

NATIONAL QUALITY FORUM

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COST AND RESOURCE USE

STEERING COMMITTEE

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THURSDAY

MAY 9, 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:

GERRY SHEA, Interim President and CEO
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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

CHAD HEIM, HealthPartners

GARY KITCHING, HealthPartners

SUE KNUDSON, HealthPartners

SYED MEHMUD, Wakely Consulting

GREG POPE, RTI International (by
teleconference)

EUGENE RICH, MD, Mathematic Policy Research

SHEILA ROMAN, MD, MPH, Centers for Medicare &

Medicaid Services

CHRISTOPHER TOMPKINS, PhD, Brandeis University

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

2 (8:31 a.m.)

3 MR. AMIN: If it's okay with the
4 Chairs, I just had two quick announcements.
5 So good morning, everyone. Thank you again
6 for all the hard work yesterday. I know that
7 it was sort of a long day going through those
8 two measures. We look forward to sort of
9 finalizing the discussion on the second
10 measure.

11 Based on the a few emails and
12 conversations I had since last night until
13 this morning, I wanted to clarify two points
14 that sort of process related and sort of
15 reflect a little bit of our discussions. The
16 first is I think many felt a little bit
17 uncomfortable with the fact that there was
18 sort of a split vote on the last measure.
19 Specifically I mean we obviously haven't gone
20 fully through the measure completely at this
21 point but we wanted to clarify that the
22 process of gaining consensus on these measures

1 doesn't just end today. After the committee
2 has its deliberations on this measure, it will
3 go out for public comment. Our NQF Members
4 broadly will vote on these measures. And the
5 committee will come together during the
6 comment -- after the comment period to review
7 the comments from the membership and the votes
8 to reflect on its conversation, vis-a-vis the
9 conversation of the broader quality community.

10 So we will think about what other
11 kind of inputs we may need at that point but
12 this is not the committee's last chance, if
13 you will, and it is not the last chance of
14 these measures in any way to move forward.

15 In addition, the committee
16 deliberations will then go to our CSAC, which
17 is intended to think about these issues on a
18 more macro level. That will address some of
19 the issues that some of the committee members
20 described in terms of the SES potential issues
21 and the dual eligible status issues in terms
22 of risk adjustment and ensuring that this

1 committee is consistent with the committees
2 across various different projects
3 historically.

4 So it is not to say -- I say all
5 that to say that the process of gaining
6 consensus takes a bit of time. It doesn't
7 just end today and it will be informed by our
8 colleagues across the NQF membership and the
9 public at large.

10 I mean obviously, some of those
11 comments already have provided during the
12 committee deliberations and in preparation to
13 the committee meeting. So that is the first
14 issue around how consensus is actually defined
15 and when we actually know we have reached some
16 level of consensus.

17 And I will say after the CSAC, it
18 will go to the Board where the Board will also
19 discuss these issues. And some of you will
20 remember that in terms of the all cause
21 discussion.

22 The second is an issue that I

1 heard yesterday, I got an email about it and
2 also heard it this morning around a little bit
3 of frustration with the fact that it feels
4 like we are giving measure developers input
5 that is much too late in the process. Why
6 does NQF kind of sit where it does? Is there
7 any way that we can provide input earlier in
8 the development process so that what we get at
9 this of whole enterprise is a better measure?
10 It is better for developers. It is better for
11 the steering committees. And it is better for
12 all of us as an enterprise.

13 So that is a bigger question and
14 that question involves sort of our forward-
15 looking thinking in terms of our own process
16 improvement efforts of NQF.

17 I will say that we, as Staff,
18 recognize that this is a challenge. It
19 doesn't really help to create a quality check
20 as anyone knows in any manufacturing process
21 it doesn't help to have a quality process.
22 That is at the end of after you have developed

1 a vehicle to then test to see if it works.
2 You want to have some process that is
3 iterative.

4 And so we are also trying to
5 maintain our role as a neutral convenor and an
6 endorser, not as a measure developer. And so
7 we are working with CMS, with ONC, and other
8 measure developers in our broader community to
9 think about how we can, as Helen is describing
10 it these days, interdigitate, which we now
11 believe is actually a word, this whole process
12 so that it is iterative and, in some way, we
13 actually have a better process at the end.

14 It is only to signal that this is
15 effort that we are working on. We don't have
16 a proposal yet, but it is something that we
17 are actively working on. So I don't know that
18 that is particularly satisfying for those that
19 raise that concern but that is, at least, our
20 forward thinking on that issue.

21 So I just wanted to close the loop
22 on two issues that were raised, the consensus

1 issue and how it can better provide input to
2 measure developers broadly. And so I will
3 turn it back to the chairs to continue our
4 discussion from yesterday on the measures.

5 DR. NELSON: Thank you, Taroon.

6 Well good morning everyone.

7 Thanks for being back. I know that there is
8 a lot of energy and deep feelings and thought
9 about the rest of this discussion on the per
10 capita cost per year measure.

11 Yesterday was were able to get
12 through one measure and had great discussions.
13 And we now have two more topics for this
14 second measure, being the feasibility and the
15 usability. Dan had mentioned that he and --
16 is it correct that Dan and Dolores had spoken?
17 Dan and Lisa had spoken. Okay, Dan and Lisa.
18 Okay. And they are going to do a
19 point/counterpoint when we get to the issue of
20 usability.

21 So I think what we want to do now
22 is pick up feasibility. And for opening

1 comments, we will have Dolores. A heads up on
2 the rest of the agenda before I go into
3 feasibility and usability.

4 The original agenda we had three
5 more fairly significant topics: harmonization
6 with other measures, specifically the one
7 developed by health partners which will come
8 after this discussion; and then risk
9 adjustment; and attribution by the end of the
10 day.

11 So this is the most important is
12 to have a thorough and good and final decision
13 on this measure. And then I think there will
14 be a brief set of remarks from the Acting CEO
15 for about ten minutes or so. And then we will
16 go to the harmonization topic.

17 So any questions about the setup
18 for today? We will finish as scheduled at
19 2:30.

20 Okay, so hearing none,
21 feasibility, Dolores.

22 MS. YANAGIHARA: So like the other

1 measure, I think that most people felt that
2 this was highly feasible, using electronic
3 data. It is data not necessarily as part of
4 care but as a byproduct of care in terms of
5 billing and is available electronically. So
6 I don't think that there was any issue there.
7 There were a couple of concerns around the
8 availability of data for other populations,
9 although if this is being approved just for
10 kind of the senior population, that may not
11 play in as well or as much. And as always,
12 kind of concerned about the cleanness of the
13 data, that the quality of the measure depends
14 on the cleanness of the data but that is
15 always the case with data.

16 So there wasn't any -- I don't
17 think there were really any major concerns
18 that were raised and so that is kind of the
19 summary of feasibility.

20 DR. NELSON: Thank you. So let's
21 open this up for discussion and comment,
22 feasibility.

1 (Pause.)

2 DR. NELSON: Did Dolores say it
3 all for the group? She didn't quite say it
4 all. Jack, thank you.

5 DR. NEEDLEMAN: I just wanted to
6 reinforce a point that Dolores made softly,
7 which is I think it is perfectly feasible for
8 CMS to do this. Any physician, any group
9 should be able to get the data they need.
10 They will be completely dependent upon CMS to
11 do it.

12 Likewise, we heard yesterday when
13 we were talking about the other measure, that
14 an insurer could implement it. But to the
15 extent that one of the prime targets for this
16 measure and other measures, the other measure
17 yesterday are the providers without access to
18 all the claims data from all your patients.
19 There is no way that a provider can
20 independently implement this measure, which
21 means that it is a measure that is important
22 to get commitment from those who have the data

1 to make the data available to those who are
2 going to use it.

3 DR. NELSON: Jack, to clarify,
4 when you said all claims, beyond Medicare or
5 just in Medicare?

6 DR. NEEDLEMAN: Well the whole
7 risk adjustment, for example, the HCC risk
8 adjustment completely depended upon knowing
9 all the diagnostic codes that were put in
10 anywhere on an ambulatory claim or a prior
11 hospitalization for these patients.

12 If you are one of Dan's docs, you
13 don't have access to all of that. And if you
14 are one of Joe's hospitals, you don't have
15 access to all of that but it is inherent in
16 the risk adjustment model.

17 DR. NELSON: Thanks for bringing
18 that point up. David?

19 DR. GIFFORD: In the spirit of a
20 warm-up, it is more of a comment I was
21 thinking about this last night. Work we have
22 done with physician groups in the past, most

1 physician groups can't tell you who their
2 panel of patients are. They don't even know
3 who they are. They can't figure it out. So,
4 I'm not sure how you can do attribution when
5 they can't event figure out who they take care
6 of themselves.

7 So from a feasibility standpoint,
8 that is just sort of a -- I find that sort of
9 almost that we are talking about an efficiency
10 measure when they don't even know efficiency,
11 who they are taking care of. So that is just
12 a broader comment on this issue. So in some
13 sense while I think I was really critical
14 attribution and concerned about it as I
15 thought about it, the docs, this is probably
16 better and helpful to them, even though it is
17 not perfect. And so I have sort of switched
18 my thinking on that. So a long way of saying
19 is I think it is very difficult and feasible
20 to do the attribution but it is better than
21 anything else that is out there.

22 DR. NELSON: Thanks, David. I

1 think the first point that you raised is we
2 will hit again in the usability discussion.

3 Okay, getting ready for the --
4 winding up for the pitch. Are we ready to
5 vote on this? Is there need for public
6 comment before voting on this topic?

7 Okay, so we are getting ready to
8 vote. Evan is going to tell us when we have
9 an opportunity to use our clickers.

10 MR. WILLIAMSON: We will now vote
11 on feasibility. You have 60 seconds,
12 beginning now.

13 (Pause.)

14 MR. WILLIAMSON: And we have 19
15 high; 5 moderate; 1 low; and zero
16 insufficient.

17 DR. NELSON: Okay, not as close as
18 scientific acceptability.

19 And so the final topic then,
20 usability and use for this measure, per capita
21 cost measure.

22 Dan and Lisa indicated that they

1 were going to work together. Is Dan suiting
2 up?

3 DR. LATTIS: I don't know. He
4 assigned me the negative. So I can start with
5 that. So the usability -- and he will
6 hopefully jump in with the positive when gets
7 back.

8 So the four things we are looking
9 at for usability is
10 accountability/transparency; improvement --
11 has there been progress demonstrated or do we
12 think this will lead to improvement;
13 unintended consequences; and then measure
14 deconstruction -- can those who are using the
15 measure understand how it was put together,
16 put the pieces together and then use that to
17 lead to improvement.

18 And so I think it is actually
19 quite easy to argue that this usability for
20 this measure is low.

21 So from an
22 accountability/transparency perspective, this

1 is just mushed together of all of your claims
2 costs. So the accountability to the
3 individual docs, since it is being reported on
4 a group level, is going to be extremely
5 difficult. As far as transparency, from a
6 public transparency standpoint, as far as I
7 can tell, there is no plan to make this
8 transparent to the public. So that is
9 something I definitely actually have concerns
10 about.

11 As far as improvement, has their
12 progress been demonstrated? This will be a
13 new measure so it hasn't been out there, yet.
14 So we don't have any evidence of this.

15 The unintended consequences I
16 think could be quite real. And maybe almost
17 in a nefarious way you could think maybe it is
18 intended, depending on if you believe there is
19 a government conspiracy of one way or the
20 other.

21 The way around this would be to
22 ensure that your more expensive population in

1 Part A and B were not in Part A and B for all
2 of the year. So all you would have to do
3 would be to shift them into MA or some other
4 arrangement for a month and they would be out
5 of your population.

6 So I don't think it would take a
7 very sophisticated group to figure that out
8 and go ahead and do it.

9 I think it would be a little
10 harder to not spend certain costs
11 inappropriately, especially given the quality
12 measures. But I think to shift them into
13 another product line for a small period of
14 time would be not that difficult and actually
15 quite easy for a sophisticated group to do.

16 As far as the measure
17 deconstruction, for a group to figure out what
18 to do based on this measure alone I think
19 would be quite difficult. I actually, you
20 know to sneak into Daniel's area, was pretty
21 impressed with the reporting. So I think that
22 there is a lot of good information in the

1 report and I think you could take a lot, take
2 some action from that, although again I think
3 you would need some sophisticated data people
4 and analysts within the group. Otherwise, you
5 are going to get lost in the 40 page report
6 and not know exactly how to act, especially
7 given that it is coming at a group level as
8 opposed to an individual physician level.

9 So I will stop there and hand over
10 the difficult job of defending it to Daniel.

11 MR. WOLFSON: Just to set this up
12 a little bit, when you do a counterpoint, it
13 is not necessarily what I believe. So you
14 have to play it like you are role playing. So
15 I just want to make sure that when you attack
16 me, you say I didn't like the counterpoint.
17 You don't attack me.

18 So I just want to also -- I don't
19 know if you went through the scoring.

20 DR. LATTS: I did not, no.

21 MR. WOLFSON: Okay. I'm sorry I
22 left the room. God, you guys were so fast on

1 feasibility it is ridiculous.

2 So anyways, the scoring was really
3 interesting. Under improvement, ten people
4 gave it an I for insufficient. I was really
5 surprised by that. And you gave it high marks
6 in accountability. Thirteen people gave it a
7 high mark for accountability and transparency.
8 Unintended consequences was eight gave it
9 insufficient in that category as well and
10 seven gave it medium. And then measured
11 deconstruction, nine said it was -- gave it a
12 high mark.

13 So I am going to take the contrary
14 view. And I know this will irk people
15 totally. But I actually think that this
16 measure actually can drive change and
17 responsibility model for physicians. The
18 assignment of physicians in a primary care
19 because they are the high utilizer will
20 actually define primary care in a
21 responsibility model that I think is actually
22 very positive. And the specialist will either

1 have to really own up if they are doing
2 primary care or stop doing primary care, which
3 I think it would be an interesting thing to
4 think about in the marketplace. So I actually
5 think that this notion of how can we make
6 specialists responsible for care is something
7 that I think is actually a positive thing. If
8 specialists want to do primary care, they
9 should.

10 I worked at Fallon Clinic. Our
11 pulmonary doctors were also primary care
12 doctors. Our cardiologists often acted as
13 primary care doctors and did that quite well.
14 They are internists to begin with we always
15 say. They have general internal medicine
16 underneath them, so they should be able to do
17 primary care. And society actually needs
18 specialists to take that role because we don't
19 have enough primary care.

20 The 25 provider thing people have
21 talked about but I actually think it coincides
22 with the notion of the law. And I think that

1 is where we are going. So I don't think it is
2 an inappropriate mark.

3 I think the attribution has
4 problems but again, I think that there is a
5 positive side to that.

6 I do think that if you look at
7 Exhibit 9, I think, there is some detail to be
8 able to look at to improve. It might not
9 coincide with how you think about your costs
10 but there is enough detail in there to
11 improve.

12 And there were some comments about
13 well, what do you want people to do, just
14 provide less? Well you know, first of all
15 professionalism kind of takes over. You know
16 people don't kick people out of panels just to
17 game the system. I think professionalism kind
18 of takes over and guides that along. So I
19 don't buy the gaming. And physicians don't
20 have time to sit and game in this day and age.
21 I find that offensive.

22 The measure --

1 (Laughter.)

2 DR. LATTI: That was a
3 counterpoint.

4 MR. WOLFSON: And she's a
5 physician. I'm just an MPH.

6 (Laughter.)

7 MR. WOLFSON: I'm trying to play
8 this pretty cool.

9 The measure -- you know there has
10 been talk about the measure is not in broad
11 use. Well, that is not true. I mean, this is
12 a commercial; people in the commercial world
13 do this all the time. And we were talking
14 they were doing it in Michigan. So I think
15 this might be new to fee-for-service and it
16 might be new to Medicare but it is not new to
17 the commercial world. It is certainly not new
18 to people in prepaid systems like HMOs and so
19 on. So I don't buy that.

20 And I do think it is relevant to
21 policy, where we are going with this law, that
22 we are really kind of matching up to. And I

1 think it is where the country is going.

2 So I, in my role as counterpoint,
3 wanted to make those points. The unintended
4 consequences, every measure that looks at any
5 cost or utilization as a tremendous unintended
6 consequence but only can be tempered by
7 quality indicators and professionalism and
8 wanting to do the right thing by patients.

9 So that is my shtick and I will
10 stand behind it only for this period of time.

11 DR. NELSON: Thank you, Dan. I
12 think the point/counterpoint has been
13 appreciated. Very good.

14 Let's open up for general
15 discussion and comment. Bill, I'm sorry. I
16 think you were first, Nancy.

17 DR. GARRETT: So I have a question
18 for the developers. So we have the exhibits
19 of the reports. Are there plans to give more
20 detailed data so just at the claims detail
21 level to providers as well?

22 MR. BALLOU: So we continue, as we

1 produce each cycle of reports to try and
2 improve on the level of detail that is
3 provided. I believe that the Exhibit 9 that
4 is being referenced is probably from last
5 year's reports. And so there are additional
6 categories and breakouts. We have heard from
7 people that they want to hear more about Part
8 B drug break outs. They want to hear about
9 any number of miscellaneous sorts of services,
10 ambulance services, et cetera. So we are
11 continuing to break those out.

12 We are breaking out -- I believe
13 we may have done this previously, evaluation
14 of management services provided by your group,
15 meaning the report recipient versus other
16 groups. And by even for the other groups, the
17 types of professionals within the group who
18 are providing that on down.

19 We are also going to provide,
20 starting with this cycle of reports coming out
21 later this summer, beneficiary level
22 information. So identifiers of the individual

1 beneficiaries that have been attributed meant
2 to be responsible to the earlier comment but
3 often times, physicians don't know who their
4 patients are. They will find out, at least
5 under this attribution role, who these
6 patients are, along with information about any
7 of the chronic conditions they may have had
8 that are of focus in this report for chronic
9 conditions; whether they had any of the
10 potentially avoidable hospitalizations that we
11 seek to capture; whether they were
12 hospitalized at all; when they were
13 hospitalized; for what purpose; where they
14 were discharged to; their discharge status
15 upon discharge. So a lot more information
16 than we have been able to give before, in
17 addition to some information on actually the
18 physicians and eligible professionals that we
19 have associated with the group.

20 DR. GARRETT: Thanks. So I think,
21 giving that information on the attributed
22 population is really key because that is a

1 huge issue is trying to understand with
2 retrospect of attribution who is actually in
3 your population. So I think that is really
4 good.

5 Just a comment from a provider
6 perspective, the report breaks out services
7 provided by your group and other groups. And
8 I think eventually having more detail on that
9 utilization outside your system is really
10 important, as we try and really move forward
11 with care coordination. The providers are
12 really blind. I mean we understand what
13 happens within our system but what happens
14 outside of our system without data from payers
15 we really don't know much about that. And it
16 is really important to be able to understand
17 who those providers are so that more of these
18 partnerships can be formed. So I think that
19 is one comment about usability is that at this
20 point with the measure there is really limited
21 ability to understand that external
22 utilization.

1 DR. ROMAN: Just to respond to
2 that, we have provided, I think since the
3 beginning of the reports, information on how
4 many physicians your beneficiary is seeing.
5 And I think that starts down that road because
6 fee-for-service has been a very fragmented
7 approach to care. And one of the objectives
8 of this program is to make care less
9 fragmented.

10 And I think physicians are often
11 very surprised at the number of other
12 physicians who are seeing their patients. And
13 I think your point is relevant to that. That
14 is information that we have.

15 DR. GARRETT: Right. And
16 absolutely within your ACO programs you are
17 giving that kind of data to providers. And so
18 the question if there isn't kind of that ACO
19 arrangement, is it also possible to start
20 providing that level of transparency.

21 DR. NELSON: I think Bill is next
22 and then Cheryl and then David.

1 DR. WEINTRAUB: So I remain very
2 troubled by this measure and I think there are
3 problems with attribution that make the
4 accountability very difficult and the
5 potential unintended consequences are large.

6 Now Gene and I had an interesting
7 conversation right before we started about
8 this measure and how it could potentially be
9 used. And I think that if you have a large
10 integrated healthcare system, really a large
11 accountable care type organization where
12 everything works together and you have primary
13 care and you have the sub-specialties and then
14 you could attribute to the healthcare system
15 as a whole, based on the number of primary
16 care physicians, you may be able to make some
17 sense of it. But we are not really organized
18 that well. We are not organized that way.

19 Yes, physicians would be surprised
20 at all the other people that are seeing their
21 patients but if that is all that was going to
22 be used for, that would be sort of

1 interesting, you know sort of interesting to
2 know something but I think that the potential
3 for this to be used in abusive ways actually
4 is very great.

5 I don't think we can attribute to
6 primary care what the orthopedic surgeons and
7 the cardiologists all are doing. And you say
8 well they ought to know. They ought to have
9 some sense of it. They really ought to in some
10 way be responsible to the healthcare system as
11 a whole and what those cardiologists are doing
12 so they are not doing things they shouldn't be
13 doing but they are not trained to do so. They
14 don't have the backgrounds to do so.

15 And so if you were going to have
16 -- if things were like at Dartmouth where
17 everything is every well organized in one
18 healthcare system and you could then attribute
19 to the healthcare system as a whole how they
20 are doing, fine. But the world isn't
21 organized that way. And the potential for
22 attribution to come all the way down to the

1 individual provider is there. That would be
2 a very bad unintended consequence because we
3 can't put on the backs of primary care
4 physicians and we can't put on the backs
5 certainly of nurse practitioners what the
6 cardiologists are doing.

7 Now should the cardiologist and
8 the orthopedic surgeons be responsible and
9 make good societal choices and not do things
10 they shouldn't be doing? Absolutely. But
11 that is where at least the way we are
12 organized right now, that is where the
13 responsibility needs to lie.

14 DR. NELSON: Cheryl.

15 DR. DAMBERG: Sheila, I wanted to
16 just probe a little bit around this care
17 coordination in sort of a siloed approach. I
18 wasn't sure whether you and your team had
19 considered a multiple attribution approach.
20 Because it seems to me Medicare has this
21 opportunity, you know the struggle in fee-for-
22 service sort of nobody is accountable. Right?

1 And so I was wondering if you had explored the
2 joint accountability and tried to come at this
3 from a much more patient-centered focus
4 looking across the entire episode, such that
5 you are giving this information back to all
6 providers who touched that particular patient
7 within an episode.

8 MR. BALLOU: Thank you. It is a
9 good question. We have tested a myriad of
10 attribution rules over the past four or five
11 years. And we have tested several multiple
12 attribution rules, one-touch; what we refer to
13 as multiple even, all costs to all providers
14 who touched; multiple proportional, all costs
15 to providers in the proportion in which they
16 touched them, to proportion measured in a
17 number of different ways.

18 So I think the answer to that
19 question is yes, we have tested it. There
20 are, as with this rule, there are pros and
21 cons to any attribution rule. So I think how
22 you feel about multiple attribution versus

1 exclusive attribution really has to do how you
2 come down on some of the issues that were
3 being discussed here.

4 DR. DAMBERG: Right. But I think
5 if you are largely using this as informational
6 to get people thinking, and talking, and
7 considering how they work with their partners
8 in the community, it seems to me that a
9 multiple attribution approach might be called
10 for. Because I do think that there are these
11 problems with just holding the primary care
12 set of providers accountable in this phase.

13 MR. WOLFSON: Can you give us an
14 example?

15 DR. DAMBERG: Of how that work?

16 MR. WOLFSON: Well just, does it
17 exist somewhere? Is there a model for it? I
18 think it is an interesting idea.

19 DR. DAMBERG: Well, RAND has done
20 some projects where we have looked at episodes
21 of care and we have looked at multiple
22 accountabilities where if somebody is -- let's

1 say they are coming in for hip replacement
2 surgery. So they are going to have their pre-
3 hospital care, the hospitalization, and then
4 maybe they maybe the end up in a SNF. And
5 then they are brought back into the community.
6 And so it is partly how you define these
7 episodes.

8 And my sense is at least within an
9 annualized basis, I think you have some
10 opportunity to stitch together discrete
11 episodes. And so I think that this measure
12 could be enhanced by kind of coming at it from
13 an episode of care. Because really, that is
14 what is going on at the patient level.

15 DR. NELSON: Thank you. David?

16 DR. PENSON: So I will keep my
17 comments brief because basically, I completely
18 agree with what Bill said.

19 I think this has got incredible
20 problems with attribution. And it is really
21 not fair either to the primary care providers
22 who are going to get dinged for the stupid

1 specialists and how expensive we are. And
2 frankly, I am not even sure it is fair to the
3 specialists because I think, Dan, speaking as
4 a specialist, I don't want credit for taking
5 primary care and I don't want to do it. And
6 I think that basically I understand what the
7 intent of the measure is to get rid of this
8 fragmentation but I think it is wishful
9 thinking that it will do so when in fact I
10 think what it will do is it will cause some
11 really bad unintended consequences.

12 I could go on, but I won't. Bill
13 basically spoke my mind. So we are of the
14 same thought.

15 DR. NELSON: So we will hear from
16 Tom, and Brent, and Jennifer, and Larry.

17 DR. TSANG: Hi. So again, I think
18 the attribution is a problem for me because of
19 several things.

20 I think the measure itself is
21 going against what we are trying to do with
22 the Affordable Care Act and with the rest of

1 the system. As Dan brought this up yesterday
2 but MGMA released some data about of the 70
3 percent of the 600,000 healthcare providers,
4 it is 70 percent of those healthcare providers
5 are in practices of ten or less and that was
6 about ten years ago but it has gone down to
7 significantly to I think about 50 percent.
8 But that portion of the disappearance of these
9 ten or less are being bought up by large
10 integrated delivery systems as coalescing with
11 larger networks.

12 So the system itself is now
13 coalescing and integrating into larger
14 practices but yet we are focusing on the
15 individual provider level data. And so what
16 I worry is that on the other side of the coin
17 are the quality measures, the clinical quality
18 measures. There is an attempt by CMS and by
19 quality measurers to think about larger group
20 attribution for clinical quality. So with the
21 promulgation of the GPRO Tool with Meaningful
22 Use demonstration allowing for group practices

1 to actually attest for group clinical quality
2 measures. So we see this other trend in
3 really attributing quality to really larger
4 groups.

5 So here is this measure that is
6 really focusing on individual provider
7 attribution but then on the flip side, we see
8 all these inducements for larger practices.

9 So I kind of see is there going to
10 be a problem as you overlay this with what is
11 going on with the other part of the ecosystem.

12 DR. NELSON: Thanks for those
13 comments, Tom. To clarify our comment, I
14 understand I think the point that you are
15 making, that we are attributing the patients
16 in this program based on a plurality of
17 services, primary care services by individual
18 doctors within a group. But then the measure
19 is applied at the group level. So it is both
20 built on individual encounters but then gets
21 applied at the group level.

22 DR. ASPLIN: Yes, that was one of

1 the points I was going to make. If you look
2 at the value based modifier, in 2015 this
3 tracks perfectly with the GPRO Tool because it
4 is going to be groups of a hundred or more.
5 This will be the denominator. So I think that
6 roll up is consistent with how they are
7 approaching the rest of the value-based
8 modifier.

9 I think Cheryl makes a good point.
10 I would argue, though that for the
11 accountability on the specialist side who
12 aren't acting as primary care, we are going to
13 have to rely on their value-based modifiers
14 whether that is through bundled efficiency and
15 resource use or other registry approaches,
16 depending -- and they are going to unfold by
17 specialty. And I don't think that is a reason
18 not to do the macro measure that we are
19 discussing. And I would respectfully disagree
20 with David and Bill that if we wait until the
21 system is perfectly organized to manage total
22 cost care, we are going to bankrupt the

1 country before we are organized to manage
2 total cost of care.

3 And we have 260 programs now that
4 are in either MSSP, Pioneer ACO, or the
5 Transitions program and this is the
6 attribution model that they are using. So
7 there is consistency.

8 Now, I am not making the argument
9 that just because it has been done before
10 means it is okay to do again. Okay, there is
11 a process here and we are asking good
12 questions about it. I agree with Jack's point
13 about the nurse practitioners, MPAs. I think
14 they should be considered eligible
15 professionals in the attribution models.
16 Those models are certainly going to evolve
17 over time.

18 I would argue that this is
19 consistent with what we are doing at a group
20 level. If we are not organized in ways to
21 manage total cost of care and deliver on the
22 triple aim for populations, we got to get

1 there. And there is a healthy tension between
2 the discomfort of being held accountable
3 because you are not organized to be able to
4 deliver and being held accountable in ways
5 that are completely unfair. And I think this
6 strikes the balance for where we are in 2013.
7 And I am going to vote for it.

8 DR. NELSON: We have quite a long
9 list here. And let me try to get the order
10 roughly right. Jennifer, Larry, Lina, Cheryl,
11 Andrea, Lisa, and Jack. And if anybody wants
12 to drop out, that's okay.

13 (Laughter.)

14 DR. NELSON: If anybody wants to
15 add in, that is okay, too. We do want to hear
16 from everybody. Jennifer?

17 MS. EAMES-HUFF: Yes, I have a
18 couple of questions for clarification. The
19 first one is on the use of the measure. Right
20 now it is intended to be used in the
21 confidential feedback reporting in the value-
22 based payment modifier. Are there any plans

1 in the future to use this in public reporting?

2 DR. ROMAN: Yes, I think that
3 there is a Physician Compare site that is
4 coming up. I think it is actually up now with
5 just informational types of data on it. And
6 they will be adding to that for public
7 reporting and eventually would plan to draw
8 from this program. We have no specific dates
9 at this point as to reporting of the value-
10 based payment modifier, per se. But you will
11 see in the upcoming rule what their plans will
12 be for 2014 on quality data that they will be
13 reporting.

14 MS. EAMES-HUFF: Okay. Thank you.

15 And then the confidential feedback
16 reports that go back, are they reports that
17 are done at the group level or do the
18 individual physicians get reports on their
19 performance?

20 DR. ROMAN: And Jeff may want to
21 respond to this as well. Since the initial
22 legislation in 2007 that asked CMS to provide

1 cost data to physicians, given that physicians
2 are the largest drivers of cost in the system,
3 the reports have been iterative. And we have
4 been, over the years, increasing the number of
5 physicians who have gotten reports. And there
6 has been a combination of individual reports
7 to group reports.

8 And at this point, for the setting
9 of the value-based payment modifier, we will
10 shifting to group reports so that the
11 attribution model that we are talking about is
12 at the group level, even though it does use
13 individuals in order to assign beneficiaries.
14 It is the group that is accountable for those
15 beneficiaries.

16 And I would point out that the
17 measure is a whole person care measure. And
18 that the groups are in the best position to
19 impact the care that they receive, the
20 coordination of the care, but probably even
21 more important than the coordination of the
22 care, the access of the individual to care,

1 and the potential to avoid unnecessary
2 emergency room readmissions and potentially
3 hospital admissions. But certainly, I think
4 an approach to access the groups can effect.

5 MS. EAMES-HUFF: Okay. So my
6 comment on that is I can appreciate starting
7 with group level reporting. And you have to
8 start somewhere but I think we have seen,
9 particularly in the quality arena, there is a
10 lot of variance at the group level that gets
11 masked when you look at the individual
12 doctors. So I also think the confidential
13 feedback reports that go to the different
14 practices there would be value having it at
15 the individual doctor level. I have seen
16 results where doctors in the same practice
17 practicing across the hall from each other
18 have widely different results.

19 And so when you move to public
20 reporting and looking at consumers who are
21 using this information to select doctors, they
22 primarily look at their individual doctor, not

1 at the group, even though they do get group
2 care. So, I am not saying one or other but I
3 think there is a place for both of them.

4 DR. NELSON: Larry.

5 MR. BECKER: So to me, it doesn't
6 matter what business any of us are in but we
7 can't improve that business unless we actually
8 measure it. Because otherwise what happens is
9 we work as we can. We do everything we can
10 possibly think of. We have no measures to
11 know if we are doing any better. And so
12 Deming would call that tinkering. We are just
13 tinkering with the system.

14 And so it seems to me that we need
15 to start with something. We need to put it
16 out there. It is certainly not perfect but I
17 think the approach of putting it out there to
18 physicians to let them see that, I think Paul
19 Tang would say there is a quality dividend by
20 doing that because people will look at their
21 own performance and they will naturally want
22 to do better. So I think there is value to

1 putting the measure out there.

2 And then as I listen the comments
3 around the room, one of the themes that I
4 think is a latent theme that we are hearing is
5 healthcare is a team sport. And so I think
6 what we are hearing is beyond this measure of
7 attribution to primary care is, and I think
8 someone said that earlier, and that is we need
9 the measure that enables the team, whoever
10 that team, that virtual team to be able to
11 look at their performance and their
12 contribution with the patient as the North
13 Star. And so when I look at the patient what
14 happened? How can we work together? Because
15 I think that is where the whole ACO concept is
16 going. As a patient, that is what I would
17 like. I want my primary care and my
18 oncologist and my cardiologist, I want them to
19 work together and I want them to know what is
20 going on with me and not to cross paths and
21 one do one thing and one do another and I end
22 up with a medication problem.

1 So I think it is incumbent upon us
2 to start here but to, as quickly as we can,
3 move to group kinds of measures so that
4 everybody can improve their performance with
5 real measures and real guidance.

6 DR. WALKER: Thank you. I will
7 keep my comments short because Larry and Brent
8 said many of the remarks that I wanted to add
9 to this conversation.

10 You know yesterday we talked a
11 little bit about how perhaps this measure is
12 a little backwards looking and not forward
13 looking but in listening to this conversation,
14 there is an element of this measure that is
15 actually forward looking, in my opinion. We
16 are moving towards integrated systems where we
17 care about team-based approaches and this
18 measure is attributed to the group. This
19 seems to be moving us in the right direction.
20 And I think it is okay to ask primary care
21 physicians or group practices to be
22 accountable for the care of the patients. And

1 I just want to say that we shouldn't let the
2 perfect be the enemy of the good.

3 DR. NELSON: Thank you, Lina.
4 Cheryl?

5 DR. DAMBERG: Yes, I just wanted
6 to go on record that I am not opposing this
7 measure. I think it is actually a very good
8 start and I would encourage CMS to continue
9 their exploration to try to move toward joint
10 accountabilities and really helping all the
11 players because my sense is as well we
12 probably generally don't like fee-for-service
13 it is with us for probably my lifetime. So we
14 have got to figure out a way to make sure that
15 all providers really understand that they are
16 in this together.

17 DR. NELSON: Andrea?

18 DR. GELZER: Yes, I agree with
19 Larry and Brent that on the concept that we
20 need a measure like this and we need a measure
21 like this as soon as we can get a measure like
22 this. But having said that, when I look at

1 this measure, I think it is fundamentally
2 flawed from a validity perspective.

3 I mean we have experience with
4 shared savings arrangements where we provide,
5 on a monthly basis, a sortable database to all
6 our large groups, which are typically hospital
7 systems with physician-owned practices. And
8 they use that data and they find that data
9 useful to manage these contracts for two
10 reasons. One, they can control leakage. They
11 can see what their leakage is. And secondly,
12 they can then work with the physicians and
13 other providers that are in their groups to
14 manage cost spikes. And so that works and we
15 need to move there and we need to move there
16 in Medicare.

17 But the attribution model in this
18 measure doesn't really bother me because those
19 groups, as long as they have the data can
20 control, control at that group level. But it
21 is really the potential, and I do think there
22 is potential, of gaming. I'm happy that the

1 duals are included but I see that there is
2 real issue with the way they have been
3 included and, as I said yesterday, the way
4 with the calendar year measure combined with
5 a Medicare Advantage Exclusion, there is real
6 potential to game this measure and not do what
7 it was intended to do, which is monitor of the
8 cost of the care that these physician groups
9 are providing.

10 DR. NELSON: Thank you. So Lisa,
11 Jack, Dan, and Matthew.

12 DR. LATTI: So I actually am also
13 in favor of this measure on a global
14 perspective. I think there are a lot of
15 problems. And when we at WellPoint in my
16 pervious life did research looking at group
17 cost and group quality, the intragroup
18 variation was actually greater than the
19 between group variation. So I think it is
20 very difficult to say this is the cost of the
21 group overall.

22 And I don't disagree, Bill I think

1 was the first one that made this comment, that
2 it is very hard to hold primary care
3 physicians accountable for the spend. But if
4 we don't let them know the spend, how are we
5 ever going to get control and get a handle on
6 our spend overall? So you can't be
7 responsible for what your specialists spend
8 but wouldn't you like to know which
9 specialists are spending a fortune and which
10 aren't? And then you can either modify your
11 referral policies accordingly or at least try
12 to understand the underlying reasons behind
13 what is going on.

14 And so I think that to provide
15 this information that there can never be harm
16 in information. It is what you do with that
17 information that is the problem. And so do I
18 think this is a perfect measure? No. Do I
19 think there is lots of room for improvement?
20 Absolutely. I would love to see Part D
21 included. I think to not to have pharmacy
22 costs in here is crazy. I would certainly

1 like to have partial year included and be able
2 to adjust accordingly. But I think we have
3 got to start somewhere.

4 DR. NELSON: Thank you, Lisa.
5 Jack?

6 DR. NEEDLEMAN: I have been
7 critical about a number of elements of this
8 measure. I actually think one of the things
9 the measure gets right is its focus at the
10 group level and starting at the large group
11 level, where much of the care is in fact going
12 to be, and referrals are going to be within
13 the group. Are some of the attributions going
14 to be wrong? Yes, the folks who get hit by
15 buses or who have heart attacks while they are
16 vacationing in Florida are going to have a lot
17 of costs attributed to a group in Minnesota or
18 New York that they had absolutely no control
19 over. But those are going to be a small
20 portion of these cases.

21 I agree with Jennifer and I agree
22 with Lisa that there is a lot of within group

1 variation that the groups need to deal with.
2 And I think a measure that is at the group
3 level that provides group data at this point
4 will allow us to figure out how to deal --
5 allow the groups to figure out how to deal
6 with that well, the within primary care
7 doctor, for instance, and frankly, the
8 referrals. And the measure provides time for
9 the smaller groups that are making referrals
10 outside of the immediate group to figure out
11 how to manage their referral networks.

12 And I know in California we have a
13 number of large integrated primary care groups
14 that are being very selective about which
15 specialists they are allowing the group to
16 basically refer to. And that is in part
17 because they have data like this about which
18 folks they think are delivering higher quality
19 care and delivering it more efficiently as the
20 integrated primary care group accepts
21 capitation.

22 So, I think the individual level

1 is not right at this point. The group level
2 feels about right starting at the large group
3 level, where the integration is probably
4 better, makes a lot of sense and gives time
5 for the smaller groups to figure out how to do
6 it. As I said, critical about a lot of
7 elements in this measure. This is not one of
8 them.

9 I would like to see a commitment
10 by CMS to deal with improved risk adjustment.
11 The purpose of this measure is to allow for
12 groups to manage discretionary care
13 appropriately. Where does the spending have
14 value? Where doesn't the spending have value?
15 But a lot of the care that is included in
16 terms of these large costs, things like SNF
17 care and some other forms of care, there may
18 not be a lot of discretion about whether the
19 patient gets that. And the risk adjuster is
20 supposed to fix that. But I would like to see
21 a lot more work on how these risk adjusters do
22 in predicting specific subsets of costs and

1 some refinement of the risk-adjustment
2 methodology to better predict individual
3 components of these costs so we know that the
4 discretionary care is what is winding up in
5 the residual.

6 Do I think we have to wait until
7 that happens to say the measure is okay? No,
8 I don't think we have to wait.

9 DR. NELSON: Thank you. Dan?

10 MR. WOLFSON: This is a great
11 conversation. I think we are talking about
12 what we want the healthcare delivery system to
13 be and I think that is great.

14 I have a few comments. On the
15 individual level, this is coming from a person
16 that works with the American Board of Internal
17 Medicine. I think we are at the right level
18 at the group. And I wanted to know from the
19 researchers whether on the individual level
20 there was stability of those measures. I mean
21 we are not talking about all payors, we are
22 just talking Medicare and I am worried about

1 those cells being too small. So I would like
2 to hear how those individual measures held up
3 from a psychometric point of view.

4 A lot of issues about gaming and I
5 wanted to know from the researchers or NQF was
6 there an audit planned for this so any gaming
7 would be caught. And just the threat of an
8 audit usually calms down gaming. Nobody wants
9 to be thrown out of the bin.

10 And I also would like to see
11 pharmacy put in. I know at only 60 percent
12 but let's see what happens to people who are
13 on Part D and who are not and see what their
14 total spend looks like. I think that would be
15 an interesting question to pose.

16 So anything on audit and
17 individual stability of the measures when you
18 get there? I am not advocating it, by the
19 way. I think the group is the place to go.
20 I would advocate not doing it but I wanted to
21 know for just the information for a medical
22 group, is that good data or not.

1 MR. BALLOU: So I can address the
2 stability, which I am inclined to address in
3 terms of reliability testing that we have done
4 at the individual level. And then I will ask
5 CMS to address the gaming and audit issue.

6 As you may recall, we have imposed
7 a minimum T size. Even for groups here you
8 need to have at least 20 attributed
9 beneficiaries. When we imposed that for
10 individuals as well, we get reliabilities that
11 we initially found to be surprisingly high.
12 It is a Medicare population but you still do
13 have a significant majority clearing the 0.7
14 threshold that we have been using for
15 reliability.

16 So you do have the reliability at
17 the individual level. However, let me back
18 up. As I told Cheryl before, we have tested
19 many rules. And I do not believe we have yet
20 tested reliability for this particular
21 attribution rule. We have tested it for a
22 more limited set of E&M codes, exclusive

1 attribution in one step.

2 So I think the takeaway there is
3 that we have evidence for exclusive
4 attribution broadly defined. These can be
5 more reliable than we originally thought at
6 the individual level. However, it hasn't been
7 tested on this current rule and we have been
8 responsive to physician feedback, which has
9 been echoed in many of the comments around
10 this room that certainly to begin, physicians
11 do expect and prefer to be assessed as groups.

12 DR. ROMAN: I think on the audit
13 side of things, I think the Agency is clearly
14 interested in preventing gaming. And we will
15 be looking at this data that there are plans
16 in our innovation center to begin looking at
17 some of their value-based payment programs.
18 I am not fully aware of a specific audit plan
19 in the innovation center for this specific
20 program but clearly we will be having our
21 contractors look at a variety of impacts that
22 occur with the institution of the system,

1 particularly as we move through the
2 implementation years. And clearly, that is
3 part of the approach of the agency in moving
4 slowly and carefully in bringing the value-
5 based payment modifier of which this measure
6 is foundational on the cost measure side. We
7 haven't talked much about the quality measure
8 side of the value-based payment modifier here.
9 I think that is reflective of the fact that
10 the Agency is concerned and will be
11 monitoring.

12 MR. AMIN: Just to quickly add
13 from the NQF perspective on this issue of the
14 audit, NQF, as part of measure maintenance,
15 any stakeholder that recognizes any -- has
16 evidence of any unintended consequences to
17 patients can submit that evidence to NQF and
18 it will trigger an ad hoc review for a
19 measure. So that would, obviously, be in play
20 for this type of measure as well.

21 DR. NELSON: Matthew, then Nancy.

22 DR. MCHUGH: So I think that I

1 would support this measure if it was what it
2 says that it is. But I have concerns, I think
3 as we have discussed, that the attribution
4 issues and validity issues really kind of
5 killed that. And it seems to account for some
6 providers in some context and account for some
7 beneficiaries and services. And it is too
8 conditional to really make it a valid measure
9 of what I think the provider community and
10 then ultimately patients would want to see in
11 terms of information around this measure.

12 I also have concerns about not per
13 se that socioeconomic status or dual eligible
14 status is controlled for. I just don't think
15 that the developers have made the case here in
16 this instance. So I think more evidence of
17 the rationale for that is necessary.

18 DR. NELSON: By too conditional
19 you mean? Matthew?

20 DR. MCHUGH: The exclusion
21 criteria. So for instance on the provider
22 side, the attribution rules excluding a subset

1 of providers from the first step. So NPs and
2 PAs, for instance. And then the kinds of
3 issues that we talked about in terms of the
4 beneficiaries that are included and the kinds
5 of cases and the information on those cases
6 that would be included, deaths and those kinds
7 of cases. I think that is valuable
8 information.

9 DR. NELSON: Thank you. And
10 Nancy?

11 DR. GARRETT: I just wanted to
12 respond to Dan's question about an example of
13 using multiple attribution rules.

14 So in Minnesota we have a project,
15 my colleagues from Minnesota can chime in,
16 called Provider Peer Grouping, which is a
17 state-level project to do provider profiling
18 and measurement. And there is a raging
19 controversy about whether to do multiple
20 proportional attribution or single clinic
21 attribution. And kind of the current approach
22 is that multiple attribution. And it is

1 really tough because intuitively it really
2 creates a usability problem. It is a lot
3 harder to understand. And so there is a lot
4 of debate. So I don't know that we have a
5 successful example for you but there is a lot
6 of conversation going on about it.

7 DR. NELSON: Thank you, Nancy.

8 I don't see any more cards up. I
9 have seen some cards go up and down. This
10 would be a great time for any final thoughts
11 on this final topic of usability and use.

12 (Pause.)

13 DR. NELSON: So we will have a
14 vote on this and then we will have a public
15 comment and then we will have a final vote for
16 this group at this time of yes or no.

17 So usability and use, Evan is
18 going to open up the polling platform.

19 MR. WILLIAMSON: We will now vote
20 on usability and use. You will have 60
21 seconds, beginning now.

22 (Pause.)

1 MR. WILLIAMSON: We are waiting on
2 one more. If everyone could please point
3 again at the -- there we go. Four high;
4 fourteen moderate; seven low, and zero
5 insufficient.

6 DR. NELSON: Thank you. So we
7 have covered the criteria one by one. And now
8 it is time to have an overall discussion about
9 this measure and to hear public comments. So
10 why don't we start with public comments and
11 then we will have a final opportunity for this
12 committee to weigh in.

13 MS. TIGHE: Operator, is there
14 anyone on the line who would like to make a
15 comment?

16 OPERATOR: To make a comment at
17 this time, please press *1. Once again, to
18 make a comment at this time, please press *1.

19 There are no comment or questions.

20 DR. NELSON: Okay, thank you. So
21 we have an opportunity for more discussion
22 deliberation before our final vote. The final

1 vote is simply yes or no or one or two.

2 Andrea?

3 DR. GELZER: Yes, I just wanted to
4 say that I do believe that there are real
5 flaws in some of the stuff in this measure
6 that we have discussed. But I do think it is
7 critically important that we have these cost
8 measures in use and people start to both deal
9 with them and gain experience dealing with
10 them and understanding them and gaining
11 additional data from them.

12 And as I think was said by the
13 chairs yesterday, you have to decide is this
14 so fundamentally flawed that you can't vote
15 for it? I would just ask CMS, I would implore
16 CMS to look at this. Whatever gaming that
17 goes on, people are going to have to
18 understand -- the first year this measure goes
19 into effect I don't think there is going to be
20 a lot of gaming. I think it is when people
21 start to see their results coming back. So I
22 would just hope and expect and really demand

1 that CMS makes this measure better and better
2 and does better, you know make sure that the
3 risk adjustment and the socioeconomic factors
4 considerations are improved as the years go
5 by.

6 DR. NELSON: Bill and then David.
7 And try to, if possible, make new comments,
8 rather than reemphasis, if possible.

9 DR. WEINTRAUB: And I will do just
10 that. I will not say what I have said before.
11 I do very much believe in economic measures.
12 I very much believed in the measure that we
13 voted in favor of yesterday. My own research
14 is concerned with that measure and I am
15 convinced that it is going to measure real
16 things.

17 I think there is a danger in
18 approving a measure, however, that I think is
19 so fundamentally flawed that it is not going
20 to drive the whole process forward but could
21 set us back. I remain unconvinced that we can
22 handle the problems of attribution with this

1 measure in a way that will be meaningful.

2 DR. NELSON: Thanks, Bill. I was
3 just giving a guideline. It is not a
4 protocol.

5 David?

6 DR. GIFFORD: Question to Helen.
7 In the past when we didn't like the yes or no
8 vote, we added a third time limited or
9 anything. That is no longer an option?

10 DR. BURSTIN: Well that is only
11 for measures that have not been tested. This
12 measure has been tested so it needs to be yes
13 or no.

14 DR. GIFFORD: I can't add anything
15 original to the discussion that has been had
16 so far.

17 DR. NELSON: Okay. Perhaps not
18 everything has been said but many things have
19 been said.

20 So time for vote. One, yes.
21 jack?

22 DR. NEEDLEMAN: I oppose the last

1 comment about provisionality. There are two
2 things that are happening here. One is CMS
3 was obligated to develop the measure and
4 implement it and it is doing it. So now the
5 question is what role does NQF endorsement
6 play in the process? And the issue, in part,
7 is is it good enough to merit endorsement and
8 the endorsement with all the comments we make
9 encourage the kinds of changes that are needed
10 to make it better.

11 Well apparently, it is the
12 withholding of an endorsement from a measure
13 that is clearly going to be used, a clear
14 signal to people that the problems that have
15 been identified in the discussion with the
16 measure need to be addressed in the future and
17 come back to us as you keep working on it.

18 So I think to me that becomes the
19 issue. And think about this. It is not about
20 whether CMS is going to use it. They are
21 going to use it. They are obligated to use
22 it. The issue is whether NQF as an

1 organization and us, as a steering counsel,
2 are signaling how much room and need for
3 improvement there is in this measure. And on
4 that basis, I am going to vote no because I
5 think the attribution that is particularly
6 important to me and some of the other issues
7 that have been raised to others are
8 sufficiently important that I want those fixed
9 before it becomes an NQF-endorsed measure.

10 DR. NELSON: Helen?

11 DR. BURSTIN: Just one brief
12 comment on that. I just want to really
13 encourage you again, I know it gets very
14 complex when you know what the intended use
15 is. You know it is already on the street and
16 you know what is going to get used for it.

17 Your role really is the science
18 here. You really need to vote on overall
19 suitability for endorsement based on our
20 criteria for endorsement. All this
21 externality stuff we can comment on and put in
22 the report. We really bring you together as

1 experts and multi-stakeholders to bring the
2 science to the table. So, please vote on the
3 science.

4 DR. PENSON: Can I make a comment?
5 Sorry, Gene.

6 So Helen, I hear what you are
7 saying and I would like to sort of live in
8 that vacuum but I am having a hard time with
9 it because we all know how this particular
10 measure is going to play out.

11 And I share everyone's desire to
12 push the field ahead and recognize that this
13 will push the field ahead but I also know
14 full-well this -- I feel this has got some
15 real problems both from the validity
16 standpoint and from the usability standpoint.

17 In the end, it is not ready for
18 prime time but it would be nice to push it out
19 there just from the science, say it is not
20 perfect but it is good enough. But this one,
21 in particular, because of its clear
22 applications and it says in the applications

1 can be used for the value-based modifier, I am
2 having a really hard time saying, okay, the
3 science is not perfect but it is okay because
4 the stakes are so high and I know what the
5 outcome is going to be. And none of us want
6 to say it but everyone in the room knows it.
7 So I don't know how to respond to that, except
8 say I am having a really hard time with that.

9 DR. BURSTIN: It is really
10 complex. We have had very similar issues with
11 some of these measures that you know where
12 they are going, you know how they are going to
13 be used. But at the end of the day there are
14 other groups that are going to take more
15 consideration about, for example, the MAP that
16 I will really think through, for example how
17 the measures are applicable or not applicable
18 and given programs. We know this measure is
19 going to get used. So I guess the question,
20 one question might be is it better to sort of
21 have it inside the portfolio and potentially
22 work with CMS to have it get modified over

1 time to be more reflective of a lot of the
2 concerns you have raised or is it a better
3 signal to indicate it is not ready for prime
4 time? That is where you have to weigh -- I
5 mean those four criteria are there
6 intentionally. You need to weigh in your head
7 -- I'm not prescribing to you that 30 percent
8 of your assessment overall endorsement should
9 be validity and 40 percent should be
10 usability. This is your chance to say I have
11 now voted on the four criteria. How do I
12 collectively weigh those four criteria to make
13 my final decision of endorsement?

14 And again, keep in mind, as much
15 as this feels like sort of a final step, it is
16 quite early in our consensus process. So this
17 measure will still go out for comment. You
18 will have another chance to reflect on it. I
19 don't know what CMS's and Mathematica's
20 capacity is to potentially respond to any of
21 the specific concerns raised today and whether
22 any of these issues are mutable in the short

1 term to actually make it a measure that might
2 be more -- you know to have less concerns.
3 But that remains an issue.

4 Yes, Lisa?

5 DR. LATTIS: So that actually was a
6 question I was going to have. Can Mathematica
7 take the concerns that we have raised today
8 and revise it before it goes to the MAP, or
9 address it, or whatever the next appropriate
10 step is?

11 DR. BURSTIN: Yes, I mean this is
12 a pretty complex measure. It is hard to
13 imagine there is a whole lot you can do
14 without having to go back, retest it, re-put
15 it forward and all that stuff. I mean what
16 the MAP, I believe, put forward was that they
17 would support the direction, depending on NQF
18 endorsement. So it is kind of back to you.

19 So I don't know. It is going to
20 be a somewhat circular argument, I think. So
21 at this point I think you really need to
22 consider it. I don't know whether Sheila has

1 any comments or anything from CMS's
2 perspective about how much and how timely some
3 of the responsiveness to some of the concerns
4 raised could be in the course of this project.

5 DR. ROMAN: I mean I don't think
6 that I am at liberty to get out ahead of the
7 Agency on this but I would say that we
8 obviously take your input quite seriously.
9 You know we purged three or four major issues
10 that have been problematic for the panel and
11 that I would go as far as to say that we will
12 be dealing with these issues, that they would
13 be probably going through our formal
14 rulemaking process. So we are not talking
15 about the next six weeks but that we have
16 clearly heard the problems and understand
17 where the committee feels that there are major
18 flaws and that we understand that we have to
19 look at that very closely. And the agency
20 will need to make some decisions on where it
21 wants to take these recommendations. And I am
22 sure that they will do it.

1 DR. GIFFORD: Helen is really
2 going to kill me. You asked me to come to
3 this meeting.

4 In the past, again I know the
5 continuous quality improvement aspect is well
6 adopted by NQF and I do think that each of
7 these panels has gotten better that I have
8 been on over the years.

9 We have held a vote and had a
10 group conference call, giving some developers
11 some time to address some questions and come
12 back to us. That is one question, is that an
13 option here.

14 And the other one is, if we vote
15 to approve it, and they make all these
16 substantive changes that they are talking
17 about doing, is that enough that it is no
18 longer -- it is different so it has to come
19 back to us anyways because you said major
20 changes have to come back to us or that only
21 applies once it has gone through the whole
22 consensus? And how do those additional

1 changes get reviewed in this process? Because
2 these aren't just like minor tweaks. They are
3 substantive changes.

4 DR. BURSTIN: And many in the room
5 will know this well since we went through a
6 fair amount of this with some of our
7 readmission measures in the past.

8 So there was certainly an
9 opportunity for the committee to vote today,
10 to put it out for comment and just so you --
11 you know, NQF had changed the policy a few
12 years ago, so all measures go out for comment,
13 regardless of whether you approve them or not.
14 In the past, we only put out for comment those
15 you approved. Regardless, those measures are
16 going out for comment, you will get, I assume
17 a significant number of comments on these two
18 measures. You will have a chance as part of
19 the follow-up conference call to review the
20 comments to consider whether any of the
21 comments and, frankly, CMS and Mathematica
22 will have an opportunity to also respond to

1 any of the specific comments directed at them
2 about the measure, in addition to responding
3 to the whole host of issues you guys raised
4 today and yesterday. So at that point, they
5 will have a chance to respond.

6 We do frequently if a committee
7 feels that based on the comments they have
8 seen, the responses from the developer, you
9 will have an opportunity to revote on that
10 post-comment call, if you feel like that the
11 world has sufficiently based on input from the
12 commenters, input from the developers,
13 additional analyses from the developers to
14 potentially respond back, to some of your
15 concerns. So that is, certainly, very much
16 part of our process.

17 Does that help?

18 DR. NELSON: Carolyn.

19 MS. PARE: I think, Helen answered
20 some of the questions I had. I am really
21 struggling because, as a purchaser, we are
22 hungry for this kind of evaluation

1 measurement. But having been from the
2 collaborative state of Minnesota and just
3 seeing some of the struggles we have had in
4 coming to an agreement on what these kind of
5 measures should look like, I just know that
6 more broadly, across the country, this is
7 going to have significant challenges and that
8 I don't want to shoot ourselves in the foot by
9 moving something forward that just really is
10 going to get so much pushback that it is no
11 going to go to a place that we want it to go.

12 I was interested, really, in
13 understanding the process. Because from this
14 point, as I understand it, if we move it
15 forward, it goes to the MAP.

16 Could you just take me through the
17 process so that I understand what kind of
18 damage my vote does at this point?

19 (Laughter.)

20 DR. BURSTIN: That is a very
21 loaded way to phrase that question, Carolyn.

22 At this point, it is truly, this

1 vote is about endorsement of the measure.
2 Please take everything else off the table. It
3 is about endorsement of the measure. The MAP
4 did indicate it has already reviewed the
5 measure, I believe, for the IQF. So they have
6 already made the recommendation that they
7 would support the direction of this measure
8 pending review by you. So I assume they will
9 have an opportunity again to reflect back on
10 whatever comes out of this process. But
11 again, it is so early in our consensus
12 process, I mean you will get, I suspect, I am
13 going to put out there, hundreds of comments
14 on these two measures that you will have a
15 chance to sort through, that Mathematica and
16 CMS will have a chance to respond to. So I
17 think there is a lot more to this process than
18 your vote today. Your vote today is important
19 because I think it signals to the wider world,
20 where the concerns are, where you think it
21 should potentially move one way or another
22 but either way, it is going out for comment.

1 And either way, there is an expectation the
2 developers will respond to those comments and
3 to any concerns you have raised today.

4 Taroon, do you want to add
5 anything, based on your prior -- where is he?
6 Okay, never mind.

7 MS. EAMES-HUFF: Can I ask just a
8 question for clarification? So if this
9 measure is not passed by the committee, it
10 still goes out for comment? Is that true?

11 DR. BURSTIN: All measures go out
12 for comment. And we put in the full
13 commentary of what happened at the meeting,
14 regardless. And I suspect this will be a
15 somewhat close vote. So either way, you are
16 going to have a fairly rich discussion in the
17 report and comments.

18 DR. LATTS: I just wondered what
19 happened then. So if we vote now, it goes up
20 for comment. Then what?

21 DR. BURSTIN: All those comments
22 come back to you on that post-comment call.

1 You review all those comments. You would then
2 have an opportunity to say, based on those
3 comments, somebody could move to say we
4 believe, based on how much comments we got,
5 the response back from the developers, we
6 would like to re-vote. So you have an
7 opportunity on that post-comment call to
8 revote on the measure again, with the
9 additional information if you think, again,
10 there is anything you are going to hear that
11 is going to potentially change your mind.

12 And again, given the number of
13 comments and the richness of the comments, I
14 think there will be a lot of substrate for you
15 to get through.

16 MR. BECKER: So this sounds like
17 it is a real struggle for everybody. And so--
18 and you might kill me on this one -- but what
19 if we didn't vote?

20 (Laughter.)

21 MR. BECKER: What if we held and
22 got all these comments and got all the work

1 and then reconvened and said okay, now we have
2 more information and we have more work done.

3 And then --

4 DR. BURSTIN: Since you are on my
5 Board of Directors, Larry, I will take that --
6 we cannot change the process in that way.
7 However, it is very reasonable for your vote
8 for all of you to consider your vote your
9 first vote. And if that helps you all to say
10 this is your first opportunity, based on
11 everything you have heard today, to vote,
12 knowing you will, in all likelihood, have an
13 opportunity to reconsider that vote, post-
14 comment. If that helps, Larry, then think of
15 it that way but we cannot, not vote.

16 DR. NELSON: So we had a pre-
17 meeting, non-binding vote. We have a vote
18 now. And then we have a vote after. That's
19 not bad.

20 MR. BECKER: It's a two out of
21 three.

22 DR. LATTS: Are you sure we are

1 not in Chicago?

2 DR. MARCINIAK: So being from
3 Chicago, I would kind of agree with that
4 comment.

5 You know, the reason why I am
6 struggling with this is not -- because we have
7 had the robust scientific conversation. We
8 have talked about multiple attributions,
9 single attribution and things of that nature.
10 We have talked about the risk adjustment. As
11 a researcher, I feel comfortable with that.

12 The struggle I am having actually
13 is where we left the validity vote yesterday
14 because we left it as a hung jury. It was
15 split 13-12. And so you look day over day,
16 our votes look a bit different today with 24
17 hours of reflection. And so when we talk
18 about usability, if it is a hung jury on
19 validity, how can it be useable. And that is
20 where I am having difficulty with this because
21 we didn't really wrestle to the ground what
22 the validity issue is. And we really didn't

1 change hearts and minds during the course of
2 the discussion of where we wanted it to go.
3 If the measure is not valid, we are not
4 getting to this question. Right? And so we
5 are getting here split. We very well still
6 may be split.

7 DR. BURSTIN: I suspect you will
8 be. And I would just encourage you to vote.

9 DR. NELSON: As a further point of
10 clarification before we vote, I think we are
11 going to vote soon, Helen, after we are done
12 voting we have a discussion about
13 harmonization. And I know I am on the MAP
14 Clinician Work Group and I know there is a lot
15 of interest in having public-private payer
16 alignment. And this harmonization discussion
17 around two per capita measures opens the
18 opportunity for thinking about alignment.

19 And so what I am wondering about
20 is the interaction, if you will, between a
21 measure that we are going to look at that is
22 behind us, the one that is in front of us, and

1 actually coming up with something better than
2 either that applies to all ages.

3 DR. BURSTIN: Either way, I think
4 we will have that discussion. And I think
5 that is all very future tense. I think
6 anybody making significant changes to align is
7 something that is not going to happen tomorrow
8 either. So I think again we do have that --
9 yes. I still think we will talk about it.

10 DR. NELSON: Okay, let's vote.
11 One, yes; two, no.

12 DR. GIFFORD: Actually since we
13 are in D.C. I would like us to start reading
14 from Harry Potter and filibuster the vote for
15 a while.

16 (Laughter.)

17 MR. WILLIAMSON: We will now vote
18 on the overall suitability for endorsement.
19 You will have 60 seconds, beginning now.

20 (Pause.)

21 MR. WILLIAMSON: And we are still
22 waiting on one response. There we go.

1 Eleven yes, fourteen no.

2 DR. NELSON: So we have had a
3 great discussion. And why don't we take a
4 break. It's ten o'clock.

5 (Laughter.)

6 DR. NELSON: And we can reflect
7 and start on our next topic. Thanks everyone
8 for a really thoughtful and deep discussion.
9 We all know that this is a high stakes
10 measure. It has been given a lot of
11 consideration and we will have a chance to
12 consider it further. Thank you.

13 MS. WILBON: Let's plan to return
14 about seven after if we can, at least be ready
15 to go by ten after. Thanks.

16 (Whereupon, the foregoing
17 proceeding went off the record at
18 9:56 a.m. and went back on the
19 record at 10:11 a.m.)

20 MS. TIGHE: Okay, thanks everyone.
21 We have Gerry Shea, our interim CEO here. And
22 he is going to lead a conversation with you

1 all about the future of Steering Committee
2 meetings, I guess.

3 MR. SHEA: Thank you, Lindsey.

4 Good morning. I did want to impose on you to
5 take a few minutes to talk about an issue that
6 has arisen in our discussions with the federal
7 agencies about these meetings. But first, let
8 me just say a big thank you for wrestling with
9 difficult issues like the one you have got
10 before you and had before you yesterday.

11 Needless to say, these are not easy but they
12 are enormously important. So the fact that
13 you are willing to come and put your time into
14 this is really very, very significant.

15 I don't know whether you have
16 heard the number but we counted last year and
17 there were 55,000 hours of expert volunteer
18 time in meetings or on webinars not in
19 preparation, not flying to get to the
20 meetings, actual meeting participation, which
21 amounts to a contribution that you and your
22 colleagues make or your organizations make of

1 about five million dollars to this whole
2 process. So thank you, very much.

3 I won't take very long this
4 morning but I would appreciate your comments
5 on something. And the situation is that due
6 to sequestration and the budget cuts that flow
7 from that, and also in the wake of the
8 scandalous GSA meeting, I guess it was, in Las
9 Vegas last year, the administration generally,
10 including HHS, has been very tough on in-
11 person meetings under federal contracts. And
12 they have moved as far as saying to us not
13 only do they have a very laborious process of
14 approving an in-person meeting, and I won't
15 bother you with my day job problems, but they
16 have said to us they really want us to move to
17 virtual meetings.

18 And we are concerned about what
19 the impact might be on the quality of the
20 process or the ability to really even do this
21 or what we are imposing on people. And the
22 bottom line here is we are not going to do

1 anything to compromise this process. But on
2 the other hand, we do want to be responsive to
3 explore the possibilities of maybe improving
4 our -- or significantly improving our
5 technology to be able to do more virtual
6 meetings.

7 But just while you are here, and
8 in light of the kind of discussion that you
9 had yesterday and this morning, I just wanted
10 to get your comments on to what extent do you
11 think these kind of meetings can be done
12 remotely and to what extent do you think or
13 under what conditions do you think they need
14 to be done in person.

15 I should say that the main
16 responsiveness to the concern is as part of
17 our reengineering of the measure review and
18 endorsement process, we are hoping to go to
19 standing committees. And those standing
20 committees will have three-year terms. So
21 once those standing committees get to know
22 each other and get sort of working, then it is

1 probably more possible to do things remotely.

2 So just as an example.

3 And we are also consulting with
4 NIH and the IOM people. And well what do you
5 do with these sort of situations? So people
6 have comparable kind of things. And we are
7 going to look at the best the brightest in the
8 global business world on how they do these
9 things, not that they are always so good or so
10 bright.

11 So I would be very interested in
12 your comments on this and just want to take a
13 few minutes and not exactly go around the
14 table, but I would encourage as many of you to
15 weigh in on this as possible. And this is
16 just useful input to us.

17 DR. WEINTRAUB: Well first, thank
18 you for having us. And this is a fascinating
19 two days. I always feel that I get much more
20 out of these than I ever contribute to it.

21 That being said, I think that the
22 in-person is what carries the day on that and

1 is extremely important. I don't think even
2 with video technology you can get the kind of
3 interchange between people that you get when
4 you are sitting around the table face-to-face
5 really discussing things.

6 So I think there remains a real
7 place for real people sitting around the table
8 and working together.

9 DR. WALKER: I think you alluded
10 to the point that it depends really on how
11 well you know individuals on the committee.
12 So I am new to this process and I don't know
13 anybody here but I had a side conversation
14 with Bill on the way to the bathroom after the
15 vote. And so would be lost in a telephone
16 meeting, telephonic meeting. That said, we do
17 a lot of those types of virtual meetings at
18 AARP and are quite effective holding those
19 types of meetings because we know everybody.
20 And what is really integral to this process of
21 the side conversations that go on and there
22 are a lot of side conversations in this two-

1 day meeting. And if you have a virtual
2 meeting, you can still enable those types of
3 conversations. You just need a little bit
4 more lead time and those conversations would
5 happen over email or somebody would pick up
6 the telephone call. But again, the key
7 components there are that you need to know
8 those individuals on you committee fairly well
9 and you need to have more time. You need to
10 build in a little bit more time before you get
11 to the point where you have your evaluation
12 and vote.

13 DR. PENSON: I guess we can just
14 go around probably. So I mean there is no one
15 who likes virtual meetings better than me,
16 except maybe my wife and my kids. And so I am
17 all for that but I will tell you that the
18 first comment that was made about a committee
19 knowing one another is critical. Having sat
20 on a number of and continuing sitting on NIH
21 study sections, you know what people are going
22 to say. You know where they sit and that is

1 helpful.

2 So I think on the one hand you can
3 say well if we put in a standing committee, we
4 won't need to do this anymore but I am going
5 to give you pushback because there is another
6 element to it as well. And that is, these
7 committees are all about building consensus.

8 It is one thing when something is
9 fairly straight forward and easy to get to the
10 bottom of. Something like these two issues we
11 have been dealing with the last two days,
12 these two measures are really hard to build
13 consensus around, as you saw. And I think
14 that you would have lost a lot of the richness
15 out of the discussion and you wouldn't have
16 gleaned the information that I think the
17 measure developers are going to need to come
18 back or other committees are going to need to
19 go forward.

20 So I think you have to consider
21 both how well the committee knows each other
22 but also the sort of controversy, I guess is

1 the best term or the -- yes, that is probably
2 the best term -- of what you are assessing.
3 And I don't think it will work for things like
4 this is my thoughts.

5 DR. MARCINIAK: So David hit on
6 some of my topics so I will move in a bit of
7 a different direction. And I work for a large
8 corporation where we believe ourselves to be
9 a very technology-enabled company in terms of
10 TeleSuites, and video, and video on demand.
11 My experience has generally been that most of
12 those technologies don't work very well. We
13 just haven't caught up to a sufficient degree
14 to enable a room of 20 or 25 people to sort of
15 effectively communicate in a way that would
16 allow any of the dialogue that we have had
17 over the last day or two to be facilitated in
18 a reasonable way.

19 So sort of bridging off with David
20 who suggested and what Lina had said as well,
21 the advantage is what conversations happen in
22 the hallway, oftentimes, not what

1 conversations that happen in the room to sort
2 of facilitate a dialogue and to help it move
3 forward if you can find the common ground. So
4 I just don't think we are there yet.

5 MS. EAMES-HUFF: As someone who
6 travels from California, I love the idea of
7 having virtual meetings but I think I agree
8 with the general consensus around the nature
9 of the in-person. But I don't think it is an
10 either/or. I think it is there are different
11 elements and it is a case-by-case basis that
12 would need to be decided if the situation has
13 the right factors for doing an in-person
14 versus the virtual.

15 The other thing I would say is if
16 you found that you tried a virtual meeting and
17 it didn't go well, I know this extends the
18 time, but there is always the possibility of
19 then calling an in-person meeting if you are
20 not getting what you need from the virtual
21 piece.

22 MR. SHEA: And Jennifer, if I

1 could just ask, would you want to identify
2 some of the elements that you think
3 distinguish meetings that could be done
4 virtually as opposed to ones in-person?

5 MS. EAMES-HUFF: I think the idea
6 of standing committees, where people know each
7 other more is a key component to having. I
8 think also if there are things done in the
9 beginning, before the meeting, if there is
10 like group warm-up that can be done virtually
11 before just starting people in with a meeting
12 is another piece.

13 I will confess for the bathroom
14 conversations, virtually I am less likely to
15 do, given my schedule. I just know I am stuck
16 here. So it is not just that I am stuck, I
17 like talking to you guys. But when I am in my
18 own office it is just much harder to do. And
19 I think that there is that factor, as well.

20 DR. DAMBERG: So I have
21 participated in some of the NIH review panels
22 recently and they do that kind of

1 teleconference where you sort of see a panel
2 on the East Coast and there is one on the West
3 Coast. And so you still get to connect with
4 others sort of in your local area. So it is
5 not completely virtual. So that might be an
6 option.

7 But one of the things that I have
8 been pondering because I think there was a lot
9 of time spent asking the measure developers a
10 lot of questions to inform people's
11 considerations of how to do the ratings. And
12 it felt to me like there were some
13 efficiencies to be had here that you could do
14 a virtual phone call or two in advance of
15 people coming together such that this meeting
16 might have only had to take place over a one-
17 day period instead of two days.

18 DR. NAESSENS: Yes, I was going to
19 say I am on a committee at Mayo Clinic where
20 we have a standing committee with
21 representation from Florida and California --
22 well, Florida and Arizona. And we started off

1 with virtual meetings about once a quarter.
2 We ended up having too much to talk about,
3 went to virtual meetings once a month. And
4 then realized that we really missed or needed
5 to create the bonding across the group and now
6 have gone first to a quarterly meeting in-
7 person with the monthly virtual meetings and
8 then have actually reduced that down for some
9 cost savings so that we only meet in-person
10 once every six months.

11 DR. WONG: Well, I'm from the
12 federal government. I feel everyone's pain,
13 especially given the circumstances several
14 years ago with our sister organization and how
15 they conducted themselves. So we struggle
16 with this all the time because we also
17 facilitate many meetings and we have gone
18 somewhat virtual with webinars and things of
19 that nature. It is not a substitution. It is
20 you have to completely rethink of what your
21 objectives and goals are.

22 In my view, a committee like this

1 is really a scientific review committee. It
2 is parallel to what you mentioned in terms of
3 NIH, in terms of the grant review process.
4 Similarly, at AHRQ, that grant review process.
5 I think that it would be helpful to kind of
6 contact the folks at NIH and even AHRQ of how
7 they want to kind of handle this sort of
8 aspect of it.

9 I think that it is important to
10 continue to communicate to others who make
11 this decision about travel rules, about the
12 compromises that you have to take. So if the
13 mandate, whether it is from AHRQ, NIH, or even
14 contractors that support these other federal
15 agencies, I think the message really needs to
16 be clear that we are not quite getting the
17 quality of the review and things of that
18 nature that we are making compromises of that.

19 DR. DAMBERG: As a confirmed
20 curmudgeon and I am working on my geezer
21 skills and I am almost there, I hate to
22 travel. If I can assign somebody else to

1 travel for me, I am going to do it. And so I
2 really did not enjoy traveling here but I
3 really feel the face-to-face is just
4 absolutely necessary. And it is more than the
5 verbal communication. There is a fair amount
6 of nonverbal communication that occurs even at
7 the table here. There is no substitute for
8 that.

9 And if it came down -- I am not
10 volunteering for anybody else but if I had to
11 pay the airfare to come myself, I would do it
12 because I think it is important enough to have
13 the face-to-face contact.

14 MR. SHEA: Thanks. And I will
15 note that the little bit of literature I have
16 read on this, which is mostly from the
17 business world does always mention as sort of
18 like a big component the sort of non-verbal
19 communication, the body language and so forth.

20 MR. WOLFSON: The one thing having
21 gone through both these in-person things now
22 for a couple of sessions and a lot of phone

1 calls, the one observation I have made about
2 the phone calls is I think it suppresses
3 minority opinions. And I think the reason
4 that happens is that you can express an
5 opinion and you don't get any immediate
6 feedback. You think am I just an idiot? Am
7 I the only person on the group that has this
8 crazy idea? And you don't know and it
9 suppresses it. It reduces the likelihood and
10 if you have a minority opinion, it is hard to
11 keep pushing it. Where at this meeting, you
12 get immediate feedback, either verbal or
13 nonverbal about whether you are heading in a
14 direction that people think is a sense. And
15 so I think that is the defect, the main defect
16 I see in the phone meetings, that you don't
17 get minority opinions expressed. And I think
18 one thing we could all probably agree on,
19 sometimes minority opinions turn into majority
20 opinions pretty fast during these discussions.
21 And so I think it is a really valuable
22 function to bring that out in the meetings.

1 DR. GELZER: I agree with
2 everything said, even with standing committees
3 we need periodic face-to-face. I really
4 believe that. It is the nature of this work.
5 It is the consensus building. It just won't
6 happen over the phone. Much less engagement
7 on the phone and we need to be engaged here to
8 reach that consensus.

9 And on the phone I don't know if
10 anybody else is guilty of this but I know I
11 multitask. And if you are multitasking do
12 this stuff -- yes. No, I mean, you can't do
13 that. Everyone understands.

14 DR. TSANG: It is harder to do it
15 here.

16 DR. GELZER: Exactly. And the
17 only other thing I would say this is a -- as
18 I understand it, this is a public-private
19 partnership. And the private piece of it, I
20 mean there is a dues structure here. We pay
21 dues.

22 So I understand the issues of the

1 government. I understand that we have
2 sequestration but I honestly believe we are
3 not a pure governmental agency and are not
4 necessarily subject to those mandatory
5 requirements such as AHRQ or one of the other
6 agencies.

7 MR. SHEA: Thank you. If I could
8 just comment on that. The situation is very
9 fluid and we are hoping to get a bit more
10 stable situation soon, predictable and so
11 forth, whatever the final outcome is or the
12 edict on meetings.

13 Over the past six months, we found
14 ourselves in a situation where we either had
15 to decide to pay for in-person meetings or we
16 thought really risk the quality of the process
17 or the further participation of people. And
18 so we have gone ahead and done that. It is
19 obviously not a great business model unless we
20 find another stream of income to pay for that.
21 And we kind of think like well if it is
22 important enough to have a big process and

1 expert input, it is important enough to do it
2 right.

3 But we are not going to -- I don't
4 think anybody, whether it was your or us would
5 stand for a compromise process. It just would
6 fall apart. So that is not going to happen.
7 And so we are thinking about all the options,
8 including finding other money to do the
9 meetings, even if the feds won't pay for it.

10 MR. WOLFSON: So I think about
11 this a lot with my organization. So I think
12 you have to put out olive branches to the
13 government. One thing I would do with this
14 meeting, I would not do a two-day overnight.
15 I would make it start at one o'clock, go to
16 nine o'clock, come in the next morning, just
17 make it one overnight. You are reducing your
18 costs.

19 MS. EAMES-HUFF: Those of us from
20 the West Coast can't --

21 MR. WOLFSON: I just said one
22 o'clock.

1 MS. EAMES-HUFF: We can't get here
2 by one o'clock.

3 MR. WOLFSON: Two o'clock. Three
4 o'clock.

5 MS. EAMES-HUFF: There is the time
6 change.

7 MR. WOLFSON: Don't have people
8 from California on this.

9 (Laughter.)

10 MR. WOLFSON: I don't know the
11 regulations but some of the people around this
12 table could have their organizations sponsor
13 them and not charge the government to be here.
14 And so I would --

15 DR. NELSON: Have the meeting in
16 Las Vegas.

17 (Laughter.)

18 MR. WOLFSON: Have the meeting in
19 Las Vegas. But I think if you ask some people
20 around this table if their organization would
21 pay for them, they would say yes, no problem.
22 We want to be here so much that we would pay.

1 And to some of these
2 organizations, it is affordable. To other
3 organizations it is not and it would be a
4 barrier and you wouldn't want to do that. But
5 people who can pay, pay. And I think that is
6 another olive branch to the U.S. government.

7 DR. LATTS: So this is the third
8 panel that I have sat on and the issues that
9 we have discussed have been incredibly
10 complex. And you can't, frankly, follow the
11 complexity over the phone. You know maybe
12 sort of with modern teleconferencing capacity
13 you could do it. But to be in those kind of
14 facilities, frankly is probably as expensive
15 as flying everybody out here for a meeting.
16 It is very expensive to access the most modern
17 teleconferencing capacities.

18 If you are reduced to having to do
19 it over the phone, I would say this committee
20 can't be this big. It has to be a third the
21 size because you just can't process this large
22 of a group on the phone, which then I think

1 you lose a lot of the nuances and the
2 complexity of the discussion. So I think that
3 would be a real shame but you just can't work
4 a group this size over the phone.

5 DR. NEEDLEMAN: Lisa actually hit
6 my point. I endorse everything that has been
7 said. Phone is extraordinarily hard except
8 for well-structured conversations or very
9 short conversations around clear decisions.

10 But look around this room. You
11 have got 30 people around this table, all of
12 whom have made contributions. All of whom
13 have made contributions. And that is not
14 possible on the phone. I don't even think it
15 is possible with videoconferencing.

16 So one of the clear tradeoffs in
17 terms of an effective process if you are going
18 virtual is you have got to go smaller and then
19 you have to decide how much you lose from
20 having a group of ten or 15, rather than a
21 group of 30 involved in the conversation.

22 MS. YANAGIHARA: I just wanted to

1 maybe give some specific ideas about when you
2 could do a phone conference and when is not.

3 I find when it is more
4 informational, a little bit more
5 unidirectional or just trying to clarify, ask
6 questions, those kind of things, like Cheryl's
7 idea about maybe we could have gotten together
8 with the measure developers and kind of gone
9 through the measure and asked questions and
10 made sure we really understood it, that works
11 pretty well on the phone. People are willing
12 to ask the questions and things like that.
13 But when you are really trying to have a
14 conversation and really delve into the nuances
15 of what this measure might mean, I think it is
16 very difficult.

17 And we have tried
18 videoconferencing. We do this a lot in
19 California with our committees. Everything is
20 multi-stakeholder what we do. And it just
21 doesn't work. And having some people on the
22 phone and some people in person, it just

1 doesn't work very well. And people will say
2 that. They are like oh, I have got to be at
3 the next meeting because this just didn't work
4 at all. I couldn't really contribute.

5 And I think the minority view and
6 those things that are really important to
7 bring forward do get lost on the phone.

8 DR. WEINTRAUB: I want to contrast
9 this meeting to a study section. Because I
10 think what goes on here is actually
11 considerably more complicated than study
12 section. So if the NIH is forced to go that
13 way, I hope we are not.

14 The American Heart Association
15 study section is already by telephone. I am
16 not on study section anymore but I understood
17 from my colleagues it works reasonably well,
18 with some problems.

19 Where it works well at the NIH is
20 with special emphasis panels, which tend to be
21 smaller. And those are already often on the
22 phone. And I have been on those and it goes

1 okay.

2 Full study section, I think, when
3 you have about this many people are even more
4 sitting around the table. I think that it
5 does impede the conversation but it is
6 possible. But here, the complexity of the
7 conversation is so extraordinary and the
8 minority views need to be stated, as already
9 has been said. But this would be more
10 difficult than an NIH study section.

11 DR. GIFFORD: Echoing the
12 complexity issue, I mean I chair a Board where
13 in our organization we have nine different
14 committees. And we do a lot by teleconference
15 and video conference by phone but we also have
16 to do face-to-face, and that is even where
17 people know each other. And here where we
18 don't -- even if you had the standing
19 committee, you need to have some of that face-
20 to-face. And I would echo the complexity.

21 When it is simple, when it is sort
22 of straight forward, you can read something

1 and make a straight up and down vote with some
2 discussion, you can do that by phone. Working
3 through this is very, very, very difficult to
4 do that without that.

5 And I wouldn't use the bathroom
6 example because Nancy and I wouldn't be able
7 to have conversations then.

8 (Laughter.)

9 DR. GIFFORD: It is not the body
10 language. It is the side-to-side
11 conversations. If you look around, everyone
12 is having little sidebar conversations. And
13 so I am leaning over and I am saying did we do
14 that or where are we going. So I am trying to
15 figure out where it is. It is really complex
16 and you lose that.

17 When we are deciding what agenda
18 items to have on our committees or other
19 stuff, and even all the five other TAGs that
20 I have been on here at NQF, you always say
21 well that item we have to reserve for face-to-
22 face. We sort of it is a little bit like

1 pornography. You know it but it is sort of
2 like you can't have that on a call. You just
3 need a face-to-face for robust discussion.

4 And so I think that would be the
5 feedback I would give to CMS. I like Dan's
6 suggestion you have got to give them something
7 to go with but there are ways around it. And
8 I think even when we are traveling, we are
9 willing to work extra hours or do different
10 times and to do that.

11 DR. LATTS: I wouldn't use the
12 pornography analogy.

13 MR. SHEA: The Cost and Resource
14 Use Panel said, you know it when you see it.

15 Larry?

16 MR. BECKER: So I go to a bunch of
17 questions. And that is so what problem were
18 we trying to solve? Are we trying to solve
19 the Las Vegas problem? Right? And so you
20 put very strict requirements on what we do and
21 how we do it and this is sort of the way that
22 is? Are we trying to solve the absolute cost

1 issue? And so are there trade-offs that we
2 make in other places to take costs down
3 because cost is the issue?

4 And then on the other side, what
5 are trying to accomplish and what is the best
6 way to accomplish that? And so in deciding
7 how we proceed, I think let's take all of
8 those elements into consideration and I think
9 that it is at least a meeting type by meeting
10 type evaluation if it isn't a meeting by
11 meeting evaluation.

12 DR. MARCINIAK: So I think the
13 only thing I would add is when you look at the
14 course of the meeting we have had over the
15 last almost day and a half now, the question
16 also becomes one of meeting efficiency.

17 So I have been no the study
18 section type calls. I have been at meetings
19 like this and I have been in meetings at the
20 corporate level. And the question becomes the
21 discipline around the meeting itself.

22 You know we said the same thing a

1 lot of times over, and over, and over again.
2 And there is nothing particularly wrong with
3 that but the challenge becomes well how do you
4 compress that all if part of the problem is
5 well we are bringing people from the West
6 Coast, we need to efficiently use their time.
7 We have people who come to Washington because
8 after NQF we have three or four other meetings
9 we are going to. So there is also a meeting
10 efficiency issue in terms of how we elect as
11 a group to sort of drive ourselves to
12 consensus.

13 MR. SHEA: Thank you, very much.
14 This was really much more than I had hoped for
15 but it was exactly what I wanted. This is
16 very helpful for us. We are going to be as
17 responsive as we can be to the people who are
18 putting up the money -- it is our money after
19 all -- to do this. We aren't going to
20 compromise the quality of the program.
21 Obviously, the difficult thing is well sort of
22 what can you do here. What can you do this

1 other way. I kind of think we are going to
2 wind up both using some more virtual
3 technology and also finding some other sources
4 of money to make sure we are able, when we
5 need to do a meeting, to do a meeting.

6 But this is extremely helpful to
7 us. We have, as with all the meetings, we
8 have a record of this. We are going to draw
9 up a summary and we will be using it
10 internally and also some of the points when we
11 meet with the HHS folks. So thank you very
12 much.

13 MS. TIGHE: Okay, great. I am
14 going to jump right into the harmonization
15 discussion. And while I am going over some
16 principles for the Steering Committee to
17 review, if the developers from CMS and Health
18 Partners want to get in position with
19 microphones --

20 MR. AMIN: One thing. Just as we
21 introduced here, clearly the harmonization
22 discussion is intended for measures that are

1 recommended for endorsement. The measure that
2 we are having a conversation about the
3 committee felt very uncomfortable about making
4 a final decision. You will, obviously, have
5 a time after comment to discuss whether or not
6 you want to, after the comments have been
7 provided by the membership, to continue to
8 move the measure forward. You know, again,
9 thinking about today's vote as sort of
10 preliminary until the third stage, which will
11 be after the comment period, which it will be
12 your final vote to the CSAC and then it will
13 go to CSAC.

14 So the purpose of today's
15 discussion is really intended to be, at this
16 point, sort of preliminary, depending on what
17 the ultimate decision of this committee is
18 after comment. So we, obviously, don't expect
19 it to go as detailed as it would have if the
20 measure was endorsed but we don't want to miss
21 this opportunity to miss this opportunity with
22 both the measure developers in the room and

1 you guys just having thought about this
2 measure.

3 The Medicare Spending Per
4 Beneficiary measure is not going away. And so
5 we want to make sure that we continue to push
6 forward our agenda around public-private
7 alignment. And so that is the nature and the
8 reason why we are continuing this discussion
9 today.

10 I will send it back to you,
11 Lindsey.

12 MS. TIGHE: Okay. And on that
13 side as part of the documentation of this
14 discussion, you have a printout of a side-by-
15 side table to compare the two measures we are
16 discussing. Well you got it yesterday. If
17 you don't know, let us know and we can provide
18 some additional copies. It was printed out.
19 It was also in the packet that we sent out.

20 So I will just jump in. Our
21 process for this conversation is that we are
22 going to just review the principles for

1 harmonization and give an overview of what
2 related measures are. We will ask the measure
3 developers, they provided a joint response
4 letter to you all which you received your pre-
5 meeting materials. We will just ask them to
6 provide a brief presentation on the rationale
7 for the measures. We will as Staff walk
8 through some of the conceptual and technical
9 similarities and differences, we will open it
10 up to committee discussion and ultimately
11 committee recommendations for areas for
12 harmonization or justification for not
13 recommending harmonization.

14 Well I will just keep talking. So
15 why do we harmonize measures? It is to
16 identify the components of the measures, which
17 can be standardized for consistent measurement
18 of a population, condition or resource. We
19 asked the developers to begin this effort
20 prior to submission of measures to NQF. These
21 developers have working together for the last
22 few months to review possible areas for

1 harmonization between their two measures. And
2 we are doing this for related measures that
3 share similar characteristics and measure
4 focus, such as the measure types, the same
5 cost and resource use service categories and
6 the same population.

7 This reiterates what I said on the
8 last slide and then we are just looking to the
9 Steering Committee to assess the value if the
10 differences and specifications are necessary
11 or unnecessary. And then the burden if the
12 differences and the specifications infect the
13 interpretability, if the differences affect
14 the data collection burden for those who are
15 being measured.

16 The desired outcomes from
17 harmonization, we are looking for consistency
18 in the measure results, interpretability
19 across levels of analysis and data sources,
20 reduced burden for the providers and
21 implementers and improved interpretability for
22 the patients who are looking at the data.

1 Principles, we look at the
2 conceptual harmonization of the measure. So
3 whether the measure intent, focus, or target
4 population is the same or needs to be
5 harmonized. And then we also look at
6 technical, which is how that measure, intent,
7 or focus is operationalized through the
8 specifications, data elements, code sets,
9 things of that nature.

10 We don't look to harmonize the
11 statistical risk adjustment, the risk
12 stratification or the statistical methods for
13 estimating measure results as of our current
14 guidance.

15 And if there is no harmonization
16 recommended, then we ask that the committee
17 just elaborate on the value of the different
18 concepts and different technical
19 specifications, making sure that the benefits
20 outweigh the potential burden or risks of
21 having un-harmonized measures.

22 And that is it. We will turn it

1 over to the developers, HealthPartners, and
2 CMS to just provide a rationale for the two
3 measures.

4 MR. BALLOU: So believe it or not,
5 I am still here. And I would like to
6 introduce basically the key harmonization
7 issues that we have talked about with our
8 colleagues at HealthPartners. The measure
9 names are somewhat long. What I am going to
10 refer to as the CMS measure is the one that we
11 just discussed, the Payment Standardized Total
12 per Capita Cost Measure for Medicare Fee-For
13 Service Beneficiaries. I am going to refer to
14 the HealthPartners measure, that is the Total
15 Resource Use Population-Based Per Member Per
16 Month Index. That is NQF Measure 1598.

17 So those are the two measures that
18 we have gotten together over the past month to
19 two months to try and identify key differences
20 in the measures and discuss which among those
21 differences might be amenable to
22 harmonization.

1 So I would like to quickly take
2 you through some of the key differences. And
3 then while I am summarizing this, what I am
4 doing here is I am summarizing the memorandum
5 which I believe, in addition to that table,
6 was included in the 400 plus page packet that
7 was emailed to you. I am doing that summary
8 but obviously, my colleagues at health
9 partners can speak for themselves. So after
10 I am done with that, I would like them to have
11 an opportunity to respond.

12 The key differences that we have
13 identified are essentially five in these
14 measures. They are both total per capita
15 resources use measures. Total comes with an
16 important qualifier that I will come to in a
17 moment.

18 First of all, they focus on
19 different target populations. I will go into
20 a bit of detail on each of these but I am just
21 listing them for the moment. They use
22 different risk adjustment and payment

1 standardization methodologies. They attribute
2 patients differently and they differ in their
3 inclusion of pharmacy data.

4 The upshot, and again we will get
5 into a little bit more detail and then the
6 discussion will ensue, but the upshot of the
7 memo is that we, meaning CMS together with
8 health partners have jointly recommended
9 maintaining each of these differences in the
10 respective measures, rather than harmonizing.

11 And the reason for this is that
12 really the key difference here is the target
13 populations. The differences in the target
14 population drive a lot of the other
15 differences that we see. The target
16 populations differ meaningfully. The CMS
17 measure, as you know, is designed and tested
18 for Medicare fee-for-service beneficiaries.
19 It is a very specific population. It is an
20 older population in general and those who are
21 enrolled in Medicare who are not over 65 are
22 not representative of the population under 65.

1 Many of these beneficiaries have
2 multiple chronic conditions. They tend to
3 have heavier use of inpatient hospital and
4 post-acute care services than commercially
5 insured populations.

6 The HealthPartners measure, by
7 contrast, is designed for, tested on, and
8 endorsed for commercially insured patients.
9 And so there is a different population there.
10 Again, younger and generally healthier. You
11 are looking at somewhat different mix of
12 services. You will, obviously, much more
13 maternity and newborn related services in a
14 commercially insured population than you would
15 see in the Medicare population.

16 Because these target populations
17 differ meaningfully, components of the
18 methodology have been tailored to make the
19 resource use measurement for the respective
20 populations as accurate as possible in two
21 respects. First of all, risk adjustment. We
22 use different approaches. CMS uses the CMS-

1 HCC risk-adjustment methodology. And as the
2 discussion goes on, if needed we can get into
3 reasons why. HealthPartners, on the other
4 hand, uses Johns Hopkins ACG risk-adjustment
5 methodology.

6 So different approaches that are
7 intended for different populations; Medicare
8 versus commercially insured.

9 Similarly, the payment
10 standardization approaches are different. So
11 in the NQF terminology these are not per
12 capita cost measures. They are per capita
13 resource use measures, which means that you
14 are somehow standardizing services to make
15 comparability across different types of
16 services. And you need a payment
17 standardization algorithm to do that. CMS
18 uses its agency-wide methodology for fee-for-
19 service beneficiaries. It is extremely
20 specific to all of the prices that are paid
21 for really all of the services that Medicare
22 covers.

1 HealthPartners uses a total care,
2 their own Total Care Relative Resource Values
3 methodology, which is very appropriate for the
4 commercial population on which their measure
5 has been tested and again is likely to get the
6 relative prices right in that population, much
7 better than say the CMS approach would be if
8 you tried to take Medicare standardization and
9 apply it to a different population.

10 So our view jointly is that if we
11 harmonized on either risk adjustment, which we
12 realize per Lindsey's observation of a couple
13 of moments ago is not necessarily recommended,
14 or is not recommended for harmonization or
15 payment standardization, this would reduce the
16 accuracy of one measure or the other. So we
17 advocate maintaining these distinct approaches
18 to risk adjustment and payment standardization
19 for the two respective measures.

20 And the other differences I am not
21 sure I need to cover in as much detail at
22 least by way of overview because they have

1 been covered so extensively in the earlier
2 discussions. The first is that we have
3 different patient attribution rules. We have
4 discussed extensively the attribution rule for
5 the CMS measure. The HealthPartners approach
6 is also a primary care-based rule but it is
7 somewhat different. When they were up for
8 endorsement, they were given the option of
9 listing the attribution approach as a
10 guideline or as a specification and the
11 measure valuation form has changed since then.
12 CMS did not have that option in the most
13 recent form. So we listed the attribution
14 rule as a specification. But this is a rule
15 that, as we discussed, is being adopted across
16 other agency initiatives. So CMS has an
17 obvious programmatic interest in maintaining
18 possibly in an improved form the rule that is
19 currently before us.

20 And then finally the CMS measure
21 does not include pharmacy data for reasons
22 that were discussed late yesterday. Many Part

1 A and B beneficiaries are not enrolled in Part
2 D. Whereas, the HealthPartners measure does.
3 I think we are all in agreement that if you
4 have pharmacy data for your patients, you want
5 to use it. And so in our view it is
6 appropriate for HealthPartners to continue to
7 include it but that it should not be included
8 in the CMS measure.

9 So that was the basis for our
10 conclusion that we recommend against
11 harmonizing on these four or five dimensions.
12 But again, I would like to give HealthPartners
13 and opportunity to also weigh in.

14 MS. KNUDSON: Thanks for that
15 summary, Jeff. Hello, everyone. I am Sue
16 Knudson with HealthPartners. I lead Health
17 Informatics there. I am joined by my
18 colleague to my right, Chad Heim also from
19 Informatics and Gary Kitching to my left.

20 I would just like to make four
21 additional points. We worked together on the
22 summary that Jeff had made.

1 The first point is we all know who
2 CMS as providers and healthcare professionals.
3 You may not be familiar with who
4 HealthPartners is. So I just wanted to
5 briefly tell you about us.

6 We are a consumer-governed non-
7 for-profit organization based out of
8 Minnesota. We are an integrated finance and
9 care delivery organization. And why that is
10 important to the relevance of our use of these
11 measures is because we are not just simply
12 reporting to others. We also need to make
13 sure the measures and information are usable
14 for our own practice in hospitals as well.

15 The other thing that I would just
16 like to point for many of you who aren't as
17 close to the Minnesota market, because we own
18 and operate both care and financing, neither
19 organization is exclusive to one another. Our
20 care delivery footprint is a multi-payer
21 footprint that is not a closed model, HMO,
22 staff model traditionally. We are practicing

1 in the open market, as is everyone else in
2 Minnesota. And likewise our payer is also not
3 exclusive to the care delivery system. As
4 many of our partners here from Minnesota can
5 attest to, we partner with everyone in the
6 region.

7 So with that, Jeff had also
8 mentioned the second point I wanted to make
9 was just the aha that the Steering Committee
10 came to yesterday with regard to the CMS
11 measure really being calibrated to the
12 payments. And so that is inherently a
13 different resource use methodology than we
14 have employed to build our tool, Total Care
15 Relative Resource use, which is really a
16 relative system across the full continuum of
17 care, folks seen simply on resource use. It
18 is a patented methodology that we spent over
19 a decade developing. We have it out in the
20 public domain now free of charge. So for
21 others to use.

22 The third point I wanted to make

1 was Jeff had highlighted that yes, our measure
2 does include the pharmacy data as it relates
3 to your interpretation of the grid that was
4 handed out. What is different about the
5 commercial population and this measure is we
6 are not excluding any information. We are
7 including -- it is a very patient-centered
8 measure. It includes all care for taking care
9 of patients and members that we have that
10 administrative claim data for.

11 What is very different is the
12 prevalence of types of services like long-term
13 care, skilled nursing care, which is much more
14 prevalent in the Medicare population. It has
15 some prevalence, not as much, obviously, in
16 commercial. So the point I just wanted to
17 emphasize, no exclusions in that regard. That
18 the differences based on the care needs and
19 the use patterns are much different.

20 And then lastly, Jeff also pointed
21 out with regard to attribution, the CMS
22 measure went through with that as a

1 specification. Ours, indeed, was offered as
2 a guideline. We shared our methodology in the
3 spirit of transparency but also in the
4 consumer and commercial market, understanding
5 that different areas around the country may
6 have rules that makes sense in those markets.

7 And just by way of example there,
8 the work that we have done in Minnesota since
9 the endorsement of the HealthPartners measure
10 in 2012 early in the year, we have worked with
11 our community collaborative to review all the
12 attributions and have landed for community
13 reporting on a single method because,
14 essentially, what we found is you know they
15 returned roughly about the same result. So it
16 was an opportunity for us to standardize that.

17 So again, I just wanted to
18 emphasize that the attribution method for the
19 HealthPartners currently endorsed measure was
20 a guideline.

21 So with that, I think we would
22 entertain questions.

1 MS. TIGHE: So just on the next
2 slide, Staff briefly went through and just
3 highlighted some of the areas where these
4 measures have overlap.

5 DR. RYAN: I have a question for
6 HealthPartners. Have any other commercial
7 payers adopted this method and can you speak
8 to their experience using it?

9 MS. KNUDSON: Yes, thanks for that
10 question. Right now this is the resource use
11 methodology that we have endorsed. We have at
12 least, I think we are up to about 60 users
13 across 21 states.

14 DR. GARRETT: So I have a question
15 about continuous enrollment. So Sue, my
16 understanding is in the HealthPartners measure
17 there is a nine month continuous enrollment
18 requirement. Is that right?

19 MS. KNUDSON: Yes, Nancy, that is
20 right. And that is with regard to
21 accumulating enough diagnoses in the
22 commercial population to make sure we have the

1 proper amount of data to do good risk
2 adjustment.

3 DR. GARRETT: Okay. And so for
4 the CMS measure, is there an equivalent?

5 MR. BALLOU: Well again, for the
6 CMS measure, we are at a looking at a full
7 year.

8 DR. GARRETT: And the
9 beneficiaries have to be enrolled for that
10 whole 12-month period continuously?

11 MR. BALLOU: They need to be
12 continuously enrolled in both Parts A and B,
13 correct, for the full 12 months.

14 DR. GARRETT: Okay, thanks.

15 MS. TIGHE: So I'm going to jump
16 in. I just wanted to highlight what Staff has
17 laid out as kind of some of the similarities
18 between the two measures and differences. The
19 target populations do have some overlapping in
20 the age ranges, given the commercial
21 population, the Medicare population aren't
22 strictly defined by age. There are similar

1 settings. They are non-condition-specific and
2 they both look at a one-year time frame.

3 The measure focus, they both use
4 standardized costing approaches, although they
5 detailed the differences there. They both are
6 per capita measures. They both hit on similar
7 resource use service categories.

8 The technical, the target
9 population, we are looking at a Medicare
10 population versus the commercial populations
11 and the measure focus. There are some
12 differences in the costing approach as they
13 have outlined and then there are also a few
14 service category differences that are related
15 to how the measures were specified.

16 So just moving to the next page,
17 we just really want the committee to take the
18 time to consider whether or not these measures
19 should be harmonized first and then from there
20 what those recommendations may be.

21 So to focus in on do the measures
22 have sufficiently different populations to

1 justify two measures. Are the standardized
2 costing approaches different enough to justify
3 having two measures? The justifications and
4 rationale provided by the developers, is that
5 sufficient for justifying two measures? Are
6 there areas where maybe these measures should
7 be harmonized? And then the last question is
8 perhaps a little bit of moot point, at this
9 point.

10 MS. CLARK: Just a question on the
11 harmonization process. So are we when we are
12 talking about that, are we saying we have an
13 option of keeping two completely separate
14 measures or we can take each of these
15 components and say some components should be
16 the same? Is that what we are saying?

17 MS. TIGHE: Yes, so you have the
18 option of keeping two measures as they are,
19 based on the justifications from the
20 developers. You could recommend areas for
21 them to harmonize related to the measure
22 conceptual focus or technical specifications.

1 Or an extreme version is to pick a best in
2 class.

3 MS. CLARK: So I guess just
4 another comment then on the approach to the
5 costing methodology. I mean, those are
6 completely different. So I mean I don't see
7 how we can say that those are equivalent. I
8 just had a question about that. I mean, as I
9 understand it, you are using relative value
10 units where there are some that exist and
11 where there aren't any that exist, you are
12 using billed charges, relative billed charges.
13 Is that right?

14 MR. KITCHING: Yes, thanks.
15 Actually, we impute those values based on the
16 billed charges. So you are correct but
17 actually it is just to create the actual
18 relatively is between the service codes, yes.

19 MS. CLARK: So that is how it is
20 done for like the pharmaceutical costs?

21 MR. KITCHING: I terms of creating
22 the relativity as across but then we actually

1 go back to get the paid, we blend them
2 differently again, just to make sure we get
3 back. We want to get back to paid amounts at
4 some point. So we do that.

5 MS. CLARK: Okay, so the final
6 measure is in dollars or RVs?

7 MR. KITCHING: I reflect it as RV
8 use. This is an RVUPMPM.

9 MS. CLARK: Okay. So that is
10 another distinction. It is a per member, per
11 month and not an annual per.

12 MR. KITCHING: Well I would say
13 you could characterize it as a PMPM but you
14 can reflect it as a per member per year. I
15 mean, it is just how you reflect it.

16 MS. CLARK: Okay.

17 MR. KITCHING: So, yes.

18 MS. TIGHE: Larry, Jennifer, and
19 then Andy.

20 MR. BECKER: So two questions and
21 maybe -- well, let me just ask the questions.
22 So the first question is so what do the two

1 developers think about harmonizing? And
2 secondly, has anybody looked at what the
3 practical effect is of trying to put these two
4 things together and what comes out the other
5 end?

6 MS. TIGHE: I will let the
7 developers hit on that first.

8 MS. KNUDSON: I will comment
9 first. This is HealthPartners.

10 If I put care delivery taken
11 action off of this hat on, I would prefer
12 measures calibrated in tune to those
13 populations. So when I really think about
14 usability and taking action on it to make
15 improvements, I think about having the
16 measures tuned, if you will, or calibrated to
17 my commercial environment, my state public
18 programs, if I have a method there, which we
19 are doing some development work to tune our
20 method to our state public programs, as well
21 as look at the Medicare population separately.
22 So that would be one response to that.

1 The second piece I would add is
2 when HealthPartners went through this process
3 a couple of years ago, many of you who were on
4 that Steering Committee will recall that we
5 have two endorsed measures. One is a total
6 cost of care measure, which is actually based
7 on allowed payments, member liability, as well
8 as planned liability. So the power in terms
9 of taking action on these measures is best
10 when they are used together because we find
11 the actionability with understanding total
12 costs and then we work with practices,
13 including our own, to understand that total
14 cost performance and all the things that have
15 been debated here over the last couple of
16 days.

17 But then this resource use measure
18 really helps to benchmark practice
19 opportunities in a way that is not confounded
20 by price differences. So we really see the
21 power in using the two measures together and
22 that is how we have actively used them.

1 So I hope that helps.

2 MR. BALLOU: Nothing substantive
3 to add, other than to reiterate our view from
4 again the Medicare Population perspective that
5 having a highly customized, highly tuned
6 standardization approach is important for
7 accurately reflecting relative resources.

8 DR. STEPHANSKY: So what would be
9 the result if we said yes, you have to
10 harmonize these two measures, what would you
11 do?

12 MS. KNUDSON: Well you know the
13 first thing I guess is -- you know, I don't
14 know that I can, in fairness, answer that. If
15 we start with the risk adjustment question,
16 for example, you know the NQF guidelines, I
17 think as we looked at those around
18 harmonization, too, it was a natural response
19 to us that they are not conducive to be
20 harmonized. The risk adjustment model used by
21 CMS is fundamentally different than what we
22 are using for a commercial population. The

1 disease prevalence is difference. There is
2 not an open source risk adjuster that would
3 work in a way that would have the results be
4 to the level of accuracy that we need them.

5 We have been open to testing our
6 measure, using an open source risk adjuster
7 when it is available in tune to the commercial
8 population but as of yet, that is not
9 available. So that is one way to respond.

10 You know, so I technically don't
11 know if it is possible.

12 MR. BALLOU: Right. And again, I
13 think I would echo that response. And even if
14 it were mechanically doable, you would get
15 numbers that, in our view, would not make
16 sense.

17 MS. EAMES-HUFF: So I will just
18 say from the get-go, I think there probably
19 are enough differences between these measures
20 that it would be difficult to harmonize. I
21 have heard though from quite a few people that
22 there is a desire to look at the commercial

1 population resource use and what is happening
2 in the Medicare population resource use. So
3 I am interested in you commenting on is there
4 some level of comparability or are they so
5 different that you can't really compare the
6 numbers?

7 MR. BALLOU: Are you asking about
8 comparability of results --

9 MS. EAMES-HUFF: Yes.

10 MR. BALLOU: -- even on a non-
11 harmonized basis?

12 MS. EAMES-HUFF: Yes.

13 MR. BALLOU: I guess I would argue
14 that I would go back to our initial point that
15 the differences in the target populations are
16 sufficient that one should not make other
17 things equal source of assumptions in making
18 those comparisons.

19 I'm not sure if that -- it sounds
20 like that doesn't quite address that.

21 MS. EAMES-HUFF: It doesn't quite
22 satisfy because I think we see we do with

1 quality measures, we compare the commercial
2 population to the public population.

3 So there may be reasons why it
4 would be different, you know, that drive
5 different cost behaviors. So we would see a
6 difference. And I think it is just
7 understanding that and whether or not these
8 two measures, looking at them, could shed
9 light on that or not. I'm not sure if that is
10 possible.

11 MR. BALLOU: Yes, I guess my take
12 and HealthPartners might or might not agree is
13 that to do that effectively you would need
14 what again we don't see being available yet,
15 which is a risk adjustment algorithm that can
16 accurately and adequately capture the full
17 spectrum of the populations that we are
18 talking about and similarly a payment
19 standardization methodology that can do that.

20 So these measures are very
21 distinct in their approaches right now. There
22 isn't one approach on either the payment

1 standardization or risk adjustment side that
2 would allow us to essentially throw everything
3 into the same comparison group. Once you had
4 more valid methodology for either and risk
5 adjustment and payment standardization, then
6 you could certainly do valid breakouts of
7 differences between the Medicare experience
8 and the commercially insured experience.

9 MS. TIGHE: Andy, Mary Ann, Nancy,
10 Cheryl.

11 DR. RYAN: So I think for payment
12 adjustment and risk adjustment -- payment
13 standardization and risk adjustment, it makes
14 sense to not harmonize the measures. It makes
15 basically zero sense to try to harmonize.

16 The one place that it seems like
17 there is a reason to do it is that they are
18 attribution because it is complicated. We
19 have talked at length about it on this
20 committee and the idea of providers having
21 different rules for different populations, it
22 seems like that would be extremely difficult

1 to manage and would create some kind of, I
2 think, challenges, and kind of comparing costs
3 kind of apples to apples based on their
4 accountability for Medicare and non-Medicare
5 patients.

6 And I also just kind of wonder
7 from HealthPartners perspective if they think
8 that their measure might just kind of become
9 irrelevant. If Medicare is moving along with
10 this other way, it might be just better to
11 kind of get in line behind what they are
12 doing. So that is kind of my question is
13 around attribution and whether -- how that
14 will play out for providers who are being
15 profiled.

16 MS. KNUDSON: So in our
17 experience, and we come from a market that has
18 a rich history of measurement and transparency
19 around it and collaboration, even though it is
20 a very competitive market as well, although we
21 tend to compete around the things that matter
22 and sometimes these definitions are not in

1 that domain.

2 So for attribution what we use is
3 attribution and what we have recently come to
4 is looking at the visits and it is looking at
5 most visits. It is primary care, as Jeff had
6 mentioned. We do include the nurse
7 practitioners and others that were discussed.

8 And then more recently in our
9 community collaborative discussions, we have
10 agreed to a look-back period so as we are all
11 creating new and more improved care designs
12 that we also don't incentivize requiring a
13 patient to come in on an annual basis, if it
14 is not necessary, moving and taking advantage
15 of virtual care and other online services that
16 can be done more cost effectively. So we are
17 trying, over time, adapt our attribution
18 models to make sure that they are moving with
19 the care designs. And so to that regard, with
20 all the reform going on and the ACO work and
21 everyone really working to improve and hit on
22 all cylinders with the triple aim, this has

1 got to move with it.

2 And so those are just some of the
3 recent innovations that we have done. We,
4 too, as Brent Asplin had spoke to earlier, are
5 familiar with this CMS attribution. Our
6 colleagues in our care group from Park
7 Nicollet are also a pioneer ACO. So we are
8 familiar with those different levels.

9 Then the last comment I would make
10 about commercial is when you are looking for
11 adoption across the country, the commercial
12 market is different. The payers are
13 different. The product design is different.
14 There might be different longevity in certain
15 plans. So it is not as though I am 65 and I
16 am now enrolled in Medicare and that is static
17 across the rest of my life. There is movement
18 in the commercial market. And so we just need
19 to be mindful of those things in talking about
20 one standard approach.

21 MS. CLARK: I am just curious. So
22 HealthPartners, I assume you have a Medicare

1 Advantage plan. Is that right or no?

2 MS. KNUDSON: As a payer, we
3 historically have not had a Medicare Advantage
4 plan. We are a cost plan. So as of right
5 now, that is why we had not used this measure
6 on Medicare because we don't have the whole
7 suite of data within our operation to run it.

8 MS. CLARK: Okay. I was just
9 going to ask you what approach you would use
10 if you did have. Or CMS, what are you
11 envisioning, you know Medicare Advantage
12 plans, how they would adopt a measure. I am
13 assuming it would be the Medicare measure.

14 MS. TIGHE: Nancy?

15 DR. GARRETT: So a couple thoughts
16 here. First of all, as a provider I think I
17 kind of think of the cost measurement as like
18 maybe ten years behind where we are in quality
19 measurement right now. It feels a bit like
20 the wild west where each commercial payer is
21 taking a different approach to all of these
22 measurement issues around attribution and how

1 to actually define these measures. So really
2 thank you to HealthPartners for advancing this
3 and starting to move towards a standard. I
4 think it is really important work.

5 So specifically on the issues we
6 are talking about harmonizing, I think with
7 risk adjustment I agree that it really makes
8 sense to have a different methodology for the
9 different populations that that works in that
10 situation. And so I don't think we should be
11 trying to harmonize there.

12 With some of the other pieces, I
13 think we need to have some more thoughtful
14 discussion. So for example, I agree with
15 Andrew, that is a place where, again, as a
16 provider when each payer has a different
17 approach to attribution that is really
18 difficult. And so is there a way that we can
19 start to move towards a national standard
20 around attribution? I think that is an
21 important goal. I don't think differences in
22 the populations justify differences in that

1 approach for attribution.

2 With pharmacy, you know, not
3 having data on pharmacy is a common problem
4 for commercial payers also because a lot of
5 employers carve pharmacy out. And so there
6 are approaches where you can calculate the
7 measure with people who have a pharmacy
8 benefit and without and then create a blended
9 PMPM result.

10 And so I think that is something
11 that CMS should consider as well, so that we
12 can have a measure that includes pharmacy. We
13 talked about in the previous discussion that
14 pharmacy is such an important component of
15 total cost of care.

16 And then the last comment is
17 around the different approach to the payments.
18 You know, as Sue said, CMS is really
19 calibrated to the payments and HealthPartners
20 is calibrated to resource use. And some of
21 that has to do with methodology and the
22 difference in the way the reimbursement works

1 but some of it is a conceptual difference in
2 the measure. And so given that conceptual
3 difference, I worry that it is not going to be
4 very clear to providers and even consumers as
5 these things get rolled out what that
6 difference is. So I am just not as convinced
7 there that we don't need to consider
8 harmonizing because of the different
9 population there. It seems like there is a
10 conceptual question. What are we trying to do
11 with these measures and what is the reason for
12 a difference in the approach?

13 So those are my thoughts.

14 MS. TIGHE: Cheryl, Jack, and then
15 Brent.

16 DR. DAMBERG: I was wondering if
17 the measure developers could comment on,
18 because I agree sort of the underlying methods
19 used to generate the measure are very
20 different and probably should stand. But I
21 guess I am wondering is there an opportunity
22 sort of kind of downstream, once you generate

1 the end result, is there any way to combine
2 these so that if CMS is giving feedback
3 reports to individual physicians, the
4 HealthPartners on the commercial side could be
5 integrated such that there is some way to
6 translate your metric onto the same metric, if
7 you will.

8 So I don't know if you guys have
9 considered that. Like is there any kind of
10 common denominator in there to allow that
11 combining of information?

12 MS. KNUDSON: I am not sure if I
13 can answer that directly because we haven't
14 specifically looked at that but if I could
15 address kind of both comments together, Nancy,
16 specifically your comments with an example.

17 The reason we have calibrated to
18 resource use and see the power of using this
19 in addition to the other measures that we have
20 created is around taking action. So for
21 example, we could be looking at the use of
22 imaging in a population as a driver of overall

1 cost and we could isolate that the resource
2 use really is predominantly in a hospital
3 outpatient environment versus a freestanding.
4 The way we have calibrated it based on
5 resource use, the resource use for that scan,
6 meaning it is the same scan in this example
7 but the difference is price. Generally
8 speaking, the hospital is a more expensive
9 price for that scan, versus an outpatient
10 ambulatory kind of setting.

11 And so by isolating resource use
12 to specifically that, it helps to make place
13 of service decisions that can improve overall
14 cost performance. And so that is why that is
15 sort of that actionability component was the
16 rationale behind us using a pure measure
17 around that.

18 So then if I go to your question,
19 Cheryl, I would say to the extent that
20 practice patterns in general hold firm in our
21 care delivery environments from our commercial
22 to our Medicare patients. If I always send my

1 patients to the hospital for a scan, I am
2 probably not going to be changing that by
3 payer. So to the extent that one source of
4 information out of in this example, commercial
5 could help you understand those practice
6 patterns, it could have some carry over effect
7 but we have not studied it specifically with
8 the measures.

9 DR. DAMBERG: Yes, I am thinking
10 more at this observed to expected. So if you
11 are going to score me is greater than one or
12 less than one, it is that consistent across.
13 And then obviously, maybe the drill down
14 reports look slightly different, so that they
15 can tease apart where those differentials are
16 coming from. But I was trying to figure out
17 is there one standard metric where these two
18 could be married in some way, without having
19 to change up the underlying structure.

20 MR. KITCHING: I think our
21 position in a lot of the work that we do, is
22 you have to make sure that you separate the

1 populations and you keep them separate. So
2 like the Medicare population is measured
3 amongst the Medicare folks and the Medicaid is
4 the same thing, and the commercial as well.
5 We don't really see value in actually
6 presenting a number that actually has all
7 those three blended. But if you were to do
8 it, you would blend it by population. But
9 again, you have got to keep them separate when
10 you measure them separately. So a commercial
11 population is measured against commercial
12 population and the Medicare against Medicaid.
13 And you rank them as such and then you can
14 blend those two based on populations
15 underneath.

16 But again, as HealthPartners, we
17 just don't see any value in actually doing
18 that because a person isn't a Medicaid member
19 and a commercial member together from a
20 transparent perspective. They are different
21 people. So actually when you are going to
22 present that information, they should be

1 separate all the time. So that is a
2 perspective that we take.

3 MR. BALLOU: And I think we would
4 share that perspective. Again, in principle,
5 we have two measures here. And as you know,
6 when we discussed earlier in the feedback
7 reports that we provide to physician groups,
8 we provide many measures. An illogical way to
9 potentially approach this if one were in an
10 environment where one wanted to study a
11 broader population than either of these
12 measures currently cover, you would simply
13 compute both measures, according to the
14 measures respective specifications. And then
15 you would report them with the appropriate
16 corresponding drill down, I think.

17 But again, as this group knows
18 that the focus of the CMS measure, at least at
19 the moment is limited to the fee for service
20 beneficiaries.

21 MS. TIGHE: Jack, Brent, and then
22 tom.

1 DR. NEEDLEMAN: Okay. To cut to
2 the bottom line, I think it is probably
3 premature to try to harmonize these measures
4 because we don't have a basis for choice among
5 the differences in them. That said, I think
6 some of the differences are probably smaller
7 in practice than they are in principle. So I
8 know that there is an extensive literature
9 that looks at different risk adjusters and
10 tries to compare their performance. And I
11 suspect that when you look at the impact, the
12 ultimate impact at the group level or the
13 provider level once things are aggregated up,
14 they don't provide that big a difference in
15 the results. They are all using different
16 nonlinear combinations of all the information
17 that is available from the administrative data
18 to try to get an estimate of likely use and
19 they do it slightly differently and they
20 produce slightly different rankings but not
21 all that different.

22 But we don't have a basis for

1 choosing ACGs versus HCCs. That is so
2 compelling that we ought to say do it one way
3 versus the other. There was a lot of
4 discussion in the first panel about the high
5 cost of the ACG methodology to people and that
6 was a real consideration. I would love to see
7 an open source, low cost publicly use version
8 of a risk adjuster that does well enough.

9 But we aren't there yet. And the
10 issue there is doing enough work with large
11 datasets to understand in practice what the
12 differences are in risk adjusters in terms of
13 the rankings, in terms of where providers are
14 classified, where patients are classified, and
15 what difference it makes in practice when
16 these measures are used. And we haven't had
17 that.

18 So I would encourage both sets of
19 developers to actually start looking and start
20 reporting what difference it makes to use one
21 risk adjuster versus another. One
22 standardization, one standardized price

1 schedule or resource schedule versus another.

2 Again, the last time last year we
3 had an extensive discussion about standardized
4 prices versus non-standardized prices for
5 whether it is useful. It could be comparing -
6 - I think the comparison was Memphis to
7 Peoria. And don't ask me why we wound up with
8 Memphis and Peoria but there we were. Memphis
9 I remember. Peoria I may be making up. Was
10 it Minneapolis? Memphis and Minneapolis.
11 Thank you, Helen. But the same thing.

12 So the real thing we have
13 discussed about standardization is the
14 compression of differences in actual costs and
15 resources used by the providers in settings
16 and how that is masked by different
17 standardizations. And that was alluded to in
18 the sense of if you use the same standard
19 price for hospital-based imaging or lab tests
20 and freestanding imaging or lab tests, you are
21 losing a source of variation in what is being
22 paid and what costs are being realized in the

1 system.

2 So standardization does that. We
3 have to understand where standardization is
4 beneficial in terms of understanding resource
5 use differences and where standardization is
6 masking important resource use differences.
7 We aren't there yet in terms of recommending
8 a single approach to standardization. So
9 again, I would encourage those who are using
10 these measures to use alternative ways of
11 pricing them to see what we learn and don't
12 learn from them and start reporting that so we
13 have a better basis for making choices in the
14 future, rather than simply looking at the
15 choices you have made and trying to infer what
16 is gained and lost by them.

17 With respect to the drugs, I am
18 going to second Dolores here. I think the
19 lack of drug information with your Medicare
20 beneficiaries is a significant weakness of the
21 measure you have got. And I know because Part
22 D with different companies makes it very

1 complex and perhaps more complex than the
2 simple carve-outs with the PB, Pharmacy
3 Benefit Managers. In the commercial market,
4 it is harder to do.

5 But we have seen some approaches.
6 Again, last year the Ingenix folks said we
7 stratify. When we have got the pharmacy data,
8 we report plans with pharmacy data. When we
9 don't have pharmacy data we report it without
10 and it is two separate sets of measures. And
11 you have got 60 percent of the folks in Part
12 D. Figure out how to get that data reclaimed
13 into a total cost measure for the
14 beneficiaries and stratify it as a first cut
15 version of how to do that. And I think that
16 will move things along and you will have two
17 or three or four years of challenge in
18 figuring out how to actually get useful data
19 from the Part D folks who don't want to give
20 it up. But it is an important thing to do and
21 that needs to start.

22 So as I said when I started, I

1 think right now harmonization is premature but
2 there are lots of explicit things that we
3 ought to be encouraging the measure developers
4 and others to do to help us to understand what
5 the differences are in these measures and what
6 difference it makes in practice so that down
7 the line we can think about what preferred
8 methodology should be adopted.

9 DR. ASPLIN: What he said. I
10 think Jack summarized quite a few of the
11 points was going to make. I accept the
12 arguments of the developers that we don't need
13 to harmonize today. And along the lines of
14 what Jack was saying, I am probably more
15 interested in what is going to trigger the
16 work that needs to happen over the next five
17 to ten years so that we would have the
18 information in front of us to perhaps make a
19 different decision in the future than we are
20 making today on this harmonization point. We
21 need to learn.

22 And I will say that HealthPartners

1 does a great job of having the very
2 conversation you just alluded to today with
3 the Liberty Systems. So when we sit down, we
4 have not only the Resource Use Index data
5 around resources but there is also the Total
6 Cost Index data. In fact on Monday, I had a
7 conversations with one of their medical
8 directors about both of those components. So
9 they look at -- so we understand both how our
10 pricing decisions affect total cost of care,
11 as well as our resource use decisions.

12 So they are having those
13 conversations, even though the measure itself
14 uses the resource standardization process that
15 they got through NQF. So they do a very good
16 job of that. And I would hope that we are
17 going to get the information we need to
18 reevaluate the decision down the road.

19 MS. TIGHE: I am actually going to
20 jump in really quickly just in the interest of
21 time. It sounds like we are kind of
22 coalescing in the idea that these measures

1 don't need to be harmonized today and that
2 there is a need for more information the
3 future. If there are any points that need to
4 be made in addition to that, let's go ahead
5 and make them but we do have the whole Day 2
6 agenda to tackle.

7 MS. YANAGIHARA: Very briefly, I
8 think that there was a question about whether
9 there is value in being able to compare across
10 product lines and I just want to iterate what
11 I hear from the physician groups in California
12 there would be value. So if it is possible to
13 get to something that is comparable and
14 combinable, they think of their whole patient
15 population. They don't think in terms of
16 which product line. And so there definitely
17 would be value. And I think the question is
18 can we get to a measure that would be
19 comparable across product lines.

20 So I just want to just keep it in
21 mind that it is an important need and so we
22 shouldn't give it up.

1 DR. TSANG: Just two quick
2 questions for HealthPartners. Understanding
3 that HealthPartners probably has very, very
4 little leakage, how that actually impacts on
5 some of the attribution issue. And then
6 secondly if you can just expand a little bit
7 about what you have learned from implementing
8 this measure and have you used it and how you
9 would actually -- I am sure you had talked
10 about how to improve upon it as well.

11 MS. KNUDSON: So I assume you are
12 referring to our own delivery system in terms
13 of leakage. Actually, we have an interesting
14 delivery system because our ambulatory
15 clinics, the Legacy HealthPartners Clinics, if
16 understand the Twin Cities you know we are
17 very divided by rivers and our clinic
18 footprint is much on the east side. But we do
19 have some clinics on the west side as well.
20 Our hospitals are all on the east side, with
21 the legacy organization. And so that means we
22 partner with others in the community for

1 specialty coverage as well as hospitalizations
2 that are not in our own care delivery, our own
3 delivery system.

4 So but for our own delivery
5 system, as well as those that we contract with
6 through our health plan, a part of the suite
7 of our information is to help them understand
8 who their referral partners are and what their
9 Triple Aim performance is as well. And so it
10 is a very transparency-enabled discussion
11 again.

12 We do have a fair amount of
13 keepage, if you will, to use the term more
14 positively but we do have a rich history of
15 partnering with other specialists and
16 hospitals in the community as well. We just
17 track that very closely.

18 And then in terms of the lessons
19 learned question, what we have very early
20 learned is this is a dialogue. It is not just
21 us going out and calling the score with those
22 that we partner with in the community. It is

1 really sharing the information, having a
2 dialogue about it, having an engaging
3 discussion about how the measures can be
4 improved and evolved, understanding practices,
5 all with this evolution of really keeping the
6 patient at the center. And once you do that,
7 there is less chance for things to go awry.

8 And we have also learned you know
9 at the high level, the precision and the
10 accuracy is very good when we start drilling
11 this stuff down to really hone into
12 opportunity areas. You know multiple payers
13 have different versions and what we are
14 hearing from providers is yes, the
15 HealthPartners report might be different from
16 my Blues report but they are directionally the
17 same. And it is those providers who are
18 taking action on those directional
19 consistencies that we are seeing have the best
20 uptake in terms of improved performance.

21 And then the last comment I would
22 make in terms of lessons learned is we very

1 intentionally pair this information across our
2 health plan applications with quality and
3 patient experience information. So it is
4 truly Triple Aim reported. And that for sort
5 of gaining the hearts and minds particularly
6 of our clinical teams, that has resonated very
7 well.

8 Does that help?

9 MS. TIGHE: Okay, great. I'm
10 going to use that to end the harmonization
11 discussion now and move on to our discussion
12 of risk adjusters.

13 So this will be a conversation
14 with Taroon Amin and Karen Pace who are both
15 NQF Staff leading, and then we also have Syed
16 Mehmud joining us. You can come up to the
17 table.

18 And then on the phone, Operator, I
19 believe we have got Steve Frank from Optum,
20 Greg Pope from RTI, Chris Tompkins from
21 Brandeis, and David Bodycombe from ACG.

22 MR. AMIN: So while everybody is

1 joining us onto the table, I just want to set
2 a little bit of the context of this
3 conversation.

4 So as we know, this is sort of
5 newer area of measurement in terms of national
6 consensus standards. The first iteration of
7 the Steering Committee provided a number of --
8 and so we are moving into much more of a
9 conceptual discussion around cost and resource
10 use measurement in general. And so we are
11 using this time with the Steering Committee to
12 really think through some of the conceptual
13 assumptions and recommendations that were
14 given from the first Steering Committee.

15 So as background, as we first
16 initiated this work noting that we have the
17 refresh of this group and we have new experts
18 joining and others that have stepped away. So
19 it is a good time to rethink some of our
20 assumptions as we worked on this effort from
21 the beginning.

22 The first cost and resource use

1 effort put together a series of guidance and
2 also the measure submission form, which
3 included various different components. Those
4 components allowed guidelines and
5 specifications, which some of our colleagues,
6 our developer colleagues referenced earlier.

7 But specifically there has been a
8 number of questions that have been raised in
9 the field related to our current guidance
10 related to risk adjustment. And this guidance
11 is consistent across quality and resource use
12 and we want to kind of bring up the issues
13 that have been raised in terms of our guidance
14 as it relates to the need in the community of
15 various different stakeholders.

16 So we have invited a number of
17 experts who are developers across the
18 spectrum, developers who have participated in
19 our first effort. Developers who were working
20 on the Medicare grouper, additional experts
21 who have participated in earlier conversations
22 to provide additional context. And so this

1 will be a little bit of, obviously, committee
2 discussion but we would at various points ask
3 our colleagues that are on the phone and in
4 the room to provide their perspectives on what
5 they are seeing from the field.

6 And I am joined here also from --
7 Syed has joined us from the Society of
8 Actuaries. Thank you very much for joining
9 us. The report that he co-authored, the 2007
10 Risk Assessment Report is often cited in the
11 specific area of looking at the relationship
12 of various different commercial groupers that
13 are available in the field.

14 And I am also joined by our lead
15 methodologist, Karen Pace, who has worked in
16 various different components of cost -- well
17 cost most recently, but also in our quality
18 side.

19 So the guidance that we are
20 looking for in the Steering Committee is to
21 reflect on these issues first in terms of our
22 guidance, the input that we are getting from

1 the community related to our guidance, and
2 then to advise the CSAC who is ultimately
3 responsible for setting our criteria and
4 guidelines in our measure submission form.

5 So with that, I am just going to
6 get started and we can ask kind of questions
7 as we go. I know that was a lot of preamble.

8 But as we discussed, various
9 different HealthPartners measures, and I am
10 using HealthPartners really as more of a case
11 study. We are not having a discussion about
12 this measure in particular. And I should also
13 preface this by saying NQF in a lot of ways is
14 very appreciative of the leadership that
15 HealthPartners has taken in this field of cost
16 and resource use measurement first by
17 participating in the first cost and resource
18 use effort but also in really working with
19 various different communities across the
20 country to try to implement this measure
21 across various different sectors. So they
22 have obviously, shown a lot of leadership in

1 this space and we want to be responsive to the
2 needs in the community related to cost and
3 resource use measurement.

4 So as background, the
5 HealthPartners measure uses the Johns Hopkins
6 ACG Risk Adjustment approach, which we
7 discussed prior, which is a commercially
8 available risk adjustment model. And so I
9 think that is pretty clear. And we can go
10 into questions as we talk about this.

11 And various community
12 collaboratives, providers, consultants to
13 health plans have worked with the developer in
14 order to use various different risk adjustment
15 models that are standard in their community.
16 And so various different, we have heard this
17 as well from various different risk-adjustment
18 methods folks. So in some communities they
19 use the ETG. In others they use the DxCG.
20 And there are others around this table that
21 have a lot of very intimate experience with
22 this sort of standard of where we are

1 currently. So I encourage you all to sort of
2 speak about this in terms of your experience
3 about trying to implement these measures
4 across various different communities.

5 So the challenge is that when you
6 interchange these measures with various
7 different risk adjustment models, so as an
8 example, if a community was trying to use this
9 measure using DxCGs, for instance, they would
10 not be able to call these NQF-endorsed for the
11 reasons that the measure with its various
12 different risk adjuster hasn't been tested for
13 reliability and validity.

14 And so this introduces a
15 significant amount of burden or barriers for
16 various organizations across the rest of the
17 country, since they have already introduced
18 and used -- invested in these various
19 different commercially available risk
20 adjustment models.

21 And so this was something that was
22 discussed during the first cost and resource

1 use project and in some ways is actually not
2 very unique to cost and resource use, as Karen
3 will describe later on, and the fact that this
4 is a very similar issue to the fact that when
5 we look at on the quality side, there is also
6 an investment in terms of risk adjusters.

7 So if you can go to the next
8 slide. There is a lot of rationale in terms
9 of allowing a single measure with multiple
10 different risk adjusters that have been
11 presented to NQF in terms of a need primarily
12 that allows markets and users to be much more
13 flexible in the risk adjustment model that
14 they have already purchased. Single markets
15 generally have commonality around a specific
16 risk adjustment tool and transitioning to
17 different risk adjustment tools is really
18 inefficient in terms of opportunity costs,
19 licensing fees and the like.

20 So the challenge here is that if
21 we are looking for national comparisons of
22 being able to compare Minneapolis, as Jack

1 described, Minneapolis in Peoria, that might
2 be the two cities of this group for today,
3 that you may potentially need a single tool
4 for those comparisons and those that are
5 actually using these tools would understand
6 that you can't use a measure with two
7 different risk adjusters and try to compare
8 the results. And that would be broadly known
9 by those that are using this measure.

10 And the challenge of comingling
11 the results would actually not really be that
12 much of an issue because of those that are
13 using these measures would understand that the
14 measure results are not necessarily
15 comparable. And we don't really need to
16 revisit or create new measures that have the
17 same specifications, just have different risk
18 adjustment models because that would introduce
19 a whole series of new measures into the
20 portfolio with only a single difference.

21 And that has been the rationale
22 that has been provided to support multiple

1 different risk adjusters. And I encourage, as
2 we get into -- we will have time to discuss
3 this, to have comments on this particular
4 issue and I encourage all those who feel
5 strongly about this issue to discuss it.

6 And so before we get to that, I
7 want to Just also turn to my colleague Karen
8 Pace to describe some of the NQF principles
9 and the relevant criteria to these questions
10 around allowing multiple different risk
11 adjusters in a single measure and this issue
12 about comparability.

13 And again, I would encourage all
14 of us to consider the fact that this criteria
15 that we use to evaluate cost and resource use
16 measures are the same criteria that are used
17 to evaluate quality measures, which is why we
18 want to make sure that we are consistent and
19 this issue actually has much more
20 ramifications then just in the field of cost
21 and resource use measures.

22 So Dr. Pace.

1 DR. PACE: Hello, everyone. So I
2 know you have had lots of discussion over the
3 last couple of days so thanks for hanging in
4 there with us.

5 I am just going to mention a
6 couple of things to keep in mind and as Taroon
7 said, this is not just an issue specific to
8 resource use measures. That risk models are
9 used with outcome measures and we actually
10 have encountered the issue of trying to
11 measure the same thing with different risk
12 models. And to the extent possible, we want
13 to be consistent across all of our measure
14 evaluation.

15 But just to lay the groundwork, as
16 you know, NQF endorses national standards for
17 performance measures that are intended for
18 both accountability and performance
19 improvement. In order to be useful to make
20 conclusions about performance, especially
21 relative performance, all entities need to be
22 measured exactly the same way. So there is a

1 couple of things here. One is standardization
2 and one is national. And so we need to think
3 about that, if there really are unique
4 differences in some of these things regarding
5 resource use measures.

6 Typically, we seek to endorse the
7 best from among competing measures whenever
8 possible because this minimizes the confusion
9 created when the accountable entities are
10 scored and ranked differently when performance
11 measure specifications are different. So the
12 two measures you were talking about this
13 morning, if providers get different scores and
14 end up in different rankings, based on those
15 two different measures, we have introduced a
16 lot of confusion in the measurement space. So
17 that is one of our main concerns of why we
18 try. And as you know, it is difficult and not
19 always possible to do that. But that is our
20 goal.

21 And to the extent possible, as I
22 already mentioned, we want our criteria to be

1 broadly applicable across performance
2 measures. And obviously, there are going to
3 be some things that are unique to certain
4 types of measures. So risk adjustment is only
5 a concern for outcome measures and resource
6 use measures. But to the extent that we could
7 have consistency about risk adjustment for
8 those types of measures, it would be a good
9 thing.

10 And so in terms of the criteria
11 that are relevant regarding the issues that we
12 are discussing is first of all that we do
13 think they should have a risk adjustment
14 strategy and that is specified. And if
15 multiple data sources or methods, and this is
16 where risk adjustment comes in, are specified,
17 there should be a demonstration that they
18 produce comparable results. So this gets to
19 the single measure issue. If we have a single
20 measure that says you can risk adjust this way
21 or this way or you have five choices, first of
22 all, we don't necessarily have a standard

1 measure. And second of all, if you applied
2 those different risk models to a group, would
3 you get comparable results?

4 The next one is validity testing.
5 So again, one of the propositions posed
6 earlier was that the only thing you would need
7 to review is the risk model metrics across
8 these measures. But I think it is still an
9 open question is would you really get the same
10 validity results if you applied different risk
11 models. Maybe so, maybe not. The same way
12 with reliability. Would you get the same
13 reliability results?

14 So I am not so sure it is just as
15 simple as just looking at each of the risk
16 models in isolation when we are talking about
17 performance measures. Next slide.

18 Okay so I just wanted to kind of
19 present the backdrop in terms of NQF
20 principles and criteria in terms of why we are
21 grappling with this and wanting to have some
22 discussions with you about it. And I think I

1 will let Taroon introduce this next discussion
2 because, as he said, this has been introduced
3 into these conversations.

4 MR. AMIN: So I will turn it over
5 to Syed in a moment. And again, I appreciate
6 you traveling here and being here with the
7 committee today. And the fact that there was
8 a 2007 analysis of health risk assessments
9 that really looked at the differences between
10 the various different risk adjustment models,
11 which has been cited a number of times by the
12 first committee that we were looking at,
13 looking at the Society of Actuaries report and
14 has been cited again also by many members of
15 the community that show -- that argue that
16 this report demonstrates comparability across
17 various different risk adjustment models,
18 which is slightly different than the question
19 that Karen has raised, which is around the
20 comparability of the measure score, which is
21 what we are really trying to understand here.

22 So Syed if you would please just

1 give us kind of a sense of the work and you
2 assessment of this question as it relates to
3 the work that you have done in the past.

4 MR. MEHMUD: Sure, thank you,
5 Taroon. And thanks for inviting me here
6 today. I think I had a chance to hear some of
7 the conversations around the table and I will
8 keep my comments brief because I know I am
9 talking to a very informed audience here.

10 I think we did this work a while
11 back, this specific report I don't know six
12 years ago, gosh. And so we looked at several
13 different adjusters that were available in the
14 marketplace at the time, I think about 12.
15 And basically ran a lot of tests on those
16 adjusters that were mostly around accuracy,
17 statistical performance and that sort of
18 thing. And the tests, one of the metrics that
19 received I guess more air play than the others
20 was the R squared metric. It is one aspect,
21 I would say of a risk adjuster and I have
22 dealt with risk adjustment in Medicare and

1 Medicaid, commercial, all settings for a long
2 time and I know that that is only one sliver
3 of the different dimensions of a risk
4 assessment tool and a risk adjustment tool and
5 that is one aspect of it.

6 The report also talked about
7 predictive ratios, which is a pretty important
8 concept, as well. And that is basically what
9 is the risk assessment tool predicting, for
10 example, the score to be? And the score is,
11 in fact, just an estimate of cost. That is
12 how these models are developed. And divided
13 by the actual.

14 And so that gets you a little bit
15 of a sense of whether there is any bias in
16 risk assessment predictions. And there is a
17 bit of a truism -- not a truism but a saying
18 amongst risk assessment practitioners that
19 sometimes it is more important to not be
20 biased than it is to be accurate. So I think
21 the report, this particular report talks a lot
22 about accuracy but bias is also an important

1 consideration.

2 And in this report, as I mentioned
3 there were several different models that were
4 tested. The models -- I had to actually print
5 it out because it has been a while so I had to
6 read, just glance at it again. The
7 methodologies employed by the different tools,
8 I was going over it this morning and I was
9 realizing that they were more diverse than I
10 had thought. Because over time, I think since
11 then it is kind of you tend more towards a
12 certain kind of developmental methodology like
13 how you build these models and regression is
14 something that comes up a lot. But then these
15 models, they employ, to some degree, different
16 methodologies. So that is not the only
17 technique in town.

18 So I think that is kind of a
19 little bit of a context in the report. So
20 coming back to I think what you are alluding
21 to, can you use different tools, these
22 different risk assessment models, to develop

1 something and then compare that thing. And I
2 have to preface that by confessing that I
3 don't know enough about these specific
4 measures that you are discussing today but I
5 do know that you are using risk scores to
6 adjust those measures in some way in order to
7 make them comparable.

8 And so I guess a real question
9 then shifts to are the risk scores comparable,
10 either on an individual level or in some kind
11 of group level, maybe by a provider or health
12 plan, and so forth.

13 And I think that there can be
14 different sources which might cause the scores
15 to be different amongst different tools. So
16 if you take different tools and apply them to
17 the same population, you may not get exactly
18 the same score from it. And one source is
19 what information is used to develop those
20 models.

21 So if one model is built using a
22 particular commercial large dataset, another

1 is built using a different dataset, another is
2 built using a different dataset. The meaning
3 of a 1.0, the meaning of a score becomes
4 different. So the score itself is not
5 directly comparable at that very kind of like
6 basic level.

7 The other differences might be due
8 to how the groupers developed, how the
9 information from ICD codes or NDC codes or any
10 procedure codes or any other information, how
11 that is used to develop clinical markers and
12 what rates are assigned to those markers.

13 Now the development of the
14 clinical markers is a clinical aspect to that
15 and if those are different, they can cause
16 differences amongst risk assessment tools as
17 well.

18 So for example if you have one
19 assessment tool might break up chronic
20 conditions such as diabetes and to fight
21 different severity levels, another might do
22 just one or two. And that would make a

1 difference of when you apply different tools
2 to the same population.

3 Then the next source becomes how
4 do you develop weights to assign to these
5 different clinical markers. And as I
6 mentioned, regression is one approach but
7 there are other approaches that these tools
8 have used. For example, there is the
9 actuarial cell approach where you have
10 mutually exclusive condition categories that
11 you develop weights for. There is the
12 episodic kind of an approach where you develop
13 episodes and see how care was being delivered
14 to a patient and then assign based on those
15 episodes. There is a hierarchical approach
16 where you develop a certain set of markers and
17 then you collapse them down, based on certain
18 hierarchical rules-based kind of logics and
19 model-building process.

20 So I think through all of these
21 different sources that might cause you to have
22 different risk scores if you take two

1 different tools and apply them to the same
2 population, there has to be some, obviously,
3 testing and validation to understand the
4 magnitude of these differences.

5 And I think I heard a point
6 earlier that on the individual level they can
7 be different but maybe on a group level they
8 aren't so different. So I think that is also
9 a good area for validation and testing.

10 The one thing, one short comment I
11 would make there, is that any risk adjuster,
12 you could take the same risk adjuster and you
13 apply it on an individual level and you group
14 those risk scores at a group level, the
15 differences amongst risk adjusters become
16 smaller and smaller.

17 So this particular report, for
18 example, that we did in 2006 at the Society of
19 Actuaries was measured performance on an
20 individual level. So when you take these
21 tools and you apply them on individuals and
22 you measure accuracy on an individual level,

1 these tools are, they produce differences
2 amongst accuracy metrics and so forth.

3 If you had done this on a group
4 level, there would still be differences but
5 the tools would get a little bit closer
6 together. But is that close enough? And I
7 think even though the risk scores themselves
8 might be closer together, they are getting
9 applied to a larger population. And so I tend
10 to come from a world where we do -- so we are
11 talking mostly about risk assessment here.
12 And I come from a world where we are very
13 heavy on risk adjustment, which is when you
14 are actually changing money, or money is
15 exchanging hands based on the calculated risk
16 score, for example, in a captive market and so
17 forth. For example, as in the ACA in 2014 or
18 in the Massachusetts market. So there, when
19 money is exchanging hands, it becomes really
20 important, even small differences in group
21 level risk scores can be significant, can be
22 material and can make a big impact to

1 organizations' bottom line in a risk
2 adjustment environment.

3 So I think it needs very careful
4 testing to understand how comparable these
5 are. But you know my opinion is that there
6 will be differences and differences could be
7 attributed to the data used to build the
8 model, the modeling, the model-building
9 methodology itself. The weight assigned to
10 methodology to the different clinical
11 conditions.

12 MR. AMIN: Thanks Syed. Before we
13 get into the committee discussion, obviously
14 there is a lot of opinions on this topic. And
15 so we have various different experts, again on
16 the phone. Many of them come from measure
17 development worlds. So if it is okay with the
18 committee first, maybe we can go through a 15-
19 20 minute sort of a comment period but a
20 little more structured, and kind of get some
21 assessments from those in the room and those
22 on the phone.

1 First the structure and the basis
2 of this conversation, so making sure that that
3 is agreed up that where we are trying to go in
4 the needs in the community in making sure that
5 that is clear. And then some general sense of
6 kind of where we are trying to go.

7 Do you guys have questions on that
8 or comments? Okay. All right, well it is
9 obviously a lot to talk about here.

10 So I mean I can go through at a
11 high level what the discussion questions are.
12 But actually I would like to wait to see if
13 there is any sort of framing comments that
14 others on the phone or others in the room have
15 before we get into sort of specifics. Go
16 ahead, Sue.

17 MS. KNUDSON: Thanks, Taroon. So
18 Taroon did a nice job of outline sort of the
19 issue we had and Syed's comments are very
20 helpful, too. And I just wanted to comment
21 briefly to kind of take it up a few thousand
22 feet from a practical developer end user point

1 of view.

2 So you know someone earlier in
3 today's discussion mentioned that we have all
4 these commercial ways of doing this. And I
5 sort of characterize that to a little bit of
6 unneeded chaos in the measurement system. And
7 so as we, as a developer, who came through
8 this process a couple of years ago, as we sort
9 of observed others who had similar measures
10 like the IHA in California, the only
11 difference is the risk adjuster, are working
12 now with uptake across the country, many
13 people ask us well can I implement this
14 because I am using ERGs in this community or
15 DxCGs or what have you. And the answer has
16 been just as Taroon had mentioned that you can
17 only call it NQF-endorsed with the AGC tool.
18 So we were thinking really more from a
19 practical point of view, we could come through
20 this round and only retest our measure using
21 a few different risk adjusters. And really
22 the spirit in which we did that, because

1 frankly we all have day jobs, too, but really
2 we are committed as an organization to more
3 affordability, sustainability in our country.
4 So rather than have all sorts of new measures
5 come through and then we have these
6 harmonizing discussions, we were thinking a
7 more rational way to do it would be to test
8 the different risk adjusters and then you,
9 basically have the same guts of the rest of
10 the measure being all the same. And so that
11 is the only difference.

12 And that, to me, is more of both
13 end strategy. We are, at one time, working to
14 meet local markets where they are at and at
15 the local market level, this is tied to money.
16 And so when we have markets invested in the
17 use of a different tool than what we have
18 endorsed, like California, for example, when
19 they have spent all this time and energy
20 getting accustomed and comfortable across all
21 the stakeholders with a tool, you don't want
22 to increase all those burdens that Taroon

1 outlined and sort of upset the whole apple
2 cart. At the same time, we have the need for
3 a national study from a policy point of view,
4 from a payment disparity and resource use
5 disparity and understanding those things from
6 a national view. So that is the other side
7 of that both end strategy. And that is, for
8 those of us who do this work in the field, we
9 know, we basically have to use one risk
10 adjuster to do those national comparisons.
11 That goes to the work that we are trying to
12 get off the ground with the Dartmouth on a
13 commercial companion to the Dartmouth Atlas
14 using this measure.

15 So that was more of the practical
16 point of view. But the NQF process,
17 particularly that section which was outlined
18 2b something or another, where it calls for
19 the comparability is I think really where
20 practically we bumped into, even though we
21 could test these, and we have tested at least
22 two other risk adjusters, we have got a write-

1 up done on one of them. You know they do
2 produce reliable and valid results when we
3 just retested them, the measure at least in
4 those two.

5 And so it was really in that
6 spirit that we wanted to meet communities
7 where they are at and at the same time know
8 the difference when you want to study national
9 comparisons and make policy decisions and
10 other more macro decisions and inform health
11 policy based on that.

12 So those are just a couple of
13 context questions or comments I would make as
14 well.

15 MR. AMIN: Are there any other
16 comments that are on the phone?

17 OPERATOR: To make a comment at
18 this time, please press *1 on your telephone
19 keypad. There are no comment or questions.

20 DR. NEEDLEMAN: I think the order
21 of the things -- you asked if we had any
22 comments about the scope of the discussion.

1 I think the order on the chart there is not
2 quite right. I think the second bullet point
3 about what would be a demonstration of
4 comparability is actually the place to start
5 this. I am blanking on the name of the person
6 from HealthPartners who just spoke. But I
7 think the word there is we have got
8 reliability, variance estimates, validity.
9 The real issue here is the last word she used,
10 which is consistency. When you apply the same
11 --

12 Yesterday we were looking at
13 measure and you split the sample in half. The
14 data, there was enough variation in the data
15 that 30 percent of the folks that were in the
16 top quintile or the bottom quintile dropped
17 into a different place. That is a data
18 variance. What we need to understand is
19 whether if you take the same data with the
20 same ultimate aggregation but a different risk
21 adjuster, how consistent are the results from
22 one across the different risk adjusters if

1 you get the same ranking of people, if you get
2 the same location of people, how similar or
3 different do those need to be? If the results
4 are consistent, if you come to the same
5 conclusion, and I think one of our colleagues
6 here talked about we use different measuring
7 and qualitatively they tell us the same story
8 and we move forward with it. That is the is
9 the issue.

10 And I didn't hear Karen and I
11 didn't hear Syed talk about whether anybody
12 has done enough study with the same data on
13 patients to ask about the final end measures,
14 as opposed to looking at the R squares or the
15 equivalent measures about the individual
16 measures. That is the comparison we need to
17 figure out where to go. And I heard that
18 alluded to by Sue. And Karen you look eager
19 to speak.

20 DR. PACE: Well I just want to
21 say, that is the whole basis of the criterion
22 that we have that if you are going to specify

1 a measure and have alternative methodologies
2 that you demonstrate comparability, which is
3 for consistency --

4 DR. NEEDLEMAN: So I see this
5 discussion is basically saying can we find
6 from some standard measures some standard
7 stuff enough evidence that whether you use
8 ACGs or DxCGs or one of the other things that
9 all produce about 20 to 23 percent R squares,
10 whether there is enough comparability we don't
11 need to test it in each new measure. We can
12 say if we have approved it with ACGs where you
13 can basically run it with these three other
14 measures and we are comfortable you will get
15 the same results.

16 DR. PACE: Right but I think that
17 we wanted to also establish some common
18 understanding because people have been
19 alluding to, if they have the same R squared
20 of the risk model that you will get the same
21 performance scores.

22 DR. NEEDLEMAN: No, I don't

1 believe that.

2 DR. PACE: And we want to
3 establish some common understanding that that
4 is not the case and that we actually do have
5 to do these empirical analyses.

6 DR. NEEDLEMAN: I agree. And we
7 have been having this conversation in the
8 field for a decade now and I am a little
9 shocked that those studies have -- we don't
10 have piles of those studies that already can
11 tell us the answers to that.

12 MR. AMIN: So actually before we
13 get started on the conversation, maybe it is
14 helpful, we set up a few questions that are
15 related to -- so if we can go to the Society
16 of Actuaries discussion question. And this is
17 going to the exact point that we are having
18 here.

19 The first thing, and again, we are
20 not, this is not just a HealthPartners issue.
21 We just want to make this clear. This was
22 raised by a number of different groups that

1 are interested in using -- and the same issue
2 around the multiple methods, the fact that we
3 allow these options within resource use
4 measures, which was a strategic design of how
5 we move forward with this first effort. And
6 what we are seeing now is some reaction to
7 that. And that is why we need, we as a
8 committee, need to be accountable for those
9 decisions and kind of where we were in terms
10 of our assumptions. Meaning that we wanted to
11 allow the flexibility in terms of various
12 different components of the measure.

13 But specifically, let's go to this
14 issue, which is that Syed did a nice job of
15 describing kind of what the Society of
16 Actuaries report described. And again, what
17 we are trying to do is make sure that we are
18 clear not only within this room but also
19 making sure that as we write this up and
20 provide some guidance back to the field in
21 terms of what we are expecting, that there is
22 this issue, which is that when you look at

1 various risk adjusters and they have similar
2 performance metrics in the sense of R squared,
3 what does that say or what does that not say
4 about whether the performance scores for
5 accountable entities are actually comparable?

6 And whether overall reliability of
7 the performance score with different risk
8 adjustment models will be similar, what does
9 that tell us? Again, Jack, this may seem to
10 some people that this is -- well you know, we
11 have been doing this for a decade. It is not
12 generally agreed upon in the field that using
13 these various different risk adjustment models
14 with "similar performance characteristics,"
15 which is --

16 DR. NEEDLEMAN: Yes. My point was
17 not that it is obvious from the R squares. It
18 is not obvious from anything in the Actuaries
19 report, as well done as it was. And it is
20 extremely well done.

21 The issue is the next step has not
22 been taken and it could have been taken five

1 years ago, ten years ago, take a validation
2 dataset, the same patients, the same
3 distribution of diseases, the same
4 distribution of use, the same distribution of
5 cost, the same measure and run it with
6 different risk adjusters and see how similar
7 or different they are. That is what we really
8 need to answer this question. It is
9 disturbing to me that we haven't done that
10 analysis yet and we are still talking about
11 mights and maybes, and we might expect and we
12 should expect. That needs to be done and it
13 should have already been done but if it hasn't
14 been, it needs to be done. I am a crude
15 empiricist here. I want to know what
16 difference it makes in the rankings and what
17 difference it makes in the estimates of the
18 values.

19 MR. MEHMUD: Yes, if I can make a
20 quick follow-up comment on that discussion.
21 I think partly the reason it hasn't been done
22 is because generally in any risk-adjusted

1 market, you don't have different risk
2 adjusters being used. You have the same risk
3 adjuster being used. And so what really, you
4 know at six years ago, whenever, when risk
5 adjustment was kind of like really coming into
6 the fore, folks were more concerned about what
7 risk adjuster should I go with for this
8 application or that market, or that program.
9 And so they were wanting information on things
10 like statistical metrics, inaccuracy metrics
11 and so forth.

12 But if you are trying to have a
13 more general application with the
14 understanding that different risk adjuster
15 models may be used, then that question becomes
16 extremely important. And I would say that
17 that is a very specific application of risk
18 adjustment.

19 And that, to my knowledge as well,
20 that study has not been done where you kind of
21 look at different tools and measure their
22 output. And to me it is not so much -- I

1 guess I am little vague on what performance
2 means but the more basic question is you take
3 the same tool, you apply it -- sorry. You
4 take the same dataset and you apply it across
5 different tools. Do they all produce the same
6 result, the same output on an average level
7 for an individual that won't perhaps, but if
8 you aggregate it up, do they produce the same
9 answer?

10 And in that study, I am taxing my
11 memory a little bit, but in 2007 we used 12
12 different models on the same dataset. And in
13 order to compare them, we could not compare
14 the output as is because you average the way
15 that you run these comparisons is that you
16 have to calculate the R squared metric and so
17 forth. But if the risk models are producing
18 scores that average to different levels, then
19 your comparisons will not be valid.

20 And so for example if one model,
21 you run say a million people through a model
22 and one would hope that the average score is

1 1.0 but it never is. It could be 1.05, for
2 example for that model, a different model you
3 run it could be 1.07. A different model could
4 be 0.93. So we have to normalize for those
5 differences across all those different models
6 first and then calculate the accuracy metric
7 so that at least we are taking that element
8 and that was the first source of variation
9 that I described is the data that is being
10 used to build the models up. So that is what
11 will need to be tested.

12 And that would be a very
13 worthwhile study if the application is, once
14 again, in that very specific application where
15 you are considering the use of multiple risk
16 adjusters in order to compare some metrics
17 across different populations and datasets, and
18 so forth.

19 MR. AMIN: Bret?

20 DR. ASPLIN: Maybe I am thinking
21 of this too simply because I am certainly not
22 a methodologist who can dive into the risk

1 adjustment like others in the room. But I do
2 think this is, practically speaking, it is
3 just going to boil down to the harmonization
4 process and groups like us reviewing both
5 qualitatively -- Jack's question is is it
6 telling the same story, this measure with
7 multiple adjusters or not -- and then
8 quantitatively measure by measuring
9 harmonization. And then over time, developing
10 guidelines for just like you have other
11 guidelines in your harmonization process now,
12 developing guidelines for risk adjustment in
13 the harmonization process. I don't know how
14 you get around groups like this, measure by
15 measure asking the same harmonization
16 questions we already do with different risk
17 adjustment models.

18 So I think one of the challenges
19 is not only some of the questions that have
20 been raised about how you do this study but
21 who are you going to put the burden on to do
22 that? Because it can't go on the original --

1 the burden to be a measure developer has
2 already gone up by such orders of magnitude
3 over the last five years that -- and Sue just
4 I think pointed that out very nicely. I mean
5 you can't expect HealthPartners to come back
6 and do all the analysis and testing. Maybe
7 they have done some of it, but to get through
8 the initial bar to a committee, to present the
9 measure with risk adjuster A and then oh, by
10 the way, here are three different risk
11 adjuster models that we have tested. It is
12 not going to happen.

13 And so if these other communities
14 that are using different risk adjusters want
15 to stick with their adjuster and have an NQF-
16 approved measure I think the burden is on them
17 to do some of the testing and bring it forward
18 for harmonization discussion. Now will people
19 do that? I don't know.

20 MR. KITCHING: If I could
21 interject, Taroon?

22 MR. AMIN: You can. Just get

1 through maybe these three and then, if you
2 don't mind. Thanks.

3 DR. GIFFORD: So of course I am
4 not a methodologist but I am a doctor so I
5 know what I am talking about on the statistics
6 of R square.

7 (Laughter.)

8 DR. GIFFORD: I am just going to
9 tell you I would agree very much with your
10 comments and expand on them a bit in that
11 there is no risk adjustment that is perfect.
12 Many times they are not even close to perfect.
13 And I am struck by how many providers and
14 groups out there, as long as you say it is
15 risk adjusted, they suddenly seem satisfied
16 with the measure, even if there is just one
17 variable in the risk adjustment model.

18 I think your suggestion makes a
19 lot of sense on the burden. Is that, we are
20 proving it with a risk adjuster. If others
21 want to use different risk adjustment, that is
22 fine. There is no pragmatic reason they want

1 to use it. It probably doesn't really vary
2 that much in the grand scheme of things, but
3 if you are going to compare providers across
4 different areas with different risk
5 adjustments, you can't do that. I think you
6 need to pick one and use it. And then if it
7 is going to be picky and say it is NQF-
8 endorsed, it has got to come through and get
9 reviewed and evaluated in a rigorous manner.
10 If others want to come through and do it, that
11 is fine. If they want to use it and say we
12 are basing our measure on NQF but we use a
13 different risk adjustment because of X, Y, and
14 Z and they can justify it to their community
15 and their community buys it, have at it. I
16 wouldn't discourage it and I wouldn't say it.
17 But to have multiple -- for us to be endorsing
18 multiple different risk adjustment, that just
19 doesn't make sense to us.

20 MR. AMIN: Nancy?

21 DR. GARRETT: So as someone who
22 has used some of these different models, I

1 think one of the things that is important for
2 everyone to understand is that these are
3 commercially available models with a lot of
4 complexity that do not -- they are not open
5 source. And you can have a couple of
6 different analysts, even in the same
7 organization implement these groupers and get
8 different results because there is so many
9 different decisions about how the data is
10 prepared, what the settings are that you are
11 using. And to have this goal of consistency,
12 I don't know that it works in this case with
13 the way these methods work.

14 The way to get consistency would
15 be to have one organization calculating the
16 data and running it through the same risk
17 adjustment grouper and using the exact same
18 methodology. To try and get consistency I
19 mean the manual would be 100 pages long. And
20 by the time it was written, the ERGs would be
21 onto the next version and things would have
22 changed. So I don't know that it is really

1 attainable in this case.

2 So I think the important thing is
3 that there is risk adjustment. But like you
4 said, David, you have to be careful about the
5 comparability and when you are comparing
6 across organizations using different methods.

7 And a lot of times, these measures
8 are going to be used for comparison over time
9 within the same provider. And so what is
10 really important is that the methods are
11 consistent over that time period to be able to
12 understand how things are changing.

13 MR. AMIN: Chad.

14 MR. HEIM: Thank you, Taroon. So
15 just to kind of follow-up with Jack had said
16 and Brent had said and Nancy had commented on.
17 Consistency is the important thing. So we had
18 to do some testing on additional risk
19 adjusters since we actually have them in-
20 house. And actually we are kind of preparing
21 for possible submission to NQF for this very
22 committee to take the technical spec as

1 written. To get at Nancy's comment for the
2 consistency where the truncation levels are
3 set, nine months' requirement for enough
4 diagnosis codes and just to follow the
5 technical spec that this committee approved
6 and just swap in the different risk adjuster
7 and see if we see any major movements in terms
8 of at the provider group level. And we have
9 found some pretty consistent results when we
10 are actually swapping in different groups.

11 So I think the key points are the
12 consistency of the technical spec that NQF
13 improved endorsement that kind of aligns going
14 across risk adjusters, because those are
15 critical decision points. But then we found
16 consistency. There was a lot of providers
17 that were if you were high, you were
18 consistently high, no matter what group we
19 were dropping in.

20 DR. WEINTRAUB: So I think I will
21 tell you a story from what goes on in real
22 life in hospitals. Because I think that what

1 is going on in the commercial space with risk
2 adjustment is a mess.

3 We found that when are looking at
4 our heart failure patient population that we
5 had using a commercial risk adjustment, and we
6 seemed to be getting very bad scores. And I
7 didn't understand it.

8 So I went and looked under the
9 hood at just what was going on and the vice
10 president of our hospital in charge of this
11 said, it is risk adjusted. There is no
12 problem here. But I went and looked and it
13 was a joke. And it was very easily
14 understandable to clinicians why it was a joke
15 and why our risks of mortality in heart
16 failure seemed to about double with risk
17 adjustment. We would have been much better
18 off just looking at it unadjusted because in
19 fact it was doing something that was
20 absolutely wrong.

21 So I think very good risk
22 adjustment is critical. And I think this is

1 a great place and vital place for NQF to be.

2 Now how to compare risk
3 adjustment. I think that an R square along is
4 not the best metric or for discrete variables,
5 a CNX, there is much more we should do.
6 Clearly, calibration of risk adjustment is
7 very important and external validation,
8 preferably with another data set.

9 And while it is hard, there is a
10 lot of work going on comparing risk-adjustment
11 methodology, I think this is a very worthwhile
12 space for NQF to be in. If it is not going to
13 be NQF, who is it going to be?

14 Now finally, I think that risk
15 adjustment applied to the individual patient
16 is not particularly been the space of NQF, at
17 least it seems to me. But it is very
18 important how we function every day because
19 more and more we are developing and applying
20 prediction models at the level of the patient.
21 And very often at that level, they are not
22 very well validated.

1 MR. AMIN: Larry?

2 MR. BECKER: So as a consumer,
3 there is another thing that is really
4 important and I think that is transparency.
5 And when I hear people talking about it is not
6 open source, I cringe because I mean, so I'm
7 sure consumers can't understand this stuff but
8 experts can. And so there needs to be some
9 endorsement of this was done according to a
10 transparent methodology. You can agree with
11 it. You can argue with it but at least you
12 can attempt to understand it and you have some
13 sort of confidence that somebody doesn't have
14 some twist on it for their own purposes. So
15 transparency is really important.

16 MR. AMIN: Gene?

17 DR. PENSON: I have a -- oh,
18 sorry.

19 MR. AMIN: Just Gene first.
20 Thanks.

21 DR. NELSON: A really good
22 conversation so far and I think going down the

1 table here what Jack is recommending that you
2 actually have data to be able to do the
3 calibration and what we here at HealthPartners
4 are trying to do is exactly what would be
5 called for to get the PROsetta Stone that
6 allows you to go from one risk adjustment
7 system to another and to do that in a way that
8 is accurate and calibrated.

9 So the second point would be that
10 I sit in the hallway, literally in the middle,
11 and on one end is Jack Wennberg and the other
12 is Elliot Fisher. So I am a little bit like
13 Forrest Gump in the middle.

14 So I have papers from the New
15 England Journal of Medicine 2010, JAMA 2011,
16 BMJ 2013, and there will be another one coming
17 out pretty soon. And they all show that there
18 is a fundamental flaw that some of you
19 probably recognize in all of the risk
20 adjustment systems that use claims data or
21 administrative data that because it is
22 confounded by the intensity of services.

1 So literally, one of these papers
2 shows, JAMA 2011, that if people go from a
3 high-intensity area, to a low intensity area,
4 lots of doctor visits, lots of hospital stays,
5 lower hospital visits, lower hospital stays
6 per capita, if you go from high to low, you
7 start to look better. Your risk adjusted
8 scores are better. And the converse is true
9 as well. If you go from a low to a high area,
10 Minneapolis to Miami, you are looking sicker
11 faster. And so there is a fundamental problem
12 for both mortality prediction, cost
13 prediction, resource use prediction, et
14 cetera, across perhaps all of these systems.
15 And so that puts us in a bad position if we
16 are trying to look out for NQF's interests in
17 national standards for performance and
18 accountability. And so I would just start to
19 think that this brief conversation that we are
20 having now really needs to be done in a very
21 rigorous way and looked across all the
22 measures.

1 Bob Brooks wrote a little
2 commentary a while back and it was labeled, in
3 effect, quality is dead, long live value. And
4 as you start moving towards needing to have
5 the building blocks to measure value, you had
6 better get the building blocks right. And
7 risk adjustment goes across a lot of these
8 building blocks, outcomes, and costs. Not so
9 much technical quality. Good for that.

10 But there is a very big issue
11 here. And there is a lot of expertise out
12 there. And the evidence is building up that
13 this risk adjustment building block based on
14 claims data has some inherent flaws. And the
15 good news is, there is probably solutions that
16 they could be improved, using modifications.

17 MR. AMIN: Okay. So before we
18 continue on in the discussion, I am going to
19 ask Evan to just go back to the criteria slide
20 and just put up a straw person for just to
21 react to, which is the fact that basically we
22 have heard a lot of need from the community

1 around various different pieces of this. And
2 the straw person basically is to continue with
3 where we are right now, which is that if you
4 have specifications that include multiple
5 methods that you have to demonstrate that they
6 are comparable and that every measure,
7 obviously, would still go through our
8 criteria, which is to require testing and the
9 various different components of our risk
10 adjustment strategy criteria.

11 So I guess that is where we are
12 landing. That is what I am hearing. That was
13 pretty clear from Brent and Jack and others.
14 I mean, it couldn't be any more clear, at
15 least from them. I mean that in the best way
16 possible, obviously.

17 So if there is others that feel or
18 want to say other things related to that, I
19 think it is important to say your opinion
20 here. You know, I am also really interested
21 to hear from those that are in the community,
22 again, to make sure that your perspective is

1 heard here. And so we will start with you,
2 Don.

3 MR. WOLFSON: I was just wondering
4 a simple minded solution is to get a set of
5 approved risk adjusters that NQF approves.
6 And if you don't use those, then you had
7 better come up with something that would
8 justify that. Why can't there be whatever
9 number of a pre-approved risk-adjustment
10 methodology?

11 MR. AMIN: Karen, there is a few,
12 I think, areas that we could take that. I
13 will start with a few and then, Karen, you
14 jump in and correct me because I am sure I
15 will go off somewhere.

16 So there is a few, which is that
17 actually it kind of goes to the foundation of
18 this conversation which is that we endorse
19 performance measures. And just because even
20 if we did say that various different risk-
21 adjustment methodologies were appropriate and
22 "endorsed," that may not actually tell us

1 anything about the output of the performance
2 measure. So that if you are actually looking
3 at they are great risk adjustment models but
4 the specifications are inappropriate, and so
5 at the end of the day what is that really
6 telling us? And so that is actually some of
7 the challenge here, which is we are endorsing
8 the end piece, which is what we care about,
9 which is the end score. So that is the first
10 issue.

11 The second is the fact that there
12 is proprietary interests here. And that is
13 reasonable. I mean obviously we accept
14 components, proprietary components within
15 measures. But we don't want to -- we probably
16 as a collective community may not want to get
17 in the business of endorsing one methodology
18 or multiple different methodologies because at
19 the end of the day you still want to have this
20 discussion around harmonization and picking a
21 best in class.

22 And so in the scenario where you

1 do have various different measures that
2 include different proprietary components in
3 them, meaning competing risk-adjustment
4 models, if you will, shouldn't we -- again,
5 this is sort of the foundation of what we do
6 here is to have a national standard. And if
7 that national standard has only one
8 proprietary -- is differentially benefiting
9 one proprietary interesting, I think we are
10 going to find ourselves in a difficult
11 position.

12 But Karen if you have anything on
13 that specifically.

14 DR. PACE: I think mainly that
15 currently NQF endorses the performance measure
16 and all of the components that go with that.
17 And it is something that certainly if that is
18 a recommendation, it can be explored in terms
19 of NQF endorsement. It is similar to does NQF
20 endorse, for example, instruments and scales?
21 We have had this discussion in our recent
22 patient-reported outcomes work. NQF doesn't

1 endorse the variety of depression assessment
2 scales but we are interested in endorsing a
3 performance measure that talks about
4 percentage of patients that actually have a
5 remission of depression. And obviously, the
6 two are closely related in that case as well.

7 So it has broader implications.
8 You know, it is certainly something we have
9 heard before. And Helen, I don't know if you
10 want to comment on that in terms of our
11 current endorsement process.

12 DR. BURSTIN: I don't really have
13 much to add. I agree with you and Taroon.
14 This is just really complicated.

15 I mean, Daniel, I completely would
16 love to just make this work for as many people
17 as possible but then you get to the concerns
18 that Bill raised and others about just
19 fairness. And I think the measures aren't
20 comparable putting them out there in that way.
21 It is just a question of whether we are really
22 fulfilling our responsibility.

1 MR. AMIN: So Syed, Dolores, Lisa,
2 and then we will open it up to comments in the
3 room and on the phone and then lunch.

4 So, Syed.

5 MR. MEHMUD: Well I will not delay
6 lunch. I will be very brief.

7 I think just hearing this
8 conversation, obviously the emphasis on
9 transparency and making the measure as
10 applicable in as many situations as possible.

11 One quick mention that I would
12 make is that 2014 will probably see one of the
13 largest scale applications of risk-adjustment
14 ever with the ACO risk assessment model being
15 applied in all the states, except one, that I
16 am aware of in the small group and the
17 individual markets. That model is going to be
18 ultimately available. And right now they have
19 published details of it. They haven't made
20 the software available yet but perhaps that
21 will be. So that is one thing to keep in mind
22 is that next year there will be that model.

1 Everyone, pretty much everyone is going to be
2 using it.

3 MR. AMIN: Syed, and that is based
4 on the HCC approach calibrated in the
5 commercial sector?

6 MR. MEHMUD: Yes, I think they
7 took the approach that they follow for the
8 CMS-HCC -- oh, well, he may have left. But
9 they took that approach and they applied it to
10 a commercial population. It is a different
11 model than the CMS-HCC but it is the same sort
12 of philosophy of model building that was used.

13 MR. AMIN: Okay, Dolores.

14 MS. YANAGIHARA: So on the
15 comparability issue, I think there is
16 different ways to talk about comparability.
17 I just want to make sure that all understand
18 what we are talking about there. And that
19 maybe all three different ways that I am
20 conceptualizing it.

21 So there is comparably valid and
22 reliable for different methods. So is each

1 method kind of comparably valid and reliable.
2 And then there is, if you are applying
3 different methods to the same providers, do
4 you get kind of a similar rank order, so to
5 speak? So that is another way to look at
6 comparability. And then there is
7 comparability if we are using different risk
8 adjusters on different populations is it
9 comparable?

10 So there is three different levels
11 of comparability and I am not sure which ones
12 we are talking about on criteria 2b6. Is it
13 all three of those that we are talking about?

14 DR. PACE: In 2b6 we are really
15 talking about that they produce comparable
16 results, meaning the score, the performance
17 score that is given to the accountable entity,
18 whoever is being measured.

19 And regarding you first that each
20 method or each method results in a reliable
21 and valid performance measure, I just want
22 mention that our discussion here does and will

1 -- and that is kind of the next set of
2 questions, doesn't necessarily preclude that
3 we could endorse multiple measures with
4 different risk models, with appropriate
5 justification. I mean I think that gets into
6 a lot of other issues but it is something that
7 we will be asking you to reflect on.

8 So I think the first thing when
9 you mention each method can produce a reliable
10 and valid performance measure, even though
11 there may not be comparable results, that is
12 the question of competing measures. We would
13 have to see them as competing measures and
14 look at each individually. Do they have the
15 same kind of reliability and validity.

16 And that is another question about
17 how far down that road we want to go. But I
18 think that is another question.

19 MS. YANAGIHARA: Yes, I think that
20 the difference that I am trying to get at with
21 the second -- and thank you for those comments
22 -- for the second and third things I talked

1 about is you can have comparable results
2 within a data -- like the comparable
3 performance, relatively speaking. But when
4 you start comparing on an absolute score, it
5 might be different.

6 So in order to compare across
7 different populations using different risk
8 adjusters, the score has to actually be
9 comparable too. Right? And so are we talking
10 about both of those?

11 DR. PACE: We are interested that
12 if the measure is specified to measure the
13 cost at the group level for all their
14 patients, that that risk model, that the two
15 different models -- so all of those other
16 specifications are the same in terms of who is
17 the accountable entity, the level of analysis,
18 the patients included. If you apply two
19 different risk models, would those providers
20 be ranked comparably?

21 If you start talking about
22 different populations, then we have other

1 questions about again, whether you can have
2 one measure that adequately addresses
3 different populations.

4 MS. YANAGIHARA: Yes, because I
5 think that that makes a big difference.
6 Because what I heard Chad saying is that if
7 you take the same population and you apply
8 these different risk adjustment methods, they
9 track pretty well. So you get pretty
10 comparable results. But then I don't know
11 that that necessarily means if California is
12 using DxCG and Minnesota is using ACG is that
13 we are going to be able to compare our
14 results. So I think they are two different
15 things and that makes big implications of what
16 we are talking about here.

17 And I almost think if this is a
18 national arena, that we need the third thing
19 is really what we need, which is really -- and
20 then you have to have one risk adjuster. If
21 you really want to be able to compare across
22 the country, you need one risk adjuster. And

1 to me, that sort of cries out for a publicly
2 available risk adjuster that performs
3 sufficiently well, like equally to the
4 proprietary ones or better. And so I don't
5 know how the HCC one that is being developed
6 for the exchanges would work. But might this
7 be something that this committee could call
8 for is a publicly available risk adjuster that
9 performs well. I mean, that would then be
10 available for everyone to use. And that might
11 be a recommendation that could come out of
12 this committee that would be very helpful to
13 take to other different organizations and
14 entities to really grapple with.

15 MR. AMIN: Lisa.

16 DR. LATTIS: Well I think sort of
17 the elephant in the room is that these are
18 proprietary systems and that there is a
19 revenue model and a business model associated
20 here. So there are several organizations that
21 their model is to show that their risk
22 adjustment methodology is better than the

1 others, so they can sell it. So there is no
2 interest in there being a public model. It is
3 the proprietary model and showing that theirs
4 is better.

5 So I think as long as that exists,
6 we are not going to get to what this committee
7 is asking for because there are entities that
8 are looking to make a profit off of this. So
9 I think that needs to be part of the
10 discussion.

11 MR. AMIN: Okay. So, are there
12 any comments on the phone? Operator, are
13 there any comments on the phone?

14 OPERATOR: To make a comment at
15 this time, please press *1. There are no
16 comments or questions.

17 MR. AMIN: Are there any comments
18 in the room?

19 MR. BANKOWITZ: Yes, I do have a
20 comment. Thank you.

21 I am Richard Bankowitz with
22 premiere. Let me say in the interest of full

1 disclosure, premiere does have a risk-
2 adjustment methodology that it works on and
3 uses in its products.

4 The first comment is about trying
5 to compare these things. It is really not as
6 cut and dry as providing saying one is better
7 than another. I have done these types of
8 studies and if all the time you can line up
9 risk adjuster A with risk adjuster B, there
10 usually is a diagonal line at 45 degrees but
11 some will over-predict and some will over-
12 predict. And it is a question of tradeoffs.
13 So one might in a different population. One
14 might be better in population B. It is not
15 quite easy to say A is better than B. That is
16 the first point.

17 I think what really would be
18 helpful for developers would be if NQF would
19 lay out some best practices or guidelines
20 about how to handle some thorny issues. So
21 two issues, one I hear about every time I am
22 at a meeting on risk adjustment and one I

1 basically never hear about.

2 The one I always hear about is how
3 are we going to handle socioeconomic status
4 and all of the things that go with it. So
5 obviously, if we have patients who have poor
6 access to care, have poor healthcare literacy
7 and have poor access to nutrition, that is
8 going to make a difference.

9 Do we model that in or not? We
10 can debate that. We had a discussion
11 yesterday it seemed clear in the population of
12 dual eligibles. We don't want to model in
13 different approaches to care.

14 So if you believe they cost more
15 because providers are just over-utilizing,
16 then don't model it in. If you believe they
17 cost more because they actually are in some
18 ways sicker, then you model it in. So I think
19 NQF could be more explicit about how to handle
20 that.

21 The thing that I actually never
22 hear discussed is how do you handle secondary

1 diagnoses that are caused by the healthcare
2 system, complications and the like? So I can
3 build a model incorporating pulmonary embolism
4 in elective surgery and that model will always
5 have a better R squared and it will always
6 have a better C statistic than one where I
7 don't model it in. And I would argue we don't
8 want to model that in because if we have a
9 patient who is off the chart because of
10 pulmonary emboli and length of stay cost for
11 mortality, we want to find that patient and
12 not risk adjust it away. But there is really
13 no guidance on a best practice because some
14 risk adjusters include everything and some
15 make an effort to model those things out. So
16 that will be very useful.

17 There are other things, too, like
18 just the patient population. Mortality has
19 been going down year after year. If you model
20 a population from 2008 you are going to get
21 very different results from modeling a
22 population from 2012. So the breadth and the

1 dates of the population could be helpful.

2 The way we handle chronic
3 diseases, that is usually not terribly
4 important, although that is what we spend most
5 of our time debating. But things like
6 outliers and transfers, how do you handle
7 those? What is the best practice.

8 And then lastly, end of life care.
9 And depending on whether you are modeling
10 inpatient mortality or you are looking at cost
11 of a population, you have to figure out how
12 you want to model that or not model it because
13 it makes a huge difference. So if NQF would
14 have maybe some guidelines or convene an
15 expert panel or summit or to help set best
16 practices, that would be very, very useful.

17 MS. KNUDSON: So I just had one
18 last comment and really ask for a
19 clarification and a reconsideration of the
20 process because I think based on Syed's
21 comment, we would support, too, that the best
22 case scenario is to have an open source risk

1 adjuster that accommodates the needs of a
2 commercial population. But absent that, what
3 we have is the best we have and those are
4 commercially available risk adjusters.

5 HealthPartners has said we would
6 test our already endorsed measure using that
7 publicly available one when it becomes
8 available. What is difficult, and Taroon you
9 teed up a measure steward burden question that
10 we really didn't get to or maybe just around
11 the edges, we would test that on our already
12 endorsed measures. So from a practical point
13 of view, we would ask for NQF to reconsider
14 the process that we wouldn't have to then fill
15 out the application, do the full vetting of
16 all of the rest of the spec that is already
17 endorsed, use another Steering Committee to go
18 through the entire specification again which
19 is already endorsed, but rather only look at
20 the specific differences in the reliability
21 and validity testing results.

22 And I know those sections include

1 more broad components that also apply to the
2 spec but I would say we would just be very
3 precise with what is different about the
4 results of this open source. Because absent
5 that flexibility in the review process, we
6 won't have the resources to do this on behalf
7 of the healthcare community in this country.
8 But we would, because we are very invested in
9 affordability for the country, we would do
10 that testing on our already endorsed measure.
11 We would just ask for flexibility in that
12 review process to be very precise around what
13 is different with that testing and not require
14 us to re-vet the entire measure again.

15 And I don't think -- I think based
16 on the discussion, I just wanted to make that
17 ask because I think it is very practical based
18 on the discussion. But I just wanted to be
19 clear about the ask because I know that was
20 part of the issue that led us to today's
21 discussion on this very topic.

22 MR. AMIN: Thanks. So let's do

1 another round if there is anyone else who has
2 comments about that. Karen, it sounds like
3 you have a few and then Bill.

4 DR. PACE: I just want to say in
5 terms of it really depends on what your
6 analysis shows. If you indeed show that you
7 get comparable results, which is one of our
8 criteria, then it can be in the one measures.
9 If that doesn't bear out, then we are to the
10 situation where you can't say that you can
11 just apply any risk. So that has always been
12 part of our process.

13 So to give you a specific answer,
14 really depends on what your results show. And
15 so I mean we can have more discussion about
16 that but I think within our current criterion
17 process, that is how it is set up. But we can
18 have other comments and discussion about that.

19 DR. WEINTRAUB: Well the problems
20 go on and on. I think I will just mention
21 three more. Well broad populations tend to
22 offer better metrics than narrow populations.

1 So an example of this is in developing models
2 to look at mortality after intervention of the
3 coronaries we look at models that are in
4 stable patients and models that are in
5 patients in shock. And if you just at the
6 model in stable patients, you get sort of
7 mediocre metrics. But if you include the
8 population in shock in that model, all of a
9 sudden the model looks great and your summary
10 statistics go through the roof. But it
11 doesn't answer a question that you really want
12 to answer because you already know there is a
13 big difference between the patients in shock
14 and the patients how aren't in shock. So you
15 really have to be careful about looking at the
16 question you want answered.

17 The other thing about the question
18 you want answered is when do you include
19 procedural details and when do you include
20 complications? it is not always wrong to
21 include complications. It depends on the
22 question you are wanting to ask. Because if

1 you want to know what the drivers of costs are
2 in you institution, you will find out that if
3 you don't include complications, it all seems
4 to be length of stay. But if you do include
5 complications, all of a sudden complications
6 become a big driver.

7 Length of stay, do you include
8 length of stay? Some people say never include
9 length of stay because it undermines all of
10 your other models. But if your model is out
11 to say what is the very best model I can use
12 to understand all the drivers across my
13 institutions, maybe you should include length
14 of stay.

15 So very complicated. One more
16 final one. Composite endpoints and how they
17 handle that. I just went through this in a
18 paper we are developing looking at long-term
19 outcomes in stable ischemic heart disease.
20 Should you have a model that includes just
21 death or should it include death plus
22 myocardial infarction? And we are absolutely

1 couldn't decide. There were drivers towards
2 one and drivers towards the other. Or do you
3 do both? But the problem of including both is
4 then your paper becomes unreadable and people
5 say what are you really trying to say.

6 So you never get to the point
7 where you can sort of resolve all these. The
8 problems in risk model development go on and
9 on and on. And the best we can do is just be
10 aware of what a complex environment this is
11 and all the mine fields.

12 MR. AMIN: Okay. So we will go
13 Karen, Andy, and then Dolores.

14 But quick point, on the issue that
15 was raised by HealthPartners, I want to
16 specifically mention that if you believe that
17 there needs to be some change in this criteria
18 to allow what we are talking about here, I
19 think that is what we need, outside of having
20 the actual data to show the comparability,
21 that is really the question. That is really
22 what we are trying to get out of this

1 conversation.

2 And again, so let's sort of keep
3 to that. So Karen?

4 DR. PACE: I just want to respond
5 to your point about what you include in the
6 risk model and it depends on your question.
7 Certainly I think that is where we need to
8 kind of think about what we are doing with
9 risk adjustment for performance measurement
10 versus understanding the drivers. So
11 certainly if you wanted to understand the
12 impact of length of stay or complications, you
13 would want to model that. But that is not
14 what we are trying to do with risk adjustment
15 when we are comparing performance.

16 And that is often why we don't see
17 as big of C statistics or R squared when we
18 are talking about risk adjustment to kind of
19 level the playing field because we are not
20 including all of the aspects about the care
21 actually received. But good point.

22 MR. AMIN: Andrew?

1 DR. RYAN: So I would say that
2 criteria 2b6 is very reasonable. And I like
3 it but I am guessing that the incentives just
4 aren't there for the developers to do this
5 because it is hard enough to get one measure
6 through a committee and the idea of having
7 tweaks on a measure and getting that whole
8 thing through is extremely difficult.

9 So it seems to me that NQF, if
10 they wanted a kind of broader approach here
11 would have to be more kind of muscular and
12 really recommending testing for different
13 types of risk adjustment strategies because I
14 am guessing that developers just really don't
15 want to do it on their own, number one.

16 And number two, perhaps the way
17 that a measure that could be specified is that
18 there is one primary risk adjustment strategy
19 that is there and then there are some others
20 that they say are comparable X, Y, and Z. And
21 then a committee could say could recommend
22 endorsement for just the primary or recommend

1 endorsement using all those strategies but
2 could, in theory, not approve all the
3 strategies but could maybe just improve the
4 one that they feel the most comfortable about,
5 which would have some more flexibility in the
6 endorsement process.

7 MR. AMIN: Dolores?

8 MS. YANAGIHARA: I just want to
9 register strong support for HealthPartners'
10 suggestion. I think it is reasonable, given
11 the resources required to get a measure
12 through endorsement and the resources needed
13 to review measures. For a measure that has
14 already been reviewed, all the other aspects
15 haven't changed. It is just the risk adjuster
16 that has changed. A limited review seems very
17 reasonable and prudent.

18 MR. AMIN: Tom and then Nancy.

19 DR. TSANG: I just have a very
20 quick question about future harmonization
21 processes as we talk about proprietary risk
22 adjustment methodologies versus open source

1 and the impact of CMS's decision to use
2 proprietary risk-adjustment methodologies and
3 whether that has any relevance in this
4 discussion.

5 I mean, Helen, is there a CMS
6 policy about not using proprietary risk-
7 adjustment methodologies?

8 DR. BURSTIN: I can't speak to it.
9 There are some other folks still here from the
10 CMS. I don't believe there are any clear --
11 yes, I don't think so.

12 There have been discussions. I'm
13 sorry, go ahead.

14 DR. ROMAN: But generally
15 speaking, CMS prefers to use open source
16 publicly available methodologies. And we have
17 encountered this in a number of areas, in
18 particular, most recently with use of episode
19 groupers and with the recommendation to
20 develop a CMS episode grouper, which would be
21 open source and publicly available.

22 DR. BURSTIN: We certainly heard

1 through the consensus process and also through
2 the MAP process concerns that when a measure
3 is picked up that has a proprietary sticker
4 attached to it, the terms unfunded mandate
5 have been spoken at these tables not
6 surprisingly. So it is an issue that comes
7 up.

8 MR. AMIN: Nancy.

9 DR. GARRETT: So I also support
10 the proposal from HealthPartners for a
11 flexible approach. I think the fact is that
12 this measure is going to be used within
13 markets. And I think the people who are doing
14 this kind of work are sophisticated enough to
15 know when they can compare things and when
16 they can't. And just from a practical
17 perspective, this is where we are with cost
18 measurement right now. And this is the
19 situation. We don't have the publicly
20 available commercial grouper yet. So I think
21 it allows us to start moving towards
22 standardization without placing an undue

1 burden on the measure developers.

2 MR. AMIN: So I just want to make
3 it clear in my own mind. Is the proposal that
4 is being suggested now to in some way relax
5 criteria 2b6 around the comparability of the
6 various different risk adjustment models?

7 DR. GARRETT: Well my
8 understanding is the proposal is that an
9 entity could use the HealthPartners measure
10 and use a different risk adjuster but still
11 have that be considered an NQF-endorsed
12 measure. Is that the proposal? Is that
13 right, Sue?

14 MS. KNUDSON: Yes, we would test
15 the other risk adjusters. We would only want
16 to review the result of that test with the
17 Steering Committee for discussion. Not the
18 entire specification and go through what you
19 have gone through the last two days with two
20 other measures. But only those certain
21 sections of validity and reliability. You
22 know, like the 2a2, the reliability testing,

1 2b2, the validity testing, 2b4, the risk
2 adjustment strategy. And then, of course, I
3 think there is a relevant discussion about
4 barriers to implementation if that is still
5 relevant, given the cost of these risk
6 adjusters. Because yes, they are commercial
7 but they don't all come with the same price
8 tag.

9 So those were the sections as we
10 looked at the criteria, which is a much more
11 precise review of what is different about the
12 measure versus what is already endorsed,
13 rather than rehash all the other aspects that
14 don't change about the measure.

15 And we would only submit if we
16 thought it was a compelling result to submit.
17 We are not going to go through this if it is
18 not showing consistent results.

19 DR. GARRETT: Would it create a
20 new measure then for each risk adjuster?

21 MS. KNUDSON: Well, yes,
22 theoretically. I mean in my mind. I am not

1 making the rules for NQF but in my mind that
2 one might be one control so you don't have
3 people comingling results of different risk
4 adjusters. But I would let NQF field that.

5 MS. YANAGIHARA: I meant to say
6 this. In my mind because it is the same core
7 measure, it would make sense to me to have the
8 measure number with A, B, C, D if you had
9 different risk adjusters or something like
10 that with a clear distinction of this is the
11 core measure with this risk adjuster. This is
12 the same core measure with this risk adjuster,
13 so that you know it is the same measure but
14 you know it is a different risk adjuster or
15 something is different about it.

16 So that would make sense to me, be
17 very clear. Because if we have different
18 measure numbers it is like so what is the same
19 and what is different about it. Anyway, and
20 then that would support the limited review
21 because it is really the same measure.

22 DR. BURSTIN: I mean that assumes

1 comparability though.

2 MS. YANAGIHARA: Correct.

3 DR. BURSTIN: That is an important
4 assumption. I think that is what we are still
5 grappling with is what does comparability mean
6 in terms of what their analyses need to show
7 to make that doable. And that is what I hope
8 we are getting some clarity on.

9 DR. PACE: And if they are not
10 comparable, then they would have to be looked
11 at as individual measures, even if they had
12 the same basic structure for the cost
13 attribution, et cetera.

14 MR. AMIN: Jennifer.

15 MS. EAMES-HUFF: Just a point of
16 clarification. When measures go through the
17 review process and become endorsed, it is
18 every three years that they get reviewed
19 again. Is that correct? And as a part of
20 that review process, is it a full review
21 process?

22 So I think the request is pretty

1 reasonable because at some point there is
2 going to be another full review process of the
3 measure, of opening it up to everything. So
4 if they wanted to have a time where you only
5 look at a specific piece because that piece is
6 changing, I think because you would continue
7 the full review every three years, your
8 maintenance piece.

9 DR. BURSTIN: Although we are
10 actually only now about a year out from that,
11 which is part of the issue of this discussion
12 because it actually now has been a while. So
13 does it make sense to kind of do this interim
14 step and then, once again, within a year have
15 them bring it all forward again? Is there a
16 way to sort of think through really a very
17 logical sort of step-wise approach that maybe
18 allows us to put something out there and
19 comment, as opposed to changing the measures
20 and then when the measure comes back in, very
21 clear clarity of what is required for
22 comparability to either get to the ideal

1 solution, which I think is what Dolores is
2 saying versus other approaches.

3 MR. AMIN: So Evan, I am going to
4 ask you can you go to the slide looking at
5 potential options and implications?

6 So I know there is a lot of
7 information on this slide. And the side ones,
8 there is no chance that you can actually read
9 that. But I will walk you through what we
10 have heard, at least today. And a lot of this
11 depends on the information that is presented
12 to us.

13 So one measure with one number,
14 which includes multiple different risk-
15 adjustment models, comparability of
16 performance scores would need to be
17 demonstrated. So in this scenario, if you are
18 using ETGs and DxCGs or ACGs, you would have
19 to demonstrate comparability. And it would be
20 difficult to do that in the short-term. But
21 even if it were done, there is some question
22 that was raised today and in the past around

1 whether those results would actually be
2 comparable. And what does comparability mean,
3 one of the issues that Dolores raised.

4 The second is multiple measures
5 with multiple different numbers. Each for
6 each different risk adjustment model. And
7 that assumes that the performance scores will
8 not be comparable, meaning the risk-adjustment
9 models are not comparable.

10 And that each additional measure
11 would be evaluated against the criteria. Now
12 that is what is being challenged here. One of
13 our assumptions here, one of the practices at
14 NQF is that no new measure can be created
15 without or endorsed without evaluation of all
16 four of the criteria. Obviously, the
17 committee can decide to move through the
18 criteria pretty quickly but it would still
19 need to evaluate the criteria. That seems to
20 be what is being raised as a question among
21 the panel.

22 Specifications besides the risk

1 models would all need to be identical and
2 there would still need to be some
3 justification of endorsement of multiple
4 competing measures, because these would be
5 considered competing measures.

6 And finally, one measure with one
7 number with multiple different risk-adjustment
8 models and the comparability is not being
9 demonstrated, NQF has traditionally rejected
10 this approach for quality outcome measures.
11 And so what would be the rationale for this
12 being appropriate for resource use measures.
13 And in the future, would it be possible to
14 have performance based on these different
15 models to be converted to a common scale.

16 So again we are kind of at the end
17 of the time on discussion of this issue, but
18 I want to just be clear on where we are
19 ending.

20 DR. PACE: But it sounds like
21 HealthPartners is saying that their initial
22 analyses is showing that they are comparable

1 and so it would be one measure with different
2 options for risk adjustment but demonstrating
3 comparability.

4 MS. KNUDSON: Well I would just
5 like to clarify that I think it goes very
6 squarely to Dolores' point and I like the
7 terminology use to sort out what are we
8 talking about when we use the word comparable
9 versus consistent results and index
10 performance. Because if you look at the
11 actual number we wouldn't want anyone to
12 compare those.

13 And so I do think there is a
14 couple of different nuanced positions that I
15 have heard through the discussion that we
16 could interpret to mean different things based
17 on these questions that Taroon just outlined.

18 We, again, I would just say were
19 compelled by the argument of this both and
20 approach. These risk adjustment tools are
21 tied to money moving in local markets, which
22 is a distinct difference with the volume of

1 money moving based on these tools than the
2 quality measures.

3 So again, it was sort of meeting
4 markets where they are at, given where we are
5 in the evolution of cost and resource use
6 measures as Nancy pointed out. Yes, if you
7 are going to do a national study, use a single
8 tool.

9 So I was just simply trying to
10 offer flexibility and I think that goes to
11 Gene's point as well about the debate of risk
12 adjustment at all in a national comparison,
13 given the issues of differences in coding and
14 practices across the country. And the fact is
15 that what we have in local markets again, to
16 make that local market argument, our providers
17 are local to that market and you don't see
18 that same level of disparity that we see when
19 we take a national view. So I am appealing for
20 practicality and driving an affordability
21 agenda.

22 And I guess my last comment would

1 be with regard to the measures coming up for
2 re-review, to me, as a measure steward, the
3 burden is no different. If I have to go
4 through with re-review with now six measures,
5 I can't do it. I can do one measure with the
6 entire spec and I can review results in the
7 relevant sections that make a difference,
8 based on the different risk adjusters. but it
9 just doesn't seem very efficient to run
10 through the same process, fill out the same
11 application for all of that and use the
12 Steering Committee time.

13 So yes, I kind of have this view
14 of where we want to go vision-wise with what
15 it is on the ground trying to get this done
16 with meeting the NQF requirements and trying
17 to advance the agenda.

18 So I am sorry if that is still not
19 absolutely clear but I do hear nuanced
20 differences in the comments.

21 DR. PACE: I think one of the
22 things that we may need to do, it is hard to

1 kind of continue to talk about this in the
2 abstract, so we probably need to get down to
3 what analyses you have actually done and what
4 they show. And perhaps that would help us
5 figure out the best forward whether it really
6 can be one measure.

7 But if the Steering Committee has
8 some suggestions on this comparability issue,
9 as I said our initial thinking of it was not
10 so much that you get a one-to-one, they came
11 out with a thousand here and a thousand on
12 this one but that they would be basically in
13 the same position in ranking, so it is the
14 consistency is I think the main issue.

15 Certainly, if you have some
16 additional thoughts about that but I think we
17 probably may need to get down to some more
18 specifics and perhaps a smaller subgroup to
19 help us sort it out.

20 And one question. This issue
21 about markets using the same risk adjuster or
22 model, I guess one of the things that we would

1 be interested in knowing is will providers in
2 those markets be getting -- so is it possible
3 that providers are going to get one health
4 plan that is using a particular proprietary
5 model versus another health plan? So a
6 hospital may get two different results.

7 So when people say markets are
8 using one risk adjuster, I am not sure how
9 accurate that is. So I guess that is what I
10 am trying to understand.

11 DR. NELSON: It is what you
12 suspect, that within one geographic area, one
13 health provider may get many different risk-
14 adjusted results.

15 DR. GARRETT: But it is usually
16 within the same payer. They would be using
17 the same approach across all of their
18 providers.

19 DR. NELSON: Right. Payer is
20 consistent.

21 DR. GARRETT: So kind of the
22 current -- yes.

1 MR. AMIN: So from a provider
2 perspective, I mean this whole issue about
3 harmonization and competing measure from a
4 consumer purchaser and provider standpoint is
5 that if you are introducing multiple measures
6 with multiple different risk-adjustment
7 models, you are still introducing a
8 significant amount of burden, potentially.

9 So it is a question, right? Okay.

10 MS. CLARK: Yes, I was just going
11 to say I like the idea of the whole
12 comparability and if you are using one risk-
13 adjustment methodology versus another, as long
14 as the rankings are the same and the people
15 come out in the same types of groupings. But
16 if the actual value is different, I mean, this
17 has come up before and I am thinking of an
18 example in cardiology.

19 For example, they have a EuroSCORE
20 and Society for Thoracic Surgery score for
21 looking at risk adjustments for mortality.
22 These are two very different methodologies.

1 One is proprietary, another is not. But
2 people kind of know that if you use a
3 EuroSCORE, you are going to get like the
4 mortality rate as through the STS score.

5 And so if there would be some way
6 to come up with an adjustment that somebody
7 would know if they were using ACGs versus DCGs
8 versus ETGs, you know you have some type of
9 way of comparing them. That would be --

10 DR. PACE: I think that is a good
11 point and it gets back to Dolores' question so
12 that even if the provider would have the same
13 ranking, if you try to use these across for
14 cross-comparisons, we are still in a problem.

15 MS. YANAGIHARA: A quick comment
16 on the market question. I mean I think there
17 are certain markets that are coalescing around
18 a particular adjusters. So in California, we
19 are using DxCG across the state, at least for
20 the program that IHA is responsible for. It
21 doesn't mean that health plans have other
22 adjusters for other programs. They probably

1 still do but at least for the statewide P4P
2 program, we are using the same thing across
3 the state. I think Minnesota has just come to
4 agreement on what they are going to use.

5 So I think there are a lot more
6 instances and I know that a lot of the states
7 in the state innovation models on the CMI
8 funding are very interested in total cost of
9 care and would be very interested in having --
10 using an endorsed measure.

11 And so to the extent that a public
12 grouper is available and can be tested and
13 that could be used, that would be great. But
14 short of that, if there are options, I think
15 that the different states would be wanting to
16 use different things, depending on what they
17 are already using.

18 MR. AMIN: Okay. So thank you,
19 everybody. This has been a very robust
20 conversation and thank you to our colleagues,
21 developers and those on the phone.

22 So we will sort of take this

1 offline, think about this, digest it, and
2 provide it back to the CSAC in terms of a
3 digestible form in terms of where we want to
4 go.

5 We have an attribution discussion
6 and a sort of a forward-looking discussion in
7 terms of how to really move toward efficiency.
8 We are supposed to break at 2:00 and we have
9 lunch. And we want to be respectful of people
10 just wanting to take a little bit of a break.
11 This has been a very intense morning and it is
12 already the afternoon.

13 So again, let's break for ten
14 minutes. I know that is not much of a break
15 but we want to at least try to have half an
16 hour for the last discussion. So I hope that
17 is okay.

18 (Whereupon, at 1:10 p.m., a lunch
19 recess was taken.)

20

21

22

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

1 (1:25 p.m.)

2 MR. AMIN: Okay, so again for a
3 little bit of context, this next discussion as
4 many of you who were on the first resource use
5 Steering Committee remember, there are
6 components of the measure submission that were
7 allowed to be submitted as guidelines or
8 specifications. And specifically what that
9 means is that the measure developers could
10 elect to provide guidelines or recommendations
11 on how the measure specific portion of the
12 measure construct could be applied in various
13 different context or they could provide
14 specifications.

15 One particular area that that
16 still exists is in the attribution, where
17 currently there is this allowing of guidelines
18 or specifications.

19 So specifically NQF, again going
20 back to this, NQF endorses national standards
21 for performance measures and that includes
22 both quality and resource use measures that

1 are intended for both accountability and
2 public improvement.

3 Actually, let me turn it over to
4 Karen. Actually this is Karen's section.

5 MS. WILBON: I will just make one
6 clarification. When we say guidelines and
7 specification, specifications are what is
8 baked into the measure and is standardized.
9 So we endorse what is specified.

10 The guidelines would be used by an
11 implementer or user who may need -- may not
12 have any idea of what attribution model they
13 might want to use. And so the guideline was
14 there for suggestions for the user but it
15 wasn't necessarily part of what was endorsed.
16 So to say that a user who was using the
17 endorsed measure must use this attribution
18 model or must use some other guideline that
19 was provided by the developer.

20 In addition to the attribution and
21 you might have seen it in the appendix, there
22 is other pieces of information that we also

1 allow developers to submit as guidance. So
2 how they would suggest that benchmarking be
3 done, how peer grouping would be performed
4 using the measure, all of these things we have
5 been categorizing and are reporting more as a
6 reporting function, as opposed to actually
7 being baked into the -- I used the word baked
8 but kind of specified and baked into the
9 measure.

10 So I just wanted to clarify that
11 so that everyone was on the same page.

12 MR. AMIN: So again, since the
13 fact that NQF endorses performance measures
14 for national comparisons as national
15 standards, the question really becomes in
16 order to make useful comparisons about
17 conclusions of performance, especially
18 relative performance at a national level, all
19 entities need to be measured in the exact same
20 way. And this again goes across quality and
21 resource use measures.

22 And specifically in quality

1 measures the attribution is part of the
2 measure specifications and is required for
3 submission. So to the extent possible, NQF
4 criteria should apply for all types of
5 measures with only a minimum number of
6 exceptions that are absolutely needed for
7 specific types of measures.

8 So the issue specifically that we
9 would like to discuss is what would be the
10 rationale that resource use measures should be
11 handled differently? And I will turn it over
12 to Karen to maybe provide a little bit more.

13 DR. PACE: And I think this is
14 generally the same discussion we just had
15 about risk adjustment models. And the bottom
16 line is if you get different results using
17 different attribution rules, then it is hard
18 to say that it is the same measure because it
19 is not standardized. And how could you
20 compare?

21 And I think there is definitely
22 more attribution questions and components in

1 a resource use measure. But as Taroon said,
2 for quality performance measures, how people
3 are assigned to whatever level of analysis it
4 is, whatever entity is being measured is part
5 of the measure. And once you start having a
6 lot of flexibility, the question is what are
7 we endorsing as a national standard.

8 MR. AMIN: David.

9 DR. PENSON: So, to start the
10 discussion, I think this may be a very short
11 discussion because I got on the assumption
12 that this was required. And to say that it is
13 a guideline, I would say that you are better
14 off having a guideline for the quality
15 measures than you are for the resource use
16 measures when it comes to attribution because
17 attribution is so critical here, how you
18 categorize the different resource use
19 categories and who does what, and particularly
20 the way these are going to end up being used,
21 I can't really think of a good reason just to
22 have it as a guideline. I am sure others may

1 disagree but I don't think many will. So I
2 don't know.

3 MR. AMIN: Cheryl?

4 DR. DAMBERG: I would agree with
5 that comment. We have done various analyses
6 looking at different attribution rules and you
7 definitely get different results. So this
8 just seems like I'm not sure why we are
9 dealing with this. I think it definitely
10 should be part of the criteria, the
11 requirements.

12 MR. AMIN: So maybe as we continue
13 going forward before we get to -- maybe the
14 straw person is that we move the attribution
15 components and the reporting components,
16 meaning the peer grouping and sample size
17 requirements components of the measure
18 submission to be specifications as part of the
19 measure. So Lina -- okay.

20 And if there is disagreements with
21 that, let's have that discussion, since that
22 seems to be the general tenor of the

1 conversation. It is only two people but let's
2 start. Jack?

3 DR. NEEDLEMAN: As somebody who
4 just voted no on a measure over the
5 attribution rule, --

6 (Laughter.)

7 DR. NEEDLEMAN: -- I actually like
8 the idea that the attribution is a guideline
9 because I don't think we know the right way to
10 do attribution yet. And what I can see is it
11 is important to figure out which costs you are
12 going to count, how you are going to deal with
13 the outliers. So you standardize what costs
14 are being counted and what costs are being
15 aggregated.

16 But in a lot of the systems in
17 which these measures are being used, there
18 will be either negotiation between the
19 insurers, typically, who are the payers who
20 are actually producing the data and the
21 providers about the way the attribution should
22 be done. And that is subject to negotiation

1 that makes the rule acceptable. And given the
2 uncertainties of that attribution I am willing
3 to see those negotiations go on.

4 And because the way the data is
5 going to be used once it gets to the providers
6 in terms of figuring out how we manage these
7 costs, which is ultimately what we are talking
8 about, not who is to blame but how we manage,
9 allowing for some flexibility in the way the
10 attribution is done gives the provider group
11 some opportunity to reflect on the management
12 problem, rather than the attribution problem.

13 So for those reasons I think that
14 there is a certain value in allowing the
15 providers who are the recipients of this stuff
16 and the payers who are the compilers of the
17 measure to negotiate what the attribution
18 structure is going to look like within some
19 broad guidelines.

20 MR. AMIN: Lina, Dolores, and then
21 Larry.

22 DR. WALKER: I have a clarifying

1 question. I guess I don't fully understand
2 the difference between requirement versus
3 specification. I was just listening to Jack
4 and you were asking for flexibility in the way
5 the attribution is done. And so how is that
6 precluded if it is a specification?

7 DR. PACE: Well, basically what it
8 means is that we endorse the measure as
9 specified and so I guess I am not sure what
10 people mean by guideline because guideline
11 tends to mean you can do it multiple ways.
12 This is one way but if you choose to do it
13 another way, you could versus if it is really
14 part of the specifications, that is what NQF
15 has endorsed the measure as specified.

16 DR. WALKER: Can I ask a follow-up
17 question? In that case, I mean I guess I
18 would ask Jack this question. We evaluated
19 the measure and, in fact, you voted the way
20 you did because of the attributions. Why
21 would you want to provide more flexibility?

22 I mean I guess we have to evaluate

1 it in the context in which they say it would
2 be measured or computed. And that hinges on
3 the attribution. So I don't even know how you
4 could evaluate it if you give them
5 flexibility.

6 MS. YANAGIHARA: This is a really
7 complicated thing because it really depends on
8 the use case. How you attribute really
9 depends on what you are trying to do with that
10 measure.

11 So for example if you are trying
12 to encourage medical homes, you are going to
13 want to attribute things to one group or
14 provider or whatever, probably group, to
15 really try to drive that that is where you are
16 responsible for these people. Whereas, if it
17 is for a different purpose, you might
18 attribute it differently.

19 So I don't think it is -- and I
20 don't know that you want different measures
21 that are exactly the same with different
22 attribution methods either. So it is just

1 really hard because it is much, especially
2 resources there is so much tied in to what are
3 you trying to accomplish with the measure.

4 And so I don't know without some
5 flexibility how you can -- I don't know. I
6 think you are just asking for more people not
7 using NQF-endorsed measure tied into a
8 particular attribution measure doesn't really
9 align with your use.

10 MR. AMIN: Joe?

11 DR. STEPHANSKY: As an example, I
12 am going to go back to Blue Cross/Blue Shield
13 of Michigan again, where the attribution
14 methodology was debated heavily for over two
15 years before they finally came up with
16 something that was acceptable to both
17 physician groups and the hospitals as to how
18 patients were linked together across provider
19 groups. Two years.

20 But now, everybody is at least
21 adequately happy to move forward. If we would
22 have had to start with a specific attribution

1 methodology as in what we were looking at in
2 the last measure, we would never be there.
3 People would have simply rejected it.

4 When we go into the commercial
5 market, we have to recognize that these are
6 negotiated contracts and measures are now
7 going to be part of those negotiated
8 contracts.

9 MR. AMIN: David.

10 DR. REDFEARN: I would like to see
11 some more flexibility from possibly sort of a
12 selfish personal interest. I would like to
13 see some attribution methodology that is
14 something other than that stupid Dartmouth
15 visit count method, which seems to have taken
16 over the world. And the reason I say that is
17 in California when we first started our ACO
18 pilots in California, I was asked to do some
19 analytics. And because I do so much episode
20 work, I thought I would take a look at our
21 episode data and see if I could use the
22 episode data, which you assign an episode

1 responsibility for an episode of care to a
2 physician and then that links the physician
3 back to the patient whether I could use the
4 episode data to build an attribution model
5 driven out of the episodes of care that the
6 physicians were managing. And I developed
7 that methodology and reported it to our
8 network people and to the medical groups that
9 we were dealing with at that time, which was
10 Healthcare Partners in Monarch. And to my
11 amazement, people liked the methodology.

12 So the initial ACO pilot for Blue
13 Cross of California was based on an episode of
14 care attribution methodology. I did some
15 comparisons with the Dartmouth methodology and
16 I think I demonstrated that the episode
17 methodology of assignment was superior, was
18 really linking patients to doctors that they
19 were really treating and not just had one or
20 another visit.

21 And then but to my dismay, the
22 corporate ACO pilot decided to adopt the

1 Dartmouth methodology and that has now even
2 disappeared in California. So all the work I
3 did is just gone.

4 So I guess what I am saying is if
5 you have some flexibility to start looking at
6 some potentially superior methods of doing the
7 attribution, that is not a bad thing. I think
8 that is a good thing. But then like I said,
9 I have a kind of personal interest in this
10 because I have been through this kind of
11 process and in fact, when I go to the
12 management and said well I think the episode
13 data is probably superior and gives you some
14 value. And it is like oh, yes, but it is too
15 hard to do. It is too complicated plus there
16 are these standards that we have to use the
17 standards.

18 I even had some discussions with
19 the Dartmouth folks that were working on the
20 method and they even sort of admitted that
21 there were some limitations to that kind of
22 methodology but said we are working on

1 improvements but it is what it is now and that
2 is what we are doing.

3 So I like that additional
4 flexibility.

5 MR. AMIN: Lisa?

6 DR. LATTS: So I think that
7 actually this whole discussion is an artifact
8 of our times because five to ten years ago,
9 nobody ever talked about attribution. So it
10 is really this whole discussion about the
11 methodology is a reflection of some reluctance
12 by whoever it is being attributed to be held
13 to this standard.

14 I think that within several years
15 there will be a clear winner but right now
16 there isn't, which is why we are even having
17 this discussion.

18 I'm okay with the flexibility as
19 long as NQF or whoever is endorsing the
20 measure comes up with a set of principles that
21 the flexibility has to adhere to. So I think
22 that if we do allow flexibility in the

1 methodology, we then have to say you have to
2 meet these five principles to insure
3 consistency. Otherwise, why are even spending
4 time approving measures because the
5 attribution could so screw things up that it
6 might not even be reproducible.

7 MR. AMIN: Daniel.

8 MR. WOLFSON: So I think
9 attribution really has to do with
10 accountability. Right? We are trying to
11 measure who should be accountable. And I know
12 my people on my right and my left won't want
13 to hear this but I do think that the
14 accountability models will change rapidly over
15 time as a source of information goes away from
16 health plans and goes back to the delivery
17 systems. And we are going to see a much
18 different way of thinking about attribution
19 accountability in the future. And where the
20 source of information will be, the rich
21 clinical information which we really need to
22 have, not claims data, will switch.

1 And so we need to be flexible
2 about those attribution models because the
3 attribution models today will be obsolete. I
4 don't know when but they will be obsolete.
5 The shift in power and influence, I know this
6 is self-serving because now I work for the
7 physicians and not health plans. But I think
8 it is true. I think it is changing because of
9 the EMR. And if we are not flexible and aware
10 of those changes, we will be in an old
11 chassis.

12 DR. PACE: I think the question
13 is, obviously as we have talked about, the
14 measures are only endorsed for three years and
15 then have to come back for endorsement
16 maintenance. So we are not talking about that
17 once we endorse a measure and an attribution
18 rule that would go with it that it would never
19 change. That is not the model of NQF
20 endorsement in the first place. The question
21 is within that three-year period, if you have
22 endorsed a measure and you all are saying that

1 the attribution is so key to that measure, how
2 can you even, what does validity of the
3 measure even mean if someone can use a
4 different attribution rule?

5 I'm just trying to understand what
6 it is you think you want NQF to be endorsing
7 if it is not -- if attribution rule is not
8 part of it.

9 MR. AMIN: Okay, Nancy and then we
10 will take some -- oh.

11 MR. WOLFSON: You can't have
12 measurements without attributions.

13 DR. PACE: Exactly. And it is
14 part of the specifications of all of our other
15 measures.

16 MR. WOLFSON: Yes.

17 DR. PACE: And the question here
18 is whether attribution should be kind of
19 outside of the specifications and allow
20 multiple ways or people can select their own
21 attribution model.

22 MR. WOLFSON: I can't comprehend

1 how it could be outside. I just --

2 MR. AMIN: Okay. So just for
3 clarification, that would actually be a
4 change, a shift from where we are now and
5 alignment with where we are in quality. And
6 that is sort of the straw person that we are
7 testing here, to make sure that we are all in
8 agreement that we are okay with moving in that
9 direction.

10 So we will go to Nancy and then
11 comments on the phone, then comments in the
12 room, and then we will go back around to Bill,
13 if that is okay.

14 DR. GARRETT: So I agree with the
15 idea of having attribution be a standard part
16 of the measure. One of these uses for these
17 total cost of care measures is going to be and
18 already is helping to shift, starting to shift
19 accountability, financial accountability for
20 population to providers. And as that happens
21 for providers to have slightly different or
22 even very different ways of defining that

1 population with all the payers they work with,
2 it gets really complex quickly.

3 And I think that this is just an
4 important role for standard setting to be able
5 to start to move toward a national standard.
6 I think it is really an important thing. And
7 we won't do it right at first but it will have
8 to evolve over time, I think, to get better
9 and better in terms of what are the best ways.

10 And unlike the previous
11 discussion, we don't have the same complexity
12 with risk adjustment where there is a need for
13 proprietary method. I mean attribution is
14 something we can write down on a piece of
15 paper and have it be completely open source
16 and we can all come to an agreement about the
17 standard.

18 MR. AMIN: Okay, Operator, are
19 there any comments on the phone?

20 OPERATOR: At this time, to make a
21 comment, please press *1. There are no
22 comments or questions.

1 MR. AMIN: Thank you. Are there
2 any comments in the room?

3 MS. KNUDSON: I guess just
4 reflecting on the comments that the Steering
5 Committee made, I point out three things.
6 First of all, I think we are moving to a model
7 of shared accountability with greater
8 accountability with those risks with the
9 providers. But I don't think the insurance
10 companies will not have any or health plans
11 won't have any accountability. I don't think
12 it is a full shift. So I think I would offer
13 that I would view it as shared accountability.

14 And as it relates to working for
15 an organization that has the benefit of
16 understanding both EMR data, as well as
17 administrative claim data, you really need
18 them both to understand resource use and total
19 cost of care.

20 The EMR is not a replacement.
21 Because when we refer our patients to our
22 partners in the community or they get

1 hospitalized outside of our own system, that
2 is where we use our administrative claim data
3 to understand those pieces. And that is not
4 in our EMR. It might be there with some
5 coordination of care notes but in a real
6 easily retrievable way. And those are the
7 realities of this work on the ground.

8 I think the other comment I would
9 make is the attribution methods. It would
10 seem to me that when we have a single payer
11 like the measures we just listened to from CMS
12 as a single national payer is sort of a
13 different bailiwick to have consistency then
14 across different markets with commercial
15 payers. And this is where I would say just
16 like based on the experience we have had in
17 Minnesota, we spent probably nine months to
18 the earlier comment vetting the different
19 attribution approaches and landed on one
20 across the different payers. But I am not
21 convinced what is going to work in Minnesota
22 will work in every other local market for

1 commercial payers.

2 So I think this again is a topic
3 that is not black and white. There is a lot
4 of gray space and particularly in the
5 commercial market. And so if we really want
6 to advance these, we should not be too overly
7 prescriptive in the commercial market with a
8 one size fits all across the entire country.
9 I think there needs to be some flexibility for
10 different market places.

11 And it will evolve, just as I
12 mentioned before, that I don't view our
13 Minnesota work as static. I think it is going
14 to evolve as we redesign and improve care
15 delivery in a way that brings in other sort of
16 virtual and alternatives to face-to-face care
17 where we are not counting visits. We have to
18 be more creative than that.

19 So with these issues, our work
20 will never be done. I guess is the main point
21 and we need to remain flexible.

22 MR. AMIN: Thanks, Sue. Bill?

1 Oh, was there any more public
2 comment? I'm sorry. Okay, no.

3 DR. WEINTRAUB: So flexible but
4 within limits. And every time in a modeling
5 exercise of any kind I hear flexibility, I
6 always get worried because it opens the door
7 to multiplicity.

8 And so a certain amount of
9 flexibility but specified in advance so that
10 people don't sit off and say well they just
11 will do whatever they want to until they find
12 the answer that they like. That is just not
13 valid when people do that.

14 MR. AMIN: Jennifer.

15 MS. EAMES-HUFF: I think this is a
16 reflection somewhat repetitive of what people
17 are saying of where we are in a point in time.
18 I don't think we have enough evidence to know
19 what is the best attribution method or which
20 one is appropriate for which use. So it is
21 hard to create a single standard without
22 having a sense of having enough evidence

1 around it.

2 Yet, this is a standard setting
3 organization and I think ultimately we would
4 like to move to some consistency across the
5 market. So it seems like there needs to be
6 some way that maybe a role NQF could help
7 start driving standardization and consistency
8 while we are still in the phase of evidence
9 gathering and trying to understand. I think
10 that is perhaps where some of the guidelines
11 or principles could come into play in terms of
12 what would be guidelines or principles that
13 the attribution methods would be sort of
14 assessed by.

15 Because I think the other thing, I
16 will just raise as another issue, is if the
17 measures don't end up in the same committee,
18 you get the variance across committees as
19 well, like it becomes a different group
20 reviewing it. So there needs to be some level
21 of consistency across groups as well over
22 time. And I think that is where the

1 principles come up as well.

2 MR. AMIN: Lina and then Jack.

3 DR. WALKER: I have a clarifying
4 question. So is it the case that when NQF
5 evaluates a measure that the committee would
6 look for best in class on all the different
7 components of the measure and also looking for
8 broad applicability?

9 So I mean I hear some of the
10 comments about like there needs to be
11 flexibility for local regions or some even
12 using the term standardization. But it seems
13 to me that if the goal is to evaluate the
14 merits of the measure, you want to -- the
15 developer should be looking at the best
16 possible approaches to achieving that
17 particular stated goal. And to say that there
18 could be different types of attribution
19 approaches, which presumably could result in
20 different outcomes for that measure, makes it
21 a little bit harder, I think, for the
22 committee to evaluate that particular measure

1 for endorsement.

2 DR. NEEDLEMAN: I think it is
3 useful in thinking through the issue of
4 getting it right. Because I am not sure that
5 there is always a best in show but we are
6 talking about trying to get it right. That
7 when we look at how measures get developed,
8 they get developed in two very different
9 contexts and we have heard that referenced
10 today.

11 In some cases, substantial
12 elements of a measure are developed in
13 negotiation with a lot of iterations from
14 experience of folks who are going to have to
15 use the measure.

16 So we heard Joe talk about the
17 negotiations in Michigan with providers about
18 attribution. And there are lessons that can
19 be learned from that because I suspect there
20 were a lot of different things on the table.
21 Some data, but perhaps not always data being
22 analyzed there but some data saying well what

1 is the implication of doing it this way versus
2 that way. And you get certain experience
3 there. And I heard I think Nancy say a
4 similar sort of thing happening in Minnesota.

5 Others of these measures, and I
6 can say this because I have developed some,
7 are developed with the data in the privacy of
8 your own room. And there are some strengths
9 to doing that. The validity, reliability kind
10 of testing can take place and take place
11 pretty quickly. But they are not necessarily
12 tempered by the experience of how does this
13 have to be adapted in practice. And I have no
14 idea how the Dartmouth people actually did
15 their attribution model. But if you asked me
16 to place a bet today, I would be betting on in
17 the privacy of our own room, which is fine.
18 But we have got a process where we have got to
19 think about getting it right and learning by
20 doing. And the question is, at what point
21 does the endorsement have to narrow the range
22 of choices in getting it right?

1 And there are some areas where I
2 think it is clear just looking at whatever is
3 coming in that something was done wrong and
4 should be reversed. There are other cases
5 where it is not clear what the right answer
6 is. I think we saw that with risk-adjustment.
7 I think we see that to some extent with some
8 of the different attribution models we have
9 seen walk in here in both Phase I and Phase II
10 of the resource use measure.

11 So what we need is to, I think,
12 allow some flexibility. But even more
13 important, we need to think about how we are
14 going to learn.

15 So if somebody were bringing in a
16 measure with attribution based upon the
17 Michigan negotiations or the Minnesota
18 negotiations, I would want to hear how did you
19 get there. Because how you got there is an
20 important part of understanding why this
21 attribution method, why you think this
22 attribution method works. What are the

1 alternatives? What happened when you tested
2 them?

3 We heard the CMS, the Mathematica
4 people say we tested a lot of different
5 attribution models. And basically, all the
6 patients wound up in the same groups most of
7 the time, almost all of the time, actually I
8 think was about the characterization. And
9 that is powerful and that is working in the
10 privacy of your own room but it is a powerful
11 test. We tried it a lot of different ways and
12 we come up with very similar results and then
13 we picked this one because within this range
14 of things, it doesn't make any difference.

15 But I think we need to hear those
16 stories in order to make decisions about
17 whether this is good enough to endorse either
18 as a standard or as a guideline or to suggest
19 how much range within guidelines should be
20 allowed when we are not quite sure what the
21 exact right answer is.

22 MR. AMIN: Gene and then Karen.

1 DR. NELSON: Jack always makes
2 great points. That attribution word can't
3 happen at the other end of the hall, so I am
4 not quite sure if it was highly collaborative
5 or in their own offices.

6 (Laughter.)

7 DR. NELSON: I will check into
8 that. We think we are good at partnering with
9 real places but we might not be.

10 But the issue of attribution, just
11 a general thought is that as we try to get
12 alignment across different kinds of
13 performance measures, be they outcomes or
14 costs or resource use or technical quality for
15 patient experience, there is the different
16 levels of performance. So it might be a
17 provider. It might be a hospital. It might
18 be a nursing home. It might be an ACO. It
19 might be a medical home.

20 So for me, I think one of the
21 issues is to make sure that the attribution is
22 consistent at different levels of

1 responsibility so that if it is a provider
2 level measure, an individual doctor level
3 measure, there should be an attribution method
4 across the different quality measures. If it
5 is an ACO, there should be an attribution
6 method across ACOs. If it is a hospital, it
7 is simpler. But I think that is one point is
8 that the attribution methods should be similar
9 across measures for different levels of the
10 health system and that we should be trying to
11 align the attribution method across all the
12 quality measures.

13 MR. AMIN: Karen?

14 DR. PACE: Yes, I just wanted to
15 clarify that I don't think that we are
16 proposing that we are ready to pick one
17 attribution method that applies to every
18 single measure. I think we are just trying to
19 sort out whether, in our terminology, if it is
20 a guideline, that means it is kind of
21 voluntary. And it sounds like when you all
22 have been evaluating measures, you have been

1 evaluating whether it is called a guideline or
2 specification for the attribution method.

3 And so I guess my question is if
4 you endorse a measure and whether the
5 attribution method was called a specification
6 or a guideline, would you expect that that
7 measure could be used in somebody say well the
8 attribution method was a guideline and I have
9 decided I am just going to use a totally
10 different attribution method that I have made
11 up. Would that still be what you intended by
12 endorsing a performance measure?

13 So I guess maybe we need to get to
14 what we are talking about with the guideline
15 and what that implies for endorsement versus -
16 - you know, maybe we are just talking about
17 words with no distinction or maybe we are
18 really talking about something very different.

19 DR. DAMBERG: Maybe I was naive
20 coming into this process but I guess I thought
21 it was part of the specifications. So it is
22 kind of interesting to hear at the end of the

1 meeting it wasn't.

2 And I guess then the question is,
3 how would that have changed my evaluation of
4 what I was looking at over the course of the
5 past two days? And I mean I totally get the
6 need for flexibility here. And I definitely
7 think it is worth considering more. Are there
8 certain specific applications where you would
9 want to call out, shouldn't be used or
10 attributed in these ways. So maybe start from
11 that side, rather than sort of saying it can
12 be applied in like a thousand flowers bloom
13 approach. So call out where it shouldn't be
14 done.

15 I don't know. I sort of feel like
16 there needs to be a few bounds put around it.
17 Because I am not sure we would have all agreed
18 that the total cost of care measure could be
19 applied in 15 different ways.

20 So I think it is just hard to
21 evaluate the measure without having some
22 context in which you are applying it.

1 MR. AMIN: It sounds like we got a
2 pretty robust conversation around this topic
3 with various different perspectives but
4 generally coalescing around where you were
5 going, Cheryl.

6 Tom. Let's kind of end it with
7 Tom and then I am going to turn it back to
8 Ashlie to talk about our gaps discussion for
9 our last hour.

10 DR. TSANG: I don't know if I can
11 kind of tweak Jack's comment about using the
12 word flexibility as much as more of the
13 parameters and the descriptors of the
14 methodology itself.

15 So in my mind, in the future I
16 would want to understand like the transparency
17 of the methodology or the robustness and the
18 reproducibility of that methodology itself,
19 not so much as is it right or wrong but rather
20 the parameters of how the organization, how
21 the measure steward and the developer came up
22 with that methodology.

1 And so with the CMS measure, like
2 we understand. They explained it and we
3 understand. And you may or may not agree with
4 it but I think we understand the flaws and the
5 characteristics and the strengths of that
6 methodology.

7 And so that is what I would take
8 home as the future evaluation process of
9 attribution. Does that make sense?

10 MR. AMIN: Yes. Okay, so I will
11 turn it over to Ashlie for our final piece of
12 today's discussion.

13 MS. WILBON: Thanks. So I know we
14 are kind of dropping like flies. So we are
15 going to -- this last discussion is really
16 more of a kind of 50,000-foot forward thinking
17 kind of providing us some insight on where we
18 go next in this particular measurement arena.

19 I do want to have one order of
20 logistics or what have you. Lindsey passed
21 around I think to some of you whose laptops
22 probably weren't open, a piece of paper with

1 some survey questions on it. We really want
2 to hear you feedback on how your experience
3 has been on the committee thus far. I think
4 she also sent out a SurveyMonkey link via
5 email. So if you are not able to do it on
6 paper before you go, please on your way home
7 or something while it is fresh in your mind,
8 submit some feedback to us. We really
9 appreciate that. So I just wanted to say that
10 before we lose any more people.

11 So this last discussion is
12 something that we generally do with our
13 committees to figure out kind of where the
14 next steps are in a particular measurement
15 area. Obviously, this is only our second
16 project around cost and resource use. So in
17 terms of the number of endorsed measures that
18 we have compared to the number of endorsed
19 quality measures is obviously, a lot less.
20 And so if we are looking at gaps, obviously,
21 there is going to be a huge gap because we
22 just don't have a lot of endorsed measures and

1 cost measures.

2 And as you have gone through the
3 process these last few days, you can see how
4 much time it takes not only for reviewers but
5 for developers to develop measures. But we
6 would really like to hear your input on kind
7 of the types of cost and resource use measures
8 that we really should be looking for. We are
9 really trying to take on a role with working
10 with developers earlier on as Taroon
11 mentioned, to really give them some insight
12 and some feedback on where the development is
13 really needed and where they should be
14 focusing their money and time.

15 So insights on that, obviously we
16 have talked about a lot of different issues.
17 We don't necessarily don't need to go back to
18 risk adjustment and attribution. But there
19 are some other issues around resource use
20 measure and our cost measurement broadly
21 within the context of maybe where we are going
22 with the healthcare system that you may want

1 to identify. We would be interested in
2 hearing those.

3 In addition to doing endorsement
4 projects, we do also convene experts around
5 specific topics, like we were talking about
6 earlier convening people around to talk about
7 risk adjustment and the impact on quality and
8 resource use measures. So those topics are
9 also of interest.

10 And then kind of this forward
11 thinking thought, your thoughts in terms of
12 where we go with the sufficiency measurement
13 issue. We have been, I think, since 2009
14 since we did our first resource use project,
15 have really been looking forward and trying to
16 figure out how we actually make this linkage
17 between cost and quality measures. What does
18 that actually look like and where do we start?
19 Is it just sitting down and figuring out which
20 quality measures, how many quality measures
21 you actually link with a cost measure? Is it
22 just one? How do you do that across an

1 episode? How to make a patient-centered.
2 What things need to align? Do risk-adjustment
3 methods for the outcome measure that you link
4 with it need to be the same risk adjustment
5 that is used in the cost measure. You know
6 there are so many different issues there but
7 any insights you have on that would be useful.

8 I know I am throwing a lot oat you
9 but we have only got 30 minutes, so just throw
10 out what you have got before you have to
11 leave.

12 And then a much bigger issue,
13 which I am sure we won't be able to get to all
14 of these but suspect, at some point in time,
15 that we will be evaluating groupers or
16 potentially a grouper. And even episode-based
17 measures and any thoughts in particular on how
18 this evaluation process, we have looked at
19 total cost kind of per capita measures, and
20 what specific ideas you have around how the
21 evaluation criteria applies or the discussions
22 that we have, how that might apply to

1 different types of cost and resource use
2 measures beyond just the per capita total
3 costs measure. I guess we did have the
4 hospital episode-based measure. But kind of
5 the more condition-specific focuses I think is
6 where I was going with that.

7 So four really big buckets.

8 Again, we are just looking --

9 DR. NEEDLEMAN: We are here for
10 another two days, right?

11 (Laughter.)

12 MS. WILBON: Yes, we could
13 probably have two-day meetings around each of
14 these things. But again, this is just kind of
15 getting your insights on some of the bigger
16 issues that we are kind of grappling with and
17 where we go on next steps.

18 So if anyone has any thoughts, we
19 are open to hearing them.

20 MR. AMIN: Daniel?

21 MR. WOLFSON: I have to say this
22 before the meeting is over. And I know this

1 is a MAP issue. But to think that we are
2 going to only look at existing cost and not
3 appropriateness misses the mark. Because
4 everything you are measuring, you think it is
5 appropriate. We know that the measure of
6 appropriateness is about 30 percent is not
7 appropriate, is not necessary and is waste.

8 So it baffles my mind that we are
9 focused on existing costs and assuming that
10 every admission is appropriate. And we know
11 that is not true.

12 So I had to say that before the
13 meeting -- I know that is a MAP issue but I
14 waited until the end to say that.

15 DR. BURSTIN: It is actually not
16 just a MAP issue. I mean, broadly we bring
17 appropriateness in our measures to every
18 single clinical committee at NQF. We have
19 actually got a couple dozen of them now. We
20 are trying to work with the specialty side to
21 get additional ones in. It just isn't
22 appropriate for this particular committee of

1 cost and resource use.

2 MR. WOLFSON: Okay.

3 DR. BURSTIN: It is usually
4 required in the clinical ones.

5 MR. WOLFSON: I knew it wasn't
6 appropriate to say. I waited until the end.

7 DR. BURSTIN: No, you said it.

8 MR. WOLFSON: I know it wasn't
9 Helen. I bit my tongue for two days.

10 And then too, I have heard it said
11 that we have to wait for outcome measures, I
12 don't know if that was true, of quality to
13 bake into an relate to the cost. And that
14 worries me because the outcome measures are so
15 underdeveloped that can we use intermediate
16 outcomes. I mean are we really talking about
17 outcome measures? Because I worry that will
18 impede the progress of cost measures, if we
19 are waiting for the ultimate outcome measure
20 to correspond to it.

21 And then if we get into process or
22 any immediate process, it really baffles the

1 mind about what would be the associated
2 process measures to go with the cost. It
3 would maybe -- mortality is pretty crude.

4 So I think that is a real huge
5 challenge but I worry about waiting for the
6 ultimate outcome measure.

7 MS. WILBON: Yes, I will just
8 comment on that. I think you are probably
9 getting that from one of the MAP input slides
10 that we had, where they were more focused on
11 pairing or linking cost measures that would be
12 endorsed with outcome measures. I think that
13 was probably their preference to have outcome
14 measures but would it be the end all/be all
15 that they wouldn't move forward with
16 recommending other quality measures that
17 weren't outcome measures.

18 And if you really kind of look
19 across the episode, an episode of care for a
20 patient, there is various areas across that
21 patient's interaction with different
22 healthcare systems and providers where process

1 measures would be appropriate and obviously
2 outcome measures as well. So it doesn't
3 exclusively mean outcome measures. But I
4 think there is a preference to have at least
5 some outcome measures in that picture.

6 MR. WOLFSON: Helen, how can I get
7 my hands on the appropriate measures that you
8 guys are reviewing?

9 DR. BURSTIN: We have a list we
10 have been generating. I can send them along.
11 We need many more but we have got a good
12 number to start.

13 MR. AMIN: Bill, Jack and
14 Jennifer.

15 DR. WEINTRAUB: So anyway, it has
16 been a great couple of days. I always say
17 that I learn much more than I could possibly
18 contribute. I think the process is
19 fundamentally a good and sound one.

20 In terms of what measures, I mean
21 these two measures, these last few days, these
22 were big ticket items. And there are big

1 ticket issues before us. And I think this is
2 appropriately where we should be, look for the
3 things that really are critical to our
4 healthcare system.

5 You know I was on the last one,
6 too, with cost and these were bigger. As you
7 and I had that discussion, these are bigger
8 and more important than the last go round.
9 And probably appropriately so because we were
10 sort of treading water or learning how to do
11 this the last time, dipping our toes into the
12 water I should say.

13 And clearly a lot of time is
14 needed for discussion. The last time we
15 didn't have enough time. There were too many
16 things we tried to do in too short a period of
17 time. This is really good that we could sort
18 of really dive in and everybody had time to
19 say what they think.

20 I just want to comment a little
21 bit on how we are going to relate clinical
22 outcomes measures to cost measures. No easy

1 task. I have been involved in cost
2 effectiveness analysis, as some of you are
3 probably aware for 20 years. And that kind of
4 methodology doesn't really apply here. At
5 least I don't think so. But I think a lot of
6 thought needs to go in on how we are going to
7 make these work together. We are probably not
8 there yet.

9 MR. AMIN: Jack?

10 DR. NEEDLEMAN: A couple of issues
11 that strike me is important is one based on
12 the past experience both in phase 1 and in
13 this phase. We talked about attribution to
14 providers today a lot and that is where we
15 finished. But we have also got the question
16 of what the scope of the costs are. And that
17 has come up when somebody gets hit by a bus
18 500 miles from where they live or 1,000 miles
19 from where they live, do those costs get
20 lumped in? Is there any way to differentiate
21 that? So you have got that issue with an all-
22 cost measure.

1 When we were looking at specific
2 diseases on the last go round, it definitely
3 came up which costs. We had some measures
4 which were patient, patients with diabetes but
5 then all costs. But we also had some measures
6 which we were trying to get at the episode
7 issue. And there are all kinds of issues in
8 figuring out what gets counted in the episode.
9 So we saw that a little bit with the first
10 measure today.

11 So that is going to be an ongoing
12 issue and one in which we are going to learn
13 through the struggle about how to think about
14 those. But we need to make sure that -- so
15 that is going to be one of the critical
16 issues.

17 We ought to be thinking about some
18 not all-patient all-cost measures but I think
19 that I would like to see us revisit things
20 like diabetes and some of the cardiac
21 patients, and some of the other patients where
22 we know that they have got high, potentially

1 high costs. And we want to look at what the
2 variations in the costs are and what the
3 variations in the outcomes are.

4 I think in terms of the risk-
5 adjustment models, as we look at this all-cost
6 thing, an issue I raised almost offhandedly
7 the other day, earlier today or yesterday, I
8 lost track, was thinking about how well the
9 risk adjusters do in predicting non-
10 discretionary use of specific services.

11 So how do we think about the
12 hospice costs being in here? How do we think
13 about the readmissions? How do we think about
14 the SNF costs? If you have had a hip
15 replacement, you are going to be in a SNF for
16 a few days.

17 So thinking about how well the
18 risk adjusters are doing it at differentiating
19 the discretionary costs and perhaps the excess
20 costs, allowing us to pull out the
21 nondiscretionary elements and think about that
22 are going to be one of the directions we are

1 going to be asking people who are doing risk
2 adjustment to be moving into or at least
3 analyzing as they get these more global
4 measures of costs and resources.

5 In terms of the outcome -- in
6 terms of measuring the other side of the value
7 thing, which is the outcomes, lots of issues
8 with process measures, including their
9 completeness. Lots of issues with outcome
10 measures, including how much they are
11 attributable to what is going to the actual
12 care. And those need to be resolved.

13 I actually like the CMS display of
14 the grid, showing the performance on the
15 measures that were there and the performances
16 on costs. Because I think that is a good way
17 of not getting a single number but looking at
18 the way things distribute. The question there
19 is were the process measures that were
20 included in where you got on that grid in
21 terms of value sufficient, adequate, complete
22 enough to be a full measure of the quality of

1 the care that one was getting. So I think the
2 completeness of those sets and how they get
3 pulled together in measurement is going to be
4 another issue that is going to come up as we
5 begin looking at the value side of the
6 efficiency measurement issue.

7 So multiple measures of outcome,
8 multiple measures of process. How they get
9 integrated and coordinated into a composite
10 measure is going to be an important issue for
11 this committee or the next committee that is
12 dealing with this set of issues.

13 DR. NELSON: Jennifer, and Dick,
14 and Tom.

15 MS. EAMES-HUFF: If we are truly
16 going to get at the affordability issue, we
17 have to go beyond just looking at resource use
18 and standardized prices. And we need to look
19 at the prices that are on the market.

20 We know that resource use only
21 plays a portion of the variation in the market
22 and that prices widely vary and that that is

1 contributing to the rising costs and the
2 unaffordable healthcare.

3 And I think this becomes even more
4 important as we are moving towards more
5 coordinated care, which I think is the right
6 direction, improving quality, having better
7 coordination but it is also bringing providers
8 together and creating market power in some
9 instances, which we could be improving quality
10 but we could also be improving prices at the
11 same time. Well not improving -- I mean
12 increasing. That is not an improvement.

13 MR. WOLFSON: CMS took a big step
14 yesterday doing that for at least 100
15 procedures and what they cost around --

16 MS. EAMES-HUFF: What they charge,
17 which charges don't really mean anything.

18 MR. WOLFSON: Well they showed
19 variations.

20 MS. EAMES-HUFF: Yes, but they are
21 not --

22 DR. NELSON: So, Dick. Dick, your

1 card is up. David -- sorry.

2 DR. REDFEARN: I just want to put
3 a plug in for more episode-based measures.
4 Because I think to some extent it adds some
5 complexity but I think it simplifies
6 attribution because you know what are you
7 attributing to taking care of that episode.
8 I think it also makes it a little bit easier
9 to choose quality measures. It simplifies
10 that.

11 So I think there is a lot of
12 advantage to that. The disadvantage to you
13 guys is you are going to have a lot more
14 measures. And for us, that means a lot more
15 time looking at measures. But I think there
16 are some inherent advantages to those because
17 they focus very nicely.

18 And the only other thing I would
19 add is that just I would suggest to reach out
20 to the vendors, and particularly to Optum to
21 try to get them involved in this process
22 because I know we have got some episode

1 measures coming up and I actually talked to
2 Tom Lin and said are you guys going to submit
3 and he said no. He said we had a bad
4 experience and we are not going to do it
5 again.

6 So I think it would be nice if you
7 could reach out to them again and encourage
8 them because I would hate to see you guys lose
9 that. They could still choose that they don't
10 want to do it.

11 MS. WILBON: We have been in
12 contact with them and we have had some calls
13 with them. So yes, thanks.

14 DR. NEEDLEMAN: We have nothing to
15 apologize for.

16 DR. NELSON: Tom?

17 DR. REDFEARN: this is actually a
18 reference to the Gretzky Group and the work
19 that you guys have done.

20 And I still have very much faith
21 in this eMeasure business. And it is related
22 to Jack's suggestion about a composite measure

1 combining these type of resource measures,
2 along with outcomes measures. And I see a
3 real future in doing that with some of the
4 outcomes data that you can gather and derive
5 from the EHR clinical data.

6 And if there is a way and a
7 mechanism of whether it is this group or
8 whether it is calling out to measure stewards
9 or whether you are going to incubate this
10 process, I think there is a real opportunity
11 to leverage and interrogate some of the
12 clinical data and combine it with some of the
13 patient-reported outcome data, as well as a
14 resource measure and really create a robust
15 platform for a composite measure.

16 DR. NELSON: Thank you. Taroon.

17 MR. AMIN: Actually, it is very
18 much along the lines of Tom, your comments.
19 it is actually a question. As we look to sort
20 of the conceptual framing, just as everyone
21 walks out -- oh, Evan, if you could go to the
22 building block slide.

1 You know this has been one of the
2 sort of conceptual framings of this Work
3 Group, in addition to the patient-centered
4 episode of care framework. But well actually
5 this is sort of where I was going. So when we
6 look at the cost and one of the things that we
7 have talked about over and over again is how
8 do we get to the measures of efficiency and
9 value. And one of the hypotheses that started
10 this group was that let's really get sound
11 measures, sound usable measures of resource
12 use and then we will be able to get toward
13 measures of efficiency and value.

14 What are we really looking for
15 when we were talking about efficiency
16 measures? Do we really think, sort of Tom and
17 Jack sort of pointed out, are we really
18 looking for some type of composite that can
19 actually build these two various different
20 sort of conceptual domains together or are we
21 may be looking for something that is not in an
22 individual measure, yet in a way that is

1 reported or more like program features,
2 meaning something that we see in sort of
3 value-based purchasing where you have various
4 different domains and you weight those domains
5 in a certain way.

6 So what exactly is it that we are
7 looking for and how do we know we get there?

8 DR. NELSON: I'm glad you asked
9 that with six minutes left. That is an easy
10 question.

11 MR. AMIN: Sorry, Gene.

12 DR. NELSON: So Jack and we should
13 have a pause for public comments and then wrap
14 up the next steps.

15 DR. NEEDLEMAN: Just one last
16 comment on the journey we have been on. And
17 this may be not our job here. But once again,
18 all of the resource measures that we have
19 looked at have basically been generated by
20 claims files, by billings. And that has very
21 important implication for actually measuring
22 resources. There are all kinds of services

1 that individual groups and physicians' offices
2 and health systems are providing, which are
3 affecting care, which are not billed for, and
4 therefore invisible to this process. And if
5 we are trying to understand, part of this is
6 to get measures to evaluate people but the
7 other is for learning.

8 And there are all kinds of things,
9 all kinds of resources being used. The way we
10 are currently measuring resources are
11 invisible and, therefore, we can't learn what
12 works and what doesn't. And that is an
13 important limitation to this.

14 The other thing is, as we go back
15 to increasing bundled payments, ACOs,
16 capitated primary, patient-centered medical
17 homes, we are expecting all kinds of
18 interactions to take place among people in
19 those organizations that are not billed
20 interactions. Yet, we will have important
21 consequences for how well they perform.

22 And if we are trying to understand

1 how well the health system does, we need to be
2 able to understand whether those are taking
3 place, whether they are taking place at
4 different rates and what difference it is
5 making in the care that people are receiving.
6 So we need to think about how to do that.

7 The other thing is, as we move to
8 bundled payments, if the past is any guide to
9 the future, the billing and encountered data
10 will become crappier again because we are not
11 getting paid on it and we have got to worry
12 about that in terms of the quality of the
13 input for even the billing based measures that
14 we are currently working with.

15 DR. NELSON: Thanks for those
16 comments. Another gap, quickly, would be the
17 indirect costs that the community and the
18 employers are paying that we aren't capturing
19 in our current approaches.

20 So Jennifer's card's up. Nancy,
21 and then public comment.

22 DR. GARRETT: Just a quick

1 comment, which is in the provider world that
2 I am in right now there is a real divide
3 between quality measures, between kind of the
4 quality type of work and type of data, and the
5 financial data. And I think that is something
6 that we are really going to have to evolve
7 towards. And I think NQF could play a
8 leadership role there. There just tends to be
9 a real segmentation.

10 And I went back last night and I
11 emailed to try and figure out where our
12 Medicare spending per beneficiary reports are.
13 And the quality person got them and sent them
14 over to finance and they were sitting on their
15 desk and no one had really looked at them. So
16 that is what I will be doing tomorrow.

17 So maybe you need to change your
18 name to National Value Forum instead of
19 National Quality Forum.

20 DR. NELSON: Public comment,
21 anyone in the room or on the phones. Not in
22 the room. Do we have anyone on the phones?

1 MS. TIGHE: Operator? Operator,
2 is there anyone on the phone who has a public
3 comment?

4 OPERATOR: To make a comment at
5 this time, please press *1. There are no
6 comments.

7 DR. NELSON: Okay, so Ashlie and
8 Lindsey, next steps. Wrap up.

9 MS. TIGHE: Okay, so next steps
10 staff will go back and take the many
11 recommendations and comments you made and try
12 to synthesize this into something that is
13 meaningful and understandable. And we will
14 send that back to you in late June, early July
15 for your review and your input. We will be
16 posting it for a public and member comment
17 period for 30 days, starting July 9th.

18 And then after we get all of those
19 comments, which the predictions were hundreds,
20 we will be convening you all via conference
21 call to review the comments and make any
22 updates to your recommendations.

1 After that, it goes through the
2 rest of the process to NQF member voting,
3 CSAC, and then ultimately Board of Director
4 review and appeals.

5 MS. WILBON: So actually after all
6 that, we actually finished on time. Can you
7 guys believe that?

8 (Laughter.)

9 MS. WILBON: One minute early.
10 Again, just a huge thank you to everyone for
11 coming out. I know a lot of you came from
12 very far away. And were really happy with
13 having such an amazing group of people around
14 the table. And so we are really excited about
15 going forward and seeing how other people feel
16 about our work today. They are as excited
17 about it as we are.

18 So again, we will be following up
19 via email. Either Lindsey or I will be in
20 touch with further information. Again, if you
21 can fill out you surveys, that would be great.

22 Thank you and safe travels.

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(Whereupon, at 2:27 p.m., the
foregoing proceeding was
adjourned.)

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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: 05-09-13

Place: Washington, DC

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