclusion of attribution guidelines  
7 within the cost and resource use measure  
8 submissions. As you all saw, it is currently  
9 an appendix to the measures. It is not  
10 something that we evaluate in our criteria.  
11 And so, we will have a conversation about how  
12 we should use that information going forward  
13 as we evaluate cost and resource use measures.

14 And then, we will also have a  
15 broader discussion about moving toward  
16 efficiency and value measures, where you take  
17 these cost and resource use measures and you  
18 pair them with quality measures, so that you  
19 can really start getting at the value of  
20 healthcare services.

21 Okay. Moving into the project  
22 background, as you all are well aware, there

1 are two measure submissions to this project.  
2 As I mentioned earlier, we will be looking to  
3 explore the potential for harmonization and  
4 discussing the application and use of the  
5 risk-adjustment models within the cost and  
6 resource use measures. This is all under the  
7 Phase 1 of the Cost and Resource Use Project.

8 We have a planned Phase 2, which  
9 will be condition-specific, episode-based  
10 measures. As it says, detailed "TBD". We are  
11 expecting that sometime this fall.

12 So, we have an eight-step  
13 consensus development process for measure  
14 endorsement. This is currently the standards  
15 review step of that, Step 3, where we have  
16 Committee review of the measures and  
17 recommendations for endorsement.

18 After this, staff will compile a  
19 draft report which we will put out for public  
20 and member comment. So, we will be getting  
21 multi-stakeholder input on the Committee's  
22 recommendations for endorsement. That is a

1 30-day period.

2 After that, we will bring those  
3 comments back to you all for consideration to  
4 determine whether or not you agree with your  
5 preliminary endorsement recommendations and  
6 want to continue to recommend the measures  
7 that you have chosen or whether some comment  
8 has come up that causes you to reconsider the  
9 endorsement recommendation.

10 From there, we move into NQF  
11 membership voting, a 15-day period where only  
12 the NQF membership can vote. Once we get the  
13 results of that, this moves on to the  
14 Consensus Standards Approval Committee. So,  
15 Carolyn will be shepherding these measures  
16 forward from today on.

17 They will give a final review of  
18 these measures at their meeting. And then,  
19 from there, it will go on to the Board of  
20 Directors for final endorsement, which Larry  
21 will continue on at that point.

22 Once the Board makes their final

1 decision, we do have a 30-day appeals period  
2 where anyone can submit an appeal if they feel  
3 that they are materially affected by the  
4 endorsement of the measure.

5 This is our timeline. So, today  
6 the Steering Committee in-person meeting, May  
7 8th and 9th.

8 Over the next two months, staff  
9 will be working hard to capture everything  
10 that we discuss today, compile it into a draft  
11 report, share that with you all to make sure  
12 that it is okay, and put it out for the NQF  
13 member and public comment period in early  
14 July.

15 So, this project runs through the  
16 fall. It ends in late October and goes  
17 through all those steps that I mentioned  
18 before with commenting, vote, CSAC, and Board  
19 of Directors approval and appeals.

20 I will stop there. If there are  
21 any questions on the background, jump in.

22 (No response.)

1                   Otherwise, Ashlie will go over the  
2                   measure evaluation criteria.

3                   MS. WILBON:    So, we have been  
4                   through this, the criteria, a couple of times.  
5                   You guys have already done your preliminary  
6                   evaluation.    So, I am not going to belabor  
7                   this, but just really try to highlight some  
8                   points that we think are important to consider  
9                   again, as you guys are now kind of convened  
10                  together as a group.

11                  So, again, the four major criteria  
12                  around importance, scientific acceptability,  
13                  feasibility, and usability.    Just to note, as  
14                  we go through the criteria today and the  
15                  discussion, both importance and science  
16                  acceptability are must-pass criteria.    If we  
17                  get to the point of importance and it does not  
18                  pass importance, we wouldn't go through the  
19                  remainder of the criteria, and the same with  
20                  scientific acceptability.    So, those are kind  
21                  of threshold criteria, if you will, and we  
22                  will go through them in the order that you see

1 listed.

2                   So, again, the subcriteria that  
3 you evaluate in your preliminary evaluations  
4 are really just to help think through how the  
5 measure would demonstrate meeting the overall  
6 criteria. And the criteria really developed  
7 around best practices in measure development.

8                   So, when you develop a measure,  
9 first, you want to start with the concept. Is  
10 the concept important to measure? And then,  
11 work your way down through feasibility.

12                   And so, obviously, the purpose of  
13 having experts here is that there is no black  
14 and white with these. These are all kind of  
15 a matter of degree in which we use experts to  
16 kind of help us make those decisions on  
17 whether or not the measure meets the criteria.  
18 So, that is what you are all here for. So, we  
19 need your expertise and judgment to determine,  
20 you know, the degree of demonstration of the  
21 criteria.

22                   So, again, the first criteria of

1 importance to measure and report, there are  
2 three subcriteria. We will walk through  
3 whether or not the developer has demonstrated  
4 that the measure focus is a high-impact area  
5 to measure.

6 We will walk through whether or  
7 not they have demonstrated information on  
8 there is an opportunity for improvement,  
9 whether or not there are variations in  
10 disparities in care delivery in this  
11 particular measure topic. And then, we will  
12 talk through whether or not the intent of the  
13 measure has been sufficiently supported with  
14 the resource use categories that are specified  
15 in the measure.

16 Right, Taroon is reminding me in  
17 my ear that we do have a Criteria 2c, which we  
18 will get to -- actually, you will see here on  
19 this slide -- for stratification for  
20 disparities. It is kind of our Lone Ranger  
21 out here in the reliability and validity under  
22 scientific acceptability.



1                   What we will be doing is kind of  
2 including that discussion of stratification  
3 and disparities under 1b and the importance  
4 criteria, which discusses variation in care or  
5 disparities in healthcare delivery. So, for  
6 those of you, I think we communicated with  
7 everyone via email who had been assigned to C  
8 on one of the measure discussions that we will  
9 be kind of asking you to discuss any issues  
10 around disparities and the importance  
11 discussion.

12                   So, the second criteria is  
13 scientific acceptability of the measure  
14 properties, which focused on reliability and  
15 validity. Within each of these areas, again,  
16 both are must-pass criteria. We will be  
17 discussing the specifications and the testing  
18 related to the measure specifications and  
19 whether or not they have demonstrated  
20 reliability and validity.

21                   Reliability is looking at the  
22 preciseness of the specifications and

1 reliability testing, either at the data  
2 element or the measure score level.

3 The validity subcriteria is  
4 focused, again, on the specifications and  
5 whether or not they are consistent with the  
6 measure intent. We will be looking at the  
7 actual validity testing, at the data element  
8 or the measure score level. It also includes  
9 the testing and justification of exclusions,  
10 the risk-adjustment model, the identification  
11 of differences in performance, and  
12 comparability of data sources and methods,  
13 which I think we discussed on one of our  
14 tutorial calls; that because there is only one  
15 data source specified, that that will probably  
16 be a moot point, but it is part of the  
17 criteria.

18 So, just to point out again, I  
19 think you have seen our little house before.  
20 Just to kind of reiterate how we have broken  
21 down the specifications of the resource use  
22 measures into these different buckets of

1 specifications or modules, if you will,  
2 general methods and kind of data protocol and  
3 how you prepare the data. And then, looking  
4 at clinical logic, how the specific patients  
5 are categorized by different clinical  
6 characteristics.

7           You also have your construction  
8 logic, which is more kind of setting up the  
9 measure, how the episode or the timeframe is  
10 defined, and how claims are assigned to the  
11 episode.

12           The resource use service  
13 categories are how the claims and codes are  
14 categorized. So, for example, pharmacy claims  
15 or E&M visits or DME or other types of  
16 categories that you would use.

17           And then, the adjustments for  
18 comparability, which is going to include the  
19 costing methodology, the risk-adjustment  
20 approach, the stratification, and then,  
21 finally, the reporting piece, which would  
22 include different guidelines for the measure

1 that you would use when you would go to  
2 report, including peer grouping. Right now,  
3 we also have attribution there, benchmarking,  
4 and other things like that.

5 So, reliability and validity,  
6 again, are not all-or-none properties. They  
7 are matter of degree, which we have asked you  
8 to rate on a scale of high, moderate, to low  
9 or insufficient. And obviously, they can vary  
10 with different conditions of the measure.

11 And again, just kind of basic  
12 principles. In order to be valid, the measure  
13 must be reliable, but, conversely, reliability  
14 does not guarantee validity.

15 And I will just note that we will  
16 be asking you to vote on overall reliability  
17 and overall validity. We don't ask you to  
18 vote on overall scientific acceptability. If  
19 you vote that the measure is either high or  
20 moderate on reliability or validity, the  
21 measure will pass scientific acceptability  
22 automatically. If you vote low on either one

1 of those, the measure would not pass  
2 scientific acceptability.

3 So, again, reliability is  
4 repeatability or precision of the measure, and  
5 validity is the correctness, the accuracy.

6 So, some threats to reliability,  
7 these are some things you will be thinking  
8 through potentially. Hopefully, you thought  
9 through these in your preliminary evaluations,  
10 but they are obviously on the table again  
11 today.

12 Ambiguous measure specifications.  
13 So, not really understanding how codes are  
14 being assigned or divided up into categories.  
15 Small case volume or sample size or rare  
16 events, those can obviously affect the  
17 precision of the measure score. And then,  
18 random errors, either for coding or for  
19 missing data.

20 Some threats to validity.  
21 Conceptual, so if the measure focus is not  
22 relevant or not strongly linked to some

1 particular cost that the measure is intended  
2 to measure. On reliability, patients that are  
3 inappropriately excluded; differences in  
4 patient mix, and measure scores generated with  
5 multiple data sources or methods. Again, we  
6 won't really encounter that with these two  
7 measures. And then, systematic missing or  
8 incorrect data.

9           So, measure testing is a huge part  
10 of how the measure developers are to  
11 demonstrate reliability and validity. We are  
12 looking for them to demonstrate the  
13 reliability and validity of the measure as  
14 specified.

15           So, another note for today is that  
16 we are looking and evaluating the measure in  
17 front of us. I know a lot of times we like to  
18 think about how we could make the measure  
19 better or if they just did this or if they  
20 just added this thing or tweaked this, and we  
21 are really going to focus on the measure as it  
22 is specified in front of us today.

1           So, this is just some additional  
2           guidance on the testing that we provide to  
3           developers: empirical evidence, basically, we  
4           are expecting them to do testing. And again,  
5           we are looking at the reliability and validity  
6           testing on the measure as specified. That  
7           would include the preciseness of the  
8           specifications and whether or not the  
9           specifications are consistent with the measure  
10          content.

11           We are not prescriptive to  
12          developers on which type of testing they need  
13          to use to demonstrate reliability and  
14          validity. We leave that to them. Obviously,  
15          they have developed the measure and are going  
16          to know the best way to be able to demonstrate  
17          that based on the specifics of their measures.  
18          So, what you see in front of you is what the  
19          developer has decided to put forth in terms of  
20          demonstrating those two criteria.

21           Specifically, I think we had maybe  
22          a couple of conversations on maybe the

1 tutorial calls about this. When we start  
2 looking at R-squared values or correlation  
3 values, we don't have necessarily set  
4 thresholds to say, okay, an R-squared of -- I  
5 don't know -- .7, or whatever, is high or  
6 moderate. That is really what we are having  
7 you here to help us determine. A lot of times  
8 those values are in the context of the measure  
9 construct and how it is being used, and so  
10 forth.

11 So, we don't set specific  
12 thresholds for that. So, within your  
13 expertise and your realm of understanding how  
14 statistical values work, we are hoping that  
15 you will bring that and help us make a  
16 decision on whether or not those are valid.  
17 And again, the testing does not replace the  
18 need for expertise and judgment, again, which  
19 you are here for.

20 I won't spend a lot of time on  
21 this, but these are some of the strategies  
22 that we have implemented in our process to



1 mitigate the burden of testing for developers.  
2 So, rather than having to submit testing at  
3 both the data element and the measure score  
4 level, we allow them to do an "either/or". I  
5 will note that the high rating on reliability  
6 and validity testing is contingent on them  
7 doing both data element and measure score  
8 testing. So, if they have done one or the  
9 other, they would only be able to score at the  
10 highest of moderate of those.

11           Again, we allow them to do testing  
12 on samples. They can use prior evidence,  
13 which doesn't necessarily apply here, but  
14 empirical evidence of data element validity,  
15 and -- I'm sorry -- a separate reliability  
16 data element is not required. So, if they  
17 demonstrate data element validity, they don't  
18 necessarily need to do reliability testing  
19 because inherently the data elements would be  
20 reliable if they are valid.

21           And face validity is accepted if  
22 it is systematically assessed, which is not

1 really applicable here.

2 Reliability assessing, these are  
3 just a couple of examples of how people could  
4 demonstrate or how developers would be able to  
5 demonstrate reliability testing at the data  
6 element level, inter-rater reliability, or  
7 internal consistency and reliability for  
8 multi-item instruments. Again, that will be  
9 dependent on the specifications and the data  
10 used to construct the measure.

11 Next. Go back one more.

12 At the measure score level, what  
13 we are looking for is for them to demonstrate  
14 that the measure is reliable and the  
15 proportion, the variation of the scores due to  
16 systematic differences across the measure  
17 entities in relation to random variation. So,  
18 again, this would be kind of a signal-to-noise  
19 analysis at the measure score level.

20 For validity testing, at the  
21 measure score or the data element level, we  
22 are looking for them to demonstrate that the

1 measure score and data elements are correct  
2 and they accurately reflect the cost-of-care  
3 resources provided. An example for how they  
4 might be able to demonstrate this for a  
5 resource use measure would be correlating with  
6 measures that are deemed to be related in some  
7 way or testing the differences in scores  
8 between those groups that are known to either  
9 differ or be similar to, have similar  
10 utilization or cost-of-resource use with the  
11 measure that is under review.

12 So, we will be going through this.  
13 As we get to the measure evaluation, we will  
14 be having some kind of discussion points or  
15 questions, things that should be considered as  
16 you are evaluating the different criteria.

17 Specifically for testing,  
18 obviously, we will be looking at  
19 appropriateness, scope, and acceptable norm.  
20 So, did they use the appropriate type of  
21 testing to demonstrate their measure was  
22 reliable and valid based on the way the

1 measure is constructed? Is the scope  
2 adequate? So, did they include an adequate  
3 sample? Did they consider an adequate number  
4 of sample entities, the number of patients,  
5 and the representativeness of the sample?

6 And then, finally, whether the  
7 results were in acceptable norms; again, back  
8 to that issue of kind of the values of the  
9 statistical tests that are performed, we will  
10 be looking for you to make that determination.

11 So, risk adjustment. We are going  
12 to have quite the discussion on this tomorrow.  
13 I am not going to spend a whole lot of time on  
14 this. But, essentially, it is used as a case-  
15 mix adjustment in the measure, controlling for  
16 patient factors that influence outcomes in the  
17 measure.

18 And generally, what we are looking  
19 for here is that the factors that are included  
20 in the measure are present; the patient-level  
21 factors that are included in the model were  
22 present with the patient before the measure

1 began. So, we are not looking for them to  
2 include patient-level factors that impacted  
3 the patient during the episode of care. So,  
4 I don't want to get into a whole lot of detail  
5 about how that could get circular where the  
6 severity of the patient is included based on  
7 things that happened during the episode. So,  
8 that is basically what that is getting at.

9 A couple of other things about  
10 risk adjustment. We general, as a rule here  
11 at NQF, don't look for them to include things  
12 that relate to disparity. So, race and  
13 ethnicity should not be included in the model.  
14 We would rather see those things be  
15 stratified, so that we can actually identify  
16 where those differences are and focus on where  
17 the improvements or additional attention needs  
18 to be focused.

19 And also, we don't expect that  
20 they would include structural characteristics  
21 for organizations. So, experience, whether it  
22 is a teaching hospital or equipment

1 availability, or things like that, in the risk  
2 model.

3 So, I have been through some of  
4 this throughout the presentation, and I won't  
5 focus on this. We will be guiding you guys  
6 through this. As we get through the  
7 evaluation, I think it is a lot easier to  
8 apply it rather than me just talking at you.

9 But, again, in order to get a high  
10 for reliability and validity, we are saying  
11 that the specifications are precise and  
12 accurate and that they have done testing that  
13 you feel is adequate and appropriate at both  
14 the data element and the measure score level.

15 And a moderate score would be,  
16 again, that the specifications are in line  
17 with what you think they should be, they are  
18 precise and accurate, and that they have done  
19 testing at either the data element or the  
20 measure score level.

21 And again, low would be that there  
22 are ambiguous specifications and that the

1 testing or the scope of testing has been  
2 inadequate or inappropriate at some level.

3 And we won't go through this.  
4 This, again, is the algorithm we will use to  
5 determine whether or not the measure has met  
6 scientific acceptability.

7 Feasibility is the third criteria.  
8 We will be looking how feasible it would be  
9 for an implementer to actually take the  
10 measure and run it or use it at their  
11 particular system or facility; whether or not  
12 the data are generated during care processes;  
13 whether or not they are available  
14 electronically, and whether or not a data  
15 collection strategy can be implemented. I  
16 think this is probably one of our more  
17 straightforward ones.

18 Usability and use, which also we  
19 anticipate will be an interesting discussion,  
20 focuses around four subcriteria, the first  
21 being on accountability. We are looking to  
22 see whether or not the measure is actually in

1 use at this point in time for, one,  
2 accountability application. If it is not, we  
3 are asking for them to provide a plan or some  
4 indication of how they anticipate the measure  
5 will be used going forward.

6 In 4C, we are looking to determine  
7 whether or not that the benefits of the  
8 measure would outweigh the harm. So, for  
9 example, if they had identified some  
10 unanticipated, unintended consequences in  
11 either the testing of the measure or through  
12 use of the measure, if the measure is actually  
13 in use, that we would ask you to look at those  
14 unintended consequences and determine whether  
15 or not the benefits of using the measure would  
16 outweigh the harms that would be imposed with  
17 those unintended consequences.

18 And then, finally, with 4d, we are  
19 asking you to determine, based on the  
20 specifications that you reviewed, would the  
21 results being shared with other stakeholders  
22 be transparent enough for people to kind of



1 deconstruct that and understand what is being  
2 measured and what the results actually mean?

3           And finally, the last part of the  
4 discussion that we will have kind of,  
5 hopefully, at the end of today will be on  
6 comparing related measures. We have a measure  
7 that we endorsed in our last resource use  
8 project from HealthPartners that we have  
9 identified as a similar measure to the total-  
10 cost-per-beneficiary measure that you will be  
11 reviewing today.

12           And once you go through the  
13 measures, the two measures that are in front  
14 of you today, make your recommendations, we  
15 will kind of reconvene and decide, have a  
16 discussion on the comparison of the  
17 previously-endorsed measure with the measure  
18 that is on the table and see where there may  
19 need to be alignment. And we have the  
20 developers here from both sides who will help  
21 us walk through that discussion.

22           Again, the rating scales for

1 today: high, moderate, low, and insufficient.  
2 And we will be kind of helping you walk  
3 through that today as we go.

4 Lindsey is going to kind of talk  
5 us through some of the broad concepts we are  
6 going to be asking you guys to think through  
7 today as you make your recommendations.

8 MS. TIGHE: Sure. So, this  
9 graphic just really demonstrates kind of the  
10 related relationship that all of our involved  
11 parties have here: that we really want this  
12 to be a two-way street where the measure  
13 developers and the measure users are informing  
14 you all, and you all are informing them with  
15 your recommendations. And the same goes for  
16 the Measures Application Partnership Work  
17 Groups and Committees.

18 So, we are really going to be  
19 looking to emphasize these relationships and  
20 just really provide that opportunity for  
21 feedback to be provided throughout all the  
22 groups, so that there is kind of consistency

1 in the work that we are doing.

2 So, that said, we just really want  
3 to highlight of the Steering Committee versus  
4 the MAP groups. So, the Steering Committee is  
5 evaluating the measures for broad use for  
6 performance improvement and accountability  
7 purposes. You are looking at whether it is  
8 useful or whether the specifications are  
9 appropriate for it to be used for performance  
10 improvement and accountability purposes.

11 The MAP is actually looking at  
12 whether it is appropriate for specific  
13 application and accountability programs. So,  
14 they are going to be looking at whether or not  
15 it should be used for reporting in PQRS or in  
16 value-based purchasing programs, something to  
17 that effect.

18 Did you have something to say,  
19 Ashlie? Okay.

20 So, what we are looking for here  
21 is we had a MAP meeting in December. They  
22 provided some input to the Steering Committee

1 for your consideration, as you are looking at  
2 the resource use measures.

3 Some of this is a little bit more  
4 broad and is related to the work that they are  
5 doing. So, it may be areas where you can  
6 provide guidance as you evaluate the measures  
7 today.

8 But they are looking for resource  
9 use measures to be linked with outcome  
10 measures. So, they are really looking to move  
11 toward that value that we discussed earlier,  
12 looking at the value of healthcare services  
13 provided.

14 And there will be a future MAP  
15 affordability family of measures that will be  
16 recommending specific quality measures to link  
17 with the resource use measures coming up.

18 They also recommended that the  
19 resource use approaches should align across  
20 populations and settings, using the same  
21 measure when feasible. So, again, just  
22 considering how the risk adjustment and

1 attribution methodologies could align across  
2 populations and settings, and assuring that  
3 the measures that we are recommending today do  
4 address the broadest target population  
5 possible.

6 And their final recommendation was  
7 that the resource use measures should be  
8 patient-centered. A way to do that would be  
9 that condition-specific resource use  
10 approaches should address multiple chronic  
11 conditions.

12 We also had -- oh, go ahead.

13 MR. AMIN: Lindsey, before you go  
14 on, I just wanted to just make sure that there  
15 are no questions about that. I know we are  
16 having some technical difficulties on the main  
17 slide deck here, which we are getting  
18 resolved.

19 But this is a very important issue  
20 around the difference between the MAP function  
21 and the Steering Committee function. So,  
22 Lindsey kind of articulated exactly what those

1 differences are. I mean, clearly, there is  
2 some informing between the two groups, but we  
3 want to make sure that this group understands  
4 its function, which is to look at whether  
5 these measures are appropriate for broad  
6 application and not specifically make  
7 recommendations during its evaluation around  
8 particular application of these measures in  
9 particular accountability programs.

10           Clearly, some of the measures in  
11 front of you are already in statute for  
12 particular programs. So, it is not like we  
13 are trying to say -- you know, clearly, you  
14 are going to have an opinion about that.  
15 There is going to be a particular time to  
16 provide that input, which will be after your  
17 evaluation of these measures.

18           So, we just wanted to make that  
19 clear, to the extent that it can be clear. If  
20 there is any discussion or questions about  
21 that, please, this would be the time to raise  
22 those concerns, questions, comments.

1                   And I will hand it back to the  
2                   Chairs on that.

3                   CO-CHAIR PENSON: Great. So,  
4                   Jack, you have a question.

5                   What I propose, just going  
6                   forward, is if you have a question, just put  
7                   your tent up. So, that way, you don't have to  
8                   raise your hand.

9                   Jack?

10                  MEMBER NEEDLEMAN: Okay. Yes, I  
11                  am now confused. The resource use -- in the  
12                  first iteration of this -- I was on that  
13                  Steering Committee as well -- we had a long  
14                  discussion about the difference between  
15                  quality, between efficiency, which in fact was  
16                  the linkage between quality and resources  
17                  used, and the resource use measures. And we  
18                  said the state of the art didn't feel like it  
19                  was ready for efficiency measures yet, that  
20                  one of the stepping stones for that was the  
21                  development of effective measures of resource  
22                  use.

1                   We are being asked to endorse this  
2 set of measures on resource use. The MAP  
3 criteria just threw up basically said: no  
4 resource use measures until we have quality  
5 measures to go with them, so we can measure  
6 efficiency.

7                   So, what are we doing? What does  
8 that criterion do to our reflection? What  
9 does that MAP concern do to our reflection on  
10 the appropriateness of endorsing this measure  
11 now?

12                   MR. AMIN: Okay. So, actually, I  
13 think it is the slide after this that Lindsey  
14 was walking through the input. And many of  
15 you were part of those discussions. I don't  
16 want to call anybody out, but you are sitting  
17 on the MAP groups.

18                   But the MAP made some  
19 recommendations to this Committee, meaning  
20 that, as you are approaching this exercise,  
21 think about the following considerations, and  
22 these are broad considerations: and those



1 considerations were around how can we get to  
2 -- it is really more of a forward-looking  
3 conversation. It goes back to sort of our  
4 evening discussion today and our discussions  
5 tomorrow, which is the fact that this group  
6 and its previous iteration of this group  
7 -- some of you were on that -- made  
8 recommendations about, first, let's get the  
9 resource use measures out there. And then,  
10 let's really come up with an approach to link  
11 the cost and quality domains to be able to get  
12 a real signal of efficiency.

13 And so, what the MAP group is  
14 providing back to you to consider is, as we  
15 are moving forward through the endorsement,  
16 post-endorsement of this, how do we move and  
17 actually get these two concepts to link? How  
18 do we actually make this happen? How do we  
19 move the measurement field to really  
20 understand how to link cost and quality in a  
21 way to really understand efficiency?

22 So, separate and apart, you have a

1 task in front of you. We want to separate --  
2 there are two different tasks that are going  
3 to be in front of us during the two days that  
4 we are here.

5 There is the actual looking at  
6 these measures against the criteria that  
7 currently exists. We are not going to make  
8 changes to criteria in real-time here. That  
9 is not the purpose.

10 At the end of the evaluation of  
11 the measures, there will be some forward-  
12 looking discussions. Those include this issue  
13 around how do we actually get to a measurement  
14 space that actually does do the linkage  
15 between cost and quality, and what does that  
16 look like? So, that we can actually start  
17 moving toward that future. That will be part  
18 of our gaps discussion later on this  
19 afternoon.

20 And then, also, the forward-  
21 looking will address issues around, as we  
22 talked about this issue around risk adjustment

1 and attribution, which still need seem to be  
2 a major issue in terms in the field about how  
3 we conceptualize this going forward.

4 So, very specifically, the answer  
5 to your question, Jack, is that these are  
6 considerations; they are not criteria. And  
7 they are meant to inform your discussions,  
8 just as the public comments are meant to  
9 inform your discussions.

10 MS. WILBON: I will just add that,  
11 in the context of this discussion, they were  
12 looking to make recommendations of linking,  
13 when they make recommendations for specific  
14 programs, to say we would like this resource  
15 use measure used with X, Y, Z quality  
16 measures, and that they are looking to make  
17 those linkages as a part of their  
18 recommendations. That still requires the need  
19 for them to have an endorsed resource use  
20 measure to include in that recommendation.

21 So, the work of this Committee is  
22 still to focus on having reliable, valid

1 resource use measures that can be a part of  
2 that discussion. The MAP -- and Dolores  
3 and Gene can chime in on this -- really tends  
4 to give deference to endorsed measures. So,  
5 they would rather make recommendations for  
6 endorsed measures that are available that meet  
7 the needs of that program before kind of going  
8 outside the box and looking for what else is  
9 out there.

10 So, the work of this Committee in  
11 going through and deciding whether or not this  
12 meets the criteria is actually really  
13 important. It allows them to have something  
14 on the table to include in their  
15 recommendations for that. So, that is kind  
16 of, I guess, some more of the context that was  
17 in there.

18 And I can open it up to anybody  
19 else, Dolores or Gene, who have been sitting  
20 on MAP and were actually there for those  
21 discussions, to add to that.

22 CO-CHAIR NELSON: Yes, just very

1       briefly, this could be considered or these  
2       could be considered building blocks towards  
3       measures of efficiency or towards measurements  
4       of value, a building block in relationship to  
5       other building blocks.

6                   CO-CHAIR PENSON:   Can I ask a  
7       question related?

8                   Oh, I'm sorry, go ahead, Joe.

9                   MEMBER STEPHANSKY:   I think some  
10       of the attempt to differentiate between what  
11       we are going to do here and what MAP does is  
12       my fault because of some questions that I  
13       raised earlier.

14                   It really comes down to, since I  
15       am from the Hospital Association, one of the  
16       viewpoints that I want to make sure people  
17       understand is that hospitals are not going to  
18       look at that, this use of the CMS measure to  
19       hold hospitals accountable for things that  
20       happen 30 days after discharge.  It may not be  
21       fair, and we don't want to really discuss that  
22       here.  We want to discuss the measure and

1 leave the use of the measure by CMS to MAP.

2 I think that is where we are trying to go.

3 MS. WILBON: And I would just say,  
4 Joe, I can take the blame off of you. We had  
5 actually anticipated that that would be, from  
6 other experience in other projects, that that  
7 was actually an important differentiation we  
8 needed to make. So, you are off the hook, and  
9 we recognize that is an issue. But there will  
10 be an opportunity to discuss that.

11 CO-CHAIR PENSON: Other questions?

12 (No response.)

13 So, I have a question related to  
14 the MAP and to our role specifically -- and I  
15 think it was mentioned in the next slide --  
16 about harmonization. So, does that fall under  
17 the Steering Committee? Does it fall under  
18 the MAP? What is expected from us as far as  
19 harmonization goes, since I see there is a  
20 discussion about it tomorrow?

21 MS. WILBON: Harmonization is  
22 actually under the purview of this Committee

1 because you guys have the opportunity to  
2 really dive into the specifications. The  
3 MAP's discussions are at a much higher level.  
4 So, when we get into the harmonization  
5 discussion, we will be talking a little bit  
6 more about conceptual harmonization versus  
7 technical harmonization, which is really you  
8 guys are really under the hood, looking at the  
9 codes, how things are defined. That is really  
10 under the purview of this Committee.

11 So, we will be specifically asking  
12 you guys to make recommendations on  
13 harmonization, and we will do our best to kind  
14 of carry those forward to the MAP Committee to  
15 make sure they understand kind of the  
16 decisions that were made here. But that would  
17 be you guys.

18 MEMBER WALKER: Just a little more  
19 clarification on the role of the Steering  
20 Committee in evaluating this measure. Now you  
21 said that we should evaluate it for broad  
22 applications. But when you read the narrative

1 from the developers, they write it, target it  
2 for a specific application. So, are we in our  
3 evaluation supposed to distance ourselves from  
4 that narrative in which they describe how it  
5 would be useful for that particular  
6 specification, because we have to think about  
7 it or evaluate it more broadly?

8 MS. WILBON: That is a very good  
9 question. It gets a little tricky. Our  
10 criteria actually is for broad application.  
11 And so, it does get a little tricky when the  
12 submission is very specific to that program,  
13 and we are trying to kind of walk that fine  
14 line between us and MAP, yes.

15 And I am going to let Taroon  
16 respond further.

17 MR. AMIN: So, the criteria is  
18 written to really think about the measure in  
19 terms of broad application. There was a group  
20 that looked at the use and usability of  
21 measures in our portfolio, with the goal, with  
22 the lens of thinking that we don't want to



1 have a large number of measures in our  
2 portfolio that are not being used in the  
3 field, because that sends a signal, even if we  
4 have looked at the use and usability of the  
5 measure, and they are not being taken up, that  
6 that is a concern. You know, that is a  
7 concern; that should be a concern for us  
8 broadly.

9           And so, what we have asked the  
10 developers to do is to provide a plan for how  
11 these measures are going to be used and their  
12 specific plan for how these measures are going  
13 to be used, as a way to inform our thinking  
14 about the fact that these measures will be  
15 taken up.

16           The developers obviously have an  
17 intent of how these measures will be used.  
18 And so, we should think about that in the  
19 context of can they be usable and can they be  
20 taken up by a program, but not necessarily  
21 whether they are appropriate for that specific  
22 program.

1                   So, that is where the difference  
2                   is, right? I mean, it is still a little bit  
3                   related. The reason why we asked for the  
4                   specific program is that we wanted to make  
5                   sure that they could actually be taken up and  
6                   used in various accountability applications or  
7                   quality improvement applications. So, that is  
8                   the context in which you should evaluate that.

9                   We will go through that in a  
10                  little more detail when we get to the  
11                  usability criteria. But is at least that  
12                  clear enough for now? And if it is not, let's  
13                  talk about that because, again, it is a really  
14                  important question.

15                  MS. WILBON: We are going to work  
16                  through it together. Don't worry. It will be  
17                  okay.

18                  (Laughter.)

19                  It is going to be hairy. We are  
20                  recognizing that, and it is difficult, but we  
21                  are going to work through it. So, bear with  
22                  us. We will get through it.

1 MS. TIGHE: Next slide.

2 So, on April 25th, we had an all-  
3 member call with the NQF membership. The  
4 purpose of this was to really start getting  
5 our membership engaged upfront and have it  
6 feed into the Steering Committee review rather  
7 than it simply being a response to the  
8 Committee recommendation.

9 This took place during the time  
10 when we had a commenting period open on the  
11 two measures for the public and membership to  
12 provide input. So, again, we are really just  
13 looking to get there, that you all can  
14 consider it as we make our initial  
15 recommendations for endorsement.

16 And that input from them was along  
17 the lines of it was also very broad and it  
18 touched on some of what we just discussed as  
19 relates to the Measures Application  
20 Partnership, but just really looking at if the  
21 measures allow for identification of high-  
22 value target areas for providers to focus

1 efforts on for reducing costs. So, kind of  
2 getting at if the measures can be  
3 deconstructed, so that providers know where to  
4 focus.

5 Looking at how access to care can  
6 be assessed within the context of cost and  
7 resource use measures. This one, again, may  
8 be a little bit more of a consideration for  
9 measures as they are developed. How are  
10 vulnerable populations addressed within the  
11 context of the measures being reviewed? What  
12 is needed to move toward assessing value of  
13 services? So, this will be a conversation  
14 that we have later today in the measure gaps  
15 discussion.

16 And then, how can drivers of cost  
17 be tied to quality of care to allow for  
18 identification of an ideal state? So, again,  
19 part of that discussion later today.

20 MS. WILBON: So, this slide,  
21 again, gets to Gene's comment earlier about  
22 building block. To kind of center us where we

1 are focused today, again, it is in that  
2 resource use box. But we completely recognize  
3 that this is a building block towards getting  
4 to value and efficiency. This is just one  
5 piece of the puzzle, and we just need to make  
6 sure this piece of the puzzle is valid,  
7 reliability, and that there is agreement that  
8 this is a valid indicator of cost and resource  
9 use. So, that is really what we are getting  
10 at today.

11 There was work done, I guess back  
12 in 2009, on defining an episode of care and  
13 applying that to how cost and resources should  
14 be measured. We like to call this the  
15 caterpillar model, to show how an episode of  
16 care for a particular patient, if you are  
17 looking at trying to develop measures in a  
18 patient-centered manner, how measures might be  
19 applied to that episode and to be patient-  
20 centered and apply across the episode.

21 So, again, you start with a  
22 population. You move into the evaluation and

1 management phase. And then, you have a  
2 followup phase.

3 And really, just kind of be  
4 thinking about this episode of care in your  
5 mind as we are evaluating measures and how  
6 these measures can be applied across the  
7 episode of care and their patient-  
8 centeredness.

9 And I won't spend time on this.  
10 We went through this in the orientation and  
11 tutorial calls. But some of the issues that  
12 we know that have come up before when  
13 evaluating these measures, and we anticipate  
14 that some of them will come up again. Just to  
15 kind of have them in your mind, and we have  
16 been here before somewhat. We expect some of  
17 these issues to come up again.

18 Again, the linking quality and  
19 cost issues; the costing approach and how that  
20 is defined and what implications that has for  
21 measurement. We will be talking a lot about  
22 risk adjustment. The impact of carveouts on

1 the outcome of the measure; not so much  
2 reliability and validity at the individual  
3 physician level, but, again, this whole public  
4 and private sector alignment we will be  
5 getting to a lot in the harmonization  
6 discussion.

7 So, again, just some things for  
8 your broad consideration. There are a lot of  
9 moving pieces to this going on in the  
10 landscape right now. We just kind of what to  
11 make sure that everyone is kind of aware of  
12 what is going on and the background.

13 So, we are getting ready,  
14 actually, to move into actually evaluating the  
15 measures, which you have all been waiting for.  
16 So, hopefully, you guys can wake up now. We  
17 are ready to start.

18 Just to talk you through a little  
19 bit how the flow of what we are going to do  
20 here today, we are going to start with a brief  
21 introduction of the measure from the Co-  
22 Chairs, the title, developer description.

1                   We will have the developers give  
2                   you guys an overview of the measure. There  
3                   have been a few, I think, last-minute changes  
4                   to the measures which are in your handouts.  
5                   The developers will kind of be talking you  
6                   through those and bringing your attention to  
7                   specific aspects of the measure that you may  
8                   need to be aware of as you dive into the  
9                   criteria.

10                   As you know, each of you has been  
11                   assigned a piece of the criteria. We wanted  
12                   to make sure that everyone was engaged. And  
13                   so, in your PDF handout that we sent out via  
14                   email -- and I am not sure if it is printed  
15                   out, but definitely in the PDF, and we can  
16                   bring it up on the screen -- we have made  
17                   assignments to everyone for pieces of the  
18                   measure. So, the Co-Chairs will be calling on  
19                   you when we get to that portion of the measure  
20                   to give your overview.

21                   We will also be putting slides on  
22                   the screen that will kind of cue you to some



1 of the discussion questions and things you  
2 should be highlighting during your  
3 presentation for each of the subcriteria. So,  
4 we will be here to help walk you through that.

5 We are going to be kind of hands-  
6 on with this first measure to make sure  
7 everyone kind of gets their feet wet and gets  
8 a feel for kind of the flow. And so, we will  
9 kind of introduce the measure, the criterion  
10 we are looking at.

11 We will have the lead discussant  
12 pick up and give a description summary of the  
13 submission relevant to your assignment, give  
14 a summary of the relevant Committee  
15 preliminary recommendations -- I'm sorry --  
16 preliminary recommendations and comments, and  
17 highlight where you think there may need to be  
18 more discussion. Or where there is specific  
19 agreement, we will try not to spend a lot of  
20 time there, but really focus on the areas  
21 where there seems to be a lot more issues to  
22 dive into for that particular area.

1           And then, we will be asking you to  
2 summarize any of the public comments that were  
3 relevant to your specific criteria to make  
4 sure those are addressed and are included in  
5 the discussion.

6           Once we kind of have that  
7 overview, we will, then, open it up for  
8 Committee discussion. So, the lead discussant  
9 is really there to kind of jump off the  
10 discussion, highlight what we need to talk  
11 about, and then, we will open it up to the  
12 whole Committee to dive in and provide input.  
13 And then, David and Gene will help facilitate  
14 that discussion.

15           And then, when you guys get to a  
16 point where you feel like you have got  
17 everything out, we will have you vote on the  
18 criteria. One thing we have kind of added in,  
19 I guess, ad hoc on the fly, we have a number  
20 of people here who are in the room from the  
21 public, and we will give them an opportunity  
22 to provide comments before you vote, so that

1       you have all the input.

2                       We want to try to have everything  
3       on the table.  Once decisions are made,  
4       sometimes it is hard to go back.  So, we want  
5       to make sure everyone has all the information  
6       before them as much as possible.

7                       We will have you vote on the  
8       overall criteria, and depending on the results  
9       of that vote, we will move on to the next  
10      criteria, and we will just go systematically  
11      through each one like you did in your  
12      preliminary evaluations.

13                      Once you vote, we will ask the Co-  
14      Chairs to kind of summarize the discussion to  
15      make sure that what we see reflected in the  
16      votes and the discussion that we heard  
17      actually kind of align, so that people  
18      understand that what they see in the votes is  
19      actually reflected by specific things that  
20      were raised as concerns or what have you.

21                      So, does that jibe with everyone?  
22      Does anyone have questions about the flow of

1       how we are going to evaluate the measures?

2                   Jack, you have this look on your  
3       face.

4                   MEMBER NEEDLEMAN:  No.  No, I am  
5       fine.

6                   (Laughter.)

7                   MS. WILBON:  I am like, is that  
8       good or bad?  Sorry, not to call you out, but  
9       I want to make sure we are all okay.

10                  MEMBER NEEDLEMAN:  If I have a  
11       problem, Ashlie, you will know it.

12                  (Laughter.)

13                  MS. WILBON:  Okay.  I know.  I  
14       know.  Thank you.

15                  Okay.  Can you go to the next  
16       slide, Evan?

17                  So, everyone should have a little  
18       pointer, an electronic voting device.  As we  
19       get to the criteria, there will be a slide  
20       that comes up on the screen.  We will probably  
21       do a test at some point.  Yes, we should  
22       probably do a test to make sure it is working.

1                   We will be asking you to vote.  
2                   You will have 60 seconds to enter your vote.  
3                   On the slide, it will tell you what number you  
4                   hit to correspond to each of the rating  
5                   scales. The votes are anonymous. We don't  
6                   know necessarily right now you are voting.  
7                   So, you don't have to feel scared about that.

8                   And then, once all the votes are  
9                   collected, it will display on the screen, so  
10                  everyone in the room will know what the  
11                  outcome of the votes was. And we will have  
12                  either staff or Co-Chairs recite what that is,  
13                  so everyone on the phone and in the room knows  
14                  what the votes are.

15                  The voting device that collects  
16                  your votes is actually on this laptop right  
17                  here where Evan is sitting. So, we will be  
18                  asking you to point in that direction. Okay?

19                  Any questions about that?

20                  (No response.)

21                  Okay. I think that is it. We  
22                  won't go over this.

1                   Okay. So, this is getting into  
2 the first criteria. And we will have, I  
3 guess, one of the Co-Chairs introduce the  
4 first measure.

5                   CO-CHAIR PENSON: Sure. Sure.

6                   Why don't we get started there  
7 with the first measure, which is 2158, which  
8 is Medicare Spending Per Beneficiary? I will  
9 just sort of summarize this as I understood  
10 it.

11                   Very quickly, I think it is, for  
12 these sorts of measures, relatively  
13 straightforward. And that is an important  
14 modifier right there.

15                   So, basically, what this measure  
16 attempts to do is at the hospital level assign  
17 cost to an inpatient episode. It starts three  
18 days before the admission for the inpatient  
19 episode and follows out to 30 days after the  
20 inpatient episode.

21                   It captures all A and B charges.  
22 Basically, once it does that, it basically

1 generates an O-to-E ratio where the expected  
2 ratio is generated by the MS-DRG, and then,  
3 that is modified against a national median, if  
4 I understand it correctly. And if I don't, I  
5 apologize. And that comes up with the final  
6 measure, with 1 being, as I understood it,  
7 fairly reflective of the median and,  
8 obviously, above 1 and below 1 going in either  
9 direction.

10 So, I think that sort of  
11 summarizes what it is at. The goal, as I  
12 understood it, was to sort of look at the  
13 hospital and try to improve coordination of  
14 care. As often, as they say in the measure,  
15 hospitals will discharge patients perhaps too  
16 early, and that can lead to readmissions. And  
17 by looking at the care around the  
18 hospitalization and counting resource use, we  
19 may be able to get towards better value by  
20 looking at the cost on either side.

21 So, I think that is fairly the  
22 overview of the measure. I am sure we will

1 get much more into the weeds as we go forward,  
2 and it will turn out that everything I just  
3 said was wrong.

4 I'm sorry, and the developer, if I  
5 am not mistaken, is CMS.

6 MS. TIGHE: Yes. If someone from  
7 that developer group wants to come and present  
8 the slides that you all put together and  
9 introduce the measure?

10 MR. ZAIDI: Good morning.

11 My name is Sajid Zaidi. I am with  
12 Acumen LLC. We are co-measure developers of  
13 the MSPB measure, under contract with CMS.

14 So, I just wanted to give a brief  
15 overview of the MSPB measure. And then, we  
16 would be happy to take any questions you might  
17 have.

18 So, the MSPB measure was actually  
19 mentioned by name in the Affordable Care Act  
20 as part of the hospital value-based purchasing  
21 initiative. CMS was required to develop this  
22 measure.



1           It measures total Medicare-allowed  
2 cost for hospitalization episodes. The  
3 hospitalization episode includes all Medicare  
4 Part A and B claims from three days prior to  
5 the index admission date to 30 days after the  
6 hospital discharge date. So, the only thing  
7 that is really not included is prescription  
8 drug claims, Part D.

9           It is an all-cause measure. It  
10 includes all conditions.

11           The measure is payment-  
12 standardized and risk-adjusted to allow for a  
13 comparison across all hospitals in the  
14 country, and it applies specifically to  
15 Medicare fee-for-service beneficiaries who are  
16 discharge during the period of performance  
17 from IPPS hospitals. So, these are hospitals  
18 that are paid under the Inpatient Prospective  
19 Payment System.

20           And so, the only main exclusion  
21 there are critical access hospitals and  
22 Maryland hospitals, which operate under a

1 waiver.

2 This measure was developed  
3 specifically for Medicare fee-for-service  
4 beneficiaries. We utilized the official CMS  
5 price standardization methodology, which has  
6 been adopted by the Institute of Medicine for  
7 their ongoing work on geographic variation.

8 The risk-adjustment model is an  
9 augmented CMS HCC model. The main difference  
10 between the HCC model that we all know and  
11 what we use is that we have added the MS-DRG  
12 as a risk adjuster.

13 And there are no similar NQF-  
14 endorsed measures to profile resource use  
15 around hospitalizations for Medicare  
16 beneficiaries.

17 So, as far the importance and  
18 usability of the measure, it is intended to be  
19 used alongside quality measures. So, when  
20 used in conjunction with other quality  
21 measures that CMS has developed, the MSPB  
22 measure allows one to identify hospitals that

1 provide high-quality care at a lower cost to  
2 Medicare.

3           So, for example, right now, it is  
4 already a part of the Inpatient Quality  
5 Reporting Program. It is publicly reported on  
6 Hospital Compare. You can go online right now  
7 and see MSPB scores for most hospitals in the  
8 country. And starting in fiscal year 2015, it  
9 will be a component of the Hospital Value-  
10 Based Purchasing Payment Adjustment, in  
11 conjunction with process-of-care measures,  
12 patient-experience measures, and outcomes  
13 measures.

14           So, the intent of the measure is  
15 to incentivize hospitals to reduce Medicare  
16 spending and delivery system fragmentation by  
17 improving coordination with post-acute  
18 providers to reduce, for example, the  
19 likelihood of hospital readmissions,  
20 unnecessary inpatient services such as  
21 multiple CT scans when they are not warranted;  
22 by reducing unnecessary post-acute care

1 services, and shifting post-acute care from  
2 intensive settings, such as the skilled  
3 nursing facilities, to less intensive  
4 settings, such as home health or other  
5 outpatient settings.

6 One thing I want to emphasize is  
7 that the MSPB measure, we have provided an  
8 unparalleled level of transparency to  
9 hospitals. We send each hospital, through the  
10 QualityNet website, three very detailed files  
11 that allow them to deconstruct the measure.

12 So, the first file that we send  
13 them is called an Index Admission File. This  
14 lists every single admission that the hospital  
15 had for Medicare fee-for-service beneficiaries  
16 during the period of performance. It includes  
17 the standardized cost for each admission and  
18 the episode as well as diagnosis codes, length  
19 of stay, and the major diagnostic category  
20 that the admission falls into.

21 And in this file, we also provide  
22 an indicator for whether or not the admission

1 was excluded, and there are various exclusion  
2 criteria that we will get into later.

3           The second file that we provide is  
4 an Episodes File. This is really the crux of  
5 our transparency efforts. This file lists for  
6 each service category, such as skilled  
7 nursing, physician cost, hospice cost, or home  
8 health cost, it lists the amount of cost in  
9 each of these settings. So, a hospital can  
10 really break down for every one of their  
11 episodes what are the components of the  
12 episode.

13           And this file also lists the top  
14 five providers for care provided in each of  
15 these settings. So, it really makes this  
16 information actionable, if you know exactly  
17 which providers are providing skilled nursing  
18 services or home health services to your  
19 patients.

20           And the last file is a Beneficiary  
21 Risk Score File, which provides all of the  
22 risk adjusters used for each index admission

1 as well as the coefficients on each of those  
2 risk adjusters. So, if the hospital wanted to  
3 and had the analytic capability to do so, they  
4 could reconstruct from scratch the risk  
5 adjustment part of the measure.

6 And the last slide is sort of a  
7 nitty-gritty list of all the steps in the  
8 construction of the measure. I will just go  
9 through it really quickly.

10 So, the first step is we exclude  
11 inpatient admissions that contain a transfer  
12 or where the beneficiary died during the  
13 episode or did not have continuous fee-for-  
14 service enrollment.

15 The next step is to construct the  
16 MSPB episode by including all standardized  
17 Part A and B claims from three days prior to  
18 admission to 30 days after discharge. And one  
19 important thing to note is that an admission  
20 can only start an episode if it is not already  
21 part of another episode. So, you can't have  
22 an admission as part of the 30-day window of

1 another episode and also start its own  
2 episode.

3           The next step is the risk-  
4 adjustment step. We calculated expected  
5 spending, adjusting for case-mix variation  
6 using the HCC model and the MS-DRG of the  
7 index admission. And the risk adjustment is  
8 actually done within a major diagnostic  
9 category. So, we run multiple regressions,  
10 one for each MDC.

11           The next step is excluding outlier  
12 episodes. These are episodes that had a  
13 residual which fell above the 99th percentile  
14 or below the 1st percentile. So, these are  
15 episodes that had predicted spending which was  
16 either far below or far above the actual  
17 observed spending.

18           And then, finally, the hospital's  
19 MSPB amount is calculated as an efficiency  
20 ratio, which is the ratio of the observed-to-  
21 expected spending over all of their episodes.

22           And the final measure that is

1 reported is the ratio of this MSPB amount to  
2 the median hospital MSPB amount. So, the  
3 interpretation is, if the measure is above 1,  
4 you cost more than the median hospital; if it  
5 is below 1, then you cost less than the median  
6 hospital.

7 So, I think that summarizes our  
8 brief description of the measure. I would be  
9 happy to take any questions, either now or  
10 throughout the discussion.

11 CO-CHAIR PENSON: I would suggest  
12 that we hold the questions as we go through  
13 the individual criteria, and that way, if  
14 people have specific questions.

15 So, I think, without any further  
16 ado, we should actually get into the various  
17 criteria. And everyone had their song. And  
18 so, I am going to ask Larry and Lina to start  
19 the discussion around the importance of this  
20 measure.

21 MEMBER WALKER: How do you want to  
22 do it, Larry?



1 MEMBER BECKER: You go ahead.

2 (Laughter.)

3 CO-CHAIR PENSON: So, Lina, I  
4 think that means it is on you. Okay?

5 (Laughter.)

6 MEMBER WALKER: Right. Very well.  
7 Very well. I am glad I did my homework then.

8 So, I am going through the  
9 measures 1a through c. And not having done  
10 this before, I am just going to briefly  
11 summarize what the scores are, summarize the  
12 comments, what I read from the public comment,  
13 and then, if there is anything that I miss,  
14 just jump in and remind me to fill in the  
15 blanks.

16 So, for the first measure, 1a,  
17 impact, the summary score is 20 high, 1  
18 moderate.

19 And I am not going to repeat the  
20 question. But the summary of the comments  
21 were, generally, most people felt that it  
22 scored it a high and had positive comments.

1       There were some comments that this measure did  
2       not demonstrate variation in total resource  
3       used by the hospital and, in fact, that it did  
4       not demonstrate performance gap, although one  
5       commenter noted that the evidence is available  
6       in the literature.

7                 Should I just proceed to 1b? So,  
8       1b is the opportunity for improvement. And  
9       the summary scores are 15 high, 3 moderate, 2  
10      lows, and 1 insufficient evidence.

11                And the summary discussions were  
12      mostly around the -- hang on a second  
13      -- around the disparities issues. One  
14      commenter thought that the measure did not  
15      address how it could be, wasn't sure how it  
16      could be used to address or improve  
17      disparities. And another felt that the  
18      measure should adjust for socioeconomic  
19      characteristics. But, by and large, a lot of  
20      the comments were -- well, it is hard to tell  
21      what were the comments for 1b.

22                For 1c, the category was measure

1 intent. It seems like there were a lot of  
2 comments around this. Some of the comments  
3 were: does a lower score on MSPB reflect  
4 improvement? And that is not clear.

5 Similarly, some felt that the MSPB  
6 measure does not equate with efficiency, which  
7 was how the developer had described that  
8 measure.

9 Many felt that it was more of a  
10 resource use measure, although one commenter  
11 noted that it really wasn't a total resource  
12 use measure, but more a measure of Medicare  
13 spending.

14 A few felt that the measure  
15 doesn't demonstrate, that the developers do  
16 not demonstrate how the measure would improve  
17 care coordination or achieve some of the  
18 stated goals.

19 A few felt that the measure was  
20 not specific or targeted enough. For  
21 instance, some of the comments were that it  
22 did not capture discharge planning, care

1 coordination, nursing, and other spending that  
2 could reduce readmission rates, which would be  
3 a target for improving care coordination.

4 One commenter felt that the  
5 average measure might not be able to achieve  
6 the stated outcome rather than a condition-  
7 specific measure.

8 And a comment that the measure  
9 does not capture appropriateness or  
10 effectiveness of care.

11 There were some questions from  
12 some of the reviewers on whether certain  
13 service categories were included in the  
14 measure. So, one felt that it was not  
15 transparent, what was included was not  
16 transparent.

17 And then, there were questions  
18 about whether transportation, home health,  
19 physicians, drug costs were included  
20 -- whether transportation, home health, or  
21 physician costs were included the measure.  
22 And then, a couple of commenters felt that

1 drug cost should be part of the measure and,  
2 also, in-kind services should be part of the  
3 measure.

4 And then, finally, many felt that  
5 -- but, in general, though, I would say that  
6 many felt that the episode-based measure was  
7 directional correct. There was one comment  
8 that the three-day pre-admission measure  
9 captures spending that is outside of the  
10 hospital's control.

11 There was some concern about  
12 unintended consequences, potentially stinting  
13 on post-acute care.

14 And then, another note that the  
15 name should reflect the unit of analysis,  
16 which is really inpatient hospital episodes.

17 And then, I think I didn't say  
18 this, but the summary score for 1c measure  
19 intent was 12 high, 6 moderate, and 3 low.

20 There were a couple of comments  
21 from the public on this measure, but they were  
22 more general comment that applied to this

1 measure and the second measure that we will be  
2 evaluating today.

3 And some of them were about shared  
4 accountability and attribution. Some felt  
5 that socioeconomic status should be considered  
6 within the measure. And this came up because  
7 of the disparities discussion.

8 Some felt that there are  
9 variations in spending that is due to patient  
10 or community characteristics that may not be  
11 reflected in race and ethnicity. Maybe this  
12 is more of a risk-adjustment section. Okay,  
13 so I am going to skip that.

14 So, that is all for now.

15 CO-CHAIR PENSON: Great. Thank  
16 you.

17 MS. WILBON: I am sorry. I know  
18 Nancy Garrett I think had 2c, which was under  
19 disparities, and we are kind of pulling you  
20 into this discussion. So, I just wanted to  
21 make sure that you had an opportunity, too.

22 MEMBER GARRETT: Do you want me to

1 do that now before we open it up for comments  
2 or?

3 MS. WILBON: Yes, if you had any  
4 kind of assessments on preliminarily what was  
5 submitted.

6 MEMBER GARRETT: Okay. I have a  
7 few slides. Evan, would you mind pulling  
8 those up?

9 So, in terms of the disparities  
10 information, it is a complex issue. So, I  
11 pulled together some of the information, just  
12 to get us all on the same page before we have  
13 the discussion.

14 So, on the next slide, the first  
15 question that I was asked to talk about is:  
16 were disparities identified in the  
17 demonstration of importance in the submission?

18 And so, if you could just make  
19 that bigger? Thank you. Perfect.

20 So, the developer cited a number  
21 of specific public studies. I just pulled out  
22 the key points from these, and the citations

1 are in your materials.

2 But, basically, in terms of SES,  
3 socioeconomic status, low-income Medicare  
4 beneficiaries are more likely to use inpatient  
5 services and home health services, suggesting  
6 that low income could be correlated with  
7 higher cost, although the home health  
8 services, it wasn't clear to me whether that  
9 would be higher or lower cost. So, I don't  
10 know all the details on that study.

11 And then, in terms of race, a  
12 number of different studies were cited; for  
13 example, end-of-life hospital care, where the  
14 study found that Blacks and Hispanics were  
15 more likely to be admitted to the ICU and  
16 receive more intensive services than Whites.  
17 In another study, Blacks had more money spent  
18 on them than Whites, but had less effective  
19 interventions. Another study, Blacks were  
20 more likely to be readmitted, a study of  
21 readmissions for AMI, CHF, and pneumonia, than  
22 Whites. And then, patients from minorities,



1 at the hospital level, patients from the  
2 hospitals that had a higher percentage of  
3 minorities had higher readmission rates. So,  
4 there is evidence in the literature that  
5 disparities are related to cost, I think is  
6 the overall summary.

7 And then, in the next slide,  
8 another question for us to consider is: were  
9 disparities identified in the demonstration of  
10 importance in the submission? And here, in  
11 terms of the actual analysis itself, not just  
12 from the literature, but the analysis itself  
13 of this data, episodes for dual-eligible  
14 beneficiaries cost more, \$859 more. But,  
15 then, at the hospital level, when they modeled  
16 this out, the results were similar in  
17 hospitals that had higher shares of dual-  
18 eligibles and higher just percentages.

19 So, it was interesting that at the  
20 beneficiary level there was a difference in  
21 cost. But, then, when they modeled it out at  
22 the hospital level, they didn't see that

1 difference.

2 Now a key point here is that the  
3 percent of dual-eligibles and the just  
4 percentages, note those are proxy measures for  
5 SES. And so, are those really capturing the  
6 underlying differences is a key question. And  
7 then, you have the different units of  
8 analysis, the individual in the hospital. But  
9 that contrast there is an interesting thing  
10 for us to discuss.

11 And then, on the next slide, now  
12 you get into the question of, okay, well, if  
13 there are disparities, what do we do about  
14 them? And so, that starts to get into the  
15 risk-adjustment discussion. And so, I will  
16 just talk about that a little bit, and then,  
17 we will talk about it more in the risk-  
18 adjustment section.

19 And so, at this point, the measure  
20 isn't including these variables in the risk  
21 adjustment or stratifying after the fact. And  
22 in terms of the risk adjustment, the rationale

1 is, as we heard already, that NQF has a  
2 position on not adjusting for socioeconomic  
3 factors.

4 And then, secondly, the measure  
5 developers said, "Well, but let's try it out."  
6 And so, they actually tried excluding dual-  
7 eligibles or adding them as a risk-adjustment  
8 factor. And that didn't result in major  
9 changes in the results or in the risk-  
10 adjustment models. So, they actually went  
11 ahead and tested it and didn't see major  
12 differences, which is interesting. So,  
13 another point for us to talk about.

14 And then, finally, the last slide,  
15 some of the comments that people submitted on  
16 this question of disparities and, then, what  
17 to do about it. One person said, "This could  
18 be a validity issue. So, why is it that we  
19 are not seeing correlation with proxies for  
20 disparities? Given that we do have this  
21 strong correlation on individual level, is  
22 that a validity question for the measure?"

1                   Another comment, "Validity of the  
2                   measure has not been fully established due to  
3                   lack of adjustments for age and race." So,  
4                   even though there is a policy not to adjust,  
5                   there are clinical factors that are present at  
6                   the start of care and should be considered.  
7                   So, I think there is even discussion here  
8                   about the policy and whether it makes sense in  
9                   this case or not.

10                   Another comment strongly  
11                   encourages the Committee to discuss the  
12                   viability of addressing socioeconomic status  
13                   within the measure.

14                   And then, another person said,  
15                   "Yes, we see disparities, but we think the  
16                   developers have a rationale for not  
17                   stratifying."

18                   So, there are some mixed comments  
19                   there. That just kind of kicks off, I think,  
20                   the discussion here.

21                   CO-CHAIR PENSON: Great. Thank  
22                   you.

1                   So, I was just talking to Ashlie.  
2                   What I think we should do is go through the  
3                   three importance criteria, 1a, 1b, and 1c.  
4                   And as we go through each of them, we will  
5                   vote on each of them in turn. And there are  
6                   questions. You will see the slide will come  
7                   back with the questions we are supposed to  
8                   address. Nancy's discussion probably wants to  
9                   come up in the 1b.

10                   To reflect back on what Lina said,  
11                   to sort of summarize, when we are talking  
12                   about 1a, what I heard -- and correct me if I  
13                   am wrong -- that there was general agreement  
14                   around 1a that the importance was generally  
15                   high, but there were really no issues around  
16                   1b. And given what Nancy said, it sounds like  
17                   there may be significantly more issues because  
18                   of the way it is parsed out. And perhaps we  
19                   should try to go in order. But I think we  
20                   will have some longer discussions about 1c  
21                   because I think there were some questions  
22                   about intent.

1                   So, why don't we try to just go  
2 through each of these in turn? What I would  
3 say we should do is we can just start and open  
4 up the floor to discussion. And if you have  
5 questions amongst Committee members, that is  
6 great. And also, with the developer here,  
7 they can address them.

8                   So, the first thing we looked at  
9 was 1a, which is the priority of the nature.  
10 Is this something that the specific national  
11 goal of priority identified by HHS or the  
12 National Priorities Partnership, I mean by  
13 NQF? Or this is an high-impact aspect of  
14 healthcare.

15                   And like I said, I got the  
16 impression that most people felt that this was  
17 important.

18                   If we can go back one slide before  
19 that? There we go.

20                   So, the discussion points really  
21 to think about are: are there large numbers  
22 affected by the measure? Does the measure

1 demonstrate variation in resource use or  
2 overall performance? And are there  
3 patient/societal consequences of high or low  
4 resource use?

5 So, I would open it up to  
6 discussion on the floor. Just put up your  
7 tent if you want to say something.

8 (No response.)

9 Very quiet. Okay.

10 There were some people who at  
11 least started with moderate. I don't think  
12 there were any lows here. If that person who  
13 is -- I don't want to call anybody out -- but  
14 does anyone feel any concerns or questions  
15 here?

16 (No response.)

17 Okay. Well, hearing none, I would  
18 say we probably should vote on it.

19 Do you want to do a test first,  
20 Evan, or just go right and vote and see if it  
21 works?

22 MR. WILLIAMSON: We don't have to

1 get a test set up, but we can use this slide  
2 to test it. And if it works, great, then we  
3 will keep the result.

4 So, I just want to make sure  
5 everybody points their clicker at this little  
6 dongle here on the computer. We will start  
7 here. You have a minute to vote, and your  
8 minute begins now.

9 (Vote taken.)

10 CO-CHAIR PENSON: I went to a  
11 meeting once, and they had the Jeopardy music  
12 on when they were doing this.

13 (Laughter.)

14 How do we know that we pointed at  
15 the right thing and our vote gets counted? I  
16 feel like I have a hanging chad here.

17 (Laughter.)

18 DR. BURSTIN: Even if you push  
19 twice, it only gets read once. So, it is not  
20 like people can vote multiple times. And we  
21 will get to see a count of how many have  
22 voted. And then, we will get a sense if it is



1 working.

2 MR. WILLIAMSON: I counted 25  
3 earlier. So, I just want to make sure  
4 everybody points. There we go. All right, we  
5 are at 25.

6 CO-CHAIR PENSON: Okay. So, we  
7 have 23 high and 2 moderate. So, the vast  
8 majority of folks think it is high, and I  
9 think that is good.

10 So, why don't we go on to 1b, and  
11 I expect there will be more discussion here.  
12 So, just to remind you, this is demonstration  
13 of resource use or cost problems and  
14 opportunity for improvement. And I want you  
15 to note that it includes a comment about data  
16 demonstrating variation in delivery of care  
17 across providers and/or population groups,  
18 which brings in that disparities issue that  
19 Nancy was talking about.

20 And we will come back to this  
21 later when we go to component 2, but I think  
22 that we want to think about this here as well.

1 Because if you feel that it is inherently  
2 flawed in picking up disparities, then I think  
3 it has to be discussed here. If it is more of  
4 a nuance, perhaps it should go on 2.

5 Some of the discussion points that  
6 you can see include: do the data demonstrate  
7 distribution of performance scores? Is the  
8 number representative of the entities? Do the  
9 data show disparities in the use of resources  
10 across care across certain populations? And  
11 then, size of the population at risk.

12 So, folks who want to start a  
13 discussion -- and there were some people here.  
14 I think there was a low here, if I remember  
15 correctly. So, I wonder, folks who have  
16 concerned, go ahead and put your tents up if  
17 you want to talk.

18 Jack, why don't you start us off?

19 MEMBER NEEDLEMAN: Okay. I think  
20 there are several issues here, not about the  
21 overall importance. After all, Congress asked  
22 for it. That is prima facie it is an

1 important measure.

2 The question is whether it  
3 actually delivers on what it promises to do.  
4 And I think there are three issues here that  
5 are all related.

6 One is it is accurately labeled as  
7 Medicare spending. But all through the  
8 discussion there is a discussion of cost, that  
9 it is a cost measure. It is not a cost  
10 measure; it is an expenditure measure.

11 And indeed, given that they are  
12 standardized, it is really a dollar-weighted  
13 unit-of-service measure, aggregate numbers of  
14 units of service. So, we get all this  
15 resource cost compression in every one of  
16 those units. So, if there are differences in  
17 how much hospitals are spending, it is  
18 invisible to this measure. If there are  
19 differences in what a physician's office is  
20 spending, if it isn't showing up on a bill, it  
21 is missing from this measure. It disappears.

22 So, we have got that issue in

1 terms of understanding. If we are trying to  
2 say Medicare expenditures, it is not bad. If  
3 we are trying to understand resource use or  
4 cost, it doesn't fully satisfy, it doesn't  
5 meet that concern.

6 When I think about what will drive  
7 this measure up, what are those cases at the  
8 high end? Given you start with a  
9 hospitalization in the middle, everybody has  
10 one and we have controlled for the DRG, so  
11 everybody's standardized hospital cost is  
12 already in there as the DRG, what is going to  
13 drive the differences and what is going to  
14 drive somebody high is readmission and SNF  
15 use.

16 Because other things are much  
17 smaller in magnitude. More doctor visits, not  
18 going to potentially make that much  
19 difference.

20 So, we have got the question of  
21 whether a measure that is fundamentally  
22 measuring differences in readmission and SNF

1 use -- and I may be oversimplifying and I  
2 would like to hear the Acumen people talk  
3 about what they see as driving up the high-end  
4 volume here, not in terms of dollars, but in  
5 terms of what units of service are driving  
6 that up.

7 But, basically, is a measure that  
8 basically captures differences in SNF use and  
9 readmissions an adequate measure to deal with  
10 the importance of measuring Medicare spending  
11 per beneficiary per hospitalization episode?

12 CO-CHAIR PENSON: So, I wonder if  
13 the developer could comment a little bit on  
14 that, only because I think Dr. Needleman's  
15 point is basically that this is really going  
16 to be driven by a few key categories in  
17 utilization. I don't know if you have found  
18 that or if you believe that is true or not.

19 MR. ZAIDI: So, we did look at  
20 this. We did a study decomposing the variants  
21 in episode cost across all hospitals. And  
22 you're right that most of the variance is

1       accounted for by broadly-defined post-acute  
2       care, which is SNF, home health use, and, of  
3       course, readmissions. So, those three  
4       categories do account for most of the variance  
5       across episodes, but I think it is important  
6       to remember that those are the high-impact  
7       categories where Medicare spends the most  
8       money surrounding hospitalizations.

9                   CO-CHAIR PENSON: So, Jack, what  
10       do you think about that?

11                   MEMBER NEEDLEMAN: So, then, the  
12       question is, are variations in that driven by  
13       patient-level factors that are not fully  
14       captured in the risk adjuster or are they, in  
15       fact, differences in resource use that reflect  
16       choices in care that are in some sense under  
17       the control of or influenced by the providers?

18                   CO-CHAIR PENSON: I think that is  
19       a very reasonable point. I am curious to get  
20       other folks' thoughts on that.

21                   Bill, you have your tent up.

22                   MEMBER WEINTRAUB: On each of the

1 points that Jack just raised, first, is this  
2 a measure of cost? Well, yes and no. What we  
3 are interested in, in principle, is total  
4 societal cost, but we can never get there.  
5 So, we use proxies.

6 I agree that, for many economic  
7 studies, I prefer using resource use of a  
8 hospital and trying to get at true hospital  
9 costs. But what Medicare is spending is a  
10 fair measure of cost. After all, we are  
11 paying our taxes to the federal government and  
12 they are spending those dollars. Some  
13 economists will say, "Well, that is just  
14 transfer of dollars. It doesn't mean  
15 anything." But others would disagree.

16 I think this is actually a fair  
17 measure of cost, seeing as there is no perfect  
18 way. I agree, though, that what we are  
19 looking at primarily, because, after all, the  
20 payments for the initial hospitalization are  
21 DRG-based, what we are primarily looking at  
22 are SNF use and readmissions.

1                   And there, the real question is,  
2                   is it fair to attribute these resources  
3                   downstream to the initial hospitalization?  
4                   And there is lots of noise because sometimes  
5                   yes, sometimes the hospitals fail to do things  
6                   and patients are readmitted. And that is sort  
7                   of a subtext that runs throughout the measure  
8                   as it is presented to us. But sometimes they  
9                   are not. And so, there is a lot of noise.

10                   Nonetheless, this is going to be  
11                   used. It is already being used, and hospitals  
12                   are very much tuning into the idea of taking  
13                   total risk, including what is coming  
14                   downstream.

15                   CO-CHAIR PENSON: Joe?

16                   MEMBER STEPHANSKY: Not all  
17                   hospitals are ready to take on that kind of  
18                   insurance risk.

19                   (Laughter.)

20                   Thank you, Jack, for your comments  
21                   because I buy into all of that.

22                   As far as Acumen, I know this



1 particular application for the measure  
2 endorsement doesn't reflect the work that you  
3 did for the Institute of Medicine, but that  
4 was essentially the same kind of finding, that  
5 it was the post-acute care, the differences in  
6 that, that were driving much of the variation.  
7 And I think home health played a bigger part  
8 in the work you did for the Institute of  
9 Medicine as far as the volume.

10 I would just like to remind people  
11 that, when a discharge occurs at a hospital,  
12 the discharge planner does not have the  
13 ability to say, "Okay, you need home health.  
14 You are going to this home health agency."  
15 There is a lack of accountability there. I  
16 mean, the patient gets to make some choices,  
17 not the hospital discharge planner, not the  
18 hospital itself. And we need to bear that in  
19 mind when we are trying to link accountability  
20 for the costs to Medicare after a discharge.

21 CO-CHAIR PENSON: Thanks, Joe.

22 David?

1                   MEMBER REDFEARN: I think Jack  
2                   made a really nice distinction. If you are  
3                   looking at the cost downstream post-discharge,  
4                   presumably, some of those costs are due to  
5                   things that the hospital may have done or may  
6                   not have done.

7                   But the other part of it, it could  
8                   be due to patient characteristics and  
9                   unmeasured patient characteristics and  
10                  incomplete risk adjustment of the patient  
11                  characteristics.

12                  And to jump ahead to one of the  
13                  comments I had about the risk methodology, the  
14                  HCC model, you got the MS-DRG, so that is  
15                  going to be pretty good characteristic of what  
16                  is going on in the hospital. But the HCC is  
17                  not a great risk model. It is a real subset  
18                  of a full model looking at a lot of things.

19                  The other thing that really  
20                  concerns me about this is they are capturing  
21                  HCCs based on 90 days pre-admission. All of  
22                  these models are designed for 12 months of

1 data. There is abundant evidence, looking at  
2 these kinds of risk models, that the accuracy  
3 of those models deteriorates dramatically if  
4 you have less than 12 months of data that go  
5 into them. In fact, it is the slope drops off  
6 dramatically at about seven months, and you  
7 are getting down to three months of data here.

8 So, this model is not going to  
9 adjust accurately for those patient  
10 characteristics, which may influence the post-  
11 discharge costs. And that concerns me a lot  
12 about this methodology.

13 CO-CHAIR PENSON: I want to raise  
14 a point as I understand it, and the NQF staff  
15 can correct me if I am wrong, which I may be.

16 But we will get an opportunity to  
17 go into attribution later and risk adjustment  
18 later. I think these points about attribution  
19 that were made before and risk adjustment are  
20 reasonable to raise here, but I think we want  
21 to look at it from a sort of 30,000-foot view.  
22 So, in other words, is it so flawed that you

1 have no chance for opportunity for  
2 improvement? Or is there still some  
3 opportunity for improvement, but there are  
4 flaws here?

5           And one of the things I heard from  
6 Nancy's discussion -- I think, Bill, that you  
7 are raising it as well -- is, when you look at  
8 this, are there patient-level characteristics  
9 that are so out of control of the hospital  
10 that they make the entire methodology invalid?

11           So, I am curious, as I hear people  
12 saying they have concerns about the risk  
13 adjustment, about the attribution, is it sort  
14 of a non-starter? That is what I think we are  
15 hearing. Correct me if I wrong about that,  
16 Ashlie.

17           MS. WILBON: Yes, David, you are  
18 right. And I just want to remind people about  
19 what we are looking for. For this 1b  
20 criteria, that the developer has demonstrated  
21 that there are resource use or cost problems  
22 in general, that this measure is needed, and

1 that there is opportunity for improvement.  
2 And by showing that there is opportunity for  
3 improvement, they would have data that there  
4 are gaps in performance across providers or  
5 gaps in care delivery for a certain  
6 population. So, really focused on whether or  
7 not they have demonstrated there is a need for  
8 this measure because there needs to be  
9 improvement in either how costs or resources  
10 are used or how care is delivered to certain  
11 populations.

12 So, just to kind of refocus the  
13 discussion, because I think the points you are  
14 bringing up are great, but will probably go in  
15 scientific acceptability.

16 CO-CHAIR PENSON: So, Lina, go  
17 ahead.

18 MEMBER WALKER: Is this the point  
19 where we talk about the disparities? Can I  
20 talk about 2c?

21 I raised the concern that the  
22 measure didn't vary with proxies for

1       disparities. To me, that seemed to be a  
2       significant limitation of the measure, given  
3       that we know that there are significant  
4       variations in spending.

5                   And it raised the question about  
6       the validity of the measure, and I don't want  
7       to go into that now. But I would like to hear  
8       a little bit more from the developer about  
9       what they thought could be driving the lack of  
10      variation and whether there were opportunities  
11      to use different types of proxies because,  
12      clearly, the ones that you used were  
13      inadequate, and perhaps they were just weak  
14      measures of disparities.

15                   MR. ZAIDI: So, as the measure is  
16      reported on Hospital Compare, there is no  
17      stratification for socioeconomic status. But  
18      for the submission form, we did look into a  
19      few measures of socioeconomic status. So, it  
20      is hard to say exactly why there wasn't as  
21      much variability or as much of a disparity as  
22      you would expect. But I think one thing is

1 that we are conditioning on the reason for  
2 admission for the initial index admission.  
3 So, if you would expect that dual-eligibles  
4 are more likely to be admitted for more severe  
5 care, we are controlling for that by  
6 controlling for the MS-DRG of the index  
7 admission.

8 And I would say that our analysis  
9 showed that Medicaid beneficiaries had about  
10 \$1,000 more expensive episodes on average.  
11 That didn't translate into a clear pattern  
12 between hospital performance. I think that  
13 would take further investigation to figure out  
14 why the per-episode variation didn't translate  
15 into between-hospital variation.

16 MS. SPALDING BUSH: Can I just add  
17 something? One of the things, this measure  
18 also went through notice and comment,  
19 rulemaking in the FY 2012 IPPS rule. And one  
20 of the comments that we received with regard  
21 to socioeconomic status was the concern that  
22 Medicare beneficiaries of lower socioeconomic

1 status would have multiple chronic conditions  
2 that we needed to account for. I think that  
3 perhaps that we capture the HCCs for every  
4 claim that is billed in the 90 days preceding  
5 the admission may help to have mitigated some  
6 of that concern.

7 CO-CHAIR PENSON: Thanks.

8 Martin?

9 MEMBER MARCINIAK: So, the  
10 question I have actually comes back to 2b. It  
11 was something that you touched on in your  
12 slide there.

13 And so, given that this gives the  
14 opportunity to drop down to the provider level  
15 and to start, quote, "changing behaviors," I  
16 would like to hear a little bit about how or  
17 what evidence you have to show at this point  
18 that it is actually changing behaviors.

19 MS. SPALDING BUSH: I think the  
20 measure is fairly new. So, we haven't seen a  
21 lot of change in behavior, but I don't think  
22 we have any analyses that demonstrate that.



1 MR. ZAIDI: No. So, I think it  
2 has been posted online for maybe a year now.

3 MEMBER MARCINIAK: Nothing that is  
4 sort of preliminary out there that is showing  
5 that, when people have actually used this, it  
6 has actually made a difference in terms of how  
7 they are actually practicing at the hospital  
8 level?

9 MR. ZAIDI: Nothing that specific  
10 that would say that there is change in  
11 behavior that is attributable to the MSPB  
12 measure.

13 CO-CHAIR PENSON: Matthew?

14 MEMBER MCHUGH: I think this is  
15 maybe related to what Martin said and, in  
16 part, is asking for some clarification about  
17 maybe what the MAP is doing.

18 But I am having a little bit of  
19 difficulty with 1b. If we are asking about  
20 whether there is distribution in performance,  
21 which I think basically there is, but if we  
22 think about what an organization is going to

1 do with that information, what does  
2 improvement mean if we can't think about it in  
3 relation to quality or efficiency? I think  
4 that that makes it difficult to evaluate.

5 MEMBER MARCINIAK: Just to bridge  
6 off of Matthew on that, I mean, that is one of  
7 the challenges I actually had when I was  
8 reading this. The context actually matters.  
9 And so, to put resource there without context,  
10 you know, frankly, I struggle with that  
11 because you are saying that you are looking at  
12 resource and you are looking at a hospital.  
13 And then, it becomes the bridge to something  
14 else, something that is not entirely clear yet  
15 in terms of what the quality measures are  
16 because it is, in fact, it is what you are  
17 trying to drive to.

18 CO-CHAIR PENSON: I do wonder,  
19 getting back to some of the other slides,  
20 about the building-blocks approach because it  
21 is going to be tough for us to sort of make  
22 that next jump with both of these. I can

1 remember in Phase 1 that was a big issue. So,  
2 you sort of have to suspend disbelief on that  
3 piece and trust that CMS ultimately will  
4 develop value measures, but I think it is a  
5 well-taken point. I don't want to minimize  
6 it, but it will kill us if we get stuck there.

7 Daniel?

8 MR. WOLFSON: I want to reflect on  
9 your opening comment about the purpose of the  
10 measure. And I am getting more concerned  
11 about that.

12 You said it was about care  
13 coordination. And then, we have heard that,  
14 really, the measure is very dependent on use  
15 of skilled nursing facilities and  
16 readmissions. So, are we really, really  
17 wanting to measure care coordination? And if  
18 we really are measuring care coordination,  
19 would this be the measure that we would use?

20 So, I am getting a little confused  
21 about the intent of the measure. Frankly, I  
22 don't think that is true. I think it is about

1 cost, and it is not about care coordination.  
2 I think we would be measuring it in a much  
3 different way.

4 CO-CHAIR PENSON: So, don't kill  
5 the messenger.

6 (Laughter.)

7 No, that's okay.

8 And that may also be the way I  
9 interpreted it, but I will turn that over to  
10 the measure developers. It may have been that  
11 I misspoke, Daniel.

12 MS. SPALDING BUSH: Yes, I think  
13 that the care coordination piece fits into the  
14 measure when we talk about how could a  
15 hospital potentially improve their performance  
16 on the measure. But I think you are right  
17 that it is a measure of cost, of resource use.  
18 So, I think you are correct. And I think care  
19 coordination plays in when we talk about what  
20 could a hospital do.

21 And as Sajid mentioned when he was  
22 going through the slides, we provide them with

1 a vast amount of information. They can see  
2 for each category what are their most  
3 expensive service delivery types within their  
4 episodes. And they actually get the names of  
5 those providers if they have had an interest  
6 in trying to coordinate care with them, to see  
7 whether they could reduce duplicative  
8 services, unnecessary services, repeat tests,  
9 that type of thing. The hospitals are given  
10 all the information that they need to try to  
11 do that.

12 But you are right, it is not  
13 intended to be specifically a care  
14 coordination measure.

15 CO-CHAIR PENSON: So, if I could  
16 reflect back on this, because it helps me with  
17 my understanding as well, while you do feel  
18 that there may be some help with care  
19 coordination, it is clearly not a care  
20 coordination measure and you are going to  
21 report out to hospitals information of the  
22 individual provider and utilization, say, of

1 imaging within the hospital admission, et  
2 cetera. So that hospitals get that  
3 information for improvement?

4 MS. SPALDING BUSH: That is  
5 correct. And I am looking at Sajid because he  
6 knows better what it is, actually, they we  
7 provide in those hospital reports.

8 MR. ZAIDI: I don't think the  
9 hospital report breaks out imaging  
10 specifically as a category, but it will break  
11 out physician services during the index  
12 admission. So, you will be able to see all  
13 the professional fees that were incurred  
14 during the index admission.

15 CO-CHAIR PENSON: Okay. So, I am  
16 sorry. Sorry, David, go ahead.

17 MEMBER GIFFORD: Helen may kill me  
18 for this.

19 In the past on some of these  
20 panels, when measures have to be interpreted  
21 within the context of other measures, we have  
22 recommended they be paired with other

1 measures. And that is what I had when I was  
2 reading this through, that by itself this  
3 measure sort of is loss in context and  
4 meaning. We may want to think about saying  
5 that, if it is used, it has to be paired with  
6 some other type of measures that are out there  
7 to link at that issue, to get at the issue  
8 Martin was bringing up.

9 DR. BURSTIN: I won't kill you.

10 But this is an issue that has been  
11 longstanding. In fact, the NQF framework on  
12 episodes very clearly said resource use  
13 measures should not be used in isolation. And  
14 there was a recommendation, I think pretty  
15 clearly. And again, I think it is reasonable  
16 to -- I think we iterated that in the first  
17 report. I assume we do that again, that these  
18 measures should always be used in concert with  
19 quality measures to really get a full picture.

20 Anything you want to add on that,  
21 Taroon?

22 MR. AMIN: No.

1 DR. BURSTIN: Great.

2 CO-CHAIR PENSON: So, I think,  
3 David, would it be safe to say that you do  
4 have a specific quality measure you would pair  
5 with it in mind. Just you have to keep it in  
6 context. Okay?

7 So, Lina, I think you were next.  
8 And then, Tom and Brent.

9 MEMBER WALKER: Forgive for  
10 keeping repeating this question, but I just  
11 want to be very clear about what we are  
12 supposed to do here. So, I want to clarify,  
13 again, how we should evaluate this measure.

14 So, what I am hearing from  
15 developers is that we should think of this as  
16 a total cost measure, and you had used care  
17 coordination as an example. So, then, as we  
18 evaluate the broad applicability of this  
19 measure, some of the things that, for  
20 instance, I would want to consider would be  
21 how that measure could be used in multiple  
22 contexts. But, then, sort of the broadness of



1 the measure might produce limitations in the  
2 broader application; whereas, in the more  
3 targeted application that you had initially  
4 provided as an example, it might have been  
5 slightly more useful.

6 So, I just want to be clear about  
7 how I should be thinking and evaluating this  
8 measure.

9 MR. AMIN: Okay. So, that is a  
10 good point, Lina. And so, what we are  
11 specifically looking at right now is to look  
12 at the question of, in the context of our  
13 theoretical construct that we are operating  
14 under, which is that resource use measures are  
15 a building block to understanding efficiency  
16 and value, and where we agree that measures of  
17 resource use need to fit all these criteria --  
18 important, scientifically-sound, usable, and  
19 feasible -- given that, which is the context  
20 in which we are having this discussion, so  
21 these points about the quality relationship is  
22 important. But, at this point in time, we are

1 looking at the scientific soundness of the  
2 measure of cost. Right now, we are looking at  
3 the question -- and again, at the 30,000-foot  
4 level -- does this measure give us an  
5 indication that there is opportunity for  
6 improvement in cost, meaning is there  
7 variation? Is there variation among  
8 providers? And is there variation among  
9 population groups?

10 These issues around disparities  
11 will clearly align with some of our  
12 conversations in the scientific acceptability  
13 portions around the appropriateness of the  
14 risk-adjustment model and the appropriateness  
15 or not of the stratification approach. And  
16 that discussion will occur at that point.

17 Thirdly, there is new information  
18 or new discussion, which I don't want to  
19 totally dismiss, but I think we will have to  
20 have it at some point, specifically in the use  
21 and usability discussion, which comes to the  
22 point of providers who are held accountable

1 using this measure, are they going to have  
2 enough information to facilitate improvement?  
3 And that will be the point to have that  
4 discussion.

5 And so, all of these are  
6 important. So, I would just encourage the  
7 Committee to consider the criteria as  
8 described, and through this first effort, try  
9 to focus the discussion there because it may  
10 be the cleanest way to have this discussion.

11 CO-CHAIR PENSON: Tom?

12 MEMBER TSANG: Yes. Sorry, I  
13 don't want to belabor this whole point about  
14 context. In my mind, I am thinking about  
15 putting this measure next to some of the 33  
16 quality measures that an ACO or an MSSP  
17 program would be facing this year.

18 And so, I am still kind of unclear  
19 about how it would work next to perhaps a  
20 bucket of diabetes measures or a bucket of CHF  
21 measures. And so, perhaps CMS or Acumen can  
22 actually walk us through a use case. I know

1 we are talking about hypotheticals, but maybe  
2 that would help me think about the context.

3 CO-CHAIR PENSON: So, before you  
4 go ahead, I am going to ask the NQF staff,  
5 because this goes back to the concept of what  
6 is the mission of the Steering Committee  
7 versus the MAP, you know, the broadness versus  
8 the specific, and how far into the weeds you  
9 want us to get with this.

10 MR. AMIN: It is an important  
11 question. If we feel it is appropriate for  
12 CMS to respond to that, that is fair. The  
13 challenge is that there are two issues here.  
14 The first is that this Committee, again, is  
15 under the construct that the resource use  
16 measures need to be scientifically-sound and  
17 meet the endorsement criteria. And that is  
18 the function of this group at this moment.

19 Questions around how we move  
20 toward cost and quality linkages or how this  
21 is used in programs together is a discussion  
22 for later on this afternoon, pretty much at

1 the end of the day.

2 And the issues around how these  
3 would actually link up together in particular  
4 programs is really the purview of the MAP and  
5 is out of scope for this Committee.

6 So, what we are intended to do  
7 right now is to evaluate these measures  
8 against these criteria. So, I would encourage  
9 the Committee and the Chairs to limit the  
10 discussion to that task.

11 CO-CHAIR PENSON: So, I hear what  
12 you are saying, and I will respect it. I am  
13 going to ask Tom and others if they need to  
14 hear a little bit about a hypothetical  
15 specific program for context to assess 1b.

16 I mean, Tom, you raised the point.  
17 If you really feel you need it, then I think  
18 we should ask CMS. But I think you have to  
19 keep it in that broad view.

20 What do you think?

21 MEMBER TSANG: Well, I hate to  
22 them on the spot, but I think, for myself, for

1 hypothetical discussion, I think it would  
2 clarify just a little bit. I mean not a full-  
3 length discussion, but take a test scenario or  
4 a use case or something.

5 DR. BURSTIN: CMS is willing to  
6 respond.

7 CO-CHAIR PENSON: Okay. Joe is  
8 raising his hand. Maybe he --

9 MEMBER STEPHANSKY: Yes, I have an  
10 example, and this may seem kind of funny  
11 coming for me coming through thinking about  
12 the fairness of the measure.

13 But, right now, the Hospital  
14 Association, some University of Michigan  
15 faculty, and Blue Cross Blue Shield of  
16 Michigan are working on just this kind of  
17 application where we are using the commercial  
18 claims data from Blue Cross Blue Shield and a  
19 cost measure somewhat similar to this, cost to  
20 Blue Cross Blue Shield where we have a  
21 different standardization method, obviously,  
22 because of the range of contracting amounts.

1                   But we are starting forward on  
2                   looking at a total cost measure per episode  
3                   using our own kind of episode groupers to  
4                   examine just these questions because we see  
5                   the variation; we know there are things we can  
6                   do to reduce the variation, reduce the cost.  
7                   We are linking them up to specific  
8                   collaborative quality initiatives, say, in  
9                   surgical infections or in urological  
10                  surgeries, bariatric surgeries. We know there  
11                  are ways that we can work together  
12                  collaboratively to reduce costs while  
13                  maintaining quality or increasing them.

14                  It is a very similar concept to  
15                  this measure. So, I have no problems at all  
16                  calling the question. Let's just vote on this  
17                  thing, say it is important, and worry about  
18                  these issues in the usability area.

19                  CO-CHAIR PENSON: So, we have a  
20                  move to call the question, but I see there are  
21                  still some tents up.

22                  (Laughter.)

1                   And I want to make sure everyone  
2                   has a chance to say --

3                   PARTICIPANT: I second that  
4                   motion.

5                   CO-CHAIR PENSON: Well, are you  
6                   guys okay with that? Bill? Brent?

7                   Use the microphone.

8                   I think I am okay. I am okay  
9                   unless someone needs another example, because  
10                  I wasn't as concerned. But if others still  
11                  are, all right.

12                  Brent, are you okay calling the  
13                  question, too?

14                  MEMBER ASPLIN: That is what I was  
15                  going to say. This is important. We have a  
16                  lot of validity questions. So, let's get to  
17                  them.

18                  CO-CHAIR PENSON: All right. I  
19                  sort of agree, but I want to make sure  
20                  everyone has a chance to talk.

21                  (Laughter.)

22                  Very good. So, I think let's call



1 the question. Thank you, Joe.

2 So, go ahead and let's have a  
3 vote.

4 MR. WILLIAMSON: We will now vote  
5 on criteria 1b, the opportunity for  
6 improvement. You will have 60 seconds. You  
7 may begin now.

8 (Vote taken.)

9 And we have 12 high, 12 moderate,  
10 1 low, and zero insufficient.

11 CO-CHAIR PENSON: Okay. Does this  
12 have to have all high or high/moderate okay?

13 DR. BURSTIN: High/moderate is  
14 okay.

15 CO-CHAIR PENSON: Okay. Great.  
16 Terrific.

17 So, here is what I would propose  
18 we do: apparently, folks on the phone can't  
19 hear me. Too close? Okay. Can you still  
20 hear me now? Can you hear me now?

21 (Laughter.)

22 It has been a long day already.

1                   So, I think let's get to 1c. I  
2 think after 1c, which I think there will be  
3 some discussion, we will take a short break.  
4 So, I ask you guys to sort of work through  
5 this.

6                   And I think that this is where  
7 people got into the issue of intent and  
8 linking to efficiency, or linking to quality,  
9 which I think we should be careful of. And I  
10 think Jack's point about this is really just  
11 resource use. That may be exactly what we are  
12 trying to do here.

13                   So, the things you want to think  
14 about as we talk about is, is the intent of  
15 the resource use measure clearly described?  
16 Is the construction consistent with the  
17 conceptual construct? Do the resource use  
18 categories align with the intent of the  
19 measure? And as you heard, some are measured  
20 and some aren't. And are all the categories,  
21 types of resources, captured in the measure  
22 that you would expect, based on the intent of

1 the measure?

2 So, with that, I will open it up  
3 to discussion. Or, Joe, you can call the  
4 question right away, if you like. I like that  
5 idea.

6 (Laughter.)

7 Nancy, you have your tent up.

8 MEMBER GARRETT: So, I think in  
9 this section, and perhaps under the  
10 transparency section as well, to me, the name  
11 of the measure is a real problem. And so, I  
12 think maybe we are stuck here because this is  
13 written in the statute in this way.

14 But this is a measure of spending  
15 for beneficiary inpatient episode. And so,  
16 the fact that it says it is per beneficiary,  
17 to me, it is very confusing. As people are  
18 trying to get their arms around it, soon there  
19 are going to be a lot of cost measures, not  
20 just two. And so, I think it is really  
21 important that it is very clear what we are  
22 talking about here and who is being held

1       accountable and what the measure is.

2                       So, I just wanted to kind of say  
3       that for the record on this section.

4                       CO-CHAIR PENSON:   Okay.  Other  
5       comments?

6                       Martin?  And then, Jack.

7                       MEMBER MARCINIAK:  I would think  
8       that as well.  I think that one of the  
9       problems that I had along with the  
10      transparency, frankly, was the listed  
11      categories.  It was hard to discern exactly  
12      what those listed categories were within the  
13      measure.

14                      We looked at the building blocks.  
15      We have spent a fair amount of time talking  
16      about those now.  I think the blocks went  
17      resource efficiency and, then, value.  Within  
18      the context of the document, it talks about  
19      this an efficiency measure and not a resource  
20      measure.  So, it might be nice to clean or fix  
21      that as we go along as well.

22                      CO-CHAIR PENSON:  I wonder, for my

1 benefit and others, you sort of have alluded  
2 to it. Can you talk a little bit about the  
3 types of categories specifically which are  
4 captured?

5 MR. ZAIDI: Sure. So, the measure  
6 captures basically everything that Medicare  
7 pays for other than prescription drugs,  
8 everything other than Part D.

9 CO-CHAIR PENSON: I mean, how is  
10 it reported back? Just as the single number?  
11 Because I think that is, to me, some of the  
12 question here about the intent. And also, it  
13 goes back to 1b as well, the improvement  
14 issue.

15 So, I understand you are capturing  
16 everything but Part D. But, then, how is it  
17 sort of broken down when you do the reports,  
18 et cetera?

19 MR. ZAIDI: So, you are right that  
20 the headline number is just one index number,  
21 but in the hospital-specific reports and the  
22 data files that we provide to hospitals,

1 currently, it is broken down into seven  
2 categories, which are inpatient, hospice, SNF,  
3 home health, outpatient hospital, professional  
4 physician, and durable medical equipment. And  
5 those are further broken down by the three  
6 time periods of the measure, which is prior to  
7 admission, those three days prior to  
8 admission; during the index admission, and  
9 post-discharge.

10 Those documents, we can, in  
11 response to comments or suggestions, I think  
12 in future years we have the ability to change  
13 those data files that we provide to hospitals  
14 to make it more usable for hospitals.

15 CO-CHAIR PENSON: Jack?

16 MEMBER NEEDLEMAN: Two things. I  
17 just want to reemphasize that this is a  
18 measure of Medicare expenditures or Medicare  
19 costs. It is not a measure of resource use in  
20 the providers. The measure compresses,  
21 because of the standardization pricing, it  
22 compresses any variations in resource use

1 within providers, within billed served  
2 category.

3 And it excludes not only drugs,  
4 but anything else which is provided within a  
5 provider which is not a billable service.

6 So, those are two important  
7 limitations. I don't think the documentation  
8 of it fully captures those limitations. And  
9 in that sense, I am unhappy with the  
10 documentation.

11 Obviously, one of the big  
12 categories of excluded expenditures in there  
13 for resources that are used is drugs. So, do  
14 you have any sense of how much drug costs are?  
15 If they were included, how much they would be  
16 adding to this and how much variation there is  
17 in that? Is it an exclusion we ought to be  
18 worrying about if the intent is to measure  
19 Medicare expenditures and use the billing  
20 categories as a proxy for cost or resource  
21 use?

22 MR. ZAIDI: So, there were a

1 couple of concerns with including Part D. The  
2 biggest one is that only about 60 percent of  
3 fee-for-service beneficiaries have Part D  
4 coverage. So, we would be missing a large  
5 number of beneficiaries, and that would reduce  
6 the number of hospitals who would meet the  
7 minimum episode criteria to be profiled. So,  
8 there is a significant missing data concern  
9 with Part D.

10 The other concern is that the  
11 prices paid for drugs vary by plan. So, the  
12 actual spending varies a lot from plan to plan  
13 because they negotiate the prices for those  
14 drugs.

15 Kim, do you have anything to add  
16 on that?

17 MS. SPALDING BUSH: No.

18 MR. ZAIDI: But we haven't done a  
19 specific analysis on the level of variation in  
20 Part D spending.

21 MEMBER WALKER: I would have to  
22 clarify what you just said. Now Part B drugs



1 are included?

2 MR. ZAIDI: Part B drugs are  
3 included. Part D drugs are not.

4 CO-CHAIR PENSON: So, I just want  
5 to reflect back to Jack because I am  
6 hearing --

7 MEMBER NEEDLEMAN: I'm sorry. And  
8 Part A drugs are included, too.

9 MR. ZAIDI: Well, not specifically  
10 because I think those are bundled into the --

11 MEMBER NEEDLEMAN: That means they  
12 are included.

13 MR. ZAIDI: Yes.

14 CO-CHAIR PENSON: So, I want to  
15 just funnel back to Jack because I am hearing  
16 your concerns, and I am curious if this is,  
17 for lack of a better way to put it, a deal-  
18 breaker for you or just of moderate concern  
19 for you.

20 MEMBER NEEDLEMAN: A good  
21 question. It is probably a moderate concern.  
22 I think it is important in terms it will come

1 back in the usability discussion. So, I just  
2 don't like the mislabeling and I don't  
3 continuing to hear people talk about this as  
4 a cost measure. It is a Medicare expenditure  
5 measure, and that is different.

6 CO-CHAIR PENSON: Okay.  
7 David?

8 MEMBER GIFFORD: I will go a  
9 little farther than Jack. I agree with his  
10 points, but, to me, I have concerns with how  
11 it is described as it is incentivizing  
12 hospitals to coordinate care and reduce  
13 unnecessary utilization. There are so many  
14 other ways to move this metric. I think it  
15 mislabels the intent and it mislabels how the  
16 results will be interpreted and used.

17 And so, I really have concerns how  
18 it is written here. Other issues with the  
19 measure, but I think the way it is written  
20 suggests the use and interpretation of the  
21 data that is very misleading and wrong. And  
22 I don't support it that way.

1 CO-CHAIR PENSON: So, what I am  
2 hearing from you, David, is actually a serious  
3 concern about the intent of the measure.

4 MEMBER GIFFORD: I am okay with  
5 the using of the measure and going out there.  
6 It is how it is written here. There are so  
7 many other ways to get and move this metric  
8 besides just incentivizing care coordination  
9 and unnecessary utilization.

10 And I think that we have heard a  
11 lot of the comments around here today. If we  
12 endorse it the way it is written, we would  
13 suggest that this measure is reflecting and  
14 changes are reflecting related to that. And  
15 I don't think -- all the comments we have  
16 heard say that there are a lot of other things  
17 that are contributing to the variation in this  
18 measure.

19 CO-CHAIR PENSON: So, I just want  
20 to reflect back because I think it is  
21 important because I am hearing very serious  
22 concern. I think it is in the right place

1 when we are talking about the intent of the  
2 measure. So, just to reflect back, I am  
3 hearing very serious concerns from Dr.  
4 Gifford.

5 Lisa?

6 MEMBER LATTS: So, a couple of  
7 comments related to what has been said. I  
8 agree, and I think probably everybody is going  
9 to agree, that to use this as a, quote,  
10 "coordination-of-care measure" is really  
11 directionally the wrong way to go.

12 So, maybe in terms of sort of  
13 moving the conversation along, we can agree,  
14 as part of our comments back to the developer  
15 in terms of the next phase, that we would like  
16 the whole coordination-of-care piece to go  
17 away. Since there are many valuable things,  
18 I think, that this measure can be used for, I  
19 just happen to think that is not one of them.

20 So, maybe so we don't keep beating  
21 this to death, which is probably too late --  
22 (laughter) -- we can give that back to the

1 developer.

2 Then, I have two more comments.

3 One, I am actually not bothered at all by the  
4 sort of resource use at the provider level.

5 I, frankly, in terms of this measure, don't  
6 care. What I care about is what it costs  
7 Medicare or what Medicare is expending on it.

8 If a provider within their own  
9 facility is more or less efficient in  
10 providing those services, to me, that is not  
11 what this measure is about, and it is their  
12 business, and they need to work that out. So,  
13 I am not bothered by that at all.

14 I am bothered by the pharmacy and  
15 the Part D, and I really wish -- I know that  
16 there is a significant percentage of  
17 beneficiaries that don't have Part D coverage,  
18 but I really wish there was a composite of  
19 this measure with Part D for those 60 percent,  
20 or whatever percentage it is that had Part D,  
21 because I am bothered by that.

22 CO-CHAIR PENSON: So, I think the

1 Part D issue, that is, for lack of a better  
2 way to put it, set in stone. In other words,  
3 you have developed the measure that way and it  
4 is going to be what it is going to be. And we  
5 have to decide if that is okay within the  
6 measure intent.

7 With regard to the coordination of  
8 care, I think perhaps I get to bear some blame  
9 for this for highlighting it in their  
10 submission. But I will ask the CMS folks, I  
11 mean, I am interpreting your comments as that  
12 is an example of one of the ways, but that was  
13 not your primary intent. Is that a fair  
14 statement?

15 MS. SPALDING BUSH: I think it is  
16 fair to say that coordination of care we view  
17 as one of the ways a hospital could  
18 potentially improve their performance on this  
19 measure, yes.

20 CO-CHAIR PENSON: But not the only  
21 way, and that was not your intent? You are  
22 not looking at this as a coordination-of-care

1 measure?

2 MS. SPALDING BUSH: Correct.

3 CO-CHAIR PENSON: Okay.

4 MS. SPALDING BUSH: And we think  
5 avoiding unnecessary utilization at the  
6 hospital level is certainly another way to go  
7 and improve performance on that measure.

8 CO-CHAIR PENSON: Larry?

9 MS. SPALDING BUSH: Provide good  
10 care during the hospitalization to avoid  
11 readmissions, all of these things that could  
12 be done, yes.

13 CO-CHAIR PENSON: Larry?

14 MEMBER BECKER: So, this is CMS  
15 data, all these pieces, and they are a big  
16 purchaser, certainly a lot larger than I am as  
17 Xerox, right? But this big purchaser is  
18 trying to identify unwanted variation in  
19 resource use, and it is trying to send a  
20 sentinel message to a portion of its supply  
21 chain as a message to look inwardly and make  
22 process improvements.

1                   So, yes, some things aren't  
2 included, and we would like to have it all,  
3 and we would like to have all of the pieces.  
4 But there is a sentinel message, and there is  
5 a bigger picture, I think. And so, I think it  
6 is important to put this out there, to get  
7 people focused on looking at resource use.

8                   CO-CHAIR PENSON: So, Daniel, you  
9 had your tent up and you took it down.

10                   I just want to remind folks, if  
11 you want to be heard, just put up your tent.

12                   MR. WOLFSON: I just wanted to  
13 say, David, that I don't think that you  
14 highlighted it. It was highlighted in the  
15 report. I mean, it clearly says care  
16 coordination is the purpose of this measure.  
17 And I just think that is a little offbase.

18                   CO-CHAIR PENSON: I am just a dumb  
19 surgeon. There is no way I would have come up  
20 with that on my own. Okay?

21                   (Laughter.)

22                   All right. I think this is



1 another one we have sort of been around a fair  
2 amount. So, unless there are any other  
3 burning questions, I think would call the  
4 question on this one, to vote on measure  
5 intent as you see it there.

6 So, Evan, if you want to turn that  
7 on?

8 MR. WILLIAMSON: We will now vote  
9 on the measure intent. You will have 60  
10 seconds.

11 (Vote taken.)

12 And we have 6 high, 16 moderate, 3  
13 low, and zero insufficient.

14 CO-CHAIR PENSON: So, what we will  
15 do now, I am told, is we need to open things  
16 up for public comment from people in the room  
17 and on the phone. And once we do that, we  
18 will take an overall vote for category 1.

19 So, any public comment either on  
20 the phone or in the room?

21 (No response.)

22 THE OPERATOR: For the audience

1 over the phone to ask a question or make a  
2 comment, please press \*1.

3 (No response.)

4 There are no questions.

5 CO-CHAIR PENSON: Great. Thank  
6 you.

7 So, what we will do now is we will  
8 do an overall vote for all three of these  
9 categories.

10 I will open the floor if there are  
11 any burning questions before I call this.

12 MR. WOLFSON: I have a burning  
13 comment.

14 (Laughter.)

15 I think what I have seen in the  
16 report that they have supplied is kind of a  
17 case study of a report that would be produced  
18 by this data. And it does get into a granular  
19 fashion. I don't know if a hospital would  
20 like it as such, but it does get into some  
21 more detail than just the high-level stuff  
22 that we have been generally looking at. So,

1 I think there is some hope that they can  
2 pinpoint areas for improvement.

3 CO-CHAIR PENSON: There is always  
4 hope.

5 (Laughter.)

6 Other comments?

7 (No response.)

8 All right. Hearing none --

9 MR. WILLIAMSON: We will now vote  
10 on the overall importance to measure and  
11 report. You will have 60 seconds. Begin now.

12 (Vote taken.)

13 And we have 8 high, 15 moderate, 1  
14 low, and zero insufficient. The measure  
15 passes overall importance.

16 CO-CHAIR PENSON: Great.

17 So, it is 10 after 11:00 now, and  
18 I think we have been going for a while. I  
19 don't know about you all, but I need a break.

20 (Laughter.)

21 So, why don't we reconvene at  
22 about 11:20 and we can go on?

1                   (Whereupon, the foregoing matter  
2 went off the record at 11:07 a.m. and went  
3 back on the record at 11:22 a.m.)

4                   CO-CHAIR PENSON: All right. So,  
5 not everyone is back in the room. But if  
6 start, I suspect people will come right back  
7 on in.

8                   So, basically, we are now going to  
9 get into sort of the scientific acceptability  
10 piece of this. I think that this will be an  
11 opportunity to get into some of these issues  
12 that have been coming up around risk  
13 adjustment, around what is measured,  
14 specifically on the validity of the piece.

15                   And this is, also, I know that NQF  
16 had a biostatistical review. And so, I know  
17 that the experts are in the room for that as  
18 well.

19                   So, what we will do is we will  
20 start with the reliability piece, as you can  
21 see there, at the various subgroups. And  
22 then, we will go on from there.

1                   So, we will start with criterion  
2                   2a1, which is the construction logic and also  
3                   goes into the various other pieces about  
4                   clinical logic and various adjustments.

5                   And the folks who we have starting  
6                   with that are Bill and David Redfearn.

7                   So, Bill, if you want to start?  
8                   And, David, you can chime-in as well.

9                   MEMBER WEINTRAUB: Sure. Thank  
10                  you.

11                  We have actually spent a fair  
12                  amount of time discussing the construction  
13                  already. So, I was prepared to sort of review  
14                  it, but I will go through it extremely  
15                  briefly.

16                  So, this is a measure of Part A  
17                  and Part B Medicare payments, using it as a  
18                  proxy for cost. It starts three days before  
19                  the hospitalization, includes the  
20                  hospitalization, and 30 days after the  
21                  hospitalization. So, overall, it is sort of  
22                  a logical construction.

1 I didn't understand the reason for  
2 exclusion of Part D until the developer told  
3 us. We can discuss that some more. I, too,  
4 was troubled by it until I heard the reason.

5 There are other exclusions as  
6 well, including deaths and transfers. And I  
7 would like to hear a little bit more from the  
8 developer about the logic for that as well.

9 And then, the rest is more down in  
10 the biostatistical weeds, which I am not going  
11 to go through.

12 Overall, the ratings by the  
13 reviewers were for construction logic. So,  
14 these are group high and moderate, 20; 1 low.  
15 Clinical logic, high/moderate, 20; zero low.  
16 Adjustments for comparability, 21 and zero.  
17 Adjustments for comparability, 21. Costing  
18 methods, 21 and zero. Adjustments for  
19 comparability 21 and zero.

20 Reliability, a little more concern  
21 here. High, 7; moderate, 11; 2 low, and 1  
22 insufficient. Overall ratings, high, 7; 10

1 moderate; 4 low, and none for inadequate.

2 The first comment, I am like,  
3 hmmm, you might think I like this measure. In  
4 some respects, I do, but there are some  
5 issues.

6 And I think that a lot of the  
7 issues that people had have already been  
8 placed on the table. Here, how concurrent  
9 conditions, high-complexity diagnosis, and  
10 planned readmissions, and other events be  
11 managed. How are we going to handle  
12 attribution within 30 days? We have really  
13 already discussed that. Why the inclusion of  
14 those transitions to Medicaid within the  
15 episode? And it is sort of more details like  
16 that.

17 The statistical review obviously  
18 was very, very important here. The R-squared  
19 and calibration statistics are acceptable,  
20 although more information like the R-squared  
21 per strata would be useful. The model appears  
22 to have a small, but consistent bias, with

1 predicted values being lower than observed  
2 than from GSK. Actually, predicted values are  
3 higher than observed. So, there is a little  
4 bit of a bias.

5 Overall, this looked to be a  
6 measure which is well-validated, which I think  
7 that is overall true. I think David is going  
8 to have more concerns about that with risk  
9 adjustment. I will let him address that.

10 Here is essentially that comment:

11 "Using a period of 90 days before  
12 hospitalization for risk adjustment isn't  
13 enough time to adequately the patient's  
14 comorbidities."

15 David, I suspect that was from  
16 you. Oh, okay, more coming. Okay.

17 MEMBER REDFEARN: I wasn't the  
18 only one.

19 MEMBER WEINTRAUB: All right. All  
20 right, there you go. I will let you address  
21 that in admission.

22 I don't understand why the



1 rationale for Medicare Advantage is excluded.

2 We will let the developer comment with that.

3           There are several problems with  
4 the reliability analysis. The authors make an  
5 untrue statement regarding risk adjustment  
6 based on the distribution of spending and R-  
7 squared by a decile. I believe that the MSPB  
8 risk-adjustment methodology is robust and fits  
9 consistently across deciles. We can let the  
10 developer comment on that as well.

11           So, I think that those are some of  
12 the major comments. One comment here is:  
13 "Not enough robustness testing. Marginal  
14 reports by statistical consultant."

15           CO-CHAIR PENSON: Great.

16           MEMBER WEINTRAUB: Yes, I will  
17 stop there.

18           CO-CHAIR PENSON: So, David, do  
19 you want to add to that?

20           Again, it is hard for me, again,  
21 to sort of remember we are starting with  
22 reliability and then validity. So, in certain

1 respects, a lot of what we are talking about  
2 with the risk adjustment issue, that comes  
3 into the validity piece more than the  
4 reliability piece, but, of course, it spans  
5 both.

6 MEMBER REDFEARN: Yes, there are  
7 three comments here. My comment is the one at  
8 the very end of this, but there are three  
9 comments here, all pointing to the thing.

10 There are two components to the  
11 issue that I think we are talking about One  
12 is, is HCC the right model to use to do the  
13 adjustment? And I realize that I am kind of  
14 swimming upstream when I say I don't think it  
15 is a good model. It is the CMS model. It is  
16 what is used for this. So, that is probably  
17 not the most important concern here.

18 But there three comments in here,  
19 including mine, that using only 90 days of  
20 that member claim experience to do that  
21 calculation for the HCC is very likely  
22 inadequate. It is going to necessarily

1 underestimate the overall risk component for  
2 that patient. It is going to under-adjust for  
3 that component of this analysis, and that is  
4 the concern.

5           Perhaps -- I am making a guess  
6 here -- perhaps the intent was to only use 90  
7 days, in the hope that you are going to  
8 capture the clinical conditions that are more  
9 closely related to the actual admission. And  
10 I can understand that that may be the case,  
11 but I don't think that is a very strong reason  
12 for restricting it to just 90 days. And that  
13 is just the kind of core concern, and several  
14 people I noticed had that same kind of  
15 concern.

16           CO-CHAIR PENSON: Go ahead, Brent.

17           MEMBER ASPLIN: Do you consider  
18 that -- kind of to the other David's points --  
19 I agree and I had the same comment, but I put  
20 that more in the validity section than  
21 reliability. I am just wondering if you could  
22 comment specifically if you have any concerns

1 in the reliability aspect of those issues.

2 MEMBER REDFEARN: I think it is  
3 predominantly validity.

4 MEMBER ASPLIN: Right.

5 MEMBER REDFEARN: But I think it  
6 can affect reliability, too.

7 One of the ways that you can look  
8 at these risk models that have a defined  
9 period of time that is less than the full 12  
10 months, you can say it is an opportunity.  
11 When you are scanning through a bunch of data  
12 looking for the diagnosis codes that really  
13 drive these models, if you look at a  
14 constrained period of time, you may not see  
15 the diagnosis codes that are actually present,  
16 simply because they haven't been coded in that  
17 period. And I think that can affect the kind  
18 of reliability, the end reliability of that  
19 score, because you just didn't happen to  
20 capture it.

21 It is there; it is existing, but  
22 perhaps the patient is not seeing the doctor;

1 they are only seeing the doctor very four  
2 months during the year. And you just never  
3 had an opportunity to see that diagnosis code.  
4 So, you are not going to generate the HCC. It  
5 is not going to go into the risk model, and  
6 perhaps it blends into reliability as well.

7 CO-CHAIR PENSON: Go ahead. Go  
8 ahead.

9 MR. AMIN: David, it might just be  
10 helpful -- sorry -- just to this point:  
11 specifically what we may want to focus on for  
12 reliability, because there is an overlap and  
13 a blend here, but we are only talking about  
14 the data element level. But let's try to keep  
15 this to whether the specifications are  
16 precise. And then, when we go into the  
17 conversations about validity, you get into a  
18 little more about the appropriateness of these  
19 various different components.

20 CO-CHAIR PENSON: Yes, I think  
21 that is very helpful.

22 David?

1                   MEMBER GIFFORD: Just tell me if  
2 this is a later section. The preciseness of  
3 the definition of long-term care using the  
4 prior 90-day period, I didn't see it really  
5 clear in there, and I couldn't tell whether it  
6 is SNF Part A or long stay with a Part B in  
7 there. And those are different populations  
8 that actually would have a very different  
9 issue on the amount, the cost of a SNF stay  
10 versus someone who is a long stay being  
11 hospitalized. They are very different.

12                   CO-CHAIR PENSON: Yes, I think  
13 that comes here. So, I will ask the folks  
14 from Acumen to comment on that.

15                   MR. ZAIDI: So, the definition of  
16 long-term institutionalization is the same  
17 that CMS uses to risk-adjust Part C payments.  
18 And so, that is we use the MDS assessment.  
19 So, it is anybody who is in a long-term  
20 facility, either SNF or just a regular nursing  
21 home, for more than 90 days.

22                   MEMBER GIFFORD: So, then,

1 individuals who had prior hospitalization, in  
2 per SNF and, then, went home would not be in  
3 that risk-adjusted group?

4 MR. ZAIDI: Not for this specific  
5 risk-adjustment variable.

6 CO-CHAIR PENSON: Nancy, you have  
7 your flag up there.

8 MEMBER GARRETT: Yes, I have a  
9 question, actually, for David. So, I also was  
10 concerned about that 90-day period not being  
11 adequate to capture enough of the diagnoses,  
12 but it looks like the measure developers  
13 actually did some modeling and they tried  
14 using a full year, and they didn't see a  
15 difference, much of a difference, in terms of  
16 how the results came out.

17 So, I wanted to get your reaction  
18 to that analysis. Does that change your mind  
19 at all about that? Or what do you think about  
20 the analysis stated?

21 MEMBER REDFEARN: It doesn't  
22 change my mind. I mean, I didn't see that

1 portion of the analysis, but everything that  
2 I have seen in terms of these models is that  
3 there is a really dramatic reduction in  
4 R-squareds when you drop below seven months.  
5 And we are only talking about three months  
6 here. That is a very dramatic subset.

7 MEMBER GARRETT: Yes.

8 MEMBER REDFEARN: And everything I  
9 have seen indicates to me that the predictive  
10 power is reduced dramatically.

11 MEMBER GARRETT: Right. So, can  
12 the measure developers comment on that?

13 MR. ZAIDI: Yes. So, we have seen  
14 the --

15 CO-CHAIR PENSON: Turn off your  
16 microphone there.

17 MR. ZAIDI: So, we are using the  
18 HCC model for a different purpose than what  
19 you might be used to. We are using it to  
20 predict short-term acute costs surrounding a  
21 hospitalization. And so, we actually did  
22 sensitivity analyses, as you mentioned, where



1 we looked at how would the R-squared change if  
2 we had longer look-backs. So, 120 days or a  
3 full year. And we actually found, to our  
4 surprise, that the R-squared was better with  
5 a 90-day look-back.

6 So, what that suggests to us is  
7 that the HCCs from the prior 90 days are more  
8 relevant to the cost drivers in the short-term  
9 acute-care setting than HCCs from a year ago.

10 But you might be right; when you  
11 are trying to predict annual cost, it is  
12 better to have more of a history. But, for  
13 this specific purpose of predicting the cost  
14 surrounding a hospitalization, we found that  
15 it was actually the model performed better  
16 with only 90 days of look-back and you get  
17 more patients, too, more eligible patients.

18 CO-CHAIR PENSON: So, I think  
19 that, just to summarize that, I think you are  
20 going to have to, the Committee is going to  
21 have to decide if that is acceptable with  
22 regard to reliability because you have heard

1 the measure developer's rationale.

2 Mary Ann? And then, Cheryl.

3 MEMBER CLARK: Yes, I just had a  
4 comment. It seems like there is a little bit  
5 of an inconsistency in, I know in the more  
6 detailed backup information, you are defining  
7 the full cost associated with all Medicare  
8 Part A and Part B services. But, yet, in the  
9 resource use categories defined in this  
10 application, it looks like some of them are  
11 missing. So, maybe that was just  
12 inadvertently they were left off. For  
13 example, home health and skilled nursing and  
14 hospice and a lot of different categories of  
15 cost.

16 MR. ZAIDI: Sorry. Where were  
17 they missing?

18 MEMBER CLARK: Under the resource  
19 use specifications.

20 MR. ZAIDI: Oh, that may have been  
21 an oversight then. It should be included.

22 MEMBER CLARK: Okay. And then, I

1 had a question about the timeframe used to  
2 capture the cost for the actual episode cost  
3 calculation. It looks like it was a certain  
4 defined time period of claims data being used  
5 from -- what? -- May through January, I  
6 believe, right? Is that going to be a  
7 consistent -- that is kind of the timeframe  
8 that is going to be used going forward? And  
9 if so, how do you reconcile with the  
10 standardized payment amounts?

11 I mean, there are two different  
12 fiscal years in effect there. So, are you  
13 taking that into account? Or is it one fiscal  
14 year for the pricing, the standardized pricing  
15 that you are using?

16 MR. ZAIDI: So, we are using the  
17 payment rates in effect at the time of the  
18 claim. So, if it is in the next fiscal year,  
19 it will have the payment rates for that fiscal  
20 year.

21 We don't think there is any bias.  
22 The only way there would be bias arising from

1 that is if some hospitals have a lot more of  
2 their admissions in one part of the  
3 performance period than others. We didn't  
4 test for that specifically, but, yes, the  
5 official CMS standardization methodology uses  
6 the payment rates that are in effect at the  
7 time of the claim. Yes, it changes by fiscal  
8 year.

9 CO-CHAIR PENSON: Cheryl?

10 MEMBER DAMBERG: I had two  
11 concerns with respect to reliability. So,  
12 when I was looking at the test/retest, I found  
13 it concerning that 30 percent of those that  
14 you would have scored in the high-cost, I  
15 guess it is quintile, would not be there the  
16 next time around. And that seems very high.  
17 I was wondering if you could comment on why  
18 there is so much shifting around.

19 And I am wondering to some extent,  
20 I mean, cost data is very noisy. My second  
21 concern, which I think relates to the first,  
22 is that in the information that you provided

1 around the reliability scoring you note that  
2 .4 is the lower limit of moderate reliability.  
3 And usually, that signals very poor  
4 reliability, and there is far more noise than  
5 signal in that estimate.

6 And I know you set the minimum  
7 threshold at 25, but I am wondering whether  
8 the reliability would be significantly  
9 strengthened if you bump it up to 50 cases.

10 MR. ZAIDI: Okay. So, I will take  
11 those in term.

12 So, the first on the quintile  
13 stability analysis, I think a lot of that is  
14 because they just, in the retest sample, they  
15 will be in the fourth quintile. So, it is  
16 like just below the cutoff for the fifth  
17 quintile.

18 So, if you look at the actual  
19 table we had, almost all hospitals that were  
20 in the top quintile in one sample were in the  
21 top two quintiles in the other sample. And  
22 the Spearman rank correlation between the two

1 samples was .8 or .835, which we thought was  
2 very high.

3 As for the reliability scores, 62  
4 percent of hospitals had a reliability score  
5 over .9, and 98 percent had a reliability  
6 score of greater than .4. And the overall  
7 average reliability score was .95. So, we can  
8 debate what the minimum reliability score is,  
9 whether it was .4 or not.

10 MEMBER DAMBERG: Right, but I  
11 think in terms of the application, I guess if  
12 I were CMS, I would be hesitant to use or  
13 report anybody's information who had a  
14 reliability probably less than .8 on this  
15 particular measure.

16 CO-CHAIR PENSON: So, Bill, I know  
17 you have your hand up there. But, before I  
18 let you talk, I am going to ask Andrew, who  
19 reviewed the -- I am sorry to put you on the  
20 spot. You reviewed the reliability testing  
21 portion, and I wanted you to weigh-in, since  
22 we are sort of getting into the weeds there.

1                   MEMBER RYAN: Great. So, there  
2 were a number of analyses that were performed  
3 related to reliability testing. The first  
4 that was noted was this test/retest  
5 reliability which was just discussed.

6                   And the kind of headline number  
7 there is that 70 percent of hospitals in the  
8 highest quintile and 70 percent of hospitals  
9 in the lowest quintile of cost remained so  
10 through retesting. Actually, I thought this  
11 was quite a good idea. I like this analysis.

12                   So, the other thing that Acumen  
13 did was this seasonality testing, which I  
14 think is kind of questionable. They said this  
15 is related to reliability, et al.

16                   The one question I had about the  
17 reliability score was kind of how this was  
18 calculated at the level of the hospital  
19 because your reliability is typically thought  
20 of as at the level of the measure rather than  
21 the hospital.

22                   But the total score was quite

1 high, over 95.95. But, again, as the authors  
2 note, this is really driven by the large  
3 number of average episodes across the  
4 hospitals. And so, the way the measure is  
5 calculated is that, basically, if there is any  
6 kind of between-hospital variation, and you  
7 have got a large "N", you know, you are going  
8 to have a high reliability. So, I don't get  
9 too excited about those numbers. I like  
10 test/retest better in this case.

11           And then, the bootstrapping  
12 analysis basically tried to get at this idea  
13 of, do changing cutoffs, how does that affect  
14 the confidence intervals for kind of the  
15 average hospital in the sample? But I think  
16 that here it would have also been good -- and  
17 I wonder if Acumen did any of this -- to see  
18 kind of, based on these confidence intervals  
19 that were constructed through bootstrapping,  
20 kind of what proportion of hospitals were  
21 statistically different from the kind of mean  
22 hospital in terms of their performance, to see



1 if there was any kind -- you know, there is  
2 variation, but can we identify kind of  
3 statistically-different variation? So, I  
4 think that would have been a nice addition.

5 Overall, I think I would have  
6 liked to have seen a little more with the  
7 testing. It was a couple of pages. It seems,  
8 when you look at the scores that the TAP gave,  
9 it was high on everything. And then, the  
10 reliability testing, it was more mixed, and  
11 the overall rating seemed to kind of line up  
12 well with the reliability testing. And I  
13 think some of us were a little disappointed  
14 with kind of how thin this was.

15 And then, you know, some other  
16 ideas I had which would be good to show is,  
17 you know, when you think about this episode,  
18 there is a couple of different components.  
19 So, there is the different costs that could be  
20 included in the episode, the kind of different  
21 risk-adjustment methods that have been  
22 discussed a little bit, and then, the kind of

1 length of episode pre- and post-  
2 hospitalization.

3           And then, I think it would have  
4 been nice to show some analysis of reliability  
5 across somewhat varying measure specifications  
6 to give a flavor as to why the 30-day interval  
7 post-discharge is giving us a more reliable  
8 signal than some other window, and why that  
9 90-day, you know, apart from the R-squared  
10 analysis, why that 90-day look-back was the  
11 right interval to cut for the HCCs. You know,  
12 to show that in terms of other reliability  
13 analysis would have been good.

14           So, those are my summary comments.

15           MR. ZAIDI: Thank you. We really  
16 appreciate that feedback.

17           I think some of these comments  
18 were included in the statistician's review,  
19 and we had a chance to conduct some further  
20 analyses in response to the statistician's  
21 review. And that is included in the  
22 memorandum. I think it was one of the

1 handouts.

2 So, we did compare a 90-day post-  
3 discharge window with a 30-day post-discharge  
4 window, and the correlation was extremely  
5 high, over .85. So, we found that the length  
6 of the post-discharge window didn't have an  
7 effect on hospital ranking.

8 Another test that we did  
9 subsequent to the statistician's review is we  
10 did a year-on-year correlation. So, we didn't  
11 have two years of data when we first did the  
12 submission, but now we have two performance  
13 periods. And we did a correlation between  
14 hospital scores between the two periods, and  
15 we had a statistically-significant correlation  
16 of .8, which we thought was very positive and  
17 statistically-significant. That is the  
18 Pearson correlation.

19 MS. WILBON: I just want to note  
20 briefly that Carlos Alzola is actually here,  
21 who did the statistical assessments. So, if  
22 you have any specific questions for him --

1       sorry, we have been caught up in the mix, and  
2       we weren't able to introduce him earlier. So,  
3       if you have any specific questions for him  
4       about the assessment that you reviewed in  
5       terms of your interpretation of that, and how  
6       it plays into the discussion, he is available  
7       for that as well. So, I just wanted to make  
8       everyone aware of that.

9                   CO-CHAIR PENSON: So, Bill, you  
10       have been patiently waiting.

11                   MEMBER WEINTRAUB: I also have  
12       some questions for the developer. I can well  
13       imagine reasons for exclusions, death,  
14       transfers, Medicare Advantage, and so forth,  
15       but I would like to hear from you.

16                   Also, unless I am missing  
17       something, cost is not generally normally  
18       distributed, and very often, in cost models  
19       the dependent variable is a log of costs  
20       rather than cost. So, if Carlos and the  
21       developer can comment on your choice of  
22       dependent variable?

1 MR. ZAIDI: We didn't test  
2 modeling log cost versus the levels of cost.  
3 That is an analysis we can do in the future.  
4 But I think the R-squareds that we have got  
5 with modeling the levels of cost were  
6 sufficiently high, but we can do that analysis  
7 in the future.

8 MEMBER WEINTRAUB: It would be  
9 worth it if it turns out to be better with log  
10 cost.

11 MR. ZAIDI: Definitely.

12 CO-CHAIR PENSON: Jack, before I  
13 let you go ahead, I am just going to ask  
14 Carlos to say a few words about the  
15 memorandum, and if you thought it addressed  
16 some of your concerns adequately or if you  
17 have remaining concerns.

18 MR. ALZOLA: Thank you.

19 I was just looking at this memo as  
20 I arrived here and trying to look at the  
21 answers that the developers gave to my issues,  
22 to the questions I raised.

1           To be quite honest, don't let me  
2           try to address all the issues that people have  
3           raised so far. I don't have any issues with  
4           the reliability. I know that you may think  
5           that reliability scores in some cases may be  
6           low, but, by and large, they are quite  
7           significant -- they seem to me pretty large.

8           And besides, their reference is  
9           quoted here, that this is considered, in all  
10          cases, the reliability is about the level of  
11          what is considered moderate reliability, and  
12          there is a reference provided for that.

13          The other issue, the thing that  
14          really makes me satisfied about the  
15          reliability testing is the test/retest  
16          reliability. I basically look at the Spearman  
17          correlation, and .85 to me is more than good  
18          enough.

19          So, that means that -- maybe I  
20          should explain what that means. The ranking  
21          of the hospitals in terms of their MSPB in the  
22          sample and in the retest sample, which is more

1 or less equivalent because it is a 50/50  
2 random split, it is pretty much the same. Of  
3 course, it is never going to be equal, but  
4 some hospitals will run lower; some will run  
5 higher. But, by and large, they have the same  
6 ranks. So, that is why the high Spearman  
7 correlation makes me happy about reliability.

8 The second issue that was  
9 mentioned, that was raised often, was the  
10 testing, the look-back period of 90 days  
11 versus one year for the HCCs. I am of the  
12 mind that the closer you get to your  
13 hospitalization, the more likely those  
14 conditions are going to be to influence the  
15 care that you get. So, I thought that 90 days  
16 was sufficient, but you also have somebody who  
17 questioned whether that was valid or not.

18 And the testing that the developer  
19 performed about that, which was using the 90-  
20 day period and using the one-year period, gave  
21 basically the same R-squared. So, I am pretty  
22 sure that, if we were going to test the

1 difference of one R-squared versus the other  
2 one, it may be significant because of the  
3 large number of cases, but it is clinically  
4 totally irrelevant.

5 So, the big question -- and I  
6 think I am going to need to ask the developers  
7 about this -- was about validity.

8 CO-CHAIR PENSON: So, why don't  
9 we --

10 MR. ALZOLA: Shall we wait for  
11 that?

12 CO-CHAIR PENSON: Yes, why don't  
13 we wait on that?

14 MR. ALZOLA: Yes.

15 CO-CHAIR PENSON: So, Jack, you  
16 have --

17 MEMBER NEEDLEMAN: Jennifer and a  
18 couple of people were in the queue ahead of  
19 me. So, I don't want to jump the queue.

20 CO-CHAIR PENSON: Okay. No  
21 worries. Jennifer go ahead.

22 I am not allowed to ask your



1 question. Okay?

2 (Laughter.)

3 MEMBER EAMES-HUFF: So, I guess I  
4 have a couple of questions here regarding the  
5 exclusions that you have used in the measure.  
6 And I am coming from the perspective of I am  
7 wondering if we potentially are unnecessarily  
8 excluding patients with high expenditures,  
9 which may skew the results of the hospitals,  
10 but also lose some opportunities for  
11 improvement.

12 And the two exclusions I would  
13 like to discuss more is the one around  
14 transfers and deaths. I think it was the  
15 transfers that count for about 5 percent of  
16 the population, which seemed like some level  
17 of significance in this population, and that  
18 it wasn't clear how to attribute the  
19 transfers. And so, that is the reason why  
20 they are being excluded. I wanted to see if  
21 you have further plans for resolving the  
22 attribution or if this is going to be an

1 exclusion sort of indefinitely, and whether or  
2 not you considered if it is really the role of  
3 the different hospitals, and if there was any  
4 consideration around attributing to both  
5 hospitals and having some level of shared  
6 responsibility and accountability for this.

7           And in terms of the death, if I am  
8 understanding it correctly, it is essentially  
9 saying, because the patient wasn't around for  
10 the entire episode, you are not capturing all  
11 their costs. But it feels like they are  
12 around for as much as they can be, and end-of-  
13 life is really important area. So, I didn't  
14 understand why patients that died were  
15 removed.

16           MEMBER WALKER: Jennifer, I have a  
17 question for you. I raised those exact same  
18 questions, but in the validity section. So,  
19 is this a question about the reliability of  
20 the measure or about the validity of the  
21 measure?

22           MEMBER EAMES-HUFF: Yes, I was

1 following the 2a1 that says comparability for  
2 inclusion/exclusion criteria. So, that is why  
3 I brought it up in this section.

4 CO-CHAIR PENSON: Yes, and you  
5 have the same structure for the validity, too.  
6 I think, with this, you really want to look at  
7 reliability vis-a-vis capturing the mechanics.

8 MEMBER EAMES-HUFF: Okay. So, we  
9 can do it in validity.

10 CO-CHAIR PENSON: So, Jack? And  
11 then, Bill.

12 MEMBER EAMES-HUFF: It doesn't  
13 matter to me as long as you get to it at some  
14 point.

15 CO-CHAIR PENSON: I think we will  
16 get to it in the validity. I think if we sort  
17 of take the reliability sort of as the  
18 mechanics and the math, and then, take the  
19 validity as the sort of underlying constructs,  
20 and does it flaw the results, is a good way to  
21 look at it.

22 Jack?

1                   MEMBER NEEDLEMAN: Yes, I share  
2 Cheryl's concern about that 70 percent, which  
3 would say 30 percent of the folks in the top  
4 quintile are different. So, I think that may  
5 be a validity issue.

6                   But, in terms of the construction,  
7 this winds up on the Hospital Compare site  
8 with hospitals better than average, average,  
9 worse than average. So, how does that 20  
10 percent -- where is the cutoff for better than  
11 average in this measure? Is it at the  
12 quintile level? Is it at the decile level?  
13 Because we ought to be looking at reliability  
14 in terms of consistent classification around  
15 the point at which people are going to be put  
16 into the worst category or the average  
17 category.

18                  CO-CHAIR PENSON: So, I think that  
19 goes to either CMS or the developer.

20                  MS. SPALDING BUSH: So, currently,  
21 on Hospital Compare, the measure is just  
22 displayed as a ratio to the national median

1 and it is not bucketed into better, worse, or  
2 average. It is rounded, but there is no  
3 cutoff where we bucket them.

4 There is a statement there that  
5 says something like: a ratio that is greater  
6 than 1 means Medicare spends more per patient  
7 at this hospital than the national average,  
8 but they are not put into buckets. That is  
9 just to help consumers understand that a  
10 higher number means more Medicare spending per  
11 episode.

12 MR. ZAIDI: Can I make one  
13 comment? For hospital value-based purchasing,  
14 the measure is going to be evaluated on a  
15 continuous basis. So, it is not like there  
16 are attainment points and improvement points  
17 that are continuous in nature. So, there  
18 aren't these kind of quartile buckets that  
19 hospital will be put on in these measures.

20 CO-CHAIR PENSON: So, here is what  
21 I would propose: I think we can call the  
22 question on this with regard to reliability.

1 And I want to remind people that we are really  
2 voting on the preciseness and the ability to  
3 put things -- you know, the precision of  
4 constructing the model, whether their  
5 test/retest works. And the actual validity  
6 and does it measure the constructs, we will  
7 get to in the next section, if everyone is  
8 okay with that.

9 So, unless there are other  
10 comments, I would suggest we take an overall  
11 vote on reliability.

12 MS. WILBON: So, before we vote, I  
13 just want to make sure that people are clear.  
14 Reliability includes reliability of the  
15 specification. So, to what degree you believe  
16 the specifications are repeatable and can be  
17 implemented consistently, as well as the  
18 reliability testing. So, we are going to vote  
19 on overall reliability for the measure, which  
20 includes both of those components. So, I just  
21 want to make sure that everyone is clear on  
22 that.

1                   And within the testing section of  
2                   that, of the reliability criteria, we are  
3                   looking at the appropriate method was used to  
4                   test the measure; the scope of the testing was  
5                   adequate, and the results were within  
6                   acceptable norms.

7                   So, if everyone feels that those  
8                   items have been discussed within the testing  
9                   and that you have a sense of how precise and  
10                  repeatable the specifications are, then we  
11                  should go ahead and vote, keeping those two  
12                  things in mind.

13                  CO-CHAIR PENSON: So, on the basis  
14                  of that, any additional discussion?

15                  (No response.)

16                  All right. Hearing none, let's  
17                  have a vote then.

18                  MR. WILLIAMSON: We will now vote  
19                  on the overall reliability. You will have 60  
20                  seconds. Please begin now.

21                  (Vote taken.)

22                  We have 10 high, 14 moderate, 1

1 low, and zero insufficient.

2 CO-CHAIR PENSON: Great. So, I  
3 was just talking to Ashlie. What I think we  
4 will do is -- we are pretty far behind on  
5 time, not that it is the end of the world  
6 because tomorrow is a fairly loose schedule.  
7 But, that being said, what I would propose we  
8 do is turn this into an -- I may get food --  
9 but a bit of a working lunch. So, maybe take  
10 15 minutes to get your lunch, come back, get  
11 started eating, and we can go through the next  
12 section, which I think will be some work.

13 (Whereupon, the foregoing matter  
14 went off the record at 11:59 a.m. and went  
15 back on the record at 12:27 p.m. for a working  
16 lunch.)

17  
18  
19  
20  
21  
22



A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

12:27 p.m.

1  
2  
3 DR. PENSON: So let's get started  
4 again because I think that this next section  
5 on validity will be an area where we have a  
6 lot of discussion. And a lot of the issues  
7 which were discussed on the reliability  
8 section really are going to come up again  
9 here. And this is where they should come up.

10 So as you can see in front of you  
11 there are a whole lot of sort of subcategories  
12 that we're going to go through. And what I  
13 think we'll do is we'll go through them each  
14 one at a time, let people talk.

15 And just remember as you can see  
16 we have issues, validity of construction  
17 logic, clinical logic, adjustments for  
18 comparability with inclusion/exclusion  
19 criteria, exclusions, adjustments for  
20 comparability with regard to risk adjustment.  
21 Then the actual risk adjustment piece which --  
22 and costing method, scoring method, et cetera.

1 So there's going to be a lot of ground to  
2 cover and a lot of folks have gone through the  
3 different parts so hopefully we'll be able to  
4 do this in a way that we can really do it  
5 systematically and come to a good vote.

6 And also at the end before we vote  
7 as Gene pointed out and he'll remind me but  
8 others should as well we'll invite public  
9 comment from people in the room or on the  
10 phone who are interested which I think this  
11 part will be important.

12 So why don't we start talking with  
13 2b1 which is the validity of the  
14 specifications. And we're looking at things  
15 that basically are on are the specifications  
16 consistent with the measure intent with regard  
17 to construction logic, clinical logic, the  
18 various adjustments for comparability and the  
19 measure score calculation.

20 So we did assign these out. And  
21 so let's start by talking about sort of the  
22 validity of the specifications. And David and

1 Martin reviewed that. So I don't know if one  
2 or both of you want to get us started.

3 DR. MARCINIAK: Sure. Why don't I  
4 take the first whack at it and then we'll turn  
5 it over to David.

6 Sort of at a high level, you know,  
7 David has pointed out that this is the section  
8 about measure specification. Are they  
9 consistent with the measure's intent described  
10 under criterion 1c the intent of the resource  
11 use measure and the measure's construct, are  
12 they clearly described and does it capture the  
13 most inclusive target population. So what's  
14 embedded in here are really sort of the three  
15 core modules. It's the construction logic,  
16 it's the clinical logic and it's the  
17 adjustment for comparability.

18 I know that we've had a large  
19 conversation around parts of this this  
20 morning. We were starting to bleed into it so  
21 I'm not going to talk to a great extent about  
22 a lot of the details at this point, assuming

1 that they'll come out in the dialogue.

2 When you look at the range of  
3 voting, so for construction logic probably  
4 skewed to the left in the high to moderate  
5 area, that we had 19 votes there for  
6 construction logic. Two were voting low.

7 When we looked at clinical logic  
8 again skewed to the high to moderate.  
9 Nineteen versus two for low.

10 And then when we looked at  
11 adjustments for comparability, particularly  
12 around inclusion/exclusion we again saw that  
13 same sort of framework in the vote. So it's  
14 a leftward skew to high/moderate.

15 Overall there seemed to be good  
16 consensus. The clinical logic and the  
17 adjustments with respect to clinical logic and  
18 adjustments for comparability. The main  
19 concern appeared to be really on risk  
20 adjustment and validity testing for both which  
21 will be covered probably a bit later in our  
22 discussion this afternoon.

1                   So, I'm going to turn it over to  
2 David to fill in any egregious gaps in my  
3 conversation before we open it for discussion  
4 I guess.

5                   DR. GIFFORD: I really don't have  
6 much to add to what Martin has said other than  
7 I think they did a nice job laying out the  
8 logic they had there.

9                   I think some of the issues in the  
10 logic really relate better to the discussion  
11 about the validity or the exclusions in the  
12 validity and later on. And some of the issues  
13 in the construction logic we've already talked  
14 about earlier on and I don't want to beat that  
15 dead horse any further as we go forward on  
16 that. But it was well laid out and made  
17 sense.

18                   The only -- I'll kick the dead  
19 horse quickly and just say they continue to  
20 repeat that this is about care coordination  
21 and I think that that doesn't come through in  
22 the logic they show and argue there. And that

1 would be the only big piece I'd make.

2 DR. PENSON: Well, if nothing else  
3 I'm feeling better that I didn't make that up,  
4 so that's good.

5 So I think this is a good time  
6 perhaps to open up a general discussion.  
7 We're going to talk a little bit about the  
8 actual statistical testing in a minute, just  
9 the way things are laid out.

10 You know, it might be valuable  
11 when I look at the list here that there's  
12 people, there was some concerns. I mean if  
13 you look at the way people talked about  
14 exclusions. And you see that a lot of people  
15 beforehand said they were moderate. There  
16 wasn't a lot of high there. So I wonder,  
17 Cheryl, you had -- pardon me, Herbert, you had  
18 talked a little bit about the exclusion so I  
19 wonder if you want to share your thoughts on  
20 that.

21 DR. WONG: Yes. So I also  
22 recognize if you take a look at the

1 distribution with the exclusion we had high --  
2 five of the folks voted high. Most folks  
3 voted it moderate and then you have two folks  
4 that are basically on the tail end.

5 And to a large extent I think that  
6 most of the comments were actually quite  
7 silent on the matter. However, we talked a  
8 little bit about the exclusions a little bit  
9 earlier on. And I think that from that  
10 perspective it -- those are the key comments  
11 that kind of percolated up.

12 One comment was just a step back,  
13 thinking about this measure in general.  
14 Should it be an overall resource measure and  
15 not specific to Medicare in itself. And the  
16 comment about exclusion was this notion should  
17 one also include other payers that are part of  
18 this episode in some way.

19 So for instance, what about  
20 transfers? How do you deal with that? How do  
21 you deal with death? How do you deal with  
22 Medicaid payments once Medicare expenditures

1 have basically expired? So I think that those  
2 comments were kind of percolated up a little  
3 bit earlier.

4 I think that there are another  
5 notion about exclusion. And I think that this  
6 spills over a little bit more on the validity  
7 testing. But it was kind of briefly mentioned  
8 in the exclusion commentary.

9 One of the notions was whether or  
10 not that when you take a look at the validity  
11 testing the methods that were employed are  
12 basically designed to kind of look at a  
13 broader aggregate analysis.

14 And the question emerged of  
15 whether or not this is well designed for  
16 individual analysis. And so as part of that  
17 you do have certain cutoffs, certain  
18 exclusions. And the person who made this  
19 particular comment kind of wondered whether or  
20 not these cutoff thresholds would actually  
21 have an impact when the measures are designed  
22 for a different purpose as opposed to



1       employing certain methodological approaches  
2       that are designed for a different reason.

3               Somewhat related to this was this  
4       notion about when -- how were the exclusions  
5       kind of performed. And someone recognized  
6       that there were roughly 89,000 outliers. And  
7       that called for some concern of whether or not  
8       the models themselves were in fact valid.

9               And to the extent that folks did  
10       not have the sensitivity analysis and things  
11       of that nature where the exclusion really  
12       designed to kind of make it more -- make it  
13       look more appealing than others. So I think  
14       that that's how -- my interpretation of the  
15       commentary there.

16              DR. PENSON: So I'm hearing some  
17       concerns about the exclusions although I'm not  
18       hearing that they're complete deal-breakers.  
19       A number of times you alluded to the testing.  
20       And so I think it may be a good time to have  
21       Cheryl comment on the validity testing and  
22       maybe also Carlos as well. If you want to

1 comment on validity testing.

2 DR. DAMBERG: In terms of what's  
3 described under 2b2 which was the area that I  
4 was supposed to address they looked at two  
5 tests of validity. One was looking at the  
6 correlation or association between the measure  
7 and the percent of beneficiaries with multiple  
8 episodes.

9 And the second test was to  
10 correlate the measure with other outcome  
11 measures, namely hospital readmission  
12 measures. And what they found was generally  
13 very weak correlation with both of those  
14 measures. And in particular, the hospital  
15 readmission measures, the correlation  
16 coefficients were 0.8. I'm sorry -- 0.08,  
17 0.07 and 0.06.

18 And although there were comments  
19 that they gave in response to some of our  
20 comments so I should highlight those as well.  
21 They say, "We wish to clarify that there is a  
22 weak positive but statistically significant

1 correlation with each of the readmission  
2 measures." So that was sort of an add-on to  
3 what was included in our documentation.

4 I think in terms of how the group  
5 scored this for validity testing high was only  
6 1, moderate was 11, low was 7 and insufficient  
7 was 2. And the issues that I would call out  
8 from the group, there were about five  
9 different issues.

10 I think pretty much across the  
11 board folks commented that these were not  
12 particularly good tests of the construct  
13 validity and suggested some other approaches  
14 that could be used.

15 The second issue that came up, and  
16 this has come up throughout the day was this  
17 issue around exclusion criteria. And wanting  
18 to better understand why we were excluding  
19 transfers, deaths, getting back to Jennifer's  
20 issues, as well as Medicaid payments. So that  
21 was the second concern.

22 The third was around the risk

1 adjustment model validation. And I think  
2 we've heard a fair amount about that today as  
3 well.

4 And the fourth issue was raised  
5 around what they considered to be an unstable  
6 model. And concern about possible co-  
7 linearity among some of the variables in the  
8 model.

9 And then another issue that was  
10 flagged because of the lack of adjustment for  
11 age and race is the potential for unintended  
12 consequences. Would this particular measure  
13 incentivize hospitals to avoid high-risk  
14 patients basically that they may have a harder  
15 time controlling the costs on. So I think  
16 generally a number of concerns and fairly low  
17 ratings for this particular measure.

18 DR. PENSON: So I wonder if other  
19 folks have thoughts about the testing and the  
20 exclusions. Go ahead, Brent.

21 DR. ASPLIN: Well, I would like to  
22 hear -- I can understand in some respects why

1 in this particular version of the measure some  
2 of these things were excluded, particularly  
3 the transfers and deaths. How are we going to  
4 manage that?

5 I mean because if you think about  
6 perverse incentives and trying to understand  
7 probably our highest cost acute care episodes,  
8 those are it. Transfers and deaths are going  
9 to be the most costly acute care episodes  
10 outside of some very high-end planned  
11 transplant or some other things like that.  
12 That's where the money is.

13 And in particular if you're a  
14 community hospital that is on the hook for  
15 this over time and you see a high-cost patient  
16 who isn't doing all that well, why not  
17 transfer him to Jim's shop in Rochester,  
18 right? If you're in southeast Minnesota.  
19 Other than the fact that all the hospitals you  
20 refer are part of Mayo too.

21 (Laughter)

22 DR. ASPLIN: You know, why not

1 unload them on a referring center? So it kind  
2 of comes back to some of the usability and  
3 maybe other issues that get separated. I  
4 don't think it's a deal-breaker yet it would  
5 be unfortunate if we don't try to grasp and  
6 grapple with those issues over time. Because  
7 they're very important.

8 DR. PENSON: So let me turn that  
9 question around because I think it's a very  
10 valid comment. To summarize what I think  
11 you're saying is that because of the exclusion  
12 criteria there's the potential for gaming the  
13 measure both consciously and perhaps  
14 subconsciously.

15 So I'll ask either the folks from  
16 CMS or Acumen to share their thoughts about  
17 that.

18 MS. SPALDING BUSH: So, we  
19 appreciate the comment and it's something that  
20 we did consider. When we first put the  
21 measure forth through rulemaking we did not  
22 have an exclusion for transfers.

1                   We received a number of public  
2                   comments on this particular issue on both  
3                   sides. So basically you heard community  
4                   hospitals saying what are you going to do  
5                   about transfers. You can't have me on the  
6                   hook for this patient that I just maybe  
7                   stabilized but knew was, you know, outside of  
8                   my realm of expertise and so I transferred it  
9                   to another medical center.

10                   We had comments from the receiving  
11                   medical centers sort of saying, well, there  
12                   may have been mistakes made at the community  
13                   hospital and that secondary to that that those  
14                   patients may have lived closer to that  
15                   community hospital. So their follow-up care  
16                   is going to be outside of the receiving  
17                   hospital's sort of realm of influence.

18                   So I think that while the  
19                   potential does exist for -- because we've  
20                   excluded these that there could be an  
21                   incentive for the admitting hospital to  
22                   transfer a patient I think that same incentive

1 would exist were we to attribute the episode  
2 to the receiving hospital. So I mean the only  
3 other option there would be to attribute it to  
4 the community hospital and then have them on  
5 the hook for this very complex patient that  
6 they potentially just didn't have the ability  
7 to care for. And so that's why they wound up  
8 excluded.

9           And I think someone's commented  
10 here that this was the least worst approach or  
11 something like that. I mean we wouldn't have  
12 used those words but I think it does come down  
13 to that. It is sort of what's the best thing  
14 that we could do in this measure.

15           And I think the other issue with  
16 attributing it to the community hospital is  
17 would we give them pause, then, to not  
18 transfer a complex patient to see if they  
19 could manage them rather than send them away  
20 because they were afraid that they were going  
21 to go to an expensive medical center and incur  
22 some huge cost that that community hospital



1 didn't want to be held accountable for.

2 This is something that we can  
3 consider and we plan to continue evaluating  
4 for maybe a future refinement of the measure.  
5 But I think for the initial implementation it  
6 seemed like the best solution given the public  
7 comment that I think was really valid that we  
8 received on the measure.

9 DR. NELSON: As a point of  
10 clarification can you tell us about what  
11 proportion of episodes involved transfers and  
12 what proportion of dollars involved transfers?

13 MR. ZAIDI: It's about 5 percent  
14 of hospitalizations overall involve a  
15 transfer. And I'll have to look up the dollar  
16 amount.

17 DR. PENSON: So I see Andrea has  
18 her hand up and then Jack and Andrew. Okay,  
19 Andrew, do you want to go first? I hear you  
20 were first. We'll get to everyone, I promise.

21 DR. RYAN: I think the point that  
22 was just made about gaming the measures is

1 great. And you could imagine hospitals kind  
2 of transferring tough patients back and forth  
3 between each other to both get off the hook.  
4 I mean I'm kind of -- it's hypothetically  
5 possible. And so if the stakes were high  
6 enough hospitals could do that.

7           The logic that was just given that  
8 why should the community hospital bear  
9 responsibility after the transfer isn't  
10 persuasive to me because we're asking them to  
11 bear responsibility for 30 days after, you  
12 know, everything that happens 30 days after  
13 the discharge. So it seems like they do  
14 control that transfer. And the idea of trying  
15 to make more high-value transfers seems  
16 reasonable to ask hospitals to do if we're  
17 thinking about making them accountable for  
18 everything that happens in the 30 days.

19           And then two other points I wanted  
20 to make. The end of life spending and  
21 excluding deaths seems like a real serious  
22 issue because you can imagine a high-intensity

1 hospital that keeps patients alive could look  
2 worse on this measure than a high-intensity  
3 hospital where patients actually die because  
4 those patients get excluded.

5           And then I didn't see any evidence  
6 that the lowest 1 percent of episodes were  
7 actually outliers. I imagine that 1 percent  
8 is probably pretty close to 2 percent in terms  
9 of the spending. And I just kind of -- I can  
10 clearly see that the top 1 percent is likely  
11 high-cost outliers. But I really do wonder  
12 how much it makes sense to exclude that bottom  
13 1 percent. So that's it.

14           DR. PENSON: So just before Jack  
15 and then Andrea, I just, I think in the end  
16 when we talk about the transfer exclusion and  
17 to some degree the issue is death as well. I  
18 think in the end we have to take it at face  
19 value and you have to make your own judgment  
20 when you vote. Because I think that the  
21 comment that, you know, it could go either way  
22 is probably well taken.

1                   So you have to decide if the way  
2                   they went is what you like or not, if that  
3                   makes some sense. So I think if the order is  
4                   correct then -- oh Daniel, it was your  
5                   question. Okay, so go ahead.

6                   MR. WOLFSON: It's deja vu all  
7                   over again. I mean when we were in the  
8                   eighties we had utilization information. And  
9                   we said well, there's unintended consequences.  
10                  To beat that system just do less and you'll be  
11                  fine. And that's why we developed quality  
12                  measures. So it just seems like we've come  
13                  full circle.

14                  And you can't do these measures.  
15                  We're just proving that you can't do these  
16                  measures without quality measures because  
17                  there's unintended consequences to game the  
18                  system. So I think that we could go around  
19                  and around but ultimately it goes back to the  
20                  notion that you can't have these measures  
21                  without quality measures alongside of it.  
22                  We're all in agreement of that. So I think we

1 can go on with the unintended consequences.

2 We know there's unintended  
3 consequences, that's why we developed quality  
4 measures. That's why NQF is here and NCQA, to  
5 combat utilization-focused measures. A little  
6 history.

7 DR. PENSON: So let me just add to  
8 that and any of the NQF folks can chime in.  
9 Because Martin came to me during the break and  
10 made a point. For those of you who remember  
11 phase I of this project you'll remember the  
12 heated discussion that we had about this.

13 And the concept particularly on  
14 the provider side that you can't -- exactly  
15 what Daniel just said. And I actually made  
16 that very pressing argument except my comment  
17 was I don't trust anyone here. You're still  
18 going to end up making it all about  
19 utilization and you have to make it quality.

20 Unfortunately I think we're going  
21 to have to trust them. So otherwise we're not  
22 going to be able to get done here.

1 I understand people are  
2 uncomfortable with that. I'm uncomfortable  
3 with it as well at times. I'm going to guess  
4 that CMS is an honest broker to start with and  
5 go from there. So I just wanted to add that.  
6 I hear you, believe me, I hear you. Jack?

7 DR. NEEDLEMAN: Yes. I have a lot  
8 of questions, issues. I'm not quite sure what  
9 they are, which bucket they fall into.

10 One is this issue of the exclusion  
11 of deaths and transfers. Given the DRG  
12 payment, given the standardization of payment  
13 it's not the hospital portion of this that's  
14 at issue, it's the gaming by transferring  
15 patients that you think are going to need lots  
16 of post-acute care.

17 And we normally expect transfers  
18 to be based upon the ability of the hospital  
19 to deliver the acute care services that  
20 patients need. And certainly this does add a  
21 gaming component to that, but we need to think  
22 about how serious it is that hospitals are

1 going to transfer based upon assessments of  
2 the post-acute needs of these patients. So  
3 that's a question.

4 The deaths, we've got deaths  
5 excluded which is an important quality metric  
6 here as Daniel noted. But we've got hospice  
7 costs included. So I'm just wondering how  
8 consistent we're being here in what we're  
9 measuring and which patients we're looking at,  
10 which patients we're excluding.

11 So I would raise that issue in  
12 terms of the appropriate scope if deaths are  
13 included. And whether the hospice patients  
14 ought to be excluded as well. So that's a  
15 question I have about whether the exclusions  
16 are right.

17 As I think about the construction  
18 of this measure with the inclusion of an  
19 indicator variable for the DRG that the  
20 patient's in we've got something that in any  
21 of these regressions for the risk adjustment  
22 is going to pick up in essence the average DRG

1 payment for the patient's diagnosis. So what  
2 the measure is really measuring is variation  
3 between no post-acute services and lots of  
4 post-acute services because we've got the core  
5 cost associated or the expenditure associated  
6 with the hospitalization already included  
7 through the DRG in the risk adjuster.

8 So we're looking at variations in  
9 pre- and post-hospitalization acute care,  
10 expenses as the major sources of variation in  
11 this measure after risk adjustment. And the  
12 question is whether the HCC risk adjuster and  
13 the age adjuster and the other adjusters here  
14 are capturing everything that produces  
15 variation there. So that's one issue in terms  
16 of the risk adjustment in general.

17 But the more specific issue which  
18 I think comes up as we look at some of this  
19 data is whether the high-cost places are  
20 relatively consistent in which sets of post-  
21 acute services are driving you into those high  
22 -- being that high-cost group. And the high



1 R squared in that group suggests there's a lot  
2 of consistency in what's happening in that  
3 group.

4 And again, it's an issue of in  
5 terms of the construction has there been --  
6 earlier we had talked about -- Acumen and CMS  
7 had pointed out yes, we see readmissions, we  
8 see skilled nursing facility, we see the  
9 outlier patients in the high-risk end of this.  
10 I know the correlation with readmissions is  
11 low but I'd like to know what the actual  
12 percentages are, particularly at the high-cost  
13 end of this measure where people are going to  
14 be very concerned and the value-based payment  
15 system is going to get very concerned.

16 How much of being a high-cost  
17 provider at the high end of the spectrum, not  
18 the full spectrum but the high end spectrum is  
19 associated with simply having a very high  
20 readmission rate or a very high outlier in  
21 terms of the patient inpatient experience  
22 rates. And whether the risk adjuster is fully

1 adjusting for which patients we can predict  
2 are going to show up in those categories.

3 DR. PENSON: So I think you've  
4 raised two points there. The first reiterates  
5 a comment you made earlier about what's  
6 driving the variation.

7 The other point that you've  
8 started a discussion is on risk adjustment  
9 which I think is an important case here. And  
10 I would also invite Nancy who was also looking  
11 at risk adjustment just to add your thoughts  
12 to Jack because we're moving along.

13 And I'll get everyone else's  
14 questions too, I promise.

15 DR. GARRETT: So it might be  
16 useful just to take a step back and get us all  
17 on the same page with what the risk adjustment  
18 methodology is I think, and then we can go  
19 into the issues. So if you wouldn't mind  
20 putting my slides up and go to slide 8.

21 So as we have already touched on  
22 the explanatory variables are looking 90 days

1 before the start of the episode. And so  
2 that's a point that we need to talk about some  
3 more I think. And so it includes severity of  
4 illness, some of the explanatory variables,  
5 severity of illness using 70 HCC indicators,  
6 an indicator of recent long-term care,  
7 disability or ESRD status. There's 12  
8 categorical age variables and then also the  
9 DRG of the index admission.

10 And then there's an OLS regression  
11 model where standardized episode cost is the  
12 dependent variable. There's a separate model  
13 for each major diagnostic category that the  
14 DRGs roll up to. And so then there's an  
15 exclusion for the outliers at the 99th --  
16 above 99th and below first percentile. And  
17 there's not an adjustment for race or for sex.  
18 So next slide.

19 So some of the key issues in terms  
20 of the comments. These are how the votes came  
21 out. One of them is the 90-day period, is  
22 that too short. The HCC model itself, that

1       it's weak compared to commercial groupers.  
2       And then not adjusting for socioeconomic  
3       factors, sex and race. And then there's some  
4       concerns about multicollinearity in terms of  
5       the correlations of the explanatory variables.

6                   And that's -- those are kind of  
7       the key issues that I captured from the  
8       discussion.

9                   DR. PENSON: So we've had a lot of  
10       discussion about risk adjustment. So I sort  
11       of an expecting comments. Cheryl and  
12       Jennifer, you have your --

13                   DR. NEEDLEMAN: Can I just, as the  
14       other person on risk adjustment --

15                   DR. PENSON: Oh, I'm sorry.

16                   DR. NEEDLEMAN: -- can I just add  
17       one thing which I didn't do as well as I would  
18       have liked to do a few minutes ago when I was  
19       sort of quickly summarizing my reaction to the  
20       measure.

21                   Which is if you think about the  
22       expenditure side of this it is the hospital

1 DRG payment, any outlier payment and  
2 everything else in Part A and B. If you think  
3 about the risk adjustment model which is being  
4 regressed on that it is the DRG and these HCCs  
5 and age categories and the other stuff.

6 Well, the core DRG payment is  
7 completely determined by the DRG category. So  
8 any variation you get in this measure that  
9 you're risk-adjusting for is the risk  
10 adjustment for the outlier payments and all  
11 the non-DRG payments. And everything which is  
12 sopping up that variance is the HCCs, the age  
13 and these other things. So that's what's  
14 going on.

15 Fundamentally if we're trying to  
16 explain variance through the risk-adjuster  
17 after the core DRG we're explaining that with  
18 these other -- with the other variables that  
19 are in here. And we've got to decide whether  
20 that makes us happy or less happy.

21 DR. PENSON: I think it's a key  
22 point. I mean I have to say that Nancy's

1        comments earlier about disparities resonated  
2        with me, that it just struck me that there  
3        were so many things that weren't accounted for  
4        in the risk adjustment that frankly wasn't  
5        completely fair. That certain hospitals serve  
6        populations and you know. I'm not a genius  
7        when it comes to HCCs, I haven't used them,  
8        but I get the impression from people that they  
9        don't capture everything in that domain.

10                    Cheryl and then Jennifer or other  
11        way around.

12                    DR. DAMBERG: Can I still talk  
13        about transfers? I just wanted to make one  
14        last comment on that.

15                    So there's so many different  
16        market dynamics in effect. And this landscape  
17        is changing dramatically. And one of the  
18        things that I've observed, we're doing all  
19        these studies of nascent ACOs. And one of the  
20        things that's going on is hospitals that are  
21        part of these ACOs are reaching out and  
22        transferring patients back into their

1 institution to be able to manage those costs  
2 more tightly. And so they're repatriating  
3 patients.

4 And so I think that transfers  
5 shouldn't be excluded. And I think CMS really  
6 needs to monitor this. And I think if you  
7 start to see very strange changes in the  
8 readmission rates you need to look at whether  
9 that's an unintended consequence or whether  
10 it's due to some of these other market  
11 dynamics that are in play.

12 DR. PENSON: So I just want to  
13 make a point. I think that's a good point and  
14 it's interesting. I hadn't even considered  
15 that.

16 One of the things we have to  
17 remember as a committee is that -- or as a  
18 panel I should say is we have to sort of judge  
19 things as they are. So while I think it's  
20 helpful to give CMS advice on perhaps how to  
21 fix it in the end the vote really has to focus  
22 on what's been put in front of us. I just

1 want to remind folks of that. Jennifer?

2 MS. EAMES-HUFF: I'm also going to  
3 beat another issue to death but I have a  
4 different conclusion that hasn't been  
5 discussed.

6 So I will say I agree with  
7 everybody around the general premises that we  
8 need to report both cost and resource use  
9 measures in conjunction with quality. And  
10 that's really important.

11 I think I drew a different  
12 conclusion around the issue of since this  
13 doesn't have a quality measure given the  
14 history lesson of 30 years ago of looking at  
15 cost and resource and not having quality  
16 measures and then doing a focus on quality.  
17 That led me to believe if we don't move this  
18 forward with a quality measure do we have to  
19 wait another 30 years to get what we want.  
20 And it seems like moving this measure forward  
21 even without the quality piece actually will  
22 get the quality measure faster.



1 DR. PENSON: Great, thanks. So  
2 David and then Brent.

3 DR. REDFEARN: Just a quick  
4 question for the developers. Why was gender  
5 excluded? Normally you run these patient risk  
6 models, you have age, gender and then the  
7 clinical categories. Why was sex excluded?

8 MR. ZAIDI: Because as we  
9 understood it NQF policy on risk adjustment  
10 encourages not adjusting for --

11 DR. NEEDLEMAN: Yes, but you  
12 included it in 2165. So you've not been  
13 consistent.

14 MS. SPALDING BUSH: I think that  
15 could probably be better explained by that  
16 measure developer. But there were some  
17 differences in the way that our statutory  
18 requirements were written to start with. And  
19 we were not required by statute to adjust for  
20 sex so we went along with the NQF position and  
21 didn't.

22 MR. AMIN: So the NQF position on

1 sort of risk adjustment is specifically on  
2 where there's areas identified related to  
3 disparities. So that variables that are  
4 identified that are known disparities in the  
5 field should not be included in the risk  
6 adjustment model for obvious reasons, the fact  
7 that they would be masked in terms of the  
8 outcome.

9 So examples could include gender,  
10 well in this case SES in particular. So it's  
11 not to say that gender should always be  
12 excluded from the risk adjustment model. It's  
13 only when there's a known disparity between  
14 genders that you wouldn't want to mask that in  
15 a model.

16 So it's up to the committee in  
17 this case if that's appropriate as it always  
18 is. Even the issue of SES, it's still a  
19 question of appropriateness in the  
20 application.

21 DR. PENSON: Brent.

22 DR. ASPLIN: So we spoke quite a

1 bit about the transfer issue. I'll leave that  
2 one. But could the developer just speak to  
3 deaths? I mean -- and why they're excluded.

4 Now to the extent they're  
5 inpatient deaths and it's all going to be  
6 captured, the majority of the costs are  
7 captured by the MS-DRG there might not be much  
8 variability left over. You can certainly look  
9 at other scenarios where the death occurs  
10 within 30 days after discharge.

11 So I'm struggling with the  
12 rationale on deaths. I understand there's no  
13 good answer on the transfer issue. Help me.

14 MR. ZAIDI: So when we looked at  
15 the issue of excluding deaths what we were  
16 finding was it's kind of a bimodal  
17 distribution. On average episodes with death  
18 cost 40 percent more than the average episode.

19 But there were a lot of episodes  
20 where they were costing far under what you  
21 would otherwise predict. And we suspected  
22 that part of was because the patient died

1 early in the episode and didn't have the  
2 opportunity to experience the claims that  
3 other patients would experience. And because  
4 we thought there was no good way to adjust for  
5 that or account for that that was the reason  
6 we excluded deaths.

7 DR. PENSON: It strikes me as  
8 ironic in the discussion of the quality and  
9 utilization that this is a good example where  
10 you've got to get the quality piece. Because  
11 in this setting if your outcome was alive or  
12 dead it wouldn't work out well for you if you  
13 were the hospital.

14 DR. ASPLIN: That appears  
15 clinically totally what I would expect, a  
16 bimodal distribution. You know, you're going  
17 to have a group that clusters right early on,  
18 they're going to die right away and you're  
19 going to have a group that's going to have  
20 prolonged stays. That to me -- it doesn't  
21 concern me. It doesn't feel like a reason to  
22 exclude them.

1 DR. PENSON: So I think what I  
2 would say again with both the transfer and the  
3 death piece is that each of you is going to  
4 have to make up your own sort of judgment as  
5 to whether or not it's kosher for lack of a  
6 better way to put it. I am hearing a lot of  
7 discussion around that and so I think that'll  
8 come out in the wash.

9 Before we move along you can see  
10 we've talked about exclusions and a lot of  
11 these discussion points. And also with risk  
12 adjustment.

13 I wanted to just give Carlos a  
14 chance to say something. I wanted to bring  
15 this up before. You know, in your original  
16 review you made a comment about the validity  
17 testing being weak. And in the response  
18 document basically noted that there's a weak  
19 positive but statistically significant  
20 correlation.

21 And I wanted to get your thoughts  
22 on whether or not you thought the responses

1 were adequate and if it's changed your  
2 opinion, Carlos.

3 MR. ALZOLA: Okay. With respect  
4 to the correlation with readmissions for the  
5 three conditions, heart attack, pneumonia and  
6 heart failure I think yes. You argue that the  
7 correlations were statistically significant.

8 But in this context with a large,  
9 very, very large number of cases a  
10 statistically significant correlation is very,  
11 is going to happen anyway. What really  
12 matters here is whether those correlations are  
13 clinically significant. And I think that the  
14 values are pretty low.

15 You do argue here, and I thought  
16 that was a good point -- let me see if I can  
17 find it -- that the cost for the readmissions  
18 only included inpatient costs. So that goes  
19 to explain the local relation to some extent.

20 I still feel that there are other  
21 ways of testing validity that are more  
22 indicative of face validity. And I think you

1 do -- you did some work in that respect. And  
2 one of them was you calculated the  
3 correlations between two different periods  
4 which -- that's a step that I consider  
5 indicative of face validity. Because you  
6 don't expect things to change too much from  
7 one year to the next. So if things correlated  
8 in 2010 they should correlate over 2011. So  
9 it's stable over time.

10 And the other one that's -- the  
11 other step that you took was to correlate the  
12 MSPB measure with service counts of various  
13 procedural categories like procedure services,  
14 emergency services, and a number of other  
15 measures of resource use.

16 And you said that you found  
17 statistically significant and strong positive  
18 correlation with professional E&M services and  
19 post-acute services including inpatient I  
20 guess and SNF. The correlation was 0.6 which  
21 that's acceptable.

22 So I do -- I think that in terms

1 of validity those things help to increase my  
2 level of confidence. But I still would like -  
3 - personally I would still like to see more  
4 detail on those analyses.

5 DR. PENSON: So just to sort of  
6 reflect back because I think it's important.  
7 I think at least for me and I suspect for  
8 others in the room that that review really  
9 influenced where I came down.

10 What I hear you saying is that  
11 perhaps it's stronger than you originally  
12 suggested in your summary but you still have  
13 some concerns.

14 MR. ALZOLA: That's correct, yes.

15 DR. PENSON: All right, terrific.  
16 That's helpful to me. Why don't we keep  
17 moving down the lists. I think we've talked  
18 a lot about risk adjustment. I see these up.  
19 Nancy, David, do you have comments? Okay, go  
20 ahead. Sorry.

21 DR. GIFFORD: My comment is on  
22 risk adjustment. I'm assuming the long stay



1 in the risk adjustment is defined the same  
2 way.

3 About two-thirds to three-quarters  
4 of those will be dual eligibles. So I'm not  
5 clear. We're excluding dual eligibles. Then  
6 we're adjusting for long stay and whether  
7 they're in there or not. Because many long  
8 stay, two-thirds to three-quarters will have  
9 Medicaid and about 80 percent of them will be  
10 women. So in essence those measures are  
11 adjusting for the very things we're talking  
12 about. I was wondering why.

13 I mean, I agree with that should  
14 be in there but then it's not sort of  
15 consistent with everything else that's going  
16 on.

17 MR. ZAIDI: So yes, we definitely  
18 found in the data that being in a long-term  
19 care institution had a very strong effect on  
20 your episode cost. And there are always going  
21 to be -- a lot of different variables are  
22 going to be co-linear with each other. So

1       yes, we couldn't find a good way to separate  
2       out the effect of Medicaid from the effect of  
3       being in a long-term care institution. But  
4       because it is included in the CMS HCC model we  
5       thought it was appropriate to include that as  
6       a risk adjuster.

7                   DR. GIFFORD: I guess I would  
8       agree but then following that logic with all  
9       of the other discussion we're having why  
10      aren't we adding other stuff in that we need  
11      to risk-adjust for? I guess that's my point  
12      I wanted to make. Either we have to be  
13      internally consistent or not. To pick and  
14      choose what we want to put in doesn't make  
15      sense.

16                  DR. PENSON: I think, you know, I  
17      keep hearing concerns about risk adjustment  
18      now. The sort of random choice of what got in  
19      and what got out adds to it. Nancy?

20                  DR. GARRETT: So I just wanted to  
21      bring up the point that we talked about this  
22      morning around the fact that episodes for dual

1 eligible beneficiaries were more costly but at  
2 the hospital level the results didn't change  
3 when they tried adjusting for that.

4 And to me that's a real validity  
5 concern. I don't understand that, what's  
6 going on. Is it some kind of -- I just feel  
7 like without knowing more about that I do have  
8 concerns about the validity of the measure.  
9 So now that we're in the validity section I  
10 wanted to bring that up again.

11 DR. PENSON: Thanks. Jack?

12 DR. NEEDLEMAN: I have a question  
13 for the developers. The more I keep turning  
14 this over the less -- I started out very happy  
15 with the risk adjustment. And the more I keep  
16 turning this over the more concerns I have.

17 And as I think about the decile  
18 results, as I look at that 0.46 R squared and  
19 the 0.6 R squared I realize you've got the  
20 core DRG in there which means you've got the  
21 core DRG payment which is a substantial  
22 portion of any of these expenses.

1                   And I'm just wondering have you  
2 subtracted the standardized DRG payment from  
3 your total standardized payment level and  
4 regressed everything except the DRG?  
5 Regressed that residual on everything except  
6 the DRG to see how much R squared -- how much  
7 variance in the rest of the payments you're  
8 actually able to explain with the rest of the  
9 risk adjuster.

10                   MR. ZAIDI: No, we didn't subtract  
11 the core DRG payment. And part of the reason  
12 is that we also include the CMS outlier  
13 payment which -- so even in the same DRG some  
14 cases will be slightly more expensive because  
15 they have that outlier payment. So it's not  
16 always exactly the same across all cases.

17                   DR. NEEDLEMAN: Basically the  
18 variance around the core DRG payment and how  
19 much of that is in fact explained or can be  
20 risk-adjusted away. I suspect a lot of this  
21 0.46 and this 0.6 is that core DRG payment.

22                   MR. ZAIDI: So we haven't analyzed

1 the R squared excluding the core DRG payment  
2 but we'd be happy to do that analysis.

3 DR. PENSON: So Nancy, do you have  
4 another comment or no? Okay. So I'm hoping  
5 for the sake of time that we're sort of  
6 getting towards the end of the risk adjustment  
7 and exclusion piece.

8 I want to go onto 2b5 which Tom  
9 took a look at which was the identification of  
10 statistically significant differences. Tom,  
11 do you want to comment on that?

12 DR. TSANG: Yes. So I was asked  
13 to look at whether the data analysis  
14 demonstrates that methods for scoring and  
15 analysis of the specified measure allow for  
16 identification of statistically significant  
17 and practically and clinically meaningful  
18 differences in performance.

19 And I think the key words here are  
20 really practically and clinically meaningful  
21 to me at least. You know, so on the  
22 preliminary scores that looked at this scored

1 with 5 in the high range and 10 in the  
2 moderate range and 3 in the low and 3  
3 insufficient.

4 I think the analysis from the  
5 measure developers actually demonstrated that  
6 most of the impact analysis showed a 0.01  
7 difference between the highest and the lowest  
8 performers. And one of the comments, the only  
9 comment that we got from the preliminary  
10 analysis which was very insightful said  
11 although the variation is hard to interpret  
12 with this 0.01 difference how significant is  
13 the performance.

14 And I think it really, again, it's  
15 the context question is it's really which lens  
16 you're looking at this and whether it's the  
17 hospital provider or whether it's the consumer  
18 looking at the Hospital Compare website or  
19 whether it's CMS looking at it. People get  
20 different I guess conclusions from the  
21 statistics.

22 And so if you're the consumer

1 looking at the value-based -- or the Hospital  
2 Compare website and you actually look at this  
3 number of -- you know, if you're a medical  
4 center and you're performing at 1.08 as the  
5 measure. And the median is 0.99, I mean what  
6 does that tell the consumer, right? So it  
7 tells them nothing.

8 But then if you look at some of  
9 the analysis looking at hospitals in the 90th  
10 percentile with a score -- costing Medicare 25  
11 percent more than per episode than hospitals  
12 in the 10th percentile. You know, that's  
13 meaningful data to CMS. So I guess the  
14 criteria here is from where do you look at  
15 this data in terms of the lens and where you  
16 sit on the fence.

17 And in terms of if you're asking  
18 me, the provider, the hospital whether this is  
19 clinically relevant I personally would say  
20 it's of low relevancy. I think for CMS and  
21 for Congress this would probably have some  
22 difference but it's not statistically or

1 clinically meaningful.

2 DR. PENSON: Thank you. I  
3 appreciate that. So the last piece in  
4 validity is something we've already talked  
5 about a good bit which is -- I'm sorry, Lina,  
6 I didn't see your -- sorry.

7 DR. WALKER: I just wanted to  
8 follow up on that comment because that was my  
9 comment. And I have a question for the  
10 developer.

11 The score that's available to the  
12 public is just that single score which to me  
13 was meaningless, especially to a consumer  
14 who's looking at that score. It was  
15 impossible to interpret. If I'm trying to  
16 assess the performance of a hospital I  
17 wouldn't -- other than the up/down, above  
18 1/below 1 it provided very little information.

19 But what you have said and what  
20 was available in the documentation is that the  
21 hospitals will receive additional information.  
22 And that information would parse out the



1 measure by different subcategories. That  
2 additional information would be meaningful to  
3 consumers.

4 And I don't know, I mean I guess  
5 my -- getting to the point of my question, you  
6 talk about intent in the beginning and I feel  
7 that this particular measure doesn't get to  
8 intent because there's so little information  
9 in the measure that's publicly reported. And  
10 if I were to evaluate it from the point of  
11 view of what's publicly available I would say,  
12 you know, it doesn't meet that criteria.

13 MR. ZAIDI: So that's well taken.  
14 It is true that on sort of the front page of  
15 the Hospital Compare website there is just one  
16 number. But the consumer can download files  
17 which show for every hospital the proportion  
18 of their costs in each of the seven types of  
19 service that I mentioned. So it's not posted  
20 right on the front page right now but that  
21 data is available to the public I think on  
22 data.medicare.gov. As well as the state and

1 national averages for all of those measures.

2 DR. WALKER: But is there a way to  
3 translate that measure though? Because I mean  
4 I think -- what you're saying is that it  
5 requires multiple steps to understand the  
6 measure. Is there a way to translate the  
7 measure if all you see is that index?

8 MS. SPALDING BUSH: I guess we're  
9 not sure what we want to translate it to. I  
10 mean I think it's a resource use measure,  
11 Medicare payment measure. So what are we  
12 looking to translate it to given that data?

13 DR. WALKER: Well, is a 0.01  
14 difference a significant difference in  
15 resource use?

16 MS. SPALDING BUSH: Okay. So  
17 that's something you think the consumer would  
18 benefit from us explaining?

19 DR. WALKER: Well, we're working  
20 towards -- this is, as I understand it, a  
21 building block towards trying to get to value  
22 and efficiency. And so if I have no way of

1 interpreting the data I wouldn't know how to  
2 use that particular building block in  
3 conjunction with other quality measures to  
4 assess value and efficiency.

5 MS. SPALDING BUSH: I think that's  
6 correct if you look at the measure as it  
7 stands alone. A few people have mentioned the  
8 Hospital Value-based Purchasing Program which  
9 has the measure in a domain that's weighted in  
10 with the clinical process of care, patient  
11 experience and outcome measures. So then you  
12 get a total performance picture that way.

13 But it was developed as a  
14 standalone cost measure so that you can use it  
15 in conjunction with those quality measures to  
16 recognize a hospital that's providing higher  
17 quality care at a lower cost to Medicare.

18 But you're correct, I think  
19 standing alone it doesn't tell you quality.  
20 But I don't think that that was necessarily  
21 its intent.

22 DR. PENSON: Yes, so I think --

1 well, I think what you have to decide is you  
2 have to again look at the measure as it stands  
3 and decide if the differences you see are  
4 meaningful, whether statistically meaningful  
5 or clinically meaningful or just common sense.  
6 I mean they're there and I don't think there's  
7 any judgment to it. Daniel?

8 MR. WOLFSON: I actually think  
9 that it's to the advantage of everybody in the  
10 room that there is not a lot of variation  
11 between the players. So ultimately we can  
12 refine over time and nobody gets hurt in the  
13 middle or in the beginning. I think it's  
14 actually a good thing.

15 Two, the biggest unintended  
16 consequence that just came up which --  
17 Americans will buy the most expensive item on  
18 the shelf.

19 (Laughter)

20 MR. WOLFSON: That's the thing  
21 that really scares me. Now, the Choosing  
22 Wisely campaign is going to change all of that

1 thinking.

2 (Laughter)

3 MR. WOLFSON: But I need a few  
4 more years. And that's the biggest unintended  
5 consequence, that when we put this out  
6 although things are changing because I think  
7 as insurance is involving the patient more in  
8 the decisions I still don't think they'll  
9 think about cost. And they'll want to go for  
10 the most expensive hospital. They don't like  
11 shopping at Walgreens for healthcare.

12 DR. PENSON: As a dedicated Apple  
13 user I don't know how you can say that.

14 MR. WOLFSON: I didn't hear you?

15 DR. PENSON: As a dedicated Apple  
16 user I don't know how you can say that  
17 Americans go for the most expensive things on  
18 the shelf. God knows we look for value.

19 So I will try to keep moving this  
20 along for the sake of time. Jack, question,  
21 comment?

22 DR. NEEDLEMAN: Yes. I actually

1 have a question for the developers but  
2 Daniel's comment, it's -- I actually think the  
3 issue here is not so much that people are  
4 going for the most expensive thing on the  
5 shelf. But they're -- consumers are very much  
6 afraid of skimping on valuable care. So it's  
7 the low-cost folks that make them wonder what  
8 am I giving up here. And so it's a different  
9 mind-set than the most expensive. It's am I  
10 being skimped on in these other places. And  
11 that's where I think the quality issues come  
12 in.

13 But Tom talked about the  
14 difference between the bottom 10 percent and  
15 the top 10 percent being 25 percent. And we  
16 had that other measure that Cheryl referred to  
17 earlier that when we looked at quintiles, the  
18 bottom 20 and top 20 percent, we saw a 6  
19 percent shift in the hospitals in each one of  
20 those, 70 percent, 70 percent.

21 So, but if we're going to look at  
22 25 percent differences now I'm concerned about

1 whether those are a function of the inherent  
2 variability of care. So if we go to the more  
3 extremes where we get this 25 percent  
4 difference can you tell us what proportion of  
5 the hospitals stay in the 10th -- the deciles,  
6 top and lower deciles? Or alternatively can  
7 you tell us what the cost difference is  
8 between the bottom quintile and the top  
9 quintile so we can compare apples and apples?

10 MR. ZAIDI: So I think you're  
11 getting at putting a confidence interval  
12 around the measure that we report.

13 DR. NEEDLEMAN: No, I'm talking  
14 about not so much a confidence interval but  
15 the stability of the measure. So we did test,  
16 retest and you know, at the top and bottom  
17 quintile 70 percent stayed in and 30 percent  
18 stayed out. That's 6 percent of the hospitals  
19 at the top and the bottom shifting at that  
20 point.

21 We heard in terms of how big are  
22 these differences at the decile level 10

1 percent and 10 percent, not 20 and 20, a 25  
2 percent difference. But I'm wondering when  
3 you did the test-retest what percentage of the  
4 hospitals are -- stay in the decile. Because  
5 that will tell us something about how  
6 reliable, how stable this measure is of high  
7 cost and low cost.

8 MR. ZAIDI: So we didn't do a  
9 decile stability analysis. But I would say  
10 that that 30 percent that drops out of the top  
11 quintile, they might be moving just a little  
12 bit below the cutoff. So it's a very  
13 discontinuous measure.

14 And I think as I mentioned almost  
15 all of them are in the top two. So that 30  
16 percent that moved out of the top quintile,  
17 they're almost all in the second most  
18 expensive quintile.

19 So a way of less discontinuous  
20 measure is to do the rank correlation. And  
21 that was, I think that was like 0.85.

22 DR. NEEDLEMAN: But what we're



1 hearing is fairly tight expenditure  
2 compression within the whole sample. So  
3 moving from the first quintile to the second  
4 quintile, particularly if you're right at the  
5 margin there may not be a very large  
6 expenditure difference. Or Medicare  
7 expenditure difference. So when we hear  
8 numbers being -- justifying this measure as  
9 the bottom decile to the top decile is a 25  
10 percent difference in Medicare expenditures  
11 standardized. That's a bigger number than 2  
12 or 3 or 4 percent differences which may be  
13 what those shifts at the quintile level are  
14 showing. So that's why I'm asking.

15 If we're going to think about the  
16 materiality of this measure which is part of  
17 what's -- part of the criterion, you know, how  
18 stable are the projections of the difference  
19 in spending from the low to the high.

20 MR. ZAIDI: Well, we don't report  
21 the quintile or the decile. Right now we just  
22 report the number and tell them whether it's

1 above or below the median.

2 But the broader point I would make  
3 about the materiality and the difference  
4 between. So the interquartile range is about  
5 10 percent which translates to about \$1,900  
6 because the median is about \$19,000.

7 But I would say that most of the  
8 variation between episodes has been gotten rid  
9 of by the risk adjustment. So that measure is  
10 actually very conservative because the risk  
11 adjustment is controlling for so many things  
12 that most of the variation between hospitals  
13 has been washed out by that procedure. So  
14 what's left I think you can have more  
15 confidence in the difference between hospitals  
16 that's left after risk adjustment.

17 DR. PENSON: So I think, Bill, I  
18 see you have a question. So I'm just going to  
19 ask folks to try to -- I mean I'm starting to  
20 hear problems with the differences but I will  
21 ask folks to so try to cover very new ground  
22 when possible only for the sake of time. So

1 I don't mean to cut you off, Bill, or stop you  
2 but I just wanted to remind -- I think we've  
3 established that some folks in the room have  
4 concerns with differences in significance.  
5 Bill.

6 DR. WEINTRAUB: Just quickly to  
7 remind everybody. There's 25 percent  
8 difference after risk adjustment. How much  
9 difference was there before?

10 MR. ZAIDI: I think it was about  
11 five times more. I don't have the number on  
12 me exactly. It was a much larger difference.

13 DR. PENSON: Okay. So other  
14 comments here? We sort of covered disparities  
15 before but we'll just go onto -- is that the  
16 next slide that you have, Evan? Okay.

17 So we've kind of gone through  
18 disparities earlier in the day. And we don't  
19 have to worry about comparability of multiple  
20 data sources. Brent, you have a comment?  
21 Okay, well no, we're not going to vote quite  
22 yet. So I just wanted to sort of summarize a

1 little bit and I also want to let anyone who  
2 has comments in the room make them and then go  
3 onto public comments.

4 So basically I've heard a bunch of  
5 different things as we've gone through this.  
6 I've heard some concerns about exclusion with  
7 regard to thresholds and the deaths. I've  
8 heard some concerns about adequacy of risk  
9 adjustment. And I've heard some concerns  
10 about the differences measured.

11 I've also from Carlos with regard  
12 to validity testing while he feels better  
13 about what's been presented he still has some  
14 concerns there. I'd like to invite additional  
15 comments for the overall validity piece and  
16 then we'll let the public comment and vote.  
17 So David and Brent, if you have one. Daniel,  
18 I don't know if you have a comment as well.  
19 David.

20 DR. GIFFORD: Well, I'm not sure  
21 where in the validity. I wanted to make some  
22 comments about their content, construct and

1 criterion validity testing. Is that later or  
2 is that right now? Okay.

3 DR. PENSON: It's right now.

4 DR. GIFFORD: So I think as we  
5 talked about their testing of the content  
6 validity with the expert panel and some of the  
7 other stuff was good, was okay. It has some  
8 face validity. But we've also talked a lot  
9 about today some concerns with the exclusions  
10 of Part D and other issues out there on the  
11 content validity of the measure and the other  
12 issues.

13 But I think most concerning is the  
14 thing we talked about, is the construct  
15 validity. The correlations with  
16 rehospitalization, multiple episodes when they  
17 add stuff in is really small with very little  
18 change. And there wasn't just in the writeup  
19 a thought process for what the direction  
20 should be that we'd see. I think we all  
21 intuitively know it but it's really poorly  
22 done. I mean it's not poorly done, sorry.

1 It's well thought through but I think there's  
2 a lot of other construct validity tests that  
3 would be interesting to look at.

4 They have some data in there but  
5 they didn't talk about it. They just sort of  
6 throw the associations out there. Urban  
7 versus rural, other types of hospitals would  
8 be interesting.

9 And then I don't know whether --  
10 I'm trying to think of a criterion validity  
11 but it's probably really construct validity.  
12 But there are a number of all-payer databases  
13 out there and it would be very interesting to  
14 look at how this measure tracks with other  
15 cost measures of hospitals from commercial  
16 insurance or elsewhere. And that shouldn't be  
17 that difficult to do. It's not national but  
18 it's enough to give a good sense.

19 I think the results that are shown  
20 there are really weak and they're not even  
21 clear what the direction they should be,  
22 either divergent or convergent validity

1 testing. So to me of all the things we talked  
2 about today, I mean, I think everything was  
3 pretty reasonable and good. This is the one  
4 area that I had a really hard time in concert  
5 with all this other risk adjustment and  
6 everything we talked about. I mean most of it  
7 I could probably could get by but this just  
8 tipped me over to say it's really hard for me  
9 to vote on it with that.

10 DR. WALKER: Could you speak in  
11 plain English about what the concern is?

12 DR. GIFFORD: Helen's muted me I  
13 think. I had to go back to my epi days with  
14 Hal Morgenstern at the School of Public Health  
15 at UCLA. And actually we're trying to submit  
16 four measures to the NQF right now so we're  
17 having to go through all this.

18 You know, in thinking about -- and  
19 it was nicely summarized I think by Ashlie at  
20 the beginning. Your three tests of validity,  
21 the content validity, the face validity just  
22 don't make sense. And the way it tested is

1 you put experts together and if we all agree  
2 then that meets that criteria. And I think  
3 you're seeing that that's sort of iffy with  
4 everything we're talking about. Probably  
5 passes enough. Given the measures that are  
6 out there I think I would say that's okay.  
7 I'd like to see it better but I'd vote okay on  
8 that.

9 Construct validity is usually --  
10 and there's other people in this room. Cheryl  
11 or other people, go ahead and correct me if  
12 I'm wrong. I didn't get an A in this, so. It  
13 really is that it should track either with  
14 measures that you expect it to track or not  
15 track with measures you expect it not to  
16 track.

17 So the hypothesis that's out there  
18 is that facilities that have lots of episodes  
19 of care or lots of rehospitalization should  
20 have higher cost than those that don't. And  
21 when they do the test they see a correlation  
22 but it's really, really weak. And is that



1 correlation strong enough for us to say we  
2 think that that passes the construct validity?

3 The issue of -- they show a lot of  
4 data showing that ethnicity really is related  
5 with higher cost in a lot of other studies.  
6 And when they stratify by the ethnicity and  
7 show the data and they adjust for it we don't  
8 see any correlation. That fails the validity  
9 test in my book.

10 You might say that there's data to  
11 suggest urban hospitals are different than  
12 rural hospitals. Do we see that trend there?  
13 Is it strong enough to say we think it passes  
14 the validity test? It might be that there's  
15 types of hospitals that are out there that,  
16 you know, women's hospitals we'd expect to see  
17 a very different cost structure. Does this  
18 measure show very big differences or not? We  
19 don't see the results of that. So I would  
20 like to have seen more of those types of  
21 tests.

22 And then criterion validity is the

1 gold standard. And I'm not sure we really  
2 have a gold standard so the closest I could  
3 come with a gold standard is we do have other  
4 cost structures. So there are many states  
5 that have all-payer databases which are claims  
6 submitted for not just hospitals but all  
7 settings from insurers. You could probably  
8 take one or two of those states and look at  
9 some similar type of measure and see if this  
10 measure tracks with that. It wouldn't be  
11 exactly correlated but it's just consistency.

12 So if Dave Gifford's hospital is  
13 really, really expensive on Medicare I'd  
14 expect United and Blue Cross to be really,  
15 really expensive too. And if it's not I'm  
16 going to go wow, what's wrong, why is this  
17 measure different. There may be legitimate  
18 reasons for it but I would think an a priori  
19 hypothesis would be that. And so I just would  
20 like to see more validity testing, more  
21 construct validity type testing here. I just  
22 didn't see it and that's my concern.

1                   And in defense of the measure  
2           developers you never can do enough reliability  
3           and validity testing. You're often never  
4           given enough money by CMS or anyone else to do  
5           the testing for it out there. And no matter  
6           what you do someone can sit and be an armchair  
7           quarterback and criticize it and say that it's  
8           not enough testing out there.

9                   So in that defense I don't expect  
10          it to be perfect but I would like to have seen  
11          a little bit more. And the testing that we  
12          did see I thought was very weak correlation  
13          and wasn't strong enough. That's my comment.

14                  DR. PENSON: So thank you. Any  
15          other comments in the room first? All right.  
16          Hearing none we're going to open the floor to  
17          public comment either from behind me or on the  
18          telephone. So we'll wait and see if anyone  
19          has any comments.

20                  DR. BANKOWITZ: Thank you, Mr.  
21          Chairman, for allowing me the opportunity to  
22          comment. My name is Richard Bankowitz. I'm

1 the chief medical officer of the Premier  
2 Healthcare Alliance which is an alliance of  
3 2,800 hospitals throughout the U.S.

4 Let me preface my comments by  
5 saying Premier is working with all of our  
6 hospitals to drive down variation. I think  
7 we're all after the same thing. We are also  
8 working with 80 healthcare systems to create  
9 accountable care organizations which we  
10 believe is fully the way we need to go.

11 Having said that I want to address  
12 concerns with the measure we have before us  
13 which I think has been rightly identified as  
14 a measure of Medicare expenditure for  
15 hospitalization or Medicare expenditure for  
16 extended hospitalization if you want to look  
17 at it that way.

18 The first concern I have is with  
19 the unit of analysis. And I'm going to talk  
20 about the scientific validity.

21 You've been using terms like "the  
22 hospital has variation of X" or "we see a

1 variation of Y in these hospitals." The fact  
2 is the variation in the hospitals is zero. If  
3 you look at the CMS data in our fee-for-  
4 service world where we've got Part A and Part  
5 B expenditures the Part A expenditure  
6 variation is zero because the DRGs have  
7 cancelled that all out.

8                   What's left is the Part B  
9 variation which is the professional fees and  
10 the ambulatory care, et cetera. We would love  
11 to have an entity accountable for that. It  
12 could be an ACO, it could be maybe a provider  
13 if we could identify an attesting -- attending  
14 physician. But we don't have one. So we've  
15 gone to the most convenient, the most  
16 convenient unit of measure which is the  
17 hospital.

18                   And I don't think we would accept  
19 this if we were putting on our scientific hats  
20 and we were reviewing a paper and the author  
21 said well, we've chosen the unit of analysis  
22 mindful of the fact that it has nothing to do

1 with the variability we observed but it was  
2 the most convenient one to choose. We would  
3 not accept that. So I'm not sure why we  
4 accept it here. That's point number one.

5 Point number two is the  
6 socioeconomic status. Looking at the dual  
7 eligibles I understand that NQF does not want  
8 to mask disparity in socioeconomic status.  
9 But dual eligibles share more characteristics  
10 beyond socioeconomic status. We know they  
11 have usually multiple chronic illnesses, we  
12 know they have complex societal issues, we  
13 know there are disparities in healthcare  
14 literacy. And I don't think NQF says do not  
15 look at those things. They should be looked  
16 at. It would be as if we would say we're not  
17 going to look at diabetes because diabetes --  
18 we might mask the disparities in care among  
19 the diabetic patients. We wouldn't take that  
20 approach. So we've got a population with  
21 chronic, complex disease and I think we need  
22 to account for that.

1 I would also say I take issue with  
2 the fact that there was no impact noted  
3 because if I look at the data that's presented  
4 on Table 14 in the appendix if you -- it's  
5 true that about 90 percent of the hospitals  
6 did not show any impact when you added that  
7 variable. But in 10 or almost 11 percent of  
8 the cases the impact brought the difference  
9 measure down by 1 to 3 percent.

10 So I guess you would say well,  
11 it's only 10 percent of the hospitals but  
12 that's maybe not important unless you're in  
13 that 10 percent. And I'd like to know who are  
14 those 10 percent. Are they safety net  
15 hospitals? Are they academic medical centers?

16 And moreover if you look at the  
17 data the bias is only in one direction. It  
18 only lowers the difference. It almost never  
19 raises the difference. So this is exactly  
20 what you would expect if there were a real  
21 impact of dual eligible. So I read the table  
22 differently.

1           The third thing I want to mention  
2           is using the MS-DRG in the regression and the  
3           particularities of doing that. You have to  
4           remember that you can get into a higher MS-DRG  
5           through a comorbidity or through a  
6           complication. So if patients have  
7           complications and they're bumped into the  
8           major CC you have now masked away the fact  
9           that they had something go wrong.

10           Even in an extreme case if a  
11           patient were to come in for a minor surgery  
12           and ended up on a ventilator through a  
13           complication for 96 hours they'd be in an  
14           entirely different DRG. So all of that  
15           quality gets masked. So we may need to look  
16           at DRG families, we may need to look at  
17           present-on-admission flags, but the way this  
18           is done masks any variation attributable to  
19           quality. So thank you very much for letting  
20           me comment.

21           MR. SHAW: Hi, I'm John Shaw from  
22           Next Wave in Albany. And I wanted to address



1 just two of the areas that seem to be the most  
2 problematic for the group. And that is the  
3 90-day period to look for for risk adjustment  
4 for the HCCs. And the unexpected results that  
5 looking at the dual eligibles didn't seem to  
6 make as much of an impact.

7 And part of what I perceive as a  
8 contributor to both of those concerns are  
9 things that are not in there. They're  
10 exclusions that aren't really explicit  
11 exclusions, they're implicit exclusions.

12 So for the dual eligible  
13 population we're looking at a measure where  
14 we're measuring Medicare covered costs. The  
15 dual eligibles have Medicaid covered costs  
16 that are not in there. And the total costs  
17 for caring for them which we're used to seeing  
18 in terms of overall expenditures are both.

19 Yes, there's patterns where the  
20 dual eligibles are high on the Medicaid side  
21 and high on the Medicare side but without  
22 looking at all of the costs it's really not

1 complete.

2                   Secondly, in looking at the  
3 diagnoses that are used for risk adjustment I  
4 was concerned too not looking out a year ahead  
5 because I know the small numbers of diagnoses  
6 that get reported and particularly in a 90-day  
7 period, the argument that those are going to  
8 be more relevant and closer to describing the  
9 episode is somewhat compelling except for one  
10 thing and that is the coding guidelines. The  
11 coders will only report on the encounter those  
12 diagnoses that affect the current episode of  
13 treatment.

14                   So that means that if you're  
15 coming in and starting this with a hospital  
16 admission and the 90 days prior is all doctor  
17 visits and outpatient something is different.  
18 So I think you almost have to look at the  
19 index stay for anything that's prior --  
20 present on admission to include in explaining  
21 what the course is likely to be for them.  
22 Thank you.

1 DR. PENSON: Thank you. Any  
2 comments from folks on the phone? Operator?

3 OPERATOR: At this time to make a  
4 comment please press \*1 on your telephone  
5 keypad. There are no comments or questions.

6 DR. PENSON: Great, thank you. So  
7 I think we're at a point where we need to vote  
8 for the validity of the measure. We've had a  
9 long discussion. I'm not going to bother  
10 recapitulating it because I think you've all  
11 heard it. So let's go ahead and vote.

12 MR. WILLIAMSON: We will now vote  
13 on the overall validity. You will have 60  
14 seconds. Please begin now.

15 DR. PENSON: Everyone try again,  
16 someone's missing. Oh no, I've got them all  
17 now.

18 MR. WILLIAMSON: We have 13  
19 moderate, 11 low and 1 insufficient.

20 DR. PENSON: Well, there you go.  
21 Okay. So on that note -- actually, what does  
22 that mean?

1 DR. GIFFORD: Is that a  
2 statistically significant difference?

3 MS. WILBON: I'm tempted to defer  
4 to Lindsey who is actually working on  
5 consensus stuff right now. But essentially  
6 for the process, and I'll let Helen and  
7 Lindsey add to this, is essentially we would  
8 move onto evaluate the rest of the components  
9 of the measure.

10 It does pass scientific  
11 acceptability although I think there's  
12 probably some additional comments or some  
13 input. We could decide on whether or not  
14 that's actually consensus or not. But in  
15 terms of votes we would move forward based on  
16 the majority votes. Helen or Lindsey?

17 DR. BURSTIN: Yes, I mean one of  
18 the issues we've had, we've been spending a  
19 lot of time with the board level consensus  
20 task forces really identifying what's  
21 consensus. And I think, you know, I don't  
22 think there's a whole lot of comfort when it's

1 split like this.

2 I think at this point in the  
3 middle of a review you just need to have --  
4 these are sort of a series of tollgates. So  
5 I think at this point you have at least moved  
6 past this tollgate, recognizing there's a lot  
7 of issues you probably need to return to  
8 before you get to the final decision-making.  
9 And then we'll have to see what the ultimate  
10 vote looks like when people overall assess how  
11 all the difference criteria come together.

12 But I think based on this you  
13 should just continue to move forward to the  
14 other criteria. Any questions?

15 DR. PENSON: So, yes. I think  
16 it's interesting to look at that and see that  
17 there were no highs there at all. And I think  
18 there is something of a consensus towards the  
19 middle to the bottom. And I guess as Helen  
20 pointed out it's really going to come out in  
21 the wash at the very end.

22 So let's keep moving along and

1 talk about feasibility. And I'm hoping that  
2 we'll be able to move through these last two  
3 points relatively quickly. I'm going to urge  
4 everyone, we've covered a lot of ground and  
5 sometimes we're covering it again and again  
6 and again. And I don't want to cut anyone off  
7 so please, don't beat the dead horse, just for  
8 the sake of time. Nancy?

9 DR. GARRETT: I just had a quick  
10 process question. So if it had been reversed  
11 and the majority were in the lower  
12 insufficient then what would that mean?

13 DR. BURSTIN: This is -- given how  
14 close it is we would probably still ask the  
15 committee to just finish the review. But  
16 technically this is a must-pass criterion and  
17 we try to respect that. Given that it's so  
18 close I think we just need to let it ride and  
19 finish it up. But it is a real concern.  
20 Unfortunately for some of the tough measures  
21 we see a fair amount of this. So let's just  
22 keep going.

1 DR. PENSON: So next we'll go  
2 through feasibility. And this is a number of  
3 different points.

4 As you can see in the discussion  
5 points here, it's really about the data being  
6 available, retrievable without burden,  
7 inaccuracies and can it be implemented for  
8 performance measurement. And because it's CMS  
9 data looking at the responses it was  
10 relatively well received there.

11 So Carolyn, you were the commenter  
12 on this.

13 MS. PARE: Yes, and first I'd like  
14 to thank staff for giving me this particular  
15 criteria because in comparison to everything  
16 else it's pretty straightforward and non-  
17 controversial.

18 I also think David pretty much  
19 covered the endpoint here in that basically  
20 everybody agrees that this is feasible. The  
21 data is being collected, it's available. I  
22 think the only concerns that I read and to do

1 a quick synopsis to save us some time is  
2 really the usual data issues of how clean is  
3 the data and how closely is the administrative  
4 claims data connected to clinical processes.  
5 Beyond that there's not a whole lot of input  
6 relative to this not being feasible because  
7 it's data that's already electronically  
8 available and collected.

9 DR. PENSON: Other comments from  
10 the room? I figured this one would be  
11 relatively easy. So I think on that if there  
12 are no other comments this one I think we can  
13 go to a vote fairly quickly. So Evan, go  
14 ahead.

15 MR. WILLIAMSON: We will now vote  
16 on feasibility. You will have 60 seconds.  
17 Please begin now. We have 23 high, 1  
18 moderate, zero low and zero insufficient.

19 DR. PENSON: So the last piece is  
20 overall usability and use. And so this has  
21 got four pieces to it, accountability and  
22 transparency improvement, unintended



1 consequences and measure deconstruction. And  
2 I want to just, again for the sake of time,  
3 not to be rude that we have covered a lot of  
4 this already. So -- well no, we don't have to  
5 vote. We shouldn't go that quick. I'm not  
6 that hardcore, Joe, okay? Because I do think  
7 it's important to just sort of cover the  
8 landscape here. But I do want to remind  
9 people that we have talked a lot about the  
10 unintended consequences. And this is the  
11 place to reflect it in your vote but I think  
12 we remember what was said earlier. So with  
13 that in mind, Joe and Dolores, you were the  
14 two reviewers for this.

15 MS. YANAGIHARA: I will start out  
16 very briefly because like you said I think  
17 most of this has been covered. And then Joe  
18 will give -- I'll give more of the conceptual  
19 and Joe will give more of the real life kind  
20 of picture maybe.

21 So the first one on accountability  
22 and transparency. As the pre-vote shows this

1 is being used already so basically it meets  
2 that criteria, it's already in use for public  
3 reporting and will be in use for payment  
4 purposes.

5 Improvement. I think that most of  
6 the comments were it's a little too early to  
7 know whether it can really drive improvement  
8 and is there sufficient detail given to the  
9 hospitals to allow them to use it for  
10 improvement. I think that we've heard more  
11 today about the types of reports that are  
12 available and so it seems like there is a lot  
13 of detail that's given to the hospitals to be  
14 used.

15 That vote was a little bit more  
16 toward the medium/low than the high side, that  
17 is the pre-vote, but that may change based on  
18 the additional information today.

19 We've talked a lot about  
20 unintended consequences. I think it bothered  
21 people that it really wasn't addressed in the  
22 submission itself. Because people as we've

1 talked today have identified several  
2 unintended consequences that are possible.  
3 And the pre-vote reflects that.

4 In terms of measure deconstruction  
5 it seems like the comments were mostly around,  
6 more around consumers and could consumers  
7 really deconstruct the measure and understand  
8 it. And I think at this point probably not  
9 because the amount of information -- well, I  
10 shouldn't say that. The amount of information  
11 that's available on the website is clearly at  
12 a high level.

13 But if you are able to get the  
14 data to the extent a consumer would be able to  
15 download and understand and use the data  
16 apparently more data are available. But I  
17 think that's still a question in people's  
18 minds. So overall it's more toward the high  
19 and medium level in the pre-vote although  
20 there were definitely some concerns as we've  
21 talked about today.

22 DR. PENSON: Joe?

1 DR. STEPHANSKY: As you can  
2 imagine I have a few issues with usability.  
3 But first I might add based on a paper that I  
4 think Helen sent some of us by the American  
5 Association of Presidents of Statistical  
6 Societies, a very riveting paper which  
7 essentially -- the Hospital Compare is  
8 probably not the right name to use, maybe  
9 Hospital Obfuscation and so on. Because  
10 consumers aren't going to get anything out of  
11 a lot of these measures, not just this one.  
12 That particular paper had to do with  
13 readmissions more than with costs.

14 But the real question is are  
15 hospitals going to have the data they need to  
16 know who to talk to in the provider community  
17 and be able to assess the performance of some  
18 of these other providers. They may be able to  
19 reconstruct the number that is on Hospital  
20 Compare based on the data that you give them  
21 but in general they're going to need even more  
22 detailed data yet. We really need right down

1 to the patient level claim data, not just any  
2 aggregation of that.

3 But there's an unintended  
4 consequence there as well. Even if we had  
5 that data how many hospitals really have the  
6 analytic capacity to do anything with it? The  
7 pool of analytic talent, the big data guys,  
8 it's a very thin pool. So if we're assuming  
9 that hospitals are supposed to be able to use  
10 patient-level data to say regroup the patient-  
11 level data into episodes where they can look  
12 at care and particular clinical areas and  
13 determine where the high costs are and the  
14 high-cost post-acute care providers we're  
15 going to be making choices among hospitals  
16 who's going to survive and who's not. And I  
17 do think you need to think about that.

18 I think CMS and whoever they  
19 contract with needs to be ready to work with  
20 hospitals to actually interpret the data, not  
21 just set it out there and let them reconstruct  
22 the 1.08 or whatever score they earned. I

1 hope that makes some sense.

2 Our experience with the Blue Cross  
3 Blue Shield data is that just looking at the  
4 total cost by those cost buckets, SNFs or home  
5 healthcare and so on doesn't tell you very  
6 much because many of those post-acute care  
7 costs in that 30 days were actually related to  
8 other conditions that the patient had, not to  
9 that actual hospitalization.

10 We've been recombining the data  
11 into defined episodes to focus in on where the  
12 actual variation is happening within a  
13 clinical service line. And we're having much  
14 more success in identifying where we can cut  
15 costs and maintain quality.

16 DR. PENSON: Great. So I'm seeing  
17 names up. So Jennifer, you have a comment.  
18 Oh, I'm sorry. Yes, go ahead.

19 MR. ZAIDI: Yes, I just wanted to  
20 say that we do have an episode-level file. So  
21 it's not at the claim level. So every line is  
22 an episode.

1                   And the cost buckets right now are  
2                   the seven buckets that I mentioned earlier.  
3                   So there are -- it's not going to tell you  
4                   whether it's an X-ray or a CT scan. It'll say  
5                   physician professional fees, or SNFs, or home  
6                   health. And it will tell you the top five  
7                   providers for each of those categories for  
8                   each episode. So generally you'll know every  
9                   SNF that treated that patient in that episode,  
10                  or every home health agency that treated that  
11                  patient.

12                  So that information is available  
13                  and we would be happy to -- it's an iterative  
14                  process. So as we receive feedback from  
15                  hospitals we have the ability to change those  
16                  hospital-specific reports and the structure of  
17                  that data. But that data is being made  
18                  available to hospitals.

19                  DR. STEPHANSKY: That makes a lot  
20                  of difference because that was not described  
21                  in the initial documentation as to what detail  
22                  level the hospitals would have.

1 DR. PENSON: Great, thank you.

2 That's helpful. So Jennifer?

3 MS. EAMES-HUFF: I just want to  
4 speak to the usability, to the consumer  
5 perspective in using this. And I would agree  
6 with what people say in terms of what gets  
7 posted on Hospital Compare has a relative  
8 limited usability to consumers without  
9 providing a lot more context.

10 I think the value of what's going  
11 out there is the downloadable files that you  
12 put on your website where many regional  
13 collaboratives and other organizations take  
14 that data and then report it in a way that is  
15 more meaningful to consumers. So I think  
16 there is ways that we can report this better.

17 And I don't have the expectation  
18 for CMS to do that. I've given up hope on  
19 that. That's my bias. But I do think there  
20 are others out there that can do it.

21 DR. PENSON: Brent?

22 DR. ASPLIN: Just a quick



1 question. And this is really in 4d, delta.  
2 You go from a ratio to an amount and then back  
3 to a ratio. And I just want to make sure that  
4 I understand the reason we're jumping back and  
5 forth there. Is that because the observed  
6 expected is based on the 25 different  
7 regressions you're doing and the various MDCs.  
8 And the amount allows you to adjust for the  
9 case mix of occurrences in the various  
10 different major diagnostic categories. Or am  
11 I off on that? I mean I'm just trying to  
12 understand why we've got to go from a ratio to  
13 an amount and back to a ratio.

14 MR. ZAIDI: So the amount is just  
15 the ratio, the observed to expected, just  
16 expressed as a dollar amount. So it's  
17 observed to expected multiplied by a national  
18 average. So you have some sense of what range  
19 of cost we're talking about.

20 So if your observed to expected  
21 ratio is 1.05 you just take that and multiply  
22 it by the national average. So that's the

1 amount.

2 And then the final measure is just  
3 dividing that amount by the median so that  
4 people have a sense of where the hospital  
5 ranks relative to the median. Does that?

6 DR. ASPLIN: Where do you go --  
7 where do you -- because you're doing all the  
8 different, 25 different regressions, correct?  
9 So where do you adjust for the different case  
10 mix of cases in that to get to the single? Is  
11 that right as you go to the amount or where?

12 MR. ZAIDI: So, after the  
13 regressions are run you have all the episodes  
14 for the hospital. And you'll have a predicted  
15 amount and an actual amount.

16 DR. ASPLIN: So it's in that  
17 observed to expected.

18 MR. ZAIDI: Yes.

19 DR. PENSON: Dolores?

20 MS. YANAGIHARA: I just wanted to  
21 offer kind of a contrary view and maybe a  
22 little bit controversial view. But about how

1 much data the measurer should be expected to  
2 provide. It doesn't need to be all of the  
3 data that the people being provided need to be  
4 able to improve.

5 Because leading a statewide  
6 coalition in California that's voluntary and  
7 collaborative there's varying views from  
8 different stakeholders about how much data  
9 really need to be provided by the program  
10 versus that the groups or the entities being  
11 measured need to just be able to drill in and  
12 figure out on their own.

13 And so I think -- I don't want us  
14 to get down path of if not every detail needed  
15 by every hospital to be able to figure out  
16 exactly what to do to improve this is provided  
17 then it's not still a valuable measure. So I  
18 think that that's just something to keep in  
19 mind that where the responsibility lies to  
20 really understand the actual improvement.

21 Yes, it needs to point you toward  
22 where you may be an outlier and where you may

1 need to focus and where you may need to drill,  
2 but in terms of actually getting the member-  
3 level every detail that may or may not be  
4 needed. So that's just a --

5 DR. PENSON: Thanks. David, do  
6 you have a comment? No. Oh yes. No. Bill.

7 DR. WEINTRAUB: I want to speak a  
8 little bit about what we just heard on the  
9 last comment and also from Joe about how  
10 hospitals are going to respond, what are the  
11 unintended consequences, what's likely to  
12 happen.

13 So this is a classic big data  
14 problem. If you want to integrate everything  
15 that involves care in your hospital and  
16 outside your hospital and you want -- from a  
17 quality point of view and from a cost point of  
18 view to integrate those and understand them,  
19 understand how you're going to improve you  
20 need to be able to bring in all these data  
21 streams and analyze them. And Joe is right  
22 that in general hospitals do not have the

1 analytic capacity to handle this.

2           So what's going to happen? Either  
3 I think we're going to see that with things  
4 like this and many other forces in our society  
5 are driving us towards consolidation so we're  
6 going to have very large systems, the Kaisers  
7 of the world which have tremendous analytic  
8 capability and will be able to deal with  
9 things like this.

10           Kaiser's interesting because  
11 that's completely different in their payment  
12 model. But you see what I mean, a very large  
13 system with tremendous analytic capability.  
14 And I think we're seeing those just beginning  
15 to emerge.

16           How can hospitals respond? And  
17 it's true you don't have to have all of this,  
18 all of the data capabilities to respond a  
19 little bit. But to fully respond to the  
20 forces in our society will ultimately require  
21 those kind of data capabilities. As I often  
22 say the healthcare systems that are going to

1 thrive are the ones that can handle their  
2 information. I've never heard anybody  
3 disagree with that.

4 DR. PENSON: Thank you. Joe?

5 DR. STEPHANSKY: Just one more  
6 piece related to that in terms of what  
7 information I need. Because I need to know  
8 who to talk to in my community if I don't own  
9 them or otherwise control them in a way to  
10 affect their behavior. Let's say the SNFs.  
11 You may tell me who the top five SNFs are that  
12 I'm discharging to but what I need to know is  
13 which of those SNFs on the Medicare side  
14 always use up the full Medicare days and which  
15 ones are only holding those patients as long  
16 as they need to be there and discharge them  
17 from a SNF.

18 Unless I know that I don't know  
19 which ones to talk to and which ones to try  
20 and partner informally with. It's key that I  
21 know the actual provider.

22 I'm going to go back to the Blue

1 Cross Blue Shield piece again where the  
2 information being shared between the physician  
3 groups and the hospitals, I know as a hospital  
4 which physician groups at Blue Cross Blue  
5 Shield are sending their patients to me. And  
6 I know what kind of costs are happening  
7 afterwards. I know which providers in the  
8 community to try and partner with. And that's  
9 going to be a key here, not just a list. I  
10 need to know the costs too.

11 MS. SPALDING BUSH: I think that's  
12 a good point and it's well taken. I think  
13 what you can see at the episode level is the  
14 SNF cost for each episode. So every discharge  
15 that creates an episode you can see the SNF  
16 cost and you can see the top five SNF  
17 providers that treated during that episode.  
18 So if your beneficiary went to more than one  
19 SNF you may have two in there. You would have  
20 a pretty good sense I think if you looked at  
21 what were your really high-cost episodes and  
22 who were the SNF providers that treated them

1 during that episode. Is that getting at?

2 DR. STEPHANSKY: The actual  
3 providers, not just a dollar amount.

4 MS. SPALDING BUSH: Right.  
5 Correct.

6 DR. STEPHANSKY: Okay, well that's  
7 more detail than I thought was in there. We  
8 shall see.

9 DR. PENSON: Great. David  
10 Redfearn, then David Gifford.

11 DR. REDFEARN: Just a question  
12 maybe for NQF. We're talking about usability.  
13 Usability to who? And there's two we've  
14 talked about. One is members and the other is  
15 hospitals.

16 My conclusion is it's not very  
17 usable for members. It's potentially usable  
18 for hospitals. So are we evaluating both  
19 types of usability? And if we are, how are  
20 they weighted in our minds in terms of making  
21 the decision about overall usability?

22 MS. WILBON: So actually probably



1 both. The way that we phrase it here is that  
2 the measure can be deconstructed for those  
3 being measured and potentially also for those  
4 using the measure. So you can drop in those  
5 buckets whoever that may be. So it may be  
6 those using the measures, it may be purchasers  
7 and consumers.

8           Those being measured obviously  
9 would be, for this particular measure would be  
10 the providers, or there may be other -- the  
11 providers as in hospitals or physicians. You  
12 could maybe put them both in that bucket. But  
13 again I think this is another one where each  
14 of you are going to have to weigh, you know,  
15 how important those things are depending on  
16 the perspective and how usable you think it is  
17 or transparent you think it is for those  
18 particular groups. So it's a value choice I  
19 think for each of you again.

20           DR. BURSTIN: Although just one  
21 comment on that is that usually the measure  
22 developer has to indicate the intended

1 audiences. So the way we have our usability  
2 criterion clearly says what's the extent to  
3 which potential audiences are using or could  
4 use performance results for both  
5 accountability and performance improvement.  
6 So some of that really comes back to who is  
7 the intended audience.

8 And it's both -- especially for  
9 new measures. It's not are they using it  
10 because we can't actually say that, but it's  
11 also could use that information for both --  
12 yes, for accountability and improvement.

13 DR. PENSON: David?

14 DR. GIFFORD: I'd just say that I  
15 mean every measure I've seen in every setting,  
16 whether it's a quality measure or this has  
17 unintended consequences with it. And each one  
18 of them is possibly gamed. And I think it has  
19 to balance it in the end.

20 But I think what we're hearing and  
21 Dave sort of said it, this would be useful --  
22 this will force hospitals to look at what's

1 underneath the covers and what goes into this  
2 and begin to look at it. It may not be -- all  
3 be robust as Kaiser or someone else but they  
4 will begin to look at this.

5 And actually transferring back and  
6 forth while it could happen it's kind of hard.  
7 If you're balancing with other measures which  
8 we've all said has to be there I think we get  
9 there. So I think -- I find this measure in  
10 the sort of cornucopia of measures that are  
11 out there incredibly useful and usable and has  
12 no worse unintended consequences than any  
13 other measure that's out there.

14 DR. PENSON: Martin?

15 DR. MARCINIAK: So in just  
16 listening to some of the conversation, you  
17 know, we've touched on a number of different  
18 topics. The thing that just comes out to me  
19 and I'd be curious to hear from the measure  
20 developers is along the lines of the question  
21 of interpretation one of the things that  
22 struck me when we were starting to click

1 people off in terms of that high cost/low cost  
2 is really trying to understand what's driving  
3 those costs and actually driving the cost  
4 throughout the system of patients who are  
5 going through this in the hospitals.

6 One point we had made was the fact  
7 when these are put on web tools people see it,  
8 may see it out of context. Is there the  
9 opportunity to help people understand where  
10 the drivers of the cost are within the measure  
11 as we see it today and can that actually be  
12 reported out?

13 MS. SPALDING BUSH: So I think if  
14 I'm understanding the question it's about that  
15 -- so on Hospital Compare we only display the  
16 one number, that's the ratio. And that  
17 website is designed to sort of be a simple,  
18 understandable website for consumers to  
19 access. So we were kind of limited in what we  
20 could actually display there.

21 That's where you would find the  
22 link though to the -- you'd have to be

1 computer savvy and click on a link and go  
2 there. But you can find a link to the  
3 spending breakdown by claim type that has each  
4 provider's spending amount broken down and  
5 compared to that provider's state and to the  
6 nation. So that information is there and  
7 accessible within two clicks maybe.

8 And I think if there were other  
9 useful files we could do something similar,  
10 link from there to a data.gov site in the  
11 future. But that's all that's linked there  
12 now.

13 DR. PENSON: Terrific. So I think  
14 at this point I don't see any new flags up.  
15 David, I think -- you don't have a comment, do  
16 you? That was from before. Okay, just want  
17 to make sure everyone's heard.

18 So I think then the next thing to  
19 do is to vote on the usability and use. And  
20 then go onto a final discussion. So Evan?

21 MR. WILLIAMSON: At this time we  
22 will vote on usability and use. You will have

1 60 seconds. Begin now. And we have 6 high,  
2 15 moderate, 3 low and 1 insufficient.

3 DR. PENSON: Okay. So we're  
4 getting towards the end with this one. We're  
5 getting to the point where we're going to sort  
6 of take an overall vote on NQF criteria for  
7 endorsement and whether or not it -- does the  
8 measure meet those criteria.

9 I think we'll start with any  
10 remaining discussion in the room and then I  
11 think one last shot at public comment. So  
12 I'll open the floor to parting blows as it  
13 were to this one. Dr. Gifford.

14 DR. GIFFORD: Having just reviewed  
15 two manuscripts in the last week I feel like  
16 the same recommendation to the editor. I  
17 really like the topic of the article. They're  
18 really addressing an important issue. I think  
19 it needs to be out there. I really encourage  
20 them to make some revisions and resubmit. But  
21 it needs some submissions. But they  
22 definitely should resubmit and it needs an

1 editorial. That's kind of where I'm leaning.

2 But I'm really worried that, you  
3 know, sometimes when you do that waiting for  
4 perfect can be the enemy of the good. So I'm  
5 actually kind of looking forward to a broader  
6 discussion of the group. Because I'm sitting  
7 on the fence as to which way I should vote on  
8 this. Because I think there's a lot of really  
9 good things about this measure but I think we  
10 also identified a lot of opportunities for  
11 improvement.

12 And if they took them back and  
13 came back with some of those I think this  
14 would be a very powerful measure and go  
15 through very quickly. But the question is do  
16 we let it go as is or not. And I will be  
17 swayed by the discussion.

18 DR. PENSON: So I want to  
19 influence the discussion a little bit not  
20 necessarily for the sake of time but for the  
21 actual process. I think depending on what the  
22 final vote is here I think the measure

1 developers have heard many of the concerns.  
2 So I think we have to vote on what we have in  
3 front of us. We know how it can be better but  
4 the question is is it good enough.

5 And I think even if it's good  
6 enough I'm sure that the measure developers  
7 will consider if it were approved as it were  
8 used, you know, tweaking it even further. But  
9 the bottom line is as it's in front of us  
10 we're going to have to make a decision. So I  
11 just want to stress that to folks. I think  
12 David's point is very important, very well  
13 taken. The key is as it is now is it good for  
14 go.

15 So we'll just go around the table.  
16 Bill?

17 DR. WEINTRAUB: So is it good  
18 enough. Probably yes, but just barely. And  
19 where does the concern lie?

20 So it's important, it did well on  
21 reliability, it did pretty well on usability.  
22 But really the concern seems to be in



1 validity. That is are we measuring what we  
2 think we're measuring. And we just barely had  
3 more people in moderate than in low.

4 I'll say publicly I voted for  
5 moderate but I'm concerned about so many  
6 people voting low and passing the measure.  
7 Where this is really critical is it measuring  
8 what we think it's measuring?

9 DR. WALKER: I echo what David and  
10 Bill just said. But I'm actually -- so I had  
11 -- my concerns were around the validity. And  
12 initially I had in the preliminary assessment  
13 ranked it low. But I was persuaded by some of  
14 the discussion at this table and had voted  
15 moderate after hearing the discussion.

16 And I'm on the fence of how to  
17 vote on this for the overall measure. And I'm  
18 looking to the technical experts at this table  
19 to help me connect the dots.

20 And so my question is one of the  
21 issues around the validity seemed to be that  
22 there was very little correlation between some

1 of the indicators of disparities and that  
2 seemed to raise some concerns. And there was  
3 very little variation in sort of the  
4 performance measure. And so there was a  
5 question of how -- are we over-controlling.

6 But our developers had I thought  
7 provided a very compelling, persuasive  
8 explanation of why you wouldn't expect to see  
9 some of that correlation, or a low level of  
10 correlation with these indicators of  
11 disparities.

12 And in fact when you gave us the  
13 data point on what the variation was between  
14 the top and the bottom quintiles without the  
15 risk adjustment it was huge. So it seems like  
16 the risk adjustment is absorbing a lot of the  
17 variation in the inpatient setting.

18 And then as Jack was saying most  
19 of the variation seems to be picking up all  
20 the post-acute care cost. So of course we're  
21 not going to see those correlations given  
22 what's happening.

1                   So my question then is is it still  
2                   a concern from the validity perspective that  
3                   we're not seeing the types of correlation in  
4                   health disparities as we would have expected.  
5                   I mean, perhaps they're over-controlling for  
6                   differences in -- perhaps their control is  
7                   picking up some of the differences in  
8                   socioeconomic status and maybe the dual  
9                   status. But some of us had recommended or  
10                  would prefer that we see controls for SES.

11                  So I don't know how to evaluate it  
12                  and I'm looking to our more technically savvy  
13                  colleagues to maybe help me connect the dots  
14                  a little bit. I mean is it still a concern?

15                  DR. PENSON: Maybe some of the  
16                  other comments will answer that for you I  
17                  hope. Andrew?

18                  DR. RYAN: The comment or question  
19                  I have is what exactly are we voting for here.  
20                  Because does CMS have to implement this  
21                  measure kind of as specified now, or could  
22                  they make some -- we approve this measure but

1 then there's some tweaks along the edges.  
2 Because I've seen, for instance, for the  
3 mortality and readmission measures that were  
4 once approved by NQF the risk adjustment has  
5 kind of been tweaked over time. And so these  
6 measures are in some way alive. And it seems  
7 to me that there is an ability for CMS even,  
8 you know, we approve it but they could still  
9 have a continuous improvement process. So I  
10 just wanted to get a sense of what happens and  
11 what it means to actually approve.

12 DR. BURSTIN: That's a great  
13 question. So in general there are sort of  
14 minor tweaks done along the edges. AHRQ and  
15 CMS know this, coding and things like that  
16 that don't rise to the level of being material  
17 or significant changes that they can just do.  
18 We see those on annual updates.

19 When there's a material change  
20 that actually affects the measure or the  
21 measure results we actually will do what's  
22 called an ad hoc review which we just did to

1 update the planned readmission model for the  
2 readmission measure. So it's true, the  
3 measures are alive, they can be modified, they  
4 can be changed, improved over time. And if  
5 there's significant enough changes they can  
6 come rapidly back through NQF for re-approval.

7 DR. RYAN: For instance, changing  
8 how transfers are treated, would that rise to  
9 the level of a subsequent ad hoc review?

10 DR. BURSTIN: Yes. And the only  
11 question is, and I don't know what the degrees  
12 of freedom are for CMS to actually potentially  
13 even, you know, depending on how this all  
14 goes, I don't know if they have an appetite to  
15 potentially even make some of those minor  
16 modifications during this process. But that's  
17 a bigger issue.

18 DR. PENSON: David?

19 DR. GIFFORD: I've chaired a  
20 couple of these and we voted a few down to  
21 CMS. And it's ranged anywhere from we never  
22 see it again to it comes back really fast from

1 CMS. I'm actually on two CMS TEPs that are  
2 reviewing measures that were voted down by NQF  
3 to try to get them back through. So you can  
4 see it back.

5 And then also they are tweaking it  
6 so they'll put TEPs together and it just  
7 depends on what it is. Sometimes they'll --  
8 if they're under pressure from Congress  
9 they'll put this out and then bring it back  
10 because they still want to get NQF endorsement  
11 but they have to meet a congressional mandate  
12 so it doesn't really matter what NQF says. So  
13 it could be all over the map.

14 But again we're also not approving  
15 this just for CMS. We're approving it for  
16 anyone else out there. I mean, there's no  
17 reason that United couldn't go and calculate  
18 this on all the hospitals out there. This is  
19 all claims data, it's out there. It's no  
20 reason that a state couldn't figure out how to  
21 do this with claims data and measure it. So  
22 we're measuring a measure that's going to be

1 able to be used out there for all sorts of  
2 reporting processes.

3 DR. PENSON: You know, I think you  
4 know again the concept is as the measure  
5 stands now. As you see it in front of you can  
6 you live with it. If the answer is it's not  
7 perfect but I can live with it and I hope CMS  
8 makes improvements I'm going to have some  
9 faith in CMS and say you all will do that.

10 If you look at it and you say this  
11 is just not ready for prime time right now  
12 then I think you have to vote it as it is now  
13 with the understanding that if it's imperfect  
14 I think they've heard what people are saying  
15 and they'll continue to tweak it. Jennifer?

16 MS. EAMES-HUFF: I would say I  
17 don't think it's perfect but I think it's  
18 worthy of enough to pass a vote.

19 I think one of the things that I'd  
20 consider even though it does need some  
21 tweaking in looking at it is how they're  
22 planning on using it and what the impact will

1 that be.

2 And so they've indicated it's  
3 going to go in the IQR program which is not a  
4 performance program. That's a reporting  
5 program. So hospitals will not be getting  
6 their payment adjustment based on the actual  
7 performance scores. It's just are they doing  
8 -- is it being measured. And of course it's  
9 CMS using the claims data so it will be  
10 measured.

11 And then when it moves into the  
12 Hospital Value-based Purchasing Program they  
13 have three composites and the third composite  
14 is the cost composite which makes up 20  
15 percent of the total score. So again I think  
16 -- when I look at this I think there's a  
17 concern around the financial impact and the  
18 potential unintended consequences that could  
19 come from it. It seems like that that is less  
20 than the impact of the attention that this  
21 will draw and the focus this will put on  
22 improving an area where we don't have a lot of



1       measures.

2                   DR. PENSON: Great, thank you.  
3       Larry?

4                   MR. BECKER: Thank you. So I'm  
5       going to state what I think I've heard and  
6       what conclusions I draw from that.

7                   So I'm sorry, I don't remember  
8       your name but at the beginning I think you  
9       stated that the law calls for the development  
10      of this measure, if that's accurate. We are  
11      at an inflection point because it seems to me  
12      based on what I've heard is that we could turn  
13      this down but CMS is going to have this  
14      measure.

15                  And so I think we're incredibly  
16      privileged to be able to have this amazing  
17      group of people together to comment, to give  
18      constructive feedback around this measure to  
19      make it better. But I think if we turn our  
20      back on this measure it could be, and somebody  
21      correct me if I'm wrong, but it could be that  
22      CMS is just going to go ahead with what it

1 wants to do without us. And what does that  
2 portend for the future?

3 DR. PENSON: Well, no, I mean it's  
4 out there but the question is, and I think the  
5 comment that David made is important. With  
6 NQF endorsement you'll see potentially uptake  
7 by private payers. And certainly there's a  
8 sort of imprimatur that comes with that  
9 endorsement. So even if by law it's going to  
10 be used by CMS I think there's something to  
11 getting the NQF endorsement that will make it  
12 more widely accepted.

13 So I don't think that people  
14 should vote yes just because the law says it's  
15 going to happen. I think you vote yes if you  
16 believe it's adequate. If that's fair.

17 Lisa? Okay, any public comment  
18 from the back of the room or on the phone?  
19 There's more in the room, I'm sorry. Who  
20 else? Hi Nancy, sorry.

21 DR. GARRETT: So I think for me  
22 what I'm really thinking about right now is

1 that validity part. And to see such a split  
2 vote on validity which is a pass or fail  
3 criterion for the whole deal, that's a real  
4 concern. And so I feel like I have to  
5 separate the uses of this and the fact that  
6 it's written into statute and all of that.  
7 And it's really about the measure before us.  
8 And those validity concerns I think are really  
9 big. And so that's a real issue I think we  
10 all have to think about as we make our  
11 decision.

12 DR. PENSON: Other comments in the  
13 room? Bill?

14 DR. WEINTRAUB: There may also be  
15 variation in how CMS uses this with and  
16 without endorsement. They're going to be far  
17 more inclined to use it for Value-based  
18 Purchasing, for instance, with endorsement  
19 than without one would think. No? Important  
20 point.

21 DR. PENSON: Tom?

22 DR. TSANG: So I have a question

1 to CMS and to the measure developer actually  
2 about the lag time of the data. Historically  
3 the claims data has always been at least, I  
4 don't know, having worked with CMS in my past  
5 life historically it's always been a question  
6 of a year to a 2-year delay in terms of  
7 getting some of the claims data back to some  
8 of the provider organizations and some of the  
9 quality organizations. So I'm wondering is  
10 this also the case for this measure in that if  
11 it's going to be a year to a year and a half  
12 to a 2-year delay or a lag, let's not call it  
13 a delay, then number one, how useful is this  
14 information giving feedback back to the  
15 hospitals if it's not within a relatively  
16 timely fashion?

17 MR. ZAIDI: So I think things have  
18 improved recently in terms of the claims  
19 delay. So for the period of performance for  
20 2012 we plan to post those numbers in October  
21 of this year on the Hospital Compare website.  
22 So that's about a 10-month delay.

1                   As far as the payment adjustment  
2                   for Value-based Purchasing that score is based  
3                   on two periods of performance, a baseline and  
4                   then a performance period in order to measure  
5                   improvement and achievement. So there is a  
6                   delay in the translation of your score into  
7                   your payment, but the information itself is  
8                   visible within a year.

9                   DR. PENSON: Great. Dolores?

10                  MS. YANAGIHARA: Sorry, not to  
11                  drag this on but a question about endorsement.  
12                  So if this is endorsed would it be endorsed  
13                  for all populations or only senior  
14                  populations? Because I think the risk  
15                  adjustment methodology has been calibrated to  
16                  the senior population. So I'm just a little  
17                  concerned.

18                  I've been ruminating on what David  
19                  said about it's out there and commercial  
20                  payers will start using it. I'm like, hmm.  
21                  So I just want to make sure what we would be  
22                  endorsing, for senior population or any

1 population?

2 DR. BURSTIN: Currently it would  
3 be endorsed for whatever the population that  
4 it's been tested and assessed on.

5 As an example though in the past  
6 CMS has previously brought us some of the  
7 mortality measures just on 65 up. We had  
8 asked them to try to make that a broader  
9 population. They had to go back and reassess  
10 the risk adjustment methodology and see if in  
11 fact it works for those under 65. So this is  
12 actually just 65 and over but it does  
13 potentially give an opening to think about how  
14 those data could be adjusted to make it work  
15 for the broader population as well.

16 DR. PENSON: Great. Other  
17 comments in the room? Okay. Public comment  
18 either behind me or on the phone? We have a  
19 comment.

20 MS. WHEATLEY: Hi, Mary Wheatley  
21 from the Association of American Medical  
22 Colleges.

1                   And I just wanted to thank  
2                   everyone for the discussion today. It was a  
3                   really thoughtful discussion about all the  
4                   issues related to this measure. And as it  
5                   comes out this is a really complex, all this  
6                   resource measurement is very complex and how  
7                   it gets implemented is very complex.

8                   I would just like to say something  
9                   about how the data can be used. And I think  
10                  a general question for the group here is what  
11                  is improvement in this measure. And maybe  
12                  this goes into a MAP discussion down the road  
13                  is how do you monitor improvement.

14                 Because although we got new data I  
15                 think a lot of hospitals are trying to figure  
16                 out how to use that data. I think it might  
17                 help in a few cases identify extreme outliers  
18                 and ways you might partner in a few cases to  
19                 reduce some of the costs.

20                 But is it enough information for  
21                 someone to easily go from a 1 to a 0.99. And  
22                 what does that mean? I think people are

1 really struggling with how do you implement  
2 this, how do you take this information you  
3 have into something I can implement into an  
4 operational piece. So I just wanted to make  
5 sure that piece was out there.

6 And again, the whole question of  
7 the scoring. I think that is also something  
8 that would be a good thing to bring up in a  
9 MAP conversation outside of the scope of this  
10 measure. But there are many ways that this  
11 measure gets pulled throughout the whole  
12 process. Thank you.

13 MS. CHAMBERS: Hi, I'm Jayne Hart  
14 Chambers with the Federation of American  
15 Hospitals. And I could just say ditto.

16 But I thank you for your robust  
17 discussion this morning. It was very  
18 interesting. I think our members are a little  
19 troubled by some of the discussion around  
20 reliability and validity of the test data.  
21 We've had some of those discussions  
22 internally.



1           I will say in terms of usability  
2           it's difficult to take the information and be  
3           able to parse it in a way -- even if it's only  
4           year-old data to be able to parse it in a way  
5           that can help us figure out what our  
6           relationships are with a number of the post-  
7           acute providers that our patients would go to.

8           And there is that element of  
9           patient choice where they choose where they  
10          want to go and how they use that. So we are  
11          concerned about the usability of the measure.

12          And I very much echo what Mary  
13          said in terms of how it's being used in Value-  
14          based Purchasing and how you can drive  
15          improvement with it. Where you see a lot of  
16          compression with the scores and how do you get  
17          from 0.99 to 0.98 or whatever it is that you  
18          need to be driving down to when you get to  
19          that level where you have an achievement score  
20          and an improvement score and you want to be  
21          able to earn points on them. So thank you.

22          DR. PENSON: Thank you very much

1 for the comments in the room. Any comments on  
2 the phone?

3 OPERATOR: To ask a comment at  
4 this time or make a question please press \*1.  
5 There are no comments or questions at this  
6 time.

7 DR. PENSON: Okay, so I think  
8 we're at the point now where we make a final  
9 recommendation. This is a simple yes/no vote.  
10 So Evan?

11 MR. WILLIAMSON: At this time we  
12 will vote on the overall suitability for  
13 endorsement. You will have 60 seconds.  
14 Please begin now. We have 15 yes and 10 no.

15 DR. PENSON: Okay. So Gene, I  
16 think it's your turn now but probably people  
17 need a break. Is that a fair statement? I  
18 kind of figured that. Me too. How long do  
19 you want to take? Dr. Nelson, when do you  
20 want to start?

21 (Whereupon, the foregoing matter  
22 went off the record at 2:30 p.m. and went back

1 on the record at 2:48 p.m.)

2 DR. NELSON: Okay, well I'd like  
3 to congratulate you for getting through the  
4 first measure. And it was a really good  
5 discussion. And I think you all did a great  
6 job. And I don't know if you knew this but  
7 David was on a redeye flight and so he's been  
8 up pretty much all night and did just a great  
9 job of facilitating this. And stayed awake  
10 the whole time. So thank you, David.

11 DR. PENSON: So now I'll be  
12 snoring for the second measure.

13 (Laughter)

14 DR. NELSON: You did well. Well,  
15 our second measure then is number 2165,  
16 Payment Standardized Total Per Capita Cost  
17 Measure for Medicare Fee-for-service. And the  
18 developers are CMS and Mathematica.

19 The measure that we just looked at  
20 was the hospital episode for Medicare  
21 beneficiaries. So that was being stretched  
22 out. And this measure of course is stretched

1 out even more. So it covers a year of time  
2 and is meant to focus on providers, on group  
3 practices specifically of a substantial size.  
4 And we'll discuss that as we proceed.

5 But similar to the prior measure  
6 it includes Medicare Part A and Part B  
7 expenditures plus some other expenditures that  
8 we'll hear about. So it's a little bit  
9 expanded in terms of the services that are  
10 covered.

11 It is price-standardized. It is  
12 risk-adjusted. And the way that the patients  
13 become associated with a group practice is  
14 through attribution. And we'll hear more  
15 about that. But essentially it's a plurality  
16 of primary care services provided by a  
17 particular group relative to other groups  
18 elsewhere.

19 And so having said a few words  
20 about the measure we should ask the measure  
21 developers to give us a brief presentation.  
22 You're over there and not here. Okay, so you

1 can introduce yourselves and get started.

2 Thank you.

3 MR. BALLOU: Good afternoon. I'm  
4 Jeff Ballou with Mathematica policy research.

5 DR. RICH: And I'm Gene Rich with  
6 Mathematica.

7 DR. ROMAN: Sheila Roman with CMS.

8 DR. KAPLAN: Frank Kaplan, CMS.

9 MR. BALLOU: So I'm pleased to  
10 introduce the Payment Standardized Total Per  
11 Capita Cost Measure for Medicare Fee-for-  
12 service Beneficiaries. This is on the next  
13 slide a per capita resource use measure and  
14 mindful of the distinction that folks make  
15 between costs, expenditures and resource use.  
16 What we're really talking about here is  
17 service utilization on a standardized basis.

18 It's a measure that is applied to  
19 Medicare fee-for-service beneficiaries  
20 attributed to medical group practices. It  
21 includes all Medicare Part A and Part B  
22 covered services during a calendar year.

1                   It does not include Part D  
2 pharmacy data. As was indicated this morning  
3 there's a significant proportion of Medicare  
4 fee-for-service beneficiaries who are not  
5 enrolled in Part D. And so including those  
6 data in this measure would unfairly  
7 disadvantage those groups who would happen to  
8 be attributed a disproportionate share of Part  
9 D enrollees.

10                   The measure was developed  
11 specifically for Medicare fee-for-service  
12 beneficiaries and the methodology has been  
13 tailored accordingly. So, for example, the  
14 payment standardization algorithm which is the  
15 same algorithm that was used in the measure  
16 discussed just previously is specific to the  
17 nuances of Medicare fee-for-service claims and  
18 payment systems. And likewise, the CMS HCC  
19 risk adjustment model which is foundational to  
20 this measure was developed, tested and  
21 calibrated on Medicare fee-for-service claims.

22                   And then finally by way of

1 overview this is the only per capita resource  
2 use measure among those either endorsed or  
3 under consideration for endorsement that is  
4 developed for and tested on this older  
5 Medicare fee-for-service population.

6 On the next slide in terms of  
7 importance and use we see the measure as a  
8 comprehensive tool that can be used to  
9 document and address variation in resource use  
10 among Medicare fee-for-service beneficiaries.  
11 It is a broadly inclusive whole patient  
12 measure that will complement additional, more  
13 targeted resource use measures.

14 It is included in confidential  
15 physician feedback reports that we provide  
16 medical group practices. And to identify  
17 drivers in resource use and variation from the  
18 national mean we report the measure not  
19 standalone but along with service-level  
20 detail, breakdowns of cost, for example,  
21 hospitalizations and the standardized risk-  
22 adjusted cost associated with those even

1 including detail on which hospitals are most  
2 frequently used by the beneficiaries  
3 attributed to the group.

4 We will soon begin -- meaning with  
5 this upcoming cycle of feedback reports that  
6 will go out later this summer -- begin also  
7 including beneficiary-level detail in the  
8 reporting tool so that providers will be able  
9 to see which beneficiaries were attributed to  
10 them and the characteristics and cost-related  
11 data of those beneficiaries.

12 In the future this will be  
13 included in the value-based modifier that will  
14 adjust physician fee schedule payments  
15 beginning in 2015 for selected medical group  
16 practices. Again here it will not be used as  
17 a standalone measure but will be combined with  
18 not only quality measures including outcome  
19 measures but other resource use measures as  
20 well to arrive at an assessment of value.

21 On the final slide I'd just like  
22 to give a high-level refresher of the



1 construction of the measure. From our target  
2 population we exclude beneficiaries for whom  
3 costs are unlikely to be adequately captured  
4 by Medicare fee-for-service claims.

5 We then attribute beneficiaries to  
6 group practices based on the plurality of  
7 evaluation and management services using codes  
8 that are commonly billed by primary care  
9 providers.

10 We then standardize attributed  
11 beneficiaries' Part A and Part B, just to be  
12 explicit here, Medicare-allowed charges. So  
13 we're standardizing Medicare payments as well  
14 as coinsurance deductibles and so on.

15 And then after handling outliers  
16 we use those standardized numbers to compute  
17 per capita observed resource use for each  
18 group. We then likewise compute or estimate  
19 per capita expected resource use as a function  
20 of beneficiary risk for each group.

21 And to clarify what might have  
22 caused some confusion in our submission we

1 used risk scores that are produced by the CMS  
2 HCC beneficiary model. And again that's  
3 foundational to what we do.

4 But then we take those risk scores  
5 and we regress our payment-standardized costs  
6 on essentially those scores to better fit the  
7 risk scores to our data. And then we use the  
8 coefficients from that model to estimate per  
9 capita expected resource use.

10 We then compute the ratio of  
11 observed to expected and express this in  
12 dollar terms much as the previous measure does  
13 by multiplying by the unadjusted national  
14 mean. And then comparing to that to the  
15 benchmark mean so that scores below the mean  
16 represent better performance.

17 Obviously this is a very quick and  
18 high-level overview. We are happy to  
19 entertain any questions of clarification as  
20 the steering committee proceeds. Thank you.

21 DR. NELSON: Thank you for that  
22 very instructive overview. Questions for the

1 measure developers? Daniel.

2 MR. WOLFSON: I would like a  
3 better explanation of attribution, whether  
4 that attribution technique has been used  
5 previously and tested. I've never seen that  
6 attribution. I've always been used to visits  
7 and not costs. So could you kind of give a  
8 history of the attribution technique and its  
9 testing and so on?

10 MR. BALLOU: Certainly. I can  
11 provide some information and my colleagues  
12 from CMS may also have information to add.

13 To the first point about counting  
14 up services, E&M visits, for example, office  
15 visits as opposed to the charges associated  
16 with those. We have tested both of those  
17 rules in a variety of settings. We find in  
18 general that attribution is very highly  
19 correlated using those two different  
20 approaches.

21 The approaches based on charges  
22 have been used in other CMS programs

1 previously including the PGP demonstration and  
2 more recently the group practice reporting  
3 option of the Physician Quality Reporting  
4 System. So attribution based on charges has  
5 been used and tested and accepted in those  
6 initiatives previously.

7 In terms of this two-step rule it  
8 is true that implementation in this measure of  
9 the two-step rule is new as of this cycle.  
10 What is meant by the two-step rule is it's  
11 meant to be a primary care-focused rule.

12 So first of all, in the first step  
13 you're looking for the plurality of primary  
14 care-related services that were billed by  
15 primary care providers. I'm sorry, primary  
16 care providers by which I mean physicians,  
17 namely those with the specialty of internal  
18 medicine, geriatric medicine, family practice  
19 or general practice. That's correct. So  
20 you're looking for -- and that's an important  
21 qualification, thank you.

22 We do, however, recognize that in

1 some cases specialists play the role of the  
2 primary care physician for some patients. And  
3 in those instances where there has been no  
4 primary care physician involvement at all we  
5 consider attribution to those specialists.  
6 And that's the second step.

7 This is a rule that has been  
8 implemented by the ACO initiative, Medicare  
9 Shared Savings Program. And the reports they  
10 currently receive which are updated on a  
11 quarterly basis use that rule.

12 DR. NELSON: And the description  
13 of services that are primary care services  
14 that get attributed would be?

15 MR. BALLOU: Actually, why don't I  
16 turn to my colleague Dr. Rich who may be in  
17 the best position to answer this.

18 DR. RICH: Sure. The specific  
19 history of the selection of those primary care  
20 services our colleagues from CMS may want to  
21 refer to. But they are largely ambulatory  
22 care or home visit or skilled nursing facility

1 visits which are -- many of which of course  
2 are done by primary care clinicians or primary  
3 care physicians.

4 So they exclude the very -- the  
5 services, the evaluation management services  
6 that might be provided in inpatient settings  
7 as well as excluding some other services, E&M  
8 services more typically provided by  
9 specialists or in some cases not covered under  
10 the Medicare fee-for-service program.

11 DR. NELSON: I'll start down the  
12 table. So, Brent.

13 DR. ASPLIN: Since we're on  
14 attribution what percentage of overall  
15 eligible beneficiaries actually end up being  
16 attributed by the method that you're  
17 proposing? What percent fall out? And of  
18 those that are attributed what percent  
19 actually are attributed based on the primary  
20 care step versus the specialty care step?

21 MR. BALLOU: Right. So I don't  
22 have the numbers exactly in front of me for

1 the first question. I recall that it's on the  
2 order of 90 percent attributed but I would  
3 have to check that.

4 Among those who are attributed,  
5 however, 85 percent are attributed in the  
6 first step and 15 percent are attributed in  
7 the second step.

8 DR. ASPLIN: That's a really high  
9 percentage of overall attributed potential  
10 beneficiaries. It's just really surprisingly  
11 high. I mean I know it's Medicare, not  
12 commercial, but I'm surprised that high of a  
13 percentage attribute which makes me have more  
14 questions about the attribution model.

15 DR. NELSON: As we go further into  
16 this discussion on all the criteria we'll get  
17 into many of these points. So why don't we  
18 take a couple of more general questions for  
19 the presenters and then we'll be able to get  
20 into the details as we move forward with the  
21 criteria. I think you were next.

22 DR. MCHUGH: So the first point in

1 the two-step process is a primary care  
2 physician claim trigger. Has there been  
3 consideration of non-physician? What happens  
4 to those beneficiaries who wouldn't be  
5 captured under that trigger but are still  
6 Medicare beneficiaries receiving primary care  
7 services by non-physicians?

8 MR. BALLOU: If they don't receive  
9 any primary care services from a physician  
10 they are not attributed under this rule.

11 DR. MCHUGH: But if they do  
12 receive care by an eligible provider who is  
13 not a physician they are excluded.

14 MR. BALLOU: Not necessarily. As  
15 long as they received some services from a  
16 physician in the group that is the candidate  
17 to which they could be attributed. It could  
18 be that most of that care is being provided by  
19 a nurse practitioner, for example.

20 DR. MCHUGH: But it has -- but the  
21 trigger is a physician.

22 MR. BALLOU: The trigger is a



1 physician in that respect, yes.

2 DR. MCHUGH: Is there a rationale  
3 for that?

4 MR. BALLOU: I think the best  
5 rationale that I could give is that this is a  
6 program that's meant to ultimately provide  
7 feedback to physicians and ultimately to grade  
8 physicians on their performance.

9 DR. MCHUGH: When you say feedback  
10 to the physicians are you talking about  
11 through the quality reporting mechanism?

12 MR. BALLOU: Feedback in terms of  
13 the reports that we give them and then  
14 ultimately they will be the ones who are  
15 judged in the value-based payment modifier.

16 DR. MCHUGH: But aren't more than  
17 physicians considered eligible professionals  
18 under that?

19 MR. BALLOU: Yes, that's correct.  
20 But they are ultimately not the ones being  
21 evaluated. The eligible professionals enter  
22 here because we're looking for groups of a

1 certain size which may include and often do  
2 include more than just physicians. But  
3 ultimately it's the physicians who are  
4 impacted in this particular programmatic  
5 context.

6 DR. MCHUGH: Would you stipulate  
7 that there's the possibility that you exclude  
8 some Medicare beneficiaries who are receiving  
9 primary care services under that attribution?

10 MR. BALLOU: Yes, I think that's  
11 true.

12 DR. MCHUGH: Okay.

13 DR. NELSON: Let's see, Cheryl?  
14 And then I think rather than keeping going  
15 we'll go into specific criteria and continue  
16 asking the specific questions.

17 DR. DAMBERG: Okay, great.  
18 Thanks. I was curious, the thinking behind  
19 using the prior year's HCC score versus  
20 something that's concurrent.

21 MR. BALLOU: There are a couple of  
22 issues here and our colleague Greg Pope from

1 RTI International I believe is also on the  
2 phone. And he is our expert having worked for  
3 many years with the CMS HCC model. So he may  
4 have a response after mine.

5 But I think the high-level  
6 thinking is that there was a concern that  
7 although concurrent models generally explain  
8 much better in large part because they're  
9 picking up a lot of the acute conditions that  
10 don't necessarily show up in the prior year.

11 There is a concern that it would  
12 be easier to confound treatment and diagnosis  
13 information in the concurrent model. There's  
14 also the problem of observational intensity  
15 bias that folks have been writing about and  
16 reading about lately that we believe is  
17 intensified by using the concurrent model.

18 I'm not sure if Greg would have  
19 anything to add to that though.

20 DR. NELSON: Okay, well thank you  
21 for those opening comments. You're going to  
22 get many questions.

1                   And our first set of criteria have  
2                   to do with importance. And we're looking at  
3                   some discussion points so our large numbers of  
4                   people, patients affected by the measure as  
5                   well as providers in this case.

6                   Does the measure demonstrate  
7                   variation in resource use or overall poor  
8                   performance? Are there patient or societal  
9                   consequences of high or low resource use? And  
10                  opportunity for improvement. Do the data  
11                  demonstrate a distribution of performance  
12                  scores?

13                  Is the number and  
14                  representativeness of the entities included in  
15                  the measure performance data? Are there data  
16                  showing disparities in the use of resources or  
17                  cost of care for certain populations? What's  
18                  the size of the population at risk and  
19                  potential consequences of the cost/resource  
20                  use problem?

21                  And criteria 1c is measure intent.  
22                  So is the intent of the resource use measure

1 clearly described. Is the construction of the  
2 resource use measure consistent with  
3 conceptual construct and the purpose of the  
4 measure? Do the resource use categories  
5 specified align with the intent of the  
6 measure? Are all of the categories captured  
7 in the measure that you would expect based on  
8 the measure intent?

9 And to get us going on this  
10 importance area we'd like to hear from  
11 Jennifer and then Carolyn.

12 MS. EAMES-HUFF: Okay. And in the  
13 interest of time Carolyn and I agreed that  
14 just one of us is going to present. So -- and  
15 also in the interest of time since the scores  
16 are pretty high on this I'm just going to keep  
17 this really quick.

18 So, overall in terms of the  
19 importance to measure and report everybody but  
20 one person gave this a high score for the high  
21 impact. In the opportunity for improvement  
22 still a significant amount scoring this high

1 but there's a little bit more variation with -  
2 - it's 16 to 4 giving it a medium and 1 giving  
3 it a low.

4 On the measure intent this is  
5 where it had the most variation in scores.  
6 And the high was 14, the medium was 5 and the  
7 low was 2.

8 In looking over the comments, at  
9 least the comments on the high impact a lot of  
10 them just said it's an important area to  
11 measure, it's a part of affordability and the  
12 Triple Aim. There's variation. So there  
13 seemed to be an overwhelming consensus on the  
14 importance of it.

15 For the other two areas there are  
16 a couple of comments that I'll just highlight.  
17 I think a lot of the comments that came in  
18 this particular area actually apply to other  
19 areas so I may just list them. But I'm not  
20 sure they're necessarily open for discussion  
21 at this point.

22 So the issue raised in opportunity

1 for improvement was the issue that this is an  
2 aggregate measure, that this is looking at  
3 total cost of care, that it's not broken down  
4 more discretely. So the question around the  
5 ability to do improvements and drive  
6 improvements was the main issue.

7 And on the measure intent the  
8 issue that was under there was around the  
9 reporting. And this is similar to what we saw  
10 in the earlier discussion of is this being  
11 reported on its own or is it going to be tied  
12 to quality measures.

13 There are a few other issues that  
14 were raised that I'm sure we'll talk about  
15 later. The issue of attribution and also  
16 again the issue of definition, of is this  
17 efficiency, is this resource use, is this  
18 expenditures. That was also raised in this as  
19 well.

20 DR. NELSON: Thanks, Jennifer.  
21 Let's have further questions and comments.  
22 Jack?

1 DR. NEEDLEMAN: Just a real quick  
2 question which was raised by the comment from  
3 the panel. I think it's important. I don't  
4 think that's going to be an issue.

5 But I just want to get  
6 clarification on the unit of analysis here.  
7 Because as I read it it looked like it was the  
8 group. And what I heard a few minutes ago  
9 said we expect this to be allocated down to  
10 the individual clinician. Those are two  
11 different levels.

12 And I just want clarification  
13 whether we're looking at a group-level measure  
14 or an individual clinician-level measure.

15 DR. NELSON: Yes, thank you.

16 MR. BALLOU: So the answer is  
17 we're looking at a group-level measure but to  
18 the extent that it impacts parties, for  
19 example, potentially going forward with  
20 respect to payment it's the physicians who are  
21 initially affected. So you have --

22 DR. NEEDLEMAN: Primary care



1 clinicians that are affected.

2 MR. BALLOU: It's all physicians  
3 in the group.

4 DR. NEEDLEMAN: It's all primary  
5 care clinicians in the group.

6 MR. BALLOU: It's all physicians  
7 in the group. There's a group score so it's  
8 a group measure in that respect.

9 DR. NEEDLEMAN: And you are  
10 counting the services provided by physicians  
11 assistants and nurse practitioners?

12 MR. BALLOU: That's correct, as  
13 well as --

14 DR. NEEDLEMAN: Who are  
15 increasingly operating as independent  
16 practitioners?

17 MR. BALLOU: That's correct.  
18 We're counting the services --

19 DR. NEEDLEMAN: And their  
20 services, their patients are being counted  
21 within this. It is primary care clinicians.

22 MR. BALLOU: Well, the patients

1 are attributed to the group. I may be  
2 misunderstanding the question. And the group  
3 is given a score based on all of the services  
4 used by the patients given the group which  
5 include all services, including those not even  
6 provided by the group.

7 DR. NELSON: To clarify, Dartmouth  
8 was part of the CMS PGP program so -- and  
9 we're an ACO pioneer so we've lived with this  
10 attribution method for about 5 years now.

11 It is true as you said we have  
12 about 800 physicians in our group,  
13 approximately 300 primary care physicians. We  
14 have about 35,000 attributed patients. And  
15 it's all of the group practice that's  
16 responsible for all of those patients even  
17 though they come into the attribution having  
18 had a primary care service.

19 Some other questions and comments.  
20 Let's see. Your card was up next.

21 DR. MCHUGH: I think you've  
22 answered my question. That's fine.

1 DR. NELSON: David.

2 DR. GIFFORD: So I'm just a dumb  
3 surgeon but it makes me feel good because I'm  
4 going on the same thing that Jack is going on.

5 So I think that Gene's example of  
6 a large group which has multi-specialties in  
7 it makes a lot of sense. That's an ACO. But  
8 I wonder what happens to, first of all,  
9 providers who are in a small group. So if I'm  
10 a primary care doc, I'm in a group of five  
11 guys, does that mean it doesn't apply to that  
12 group at all and so those providers are out of  
13 the game?

14 And then my second question is we  
15 have -- there are a fair number of large  
16 single-specialty groups. So let's say you're  
17 a large single-specialty group and you're  
18 referring your patient out to specialists.  
19 But those costs are going to be attributed to  
20 you, is that correct?

21 MR. BALLOU: I guess I'd like to  
22 give this one to Dr. Rich and perhaps after

1 that CMS can comment on maybe any future plans  
2 for expanding the measure.

3 DR. RICH: Yes, so the first  
4 question. Yes, the attribution method is  
5 intended to provide information on per capita  
6 costs of beneficiaries to that medical group  
7 that looked through the attribution method to  
8 be providing the primary care role for that  
9 beneficiary.

10 And like any per capita cost  
11 measure there could be a single-specialty  
12 family medicine group that is not providing  
13 all of the services. It's a single-specialty  
14 family medicine group. But now these primary  
15 care clinicians are for the first time given  
16 the information about the per capita costs of  
17 all the patients that at least according to  
18 this rule appear to be their primary care  
19 patients in the Medicare fee-for-service  
20 program.

21 It's also true that you might be a  
22 single-specialty cardiology group that you are

1 also being attributed Medicare beneficiaries,  
2 recognize that you would only be attributed  
3 Medicare beneficiaries if you -- if those  
4 beneficiaries had no visits with a primary  
5 care physician that year. Because those  
6 beneficiaries would have been attributed to a  
7 primary care group.

8           So the idea is then, well, you're  
9 a single-specialty cardiology group. We're  
10 all aware that there are some medical  
11 specialists and surgical specialists who  
12 fulfill the primary care role for their  
13 patients. And if there was no primary care  
14 physician involved in that beneficiary's care,  
15 then if you provided the plurality of these  
16 primary care type evaluation and management  
17 services that single-specialty group gets  
18 attributed.

19           And then this -- the issue that  
20 was raised earlier regarding -- regarding non-  
21 physician clinicians. It's my understanding,  
22 and Sheila may want to comment, that the

1 legislative requirement indicated that  
2 basically it needed to be -- this was intended  
3 to be a physician program and that's why the  
4 first step attributes patients to physicians.

5 But in the second step if there  
6 were no primary care physicians involved then  
7 the -- then PAs or nurse practitioners who  
8 provided the plurality of primary care  
9 services could be the basis on which the  
10 patients were attributed.

11 DR. PENSON: But the level of  
12 reporting then is still the group and not the  
13 individual physician.

14 DR. RICH: But the attribution is  
15 based on individual physicians. But the  
16 reporting is to the group.

17 DR. PENSON: But it reports at the  
18 group level. Gotcha.

19 DR. NELSON: And we're trying to  
20 work on this first criteria but I think  
21 there's some for many of us trying to figure  
22 out how this measure basically works as well

1 as this first criteria. So we'll be pursuing  
2 both of these for a bit. Bill.

3 DR. WEINTRAUB: So I think you  
4 sort of can't do one without the other without  
5 so having some sense of how this is going to  
6 be done to get a sense of why it's important.

7 So David, my knuckles are dragging  
8 lower than yours as a cardiologist and so I'm  
9 going to make a little bit of trouble here and  
10 say I'm not convinced that this measure makes  
11 any sense whatsoever.

12 You're going to have groups of  
13 different sizes and different compositions,  
14 some of which is primary care providers but  
15 some of which are multi-specialty groups and  
16 some of which are -- just have cardiologists.  
17 So they're just specialists.

18 And they're going to be -- they're  
19 going to attribute to that group a variety of  
20 types of services of which they may have  
21 nothing to do with it whatsoever. So that the  
22 patient who's seeing primary care for the

1 colds, that patient then goes and has a  
2 myocardial infarction, is hospitalized 100  
3 miles away and taken care of, completely  
4 different sets of doctors and has angioplasty.  
5 It's complicated and they have coronary  
6 surgery. And then they go to a SNF for 6  
7 months. And all of this is being attributed  
8 back to the primary care group.

9           So I'm sorry to be difficult but  
10 I'm not convinced that this measure gets at  
11 anything that's really going to be helpful to  
12 us as a society in understanding and  
13 controlling healthcare costs and improving  
14 outcomes.

15           DR. NELSON: Andrew.

16           DR. RYAN: Just to change gears a  
17 little bit. I know there's been various  
18 concerns about using tax IDs to identify  
19 groups. And I remember on the CMS GEM project  
20 there were some, you know, they went ahead and  
21 did it with some caveats that this might not  
22 be the best way to identify groups. So I was



1 wondering if the measure developers could  
2 present any evidence that they think the tax  
3 IDs are accurately reflecting the physician  
4 practices.

5 MR. BALLOU: We are aware of the  
6 concern. We think that it is a legitimate  
7 concern. Where we are starting right now we  
8 have the tax ID number available to us as  
9 something that we can use to characterize  
10 groups. In some cases that's going to be  
11 accurate, in others most likely not.

12 DR. WALKER: Andrew, could you  
13 explain what the concern is?

14 DR. RYAN: Well, I think there's  
15 potentially false positives and false  
16 negatives. I think there's some idea that  
17 some small, smaller physicians that aren't  
18 really a group would bill under the same tax  
19 ID. This is more of the concern I've heard so  
20 that some solo and small physicians could look  
21 like they're part of a bigger group when  
22 they're not really.

1 MR. BALLOU: The only thing I  
2 would add to this is that the tax ID is  
3 ultimately used as a unit of payment and  
4 ultimately where we're going towards is  
5 rewarding groups for high-value performance.  
6 So it will remain relevant there. But the  
7 concern is a legitimate one that you express.

8 DR. GIFFORD: While I think Bill  
9 and I may agree on some things I'll disagree  
10 on this one part. I think conceptually this  
11 is an important measure. And I think do  
12 physician groups need to understand where  
13 patients are going? We sort of have always  
14 sort of let patients come in to us and say  
15 when they come into us we'll take care of  
16 them, not proactively, how do we address it  
17 and where do we coordinate the care that's  
18 going out there. So I think conceptually this  
19 is an important measure. It's trying to  
20 measure an important issue.

21 I have all sorts of questions  
22 about the attribution. I have all sorts of

1 questions about how it's calculated and  
2 whether the measure results are meaningful.  
3 But the concept that it's trying to measure,  
4 what it's trying to do it passes to me very  
5 high on everything else. It's really the  
6 devil's in the details.

7 And if you put those together I  
8 had trouble with the importance. If you  
9 separate them then it's easier to say that  
10 there's a higher importance here.

11 DR. NELSON: Let's go to David and  
12 then Daniel.

13 DR. REDFEARN: This is a question  
14 for the developers. Is there not a rule that  
15 says you only assign and use groups that have  
16 25 physicians in the group and at least 20  
17 patients assigned?

18 MR. BALLOU: Twenty-five eligible  
19 professionals at least one of which must be a  
20 physician.

21 DR. REDFEARN: Okay. That would  
22 mean to me that this is probably really a

1 group even if you're driving it off tax IDs.

2 Thanks.

3 MR. WOLFSON: This seems to be a  
4 measure that follows legislation. Could we  
5 get some background on the legislation? I  
6 mean the 25 is not an artifact of anything but  
7 legislation I believe. So I think it would be  
8 important for us to hear that because I think  
9 this is fulfilling a legislative need that we  
10 should understand.

11 I also want to say that this is a  
12 wonderful opportunity for PCPs, primary care,  
13 to step up to the plate. So I don't buy that  
14 they shouldn't be responsible for the care  
15 that's received. This is all about  
16 coordination of care and primary care is  
17 supposed to be doing that. So I don't buy  
18 that responsibility model.

19 DR. NELSON: Would you like to  
20 respond to Daniel's first question?

21 DR. ROMAN: Yes. The legislative  
22 history actually goes back to 2009 and

1 predates the Affordable Care Act. And  
2 includes legislation for -- to provide  
3 physician feedback -- that legislation  
4 included a mandate to provide physician  
5 feedback reports that gave information on  
6 cost. And quality was actually secondary in  
7 that initial legislation.

8 With the Affordable Care Act there  
9 were then two mandates. One continued  
10 essentially the physician feedback reports and  
11 the other mandate -- and was very clear about  
12 that being relevant for both cost and for  
13 quality. And the second mandate was for the  
14 value-based payment modifier.

15 MR. WOLFSON: -- specified the 25.

16 DR. ROMAN: No.

17 MR. WOLFSON: So how did that come  
18 to be, the 25? Was it a methodological cutoff  
19 or was it?

20 MR. BALLOU: This was specified in  
21 the rulemaking process. In terms of how it  
22 came to be we were engaging in reliability

1 testing. There's the question of whether this  
2 attribution rule, for example, even if  
3 appropriate for larger groups is appropriate  
4 for smaller groups, et cetera. So there's a  
5 combination of conceptual issues that we were  
6 thinking about that seemed to make more sense  
7 for larger groups. And also the reliability  
8 of the measure as well.

9 DR. NELSON: In the application  
10 materials I saw terms like "optional,"  
11 "confidential," "phased in." And starting  
12 with groups of 200 going to groups of 25. And  
13 so I think there's a trajectory and a process  
14 of phased implementation behind this as well  
15 that may be helpful for everyone to  
16 understand.

17 DR. ROMAN: Yes, that's true. The  
18 physician feedback reports have been  
19 confidential reports to date to the physicians  
20 and remain so at this time.

21 The phase-in that I think is being  
22 referred to is for the value-based payment

1 modifier. The initial application of the  
2 value-based payment modifier to the physician  
3 fee schedule will begin in 2015. We have  
4 stated in our -- and finalized in our rules  
5 that it will initially apply to groups that  
6 have 100 or more eligible professionals. And  
7 that will be applied in 2015 based on 2013  
8 performance year.

9 But it will phase in between 2015  
10 and 2017 to all physicians. So that by 2017  
11 all physicians will have the value-based  
12 payment modifier applied to their physician  
13 fee schedule reimbursements.

14 MS. TIGHE: Sorry, I'm just going  
15 to jump in. I know we spent so much time at  
16 the micro level on the last measure. This  
17 criteria is really looking at the measure  
18 focus. The conversations that we're having  
19 now really are more relevant to the next  
20 criteria, the scientific acceptability.

21 So, I do just want to pull  
22 everyone back, save these conversations and

1 refocus on what we're discussing here. And  
2 once we get through these votes we can revisit  
3 just to echo David's line separating the  
4 importance from the technical specifications.  
5 Let's start there and then move into the  
6 technical specs.

7 DR. ROMAN: I'll just address this  
8 last question. It's physicians as defined by  
9 Medicare.

10 DR. NELSON: PQRS.

11 DR. ROMAN: Physicians which is --  
12 physicians including MDs, ODs, doctors of  
13 dental surgery and a couple of others. But  
14 not the other types of eligible professionals.  
15 That may occur after 2017. It depends on  
16 legislation.

17 DR. NELSON: Other questions or  
18 comments related to impact, improvement and  
19 intent? Yes.

20 DR. GARRETT: So my comment is  
21 about outpatient pharmacy costs, that they're  
22 not included. I understand the practical



1 reasons for that but it really is a limitation  
2 when you're trying to measure total cost of  
3 care. They have a huge impact on health  
4 outcomes and ability to really improve health  
5 in a population. You know, somewhere around  
6 20 percent of cost that we're missing here.  
7 So something to think about.

8 DR. NELSON: And Brent.

9 DR. ASPLIN: This is stepping into  
10 MAP a little bit. Just so I understand the  
11 intent of how it would be used though.

12 If you have a 110 eligible  
13 professional single-specialty group that bills  
14 under its tax ID number and say it's a  
15 cardiology group. And a small portion of  
16 their patients attributes to them because they  
17 don't have any primary care visits and they're  
18 exclusively managed by their cardiologist.

19 As the value-based payment  
20 modifier is developed for the other  
21 specialties which measure would trump as the  
22 denominator and measure resource use or

1 expenditures? The ones that are developed on  
2 registries for the specialties, or this all --  
3 total per capita cost measure?

4 And I know -- we can handle it  
5 offline if you want, I just -- it helps me  
6 understand. Because if it's this one, I mean  
7 I would hope that for single specialties we  
8 probably would have more focused measures of  
9 resource use for the denominator portion of  
10 the value-based modifier by 2017 than this.  
11 When you think of all the activity that that  
12 cardiology group would do and what a small  
13 portion of the resource use this measure would  
14 address.

15 DR. NELSON: David, is your card  
16 up?

17 DR. ROMAN: Currently for resource  
18 use specifically we have this measure and  
19 total per capita measures for chronic diseases  
20 one of which is CAD that would be included in  
21 the composite for cost in the value-based  
22 payment modifier.

1 DR. NELSON: Jennifer?

2 MS. EAMES-HUFF: So the intent of  
3 the measure is to assess physicians that are  
4 in a particular -- at least meet a minimum  
5 threshold for a medical group size. Can you  
6 talk about how many physicians do not fall  
7 under that? So how many does this apply to  
8 and how many does this not apply to?

9 MR. BALLOU: I can only give rough  
10 numbers right now. So, for example, the  
11 reports that we are getting ready to put out,  
12 there are about 7,000 groups nationwide that  
13 have 25 or more eligible professionals. And  
14 those groups together capture about three-  
15 quarters of all physicians billing under  
16 Medicare. So it's a minority of groups as  
17 defined by taxpayer identification numbers but  
18 of course it's the biggest ones.

19 DR. NELSON: Okay. Any other  
20 comments on this? Dan, your card's up. Are  
21 you good? Okay. So we've been discussing  
22 impact, improvement and intent. Further

1        comments before we have a vote?

2                    MR. WOLFSON:    Just a note about  
3        how many doctors practice in groups of less  
4        than five.    I think it's around 60-70 percent.  
5        So let's face it, this is to reward group  
6        practices with a value modifier.    And that's  
7        why we have the 25.    We're not trying to take  
8        in all the physicians in the country.    We're  
9        only trying to adjust for those ones that are  
10       in group practices above 25.    Or we wouldn't  
11       be measuring this like this.    We would be  
12       measuring much less.    That's where all the  
13       doctors are.

14                    And that hasn't changed.    I mean  
15        you think that group practices is growing but  
16        that number of disproportionate people in  
17        groups of less than five has been pretty  
18        stable.    And ACP could give you that kind of  
19        information.    I mean we are not trying to get  
20        the universe.    This is a group practice score.

21                    DR. GARRETT:    But you're required  
22        to do that by regulation, right?    This measure

1 has no leeway because regulation requires it  
2 to be 25. Did I understand that correctly?

3 DR. ROMAN: The legislation does  
4 not require it to be 25.

5 DR. GARRETT: The regulation did  
6 though.

7 MR. BECKER: I thought I heard you  
8 say that you're starting at 25 and by '17  
9 you're going to start to move it down. So  
10 you're piloting a group and getting some  
11 experience and then over a period of a few  
12 years you'll move it to the rest of the folks.

13 DR. ROMAN: Yes. Actually we're  
14 starting with groups of 100 or more eligible  
15 professionals for 2015 and by legislation we  
16 are to include all physicians by 2017. All  
17 physicians.

18 DR. NELSON: Another aspect of  
19 this topic has to do with disparities and the  
20 use for disparities, understanding  
21 differences. Any comments from the committee  
22 on that? Or questions?

1 DR. WALKER: That was my homework  
2 as well. So the developer said they examined  
3 per capita cost by various demographic  
4 characteristics and found no consistent  
5 pattern. And I would ask them to elaborate on  
6 that a little bit.

7 MR. BALLOU: We tested it a  
8 variety of different ways. We looked in  
9 particular at breakdown by race, in particular  
10 white versus non-white, and dual eligible  
11 status, dual eligible versus not. And we  
12 ranked groups in terms of the proportion of  
13 their assigned beneficiaries. For example,  
14 proportion of their assigned beneficiaries who  
15 were duals.

16 And then we did testing in a  
17 number of different ways. I believe what  
18 you're looking at in the report are deciles.  
19 So we looked at who was in the mean per capita  
20 costs among those in the bottom decile meaning  
21 having the fewest dual eligibles attributed to  
22 their group versus those who were in the top

1 decile, meaning those who had the most  
2 attributed to their group. And we found, the  
3 numbers are in here, relatively modest in our  
4 view differences in the 9,000's versus the  
5 10,000's on a risk-adjusted per capita basis.  
6 And then we did the same thing for white  
7 versus non-white and similarly found  
8 relatively little difference between the  
9 bottom and the top deciles at the mean.

10 DR. NELSON: Any further questions  
11 or comments?

12 DR. ASPLIN: I'm just reading body  
13 language but I don't think a lot of us believe  
14 that. We believe what you're saying, it just  
15 doesn't make sense. Help us understand I  
16 guess. I believe what you're saying. I'm  
17 trying to understand it.

18 MS. WILBON: Can you use your  
19 microphone, please?

20 MR. BALLOU: To answer the  
21 question. So how could these numbers be  
22 essentially I think is the question. We

1 haven't done a thorough examination breaking  
2 down the numbers but by and large you would  
3 expect these numbers to be larger if the same  
4 groups tended to get all of the duals and the  
5 same groups tended to get none of the duals.  
6 And that's certainly going to be true for some  
7 groups. But to the extent that there isn't a  
8 lot of variation, you know, at least across  
9 these deciles perhaps these numbers are this  
10 compressed.

11 The other thing is that we're  
12 comparing -- I'm trying to give you a better  
13 answer than the one I just gave. The other  
14 thing is that we're comparing after risk  
15 adjustment here. And so risk adjustment for  
16 this particular model does include dual  
17 status. So it's possible that if we had  
18 looked at observed as opposed to risk-adjusted  
19 costs we might have seen a larger disparity.

20 DR. NELSON: Any further questions  
21 or comments before we move to votes? Okay.  
22 As we did this morning we have votes on 1a,



1 lb, 1c and then an overall vote. And we would  
2 ask for a public comment before the overall  
3 vote.

4 So the first issue then is impact,  
5 high-priority impact. And the numbers  
6 affected by the measure. Does the measure  
7 demonstrate variation in resource use or  
8 overall poor performance? Are there patient  
9 societal consequences of high or low resource  
10 use? So those are what we'd like to keep in  
11 mind for the first criteria. Ready to vote?

12 MR. WILLIAMSON: We will now vote  
13 on criteria 1a which is high-priority. You  
14 will have 60 seconds. Begin now. And we have  
15 20 high, 2 moderate, 2 low and zero  
16 insufficient.

17 DR. NELSON: Okay, thank you. The  
18 next criteria, opportunity for improvement.  
19 Do the data demonstrate a distribution of  
20 performance scores? Is the number  
21 representative of the entities? Is there data  
22 showing disparities in the use of resources or

1 cost of care? What's the size of the  
2 population at risk? Potential consequences.

3 MR. WILLIAMSON: We will now vote  
4 on criteria 1b, the opportunity for  
5 improvement. You will have 60 seconds. Begin  
6 now. Eleven high, ten moderate, four low and  
7 zero insufficient.

8 DR. NELSON: Thanks, Evan. And  
9 the next criteria is -- scroll that up please  
10 to 1c. Oh, 2c. Do we go to 2c or 1c? 1c,  
11 okay. Okay. So the intent of the resource  
12 use measure and the measure construct, are  
13 they clearly described? The resource use  
14 categories, types of resources and costs that  
15 are included in the resource use measure, are  
16 they consistent and representative with the  
17 intent of the measure?

18 MR. WILLIAMSON: We will now vote  
19 on criteria 1c, the measure intent. You will  
20 have 60 seconds. Begin now. Eight high,  
21 thirteen moderate, four low and zero  
22 insufficient.

1 DR. NELSON: Okay. Thank you for  
2 those votes. Let's hear if there are any  
3 public comments from the people in the room or  
4 on the telephone.

5 OPERATOR: To make a comment or  
6 ask a question at this time please press \*1.  
7 There are no comments or questions.

8 DR. NELSON: Okay. So then we'd  
9 like to have an overall vote on this -- right,  
10 on the domain importance to measure. And you  
11 have the usual choices, 1, 2, 3, or  
12 insufficient.

13 MR. WILLIAMSON: We will now vote  
14 on the overall importance to measure and  
15 report. You will have 60 seconds. Begin now.  
16 Eleven high, ten moderate, four low and zero  
17 insufficient.

18 DR. NELSON: Okay, very good.  
19 Thank you. So we've moved through the first  
20 topic. And next we go to reliability and  
21 testing, and the whole area of scientific  
22 acceptability.

1           So we'll begin with reliability  
2 specifications. And we'd like to have Brent  
3 and Mary Ann lead off the discussion around  
4 topics of construction logic, clinical logic  
5 and adjustment for comparability. So who'd  
6 like to go first? Brent? Mary Ann?

7           DR. ASPLIN: I can go ahead. It's  
8 -- overall I'll just start with the ratings.  
9 The vast majority of committee members ranked  
10 the construction logic, clinical logic and  
11 these adjustment categories as either high or  
12 moderate in all of the criteria.

13           The reliability testing which may  
14 be the next phase of this was rated a little  
15 bit lower. And in general I would say that  
16 some of the comments, the written comments as  
17 well kind of mirrored the first measure in  
18 that they probably raised some more validity  
19 questions than they do reliability questions.

20           So I don't personally have  
21 significant questions although I do believe  
22 that based on the voting and some of the

1 written comments, and I don't know if this is  
2 2a1 or 2a2 but perhaps some additional  
3 comments from the developer around the  
4 reliability testing and the results of that  
5 would be helpful for the committee.

6 DR. NELSON: Mary Ann?

7 MS. CLARK: Sure. Additional  
8 comments. I mean I guess I felt like this  
9 particular measure, the way -- the  
10 construction logic is very confusing. I mean  
11 I'm glad that you are here to help explain it  
12 a little further. But the way it's explained  
13 in the documentation I don't know that the  
14 typical user would be able to follow it very  
15 easily.

16 It's still -- I would like to see  
17 a little bit better explanation of how it's  
18 put together, especially for the attribution.  
19 That's primarily what I'm talking about. So  
20 in certain places it talked about primary care  
21 services but then it also said other. Well,  
22 actually it was talking about the requirement

1 of having at least two office or other visits,  
2 other outpatient services. And then there  
3 wasn't really a definition of what that meant.  
4 So I know there was a listing of different E&M  
5 services there, but is that the inclusive list  
6 or were there others that were used to define  
7 this particular criteria?

8 And also I was a little confused  
9 on the data being used to create this measure.  
10 It looked like you were using -- was it just  
11 a test case? Because it looked like it was  
12 only nine states or something like that worth  
13 of claims data. So now it's being expanded  
14 out, is that right? Okay.

15 I am still a little concerned  
16 about the inclusion -- mainly the exclusion  
17 criteria. And again this is one where  
18 patients who died are excluded. Patients with  
19 outlier costs are excluded. So it's kind of  
20 the same concerns that I had on the first  
21 measure as well.

22 And you know, it seems like those

1 are something that should be considered  
2 because those are the areas where there may be  
3 the most room for improvement. So I think  
4 those are my comments.

5 DR. NELSON: Thanks, Mary.

6 Replies from the developers?

7 MR. BALLOU: Sure, I can give some  
8 initial replies and others might join in.

9 First of all, the reference to two  
10 or more office visits unfortunately is a typo  
11 that shouldn't have been in here. So the  
12 codes that are listed in the appendix are the  
13 correct codes. It is the two-step rule that  
14 we started off the conversation by talking  
15 about.

16 In terms of the exclusions we have  
17 in previous iterations included what we've  
18 referred to as part-year beneficiaries. And  
19 that's largely what we're talking about with  
20 the exclusions, not exclusively. And those  
21 are the folks for whom we only have part of a  
22 year of either Part A costs, Part B costs or

1 expenditures or both.

2 The way we've considered doing it  
3 in the past is we've done weighting in our  
4 risk adjustment model that takes into account  
5 the number of months of data for which we do  
6 have them. But there's an implicit imputation  
7 there when we try and include these part-year  
8 folks that was not well received by physician  
9 stakeholders.

10 That is to say you're telling me  
11 that you're judging me on a full year of care  
12 when I only provided 6 months of care to this  
13 person. And you're simply doubling that. And  
14 you can do more sophisticated imputation than  
15 that. But the imputation in general is  
16 something that was, again, not well received.

17 And so I think largely for that  
18 reason the part-years were excluded. We  
19 realize that there are some implications,  
20 however, which the commenter was just  
21 mentioning to doing so.

22 DR. NELSON: Jack?



1 DR. NEEDLEMAN: I need a  
2 clarification of how the measure is  
3 constructed. In the previous measure that we  
4 were talking about there are a whole series of  
5 indicator variables for the different HCCs,  
6 for the age categories, for the DRG and so  
7 forth. There's a regression of the  
8 standardized billings on those indicator  
9 variables and that produces the ability to get  
10 an expected value.

11 I thought that was what was going  
12 on here but then I see some reference to an  
13 HCC score and one part of your documentation  
14 has a score which looks nothing like an  
15 expected dollar value. It's in the orders of  
16 ones and twos.

17 So can you explain how the risk  
18 adjustment score is actually being constructed  
19 in this? Because it does not look like an  
20 expected dollar amount based upon a regression  
21 on indicator variables.

22 MR. BALLOU: No, that's correct,

1       it's not. And essentially the HCC risk score  
2       is an output of a series of CMS HCC risk-  
3       adjusted models. We do not construct that  
4       risk score. It is a value of -- this is a  
5       high-level summary -- of 1, less than 1 or  
6       greater than 1 indicating expected costs for  
7       that beneficiary.

8                       We take that risk score -- so for  
9       example, a risk score of 1.5 would be a  
10      beneficiary who based on prior year diagnoses  
11      and demographic information would be expected  
12      to have costs 50 percent higher than the mean.

13                      We then take that risk score and  
14      we also take its squared value. And this is  
15      meant to get at some outlier issues a little  
16      bit, and we also take an indicator for ESRD  
17      status. And we regress our standardized  
18      billings on those variables. So that's a  
19      high-level summary.

20                      In terms of how the risk scores  
21      come about that would be a question for Greg  
22      Pope on the phone about the CMS HCC risk

1 adjustment model. But that may not be what  
2 you're asking.

3 DR. NEEDLEMAN: No, no, that's  
4 exactly what I'm asking. Because we've got  
5 this composite score and I don't know where it  
6 came from. So Greg?

7 MS. TIGHE: Operator, can you make  
8 sure Greg Pope's line is open?

9 MR. POPE: Hello, can you hear me?  
10 This is Greg Pope.

11 MS. TIGHE: We can.

12 MR. POPE: Okay. So the CMS HCC  
13 score is calibrated on Medicare fee-for-  
14 service data regressing a beneficiary's  
15 current year expenditures, his or her prior  
16 year demographics and diagnostic indicators.  
17 And then that does produce a predicted dollar  
18 expenditure but then it's divided by the  
19 sample mean to turn it into a relative score  
20 with 1.0 indicating an average predicted  
21 expenditure, 1.5, 50 percent above average and  
22 0.05, 50 percent of average.

1 DR. NEEDLEMAN: Okay, so when we  
2 see the full risk model described in the  
3 documentation with the HCCs, the age  
4 categories interacted with sex and the others  
5 basically the expenditures for that individual  
6 is being regressed on indicator variables for  
7 all those, producing an expected value and  
8 then that's divided by the average expected  
9 value for the whole sample to get that ratio -  
10 -

11 MR. POPE: Correct.

12 DR. NEEDLEMAN: -- of expected for  
13 the patient -- and that's what's going into  
14 the second stage risk adjustment model.

15 MR. POPE: Correct. That's  
16 correct.

17 DR. NEEDLEMAN: Okay, got it.

18 DR. NELSON: Other questions or  
19 comments? David.

20 DR. GIFFORD: Can I ask about the  
21 attribution here or is that a different  
22 section?

1 MR. AMIN: If it's a question  
2 around the preciseness of the attribution this  
3 would be a place to discuss it, or if it's a  
4 question of the validity or the  
5 appropriateness of the attribution that would  
6 be a validity question.

7 DR. GIFFORD: I guess I don't  
8 understand the attribution question to be able  
9 to discern that. I just need to understand  
10 how the attribution works and then maybe I may  
11 or may not have questions on it.

12 So you used the E&M codes and the  
13 charges to attribute. And the maximum amount  
14 got you into the group practice, assigned to  
15 a group practice. Is that my understanding?

16 So my interest is this  
17 understanding of all internists are not  
18 primary care physicians. And I guess that's  
19 where I'm looking at it. So maybe it goes  
20 under the validity question. So I can wait  
21 till then. Sorry, I had to talk that through  
22 in my head.

1 MR. AMIN: I don't mean to be  
2 overly restrictive but if we can.

3 DR. NELSON: More on reliability.  
4 I think Herbert was going to open up the topic  
5 of reliability testing.

6 DR. WONG: So in terms of  
7 reliability testing overall the pre-testing  
8 indicated that folks were basically  
9 comfortable with the approach. It was pretty  
10 much divided between high and moderate, 9 with  
11 high and 11 with moderate and 1 person voting  
12 insufficient.

13 The way I would characterize it is  
14 that for the two comments that I kind of  
15 highlighted in terms of the reliability  
16 testing one basically questioned the notion of  
17 using prior year data as opposed to concurrent  
18 data. And I think that that was addressed a  
19 little bit earlier.

20 I think that in general the  
21 viewpoint of those who had some concerns with  
22 reliability was this notion that it was pretty

1 much the standard sort of package and they  
2 wanted to kind of see more in terms of some of  
3 these other components to kind of highlight  
4 the fact that the reliability is really on  
5 target. I would characterize it in general  
6 that folks were relatively comfortable with  
7 it.

8 DR. NELSON: Okay, thanks Herbert  
9 for that opening. Questions, comments on  
10 reliability testing. Bill.

11 DR. WEINTRAUB: Well, this sort of  
12 gets back to what David was talking about also  
13 about reliability and validity. And so it's  
14 worth remembering that you can be very precise  
15 and totally inaccurate. So this may seem to  
16 work and be reliable but we may not be  
17 measuring what we think we are. And we'll  
18 discuss that in the coming section.

19 MS. WILBON: Gene, just real  
20 quickly. Just so everyone's on the same page  
21 about what the reliability testing was I'll  
22 just ask Carlos to kind of summarize what he

1 found in the testing and kind of give an  
2 overall assessment just so everyone is on the  
3 same page.

4 MR. ALZOLA: Okay. Thank you,  
5 Ashlie. My comment on the reliability was  
6 that we have two components here. We are  
7 looking at the size of the groups in terms of  
8 EPs and then we have the size of the groups in  
9 terms of beneficiaries.

10 So the reliability testing that  
11 was done was based on reliability scores. And  
12 again the -- as in the previous measure when  
13 we look at the individual groups the question  
14 was how high was the reliability score in each  
15 of those cases.

16 There were -- the analysis was  
17 presented in terms of the size of the groups.  
18 And we have, for instance, we have the  
19 category of 25 to 50 EPs, and then we have for  
20 that group we have that 99 percent of all  
21 groups exceeded the 0.5 reliability score.  
22 And for -- and 93.2 percent of all the groups



1 exceeded reliability score of 0.7.

2           So in general all those numbers  
3 held across the size of the group. As the  
4 groups grow larger the reliability scores  
5 improved. For the very large groups with 201  
6 or more EPs the reliability was 100 percent.  
7 I mean, all groups had reliability exceeding  
8 70 percent.

9           The other way of looking at that  
10 was when we look at the number of attributed  
11 beneficiaries on the group. So they look at  
12 the lowest quartile from 20 to 249  
13 beneficiaries and then we have that in that  
14 case 97.5 of groups had reliability exceeding  
15 50 -- 0.5. And 83.6 of groups had reliability  
16 exceeding 0.7.

17           As the number of attributed  
18 beneficiaries increased we move onto the  
19 second, third and highest quartile, then all  
20 groups had reliability exceeding 70 percent.  
21 So based on those numbers and that criteria we  
22 can say that the reliability is very high.

1 Any questions, comments?

2 DR. NELSON: Thank you, Carlos.

3 Any questions? David.

4 DR. GIFFORD: Just reliability  
5 about the attribution. And I know that  
6 patients are changing but how well did that  
7 stay over time, repeat over time? And did  
8 group size being defined as 25 change over  
9 time too?

10 MR. BALLOU: So we did not test  
11 actual changes over time. We had the one  
12 current year of data and we used the signal to  
13 noise approach to do it. Changes over time  
14 have not yet been tested.

15 DR. NELSON: Other questions or  
16 comments on reliability? Okay. Okay, any  
17 public comments? Nancy.

18 DR. GARRETT: I have a question  
19 about risk adjustment. Would this be the  
20 right time or is that the next?

21 DR. NELSON: We heard it depends  
22 on what you ask.

1 (Laughter)

2 DR. GARRETT: All right, well I'll  
3 defer then. I'll ask in the next section.

4 DR. NELSON: Nancy, go ahead.

5 DR. GARRETT: So, as I understand  
6 it in this model it's adjusting for sex and  
7 for dual eligibility status. And I think it's  
8 perhaps because that's how the CMS HCC model  
9 works. But for us who have been here all day  
10 in the last discussion we heard that we  
11 weren't adjusting for those things because it  
12 was against the conceptual idea of -- the NQF  
13 position on risk adjustment where you try not  
14 to adjust for socioeconomic status up front  
15 which I don't know if all of us agree with  
16 that. But it sounds like that was the -- kind  
17 of some of the thinking. So I just wanted to  
18 hear from the measure developers about the  
19 philosophy behind this.

20 MR. BALLOU: Right. Greg, if you  
21 are still on the line would you be able to  
22 address the question of the inclusion of dual

1 status in the model as well as age and gender?

2 DR. GARRETT: Specifically gender.  
3 I think age is a more clear one.

4 DR. NELSON: And Greg, are you on  
5 the phone?

6 MR. POPE: Yes. Can you hear me?

7 DR. NELSON: Very good, thank you.

8 MR. POPE: Yes, just from our  
9 point of view I think as has been mentioned  
10 this model was developed for Medicare  
11 Advantage and those were the historical  
12 demographic factors that have been used by the  
13 CMS actuaries going back to the old adjusted  
14 average per capita cost.

15 So it's carried over and it's been  
16 found that those factors predict cost even  
17 aside from holding constant diagnosis. So  
18 they've been carried along and I guess the  
19 age/sex in particular are regarded as  
20 exogenous or not subject to manipulation by  
21 health plans. So you know, in the Medicare  
22 Advantage context we want to avoid selection

1 incentives for plans to avoid certain types of  
2 beneficiaries based on their age or sex. So  
3 that's the rationale for including it in that  
4 context.

5 DR. GARRETT: And dual eligibility  
6 status?

7 MR. POPE: I think it's similar,  
8 that that's been found to correlate with cost  
9 even holding other factors constant. And it  
10 is regarded as sort of a low SES type  
11 indicator to avoid giving plans incentives for  
12 avoiding enrolling those people if you didn't  
13 adjust for that. We don't want plans to want  
14 to avoid dual eligibles.

15 DR. GARRETT: So what I'm hearing  
16 is those variables are in the model really  
17 because it was developed for the Medicare  
18 Advantage purpose, not for the purpose of this  
19 measure. But it's being used in this measure.  
20 Is that right?

21 MR. BALLOU: It is being used in  
22 this measure. I would add to the information

1 that Greg has already provided that the ACA  
2 actually requires us to adjust for SES  
3 characteristics. And we view the inclusion of  
4 this variable in the model as one way of  
5 accomplishing that.

6 DR. GARRETT: Interesting. Okay.

7 MR. BALLOU: Sheila, did you want  
8 to add to that?

9 DR. ROMAN: Basically I was going  
10 to say the same thing, that the ACA asks us to  
11 adjust for SES and for demographic  
12 characteristics.

13 DR. NELSON: Thank you. Carlos?

14 MR. ALZOLA: I have a question. I  
15 have heard that the SES and dual eligibility  
16 is in the model. But when I look at this  
17 documentation it clearly is not. So I'd like  
18 to clarify whether it is or not.

19 MR. BALLOU: Yes, I regret the  
20 confusion this might have caused. It is in  
21 there in the sense that it's included in the  
22 risk scores which are then inputs into the

1 second-stage regression. So that risk score  
2 is informed by, among other variables, the  
3 dual eligible status.

4 MR. AMIN: I'd also like to just  
5 clarify in terms of the NQF criteria which has  
6 been brought up a number of times now which is  
7 in the validity section but for the sake that  
8 this has been discussed a few times. I just  
9 want to be crystal clear in terms of what  
10 NQF's position is related to these factors.

11 So when we look at the next  
12 criteria under validity which is 2b4 we  
13 require that any risk adjustment strategy is  
14 evidence-based and that they are based on  
15 patient clinical factors that are associated  
16 with -- that are present at the start of care  
17 to avoid this issue around the fact that there  
18 are components, there are factors that could  
19 occur during the measurement period that we  
20 don't want to create the circular issue which  
21 is that then they're included in the risk  
22 adjustment model and the overall predicted

1 value would go up.

2 Secondly, related specifically to  
3 the issues around SES, race, or potentially  
4 dual eligibility status, the concern here is  
5 that even if there's a recognition that it's  
6 related to the outcome of interest in the  
7 application that we're looking at right now  
8 which is a performance measure we want to make  
9 sure that there is an understanding of -- that  
10 there's no obscuring of the disparities of  
11 care, that they should be highlighted, either  
12 stratified and not buried in terms of the risk  
13 adjustment model. Because if it is in the  
14 risk adjustment model you're not able to  
15 actually see the disparities across the  
16 different population groups.

17 So the question that's in front of  
18 the committee to think about as you're  
19 thinking about the risk adjustment model is  
20 whether or not that -- these variables,  
21 particularly dual eligibility status in this  
22 particular application is appropriate given



1 that if there is actual variation on dual  
2 eligibility status that are outside of patient  
3 clinical factors is there an a priori reason -  
4 - or is there an appropriate a priori reason  
5 why a provider should be having a difference  
6 in resource use based on the fact that you're  
7 dual eligible outside of patient clinical  
8 factors. That's the critical question that's  
9 in front of us.

10 Generally it has been NQF  
11 tradition and guidance to avoid having these  
12 characteristics in the risk adjustment model  
13 for the reasons of obscuring disparities.  
14 Now, if there is a justifiable reason in this  
15 space why that would be necessary we need to  
16 have that conversation in the context of the  
17 validity of the measure.

18 And that is a serious question to  
19 be considered by this committee. That would  
20 be different than the tradition of the past  
21 but if it's considered to be appropriate in  
22 this context we can have that discussion. But

1 thank you for bringing these up, it's a very  
2 important question. Hopefully that was clear.

3 MS. TIGHE: And I think actually  
4 that said if we could hold the validity  
5 conversation and get through the vote on  
6 reliability.

7 DR. NELSON: Public comment? Any  
8 public comments?

9 OPERATOR: At this time if you  
10 would like to ask a question please press \*1  
11 on your telephone keypad. There are no  
12 questions at this time.

13 DR. NELSON: Thank you. So, we've  
14 heard discussions about -- under the topic of  
15 reliability about exclusion criteria and  
16 methods of construction and attribution. And  
17 the specifics of the reliability testing  
18 methods that were used and this issue of dual  
19 eligibles being in the adjustment model.

20 So I think we're ready to vote.  
21 And this vote, it's all things considered for  
22 reliability what's your assessment, high,

1 moderate, low, insufficient. So I think we're  
2 ready to vote.

3 MR. WILLIAMSON: At this time we  
4 will vote on overall reliability. You will  
5 have 60 seconds beginning now. Five high,  
6 eighteen moderate, one low and zero  
7 insufficient.

8 DR. NELSON: Okay, thank you. So  
9 the second half of scientific acceptability  
10 has to do with validity testing. And we have  
11 several topics here that we'll be addressing.  
12 The specifications, construction logic,  
13 clinical logic, adjustment of comparability.  
14 And then validity testing exclusions and risk  
15 adjustment, identification of statistically  
16 significant differences and substantial  
17 substantive differences and disparities. We  
18 opened up the disparities conversation  
19 earlier. We can return to that as helpful.

20 So to open the discussion on  
21 validity testing, Jim.

22 MS. TIGHE: Sorry, and Jim, we'll

1 start with the validity of the specifications  
2 and then.

3 DR. NELSON: Sorry, I dropped down  
4 a row. So validity of specifications. Thank  
5 you, Lindsey. So Matthew and Lisa.

6 DR. MCHUGH: So Lisa and I split  
7 our work. I'm going to start with the  
8 construction logic. We reviewed the seven-  
9 step logic. I'll say that the overall rating  
10 for this was 16 high or moderate and 4 low.

11 The concerns that were raised some  
12 of which we have gone over, I'll just kind of  
13 summarize a few of these around attribution  
14 logic. Again we've covered a number of these  
15 but there were questions about whether a more  
16 appropriate approach would be to assign cost  
17 proportionally. There are questions about the  
18 match with intent in that the measure only  
19 covers groups with 25 eligible professionals  
20 and 20 attributable patients.

21 A number of concerns raised around  
22 the use of services provided by nurse

1 practitioners, physicians assistants being  
2 only accounted for in the second stage which  
3 may increasingly be outmoded as primary care  
4 changes. So that's maybe excluding a large  
5 proportion -- a growing proportion of  
6 practices.

7           There may be issues with patients  
8 that leave certain practices, particularly if  
9 they differ in terms of their cost profiles.  
10 And there was also concern raised that the  
11 measure does not capture a number of important  
12 costs, potentially drug costs and unbilled  
13 services around patient care coordination,  
14 education, other kinds of drug -- well I  
15 mentioned drug expenses and in kind services.

16           DR. LATTIS: I'll take on the  
17 clinical logic and adjustments for  
18 comparability inclusion and exclusion  
19 criteria. As far as clinical logic goes there  
20 essentially isn't any. It's not really  
21 directly relevant to this. It's just total  
22 measurement for all situations for the year.

1                   In terms of inclusion/exclusion  
2                   criteria it is very similar to the other  
3                   measure this morning in that it is a  
4                   continuous enrollment for everybody in Part A  
5                   and Part B for the entire calendar year. So  
6                   if you are out for any reason including death  
7                   for part of the calendar year you're out. If  
8                   you were excluded earlier from attribution and  
9                   we've talked about some of that you're not in.  
10                  If you are Medicare Advantage for any part of  
11                  it it's in. It is Part A and B as I said so  
12                  it does not include any Part D claims. If  
13                  you're not in the United States you're not in.  
14                  So those are the main inclusion/exclusion  
15                  criteria.

16                   The voting on both of those were  
17                   quite high, 18 for the high or medium for both  
18                   and 3 for the low.

19                   DR. NELSON: Thank you, Matthew  
20                   and Lisa. Questions, comments on this topic?  
21                   Jack.

22                   DR. NEEDLEMAN: In contrast with

1 my usual calm, reasonable self I have  
2 fundamental problems with the attribution  
3 model here as it relates to nurse  
4 practitioners and physician assistants. They  
5 are increasingly providing primary care  
6 services. They are increasingly for a large,  
7 significant portion of the population, maybe  
8 not a large portion of the Medicare population  
9 yet their primary care providers. They belong  
10 in the first stage of this model, not the  
11 second stage.

12 I can imagine a case somewhat  
13 extreme but we can -- of a community health  
14 center, heavy nurse practitioner, heavy  
15 physician assistant doing primary care, an  
16 occasional consult out of the group for  
17 consultation on a diabetes care or an  
18 arthritis patient and they come back after the  
19 consult. But because the only counts of  
20 primary care services are the physicians that  
21 patient gets attributed to the group that the  
22 referral for the consult was when that's not

1 the group delivering the primary care.

2 I think it's perhaps not a large  
3 problem now. As we grow the nurse  
4 practitioner and physician assistant  
5 populations, as they do more and more primary  
6 care it's going to be a growing problem. I'd  
7 rather see this measure be adapted to the  
8 future we're facing, not to the past we've  
9 been in. And frankly until the attribution is  
10 changed I will vote no on this issue. This  
11 will cause me to vote no on this measure.

12 DR. NELSON: As a point of  
13 information do you have a sense of what  
14 proportion of primary care is currently being  
15 provided by nurse practitioners or PAs?

16 DR. NEEDLEMAN: Well, from the  
17 American Nursing Association I got told that  
18 there are nurse practitioners, not the PAs,  
19 just nurse practitioners are providing  
20 services to 6 million Medicare fee-for-service  
21 patients. That's roughly 1 in 5 or 1 in 6.

22 DR. LATTS: But the other relevant



1 question here has to be what percentage of  
2 those nurse practitioners are billing  
3 independently versus billing under another  
4 physician. And that's what we need to know.

5 DR. NEEDLEMAN: I think this came  
6 from billing independently.

7 DR. LATTS: Okay, yes.

8 DR. RYAN: I'll just add to that.  
9 Most of these data that I'm familiar with as  
10 well are related to data. So there are enough  
11 to generate measurable, sizable numbers around  
12 --

13 DR. NELSON: Lisa?

14 DR. LATTS: Well, so I agree with  
15 Jack's comment and I think this is critically  
16 important. So I just wanted to ask the  
17 developers is this something you can do? I  
18 mean why didn't you do it up front and could -  
19 - you know, if this committee said we  
20 absolutely need to add other professionals to  
21 clinician -- to the physicians, is that  
22 doable?

1 MR. BALLOU: I'd like to defer to  
2 CMS on what might be doable in the future or  
3 acceptable.

4 DR. ROMAN: I think it's difficult  
5 for me to say with any specificity since it  
6 would have to go through rulemaking. I think  
7 you see the attribution model as it is because  
8 this was a measure that was aimed to look at  
9 per capita costs for physicians. So the  
10 physicians were the entry point into the  
11 attribution model.

12 I think that when we're talking  
13 about attribution we're talking about  
14 attribution to the group that does include the  
15 nurse practitioners and other eligible  
16 professionals. And that in the second stage  
17 of the attribution model we certainly are  
18 counting those eligible professional primary  
19 care services as the plurality for the  
20 assignment.

21 DR. NEEDLEMAN: Only if after  
22 you've counted physician services and you

1 haven't made an attribution based upon  
2 services provided by a physician. I'm saying  
3 that's a fundamentally flawed model, that the  
4 primary care services provided by nurse  
5 practitioners and physician assistants should  
6 be included in that first stage count of where  
7 are the plurality of services being provided.

8 DR. RYAN: I agree with Jack on  
9 that. I think that the -- and just by looking  
10 at claims where Medicare -- we know that  
11 they're Medicare patients. And as Jack  
12 pointed out it does tend to be more dual  
13 eligible, but where patients are receiving  
14 almost all, if not all their services from  
15 these providers. I'm trying to figure out if  
16 we are in service of the statute alone or in  
17 a fundamentally sound measure.

18 MR. AMIN: Gene, can I just jump  
19 in here real quick? I just want to point the  
20 committee to the fact that when we're looking  
21 at validity, and this is no pro or con  
22 anyone's position, but the question is really

1 whether the measure specifications are  
2 consistent with the measure's intent as  
3 described under 1c which is what the developer  
4 put in 1c.

5 Now, the question becomes you need  
6 to assess how accurately this actually  
7 reflects the measure intent. But I just want  
8 to make sure that we're not -- you don't want  
9 to create a measure here. The goal is to  
10 really assess what's in front of you.

11 DR. NELSON: Thank you for that  
12 comment. Just a perspective not as a  
13 facilitator but as a perspective on the  
14 conversation. I appreciate Jack and Matthew's  
15 point on the importance of nurse practitioners  
16 and PAs in providing primary care.

17 Another issue is one reason that  
18 this kind of measure is going forward is the  
19 rate of increase in per capita healthcare  
20 costs, and how to get a handle on that big  
21 issue. And so that's another factor in moving  
22 and considering this kind of a measure is that

1 we're trying to get a handle as a country on  
2 per capita healthcare costs and measures  
3 related to that. And the majority are  
4 associated today with physicians. And so  
5 we're into this conversation and into this  
6 measurement in part driven by this very  
7 serious per capita cost issue. So I wanted to  
8 raise that as part of our thinking about the  
9 environment that we're working in.

10 DR. RICH: I think there was also  
11 a question regarding sort of what the data  
12 were telling us. And this is absolutely  
13 looking at the past rather than looking at the  
14 future.

15 We looked at other attribution  
16 models in 2010 data. And it turned out that  
17 very few nurse practitioners in our data set  
18 were attributed patients under other sort of  
19 E&M-based models.

20 And our anticipated explanation  
21 for this is that, as many of the clinicians  
22 here will recognize, many PAs or nurse

1 practitioners in many settings bill an  
2 incident to type of code so that their billing  
3 number does not show up. It shows up under  
4 the name of a physician in that practice.

5 Now, clearly again that's looking  
6 at the past, not at the future. It's  
7 reflecting a time when there were few  
8 practices where there were no physicians and  
9 only nurse practitioners and PAs. But there  
10 was a question about the data and that's what  
11 the data showed at that time.

12 DR. NELSON: Joe?

13 DR. STEPHANSKY: The modeling  
14 seems to assume a somewhat stable physician  
15 marketplace in a state. And we don't have  
16 that in Michigan. I mean, we're looking at  
17 mergers between hospital systems and new tax  
18 identification numbers. We're seeing big  
19 groups split into smaller ones because they  
20 want to take on different ACO contracts. And  
21 so they have a new TIN for each one of those.  
22 It is shifting.

1                   And we have a whole lot of really,  
2                   I don't want to say elderly but approaching  
3                   retirement physicians where those practices  
4                   may completely split up once the principals do  
5                   retire. And the idea that we're going to  
6                   continue to be able to look at a physician  
7                   group over a year, over an extended period of  
8                   time just to me doesn't seem to match.

9                   And that's why when we go back to  
10                  Brent and his question about how many Medicare  
11                  beneficiaries were attributed somehow those  
12                  numbers still don't seem right to me when I  
13                  think about the physician marketplace. And to  
14                  me that's a validity question.

15                  DR. NELSON: Thank you. Tom?

16                  DR. TSANG: I was actually going  
17                  to ask the same exact question. And then I  
18                  have a second question for the measure  
19                  developers. And that piggybacks on Jack's  
20                  point is that a large sector of the primary  
21                  care services are provided by a few HCs. Jack  
22                  mentioned some of the nurse practitioners

1 actually work in them. So they have a  
2 different Medicare payment system. They get  
3 paid by a Medicare PPS system. And that --  
4 and a lot of the FQHCs actually don't even use  
5 EMM codes and CPT codes. So I'm just  
6 wondering how this measure would actually  
7 account for a large sector of the primary care  
8 services being delivered by FQHCs.

9 And the other thing is that FQHCs  
10 will double to roughly about 2,300 or 2,400  
11 over the next 2 or 3 years. A large segment  
12 of the 30 million that's uninsured that's  
13 going into the exchanges will probably seek  
14 out primary care services in the FQHCs as well  
15 as the rural health clinics. So I just want  
16 to understand the context as well.

17 DR. NELSON: Great question.

18 MR. BALLOU: So in terms of the  
19 FQHCs you are right that they do bill  
20 different codes, they do bill in a sense under  
21 a different system. So we, again, when  
22 driving toward value-based modifier related



1 work we're talking about modifying payments to  
2 the physician fee schedule. So attribution is  
3 based on physician fee schedule services only.

4 It is true then that a lot of the  
5 FQHCs, they are not picked up. That's  
6 something that we are looking at, how one  
7 might incorporate going forward. But they're  
8 not there right now.

9 DR. NELSON: Bill?

10 DR. WEINTRAUB: Most of the  
11 discussion so far is on construct validity.  
12 And there are lots of questions being raised  
13 around the table on stability of the groups,  
14 what to do about nurse practitioners, what to  
15 include in the risk adjustment model. I'd  
16 actually give kudos to the development team  
17 for trying to do the impossible here because  
18 I think that the fundamental problem is not  
19 with construct validity but with face validity  
20 and criteria validity.

21 The face validity of this to me  
22 makes no sense as I said before. It's sort of

1 the interplay between the problems of validity  
2 and the problems of the importance of the  
3 question then.

4 In criteria validity we have no  
5 gold standard to measure this against. So I  
6 think we're really in very deep water on this  
7 measure.

8 DR. GIFFORD: Now I can ask my  
9 attribution question. I think it would be  
10 helpful to see, since you're saying this  
11 attribution by cost is better than by visits,  
12 and some of us are familiar with seeing the  
13 visits, see data that shows why you think it's  
14 superior, better, or different. Or what would  
15 happen if you did it a different way. I  
16 didn't see any of that there. Maybe it was on  
17 some of the website links I couldn't get to.

18 The other is I'm still trying to  
19 understand this, the internist question. Now  
20 I know how geriatricians and primary care  
21 internists bill because that's what I am. And  
22 I was in a large group practice with about 50

1 or 60 physicians and about 20 of us were  
2 primary care and the rest were specialists.  
3 And I should know how they bill, but. Are  
4 they using the same E&M codes, 211 through 215  
5 for follow-up visits?

6 DR. RICH: Yes, particularly -- so  
7 the outpatient evaluation and management  
8 services, some of us will remember when there  
9 were E&M codes that were for visit codes and  
10 there were E&M codes for consult services.  
11 Those, the consult services still exist in the  
12 CPT codes but they are not reimbursed under  
13 Medicare and therefore for billing Medicare  
14 physicians providing outpatient evaluation and  
15 management services all use the same codes.

16 So let me speak to, I think you  
17 mentioned the internist question several times  
18 so let me unpack that briefly. I think you're  
19 alluding to the fact that there has been  
20 sometimes a policymaker assumption that an  
21 internist equals a primary care physician and  
22 you're positing that that may not be the case.

1 And yes, I think that this attribution model  
2 attempts to deal with that in the following  
3 way.

4 There can be an internal medicine  
5 physician who's identified themselves as  
6 internal medicine who's doing outpatient  
7 general medical care. So that sounds like a  
8 primary care physician.

9 There may be one who's a  
10 hospitalist that is not a primary care  
11 physician. There may be one who is actually  
12 working in an emergency room. That is not a  
13 primary care physician. There may be one who  
14 reported themselves as an internist but  
15 restricts their practice to cardiology or some  
16 focus area and is not attempting to do primary  
17 care for their patients.

18 The hospitalist, since the codes  
19 that we're looking at are only -- are not in  
20 the observation status or inpatient codes the  
21 hospitalist is out. If the physician is  
22 working in an emergency room billing emergency

1 room service codes they're out. So the  
2 internist working as a hospitalist and the  
3 internist working in the emergency room is not  
4 going to be attributed patients under this  
5 model.

6 Now, the internist who is doing  
7 mostly cardiology may be attributed patients  
8 in the same sense that a cardiologist is  
9 attributed patients except in this case that  
10 internist since they're an internist will be  
11 attributed patients for the first step of the  
12 rule rather than isolated to the second step.  
13 So if that sort of helps you sort of think  
14 about.

15 So the fact that the primary care  
16 services only look at outpatient evaluation  
17 and management codes, SNF, home visits, those  
18 sorts of codes. It excludes hospital visits,  
19 it excludes emergency room visits, critical  
20 care visits, et cetera.

21 DR. GIFFORD: Yes, so I actually  
22 assumed with the codes the ER and the

1 hospitalist were cut out. So my worry is, so  
2 my patient goes to -- has a pacer in, has  
3 COPD. And they see a pulmonologist and a  
4 cardiologist. They bill 211 or 215 or  
5 whatever. I see him and bill 211. The  
6 cardiologist has a few extra bills or sees him  
7 maybe more, sees it's a new patient and  
8 anything else. Their cost structure could be  
9 higher to attribute to the cardiologist than  
10 me. And you attribute it to the cardiologist  
11 group as the primary care. That's what I'm  
12 saying. How do you differentiate when you're  
13 seeing the internist?

14 DR. RICH: Well, so long as those  
15 internists that you were referring to  
16 designated themselves in their specialty to  
17 CMS then the first step of the rule, you would  
18 be the internist.

19 DR. GIFFORD: Can't a cardiologist  
20 designate as an internist and a cardiologist?

21 DR. RICH: Sheila?

22 DR. GIFFORD: I think they can,

1 can't they?

2 DR. ROMAN: I believe they can.

3 DR. GIFFORD: So how do you  
4 discern --

5 DR. ROMAN: -- primary and a  
6 secondary.

7 DR. GIFFORD: Yes, so how do you  
8 discern that?

9 MR. BALLOU: Based on the  
10 specialty that's listed on the plurality of  
11 claims. If you've listed several specialties  
12 but the carrier has placed based on the  
13 services you've provided internist on the  
14 plurality of your claims you're then an  
15 internist from CMS.

16 DR. GIFFORD: I would like to see,  
17 and you probably take, since you have large  
18 groups of 25 it may be worth taking a few of  
19 these at random and going in and seeing what  
20 these groups look like and how you're  
21 assigning them and doing some testing.  
22 Because I just, I just think that there's such

1 room for problems with the assignment.

2 The other question that I had with  
3 assignment is so, and this is sort of about  
4 the broader cost. My group practice of 50  
5 that's got 10 of us that are internists, are  
6 the costs of the entire group of all 50 or  
7 just us 10, the population of our 10? How are  
8 you doing that cost for a group?

9 MR. BALLOU: Well again, once you  
10 are attributed a patient through the rule  
11 which again is physician triggered and it  
12 relies on relationships between individuals,  
13 patient and provider, that attribution, that  
14 patient is attributed to the group. And so  
15 from again the perspective of doing costs  
16 we're talking about then the group is not  
17 accountable for that patient's entire  
18 standardized services.

19 DR. GIFFORD: It's only those that  
20 are attributed to the 10 of us that you  
21 consider primary care. The other 30 who are  
22 specialists, their costs are attributed to us



1 but the patients they see are not included in  
2 there.

3 MR. BALLOU: Unless they were  
4 attributed, those patients -- or the group has  
5 attributed those patients under the second  
6 step of the rule.

7 DR. GIFFORD: Under the second  
8 step as the primary care. Okay.

9 MR. WOLFSON: It is only  
10 ambulatory care. It is no inpatient skilled  
11 nursing facility, no institutional cost. No,  
12 no, the total -- the cost is everything. It  
13 doesn't just include ambulatory, it includes  
14 inpatient. Right? Every dollar spent.

15 DR. NELSON: We've got about a  
16 half an hour before we adjourn. And so in  
17 order to cover more territory around this  
18 large issue of validity let's ask each person  
19 to present and then we'll come back and open  
20 it up for questions. So it would be Jim and  
21 then Andrea and David and then Herbert and Joe  
22 and then Martin and we covered Lina. So let's

1 get more on the table and then we'll open it  
2 up for discussion and comment again. So Jim.

3 DR. NAESENS: Yes. Basically  
4 they did three assessments of validity  
5 testing, correlation of the standardized risk-  
6 adjusted scores with non-standardized payments  
7 and non-risk-adjusted totals, correlation with  
8 other utilization and a correlation with other  
9 utilization in 2010 and 2011 for a subset of  
10 states. They also did a face validity on a  
11 small sample of physicians based on  
12 interviews.

13 The scope of the testing for the  
14 subset of states was limited like I said to a  
15 handful of states. In that assessment there  
16 was an exclusion of a large number of  
17 practices in that only 55 percent of practices  
18 in those eight states were included.

19 Our evaluations of testing were  
20 actually fairly good, 3 high, 13 medium, 3  
21 lower and 2 insufficient. Overall the  
22 comments reflected that there appears to be

1 some under-prediction at the top of the  
2 distribution with some high variability at the  
3 top of the distribution with the suggestion  
4 that the trimming may have been at too high of  
5 a level.

6 Testing correlation of the  
7 adjusted and the unadjusted values is not  
8 compelling evidence for validity. That they  
9 could have tested the correlation with other  
10 measures from other data sets. The suggestion  
11 was looking at the Dartmouth end of life data  
12 and assessing that on a practice basis.

13 Prediction variability is  
14 increasing as the value increases. There's  
15 more information about anticipated variation  
16 across groups -- oh, more information about an  
17 anticipated variation across groups would be  
18 helpful for assessing meaningful differences.

19 And there were some public  
20 comments related to validity raising issues  
21 again about attribution.

22 DR. NELSON: Thank you for that

1 summary. Carlos, do you want to add in at  
2 this point?

3 MR. ALZOLA: One of my comments  
4 about validity was that, one was the large  
5 number of practices that were dropped off the  
6 analysis because of the restrictions imposed.

7 And the other one is that  
8 geographically there is no representation of  
9 some important areas of the country. That  
10 would be the northeast and the southeast.  
11 That's the data they have.

12 And then I also raised an issue  
13 about the high correlation of the unadjusted -  
14 -

15 MS. WILBON: Operator, can you  
16 mute the line that was having some  
17 breakthrough noise? Thank you.

18 OPERATOR: Yes, ma'am.

19 MR. ALZOLA: I raised an issue of  
20 I did not consider a correlation of the  
21 unadjusted and unstandardized per capita costs  
22 with the standardized risk-adjusted values and

1 appropriate validity tests. They were  
2 receptive to that comment.

3 And they presented a similar  
4 analysis summarizing all the utilization  
5 statistics and correlating them with the risk-  
6 adjusted standardized total per capita costs  
7 which show a high correlation which it was a  
8 correlation of 0.7 in 2011 and a correlation  
9 of 0.529 in 2010.

10 The other change they made was  
11 that in the exhibit that they presented they  
12 were correlating total costs versus the --  
13 instead of the per capita costs which they  
14 corrected in the new table. The new  
15 correlation values ranged from a low of 0.25  
16 to 0.705. 0.776 is the highest which is a  
17 correlation with the number of post-acute  
18 services.

19 In general their -- I think these  
20 values are indicative of validity. There are  
21 a couple of them in the 0.3-0.4 range but the  
22 highest one would be with the one that is the

1 most important which would be with all  
2 services is 0.705 which is a good number in my  
3 opinion.

4 So the other criteria that they  
5 used to test validity were, let me find that.  
6 They did some test of face validity. In 101  
7 interviews with 20 of 25 physicians in  
8 Baltimore, Boston and Indianapolis. And the  
9 findings were that the physicians responded  
10 favorably to holding multiple providers  
11 responsible for the patient costs.

12 And in general they were in  
13 agreement with the measure. So on those  
14 grounds I consider that validity is being  
15 appropriately tested and I find it -- that's -  
16 - it has been reasonably shown that the  
17 measure has validity.

18 DR. NELSON: Thank you for those  
19 comments, Carlos. Andrea and David,  
20 exclusions.

21 DR. REDFEARN: I think we've  
22 beaten the exclusions, the horse dead, well

1 dead, so I don't want to go over it again.  
2 The only thing I'd mention is that Medicare  
3 Advantage patients are being excluded and  
4 anybody who resided outside the U.S. for good  
5 reasons because you're not going to capture  
6 that data.

7 And again indirectly through the  
8 contiguous enrollment requirement patients who  
9 have died are being excluded. We talked about  
10 that a lot for the other measure.

11 DR. GELZER: And I'm just going to  
12 add on the two exclusions, the newly enrolled  
13 or disenrolled, the continuous enrollment in  
14 Medicare Part A or Part B and the Medicare  
15 Advantage exclusion. So individuals have to  
16 be enrolled for that whole calendar year. As  
17 you've said that decision has been made. And  
18 Medicare Advantage individuals are excluded.

19 So if the intent of the measure is  
20 to measure performance, reduce variability and  
21 ultimately reward practices based on the total  
22 cost I'm a little bit concerned about validity

1 of the measure because of I think a potential  
2 to exclude dual eligible costs from the  
3 calculation.

4 I know that T testing didn't show  
5 any statistically significant differences in  
6 beneficiary demographics and duals. Dual  
7 eligible status and distribution of risk  
8 scores of those included versus excluded  
9 weren't statistically different. That  
10 surprises me like it has surprised others.

11 But there's sort of a double  
12 exclusion whammy because of the calendar year  
13 requirement. And then the Medicare Advantage  
14 exclusion from measurement. I think that can  
15 lead to some real gaming of the measure in  
16 that large, sophisticated practices will learn  
17 that they can actually shift some of these  
18 higher cost members to dual SNP plans and no  
19 longer have them in their -- still have them  
20 in their practice but no longer have them in  
21 the measurement.

22 DR. NELSON: Thank you for those



1        comments.  And Herbert and Joe, risk  
2        adjustment.

3                    DR. WONG:  So I'll give it a start  
4        and Joe can put in his two bits on it.  So I  
5        think that we've already ventured into this  
6        territory a little bit in terms of risk  
7        adjustment.  From the pre-voting we had 10  
8        high, 6 moderate and 5 low.  And I think that  
9        the substance of the comments I think by going  
10       through this is this really fundamental belief  
11       that it's the standard Medicare analytics in  
12       terms of risk adjustment.  And there was this  
13       notion that folks wanted to kind of see more  
14       in terms of some sophistication beyond that.

15                   There was a general assessment  
16       that for those who are concerned that the HCC  
17       model is basically weak and that there could  
18       be some additional robustness testing to kind  
19       of explore it.

20                   One person commented about the  
21       distribution in terms of looking at basically  
22       cost information that is heavily skewed, the

1 distribution could in fact be different and  
2 that different models should be considered,  
3 whether it's a negative binomial or gamma  
4 distributions, things along those lines.

5 I think that the regular themes  
6 that we've heard a little bit earlier with the  
7 other measure I think kind of came out here as  
8 well. In terms of inclusion of some  
9 socioeconomic characteristics or market factor  
10 characteristics because some believe that the  
11 R squared was relatively low.

12 So I think that that's kind of my  
13 broad summary. And Joe, if you have other  
14 comments?

15 DR. STEPHANSKY: Dead horse.

16 MR. AMIN: I have a quick question  
17 for the reviewers on this. The specific issue  
18 that was raised around dual eligibility status  
19 considering the fact that there was data  
20 demonstrated by the developers in terms of its  
21 relationship to the outcome or the lack  
22 thereof. Is there -- can you describe your

1 opinion on the appropriateness of the  
2 inclusion of dual eligibility status in the  
3 risk model considering the NQF guidance  
4 related to this.

5 DR. WONG: You know, I would let  
6 others on the committee kind of chime in on  
7 that particular aspect of it since you're  
8 honing on an issue that other folks have  
9 raised.

10 DR. NELSON: Brent.

11 DR. ASPLIN: I have a couple of  
12 other questions too. I think this issue is  
13 going to -- other than the fact that it's  
14 buried in the risk score so maybe it won't be  
15 so obvious I think it could blow up in NQF's  
16 face, frankly.

17 I think it's going to be very  
18 challenging because people are going to say  
19 the same thing, well, why didn't you include  
20 it then in the readmissions measure. And why  
21 didn't we put it into the risk model on the  
22 measure we talked about this morning.

1                   Because you have the policy, and  
2                   we're kind of stuck between Congress and NQF  
3                   here. You know, this is an NQF meeting but if  
4                   Congress mandated the sex and dual eligibility  
5                   status in the risk model, although I didn't  
6                   hear that about the duals. That was more of  
7                   a historical reference from an earlier  
8                   comment.

9                   I just think you're going into --  
10                  you're changing and unless -- I was trying to  
11                  think of a rationale for the change and was  
12                  struggling a bit. But perhaps it is if you're  
13                  talking about a pure quality measure you don't  
14                  include those demographic and SES factors in  
15                  the risk model because you want to see the  
16                  disparity and you don't want to send a message  
17                  that it's okay to have poor quality if you're  
18                  from a low SES status. Okay, so maybe you  
19                  could distinguish quality from resource  
20                  measures with the rationale on the latter  
21                  being you wouldn't want to incent providers to  
22                  exclude taking care of those patients.

1                   That's the best rationale I can  
2                   come up with but most people do not believe  
3                   the all-cause readmissions measure is a  
4                   quality measure. They think it's a resource  
5                   measure, a cost measure. And so they would  
6                   come right back at and want you to put it  
7                   right back into it. I don't know how you  
8                   square this. It's going to be challenging.  
9                   Sorry, I'm not very helpful. Now you're  
10                  supposed to say something brilliant.

11                  MR. AMIN: Well, in some ways  
12                  actually you're asking the precise question  
13                  that I'm asking the committee. Which is that  
14                  NQF guidance is very clear on this matter.  
15                  And this committee if it so chooses to move  
16                  forward a measure that has a marker of SES,  
17                  dual eligibility by most standards is a marker  
18                  of that, there would need to be a clear  
19                  justification of that reason.

20                  And this argument -- I mean some  
21                  have made the argument that there's a  
22                  difference in quality and resource use. The

1 argument being that if it's used to decide a  
2 payment as it would be in potentially Medicare  
3 Advantage and the original purpose of the way  
4 that this risk-adjusted model was created,  
5 that would be appropriate in the sense that  
6 you're describing which you don't want to  
7 incentivize providers to shirk these types of  
8 patients because you want to adjust for the  
9 cost expectation. But what is the a priori  
10 assumption here besides the patient clinical  
11 factors and making that rationale clear?

12 As this measure moves out of this  
13 committee into CSAC that is the exact question  
14 that the chairs and others will have to  
15 defend. And so that is what we're putting  
16 back into the discussion specifically because  
17 this is the place to have it. And the  
18 committee will have to defend that position.

19 DR. NELSON: There's several  
20 people that wish to comment. Let's get one  
21 more perspective on validity and then come  
22 back to these comments. Martin on

1 identification of statistically significant  
2 differences.

3 DR. MARCINIAK: Sure. So unlike  
4 the last time I spoke I'll break it out in  
5 terms of the vote to start because there was  
6 a better distribution this time. We had seven  
7 who voted high, eight moderate, four low and  
8 then two sort of in the inclusive range.

9 If you're looking at the remit was  
10 the data analysis sort of demonstrates the  
11 methods for scoring and analysis of the  
12 specified measure allow for identification of  
13 statistically significant and practically  
14 clinically meaningful differences in  
15 performance.

16 And so we've heard through the  
17 course of the day, you know, part of this is  
18 about getting a handle on the rising sort of  
19 per capita rate of healthcare that we're  
20 currently experiencing in this country.

21 And so three things popped out in  
22 my mind. And frankly they're three things

1 we've talked about throughout the course of  
2 the day. I mean there were things such as  
3 attribution. There was the question of the  
4 measure being reported at either the group or  
5 practice level versus the individual level.  
6 And so if it's one or the other it becomes  
7 very hard to discern. And what is clinically  
8 meaningful. You know, clinically meaningful  
9 at what level? Is it at the individual? Is  
10 it at the group? How do you discern that?

11 Finally, with sort of -- we've  
12 touched on things that I'll link to sort of  
13 face validity and some of the challenges that  
14 we're having sort of pulling that dialogue  
15 together. And when you think about the  
16 measures themselves you kind of look and say  
17 well, you know, \$25 change on \$5,000, you  
18 know, in a large sample size, well that's  
19 statistically significant. But is it really  
20 clinically meaningful? How does it shape or  
21 affect or alter practice?

22 And sort of when I looked through



1 the comments and I thought about the comments  
2 that I had made into the system those were  
3 things that were sort of coming to my mind as  
4 we went through it. So I could go through  
5 some of the comments that were made. I think  
6 everybody is sort of seeing what those look  
7 like. But it might be fruitful now just to  
8 open it up for a general dialogue.

9 DR. NELSON: Thank you. So we  
10 have several cards up. Why don't we just go  
11 up the row and then across. So Dolores. Or  
12 is it Jack? Jack.

13 DR. NEEDLEMAN: So, on the risk  
14 adjustment issue and the inclusion of dual  
15 eligibles what we've seen is it's a challenge  
16 because there are two components to that. One  
17 is we'd like to be able to look at SES because  
18 we're interested in discrimination against  
19 people of low SES, problems of access or  
20 higher use of some services because of delayed  
21 care and any number of other things. And if  
22 they're buried in the risk adjustment model

1 it's hard to see that.

2 On the other hand we have heard  
3 and seen documentation that the dual eligibles  
4 also seem to have more healthcare use than can  
5 be strictly attributed to their HCC status  
6 which would argue that there's something being  
7 captured clinically about that population it's  
8 important to risk-adjust for if we're trying  
9 to understand the differences in groups that  
10 have large numbers of, higher numbers of dual  
11 eligibles having higher costs. That you'd  
12 want to risk-adjust for that if those costs  
13 are due to their clinical situation. So  
14 that's the challenge we have.

15 And right now part of the problem  
16 with the risk adjustment model is that the  
17 ability to analyze that is buried in the model  
18 because the adjustment takes place at a very  
19 early stage. It is hidden in that percentage  
20 of expected -- the -- it's hidden in that  
21 percentage of expected cost figure that's  
22 subsequently used in the risk adjustment

1 model.

2                   So at some point it would be good  
3 if one could simply get as an ancillary set of  
4 analyses what the dual eligibles look like on  
5 that measure and some other use measures so  
6 that one can analyze their experience  
7 separately to look for the kind of disparities  
8 that's the rationale for not putting the SES  
9 into the risk adjustment because we want to be  
10 able to analyze it explicitly.

11                   DR. NELSON: Thank you. Brent?

12                   DR. ASPLIN: Quickly on the  
13 exclusion of decedents is I think just a big  
14 policy gap. I don't know that just throwing  
15 them into the model beneficiaries who die  
16 during the year, that may complicate things.  
17 But either running a separate model or  
18 reporting both a version that includes  
19 decedents and one that does not would be  
20 important from a policy perspective given what  
21 we know about expenditures in the last year of  
22 life and how critical that is. So I feel

1 pretty strongly about that.

2 And then a quick question on the  
3 attribution. How closely does this mirror the  
4 attribution model in MSSP and Pioneer?

5 Because you have 260 organizations in these  
6 now. I know it's close but it doesn't feel  
7 like it's exactly right. Or is it? That's my  
8 question.

9 DR. NELSON: Let's get an answer  
10 from the developers.

11 MR. BALLOU: I'm not sure if I'm  
12 understanding but in terms of mirroring, in  
13 terms of the construction logic it's the same.  
14 It's the same rule.

15 DR. ASPLIN: Identical?

16 MR. BALLOU: It's the identical  
17 rule. And that's a large part of why it was  
18 adopted.

19 DR. NELSON: Thank you. Nancy?

20 DR. GARRETT: So I think, Brent, I  
21 think you captured the issue before us very  
22 well here in terms of the situation we're in

1 with -- if we adjust for socioeconomic status  
2 in this measure then what are the implications  
3 of that from a broader perspective.

4 But I'm going to argue that I  
5 think we should. And so my thought process is  
6 that, first of all, based on coming from a  
7 safety net care system every day we see  
8 patients where their exposure to risk is  
9 different because of the vulnerability of  
10 their situations.

11 And so, you know, situations like  
12 a 23-year-old who is exposed to gun violence.  
13 A 40-year-old who comes in with advanced liver  
14 disease because of alcohol abuse. I mean  
15 these are real issues that they face because  
16 of their situation economically. And so it  
17 affects their exposure to risk but it also  
18 affects their ability to manage health.

19 And when we discharge a patient to  
20 a homeless shelter and they're kicked out from  
21 8 o'clock in the morning until 6 o'clock at  
22 night and it's the middle of winter in

1 Minnesota that's dangerous for someone who got  
2 discharged with pneumonia. And so they're  
3 these social factors that are hard to measure  
4 but they absolutely affect health and our  
5 ability to take care of the patients.

6 And so while we need to be and  
7 we're working on lots of creative ways to  
8 address those situations for us to be compared  
9 on a level playing field with providers that  
10 have a very different kind of population I  
11 think that that is a problem with these kinds  
12 of measures. So I argue that I think we  
13 really should stratify it.

14 And in fact I think dual  
15 eligibility status is a good start but it's  
16 not enough. There's huge variation even  
17 within a Medicaid population in terms of  
18 access to resources and social factors like  
19 social support and all the other constellation  
20 of things that go along with social risk.

21 MS. WILBON: I'm sorry, I just  
22 have a question, Nancy. I thought I heard you

1 say you think that we should stratify by? Did  
2 you mean include it in the model or did you  
3 mean actually stratify it?

4 DR. GARRETT: I meant include it  
5 in the model. I'm sorry, yes.

6 MS. WILBON: Okay, I just wanted  
7 to clarify that?

8 DR. GARRETT: Yes. And one of the  
9 reasons I think that's important is because  
10 from a practical perspective the complexity of  
11 these cost and resource measures, it's going  
12 to be really hard to stratify afterwards in  
13 any way that's meaningful from a policy  
14 perspective. I think it has to be built into  
15 the measure in order for it to be really  
16 applied in a way that starts to level the  
17 playing field.

18 DR. NELSON: Cheryl?

19 DR. DAMBERG: I just want to make  
20 sure I'm understanding this dual status.  
21 Because I'm looking at the one table that  
22 shows the distribution of people with dual

1 status versus not across these groups by  
2 different group size and I don't see any  
3 variation.

4 DR. NELSON: What table are you  
5 looking at? In case others wish to view it.

6 DR. DAMBERG: Exhibit 1.2. It  
7 says, "Summary of characteristics of  
8 beneficiaries attributed to medical group  
9 practices for groups with at least 25 eligible  
10 professionals and at least 20 attributed  
11 beneficiaries by group size."

12 So the groups are 25 to 50, 51 to  
13 100, 101 to 200 and more than 200. And I  
14 guess I was expecting to maybe see the duals  
15 congregating in certain group sizes but I'm  
16 not seeing that. So if they're sort of  
17 equally distributed.

18 Now, maybe they're not equally  
19 distributed at an individual physician level  
20 and that's something I can't tell from this  
21 table.

22 DR. NELSON: David?



1 DR. REDFEARN: I just want to  
2 throw one more punch at that poor horse and  
3 mention something that nobody else has  
4 mentioned so far. The risk scores that they  
5 calculate are composed of -- there's two  
6 different types of patients. There's the new  
7 enrollee, the community new enrollee and then  
8 there's the enrollees in the full one. The  
9 full one uses the HCC. The other one only  
10 uses demographic risk factors.

11 It's going to be a worse  
12 adjustment factor no matter how you look at  
13 it. And they're mixed in here. And you're  
14 going to have both of them going on and  
15 they're based on different structure. And  
16 that concerns me because there's going to be  
17 variation in how well that adjustment factor  
18 works depending on the status of the patient.  
19 That's an issue.

20 DR. NELSON: Would you like to  
21 respond?

22 MR. BALLOU: Yes, thank you.

1 That's certainly true and I'm not sure if Greg  
2 Pope is still able to join us on the phone.  
3 He may want to respond afterwards as well if  
4 he's still on the line.

5 The new enrollee model does not  
6 predict as well as you would expect, right.  
7 It doesn't have the comorbidities included.

8 Effectively what happens in our  
9 second stage risk adjustment then is we have  
10 new enrollees in a group are essentially  
11 compared to new enrollees in other groups.  
12 And continuing enrollees with the community  
13 data with the comorbidities in the same group  
14 are compared to continuing enrollees in other  
15 groups.

16 So I think that while it's correct  
17 that the precision will not be there for the  
18 new enrollees as it will be for those with the  
19 comorbidity data included we have not seen  
20 evidence to suggest that any meaningful groups  
21 is attributed a disproportionately large  
22 number of, say, new enrollees compared to

1 continuing enrollees as might happen when  
2 groups have, you know, they happen to get all  
3 the new Medicare beneficiaries that are just  
4 enrolling, for example. And I think that's  
5 where that would become more of a concern.

6 DR. NELSON: Daniel.

7 MR. WOLFSON: I want to take a  
8 contrary view about socioeconomic class. I  
9 don't think you should adjust for it. I think  
10 it gives providers a pass. And I can remember  
11 Patty Gabow from Denver Health who has a very  
12 difficult population who outperforms every  
13 hospital in the country on any quality  
14 measure. And she's set up services to do  
15 that.

16 If we let the socioeconomic class  
17 be a pass then why would somebody be motivated  
18 to have the proper services to deal with  
19 difficult populations? I would do something  
20 different and I would revert to percentage of  
21 improvement from one year to another. So I  
22 would adjust for where people begin in

1 resource use.

2 So I think there's other ways to  
3 do that. But to mask the socioeconomic, I  
4 think that's why people keep saying not to do  
5 that. And maybe -- well, we already have a  
6 two-class system. But we'll have a worse two-  
7 class system and it will just perpetuate the  
8 two-class system I think by adjusting for it.

9 And Patty Gabow's Denver Health is  
10 an excellent example of somebody who's  
11 overcome very difficult populations and  
12 outscores everybody in the nation.

13 DR. NELSON: It's 5 o'clock.  
14 About time to adjourn. Difficult area here,  
15 validity. We should I think take a vote.  
16 Before doing that, any public comments?

17 OPERATOR: At this time if you  
18 have a question or a comment please press \*1  
19 on your telephone keypad.

20 MS. WHEATLEY: Hi, Mary Wheatley  
21 from the AAMC again. We've been working with  
22 the academic practices looking at these

1 quality resource use reports and looking at  
2 the data and trying to understand the cost  
3 measure for the past couple of years.

4 I think there are a couple of  
5 things that I'd like to give from that  
6 perspective of trying to analyze and trying to  
7 understand this data.

8 One is this is -- we've actually  
9 not seen the data with this new attribution  
10 methodology. So it's new to the chief pro  
11 groups.

12 Before it was based on all  
13 specialty care and we actually thought that  
14 brought in a ton of noise, especially when  
15 you're pairing that with primary care  
16 measures. So we actually encourage going to  
17 a primary care attribution methodology but we  
18 haven't seen how that actually plays out in  
19 the real world in knowing how well this  
20 particular attribution methodology works. And  
21 if there needs to be additional tweaks.

22 And then the other thing that I

1 think needs to go with that is for a whole  
2 host of reasons we don't even know the full  
3 patient populations. Like the transparency  
4 that goes in with some of this measurement has  
5 not, you know, we know who gets assigned to  
6 the quality buckets that are kind of paired  
7 with these patients, but we actually don't  
8 know who the patients are.

9           And it's kind of this, you know, a  
10 lot of drilling down and trying to figure out  
11 what's going on with this data. And there's  
12 a lot of information that's not yet available.  
13 So I think that there's been a lot of progress  
14 made but there's a lot more that really needs  
15 to be done to really make sure we know that  
16 this attribution is right.

17           And then the last thing I would  
18 like to say is I know this new attribution  
19 methodology is used with the MSSP ACO models  
20 so those groups may have more experience with  
21 these measures. But this program and how this  
22 measure is being used in this cost metric is

1 a little different because you're not  
2 comparing yourself to your own historical  
3 history, you're comparing yourself across  
4 different organizations. And so that makes it  
5 a different way to consider this attribution  
6 method. Thank you.

7 DR. NELSON: Any other comments?

8 OPERATOR: We have no public  
9 comments at this time.

10 DR. NELSON: Very good, thank you.  
11 Any further comments from our committee or  
12 from our measure submitters? CMS,  
13 Mathematica? Okay. Good discussion. Complex  
14 issues.

15 So this is an all-in vote on  
16 validity, one to four. And I think we're  
17 ready to take the vote.

18 MR. WILLIAMSON: We will now vote  
19 on overall validity. You have 60 seconds  
20 beginning now. And we have 12 moderate and 12  
21 low.

22 MR. AMIN: And Larry's out of the

1 room.

2 DR. NELSON: So a second time. Do  
3 you want to clear the system?

4 MR. WILLIAMSON: We'll now vote  
5 again on overall validity. You have 60  
6 seconds beginning now. We have 13 moderate  
7 and 12 low.

8 DR. NELSON: Is that a correct  
9 count of everyone that should be voting?

10 MR. WILLIAMSON: Yes, that's 25.

11 DR. NELSON: Okay.

12 MS. WILBON: So.

13 DR. NELSON: We've seen similar  
14 numbers today.

15 MS. WILBON: Yes, we definitely  
16 have. You know, same scenario with the last  
17 measure. We will -- we'll continue tomorrow.  
18 You guys have done a great job today. Thanks  
19 for hanging in there. It's been exhausting,  
20 I know.

21 Well reconvene tomorrow. Again, I  
22 think tomorrow we're going to put our heads



1 together. Whether this actually means there's  
2 consensus obviously, probably not, but just  
3 based on operationally we will continue to  
4 evaluate the measure and see how things pan  
5 out in the end of the recommendation.

6 And we'll reconvene tomorrow  
7 actually at 8:30. So the agenda I think for  
8 tomorrow that we sent out said that we would  
9 start at 9:30. Because we kind of went so  
10 long today and had an extended conversation,  
11 which is great, we are going to start an hour  
12 early tomorrow. So we will be starting the  
13 meeting at 8:30. So if you can come by 8:15,  
14 breakfast will be out by 8 but at least if you  
15 can plan to be here by 8:15 so we can start  
16 promptly at 8:30 that would be great.

17 Again, if you have any juice,  
18 anything left and you want to come and hang  
19 out for drinks we will be there. So feel free  
20 to do that. We've emailed everyone the  
21 address and the location and time for that if  
22 you'd like to join.

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Thank you, everyone, for a great discussion today. And to our co-chairs for leading us through.

(Whereupon, the foregoing matter went off the record at 5:05 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 Steering  
Committee

Before: NQF

Date: 05-08-13

Place: Washington, DC

was duly recorded and accurately transcribed under  
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