

NATIONAL QUALITY FORUM

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COST AND RESOURCE USE STANDING COMMITTEE

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WEDNESDAY

MARCH 15, 2017

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

PRESENT:

BRENT ASPLIN, MD, MPH, Co-Chair

CHERYL DAMBERG, PhD, Co-Chair; Principal Senior Researcher, RAND Distinguished Chair in Healthcare Payment Policy

LARRY BECKER, Retired*

MARY ANN CLARK, MHA, Vice President, Avalere*

JENNIFER EAMES HUFF, MPH, CPEH, Principal, JEH Health Consulting; Senior Advisor, Pacific Business Group on Health

TROY FIESINGER, MD, FAAFP, Physician, Chairman Quality Committee, Village Family Practice of Fort Bend*

NANCY GARRETT, PhD, Chief Analytics Officer, Hennepin County Medical Center

ANDREA GELZER, MD, MS, FACP, Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas*

MARTIN MARCINIAK, MPP, PhD, Vice President, US Medical Affairs, Customer Engagement, Value, Evidence and Outcomes,

GlaxoSmithKline

KRISTINE MARTIN ANDERSON, MBA, Executive Vice
President, Booz Allen Hamilton

JAMES NAESSENS, ScD, MPH, Professor, Mayo Clinic

JACK NEEDLEMAN, PhD, Professor of Health Policy
and Management, UCLA Fielding School of
Public Health

JANIS ORLOWSKI, MD, MACP, Chief Health Care
Officer, Association of American Medical
Colleges

BETTY RAMBUR, PhD, RN, Routhier Endowed Chair
for Practice and Professor of Nursing,
University of Rhode Island*

JOHN RATLIFF, MD, FACS, FAANS, Associate
Professor of Neurosurgery; Vice Chair,
Operations and Business Development; Co-
Director, Division of Spine and Peripheral
Nerve Surgery, Department of Neurosurgery,
Stanford University Medical Center,
American Association of Neurological
Surgeons*

SRINIVAS SRIDHARA, PhD, MHS, Managing Director,
The Advisory Board Company

BILL WEINTRAUB, MD, FACC, Chair of Cardiology,
Christiana Care Health System*

HERBERT WONG, PhD, Senior Economist, Agency for
Healthcare Research and Quality

DOLORES YANAGIHARA, MPH, Vice President,
Performance Measurement, Integrated
Healthcare Association

NQF STAFF:

TAROON AMIN, MPH, PhD, Consultant

HELEN BURSTIN, MD, MPH, FACP, Chief Scientific
Officer

HIRAL DUDHWALA, RN, MSN/MPH, Project Manager

ERIN O'ROURKE, Senior Director

RACHEL ROILAND, MS, PhD, Senior Project Manager

IRVIN SINGH, MPH, Project Analyst

ASHLIE WILBON, RN, MPH, Senior Director

MARCIA WILSON, PhD, MBA, Senior Vice President,
Quality Measurement

ALSO PRESENT:

CHAD HEIM, Vice President, Health Informatics,
HealthPartners*

GARY KITCHING, Senior Manager, Health
Informatics, HealthPartners*

SUE KNUDSON, MA, Senior Vice President, Health
Informatics, HealthPartners*

SRINIKETH NAGAVARAPU, PhD, Senior Policy
Associate, Acumen

KIMBERLY SPALDING BUSH, OT, Director,
Performance-Based Payment Policy Group,
Center for Medicare, Centers for Medicare &
Medicaid Services

SCOTT WETZEL, Senior Specialist, Quality
Reporting, Association of American Medical
Colleges

* present by teleconference

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

2 (9:10 a.m.)

3 DR. ROILAND: All right, good morning
4 everyone and welcome to today's meeting of the
5 Cost and Resource Use Standing Committee. My name
6 is Rachel Roiland, and I'm the Senior Project
7 Manager for this project and, along with the rest
8 of the staff up here today, we'll be guiding you
9 through this evaluation of three measures today.

10 But before we do that, I just want to
11 provide some housecleaning details. Irvin, if
12 you could go to the next slide please? All
13 right. We'll just wait until it loads there --
14 all right.

15 Just so you all are aware -- if you
16 could go back one slide Irvin -- there are
17 restrooms available on this floor of the
18 building. If you go outside this room and go
19 straight past the elevators and hang a right,
20 that's where you'll find the restrooms.

21 We do have two breaks scheduled for
22 today, the first at 10:45 in between our

1 evaluation of the two health partners measures,
2 and then lunch is also provided today by NQF.

3 For those of you with laptops and cell
4 phones in the room, we do have a WiFi network
5 available for you and the log-in and username and
6 password are available upon the screen.

7 We do ask those of you who have cell
8 phones if you could please mute then during the
9 meeting just to minimize distractions.

10 And if you do need to take a phone
11 call you're more than welcome to do that, we just
12 ask that you go out into the area where you
13 picked up your name tags, just to minimize the
14 background noise when we're having discussion.

15 For those of you in the room, we do
16 ask that you use your microphones when you're
17 talking and talk directly into the microphone,
18 just so that it helps the folks who are listening
19 in to better hear everything going on.

20 And it also helps our court reporter
21 take a better transcript. And also just a little
22 note -- there can only be three microphones on at

1 one time, so when you're done speaking, please
2 make sure to turn your microphone off.

3 And then when you do want to speak, we
4 ask that those of you in the room put your name
5 tents up, like this. It just helps Brent and
6 Cheryl know who to call on.

7 And then for those folks on the phone,
8 or participating in the webinar, we ask that you
9 raise your hand by the webinar platform, and that
10 will signal to us that we need to let Brent or
11 Cheryl know that you'd like to jump in and be a
12 part of that conversation.

13 So that's all the housekeeping stuff,
14 and now I'll turn it over to Erin O'Rourke, our
15 Senior Director, to just give us some opening
16 remarks, and we'll introduce the rest of the
17 staff.

18 MS. O'ROURKE: Thank you so much
19 Rachel, and thank you to all of you for braving
20 the inclement weather and getting down here, or
21 for those of you who are on the phone, for
22 bearing with us for an extended web meeting. We

1 really appreciate everyone's efforts to come
2 together today and do this work, so thank you.

3 So I think with that, I can just
4 introduce myself. I'm Erin O'Rourke, the Senior
5 Director supporting this project and I'm excited
6 to work with you all, joined by obviously Rachel,
7 our Senior Project Manager, Hiral Dudhwala, our
8 Project Manager, and Irvin Singh, our Project
9 Analyst. We also have Taroon Amin, consultant
10 for NQF helping to support this work. I think
11 many of you have worked with him in the past.
12 We're joined also by Helen Burstin, our Chief
13 Scientific Officer, and Marcia Wilson, our Senior
14 Vice President. So that's the NQF team, and I
15 think with that I can turn it over to Brent and
16 Cheryl to say a few words.

17 CO-CHAIR DAMBERG: Great, thanks
18 everyone for joining us in person today, and for
19 those of you on the phone, I know it's going to
20 be a long day but thanks for joining us and
21 hanging in there throughout the day.

22 We have three measures that we're

1 going to review today and I know all of you spent
2 a fair amount of time looking through them and
3 probably have a lot of interesting comments to
4 provide, and so we'll look forward to that
5 discussion.

6 CO-CHAIR ASPLIN: Good morning
7 everyone. Brent Asplin. It's good to see a lot
8 of familiar faces in the room, and look forward
9 to the conversation today.

10 And background, emergency physician,
11 I was recently at Mercy Health in Ohio and
12 Kentucky as the Chief Medical Officer, and look
13 forward to the conversation and the dialogue
14 around these methods this morning and this
15 afternoon.

16 And with that I'll turn it over to
17 Marcia Wilson, and we can go through the
18 declarations of conflicts.

19 DR. WILSON: Thank you so much,
20 Brent. As Erin said, I'm Marcia Wilson, Senior
21 Vice President for Quality Measurement, and I'm
22 filling in for our general counsel today.

1 It's our custom here at NQF to combine
2 introductions and disclosures of interest. And I
3 know when you signed up for this committee, you
4 got a very long DOI form, disclosure of interest
5 form.

6 And today we're going to ask you to
7 orally disclose any relevant activities, relevant
8 in terms of the work before this committee.

9 So, it's not necessary to summarize
10 your resume, you are a stellar committee, and so
11 we bring considerable expertise to this panel,
12 but we do want to know if you have any
13 activities, funded or unfunded, that are directly
14 related to the measures and the issues coming
15 before the committee today.

16 So, just a couple of reminders. You
17 sit on this committee as an individual, you don't
18 represent your organization. So, for example,
19 when you do your introduction you would say, hi
20 I'm Marcia Wilson and I work at the National
21 Quality Forum.

22 So you are seated as an individual,

1 and just because you disclose something, it does
2 not mean that you have a conflict. But we do this
3 is the spirit of transparency and openness. So,
4 what we are going to do is start with
5 introductions and disclosures.

6 Here in the room, I'm going to start
7 with our Co-Chairs. We'll go around the room and
8 then I know we have quite a few committee members
9 on the phone today, and I will call your name and
10 you can do an introduction and disclosure once
11 we're finished in the room. So Cheryl, if you
12 won't mind starting please?

13 CO-CHAIR DAMBERG Sure, Cheryl
14 Damberg, I'm the Senior Researcher at the RAND
15 Corporation. I have a number of contracts with
16 CMS. One of them in particular is around the
17 Medicare star ratings, which involves us
18 analyzing performance measure data that's
19 submitted by health plans to Medicare and
20 generating the star ratings. But other than that
21 I don't think I have any conflicts related to
22 these three measures.

1 CO-CHAIR ASPLIN: Brent Asplin,
2 currently independent. I do not have any
3 disclosures, although I do think the committee
4 should know that I worked as an Emergency
5 Physician for Health Partners Medical Group about
6 a decade ago, but did not have any direct
7 involvement in the development of the measures
8 we're going to be reviewing today.

9 DR. WILSON: Thank you Brent. And if
10 we go to Janis, next.

11 MEMBER ORLOWSKI: Good morning. I'm
12 Janis Orlowski, and I am the Chief Health Care
13 Officer working at the AAMC, and I have nothing
14 to disclose.

15 DR. WILSON: Thank you.

16 MEMBER NAESSENS: I'm Jim Naessens,
17 I'm a Health Care Researcher at the Mayo Clinic
18 and I have nothing to disclose.

19 DR. WILSON: Thank you.

20 MEMBER SRIDHARA: I'm Srinivas
21 Sridhara I work for The Advisory Board, and I
22 have worked with all three measures actually,

1 part of grant programs in the past and both
2 implementing and testing for the health partners
3 measures, along with Henry so that, though I'm no
4 longer engaged in that and have no role in the
5 measure development process.

6 And for the Medicare spending for
7 beneficiary, we've tested and implemented in both
8 the State of Maryland, and now The Advisory
9 Board. So, but again, no association with
10 measure developers currently.

11 DR. WILSON: Okay.

12 MEMBER NEEDLEMAN: Morning. I'm Jack
13 Needleman, and I'm a Professor in the Department
14 of Health Policy and Management at the UCLA
15 Fielding School of Public Health.

16 I don't think I have any conflicts but
17 in the interest of full disclosure, as Marcia
18 said, I'm sitting as a member of the technical
19 expert panel that CMS is using to evaluate the
20 trends in their quality measures over time, and I
21 believe this measure today is included in the
22 purview of that committee.

1 DR. WILSON: Thank you.

2 MEMBER GARRETT: Good morning, I'm
3 Nancy Garrett, I'm the Chief Analytics Officer at
4 Hennepin County Medical Center, which is a safety
5 net provider in Minneapolis.

6 And I don't have any conflicts to
7 disclose other than just being aware that the
8 HealthPartners measure is used in Minnesota
9 through our Minnesota community measurement
10 organization, and I've been involved in kind of
11 that roll out and using it as a provider as well.

12 DR. WILSON: And again, using measures
13 does not present a conflict.

14 MEMBER WONG: Good Morning. My name's
15 Herb Wong. I am an economist with the Agency for
16 Healthcare Research and Quality and I have
17 nothing to disclose.

18 MEMBER MARCINIAK: Hello, I'm Martin
19 Marciniak, I'm a Vice President with
20 GlaxoSmithKline and a policy economist by
21 training. I worked in the U.S. medical affairs
22 organization.

1 MEMBER YANAGIHARA: Good Morning I'm
2 Delores Yanagihara, I'm Vice President of
3 Analytics and Performance Information at
4 Integrated Healthcare Association in California,
5 and I have nothing to disclose.

6 MEMBER EAMES HUFF: Hi, my name is
7 Jennifer Eames Huff, I'm an independent
8 consultant and participating in this on behalf of
9 the Pacific Business Group on Health. I have
10 nothing to disclose.

11 DR. WILSON: Thank you, and we'll now
12 go to the committee members on the phone,
13 alphabetical just to give you a heads up. We're
14 starting with Larry Becker, are you on the phone?

15 MEMBER BECKER: I'm here Marcia, I'm
16 Larry Becker. Recently retired from Xerox. I'm
17 on the Board of NQF and I have nothing else to
18 disclose.

19 DR. WILSON: Thank you. Mary Ann
20 Clark?

21 MEMBER CLARK: Yes, good morning. It's
22 Mary Ann Clark. I'm a Vice President of Health

1 Economics and Advanced Analytics at Avalere
2 Health. Although I personally have nothing to
3 disclose, I believe in the past some others in
4 our company have worked on behalf of our client
5 to develop quality measures for submission to
6 NQF, but I have not worked directly on any of
7 those and that was in the past.

8 DR. WILSON: Thank you. Is it Troy
9 Fiesinger?

10 MEMBER FIESINGER: Yes, this is Troy
11 Fiesinger. I'm a physician in balmy Houston, I
12 have no conflicts to disclose for today's
13 meeting.

14 DR. WILSON: Thank you. Andrea
15 Gelzer?

16 MEMBER GELZER: Hi, Andrea Gelzer, and
17 I'm Corporate Chief Medical Officer at
18 AmeriHealth Caritas, and I have nothing to
19 disclose.

20 DR. WILSON: Thank you. Kristine
21 Martin Anderson?

22 MEMBER MARTIN ANDERSON: Hi, I'm

1 Kristine Martin Anderson, I'm with Booz Allen
2 Hamilton. I have no conflicts, but Booz Allen
3 does have a number of contracts with CMS, OCM, VA
4 and others, where we are selecting measures for
5 use in new programs, which include efficiency
6 measures.

7 DR. WILSON: Okay, thank you. Betty
8 Rambur?

9 MEMBER RAMBUR: Hi. Betty Rambur,
10 Routhier Chair for Practice and Professor of
11 Nursing at University of Rhode Island and very
12 recently moved from Vermont where I was a member
13 of the Green Mountain Care Board, and I have no
14 conflicts of interest to disclose.

15 DR. WILSON: Thank you. John Ratliff?

16 MEMBER RATLIFF: Hi, good morning.
17 I'm John Ratliff, I'm a neurosurgeon at Stanford.
18 I've done some consulting and collaborative work
19 with Acumen one of the developers on episode
20 groupers for CMS, but I have no conflicts
21 relevant to these measures.

22 DR. WILSON: Thank you. Bill

1 Weintraub? Bill, are you on the phone? Do you
2 show him signed up?

3 Okay, Bill, it may be that you're
4 signed onto the webinar but not called in, so I'm
5 going to go ahead and keep moving on with the
6 DOIs, and then if you are able to join us by
7 phone then you give a -- introduce yourself and
8 give us a disclosure.

9 And I think -- is there anyone else on
10 the phone that I have not called? Okay, just a
11 final comment that if at any time during the
12 meeting you think that you have a conflict of
13 interest, or if you perceive that someone else
14 had a conflict of interest, we do ask that you
15 speak up.

16 You can approach our Co-Chairs, or any
17 of the NQF staff. What we don't want is for you
18 to sit there and think that there's some conflict
19 going on and not bring it to our attention in
20 real time as opposed to waiting later.

21 So, based on what you've heard from
22 your colleagues on the committee, and from the

1 remarks, does anyone have any questions? Okay,
2 thank you very much.

3 DR. ROILAND: All right. Thank you
4 Marcia. Hi everyone, again. This is Rachel for
5 those of you on the phone, and I'm just going to
6 give you a brief introduction to the project that
7 we have today, as well as give a little bit of
8 historical context of where we've been and how
9 we've gotten to where we are today.

10 This will be old news to all of you
11 who worked on most of these projects but just to,
12 sort of, touch base again on them.

13 NQF's prior work in cost and resource
14 use has really focused a lot on doing a lot of
15 conceptual work and trying to come up with
16 frameworks that we can utilize to evaluate these
17 measures, as well as in applying those evaluation
18 criteria that were developed to various cost and
19 resource use measures.

20 So here up on the slide we just list
21 those various projects that a lot of you are most
22 likely involved in.

1 And so we begin with Episodes of Care
2 Measurement Framework, which really laid the
3 groundwork for how we look at episodes of care
4 and apply quality measurement to those episodes,
5 and then --

6 MEMBER WEINTRAUB: Excuse me. Bill
7 Weintraub, I was only on the webinar, my headset
8 didn't work, but I'm now on the phone.

9 DR. ROILAND: Oh, thank you Bill. And
10 did you have anything to disclose?

11 MEMBER WEINTRAUB: Yes, well I do have
12 -- I'm a cardiologist, Christiana Care in
13 Delaware, outcomes researcher. I had a CMMI
14 outcome support --

15 (Telephonic interference.)

16 MEMBER WEINTRAUB: -- included.

17 DR. ROILAND: Okay, thank you so much
18 Bill. We appreciate it. All right, so just to
19 bring us back to talking mode and NQF's prior
20 work in this area.

21 So there's been three phases before
22 this phase where we've applied the cost and

1 resource use evaluation criteria to various
2 measures, and this fourth phase is actually our
3 first maintenance phase.

4 So we'll be taking three of those
5 measures that you all have reviewed before and
6 putting them through the maintenance process for
7 NQF. So it's a bit of a new territory, a mix of
8 old and new. The measures you've seen before, but
9 the maintenance process is new for these
10 particular measures.

11 And then there's been various other
12 projects talking about different methodological
13 challenges when developing and evaluating cost
14 and resource use measures as well.

15 So, you all have done a lot of work
16 thus far, and will do a lot of work today as
17 well. So, we look forward to it, and thank you
18 all again for being here today.

19 Go to the next slide. This slide just
20 lists our current portfolio of NQF endorsed
21 measures for cost and resource use measures.

22 And this also includes the three we

1 will be looking at today which include the first
2 two, the Total Resource Use Population-based
3 index, as well as the Total Cost of Care index,
4 and the one listed on the bottom, the Medicare
5 Spending Per Beneficiary hospital.

6 Go to the next slide. And this just
7 reiterates the same point that this project today
8 will be evaluating measures related to cost and
9 resource use that can be used for accountability
10 in public reporting for the population that
11 they've been specifically tested for.

12 And so, again, the three measures
13 we'll be reviewing today are listed at the bottom
14 of the slide there. So, three measures today,
15 but we expect it to be a rich discussion, so we
16 look forward to hearing all of your thoughts.

17 And with that, I will turn it over to
18 our Project Manager, Hiral, who will walk us
19 through the evaluation process we'll be going
20 through today, as well as voting procedures. So
21 Hiral, over to you.

22 MS. DUDHWALA: Okay, thank you. So

1 again, this will probably just be a refresher for
2 all of you. Next slide we're just going to go
3 over a quick overview.

4 So, the roles of the standing
5 committee during our evaluation meeting today is
6 to act as a proxy for the NQF multi-stakeholder
7 membership to work with the NQF staff to achieve
8 the goals of the project.

9 Evaluate each measure against each
10 criterion. Indicate to the extent to which each
11 criteria is met and rationale for the rating.
12 Make some recommendations regarding endorsement
13 to the NQF membership.

14 Oversee the portfolio of our cost and
15 resource use measures, as well as select two to
16 three year terms for our new committee members.

17 Next slide, please. All right, and
18 also just some ground rules for our meeting
19 today.

20 So during our discussion, committee
21 members should be prepared, having reviewed the
22 measures beforehand, base evaluations and

1 recommendations on the measure valuation criteria
2 and guidance.

3 Remain engaged in the discussion
4 without distractions. Attend the meeting at all
5 times except breaks. Please keep comments precise
6 and focused. Avoid dominating a discussion and
7 allow others to contribute. Indicate agreement
8 without repeating what had already been said.

9 For those that are participating on
10 the phone, please make sure to use your raise
11 your hand function and we will be monitoring and
12 call out your name so that you may also
13 participate.

14 Next slide. Okay, so again review the
15 measure evaluation process. You have received a
16 measure worksheet which includes a preliminary
17 analysis.

18 The committee pre-evaluation comments
19 are included in that, as well as the pre-meeting
20 public and member comments, as well as any
21 evidence and testing attachments.

22 We just want to stress that -- NQF's

1 staff would like to stress that preliminary
2 analysis is intended to be used as a guide to
3 facilitate the committees discussion and
4 evaluation. Next slide please.

5 Okay, so measure discussion and
6 voting. There will be a brief introduction by the
7 developer, about three to five minutes to begin
8 with. There are lead discussions which will
9 begin the committee discussion by providing a
10 summary of the pre-meeting evaluation comments as
11 well as emphasizing areas of concern or
12 differences of opinion.

13 The developers will also be available,
14 whether in person or by phone, to respond to any
15 questions. The full committee will discuss and
16 then vote on the criterion before moving on to
17 the next criterion.

18 So voting process for today. The
19 voting tool. All in person voting members have a
20 remote clicker to vote. You should all have it
21 right next to you.

22 For those that are on the line, we

1 have already communicated with you how you can
2 send your votes to an NQF staff member and they
3 will do the clicking for you here. All voting
4 members, as I just said, who are remote, we have
5 those instructions already provided to them.

6 So, with the clickers, make sure to
7 point the clicker towards our staff member here
8 in the corner, Irvin. When voting, the remote
9 will briefly display your vote choice.

10 You do have the chance to change your
11 response, so whatever is your last option that
12 you choose on your clicker is the voting that
13 will be the final vote. So, you can change it if
14 you do make an error, so --

15 Okay, next slide. All right, so, for
16 achieving consensus, quorum would be 66% of the
17 committee, so that would be, for this meeting, 13
18 committee members.

19 Pass -- recommend greater than 60% of
20 the committee who vote yes, which would be High
21 plus Moderate. Consensus not reached would be 40-
22 60% yes votes, inclusive of 40 and 60%. So does

1 not pass, not recommended, less than 40% yes.

2 Next slide.

3 Okay we just went over quite a few
4 items, so if there any questions from anyone in
5 the room or by committee members on the phone?

6 Okay. All right. Next slide. Okay.
7 Well, I will go ahead and pass it on to our Co-
8 Chairs, as we begin the candidate measures. Brent
9 and Cheryl.

10 CO-CHAIR ASPLIN: Very good, thank
11 you, Hiral. And good morning, we're going to
12 start with Measure 1598, the Total Resource Use
13 Population-Based Per Member Per Month Index. The
14 developers, Health Partners.

15 And we'd like to begin by inviting the
16 developers to provide a brief overview of the
17 measure, and I'd ask them to introduce
18 themselves. I'm not sure if the developer is here
19 or on the phone.

20 DR. ROILAND: They're on the phone,
21 Brent. So if, Operator, if you could open their
22 lines, if they are not already open.

1 MS. KNUDSON: Hi this is Sue Knudson
2 from HealthPartners, can hear me okay?

3 CO-CHAIR ASPLIN: Yes, good morning,
4 Sue. We can hear you just fine.

5 MS. KNUDSON: Hi, okay thank you.
6 Just to let you know, I'm joined by my
7 colleagues, Chad Heim, Gary Kitching, Erica
8 Vetta, and Kim Ritten.

9 So I'm going to do just a brief
10 introduction, and before I do that I just want to
11 say thank you to the NQF staff and to all the
12 committee members. We know this is a big time
13 commitment for all of you, and appreciate the
14 attention. Both the NQF as well as all of you
15 individually are going to address this important
16 topic in health care.

17 So first, about HealthPartners. We are
18 a consumer-governed non-profit organization.
19 We're both an integrated health care and
20 financing organization with about 2300 team
21 members located mostly here in Minnesota.

22 Our health plan has about 1.5 million

1 members. We're ranked by NCQA among the top 30 in
2 the nation. From a care group perspective, we
3 care for about a million patients. We have about
4 1700 physicians that cover multiple specialties.

5 Six hospitals including a level one
6 trauma center in the heart of St. Paul, all the
7 way down to community critical access hospitals
8 in size.

9 Our mission is to improve the health
10 and well-being of those we serve in partnership
11 with our members, patients and the community.
12 And our vision is an important one, because it
13 helps you to understand where this work comes
14 from, health as it could be, affordability as it
15 must be through relationships built on trust.

16 So we're also an organization, and a
17 group of team members, that is committed to
18 health equity and serving community needs, so to
19 that end, that includes providing and advocating
20 for mental health services.

21 And we are number two in the state for
22 charity care services, and number one in the East

1 Metro of the Twin Cities.

2 So, just quickly about our measures.
3 There's two measures that we'll be reviewing
4 today: total cost of care and resource use,
5 starting with resource use. They are for a
6 commercial insured population. They're based on
7 all care that's provided to patients, so we refer
8 to them as a population based measure approach.

9 We developed them upwards to 20 years
10 ago on the TCOC side, and in the early 2000's
11 created the algorithm that creates the resource
12 use measure that we will be covering first. The
13 costing technique is the only difference between
14 the two.

15 So for total cost of care, it's the
16 allowed payments, which is inclusive of what the
17 plan pays as well as what the member pays.

18 But for resource use, where we're
19 starting, that uses our standardized patented
20 algorithm for standardizing the cost approach.
21 So, we'll talk I'm sure a bit more about that.

22 The measures are powerful when used

1 together, because by having the two you can do
2 the simple math to understand price drivers as
3 well. However, resource use on its own is also
4 very powerful in helping to drive care delivery
5 improvement by steering, in a focused way, where
6 there are pockets to improve in the overall
7 performance.

8 So again, their commercial members are
9 measured. We have as an organization calibrated
10 for Minnesota, for our own use, a Medicaid model,
11 but that is calibrated, we've been under a
12 bidding system in the state for several years now
13 that is not translatable to other states,
14 therefore we did not submit it.

15 We are a Medicare cost plan, planning
16 to transition to Medicare Advantage, so we do not
17 have the full suite of Medicare claims, so
18 therefore we could not calibrate at this time a
19 Medicare model.

20 And if users have those data, we still
21 recommend segmenting the measures among the
22 different populations to account for differences

1 in disease prevalence, enrollment profiles and
2 the like.

3 So what I think is important in terms
4 of context for the committee to understand is we
5 do measure everything from a particular point of
6 view here at HealthPartners, so our quality
7 results from a care group point of view lead the
8 state at community measurement, and we've been
9 able to make improvements using these measures.

10 At the same time, our quality has
11 improved, we're assisting at very high levels,
12 and for a health plan point of view, the same
13 goes with being ranked in the top 30 in the
14 country.

15 So since the initial endorsement in
16 2012 before we get into the measures, just to
17 close my comments. The spread and the uptake of
18 the measures has been impressive. We have well
19 over 200 users across the country. Those types of
20 users -- manned health plans, providers,
21 consultants, and measurement collaboratives, as
22 well as researchers.

1 We've enhanced our public domain
2 website beyond just containing the
3 specifications. We also have out in the public
4 domain the software to actually create the
5 measures. We've also included software that, if
6 a user would like, they can create the full suite
7 of reports that HealthPartners produces for our
8 network providers as well.

9 And one thing I forgot to mention
10 about. This is just not a health care or a
11 HealthPartners set of measures. We do the same
12 reporting for every contracted partner in our
13 health plan network, and work with them, because
14 our attitude is their success is our success.

15 So in terms of usability, there's been
16 a strong uptake, and we've gotten very favorable
17 results by being very transparent and putting all
18 of our tools, if you will, out there because
19 we're an organization that wants to compete on
20 our results, not just the techniques.

21 So several of those users include, and
22 you guys probably saw the comments from several

1 of the delivery systems that we work with. For
2 example, Sanford, or Ascension Health, or
3 Fairview. And then also, the national Network
4 for Regional Healthcare Improvement and all of
5 their sites in different states cross the
6 country.

7 And Nancy mentioned in her comment,
8 the uptake here at Minnesota community
9 measurement. So the work has been really great
10 to be a part of, and we're proud of this spread,
11 and it's what we can do as a consumer-governed
12 non-profit to contribute to the issue of
13 affordability in healthcare. So, that would
14 conclude my comments, Brent.

15 CO-CHAIR ASPLIN: Very good, thank
16 you, Sue. I appreciate your comments and being
17 on the phone here this morning. And we're going
18 to move forward then with the review of the
19 measure, and I'll just -- for review, for many of
20 you, but we have some new committee members.

21 Just want to -- for efficiency's sake,
22 stay disciplined about the focus of the

1 conversation today. Because for each measure, if
2 it doesn't pass on importance to measure or
3 scientific acceptability -- those are must pass
4 criteria -- so we want to do it in order and
5 restrict our comments to the topic.

6 We will vote after each section. There
7 will be plenty of time at the end of the
8 conversation, if we get through all the areas,
9 for summary comments from committee members, if
10 you wish, before our final vote, which is a
11 recommendation to endorse or not to endorse after
12 we've gone through all the different sub
13 categories.

14 So with those comments, let's get
15 started. On 1598, Larry Becker is our lead
16 discussant for importance to measures, so Larry,
17 the floor is yours.

18 MEMBER BECKER: Thank you very much.
19 Can you hear me?

20 CO-CHAIR ASPLIN: Yes, we can hear you
21 just fine. Thank you.

22 MEMBER BECKER: Good. Thank you.

1 And so one thing I would note in the
2 document, that the developer, to marry the two
3 measures together on importance. But let's begin
4 with 1598. I think everybody would agree that
5 cost and affordability is a major concern in the
6 healthcare system. And it contributes to the
7 number of uninsured. It contributed to budget
8 deficits. It contributes to medical bankruptcy.

9 Before you can understand how to
10 effectively lower costs without decreasing
11 quality you need to understand the total cost of
12 virtually everything that goes into the care
13 equations here. And one of the things that I
14 noted in the developer's discussion of this is
15 that most, if not all, of those contributors are
16 inside these indices around primary care: so,
17 professional; facility; in-patient and out-
18 patient; pharmacy; radiology; lab; ancillary and
19 behavioral health. There may be more but that
20 seems to me that those are the biggest
21 contributors to these things.

22 And in my experience in industry,

1 having worked for Xerox for nearly 30 years, is
2 that one of the ways you begin to think about
3 cost is you look at something called UMCs, unit
4 manufacturing costs. In other words, what are
5 all the contributors to developing an output.
6 You know, in this case it might be an office
7 visit. It might be a surgery. It might --
8 whatever it is.

9 And that's the only way in industry
10 that we are able then, once we understand the big
11 costs, is to look at all the contributing
12 elements, all of the inputs to that and begin to
13 break it down, and look at the individual pieces
14 to understand where inefficiencies are, where
15 there are opportunities, as opposed to, you know,
16 just sort of saying arbitrarily we're going to
17 change this or that.

18 The other really important thing here
19 that we learned in industry is something called
20 entitlement. It's a Lean Six Sigma term. It's
21 probably not what you're thinking. It's not that
22 people are entitled to A or B. Entitlement in

1 the Lean Six Sigma context says that you are able
2 to compare what you do to what else is being done
3 by similarly situated people or processes out
4 there, so that if somebody is producing that
5 output at, say, 100 and you're at 90, you know
6 that you could, given the right input, be able to
7 get to that same hundred. Somebody else has
8 achieved it. And that's what they mean by
9 "entitlement."

10 So, by being able to look at total
11 costs and looking at people, benchmarking across
12 multiple systems, multiple providers of the same
13 type, you begin to begin to be able to make
14 comparisons and say, I'm here; it's possible for
15 me to get there.

16 And so, the importance in this measure
17 is to begin the conversation and to begin to sort
18 of, if you will, level the playing field so that
19 people can make appropriate comparisons to be
20 able to take appropriate action.

21 So, I'm going to stop there and ask if
22 others wanted to add to that.

1 CO-CHAIR ASPLIN: Thank you, Larry.

2 Any comments from committee members on
3 this area? We'll have three votes under the
4 overall importance. The first will be on the
5 priority, our assessment of the priority of the
6 measure.

7 The second would be on opportunity for
8 closure in care gaps.

9 And then the third is around the
10 measure intent.

11 So, are there any comments from
12 committee member at this time? Martin.

13 MEMBER MARCINIAK: So I'm echoing
14 Larry's concerns. I mean, one of the things that
15 I saw when I reviewed this measure, and reviewing
16 it I guess now three years ago, was a general
17 concern that when things are aggregated it speaks
18 to Larry's point: how do you disaggregate it to
19 really find quality improvement?

20 That was something I was looking for
21 when I read through the review this past time.
22 Didn't really feel I saw that. It would be nice

1 if at some point the measure developer might
2 comment on that.

3 CO-CHAIR ASPLIN: Sue, do you have any
4 comments in response to that?

5 MS. KNUDSON: Yes. Sure, I'd love to.
6 Thank you for those questions and comments.

7 What we have found to be very useful
8 -- and you could see this on our public website
9 as well as in the Minnesota Community Measurement
10 work, for example, they've taken a different
11 approach. But there is drillability to the
12 measures. And so what we've provided in our
13 reporting suite is a dashboard, if you will, that
14 include this measure and then companion
15 utilization measures that go along with it.

16 And so, for example, as an
17 organization on our own, as we are working with
18 providers we will benchmark back to our plan
19 average performance. And not that folks aspire
20 to be average, but they can set goals. It makes
21 the map easy and they can set goals that might be
22 10 points better than average, for example.

1 And then by pointing to those risk-
2 adjusted utilization measures that would flow
3 right in the same reporting suite -- and by the
4 way, this is the software also that we've put out
5 on our public domain website for others to
6 replicate -- the measures just begin to cascade
7 down. And so you can understand do you have,
8 compared to your peers, an opportunity with
9 admissions, do you have an opportunity with high-
10 tech imaging used outside of the ER at higher
11 rates; so, those major contributing factors that
12 drive the overall performance. So we've made
13 that available.

14 Does that help?

15 MEMBER MARCINIAK: It does for me.

16 Thank you.

17 CO-CHAIR ASPLIN: So, go to Jack next.

18 And then, Troy, I see that you've raised your
19 hand. You'll be following Jack.

20 MEMBER NEEDLEMAN: Okay. It probably
21 reflects the fact I've been doing this too long.
22 But somewhere in the documentation is a

1 reference, and it may -- so this is a quality
2 measure. And so I just think because it always
3 permeates our discussions, comes up at some point
4 or another, I think it's important to note at the
5 beginning this is not a quality measure. Cost
6 and resource use are not measures of quality.
7 Nor is it an efficiency measure, which is where
8 people ultimately want to go is Are you more or
9 less efficient?

10 But, as we have discussed in the past,
11 more or less efficient is contingent upon how
12 your resource use translates to your performance
13 on other kinds of measures of quality or
14 outcomes. And without that mapping and without
15 that examination of the correlation, it's hard to
16 talk about efficiency here either. So, this is
17 an input to the discussion about efficiency as
18 the developer, I think, pointed out.

19 And I think one of the issues of
20 importance is, by itself the resource use measure
21 has some interest but is not getting all the way
22 we want to go. So, the question I would ask the

1 developer is the extent to which they have
2 provided mapping tools for looking concurrently
3 at their outcome measures and quality measures,
4 which are also included in the suite of things
5 they do, and the resource use or cost use
6 measures that make it up.

7 CO-CHAIR ASPLIN: Thank you. Sue.

8 MS. KNUDSON: Chair, would you like me
9 to address that?

10 CO-CHAIR ASPLIN: Yes, please.

11 MS. KNUDSON: Yes. So, we have take
12 -- we totally agree with what you are saying,
13 this is one of the building blocks that would
14 help drive to that overall efficiency or value
15 equation. We have taken a multi-step approach.
16 And so when we display information we generally
17 do not display cost information on its own, it
18 would always be paired with quality and
19 experience information, if you will.

20 But we look at those from two
21 different bars. So, for example, in our shared
22 savings contracts with our provider network, you

1 must meet the thresholds that we have in place
2 for quality and experience assessments. And then
3 if you perform well in this cost of care and
4 efficiency, then you would, you know, benefit by
5 having bonus and/or shared savings payments paid
6 out.

7 We use the same approach with
8 transparency on our website. We offer both a
9 quality and experience score for consumers to
10 use, as well as that being paired with the
11 overall cost information. Because the literature
12 is pretty solid that there is no direct
13 correlation between cost and quality, we have
14 actually not take it that step further and done a
15 value equation, which I think is perhaps the
16 spirit of where you're heading in the discussion.

17 And we have done that because
18 sometimes the map doesn't quite work out. And
19 consumers, particularly, need to make choices
20 based on where they're at in a particular point
21 of care. And sometimes that quality information
22 on its own might be the driving force and/or the

1 costing combination.

2 So that is the way we have used it.

3 CO-CHAIR ASPLIN: Thank you, Sue.

4 Troy and then Andrea.

5 MEMBER FIESINGER: Yes. This is Troy

6 Fiesinger from Houston.

7 You already addressed part of my
8 question about drillability. But in my mind I
9 want to make sure I understand clearly. How low
10 can you go? I mean, if I have a 4- to 10-doctor
11 group over a 50-doctor practice and then 500
12 physicians in an ACO, how long in unit can you
13 get down to get to applicability and usability?

14 MS. KNUDSON: So, we're asking for
15 endorsement on the measures at 600. And the
16 reason we're asking at 600 even though we've
17 tested and they're, they're good at lower levels,
18 is because that's the sweet spot where we have
19 found we have that robust quality and experience
20 information available for all those uses that I
21 had mentioned.

22 They are -- we have done testing --

1 they are reliable and valid at lower levels. We
2 also, in terms of the drillability, to your point
3 in the question, we can drill that all the way
4 down to the physician level. But what I will
5 tell you is that from, you know, a real lift in
6 improvement point of view, when we consult and
7 work with groups we have found the best way to
8 drive improvement is recognizing the fact that
9 all of us as individuals, care team members
10 included, come to work wanting to do the best
11 they can. And we have often and predominantly
12 found that putting in place system solutions,
13 whether they be computer solutions or process
14 solutions across the team, are the best way to
15 list performance and drive results that you can
16 see.

17 So, we really take that approach with
18 it and have found very few individual physician
19 opportunities. And that's largely recognizing,
20 yes, we are largely a group practice state. But
21 we do have smaller groups and single-specialty
22 practices that we work with as well. But

1 generally it's the same types of solutions.

2 So, you can let me know if you still
3 have outstanding questions based on that. I'd be
4 happy to answer them.

5 MEMBER FIESINGER: Thank you. That
6 answered the bulk of my questions. Also to be
7 able to aggregate your data by payer contract.

8 MS. KNUDSON: Yes, we can. If I put
9 my care group hat on, you know, using the
10 Minnesota Community Measurement, that is all
11 aggregated together, you know, from a usability
12 point of view. Our care group colleagues would
13 get reports from each of their payers which would
14 directionally show different levels of
15 performance.

16 But these measures themselves, they
17 are drillable down to conditions, procedures, et
18 cetera. So you can also understand those
19 drivers. And what we have heard from care groups
20 is directionally, you know, the different payers
21 may be kind of honing in on the same things using
22 a slightly different methodology. But that's the

1 credibility about these measures is that when we
2 bundled all of our data together at Minnesota
3 Community Measurement it's pretty much singing
4 the same song. So the standardization of the
5 approach has been really useful.

6 CO-CHAIR ASPLIN: Thank you. Andrea
7 and then Jennifer.

8 MEMBER GELZER: Hi. Thank you.

9 I would just note that this is a
10 widely-adopted measure, even by state Medicaid.
11 We do it in multiple states. And we're seeing it
12 increasingly being adopted and, you know, have
13 supported it.

14 And it's a given that this wouldn't be
15 used in a vacuum without a, without quality, you
16 know, metrics. And the quality -- and to me, as
17 a resource use measure, you know, it's the start.
18 It's an overall global cost and then you -- or
19 and then you need to go digging. And you have to
20 have the data, obviously, to do the digging. But
21 more and more we are able to do that, and not
22 just payers able to do that, but providers as

1 well.

2 The quality metrics are driven by --
3 that we would pair with this measure are, you
4 know, driven by the population and driven by the
5 issues that we observe in the population. I
6 would say that, you know, let experience with the
7 measure inform it and improve it going forward.
8 But it's a valid measure.

9 And I would ask the measure developer
10 how -- what are the main categories and areas
11 that were changed from the beginning to the
12 current iteration, if any?

13 MS. KNUDSON: Yes. The only
14 difference is really in our truncation limit. We
15 boosted that from 100,000, or our Winsorizing, to
16 125. And that is just in recognition of
17 inflation and where medical costs are at. So
18 that is really the only substantial change.

19 MEMBER GELZER: Thank you.

20 CO-CHAIR ASPLIN: Thank you.

21 Jennifer.

22 And then one quick comment. For those

1 of you on the phone using the raise-hand
2 function, after you've given a comment or asked a
3 question if you could lower your hand so we know
4 whether you're asking to speak again or not.

5 Thank you.

6 MEMBER EAMES HUFF: Hi. I just want
7 to say I agree with all the comments so far that
8 have been talking about the support to the team
9 on a high priority measure. I want to drill down
10 a little bit more on the performance gap area.
11 And I think the evidence that we showed does
12 indicate there's variability.

13 My question is more about since this
14 is a relative score, how does looking at the, for
15 example, the medical variability that's included
16 here, how does looking at medical group
17 variability from year to year, how does that
18 adjust since it is a relative score in terms of
19 thinking about how improving opportunities are
20 having an effect?

21 MS. KNUDSON: Yes, I'll start and then
22 ask one of my colleagues, if I don't cover it

1 sufficiently, to add on.

2 We do that in a couple of ways. We
3 always index performance to the current year.
4 And in order to -- so we understand where any
5 group or drill level is performing relative to
6 current performance of peers.

7 However, we also in our reporting
8 suite offer the capability to index those last
9 two years previously also to the current year, so
10 you can always see how you're moving over time.
11 And all of that's available in a class of
12 different measures as well.

13 Does that help, Jennifer?

14 MEMBER EAMES HUFF: Yes. Thank you.

15 CO-CHAIR ASPLIN: Let's see, Jack,
16 probably the last time.

17 And then we're going to move to our
18 first vote in this area.

19 MEMBER NEEDLEMAN: Okay. Well, this
20 is interesting because Jennifer read the variance
21 in these measures differently than I did. And
22 what I'm about to say, you know, I think it's

1 important, let me start out by saying I think
2 it's important to have a measure of resources,
3 measured resources over time given the goal for
4 efficiency.

5 But I found that when I look at the
6 variance on the resources measure, not the cost
7 measure but the resources measure, the
8 standardized pricing model, with the exception of
9 a few groups that are at the tail that seem to be
10 more extreme, folks seem to be pretty tightly
11 clustered. And when I look at the report you
12 provided of the 3-year data on the groups, it
13 looks like about half the groups are going up
14 over three years and half the groups are going
15 down, none by very much on this measure.

16 So, since one of the elements of
17 importance is room for improvement, and variation
18 in performance, I'm wondering if you can provide
19 a little bit more insight into how much variance
20 are you actually seeing in this measure, leaving
21 aside the three or four or five groups that are
22 at the extreme tails, which could be very

1 peculiar patient experiences that year for those
2 groups?

3 But how much variance are you seeing
4 and how much improvement are you seeing over
5 time, not in the index but in the actual measure
6 itself, which is a measure of resource use? How
7 much change or trend over time are you seeing?
8 And how consistent is that across the groups?

9 MS. KNUDSON: Yes. Thanks, Jack, for
10 that astute question. Because we're not just
11 managing for the tails. If we did that, we
12 wouldn't be making an improvement. And really to
13 sort of be one with the results of these data is
14 really important for the different users and
15 these folks who are being measured. Because I
16 will give you an example from our own delivery
17 system, our west side delivery system here in the
18 Twin Cities.

19 Even a point of improvement in
20 resource use is about a \$4 million improvement in
21 affordability that we can return to patients and
22 purchasers. So even the small, even around the

1 averages, it's really important to really drill
2 into the data and look for performance. It is
3 very hard to get like a 10 point improvement.

4 So that is not how the numbers should
5 be interpreted. And so we're really looking to
6 those utilization metrics and other things that
7 help with usability to drive those. It's sort of
8 a steady pace of an improvement portfolio. And
9 even at a half a point improvement, that is a lot
10 of dollars to be returned.

11 CO-CHAIR ASPLIN: Thank you, Sue.
12 Janis, a quick comment?

13 MEMBER ORLOWSKI: I want to raise
14 concerns regarding the disparities adjustment in
15 this measure. And --

16 CO-CHAIR ASPLIN: Yes, can we table
17 that? Because that I know is going to come up
18 later on. But if could just hold off and get
19 into our votes on importance, if you don't mind.
20 And remind me, so I don't, don't miss --

21 MEMBER ORLOWSKI: But you don't think
22 it's critical to the importance? You feel it's a

1 separate subject?

2 CO-CHAIR ASPLIN: I think it's going
3 to be in the validity section. So it should be
4 tied to the second vote.

5 All right, very good. With that,
6 let's move the first vote in importance to
7 measure is under the category priority.

8 And, Rachel, how are the folks on the
9 phone going to vote? Do you want to quick go
10 over how we're going to handle that today?

11 DR. ROILAND: Sure. So, hello,
12 everyone. So for the folks who are participating
13 on the phone, we have reached to you individually
14 and told you who of the staff is going to be your
15 proxy. And they will be emailing or texting us,
16 whatever works best for them. So that's the
17 process that will be happening.

18 And we have our clickers labeled so we
19 know who's getting what.

20 CO-CHAIR ASPLIN: All right. So,
21 good. And any questions from those on the phone?
22 We are ready to roll.

1 MEMBER WEINTRAUB: Yes, I have a
2 question. Can you hear me?

3 CO-CHAIR ASPLIN: Yes, we can.

4 MEMBER WEINTRAUB: So if I was to look
5 and get an email from someone as my proxy, I
6 don't see it.

7 CO-CHAIR ASPLIN: Is that Troy?

8 MEMBER WEINTRAUB: It's Bill
9 Weintraub.

10 CO-CHAIR ASPLIN: Bill. I'm sorry,
11 Bill.

12 MEMBER GELZER: And Andrea Gelzer.
13 I'm having a hard time locating the specific
14 email.

15 DR. ROILAND: Okay. We'll send an
16 email right now. Just one moment, please.

17 (Pause.)

18 DR. ROILAND: Bill and Andrea, if it
19 works better for you, you can actually just chat
20 it to us in the webinar platform. Would that
21 work for you?

22 MEMBER GELZER: That would be great.

1 MEMBER WEINTRAUB: Yes, well let's try
2 it and make sure it works. We'll try on this
3 first go-around.

4 MEMBER FIESINGER: This is Troy. I
5 think chatting it would be easier for me, too.
6 Then I don't have to jump between screens on the
7 computer.

8 DR. ROILAND: Okay.

9 Irvin, can you set up the voting
10 slide, please.

11 MR. SINGH: Yes, absolutely. So --

12 MEMBER WEINTRAUB: All right, so you
13 want us on the phone to put it in right now?

14 DR. ROILAND: Let Irvin read out what
15 we are going to be voting on and the voting
16 options. And then once he is done with that he
17 will ask you to submit your votes. And folks
18 can, who are on the phone if you prefer you can
19 submit it through the webchat. Or if you want,
20 you can submit your vote through the email or
21 text that we had arranged before. But whatever
22 works best for you, we'll figure it out up here.

1 MEMBER WEINTRAUB: All right. So,
2 just give us feedback that it works after this
3 first vote; okay?

4 DR. ROILAND: Sure. We definitely
5 will.

6 MR. SINGH: Good morning, everybody.
7 We are going to commence the voting process. And
8 just want to make sure that the voting platform
9 is working okay, making sure that your votes are
10 being captured.

11 The first thing we're going to do is
12 run a test vote to make sure that the clickers
13 are working and that you're able to submit a
14 response. So go ahead and submit your test vote
15 now. And just point your clickers to this
16 direction because this is where the receiver is.

17 DR. ROILAND: And for folks on the
18 phone, you can't see the voting slides. We're
19 not able to show them on the webinar platform.
20 So the test slide, your voting options are 1 for
21 high; 2 for moderate; 3 for low; and 4 is for
22 insufficient.

1 So, if you could submit those via the
2 method that works best for you we'd appreciate
3 it. Thanks.

4 MEMBER WEINTRAUB: All right. So it's
5 not clear to me how to use this chat function. I
6 typed "chat" and what I see here is several
7 messages. How do I respond back with a chat?

8 MEMBER BECKER: At the bottom -- this
9 is Larry -- at the bottom you see a box that says
10 "send" next to it?

11 MEMBER WEINTRAUB: No.

12 DR. ROILAND: Bill, if you are
13 comfortable with saying it over the phone you can
14 do that or you can email me.

15 MEMBER WEINTRAUB: Well, let's see if
16 this works.

17 DR. ROILAND: Okay.

18 MR. SINGH: Does everybody who has a
19 clicker showing like a number on the remote when
20 you hit it?

21 MEMBER NEEDLEMAN: Mine didn't.

22 CO-CHAIR ASPLIN: I just want to

1 reassure everybody, we'll pick the pace up as we
2 go on.

3 (Laughter.)

4 CO-CHAIR ASPLIN: This is only going
5 to happen once.

6 MEMBER WEINTRAUB: Rachel, did you
7 check? Did you see the chat response?

8 DR. ROILAND: Hi, Bill. Yes, this is
9 Rachel. I have your vote on the chat response.
10 And I also have a vote from Andrea Gelzer and
11 Troy. And Mary Ann, I have your text. Yes, I
12 have your vote as well.

13 MEMBER RAMBUR: And do you have
14 Betty's? I sent mine via text and email.

15 DR. ROILAND: Yes, I got it.

16 MEMBER RAMBUR: Thank you.

17 MR. SINGH: And, Dr. Ratliff, I also
18 captured your vote, too.

19 DR. ROILAND: And, Larry, this is
20 Rachel. I got your vote as well. So we should
21 be all, so we should be all good to go. Sorry
22 about that.

1 MEMBER BECKER: Terrific.

2 MR. SINGH: So it appears that the
3 voting platform is good to go. We've got
4 everybody situated and all the clickers are
5 going. So now we are going to be commencing our
6 official vote for Measure Number 1598, Total
7 Resource Use Population-based PMPM Index on the
8 first criterion on a high priority.

9 Your options are 1, high; 2, moderate;
10 3, low; and 4, insufficient. Please vote now.

11 (Voting.)

12 MR. SINGH: Everybody in the room and
13 everybody on the phone -- or everybody in the
14 room, can you please submit your vote one more
15 time.

16 (Voting continues.)

17 MR. SINGH: One last time.

18 MEMBER WEINTRAUB: Did you get
19 everybody on the phone? Do you want us on the
20 phone to do it again?

21 DR. ROILAND: No, we can resubmit your
22 votes. Thank you though.

1 MEMBER WEINTRAUB: Okay.

2 MR. SINGH: Dr. Weintraub, can you
3 please submit your vote via your proxy? Thank
4 you.

5 MEMBER WEINTRAUB: Oh, you want me to
6 do that rather than the chat now? I'm still, I
7 don't see email from a proxy to respond to.

8 MR. SINGH: The chat can work, too.

9 MEMBER WEINTRAUB: All right. I will
10 do it again on the chat. All right? We'll try
11 it again. Please let me know if you get it.

12 DR. ROILAND: We have your vote, Bill.
13 Thank you.

14 MEMBER WEINTRAUB: Thanks.

15 CO-CHAIR ASPLIN: We're just sorting
16 through the proxy issues here with the number of
17 people we have on the phone to try to get the
18 right denominator. Once we get rolling this is,
19 this is going to be much more efficient. This is
20 not going to be a Chicago-style vote, however.

21 DR. ROILAND: Can we do it one more
22 time? And if not, we can maybe move to a hand

1 vote.

2 CO-CHAIR ASPLIN: I think it's worth
3 the time to get this because it's going to be
4 really cumbersome to do anything else.

5 MR. SINGH: So, we're at 19 now.

6 Okay, so voting is now closed.

7 The results for --

8 CO-CHAIR ASPLIN: For clarity, we're
9 voting on high priority, last time. Those of you
10 on the phone, we already have your votes.

11 MR. SINGH: Okay. So, all votes are
12 in. The voting is now closed for priority one
13 for high priority for 1598. The results are 100
14 percent high.

15 MEMBER MARCINIAK: That wasn't my
16 vote. I'm from Chicago. I feel very comfortable
17 with that.

18 (Laughter.)

19 MS. O'ROURKE: For those of you on the
20 phone, we're just discussing in the room how to
21 proceed with voting. So apologies for the delay.

22 Why don't we just, if everyone is

1 comfortable, take a vote by hand on this
2 criterion just to get us back on track. And then
3 we'll try the clickers again for the performance
4 gap vote.

5 So, people on the phone, we have your
6 votes. If you don't want to change, no action
7 needed for you.

8 In the room, if you could just raise
9 your hand as we go through.

10 Well, first let me say, does anyone
11 mind voting publicly? Okay, so if you, for high
12 priority, if you wish to vote high, please raise
13 your hand now.

14 (A show of hands.)

15 MS. O'ROURKE: Okay, we have eight in
16 the room.

17 If you wish to vote moderate.

18 (A show of hands.)

19 MS. O'ROURKE: We have two in the
20 room.

21 And if you wish to vote low.

22 (A show of hands.)

1 MS. O'ROURKE: We have one in the
2 room.

3 When we add those to the phone votes
4 we have our correct total?

5 DR. ROILAND: So we have 16 for high;
6 2 for moderate; and 1 for low. And that equals
7 19; right? Okay. So that's the vote for high
8 priority for Measure 1598.

9 MS. O'ROURKE: And we apologize for
10 that. We are going to get you back on
11 conversation while we fix the voting software in
12 the background. So apologies. Thank you for
13 your patience, everyone.

14 CO-CHAIR ASPLIN: Very good. Thank
15 you.

16 So, we are going to move on to the
17 performance gap. And we will also be voting on
18 this gap here, an opportunity for improvement.
19 And before moving to the vote, are there any
20 additional comments? We did discuss this a
21 little bit. Are there any additional comments on
22 the performance gap in this measure, an

1 opportunity for improvement?

2 (No response.)

3 CO-CHAIR ASPLIN: None in the room.

4 And I'm not seeing any online.

5 So, if we could move ahead to -- Are
6 we ready or do you want to do another manual
7 vote?

8 MS. O'ROURKE: Let's try the software.
9 And if it doesn't work the first time we'll just
10 move to a manual vote and get someone up to
11 reboot it for us.

12 So, Irvin, if you could read the
13 platform.

14 MEMBER WEINTRAUB: So, we should go
15 ahead and use the chat function?

16 MS. O'ROURKE: Yes. If you are
17 online, please go ahead and chat your votes to
18 us.

19 In the room, if you could use the
20 clickers.

21 MR. SINGH: Okay. So we will be
22 voting on the second criterion and that is gap in

1 care/opportunity for improvement for Measure
2 1598. Your options are 1, high; 2, moderate; 3,
3 low; and 4, insufficient.

4 Please begin voting now.

5 (Voting.)

6 MR. SINGH: This one looks good.

7 So, the results for the second
8 criterion gap in care/opportunity for improvement
9 is as follows:

10 We have 8 votes for high; 10 votes for
11 moderate; 3 votes for low; and 0 votes for
12 insufficient, which equals out to 42 percent
13 high; for number 2, 53 percent; for number 3,
14 low, 5 percent; Number 4, 0 percent for
15 insufficient.

16 CO-CHAIR ASPLIN: Very good, thank
17 you.

18 And we will move on to the final vote
19 in importance which is measure intent. Are there
20 any comments prior to the voting? If not, we can
21 read the slide. We'll have some additional
22 information about the specific nature of the

1 vote.

2 Let's move on to measure intent.

3 MR. SINGH: Okay. So we are voting on
4 the third criterion, measure intent for Measure
5 Number 1598. Your options are number 1, high;
6 number 2, moderate; number 3, low; and number 4,
7 insufficient.

8 Please vote now.

9 CO-CHAIR ASPLIN: For those of you on
10 the phone, the description of this third vote is
11 the measure intent of the resource use measure
12 and the resource construct is clearly described.

13 (Voting.)

14 MR. SINGH: Okay. So the results for
15 measure intent is 12 high; 2, moderate, and 6
16 votes; number 3, low, 1 vote; and there were 4
17 insufficient.

18 So just to reiterate, for 1 high,
19 there's 12 votes; number 2, moderate, there's 6
20 votes; number 3, low, is one vote; and number 4,
21 insufficient, 0 votes.

22 CO-CHAIR ASPLIN: Very good. So those

1 are our votes on importance.

2 And we can move on to scientific
3 acceptability. And our lead discussant for the
4 first section of scientific acceptability is
5 Herbert Wong. Herbert.

6 MEMBER WONG: Very good, Brent.

7 So, I'm thinking about for the
8 purposes of efficiency, talking about the
9 scientific acceptability both in terms of
10 reliability and validity all in one conversation
11 because they often kind of spill over into these
12 different characters. When we do the voting
13 itself, I think that we can go systematically
14 through this.

15 So, you know, just as a reminder for
16 folks that the numerator for this particular
17 measure is a risk-adjusted total resources that
18 are associated with treating our members. This
19 includes professional facility in-patient and
20 out-patient. It includes pharmacy, labs,
21 radiology, ancillary, and behavioral health.

22 The denominator is really a care group

1 average. Right? And it's designed to be
2 somewhat flexible, depending on what the --
3 whoever is deploying it is. So you have a
4 numerator aligned to values and you have a peer
5 group.

6 There are a number of exclusions that
7 are included in this particular metric. They're
8 excluding services that are not office-based.
9 They are excluding convenience care clinical
10 visits. They exclude providers that are not a
11 physician, physician assistants, and nurse
12 practitioners.

13 They look at service lines for
14 specialty-based services, practice, and
15 specialty.

16 They include the following
17 specialties: family medicine, internal
18 medicines, pediatrics, OB/GYN, and pediatrics.

19 There are a number of other
20 adjustments. Basically member aged over 64 are
21 excluded; members aged -- under age 1 are also
22 excluded.

1 There is a criteria there that the
2 enrollment has to be more than 9 months,
3 basically excluding anyone who has less than 9
4 months, up to a year's time.

5 Members who are not attributed to a
6 primary care provider is also excluded.

7 One of the things that was mentioned
8 earlier on was the dollars per member has to be -
9 - if it's above \$125,000, those components are
10 excluded.

11 The risk adjustment is designed for
12 age, gender, and diagnoses.

13 In terms of the reliability testing,
14 when they first started -- when this was first
15 approved they basically deployed three different
16 methods in terms of looking at reliability. They
17 deployed 90 percent random sample, a
18 bootstrapping technique, and the analysis of
19 performance over time.

20 The data that they employed was from
21 health partners looking at the years 2007, 2008,
22 2009, for 19 individual providers in this

1 particular area. And, roughly, the members in --
2 for each of these years was roughly 250,000 to
3 300,000 members.

4 In terms of the new data, looking at
5 reliability they looked at I believe it was the
6 years 2014 and 2015, and they had roughly 470,000
7 members involved there.

8 So, in terms of reporting the
9 reliability, they honed in on the bootstrapping
10 and 90 percent sample. Over all, the results are
11 consistent across -- are consistent within a
12 group. There is some variation across the group.

13 So, in general, the assessment from
14 both the staff here at NQF, and members'
15 preliminary analysis of that, kind of gave the
16 assessment in terms of reliability over all, in
17 terms of the testing, as high. And that's in
18 generally I'm speaking.

19 In terms of scientific validity, again
20 the data source that they deploy were the same
21 years that they used for the reliability, again
22 focusing on health partners' commercial

1 population again, with roughly 470,000 members.

2 They examined correlations between
3 measure components and measure scores with other
4 markers of utilization.

5 There are a large number of tables
6 that I'm sure that folks have kind of reviewed
7 there that look at these correlations. I won't
8 go through them all there.

9 Here are some of the take-aways I
10 think I have looking at both the reliability and
11 the validity. I think that in general I think
12 that committee members, at least in the
13 preliminary stages, looked at reliability and
14 kind of rated it as high over all.

15 When they looked at validity, I think
16 that folks kind of rated that in a more moderate
17 level a little bit.

18 The big concerns that kind of emerged
19 from this conversation were, one, concerns about
20 attribution. The second concern was a concern
21 about some of the conceptual bases of trying to
22 pull this metric together. Namely, why is it

1 that one used a 9-month cutoff as opposed to
2 something else?

3 There is a notion of generalizability
4 that much of the testing was done in a localized
5 area. And so there was some question of whether
6 or not this particular metric is applicable on a
7 nationwide scale. And then there were also some
8 comments about how looking at some of the
9 specialty groups that were relatively narrow,
10 looking at some of them, but didn't include other
11 specialty groups.

12 My own general comments about this is
13 this notion that when you look at this particular
14 metric I think that one has to be a bit cautious,
15 in particular looking at the peer group. So you
16 do have a denominator. You do have a -- you have
17 a numerator of a group that you want to compare.
18 You have a denominator where you want to
19 benchmark it to another group.

20 There is some notion there from a
21 conceptual point of view of how you could have
22 some flexibility of choosing that. So, for

1 instance, if it's cutting across a geographic
2 space, if you have a large health plan and
3 you're looking at this, and how you choose your
4 denominator, your peer group becomes important.

5 So, for instance, if you have two
6 different locations, one is, say, New York and
7 one is in Florida, if you don't choose the right
8 peer group what's -- who's to say that you have
9 the right metric, that is the right average,
10 unless you thought all about how one is basically
11 doing that?

12 There the exclusion of \$125,000, there
13 were some comments, I think, that reviewers had
14 of whether or not that was a bit arbitrary. And
15 I know that it was well-established back in 2012
16 that the developers basically increased that rate
17 from 100,000 to 125,000 to reflect some inflation
18 sort of basis there.

19 Let's see. I think that for the 9-
20 month period some additional sensitivity analysis
21 could have been done to kind of demonstrate that
22 this is not, should not be a concern, whether or

1 not you remove some of that restriction, some
2 comparison groups there.

3 So, I would say that over all the
4 approach, both in terms of reliability and
5 validity, are pretty well-accepted methods in the
6 literature and that the approach is pretty solid
7 in terms of how they approached it.

8 I think that some sensitivity analysis
9 might be in order for some of these parameters.

10 I think that some of the conclusions
11 that one can come up with is that for these
12 particular metrics is is generalizable within
13 groups, but one has to be cautious when looking
14 at it across groups.

15 So high level kind of comments on both
16 reliability and validity. I'm sure that the
17 committee members will kind of add their two bits
18 to it as well.

19 CO-CHAIR ASPLIN: Thank you, Herbert.

20 So, we are going to address and assess
21 reliability first. And then we will have the
22 conversation around validity and several things

1 that I have heard mentioned here around
2 attribution, truncation changes, exclusions, et
3 cetera, will be talked about in the validity
4 section.

5 MEMBER WONG: Yes.

6 CO-CHAIR ASPLIN: Any specific
7 comments on the reliability? Sue, do you have
8 anything to respond initially to on reliability
9 before we get the committee comments? Or would
10 you just want to wait for committee members?

11 MS. KNUDSON: You know, I think the
12 most general comment I'd have -- and I'd ask Gary
13 and Chad, too, because we are all intently
14 listening -- is so it's our understanding
15 attribution, with this round of review of our
16 measures, continues to be guidelines. So we have
17 offered the attribution method that we have used
18 within our health plans.

19 What I'll add onto that is in our work
20 across the state with Minnesota Community
21 Measurement we analyzed different attribution
22 measures. So, first-off, the inclusion of the

1 specialties in ours, what works, that works in
2 our market. And that is widely accepted by our
3 group.

4 And so when we do apply the measures,
5 either statewide like we did, or nationwide, as
6 that comment was made, it is important to have an
7 agreeable attribution that we were able to derive
8 to that. What we found here in this state was,
9 you know, most of the models are returning the
10 same types of results. So, it's as much about
11 the inclusion of a type of providers as the
12 culture that you're operating in.

13 So that would just sort of be my
14 general comments on attribution, which I think is
15 -- follows both of these sections. And then the
16 other comments about the peer group, the
17 truncation limit, and the 9-month continuous
18 enrollment we'll handle in the reliability.

19 CO-CHAIR ASPLIN: Okay. Comments on
20 reliability? Cheryl.

21 CO-CHAIR DAMBERG: Thank you. I
22 appreciate the information provided on the

1 reliability in terms of consistency of results,
2 test/re-test. But I don't think I saw in the
3 materials any signal-to-noise test to be able to
4 look at whether you are able to discriminate the
5 performance between providers.

6 And that was concerning from my
7 perspective, given that this type of measure is
8 frequently used in the context of value-based
9 payments.

10 MS. KNUDSON: Do you want us to handle
11 all the reliability questions now, Brent?

12 CO-CHAIR ASPLIN: Yes, that would be
13 great, Sue. If you could respond to that, that
14 would be great.

15 MS. KNUDSON: Okay. We'll start with
16 that signal-to-noise one. I'm going to have Gary
17 respond to that.

18 MR. KITCHING: Sure. In that paper,
19 when we ran our paper we looked at the bootstrap
20 analysis. And what we did was we compared the
21 bootstrap analysis, or the result, to the actual
22 result. And that's kind of the noise, if you

1 think of it that way; so the differences within a
2 provider group.

3 When you compare that to the what
4 you're trying to measure against, so that's
5 across all provider groups, and this is the
6 spread between each provider group is about 110
7 percent. So the signal-to-noise issue, what
8 we're looking at is less than 1 percent would be
9 the noise. And the signal then is all the 110
10 percent.

11 So, really, if you look at a provider
12 group that has a range of, say, 0.9, the noise in
13 there is going to be, like, 0.89 to 9.1, or 9.1.
14 But the spread that we're talking about is over
15 the course of, you know, 100 points. So you'd be
16 able to confidently say that that person, the
17 ranking we gave them is their result. And I
18 think that's what we're, what we're trying to
19 conclude, or that's what the paper concludes.
20 And that's what that testing mechanism does.

21 We've also done the reliability, which
22 I think you're referring to, which is I think

1 people actually try to think about that 0.7
2 reliability stat. We've done that test as well,
3 and it's on our website. And we're actually just
4 performing that now. And we'll have it up there
5 soon.

6 Those results have the same, conclude
7 the same results, but that 0.7, if you have a 600
8 and above population size, that returns back a
9 reliability score that's positive as well.

10 CO-CHAIR ASPLIN: Thank you. Jim.

11 MEMBER NAESSENS: Yes. Actually, most
12 of my comments are more about the attribution
13 methods. And as a result of attribution in this
14 whole process we've experienced in Minnesota
15 Community Measurement, you know, experience where
16 there's actually a little bit different
17 attribution applying the same total cost of care
18 and research. And in that attribution process it
19 turns out that they used similar definitions of
20 specialties, really focusing, understanding as an
21 intended frame to the primary care practice.

22 But in the way that the attribution is

1 applied we end up identifying lots of patients
2 who see many nurse practitioners and physician's
3 assistants in specialty clinics. But because
4 they're labeled all physician assistants and
5 nurse practitioners as primary care providers, we
6 see many referral patients being counted and
7 captured in our system and attributed to us as
8 primary care patients and being included in these
9 measures.

10 So, for example, only 3 percent of our
11 primary care practice gets picked up because it's
12 only a selected care group. But, also, 60
13 percent of the non-primary care patients who get
14 captured have cancer in the care patients, which
15 will really skew the information.

16 So, if we're accepting a method and
17 saying that it's valid without an actual -- with
18 only a recommended patient attribution method,
19 how do we say that -- or what, what sort of
20 standard does National Quality Forum have to put
21 on a measure whose underpinnings are not really
22 valid in terms of patient inclusion?

1 The other comments, while I just have
2 the floor, would be some of the things that Herb
3 mentioned as exclusions are actually exclusions
4 in their attribution, not exclusions in their
5 measures. So the only exclusions, it's primarily
6 who's between that age of 1 and 64, outlier
7 patients get truncated, they don't get excluded.
8 And the threshold, if the intent of eliminating
9 outlier patients is to make a more normalized
10 distribution, it still leaves a chunk of patients
11 about 20 percent higher than the mean in the
12 distribution.

13 In our experience with the data across
14 Minnesota we have 5 percent of the whole
15 population being outliers, which doesn't
16 normalize that distribution very much.

17 What I would recommend that we do in
18 terms of approving the handling of outliers is to
19 actually exclude them. Just like the Medicare
20 spending per beneficiary excludes patients who
21 are transferred between systems, in this case
22 many of those outliers are actually not being

1 handled by the primary care group who is
2 monitoring and managing most of the patients.
3 The specialty practice is only seeing part of the
4 care, and those patients would also be best to be
5 just left out of the analysis rather than skewing
6 information. They'd be handled in a very
7 different fashion.

8 CO-CHAIR ASPLIN: All right. So a
9 couple different issues. Taroon is going to the
10 first part of your comment, Jim, relative to the
11 NQF's position.

12 DR. AMIN: So, and there's many of you
13 on the committee that participated in the
14 original construction of what we discussed in
15 terms of the measure specifications. And this is
16 what actually is going to key up for conversation
17 later this afternoon as it relates to our
18 attribution panel.

19 To address the attribution question in
20 particular, as we looked at the measures, as we
21 looked at cost and resource use specifications,
22 originally this standing committee, former

1 members but the standing committee, outlined
2 there are several components that could be
3 submitted as specifications for guidelines. So,
4 by nature, some elements of measure submission
5 while they're important to understand for
6 context, were not part of the measure
7 specifications that would be under review for
8 this committee.

9 And one of those elements is the
10 attribution model. That certainly, so that is
11 the current construct of what this committee
12 should evaluate this measure by.

13 I think, Jim, you're pointing out a
14 really interesting challenge with that construct
15 which, obviously, has been challenged by our
16 Attribution Committee, which will be part of our
17 conversation later today around whether that
18 needs to be not just a guideline but essentially
19 a specification in the measure. However, that is
20 not what is in front of the committee at this
21 point.

22 The committee's current guidance to

1 the developers and current evaluation process
2 still allows that to be a guideline. I think you
3 will, each of you will have to struggle with how
4 to interpret that in the context of the validity
5 and the reliability of the measure
6 specifications.

7 And I will keep the second point
8 around exclusions up for the committee
9 discussion.

10 I don't know if that answers your
11 question or may or may not be satisfying, but
12 that is currently what the evaluation process
13 that we've laid out is structured as.

14 CO-CHAIR ASPLIN: Thank you, Taroon.

15 So, my sense is that we're going to
16 have more issues to talk about on the validity
17 side than the reliability here. So I'm just
18 going to ask Jack or Srinivas, did you have
19 reliability comments or questions? Jack, go
20 ahead.

21 MEMBER NEEDLEMAN: Just very quickly.

22 I want to reinforce what Cheryl said. And I

1 think Jim's comment underscored the issue.

2 The data that's available for
3 constructing these measures is at the individual
4 patient level. But the unit of analysis is the
5 group or the medical group or what the -- or the
6 individual provider, whatever the aggregate is
7 that's actually in those reports. And the
8 reliability measures should focus on what's
9 happening at that level. And, frankly, I'm not
10 seeing very -- I'm not seeing as much as I would
11 like to see to really evaluate the reliability
12 there.

13 A lot of reporting of what the
14 population, stability at the population level,
15 but not a lot of reporting of the stability at
16 the group levels and the intergroup levels. And
17 it's very hard to assess how reliable this is in
18 practice as opposed to how reliable it is at the
19 population level, where it looks very stable.

20 CO-CHAIR ASPLIN: Sue.

21 MS. KNUDSON: Yes. I just want to
22 clarity, Brent. Those are our group. That is

1 the group-level testing.

2 MR. KITCHING: Population level.

3 MS. KNUDSON: Yes. Population at the
4 group level, so 66 groups.

5 MEMBER NEEDLEMAN: Yes, but just to be
6 clear. What has to happen is we've got to be
7 looking at what the averages are across the
8 groups, not what the averages across the
9 population and how stable. A 90 percent sampling
10 from, or bootstrapping at the population level is
11 not the same thing as getting a separate set of
12 bootstrapping or estimates of the stability of
13 the measure group by group and looking across the
14 different groups at that.

15 MR. KITCHING: Yes, this is Gary
16 again. Yes, we did the -- the sampling is
17 actually within the group. So the random sample
18 that we take, with replacement for the bootstrap
19 technique, is within the 66 groups. So in
20 essence you sample them 500 times within that
21 whole, within the group. And then you compare
22 that end result to the actual. And that's how we

1 know that the resulting variation is within that
2 particular group.

3 There again it's across the entire 66
4 population of groups, that's the 110 percent. So
5 we're confident that we know the signal-to-noise
6 ratio and we can tell the difference between
7 performance for each of those 66 groups. So it
8 is a group analysis.

9 CO-CHAIR ASPLIN: Are you satisfied,
10 Jack? Or this seems like an important -- because
11 I, I interpret it, just like they said, that the
12 testing was at the group level. So maybe I want
13 to make sure we don't have -- we're not talking
14 past each other here, that we all agree on what
15 was done. So, does that make sense, Jack?

16 MEMBER NEEDLEMAN: It makes sense.
17 Again, the relevant number here is not those .00
18 -- I forget, there was a third zero before you
19 get to the first figure number. But that 110
20 percent variance. And that's got to be compared
21 against the variance across the groups to figure
22 out how stable and reliable the measure is. If

1 we're trying to measure intergroup comparison,
2 110 percent actually looks large as the degree of
3 uncertainty around what's a relatively small
4 group variance in the RCI measure.

5 MR. KITCHING: Yes, I think, just in
6 layman's terms I'll just try and communicate what
7 we're trying to test here.

8 So, if we take any one of those
9 provider groups, the resulting score, those three
10 bars, if you look at the graphic, they're pretty
11 tight. There's no difference between the index
12 scores for all the different testing techniques
13 that we put in place. So, for any different
14 group there's no difference in the results,
15 depending on what sampling we did for it.

16 The 110 percent it's at the range of
17 performance across our whole network. So we have
18 some provider groups that are performing at 70
19 percent of average; other provider groups that
20 are at the 1.8 percent of average, so 80 percent
21 higher than the average.

22 So the difference between one provider

1 group that's performing really well -- 70 percent
2 of average; another group of 80 -- 100, yes, 80
3 percent above average of 1.8; that's actually the
4 range we're measuring. So we can tell that
5 provider group that's at the very best performer
6 or very worst performer, or highest performer, is
7 that high at 1.8.

8 MEMBER NEEDLEMAN: Yes, but if you
9 pull into the 10 to 90 percent range as opposed
10 to the extremes you get a much, much smaller
11 variance than that. Much smaller.

12 MR. KITCHING: Well, I mean obviously
13 it's 10 percent of average and 90 percent, so,
14 yes, I would agree. There's still a 1 percent
15 variation in that performance score. And that's
16 still vague. I mean, there's still 20 points
17 between 10 percent above and 10 percent below
18 average. And you're still looking at that 1
19 percent variation in that person's score. And
20 he's not going to go from 10 percent below to 10
21 percent above, he's only going from 10 percent
22 below to 9 percent below. And that's the noise.

1 MS. KNUDSON: And as I mentioned
2 before, 1 percent is still meaningful.

3 CO-CHAIR ASPLIN: Srinivas.

4 MEMBER SRIDHARA: Thank you. So, I
5 wanted to just comment a little bit about sort of
6 practical implementation, so just for context as
7 I mentioned before. Prior to my current role
8 here, Advisory Board, I was the Maryland HCC
9 director, and we tried to actually implement this
10 measure set along with several other
11 organizations as part of an NHRI Robert Wood
12 Johnson Foundation.

13 So, just in terms of some of the
14 things that we're talking about, whether the
15 attribution being guideline instead of a
16 specification, two comments on that: one from
17 having sat on the Attribution Committee; and two
18 from sort of the actual approach here.

19 These sorts of flexibilities, be it
20 the attribution approach or the local reference
21 populations, actually make adoption more likely.
22 And including sort of some conversations around

1 how you might define primary care. All of these
2 and how someone might go about implementing it
3 actually are important in getting it through and
4 actually using it, convincing the provider
5 groups, tuning it to your local population and
6 making that work.

7 That said, that makes it harder to
8 sort of say how do we measure reliability across
9 nation due to, you know, sort of external
10 validity that was just discussed as well. So,
11 you know, you wish there was a national benchmark
12 to compare it to and make that easier to do, but
13 in terms of comparing local provider populations,
14 usually, at least we found that you had a better
15 success, say, comparing to other providers that
16 are under the same payment models or related
17 factors that are going on.

18 So in that way in sort of
19 statistically performing it and doing it and
20 convincing folks in a practical side, it made
21 sense. So, I think there is a tradeoff between
22 getting very explicit and specific on how you do

1 every element of it, which helps us do the
2 scientific study of it. But in terms of
3 application, I think even if you endorsed it that
4 way I think individual folks or groups who would
5 implement it would have to necessarily tune it to
6 make it applicable in their population.

7 I think on the attribution part, you
8 know, we've discussed some of that. And I think
9 we have a whole lot of debate in the Attribution
10 Committee around whether it should be a
11 fundamental unit of, you know, the specification
12 or is it flexible? And I think, again, in terms
13 of evaluation it makes it easier if you have a --
14 you know, you need the attribution as context, at
15 least for the evaluation, which we've talked
16 about here. But I think, again, in terms of
17 applicability it's you would want the
18 flexibility.

19 The second is some of the concerns
20 around, say, the 9-month, you know, period of
21 enrollment, et cetera, these are to me things
22 that are relevant for commercial population. And

1 then I think it makes sense if you thought about
2 what is the average enrollment period and sort of
3 if you look -- you know, and people do, actuaries
4 do PM calculations and comparisons across
5 commercial populations, 9 months is probably a
6 pretty good number, if you think about it. It's
7 different, say, if you did Medicare, and
8 certainly very different if you did Medicaid.

9 And so I think that's, that's an
10 important thing to keep in mind here. You know,
11 something that I wish this group had taken on, I
12 know that was mentioned already about lack of
13 that kind of data in their population, but
14 thinking about how to apply it to Medicare or
15 Medicaid, they've done some work to think about
16 it. But I think figuring out how this might
17 apply in those populations would be important and
18 specific guidelines.

19 I just wanted to provide that for
20 context.

21 CO-CHAIR ASPLIN: All right, very
22 good.

1 We are going to move on to the vote on
2 reliability. Irvin.

3 MR. SINGH: Okay. So we're going to
4 be voting on the reliability criterion for
5 Measure 1598. Your options are Number 1, high;
6 Number 2, moderate; Number 3, low; Number 4,
7 insufficient. Voting has begun now.

8 (Voting.)

9 MR. SINGH: Okay, so all votes are in.
10 Voting is now closed.

11 So the results for reliability for
12 Measure Number 1598 are there's 10 votes for
13 high; 7 votes for moderate; 1 vote for low; and 1
14 vote for insufficient, which accounts for 53
15 percent high; 37 percent moderate; 5 percent low;
16 and 5 percent insufficient.

17 CO-CHAIR ASPLIN: Thank you.

18 We then turn it over to Mary Ann Clark
19 who is the lead discussant on the validity
20 section of scientific acceptability. Mary Ann.

21 MEMBER CLARK: Yes, hi. I guess I was
22 under the impression I was doing the 1604

1 reliability and validity, so I kind of focused on
2 that.

3 CO-CHAIR ASPLIN: Well, Herb sort of
4 covered both here. Maybe --

5 MEMBER CLARK: Yes.

6 CO-CHAIR ASPLIN: -- I have it wrong
7 in the documentation. So that's, that's fine.
8 We can just open it up. We've already raised
9 many of the validity areas that committee members
10 want to address.

11 MEMBER CLARK: Right.

12 CO-CHAIR ASPLIN: So --

13 MEMBER CLARK: Right.

14 CO-CHAIR ASPLIN: -- that's fine. We
15 can table your comments till 1605 then. That's
16 okay.

17 Yes, Janis?

18 MEMBER ORLOWSKI: Based on the
19 discussion where a number of the reliability
20 issues were raised, the vote is surprising. And
21 I think it would be helpful if, it would be
22 helpful to hear both sides of the story. You

1 know, again, the vote does not reflect the
2 discussion we had. And that makes it difficult
3 to be able to hear both sides, is my comment.

4 CO-CHAIR ASPLIN: I guess it depends
5 on how you interpret the conversation. Because I
6 -- Is there a concern though that you think was
7 not being addressed in terms of questions about
8 reliability?

9 DR. AMIN: Brent, maybe I can help.
10 Maybe I can help.

11 So, the conversation around
12 reliability focused a lot in terms of -- and
13 Jack, I'm going to, Jack and Herb, I'm going to
14 ask you guys to weigh in here -- it sounds like
15 there was a lot of concern around the reliability
16 testing approach that was used by the developer.
17 And I think the question that's being raised is
18 did, generally -- it sounds like the committee,
19 while it had some concerns around the reliability
20 testing generally still moved it with a high
21 rating.

22 And I think there's a question of, you

1 know, can we have a little bit of discussion
2 around everybody sort of reconciled that.

3 Is that a fair question that's being
4 raised by a committee member? So given, Herb,
5 your discussion, and Jack, that you had raised
6 this concern, maybe having a little conversation
7 around how you weighed the testing here, not
8 necessarily -- and others who may agree to that.

9 MEMBER WONG: Right. So I'll, I think
10 I'll start it off or at least kick it off.

11 I think that, you know, from -- I
12 think that part of the thought process here is to
13 think a little bit about the measure from two
14 aspects of it. One is a conceptual basis, and
15 the other is from the testing aspect of it in
16 terms of the reliability. I think that part of
17 the conversation had drifted towards a conceptual
18 basis of that. And some of these components,
19 whether, you know, one of my comments, for
20 instance, is looking at the denominator and
21 making sure that we have the right baseline and
22 things of that nature. That gets into a space

1 that's a little bit, I would say, conceptual.

2 Right?

3 And there is some flexibility that is
4 basically built into that.

5 When you go into reliability in terms
6 of looking at the data of what they have and what
7 they have done, the methods are traditional,
8 standard. The approaches are really out there,
9 as has been well known, it's well documented how
10 you do those sort of things. And they have done
11 that.

12 And the, in terms of the findings on
13 it, you know, one of the things I characterized
14 from taking a look at the tables on that in terms
15 of what was reported out, that in my judgment if
16 you take a look at those correlations and things
17 of that nature, it seemed to be performing better
18 when you look at it from a group perspective.
19 But if you look at it from across groups there
20 was greater variation. There was greater
21 concerns there.

22 So, you know, in that judgment, you

1 know, from my thinking of it, it would be in
2 either the high or moderate space over all. So
3 trying to separate some of the concepts versus
4 what they had deployed. So, you know, high level
5 kind of characterization there.

6 I'm not sure if Jack has anything to
7 add.

8 MEMBER NEEDLEMAN: Yes. Very quickly.

9 I, the comments of the developers got
10 me back looking at the documentation, and on 43
11 of the -- page 43 of the PDF there is actually a
12 group by group description of the results of the
13 reliability testing. And I went back to look at
14 that.

15 It's not clear from the earlier
16 summary description, but I did go back and look,
17 and the variance at the group level in these
18 measures between the 90 percent sample, the
19 bootstrap sample, is in the third decimal place
20 of a measure that's measured somewhere in the,
21 you know, where the relevant number is in the
22 first and second.

1 So, I, having looked at that data I am
2 now comfortable the reliability of the measure is
3 fine. We can discuss the validity a little bit
4 more.

5 CO-CHAIR ASPLIN: Thank you both for
6 jumping on that. Thank you.

7 All right, so I have heard a few
8 different topics come up. Attribution is really
9 a -- we could talk about that from a validity
10 standpoint or usability. And it sounds like
11 that's going to be one, another one of those
12 issues that will be difficult for us to fully
13 resolve, given the current guidance to developers
14 and the charge of this committee today. And
15 maybe another moving target in terms of the
16 overall endorsement process over time.

17 Exclusion, truncation, and then,
18 Janis, I believe you had some comments earlier
19 around. that came up in the importance dialog
20 around sociodemographic factors. Do you want to
21 make those comments now? Great.

22 MEMBER ORLOWSKI: I would say that my

1 comments fall into two specific areas regarding
2 the risk adjustment for sociodemographic status.

3 First is that I believe that the two
4 tests that were done are inadequate. I believe
5 that taking a look at income and poverty level at
6 a 5-digit ZIP Code is an inadequate measure. And
7 there's been much reported about this particular
8 thing.

9 I also find a black versus non-black
10 again surprising and unreliable. And so I do not
11 believe that there has been adequate assessment
12 of disparity.

13 The second comment that I would make
14 is that the developer says that by using these
15 two measures, both of which I already said I
16 believe are inadequate, I see no more than X
17 percent movement. So that in one case 97 percent
18 of the hospitals had no movement. The other 95
19 percent. And when you look at it at the level of
20 the hospital, I would argue that you are looking
21 at it to say that there is minimal movement, that
22 that may be an appropriate statement.

1 And so, for example, 5 percent of the
2 hospitals across the United States are large
3 academic medical centers and they care for 25
4 percent of Medicare patients and 40 percent of
5 Medicaid. So, so to have a 5 percent of hospital
6 movement you'd have to say which hospitals.

7 Are urban hospitals affected by this
8 movement? Are rural hospitals? And I don't
9 believe that I have enough information to be able
10 to take a look at those particular variables.

11 And so I would say, and then I think
12 the third thing is is that the -- we've already
13 talked about this before -- is that for the
14 majority of this measure you're bunched between
15 10 percent and 90 percent. And I'm not sure that
16 these measures help you look at variations in SDS
17 within the population.

18 CO-CHAIR ASPLIN: For clarity, some
19 of, the middle section of the comments sounded
20 like it may have been related to the 2158
21 measure, the Medicare Spending Per Beneficiary,
22 since this is not a hospital accountability

1 measure?

2 MEMBER ORLOWSKI: Oh, you know what,
3 I'm sorry. I --

4 CO-CHAIR ASPLIN: Okay.

5 MEMBER ORLOWSKI: -- was reading from
6 my -- that's right.

7 CO-CHAIR ASPLIN: Okay. Now, other
8 comments on validity? Or do we -- Jack, go
9 ahead.

10 MEMBER NEEDLEMAN: Yes. I have a
11 question about measure construction because we
12 can't talk about validity until we know what's in
13 it.

14 So, standardized pricing model, and
15 I'm curious to know how, what standardized prices
16 are being used for the hospitals. Some
17 hospitals, some insurers that pay on the basis of
18 charges or discounted charges, still a fair
19 number still do it that way. Medicare pays on
20 the basis of DRG. So I'm wondering at what level
21 is the hospital visit priced? Are we capturing
22 the differences in variations in charges for

1 hospitals? Are we simply looking -- and this is
2 both for the standardized measure but also the --
3 it will be more important when we look at the
4 second measure in this group, the pricing, the
5 prices paid measure.

6 So what's the level at which the
7 hospital prices are standardized and aggregated?
8 DRG? Individual charges? Individual diagnosis?
9 I need to -- it's not, I did not see it specified
10 here.

11 CO-CHAIR ASPLIN: Sue.

12 MS. KNUDSON: So, two things. First-
13 off, I just want to be crystal clear on the
14 previous commenter before Jack, Brent. We did
15 SDS testing but that is not the SDS testing as
16 described, that was our testing. So, I think
17 those comments do apply to the other measure and
18 not ours. So, we'll get to that because that is
19 not descriptive of the testing we did.

20 And then on this particular question
21 about the standardized pricing, Chad will be
22 taking that question.

1 MR. HEIM: Yes. So just to give a
2 real brief overview of how the key CRVs are
3 calculated, again, our approach hasn't changed
4 since the last endorsement. Key CRVs, which is
5 the resource use that we are using, base is a
6 linear scale where we are doing a patented
7 approach for assigned resources to draw
8 healthcare services. So we are getting that
9 relativity within using well-established CMS
10 weight at the starting point to get the relative
11 event.

12 And specific to your question, Jack,
13 we are using MS-DRGs for that relativity using
14 CMS weight system there.

15 And then to get the relativities
16 across in-patient to out-patient to professional
17 legal through a repricing scenario to get that
18 relativity going across.

19 CO-CHAIR ASPLIN: You have a follow-
20 up, Jack?

21 MEMBER NEEDLEMAN: Yes. Not on that
22 but a second question related to the

1 construction.

2 You mentioned in the documentation
3 where drugs are carved out you're putting in the
4 average drug price across those. You said and
5 other carve-outs we deal with the lowest common
6 denominator. One of the most common carve-outs
7 is mental health/behavior health services. And
8 it's not discussed explicitly.

9 So, what percentage of your groups
10 have mental health or behavioral health carved
11 out? And how precisely are you dealing with
12 those carve-outs in the construction of these
13 measures?

14 MS. KNUDSON: That's a good question,
15 Jack. Glad you raised that.

16 You know, Minnesota has parity with
17 mental health benefits for years. As an
18 organization and one of the top providers of
19 mental health services and leaders in the state,
20 we are quite committed to both covering as well
21 as caring for patients and members with mental
22 health conditions. And so we have 100 percent in

1 our data.

2 We were just simply making that
3 notation because we know that in other markets it
4 could be, in historic data, carved out at higher
5 rates. But we do not have that issue, it's all
6 in.

7 CO-CHAIR ASPLIN: Any other -- Well,
8 one quick question I had, Sue. Are you aware of
9 users that are -- this is obviously developed
10 using the Hopkins ACG risk adjustment tool,
11 obviously a widely used commercial risk
12 adjustment methodology. Are you aware of anyone
13 using a similar approach with different risk
14 adjustment tools?

15 MS. KNUDSON: Yes, honestly that's
16 something that we talked about in the first
17 endorsement process, for some of the committees
18 who remember that dialog. Yes, I think, so for
19 example, different states might have a lot of
20 payers or providers who are used to the Optum ERG
21 risk adjustor. And it's something their
22 communities invested in, each organization

1 individually.

2 So I know lots of folks are maybe
3 using our specs but applying a different
4 commercial risk adjustor. I think the bottom
5 line in our testing around that was that for the
6 commercial population, given the disease
7 prevalence, et cetera. And ACG is the one we
8 used, but recognizing other markets use other
9 commercial risk adjustors and they're applying
10 them.

11 We do let them know that it's endorsed
12 with ACGs but I think it goes to their uptake and
13 what they're able to deploy quickly in their
14 marketplaces.

15 CO-CHAIR ASPLIN: Thank you.

16 Toy online and then Nancy in the room.

17 MEMBER FIESINGER: This is Troy
18 Fiesinger.

19 I appreciate your explanation about
20 SES and risk adjustment. I am still concerned
21 that if we include and, if possible, come up with
22 a test model in other diverse communities to see

1 if your data still holds true. It's clear that
2 there's going to be very large disparities in
3 income and cost of care/quality of care. And we
4 have patient net systems working hand-in-hand
5 with commercial systems.

6 But it would help to have more
7 reassurance that's been tested in multiple
8 communities.

9 MS. KNUDSON: I'm not sure I
10 understand that question. But just here's what I
11 know.

12 In our SES testing we tested
13 socioeconomic status variables and discussed
14 those. We did not test race, ethnicity, and
15 language per the NQF kind of position on that.
16 We take an approach as an organization, we are
17 very committed to health equity. And so if we
18 talk about race, ethnicity, and language, or REL,
19 for our quality measures, for example, we use a
20 segmentation approach and identify gaps in care
21 and work to close them.

22 But we did not do that testing because

1 it was specific around SES, which is different
2 variables, income, education, et cetera.

3 So, Taroon or one of the NQF staff,
4 I'm not sure if maybe you want to comment on that
5 direction?

6 DR. AMIN: I think we had a little bit
7 of conversation around this SDS question. I
8 think what might be helpful is to just if you
9 help our understanding, if you don't mind just
10 reviewing what you did in terms of SDS, just so
11 that we're all on the same page in terms of
12 methods that you used and the variables that you
13 tested, just so that we're all working off the
14 same songbook. And then everybody in the room, I
15 would just encourage you to take a look at the PA
16 as we are talking about this and just make sure
17 that we're all on the same page because it's,
18 obviously, an important question for everybody
19 and we just want to make sure we all understand
20 what was done here.

21 MS. KNUDSON: Okay, yes.

22 DR. AMIN: Is that a fair ask?

1 MS. KNUDSON: So Gary is going to go
2 over our approach to socioeconomic testing.

3 DR. AMIN: Thank you.

4 MR. KITCHING: Okay, yes.

5 So what we ended up doing was we took
6 two different data sources for our SES. We have
7 this one that's the census, that's at the track
8 level. Again, just for informational purposes, a
9 track level is at, you know, 1,000, an average of
10 1,000 patients up to 8,000 patient blocks. Not
11 any ZIP Code level or by ZIP, but actually a
12 little bit more precise. But still, you know, a
13 good swath of folks.

14 And then we have another database that
15 we purchased that's actually a commercial
16 database that has household-level data. So we
17 did the testing at both those levels just to kind
18 of verify. We know that people are going to have
19 that additional, more precise data set, so we
20 wanted just to make sure we test the census data
21 and then we go back and actually test on a more
22 precise data set to see if we see the same

1 findings.

2 And so we did that testing. We just
3 ran a, you know, a simple regression analysis. I
4 say simple, but obviously there's a lot that goes
5 into that. But we took a look at the income
6 levels. So we took the average of the income
7 levels that we have and use those tracks, put
8 that into the model. We took the ACG score, we
9 put that into the model -- clinical risk
10 adjustment.

11 And then we both put the commercial
12 population and then we expanded it out to the
13 Medicaid population because we wanted to make
14 sure we cut across to show that there is some
15 variation when you do include low income folks.
16 And we're saying that the Medicaid folks are
17 going to be at lower income than the commercial
18 folks.

19 And so when you put all that in there,
20 into the model, and then the table that we have
21 displayed shows you what factors are driving the
22 end result. And so then PMPM, the risk

1 adjustment PMPM, and the resource use would be
2 the TCRV PMPM.

3 And so you can see in the one table
4 already produced the top line, \$0.13 is going to
5 be the total reimbursement attributable to the 1
6 percent increase in income. So that's kind of
7 how that would bear out.

8 And then you look at the ACG score,
9 it's \$4.22. So there's obviously considerably
10 more association with the clinical risk than
11 there is with the income. And then, furthermore,
12 you go out to the commercial risk and Medicaid
13 and you have \$133 in that one example there.

14 So you compare \$0.13 for income versus
15 \$4.22 for ACG or clinical risk, and then the
16 payer market or the payer delineation of Medicaid
17 to commercial is \$133.

18 So, obviously, those factors are a lot
19 more substantially influential on the end result,
20 ACG and the payer, than there is on income. So
21 we were able to include that income really has no
22 discernible variation or driver on a provider

1 score beyond when we already control for the ACG
2 and the clinical risk and the payer.

3 So when you look at it that way, we
4 concluded, as I think most of you will, that when
5 you adjust for the ACG or the clinical risk and
6 the payer, you're controlling for most of the
7 variation that's going to come from any kind of
8 an SES analysis or any SES adjustment that would
9 be needed.

10 So that's kind of the approach we
11 took. When we tested it with the Experian data,
12 which is again the household level data, a lot
13 more accurate information, the same results bore
14 out. And, actually, the income had less of an
15 impact, to be honest.

16 MS. KNUDSON: And I would just note
17 that Gary has said in that opening comment that
18 we tested both sources we had available to us,
19 but understanding from an uptake point of view,
20 census track is most available. But because we
21 had that secondary commercial source for our
22 other business purposes, we wanted to do a more

1 granular test to more inform the outcome of this
2 work.

3 MR. KITCHING: Thank you, Sue. Yes.

4 CO-CHAIR ASPLIN: Thank you, Gary.

5 Thank you, Sue.

6 Nancy.

7 MEMBER GARRETT: So I just wanted to
8 comment, a couple of comments on the SES
9 adjustment that this is.

10 So, first of all, I think it's really
11 great that they went to the census tract level.
12 A lot of the work we're seeing in some of the
13 Medicare measures has been at the 5-digit ZIP
14 Code level. And as Janis mentioned, that is
15 really, a lot of research is showing that just
16 doesn't get precise enough to start to attribute
17 to individuals. So I think that's really
18 helpful.

19 And the extra step of looking at the
20 Experian data also I think is really interesting.
21 One caution I would give there is that we've been
22 trying to understand better how that, those kind

1 of commercially available data sets can be used
2 as a SDS indicator. And one of the things that
3 we worry about is that potentially people at
4 different income levels might have different
5 digital footprints and different availability of
6 that kind of data. So, you think about credit
7 cards scores; someone who doesn't have a credit
8 card might not show up.

9 And I think you had this data on 70
10 percent or something of the population. So
11 that's just a caution, I think, as we move into
12 this world of trying to creative with measures.
13 It's something to be aware of.

14 And I also wanted to note I'm a little
15 confused about the Medicaid part because in the
16 second measure with the population-based total
17 cost of care you have the analysis showing that
18 when you put Medicaid into the model that there
19 was more utilization from a cost perspective by
20 \$75 a person. And so but the cost of Medicaid is
21 reimbursed so much less that it averages out to
22 be less.

1 So, that's just something to keep in
2 mind. I know Health Partners' recommendation is
3 that these are used within populations so you
4 would use this only for Medicaid, only for
5 commercial. But it's just something to be aware
6 of, that that is potentially an indicator of the
7 impact of sociodemographic status on these
8 measures.

9 And then just to share a little bit
10 about some of the research we are doing at my
11 organization. We've been looking at the impact
12 of homelessness on different kinds of measures,
13 quality measures, utilization, et cetera. And
14 one of the things that we're learning is that for
15 something like length of stay that can be kind of
16 a bimodal distribution, so you can have people,
17 for example, experiencing homelessness might
18 have, there's a group of them who might have
19 lower length of stay than typical for a certain
20 DRG. And we think that's partly because those
21 folks are about the kind of social supports
22 available. But medical diagnosis might actually

1 require hospitalization in order to keep them
2 safe because they don't have those community
3 supports.

4 And at the other end of the spectrum
5 we have people who are in our hospitals for 6, 9
6 months because there's nowhere else for them to
7 go but they're medically stable. And so the
8 truncation of the outliers is going to wipe out
9 some of that, those effects that you see. But it
10 also might, the other side of it might be pulling
11 that effort down.

12 And so there may be reasons
13 conceptually that we're not seeing a
14 relationship. But I think we'll be learning more
15 about it, so.

16 MS. KNUDSON: So, Nancy, thanks for
17 those comments. It's important. And you got the
18 results. You also understand that it's very
19 important to understand the population that a
20 provider might have as a whole, but then also
21 appreciate how we're recommending segmenting
22 these measures so that you can really get at that

1 action and validity of pieces.

2 So, for this, for this commercial
3 population, you know, it sounds like you, you
4 have congruent comments with our findings. But
5 as any of us serving a homeless population and
6 also a large Medicaid population, it's important
7 for us to understand different methods to measure
8 and inform appropriate interventions for those
9 population.

10 But this is a commercial measure. As
11 Gary described, the clinical risk adjustment, as
12 well as the fact that it's segmented to a
13 commercial product, really drove these results.

14 CO-CHAIR ASPLIN: Thank you. Janis.

15 MEMBER ORLOWSKI: I just want to go
16 back to my comments and state I find it -- I, you
17 know, and a number of other people here may know
18 and may be familiar with the commercial risk
19 adjustment methodology. But I think it's
20 inadequate to use it for a measure that there's
21 not full transparency in that measure. And to
22 say that we have utilized this opaque methodology

1 and we've looked it and we find no difference
2 and, therefore, there's no disparity, it's just
3 an inadequate measure for an NQF standard.

4 And I think what we have to do is we
5 have to be able to fully look at all the
6 attributes, you know, of disparity measurement.

7 CO-CHAIR ASPLIN: Kristine.

8 MEMBER MARTIN ANDERSON: This is a
9 little bit in a different direction, so I just
10 want to put it out there.

11 When I think about validity of these
12 types of measures that are used in partnership
13 with other quality measures to tell something
14 about value, to me the validity test that you
15 really want to have is when you make a change and
16 then you impact this resource use measure, that
17 you are then able to show that the quality at
18 least maintains the same -- you know, there was
19 an impact; right? So you make a change and there
20 was an impact on the measure. That's test one.

21 And then test two is that then when
22 you look at the quality measurement you are

1 seeing the right interaction.

2 And so I, I do think that as we think
3 about resource use measures and the validity of
4 them, for what they're meant for in the over all
5 purpose you need to figure out how to link it to
6 the quality measures and, also, how to link it to
7 intervention so that you know whether or not
8 someone can affect it; right?

9 So, maybe the easiest ones are things
10 like correlations with readmissions or things
11 that you know are going to relate to resource
12 use. But the harder ones I think around the
13 other quality measures.

14 Because I think when we say, oh well,
15 cost and quality are not correlated, we're saying
16 that largely because they're both all over the
17 board; right? And they can be in multiple
18 directions. I just think there needs to be more
19 work to try to figure out at least the value and
20 the validity question.

21 CO-CHAIR ASPLIN: Thank you. Cheryl,
22 Jack, and then Nancy you have another comment?

1 CO-CHAIR DAMBERG: Oh, I just wanted
2 to follow up on Kristine's comment.

3 So, I view validity as do providers
4 have control over their ability to influence
5 things, recognizing multiple factors will
6 influence this outcome? And I think the issue of
7 SES comes into play in terms of their ability to
8 affect all of the utilization of care that may be
9 also under control.

10 So I think that's sort of the issue
11 that's on the table.

12 And, you know, I personally have some
13 concerns about the extent to which they fully
14 explored the SES space here. And so I do have
15 reservations on that front.

16 CO-CHAIR ASPLIN: Jack.

17 MEMBER NEEDLEMAN: I want to make a
18 comment on the SDS methodology and then to a
19 couple of other aspects of validity.

20 I don't fault the developers here on
21 their SDS testing. We have seen this kind of
22 approach done before on other measures and it

1 seems to be the way people have been presenting
2 the data. But I think -- and this is the point -
3 - when we are concerned about SDS, to some extent
4 we're concerned about unmeasured need for
5 populations that are disadvantaged that are not
6 captured in the risk adjuster. And for that, the
7 kind of regression analysis that was done here
8 may make sense.

9 But there are at least two other
10 aspects at the provider level that we're
11 concerned about SDS. And this particular
12 methodology does not speak to it. And I think NQF
13 has to think about how to deal with these issues.

14 One is the issue that providers that
15 disproportionately treat the poor and
16 disadvantaged populations have fewer other
17 resources to deal -- to provide care to those
18 folks. And, therefore, it shows up in increased
19 use of other resources on things like
20 readmissions.

21 And that's a provider-level data.
22 It's based upon the proportion of the population

1 in the practice that is disadvantaged. And the
2 individual level measurement doesn't get at it.

3 And the other issue that we're dealing
4 with is the issue Nancy raised, same thing,
5 higher proportion of patients who are
6 disadvantaged in communities with fewer
7 resources, within fewer resources at family
8 level, and the provider has to replace those with
9 additional care. And, again, that's going to be
10 something we see at the group level based upon
11 the aggregates in the care that's provided for
12 those populations. It's not going to show up,
13 clearly, in a linear regression in which the high
14 income people and their experience complete
15 offset the lower income people in a way that does
16 not capture the concern that we have about SDS at
17 the provider level.

18 So I think NQF really needs to think
19 about what guidance you need to, we need to give
20 people about these measures if we're really going
21 to understand the impact of concentrated low
22 income or disadvantaged populations in provider

1 groups and their impact on the care that those
2 groups are providing. So, I want to say that.

3 In terms of the other issues of
4 validity here, I think we come back to the issue
5 of how much variability can a group expect in
6 this measure just from the luck of the draw, not
7 because of poor performance or anything. This is
8 a measure with very tight variance in that 10 to
9 90 percent population. So, if a 1 percent, 2
10 percent variation year by year, not about
11 reliability but just the luck of the draw of who
12 the patients were this year, is there then it
13 could completely substantially shift where a
14 group is ranked but also what the group ought to
15 do. If they're reacting to small, you know,
16 random variations in use around individual
17 patients then I think you've got a problem here.

18 And I think we need to think about the
19 variability, within-group variability from random
20 years, not the patients, random years versus the
21 degree of variability we're seeing across the
22 groups. And I'm not sure it's that high. I

1 think it may be a problem around the resource use
2 measure here, but I'm not quite sure about it
3 yet.

4 MEMBER WEINTRAUB: So this is Bill.
5 Let me comment. I tried raising my hand. I
6 don't find it's working very well.

7 Because I think Jack raises a very
8 important point. But, you know, this runs
9 through, this problem of stochastic error runs
10 throughout when we're trying to apply broad --
11 apply measures broadly to large groups. Some
12 people are just going to stand out just on a
13 stochastic basis not looking very good. Or
14 others may look particularly good when they're
15 not good. And that's in the nature of this.

16 People have tried to use statistical
17 approaches like Bayesian hierarchical modeling.
18 And I don't see that within this measure.

19 Have the developers thought about
20 that?

21 MS. KNUDSON: So this is Sue. I'm
22 going to give a shot here with a high, kind of

1 high level response, and then would ask Gary and
2 Chad to comment as well on some of the details.

3 You know, this measure is not going to
4 solve all of our problems from a population
5 health issue when we think about the full panel
6 of patients we care for across the full spectrum
7 of commercial, Medicaid, and Medicare. When you
8 wrap in the different ages that people are and
9 how that might customize the needs that they have
10 and/or the interplay with their income levels and
11 education and health literacy.

12 And, honestly, even for those of us
13 who are well-educated, sometimes when you are
14 thrown in the middle of a catastrophic diagnosis
15 you are not at your best performance level. So,
16 we can all -- if I put my care delivery hat on --
17 we can all relate to the things you are saying.

18 As it relates to provider
19 accountability, I think it would go back to the
20 culture question I would have. You know, that
21 comment I made earlier. And moving, seeing
22 directional improvement in both the resource use

1 metric and quality, that we have examples that
2 we've worked with a provider in Northern
3 Minnesota, for example, that the resource use,
4 really high in the pharmacy component for their
5 patients with diabetes. They realized they had
6 some large group of patients on the higher end of
7 BMI, and they were prescribing pens, which were
8 very expensive. Patients were going to multiple.

9 They switched over to vials. And, you
10 know, it was both a price piece, so getting into
11 total cost of care, but a resource use component
12 that sort of led them there as well. Just and
13 then you sort of keep digging. And at the same
14 time realized better quality improvement in their
15 quality results for those patients.

16 So, the examples are there. It goes
17 to accountability. We're just looking for
18 directional movement at the same time.

19 And then getting back to the SES
20 component and what we can do as groups, I think
21 it's important. I know as a provider ourselves -
22 - and I'm not a clinician but I work side by side

1 with the clinicians, and I in my career have been
2 an administrator in our care group. And our
3 approach is really to understand individual
4 patient needs.

5 At the same time we're understanding
6 our overall population health results. And that
7 means segmenting the population, as we have
8 talked about, in some important ways, but also
9 tailoring those interventions, whether it be for
10 low income people, we will understand who's at
11 higher risk for a readmission and wrap some
12 community services around them. Whether it's our
13 partnering with the firefighters for post-
14 discharge visits and really identifying food
15 scarcity issues that are the results for the
16 readmission.

17 But that's a strategy largely in our
18 low income population. So I'm just saying it's
19 sort of an all hands on deck.

20 And for our commercial population for
21 which these measures are intended to endorse --
22 be endorsed, we have, we have a purchaser

1 population, large, small, and independent groups
2 that are funding their group insurance. And we
3 also have that important group as a constituency
4 to make sure that we're providing high quality,
5 most affordable solutions for them.

6 And so it's, you know, as a provider
7 we've got to be accountable across the whole.
8 And as a payer, we also need to help providers by
9 segmenting these measures. And what we have in
10 front of us today is sort of a commercial, that
11 commercial segment.

12 So, I know it gets very challenging
13 when we think about the broad panel. So those
14 would be my sort of high-level comments just
15 acknowledging the comments and concerns that are
16 being raised, but also trying to hone in on what
17 this measure is intended to do.

18 CO-CHAIR ASPLIN: Thank you, Sue.

19 Srinivas.

20 MEMBER SRIDHARA: Yes. Just a comment
21 on the SDS work. I haven't been engaged with
22 NQF's work in it in the past. So just as a -- I

1 may be missing the point perhaps; I don't know.

2 So, from a public health background,
3 critical obviously, and we need to measure it.
4 However, I think in practical terms, if we skip
5 ahead a few sections to usability or feasibility,
6 if you insisted on being able to have information
7 that could tie particular location level of this
8 kind of information, this would be nearly
9 impossible to implement anywhere for anything.
10 It's a -- at least if you're going on a claims-
11 based analysis.

12 So unless you happen to have an
13 approach to do that, I'm not sure what else they
14 can do other than these sort of applications of,
15 you know, census tract or other data that you
16 might get from census, or if you take the
17 experience-type data that they have. I'm not
18 sure you can realistically implement it. I think
19 it's a worthwhile line of questioning how you
20 might use it or as guidance to the end user. But
21 I certainly wouldn't want it to be a part of the
22 measure definition in any way because then it

1 would make it nearly impossible to use because
2 most of them would not have access to that kind
3 of information.

4 So just a comment.

5 CO-CHAIR ASPLIN: One quick comment
6 I'll make on validity as well. It's somewhat
7 usability but it speaks to the validity.

8 So the context of these measures, and
9 I'm going to speak now from the standpoint of
10 leader at Fairview which had a shared savings
11 contract with HealthPartners, had a commercial
12 population at risk. It's always in the context
13 of this, paired with the total cost measure,
14 paired with your contract performance. Right?

15 So you have a shared savings
16 agreement. And I'm not saying this solves all
17 the validity questions, it's just I never had a
18 situation where the three didn't match. Right?
19 So, you know, you're upside down on your shared
20 savings but your resource use looks really good;
21 never happens. Right? So they were always in
22 agreement relative to the results of our shared

1 savings outcome. And then these two measures
2 paired really helped us try to understand where
3 practice patterns may be driving cost and
4 research use versus the pricing problems were
5 driving total cost of care challenges.

6 And so from that standpoint it all
7 held together very well in terms of validity.
8 And, you know, I found it very useful from that
9 perspective.

10 Helen.

11 DR. BURSTIN: Thanks. I just want to
12 make a brief comment to some of the broader
13 conceptual issues raised by Jack and Janis about
14 the over all approach.

15 One thing we have heard repeatedly is
16 this is continuing to be a difficult issue. At
17 times I think it's fair to say we don't -- the
18 data are not yet available in a form that's
19 readily accessible to perhaps get at the best
20 variables. That's number one. And we continue
21 to struggle with that throughout the process.

22 I think the second issue is that the

1 original work of the SES panel -- and some of you
2 were on that original panel -- specifically
3 focused in on individual-level variables, not
4 provider-level variables, so not percent
5 Medicaid, for example, but individual level
6 factors.

7 And, actually, one of the things after
8 a recent discussion on recent readmission
9 measures we looked at is our Disparities
10 Committee in the next couple of months is going
11 to spend a section of time specifically thinking
12 about how would we begin thinking about the use
13 of the provider-level and community-level
14 factors. Because, again, it's something that
15 keeps coming up. A lot of concerns were raised
16 that that may not be the best approach in terms
17 of adjusting for provider-level differences and
18 then being able to see provider-level differences
19 in the outcome.

20 But those are issues very much on our
21 radar. I think, you know, this particular
22 measure at least laid out their methodology. And

1 I think you have to judge it based on the data
2 they have available at this time and whether you
3 think it's adequate certainly.

4 And then lastly, at least for the
5 measures we have been looking at to date,
6 including the recent cost measures as well as the
7 readmission measures, the first issue I mentioned
8 about the availability of adequate data to assess
9 SES and SDS has made us indicate that these
10 measures should come -- be reexamined on an
11 annual basis as part of the annual update for the
12 measure developer to ask about the availability
13 of newer adjusters. Because I think as we get
14 better adjusters -- and again, we're going to
15 continuously be left with this question of are
16 the adjusters adequate to the past of what's
17 available? And if we had better adjusters we
18 would find more differences. And then as we
19 begin to explore, how do we move into looking at
20 provider and community-level factors which other
21 papers in other areas have found to be quite
22 significant?

1 CO-CHAIR ASPLIN: Janis.

2 MEMBER ORLOWSKI: Just to respond.

3 So, Helen, that sounds great. And back to what
4 Jack was saying.

5 I think when you take a look at this
6 the question is is if, for example, in a
7 community there is 20 percent of the population
8 that has increased needs, whatever the increased
9 needs are: whether they're dual-eligible;
10 whether there's high mental health issues;
11 whether there's, you know, poverty; what you want
12 to do is you want to be able to incent the
13 providers and the hospitals and, you know,
14 everyone within the health field to continue to
15 provide care to those individuals and not e
16 "hurt" in a measure like this.

17 So if 20 percent of your population
18 ends up to have higher burden of care, what can
19 we do so that, you know, there's, there's two
20 responses: one is, you know, we're just going to
21 be on the lower end of this measures. That's
22 response one.

1 Response two is, you know, you -- I
2 try to limit the number of individuals that you
3 care for. Completely the wrong thing that you
4 want to incent.

5 And so, I like the idea of taking a
6 look at the burden of, you know, sort of the
7 burden of the SDS within the community. I think
8 that's a very interesting and probably gets us
9 away from this incremental, you know, patient by
10 patient, you know, what are the factors that
11 address them.

12 So, very nice.

13 CO-CHAIR ASPLIN: Very good.

14 MEMBER WEINTRAUB: Good in principle,
15 but can you do it? Can you get the adequate
16 measures to allow you to accomplish that? That's
17 always the question.

18 DR. BURSTIN: At least on the
19 readmission side, for example, people have been
20 pulling some community-level indicators. For
21 example, housing vacancy in a health affairs
22 paper last year off census looked to be

1 important. Again, those are probably indicators
2 of what's happening.

3 The other piece I just want to mention
4 to this group as well is we are increasing
5 recognizing, even before the impact report, but
6 particularly since the impact report came out
7 just a few months ago on SES factors, that some
8 of what we think may be SDS is probably
9 unmeasured clinical complexity. And if you look
10 at the SDS -- if you look at the impact report,
11 for example, they raise issues of, you know,
12 measures of frailty are probably playing into
13 percent dual-eligibility influence and at least
14 on the Medicare side.

15 So I think these are going to be
16 issues we're going to try to tease out. I think
17 it's probably just time for all of us to have
18 sort of a risk adjustment 2.0 reboot. How do we
19 really look at risk adjustment broadly? And how
20 much are we picking up that's SDS that's really
21 clinical complexity that we need to recognize and
22 take care of, as opposed to some of these other

1 factors. So I think it's a really big, important
2 issues.

3 Just one last quick thing. The other
4 thing the SES panel had said when that report
5 came out a couple of years ago is risk adjustment
6 is just one approach. And I don't want to forget
7 that. Payment differences, as we just saw, is
8 part of the 21st Century Cures Act in terms of
9 comparing. Like providers to like providers is
10 another.

11 The third one that this group has
12 emphasized was stratification, you know, the fact
13 that they have emphasized the use of
14 stratification by payer is something you could
15 include, for example, as part of the measure
16 going forward.

17 CO-CHAIR ASPLIN: All right. So I'm
18 just doing a -- going to pull back for a second -
19 - time check. We lost our break. We were
20 supposed to be about done with 1604 at this
21 point. We already are going to have a working
22 lunch. So just, just saying. Try to keep your

1 comments concise.

2 Nancy, Mary Ann, then we're going to
3 vote on validity.

4 MEMBER GARRETT: So just one thing to
5 add to Helen's list of possible alternative
6 approaches to risk adjustment. Another one that
7 was suggested by a recent National Academy of
8 Sciences report is actually identifying measures
9 and labeling them as to whether they are
10 sensitive or not to social disparities. So I
11 mean like a diabetes measure where there's lots
12 of outcomes in the measure, like is your blood
13 pressure in control, et cetera, highly influenced
14 by the resources you have available to you. And
15 something like central line infections in the
16 hospital maybe not so much.

17 And if we can categorize measures
18 according to how sensitive they are, then that
19 would inform how they're used to move money
20 around between, you know, systems and that kind
21 of thing. So just another thing to add to your
22 idea.

1 DR. BURSTIN: And that's actually part
2 of our disparities work as well. We're going to
3 take up our old disparities sensitivity algorithm
4 and refresh it with the current Disparities
5 Committee and think about -- and the impact
6 report also very clearly said you need equity
7 measurement. And we think that's part of it. We
8 see this as really an interconnected set of
9 issues. And this is just bringing it around.

10 CO-CHAIR ASPLIN: Mary Ann.

11 MEMBER GARRETT: If I could make one
12 other quick comment.

13 CO-CHAIR ASPLIN: Oh, I'm sorry.

14 MEMBER GARRETT: Sorry.

15 Just I, I just want to also make the
16 point that while we're talking about a commercial
17 population for this measure, there's certainly a
18 lot of disparities within commercial populations.
19 And just as one example, my health system runs a
20 small food shelf. And a lot of the patients that
21 we give food to have commercial insurance.

22 So I don't want us to assume that

1 there aren't issues within commercial populations
2 as well as we're thinking of this.

3 CO-CHAIR ASPLIN: Mary Ann.

4 MEMBER CLARK: Yes, hi. Just a couple
5 of things.

6 One is the discussion about -- I don't
7 know if we've discussed the pharmacy costs and
8 how to account for that. Before it was estimated
9 for the patient members who did not have -- who
10 had it paid for through a PBM, for example. And
11 I'm trying, I'm trying to remember that percent
12 of members where that was the case.

13 Can you remind me of that?

14 And then also, if it was a large
15 percentage was there any type of sensitivity
16 analysis on that? You know, I know that you, you
17 used an average for that, for that provider, I
18 believe, on pharmacy costs for the patients who
19 did not have pharmacy cost data.

20 MR. HEIM: Yes, this is Chad.

21 Our carve out rate for data that we're
22 doing the testing on was about 20 percent

1 pharmacy carved out.

2 MR. KITCHING: And then -- this is
3 Gary -- and then that will vary depending on the
4 provider because, obviously, providers are going
5 to have different rates of carve-outs. And
6 tested that down and the lowest one we got to was
7 about 70 percent of people had carve-outs -- or
8 had pharmacy at a 30 percent carve-out rate.

9 We're going to do an analysis right
10 now that kind of tests that all the way down to
11 see where it be breaks, to be honest. We never
12 did that before because we never experienced it
13 in our market. Most folks, to be honest, have a
14 high -- only a low percentage of that carve-out.
15 And that came back invalid.

16 So we're going to try to test that
17 down to, again, see where that carve-out level
18 breaks. And we'll have it on our website at some
19 point in the future.

20 MS. KNUDSON: But we haven't had that
21 be an issue with the users so far.

22 MR. KITCHING: Yes, it hasn't been an

1 issue in our market or anybody across the nation
2 that have actually depended on the measure.
3 Again, just for because we want to do our due
4 diligence, we want to make sure we test that
5 down.

6 MEMBER CLARK: Okay, great. And then
7 just one other questions I had.

8 We haven't talked about validity. And
9 I know -- I mean face validity. And I realize
10 that, you know, the important thing is the
11 empirical testing. But I know that you did some
12 extensive face validity testing as well. And
13 that's kind of where, in one sense where, you
14 know, it's pretty valuable to your, you know,
15 your users there.

16 So I was just curious if you might be
17 able to summarize briefly what was found in that
18 face validity testing?

19 MR. HEIM: Yes. So, a couple
20 examples, one with our business. When we run
21 our, run our total cost of care and resource use
22 results we make those available to our provider

1 networks for them to review and vet. And we have
2 a 45-day comment period for them to review those
3 results.

4 And in addition, we meet frequently
5 internally with medical directors in a broader
6 relation in going through those results. And as
7 well as then meet with the providers frequently
8 to walk them through those results.

9 Other examples for face validity is
10 implemented at measurement where there's a multi-
11 stakeholder committee with numerous stakeholders
12 having, in essence going through NQF endorsement
13 through over a year-long process re-vetting the
14 measure and providing input on that as that was
15 rolling out.

16 And then same was true when we rolled
17 out research use with measurement.

18 And then the other example would be
19 NHRI who have -- are just like measurement, they
20 have regional stakeholders involved reviewing and
21 vetting the measures as well.

22 MEMBER CLARK: And in terms of what

1 you found though, in general there were no
2 issues? Or if there were issues, how were those,
3 you know, addressed?

4 MS. KNUDSON: You know what, we did
5 not have issues with the measure. I think most
6 of the things that we -- if we ran into anything
7 it was in the "how to" in rolling this out. But
8 it wasn't in the measure itself.

9 And so we haven't had any of those
10 issues. And I think many of the national
11 organizations who have taken up the measure, or
12 our local constituents who wrote in positive
13 comments would also help with that face validity
14 piece, as well as Brent's previous comment. So,
15 thanks for that from usability from a Fairview
16 perspective.

17 That's commonly what we hear from
18 organizations. And, you know, we're so super
19 transparent because of the idea that we want to
20 compete on our results, that I think that really
21 helps particularly our clinical colleagues
22 because they've never really seen anyone be this

1 transparent with methods. And all that
2 consultation and data sharing to drive an
3 improvement portfolio that goes along with it.

4 So it's partly in the "how to."

5 MEMBER CLARK: Thank you.

6 CO-CHAIR ASPLIN: All right. Thank
7 you.

8 Let's move to the vote on validity.
9 We've had a good conversation, good discussion.
10 And unless I see any objections to moving to the
11 vote, I think we should move forward with that.
12 So, Irvin.

13 MR. SINGH: Thank you. So, we're
14 going to begin voting on validity for Measure
15 1598. Your options are 1, high; 2, moderate; 3,
16 low; or 4, insufficient.

17 Please vote now.

18 (Voting.)

19 MR. SINGH: So all votes are in.
20 Voting is now closed for validity for Measure
21 Number 1598. The results is as follows:

22 2 votes for high; 14 votes for

1 moderate; 2 votes for low; and 0 votes for
2 insufficient. That accounts for 11 percent of
3 the votes being high; 78 percent of the votes
4 being moderate; 11 percent of the votes being
5 low; and 0 percent for the votes for
6 insufficient.

7 The measure passes for validity.

8 CO-CHAIR ASPLIN: Thank you. Bill,
9 you have -- I think just from a time check
10 standpoint we're going to try to plow through and
11 finish 1598. And then we'll break to grab lunch
12 for about 15 minutes and then do a working lunch
13 and consider 1604. So that's the overall game
14 plan.

15 And, Bill, to your comments, please,
16 as the discussant on feasibility.

17 MEMBER WEINTRAUB: Right. So,
18 obviously, this is a much simpler one than what
19 we just discussed.

20 The measure has been around and it's
21 been retested. It's been shown that people can
22 apply it. However, so we seem to be really

1 feasible from that standpoint. Also, no new data
2 is required; it's all administrative data.

3 Again, it suggests high feasibility.
4 There are a couple of caveats though. Well, I
5 mean this really applies to the commercial space
6 rather than Medicare and Medicaid, which is fine
7 as long as we keep within that space.

8 The other caveats are that the data
9 we're seeing are from Wisconsin and Minnesota, as
10 I understand it. This is applied widely. But
11 we're not seeing data quite as widely as we
12 might.

13 And, finally, that it does require
14 applying some commercial software. So there is
15 some expense related to it.

16 But that's really it. I mean, I think
17 that this is really pretty simple and does not
18 require additional data collection, which is very
19 good.

20 CO-CHAIR ASPLIN: Thank you, Bill.

21 Any other comments or questions
22 relative to the feasibility of Measure 1598? I

1 see none in the room and I do not see any hands
2 raised online.

3 So, without objection, I think we
4 should move forward to the vote on feasibility
5 for 1598.

6 MR. SINGH: Okay, thank you.

7 So we're going to be voting on
8 feasibility for Measure Number 1598. Your
9 options are as follows:

10 Number 1, high; number 2, moderate;
11 number 3, low; number 4, insufficient. Please
12 begin voting.

13 (Voting.)

14 MR. SINGH: So all votes are in. And
15 voting is now closed for feasibility for Measure
16 Number 1598. The results is as follows:

17 14 votes for high; 4 votes for
18 moderate; 0 votes for low; and 0 votes for
19 insufficient. That accounts for 78 percent of
20 the votes for high; 22 percent of the votes for
21 moderate; 0 percent votes for low; and 0 percent
22 votes for insufficient.

1 This measure passes for feasibility.

2 CO-CHAIR ASPLIN: Thank you, Irvin.

3 Jack, you're the lead discussant for
4 usability on this measure. Your comments,
5 please.

6 MEMBER NEEDLEMAN: Okay. So, again,
7 I think the conversation here can be relatively
8 short. The first measure of usability is it's
9 used. And it has been wide -- it has been
10 extensively used. If anything, according to the
11 documentation we received, the use has expanded,
12 which suggests a high level of usability.

13 When I look at the measure and when I
14 look at the comments that have been made two or
15 three things stand out in terms of usability.
16 One is part of what makes this usable is the
17 disaggregation by type of service that is
18 provided. So you get those as well.

19 And without that it would be a lot
20 more difficult to make use of the measure. But
21 that is present. That seems to be part of the
22 methodology, so that solves that problem.

1 The attribution issue was raised in
2 some of the online comments about the
3 appropriate, you know, usability. Similarly,
4 comparison groups were raised in some of the
5 online comments, with specifically the example of
6 gynecologists being treated as primary care
7 providers and yet having potentially very
8 different kind of resource use pattern than other
9 primary care providers. That would seem to be
10 solvable in terms of the groups that are using
11 it, in terms of getting appropriate comparisons.

12 But overall, the usability looks like
13 it meets those criteria by virtue of the fact
14 that it's been widely used. And folks like Brent
15 have indicated that it was useful to them.

16 CO-CHAIR ASPLIN: Thank you, Jack.

17 Any comments, additional comments
18 before we move forward?

19 Yes, I would just for my own
20 perspective add quickly, I had opportunity to
21 work with ACOs, track 1, track 3, primary ACO,
22 commercial shared savings, Medicare Advantage,

1 with, in multiple markets with regional carriers
2 and national carriers. And, quite frankly, for
3 feedback on cost and resource use, the
4 HealthPartners measures are completely in a
5 league of their own. There's nobody that's
6 close, in my experience, in terms of actionable
7 feedback on your cost and resource use.

8 Nancy?

9 MEMBER GARRETT: So, I was just going
10 to share that my experience as a provider in the
11 market in Minnesota where Minnesota Community
12 Measurement has adopted this measure, and I think
13 it's great that HealthPartners is providing a lot
14 of the kind of analytic tools and ability to
15 disaggregate the data.

16 Community Measurement, so what they're
17 doing is they're calculating this on a system
18 basis. So, for my medical system I get a report
19 for commercial patients showing these two
20 measures, the resources and the total cost of
21 care across all my commercial patients. And it's
22 super helpful because otherwise we're getting a

1 different report from the rate payer, and they
2 all say different things. And so now this
3 aggregates together in a much bigger population.

4 But that organization isn't adopting
5 all of the tools that HealthPartners provided
6 since we're in a contract with them, and so in
7 that sense it's been less usable because keep in
8 mind that this measure, it includes utilization
9 within your own provider system but also external
10 utilization. So anyone attributed to you for
11 primary care, it's all the services they're
12 using, no matter where they are. And if you
13 don't have any information on that, there's, you
14 know, a lot less ability to kind of use those
15 figures.

16 So, that's not a fault of the measure
17 but it's just kind of a practical reality of
18 implementation of this.

19 CO-CHAIR ASPLIN: Thank you, Nancy.

20 I think we'll move forward, unless
21 there's objection, to a vote on usability.
22 Irvin.

1 MR. SINGH: Thank you. So, we're
2 going to begin voting on usability and use for
3 Measure Number 1598. Your options is as follows:

4 Number 1, high; number two, moderate;
5 number 3, low; number 4, insufficient. Please
6 begin voting now.

7 (Voting.)

8 MR. SINGH: So all votes are in. And
9 voting is now closed for usability and use for
10 Measure Number 1598. The results is as follows:

11 13 votes for high; 5 votes for
12 moderate; 0 votes for low; and 0 votes for
13 insufficient. That accounts for 72 percent of
14 the votes for high; and 28 percent of the votes
15 for moderate; 0 percent votes for low; and 0
16 percent of votes for insufficient.

17 This measure passes for usability and
18 use.

19 CO-CHAIR ASPLIN: Thank you. So the
20 measure has passed all the must-pass criteria, as
21 well as feasibility and usability. So our final
22 vote on this measure is the overall suitability

1 for endorsement.

2 And, Irvin, could you walk us through
3 this?

4 MR. SINGH: Yes. So we're going to
5 begin voting on overall suitability for
6 endorsement for Measure Number 1598. And the
7 options are number 1 for yes, and number 2 for
8 no.

9 Please begin voting now.

10 (Voting.)

11 MR. SINGH: John, if you could please
12 submit your vote now.

13 MEMBER RATLIFF: Excuse me. Sorry for
14 the delay.

15 CO-CHAIR ASPLIN: So everybody's
16 voted. We're at 17. We've been at 18 the last
17 few.

18 MR. SINGH: John, can you please email
19 your vote.

20 CO-CHAIR ASPLIN: While we're waiting
21 for that vote, Operator, if you could prepare.
22 Our published agenda has opportunity for public

1 and member comment right now on the published
2 agenda. And so, before we break for lunch we
3 just want to honor that published agenda in case
4 someone has dialed in and would like to make a
5 comment at this time.

6 Irvin's got the results here. And
7 then, Operator, if you could open up the lines
8 for public comment.

9 MR. SINGH: So all votes are in. And
10 voting is now closed for overall suitability for
11 endorsement Number 1598. The results is as
12 follows:

13 18 votes for yes and 0 votes for no.
14 It accounts for 100 percent for yes.

15 CO-CHAIR ASPLIN: Thank you. Thank
16 you to the committee. I get an F for honoring
17 breaks so far today. We'll try to improve,
18 although we're behind the 8 ball now. But,
19 hopefully, we got a lot of the comments out. And
20 1604 we'll have some similar topics I'm sure.

21 But, Operator, could you see if there
22 are any public comments at this time.

1 OPERATOR: Yes, sir.

2 At this time if you would like to make
3 a comment, please press star then the number 1.

4 Okay, and at this time there are no
5 public comments.

6 CO-CHAIR ASPLIN: Thank you. And
7 thank you to the HealthPartners team. We're
8 going to break for 15 minutes and reconvene. The
9 lunch is available here in the room. So 12:15
10 Eastern we'll start with the conversation on
11 1604. Thank you.

12 Sorry. Are there any comments in the
13 room on 1598?

14 (No response.)

15 CO-CHAIR ASPLIN: All right, very
16 good.

17 (Whereupon, the above-entitled matter
18 went off the record at 12:00 p.m. and resumed at
19 12:18 p.m.)

20 CO-CHAIR ASPLIN: Okay. We are going
21 to move ahead and get started with 1604. And
22 I've been informed we have an option on

1 importance to measure.

2 We have an option on importance to
3 measure for Measure 1604, given the similarities
4 between Measure 1604 and 1598. That's 1604 and
5 1598. The Committee has an option to roll its
6 votes from 1598 and having them apply on 1604
7 just for this category, for importance to
8 measure.

9 Unless -- if there's objection to
10 that, we can hold a separate vote. And if there
11 are specific comments on importance to measure
12 that people would like to make in distinction for
13 1604 versus 1598, we obviously will entertain
14 those.

15 Larry, you were the lead discussant,
16 did you have any differences in terms of your
17 comments on importance to measure for 1604?

18 MEMBER BECKER: Not substantive.

19 CO-CHAIR ASPLIN: Is there objection
20 to using our votes for importance to measure only
21 from 1598 and applying those to 1604?

22 (No response)

1 CO-CHAIR ASPLIN: Seeing none, anyone
2 online have an objection?

3 (No response)

4 CO-CHAIR ASPLIN: Hearing none, we
5 will apply the votes for importance to measure
6 from 1598. And it will pass that criterion and
7 that includes all three votes, correct?

8 MS. DUDHWALA: All three votes.

9 CO-CHAIR ASPLIN: Very good. So we
10 will move to scientific acceptability. And Mary
11 Ann, I apologize because I misread the notes that
12 were very clear now that I read them. And when I
13 called on you last time.

14 But, Mary Ann is our lead discussant
15 for scientific acceptability for 1604.

16 Mary Ann are you online? She maybe
17 thought we were going to take a little bit longer
18 on importance to measure.

19 Mary Ann, if your --

20 MEMBER CLARK: Sorry about that. I
21 had a little emergency I had to attend to here.
22 But I am back now. So, we're talking about the

1 next measure.

2 CO-CHAIR ASPLIN: Correct. We applied
3 our votes for importance to measure from 1598 to
4 1604. So we went through that with lightning
5 speed.

6 So now we are on scientific
7 acceptability. And we do have to do a full
8 discussion of the acceptability.

9 MEMBER CLARK: Okay. So I need to
10 vote on the other one I guess, right?

11 CO-CHAIR ASPLIN: You do not. We --

12 MEMBER CLARK: Oh. Okay.

13 CO-CHAIR ASPLIN: Didn't do individual
14 votes. So we accepted their votes from 1598 just
15 for the importance to measure criteria. Those
16 three votes.

17 MEMBER CLARK: Okay.

18 CO-CHAIR ASPLIN: So, take us through
19 the scientific acceptability on 1604 if you
20 would, please.

21 MEMBER CLARK: Sure. Let me just
22 bring up my documents here. I think in general

1 it's going to be fairly similar, you know, to the
2 resource use measure.

3 I mean, but we're looking at it from
4 a cross perspective where a, you know, allowable
5 -- allowed payment perspective. So, that's
6 really the difference.

7 You know, the same -- the data has
8 been updated, you know, from the previous
9 endorsement. So we have a new data set being
10 used.

11 But basically the numerator is the
12 total per member per month medical costs, and
13 pharmacy costs. And then of course risk adjusted
14 with the same ACG risk adjustor. And then that
15 being divided by the comparison group measure.

16 In terms of the exclusions, it's the
17 same exclusions as before. Members under the age
18 of one, members 65 and over, and members with
19 less than nine months of enrollment.

20 Let's see, commercial payer claims.
21 And for the socioeconomic testing of course the
22 Medicaid data was used as well.

1 And let's see, the measure was tested
2 at both the data element and the score level on
3 the -- for reliability. And again, using the
4 same methods as in the resource use measure, the
5 90 percent random sample and bootstrapping sample
6 as well as changes over time.

7 Let's see -- the results, you know, of
8 those two tests for reliability, they were
9 basically what we talked about for the other
10 measure. So, I don't know how much we want to go
11 into that here.

12 I mean, there was some data that
13 looked at, you know, the results of the first
14 endorsement compared to this endorsement, I
15 guess. And they did change slightly, I guess.

16 It looks like the variance actually
17 got a little smaller. And let's see, it looks
18 like in terms of the provider performance across
19 the years that the data was relatively consistent
20 across all three years with a difference on
21 average of about three percent.

22 So, let's see, what were some of the

1 issues? I think in general people felt like this
2 measure was reliable.

3 And I think in terms of the concerns
4 voiced, they were very similar to the resource
5 use measure. Had to do with attribution methods.
6 Some people wanted to know more about the risk
7 adjustment method being used.

8 But, in general, I think, they -- the
9 comments were that the reliability was high and
10 that the measure is clearly defined and
11 implemented.

12 Let's see here, the same -- a similar
13 concern is on the other measure about the testing
14 of the data that was in a one payer that was
15 restricted to, you know, a certain geographic
16 region of the country. And whether that would
17 have an impact on the generalizability of the
18 results.

19 So, I think, -- let's see. In terms
20 of answering the questions for reliability that
21 were posed, let me get to those here.

22 Are all the data elements clearly

1 defined and the appropriate codes included? Is
2 the logic in the calculation clear? Can it be
3 consistently implemented?

4 And is the construction logic clear?
5 I don't think that most people had issues with
6 that.

7 In terms of the testing, is the sample
8 adequate and generalized to widespread
9 implementation? And do the results demonstrate
10 sufficient reliability so that the differences in
11 performance can be identified? Yes, so again,
12 these testing results for the empirical test were
13 fairly similar to the resource use results as
14 well.

15 So, I don't know if anyone has any
16 other questions or anything to add to the
17 reliability.

18 CO-CHAIR ASPLIN: Thank you, Mary Ann.

19 MEMBER CLARK: Yes.

20 CO-CHAIR ASPLIN: I appreciate it.
21 So, let's start with reliability in terms of
22 comments, questions, concerns about reliability

1 on measure 1604.

2 I do not see any hands in the room or
3 online. Nancy, do you have any comments on
4 reliability?

5 MEMBER GARRETT: No.

6 COOCHAIR ASPLIN: All right. Very
7 good. Let's move forward to the vote then for
8 reliability on 1604. Irvin?

9 MR. SINGH: All right, thank you. So
10 we're going to begin voting on reliability for
11 Measure Number 1604. Your options are one high,
12 two moderate, three low, or four insufficient.
13 Voting has now begun.

14 (Voting)

15 MS. DUDHWALA: Andrea Gelzer, we're
16 just voting on reliability for Measure 1604. If
17 you could enter your vote.

18 MEMBER GELZER: Did you get it?

19 MS. DUDHWALA: Yes. We got it.

20 MR. SINGH: Okay. So all votes are
21 in. And voting is now closed for reliability for
22 Measure Number 1604.

1 MS. O'ROURKE: We got an extra vote.
2 So, to avoid any corruption concerns, if we could
3 all just vote again.

4 MR. SINGH: All right. So we're going
5 to begin voting again on reliability for Number
6 1604. Please vote now.

7 (Voting)

8 MS. O'ROURKE: I think we're missing
9 two. So if you could -- if everyone could hit
10 their clicker one more time.

11 MEMBER WEINTRAUB: Did you get the
12 phone-in votes?

13 MS. O'ROURKE: I believe we have all
14 the phone-in votes. So, the missing vote -- oh,
15 we have 18.

16 MR. SINGH: All right. So all votes
17 are in and voting is now closed for reliability
18 for Measure Number 1604.

19 The result is as follows: ten votes
20 for high, eight votes for moderate, zero votes
21 for low, and zero votes for insufficient. That
22 accounts for 56 percent of the votes for high, 44

1 percent of the votes for moderate, zero percent
2 of the votes for low, and zero percent of the
3 votes for insufficient.

4 This measure passes for reliability.

5 CO-CHAIR ASPLIN: Thank you. We'll
6 now open up the conversation on the topic of
7 validity. Comments from committee members
8 related to validity for Measure 1604. Jack?

9 MEMBER NEEDLEMAN: It's just, I need
10 some clarifications from the developers of how
11 price is paid or included in here. Again, around
12 hospitals for example, some payers maybe paying
13 DRGs. Others may be paying discounted charges.

14 Is the -- what is the basis for
15 including -- for the prices that are in the
16 model? Where there are variations in how the
17 units of payments?

18 MR. KITCHING: So the full cost
19 measure again, is using a loud amount, which the
20 plan liability plus the member liability, and
21 then looking at -- specifically at the riders.
22 The prices select, for example, hospitals, could

1 be varied. They could be on a DRG payment system
2 or they could be on a discount or fee-for-service
3 basis as well.

4 But all those payments are aggregated
5 up from the hospital from what the plan is
6 paying, but as well as the member liability. And
7 that's rolled together for the total cost of care
8 for the all-in-one.

9 I would just add that the majority is
10 prospectively priced.

11 CO-CHAIR ASPLIN: Thank you. Other
12 questions from the committee relative to
13 validity?

14 (No response)

15 CO-CHAIR ASPLIN: Seeing none online
16 and none in the room, let's move forward to the
17 vote on validity for Measure 1604. Irvin?

18 MR. SINGH: Thank you. So, we're
19 going to begin voting on validity for Measure
20 Number 1604. Your option is as follows: number
21 one high, number two moderate, number three low,
22 and number four insufficient.

1 Please begin voting.

2 (Voting)

3 MS. O'ROURKE: So we have another
4 phantom vote. It got to 19. So we're going to
5 need to do it one more time in the room. The
6 folks on the phone, we have your votes. No
7 action needed on your part.

8 People in the room, please vote one
9 more time.

10 (Voting)

11 MR. SINGH: All right, so all votes
12 are in. And voting is now closed for validity
13 for Measure Number 1604.

14 The result is as follows: three votes
15 for high, 14 votes for moderate, one vote for
16 low, and zero votes for insufficient. That
17 accounts for 17 percent of the votes for high, 78
18 percent of the votes for moderate, 6 percent of
19 the votes for low, and zero percent of the votes
20 for insufficient.

21 This measure passes for validity.

22 CO-CHAIR ASPLIN: Thank you. We'll

1 now move onto feasibility on 1604. Bill, do you
2 have any additional comments relative to
3 feasibility for Measure 1604?

4 MEMBER WEINTRAUB: No. Exactly the
5 same comments I had on the previous measure.

6 CO-CHAIR ASPLIN: Thank you. Now open
7 for committee discussion, comments, questions
8 related to feasibility.

9 (No response)

10 CO-CHAIR ASPLIN: Seeing none in the
11 room, I see no hands raised online. Let's move
12 forward to the vote on feasibility for Measure
13 1604. Irvin?

14 MR. SINGH: We're going to begin
15 voting on feasibility for Measure Number 1604.
16 Your options are one high, two moderate, three
17 low, or four insufficient. Please start voting.

18 (Voting)

19 CO-CHAIR ASPLIN: In the room, just
20 hit your button again in case we're missing one.

21 MR. SINGH: Okay. So all votes are
22 in. And voting is now closed for feasibility for

1 Measure Number 1604.

2 The result is as follows: 12 votes
3 for high, six votes for moderate, zero votes for
4 low, and zero votes for insufficient. That
5 accounts for 67 percent of the votes for high, 33
6 percent of the votes for moderate, zero percent
7 of votes for low, and zero percent of votes for
8 insufficient.

9 This measure passes for feasibility.

10 CO-CHAIR ASPLIN: Thank you. Relative
11 to usability. Jack, any additional comments on
12 1604?

13 MEMBER NEEDLEMAN: Yes. I actually
14 have a question for the developers on this. The
15 earlier measure uses standardized prices to -- so
16 it's basically utilization weighted --
17 standardized price weighted utilization measure.

18 And then you get that disaggregation
19 by different types. This includes the actual
20 prices paid. So, you see a price-weighted
21 utilization measure, where actually the prices
22 are being paid.

1 If in terms of usability you want to
2 be able to know how -- you want to be able to
3 disaggregate how much of the effect is associated
4 with pricing, how much you're paying versus the
5 volume of use.

6 And in the documentation, it's not
7 part of the measure, but in the documentation
8 there is a price index which looks like it's the
9 ratio of the total TCI measure and the RUC
10 measure.

11 I could not see in the materials
12 provided whether that calculation is done down to
13 the individual types of services that are being
14 provided. Which would clearly affect the
15 usability.

16 You have to know whether you're paying
17 a lot more for hospitals than the average. Or
18 whether you're paying a lot more for your E&M
19 services than average in order to figure out
20 whether you're getting value for those additional
21 payments.

22 So, I'm just asking the developers,

1 does that calculation of the price index, not an
2 inherent part of the measure, but part of your
3 documentation, is that carried out down to the
4 individual types of services there for which data
5 is provided?

6 MR. HEIM: Hi Jack. This is Chad.
7 Yes. And that's where the actual billing starts
8 playing out when you're using these measures
9 together.

10 But yes, it's a simple ratio of the
11 cost divided by the research use. And then
12 that's drillable all the way down to the
13 procedure level.

14 So you can start understanding within
15 a hospital setting or a professional setting,
16 E&Ms if the price is driver or utilization is
17 driving.

18 MEMBER NEEDLEMAN: Great. Thanks for
19 the clarification.

20 CO-CHAIR ASPLIN: Other comments or
21 questions related to usability? Troy, you have a
22 comment?

1 MEMBER FIESINGER: Yes. A question
2 for the developers. Can you ask them if the
3 implementation cost as a pair of measures. I'm
4 thinking of smaller systems or smaller physician
5 groups that want to use this. It ties into my
6 usability question.

7 MS. KNUDSON: You know, we don't
8 really get into that at all with the users. It's
9 -- but what I will say is most of our users have
10 been able to bring this up with their existing
11 staff.

12 And the only external cost is the
13 commercial risk adjuster. But some of them, and
14 many of them already have those licenses in
15 place. So it wouldn't be incremental cost.

16 For some of the organizations that
17 have brought it up from scratch like NHRI or
18 Minnesota Community Measurement, the risk
19 adjuster, at least the one Johns Hopkins makes
20 available, they do have a much significantly
21 lower cost research based license fee that is
22 very affordable. Like around the thousand-dollar

1 range versus what us as commercial payers would
2 pay.

3 So often these tools are already
4 available by the users. And if they're not, they
5 seem to be for these organizations that give a
6 much more affordable price break and then
7 existing staff.

8 And then we have seen some care
9 groups, you know, work with their consultants.
10 But they're not hiring like brand-new
11 consultants. It's their existing relationship.

12 So -- but I don't have a specific
13 number for you. But that's our observation.

14 MEMBER FIESINGER: Okay. That's still
15 helpful. And then are you able to aggregate, it
16 sounds like all the different commercial payers
17 data, for the organization if you're contracted
18 to it?

19 MS. KNUDSON: Yes. If you're
20 contacted to do it as a vendor, we just require
21 the vendors to, you know, the software is free of
22 charge. But we do have a license agreement for

1 the resource use. And that is because we have a
2 patent on our resource use.

3 And our whole idea was to put this
4 stuff out there in the public domain free of
5 charge. So we didn't want folks to commercialize
6 it and then have additional funding be an
7 impediment of users adopting it.

8 So we do require vendors to license it
9 one client at a time. Which is super easy to do.

10 MEMBER FIESINGER: Okay. Thank you.

11 CO-CHAIR ASPLIN: Thank you. Seeing
12 no other comments, let's move to the vote on
13 usability for 1604. Irvin?

14 MR. SINGH: Okay. Thank you. So,
15 we're going to be voting on usability and use for
16 Measure Number 1604. Your options are one high,
17 two moderate, three low, and four insufficient.

18 Please begin voting.

19 (Voting)

20 MR. SINGH: Okay. So all votes are
21 in. And voting is now closed for usability and
22 use for Measure Number 1604.

1 The result is as follows: 12 votes
2 for high, six votes for moderate, zero votes for
3 low, and zero votes for insufficient. And that
4 accounts for 67 percent of the votes for high, 33
5 percent of the votes for moderate, zero percent
6 of the votes for low, and zero percent of the
7 votes for insufficient.

8 This measure passes for usability and
9 use.

10 CO-CHAIR ASPLIN: Thank you, Irvin.
11 And we can now do our final vote, overall
12 suitability for endorsement. The yes/no
13 question. We can move to that at this time,
14 Irvin.

15 MR. SINGH: Thank you, Brent. So,
16 we're going to begin voting on overall
17 suitability for endorsement for Measure Number
18 1604. Your options are one yes, two no.

19 (Voting)

20 MR. SINGH: Okay. So all votes are in
21 and voting is now closed for overall suitability
22 for endorsement of Measure 1604.

1 The results is as follows: 18 votes
2 for yes, and zero votes for no. And that is 100
3 percent of votes for yes.

4 CO-CHAIR ASPLIN: Thank you. So this
5 concludes our discussion of Measure 1604. We are
6 going to open up before the developers leave
7 here, open up for public comment on -- I'm going
8 to start it with 1604.

9 So, if there are comments online,
10 Operator, can you open that up for 1604. And
11 just for anyone who's online and has a comment
12 for 2158, we're going to do that next before we
13 start the conversation on it.

14 So, 1604 any public comments on the
15 total cost index, 1604. Operator?

16 OPERATOR: Okay. At this time if you
17 would like to make a comment, please press star
18 then the number one.

19 (No response)

20 OPERATOR: And there are no public
21 comments at this time.

22 CO-CHAIR ASPLIN: Thank you. Are

1 there any comments in the room on 1604?

2 (No response)

3 CO-CHAIR ASPLIN: Thank you. And with
4 that I'd like to thank Sue Knudson, Chad Heim,
5 and Gary Kitching for your comments and support
6 in terms of the conversation today. It was very
7 helpful to have you on the line to answer
8 questions.

9 So, thank you to the three of you.

10 MR. KITCHING: You're welcome.

11 MS. KNUDSON: Thank you.

12 CO-CHAIR ASPLIN: And with that, I'm
13 going to hand this over to Cheryl. Because she's
14 going to be leading the conversation on 2158.
15 And we've had a request to do the public comment
16 first.

17 So Cheryl, go ahead.

18 CO-CHAIR DAMBERG: Sure. So we're now
19 focused on Measure 2158. The measure -- excuse
20 me, the Medicare Spending Per Beneficiary.

21 This is a hospital only measure. My
22 understanding is that there is a measure in

1 development that will focus on physicians.

2 But, before the committee begins its
3 work, because I know folks on the line
4 potentially have been waiting a long time, we're
5 going to accept comments at this point.

6 So Operator, can you find out if there
7 is anyone who would like to make a comment on
8 2158?

9 OPERATOR: Yes, ma'am. At this time
10 if you would like to make a comment, please press
11 star then the number one.

12 (No response)

13 OPERATOR: And there are no public
14 comments at this time.

15 CO-CHAIR DAMBERG: All right. And are
16 there any comments from folks in the room?

17 MR. WETZEL: Yes. One comment. Hi,
18 this is Scott Wetzel. And I am filling in for
19 Janis Orlowski, who unfortunately had to leave.

20 But one comment we wanted to make was
21 on SES and our concerns with that. The WUMC is
22 concerned with the conclusions drawn from the SES

1 analysis of the Medicare Spending Per Beneficiary
2 Measure and the impact that it has on hospitals
3 who care for disadvantaged patient populations.

4 As highlighted earlier by Dr.
5 Orlowski, we have concerns with the variables
6 used. Particularly concerning the black/non-
7 black variable. And request additional insights
8 from the developer as to other variables that
9 were considered for this measure.

10 We also have questions around the
11 income-to-poverty ratio variable. Which resulted
12 in a plus or minus difference of 0.01 or less for
13 97 percent of hospitals.

14 Due to the tight clustering of
15 performance scores for this measure, a difference
16 of 0.01 may significantly affect hospitals caring
17 for disadvantaged patient populations that may
18 require higher utilization of services. So, we
19 request great detail as to whether any particular
20 type of hospital was among those who were -- that
21 moved 0.01 or more under this measure.

22 These comments were submitted to the

1 committee beforehand. So they are included on
2 the worksheet as well. That's it.

3 CO-CHAIR DAMBERG: Okay. Thank you.
4 Are there other comments before we get into
5 discussing the measure?

6 (No response)

7 CO-CHAIR DAMBERG: All right. Seeing
8 none. I am mindful of our time. Brent did a
9 great job of getting us mostly back on track.
10 But, we're running about 25 minutes behind
11 schedule.

12 So, I would ask committee members to
13 stay focused in your comments. And similar to
14 the past two measures, I think most of the
15 discussion is going to fall into the validity and
16 reliability sections.

17 What I would like to do is begin by
18 asking the measure developers to come to the
19 table and give us a very brief overview of the
20 measure. We have two folks with us today, John
21 Pilotte from CMS and Sriniketh from Acumen.

22 So, please come to the table and join

1 us.

2 (Off mic comments)

3 CO-CHAIR DAMBERG: Okay. So for those
4 on the phone, if you couldn't hear, Kim Spalding
5 Bush is here from CMS in lieu of John.

6 DR. NAGAVARAPU: So, thanks very much
7 for the opportunity to speak and answer your
8 questions. I'll give just a very quick overview
9 along the NQF evaluation criteria.

10 So the Hospital MSPB Measure measures
11 total Medicare Parts A and B standardized
12 allotted amounts during episodes of care for
13 hospitals paid under the inpatient respective
14 payment system across all conditions and
15 admissions. The incentive care are designed to
16 include the period immediately prior to, during,
17 and in the 30 days after hospital discharge.

18 In terms of importance to measure and
19 report, the measure addresses a high priority
20 aspect of rising Medicare expenditures in a
21 particular setting in which there are performance
22 gaps.

1 The intent is to incentivize hospitals
2 to coordinate care for patients and reduce
3 unnecessary utilization and adverse outcomes
4 during the period of time encompassing the
5 inpatient stay and immediately after. And there
6 are a large number of hospitals that are covered
7 by the measure, over 3200 with at least 25
8 episodes and 20 percent.

9 The measure has been a well-accepted
10 measure that served a purpose both on its own and
11 informing hospitals about costs. As well as
12 serving as kind of a tool to reorient hospitals
13 towards the new emphasis in areas in CMS programs
14 on bundled payment sorts of programs and care
15 coordination.

16 In terms of scientific acceptability,
17 in the pre-evaluation comments, we saw questions
18 about the reliability threshold. And wanted to
19 provide numbers for a higher reliability
20 threshold of 0.7.

21 And 93 percent of providers at the
22 case mean of 25, meet or exceed the reliability

1 threshold of 0.7. The requirement of a higher
2 threshold then that maybe difficult given that
3 there's natural variation spending across
4 patients that we actually want the measure to
5 reflect.

6 In terms of test/retest results from
7 year to year, as was across random samples within
8 the year, the Spearman ranked correlations and
9 Pearson correlations are very high.

10 Especially considering if you think
11 about kind of a time series model with just a
12 standard moving average process, the maximum
13 correlation you can get is 0.5. And so the
14 correlation above a 0.8 in 2014 and 2015 is
15 incredibly high.

16 In terms of validity, we know a lot of
17 the discussion will focus on socioeconomic
18 status. We did use income-to-poverty ratios at
19 the zip code level as well as race defined by
20 black and non-black.

21 We use those items in risk adjustment
22 and then at calculated measure scores for

1 hospitals based on the new risk adjustment
2 equations.

3 The results cited in the submission
4 form showed that there's not much of a difference
5 in terms of measure scores. With a large
6 percentage of hospitals within a .01 change
7 greater than 95 percent and 97 percent, depending
8 on the specification.

9 The reason we use income-to-poverty at
10 the zip code level is to strike a balance between
11 the desire to look at individual beneficiary
12 attributes, as well as looking at the community
13 attributes that everyone's talking about in the
14 previous session. Because we do think those
15 sorts of community attributes are an important
16 aspect of this that wouldn't necessarily be
17 captured by a Census tract.

18 However, we saw the pre-evaluation
19 comments. Realized that people wanted to see
20 something that was more targeted towards
21 individual beneficiaries. So we also ran an
22 analysis recently looking at the fact of

1 individual dual status.

2 We ran risk adjustment specifications
3 with dual eligibility dummies, recalculated the
4 measures and looked at changes in the measure.
5 For greater than 90 percent of providers, the
6 change in the measure is less than .01. Sort of
7 varying between .008 change on one end, versus
8 .005 or 6 on the other.

9 The measures have -- and that's
10 something we're happy to talk about. As we're
11 familiar with the other analyses that we haven't
12 fund along this dimension. And happy to talk
13 about sort of the community attributes and how
14 that factors into performance on the measure.

15 In terms of the other sort of standard
16 metrics, for validity, the predicted ratios are
17 remarkably stable across risk four deciles. And
18 we can talk about the longer HCC look back and
19 potential problems with that.

20 And the reasons why it doesn't
21 increase predictive power to -- and it provides
22 support for the 90-day look back.

1 The measure is highly correlated with
2 spending at the hospital referral region level in
3 an other publically available measure of resource
4 use. And it's also correlated with service
5 utilization rates.

6 We realize there are some questions
7 and pre-evaluation comments about correlations
8 with readmissions. And so we looked at that in
9 order to see whether hospitals with readmissions
10 tend to have higher or lower measure scores.

11 What we found is that for hospitals
12 with less than 5 percent of their episodes having
13 readmissions, the measure score was approximately
14 .88 on average. For hospitals with greater than
15 20 percent of their episodes having readmissions,
16 the hospital measure scores were greater than one
17 with the hospitals with especially high
18 readmission rates, up along 1.2 or so. So we
19 wanted to be responsive to that.

20 In terms of feasibility and usability
21 and use, the measure is reported in the hospital
22 IQR, Hospital Compare, and Hospital Value-Based

1 Purchasing Programs. It's used for payment
2 modification and goes through rulemaking each
3 year.

4 And so there's rounds of public
5 comments that are taken in every year. So the
6 measure is well vetted and it's -- there's
7 opportunities for hospitals to comment on the
8 measure periodically, and for CMS to take into
9 account, changes that are suggested by hospitals
10 where appropriate.

11 And the measure is highly actionable.
12 There's a question and pre-evaluation comments
13 about how hospitals can make use of this. And
14 how they can control their post-discharge
15 spending.

16 The hospital-specific reports that
17 come with the measure is as long -- as well as
18 the episode files, allow hospitals to understand
19 where spending is being driven by, which
20 providers in the post-discharge period are
21 driving most of the spending.

22 And that allows for physicians to

1 coordinate with providers in those specific
2 facilities in the post-discharge setting. As
3 well as to take into account other more
4 systematic improvements across hospital
5 coordination with post-acute care facilities.

6 The measure's been vetted through
7 multiple periods of public comment. And we're
8 happy to hear your feedback and answer your
9 questions.

10 And so I can circle back to several of
11 these points with more detail if people are
12 interested.

13 CO-CHAIR DAMBERG: Thank you so much
14 for that great summary. And also appreciate some
15 of your additional analytic work to address some
16 of the questions that were raised in the pre-
17 review.

18 What I'd like to do now, is turn to
19 our reviewers. And Jennifer Eames Huff is first
20 up to review importance. Jennifer?

21 MEMBER EAMES HUFF: Hi. I'm going to
22 say this morning Larry did a great job of setting

1 the context of the importance of cost and
2 resource use. So, I'm going to jump directly to
3 the measure.

4 So, in terms of high priority, to
5 demonstrate this, the developers' site data, I
6 think which we are all familiar with, the percent
7 Medicare expenditures account for the gross
8 domestic product as well as how much hospital
9 costs account for Medicare expenditures in total.

10 The staff review scored this as high.
11 And the comments were overwhelmingly in agreement
12 with the review.

13 In terms of performance gap, they used
14 2015 data. And the Medicare spending per
15 beneficiary, the hospital measure score was .99
16 with a standard deviation of plus or minus .99.

17 The provider score ranges from a
18 minimum of .59 to a maximum of 2.25. The median
19 value was .99. And they had the 25th and 75th
20 percentile of the measure score as .94 and 1.03.

21 They also did a similar analysis for
22 the cost piece. So, the mean -- Medicare

1 standardized cost. Mean Medicare spending per
2 beneficiary, the hospital amount was
3 approximately 20,000 with a standard deviation of
4 1800 dollars.

5 The provider amounts range from a
6 minimum of approximately 12,000 to a max of
7 46,000. The median was 20,221. The 25th and
8 75th percentile amounts were around 19,000 and
9 around 21,000.

10 They also did an analysis of the
11 provider score changes between 2014 and 2015.
12 And the results showed that 47 percent of
13 hospitals improved on their measure score. Which
14 is defined as having a lower score.

15 In terms of disparities, I think we
16 just -- it was focused on the SDS risk
17 adjustment. And I think we just heard the
18 measure developer summarize that. So, I'll skip
19 over that and say the staff review was scored as
20 high.

21 In general the comments were
22 supportive of this particular area, I think.

1 There's overall agreement, but there were some
2 caveats. Concerns were raised with regards to
3 the opportunity for improvement and the challenge
4 for hospitals to affect change in what this
5 measure covers.

6 And there were also some critiques
7 about the SDS. Which I also think we heard some
8 of that in the public comment.

9 The intent of the measure is to incent
10 hospitals to coordinate care and reduce
11 unnecessarily -- unnecessary utilization during
12 the episode. This is also scored as high. And I
13 didn't see comments on this in the updated
14 measure sheet.

15 CO-CHAIR DAMBERG: All right. Thanks
16 Jennifer. Why don't we start by seeing if anyone
17 has any questions, comments in the room before we
18 turn to the phone.

19 (No response)

20 CO-CHAIR DAMBERG: All right. Seeing
21 none in the room, any folks on the phone have
22 questions?

1 (No response)

2 CO-CHAIR DAMBERG: All right. Hearing
3 none, I think we can move to a vote.

4 MR. SINGH: Okay. So we're going to
5 begin voting on Measure Number 2158 regarding a
6 high priority. Your options are one high, two
7 moderate, three low, or four insufficient.

8 Please begin voting.

9 (Voting)

10 MR. SINGH: Okay. So all votes are in
11 and voting is now closed for high priority for
12 Measure Number 2158.

13 The results is as follows: 18 votes
14 for high, zero votes for moderate, zero votes for
15 low, and zero votes for insufficient. That
16 accounts for 100 percent of votes for high.

17 And this measure passes for high
18 priority.

19 CO-CHAIR DAMBERG: All right. Thank
20 you. Right, we're now going to shift to what I
21 think is going to be a little more challenging
22 space. Dolores Yanagihara has offered to take us

1 through the scientific acceptability.

2 MEMBER YANAGIHARA: Offered?

3 (Laughter)

4 CO-CHAIR DAMBERG: You're a really
5 good volunteer. I'm sorry.

6 CO-CHAIR ASPLIN: Cheryl, could we
7 just take the remaining --

8 CO-CHAIR DAMBERG: Oh, I'm sorry.

9 CO-CHAIR ASPLIN: The remaining votes
10 for gap and intent. And then we can move onto
11 science.

12 CO-CHAIR DAMBERG: Okay.

13 CO-CHAIR ASPLIN: So we've got two
14 more just sub-criteria votes here.

15 CO-CHAIR DAMBERG: Sorry. I'm kind of
16 new at this game.

17 CO-CHAIR ASPLIN: No, no. It's okay.
18 I think everybody wants to get to that section
19 for discussion.

20 CO-CHAIR DAMBERG: All right. So, the
21 next section is, I'm going to need your help.

22 CO-CHAIR ASPLIN: It's 1B, gap in

1 care. So, Irvin, you want to just walk us
2 through the voting slides, please?

3 MR. SINGH: Sure thing. So, we're
4 going to be voting on gap in care/opportunity for
5 improvement for Measure Number 2158. Your
6 options as follows: one high, two moderate,
7 three low, four insufficient.

8 Voting has now begun.

9 (Voting)

10 MR. SINGH: Looks like our denominator
11 is off. So, we might need to start voting one
12 more time.

13 All right. So we're going to start
14 voting again for gap in care/opportunity
15 improvement for Measure Number 2158. Please
16 submit your votes.

17 (Voting)

18 MS. O'ROURKE: So we have the phone
19 votes, right? So folks on the phone, you are
20 okay. Folks in the room, we're going to clear
21 the slide and vote again.

22 We're having the same issue where it

1 seems to have only captured the high votes. So,
2 if you could vote one more time.

3 MR. SINGH: Vote now.

4 MS. O'ROURKE: I'm sorry, vote now.

5 (Voting)

6 MR. SINGH: Okay. So all votes are in
7 and voting is now closed for gap in
8 care/opportunity for improvement for Measure
9 Number 2158.

10 The results is as follows: 12 votes
11 for high, six votes for moderate, zero votes for
12 low, and zero votes for insufficient. That
13 accounts for 67 percent of the votes for high, 33
14 percent of the votes for moderate, zero percent
15 of votes for low, and zero percent of votes for
16 insufficient.

17 This measure passes for gap in care
18 and opportunity for improvement.

19 CO-CHAIR DAMBERG: Great. So we have
20 one more component. And that is measure intent
21 that we're going to vote on next.

22 MR. SINGH: Okay. So we're going to

1 be voting on measure intent for Measure Number
2 2158. Your options are one high, two moderate,
3 three low, and four insufficient.

4 Please submit your vote now.

5 (Voting)

6 MR. SINGH: So it looks like our
7 denominator is off. We had a couple of phantom
8 votes. So, we have 20 this time. I don't know
9 how that happened.

10 Just bear with me while I restart the
11 vote. Please submit your vote now.

12 (Voting)

13 MR. SINGH: All right. So all votes
14 are in and voting is now closed for measure
15 intent for Measure Number 2158.

16 The result is as follows: 13 votes
17 for high, five votes for moderate, zero votes for
18 low, and zero votes for insufficient. That
19 accounts for 72 percent of the votes for high, 28
20 percent of the votes for moderate, zero percent
21 of the votes for low, and zero percent of the
22 votes for insufficient.

1 This measure passes for measure
2 intent.

3 CO-CHAIR DAMBERG: Great. Okay, so
4 let's go back to scientific acceptability. And
5 Dolores, do you want to walk us through the
6 components? Thank you.

7 MEMBER YANAGIHARA: Okay. So, we'll
8 start with reliability. So the numerator for
9 this measure is basically risk adjusted average
10 spending. So, observe to expect tons of national
11 average spending.

12 The denominator is episode weighted
13 median spending nationally. And the exclusions
14 are zero dollar claims, transfer -- acute to
15 acute transfers, those hospitals not paid through
16 IPPS, the top and bottom one percent, those
17 patients who may have incomplete data, so part A
18 only, became deceased, Medicare Advantage, or
19 Medicaid Primary.

20 And then certain hospitals with --
21 that focus on psychiatric rehab, pediatrics, or
22 primary cancer or research focused.

1 Some of the -- one of the issues
2 raised with kind of the specifications was the
3 disability code used. There was a suggestion
4 that using the OREC code, the original reasons
5 for eligibility code, would have been preferable.

6 And then there was one comment about
7 kind of a concern about just basing performance
8 on DRGs is limiting. It's not kind of the full
9 scope.

10 In terms of testing for reliability,
11 there was new data that was provided. The data
12 was from all of the hospitals for 2015 from
13 January through December 1.

14 There was no real testing done on the
15 data element aside from the regular CMS testing
16 that's done, the auditing that's done and data
17 analysis that's done to look for data
18 completeness. But at the measure score level
19 there was testing done.

20 There were two different kinds of
21 test. Well, two different kinds of tests and
22 then two variations within one of the tests.

1 So there was a test/retest done. The
2 first one was done between 2014 and 2015. And
3 for that test/retest, about three quarters of the
4 hospitals that were high or low, were steady
5 between those two periods.

6 And the correlations were -- both a
7 Spearman correlation and the Pearson correlation
8 were both very high. Over a .8.

9 There was also a test/retest done with
10 random subsets within 2015. That one the
11 agreement between the subsets was a little bit
12 lower, but still over 70 percent of the high or
13 low quintile hospitals stayed in the same
14 quintile.

15 And again, the Spearman rank
16 correlation was high, .82. Pearson was a little
17 bit lower, .7. But that was expected.

18 The other test that was done was a
19 reliability test. And that was done for
20 hospitals with greater than or equal to 25
21 episodes.

22 For -- and I think that Sriniketh

1 brought some additional information that I'll try
2 to incorporate in here. But, 68 percent were
3 over a .9 reliability.

4 And then he added that 93 percent were
5 over a .7 reliability. Which means there would
6 be 7 percent that were, you know, less than .7
7 reliability.

8 Ninety-nine percent were above .4.
9 Which was the threshold that you had originally
10 used. Some -- the concern -- the basic concern
11 raised was the .4 reliability and you adjust
12 that.

13 So, I think that was my notes, what I
14 had for reliability.

15 CO-CHAIR DAMBERG: All right. I'm
16 going to open it up for questions, comments. For
17 those on the phone, please raise your hand and
18 I'm going to start with Nancy in the room.

19 MEMBER GARRETT: So I have a question
20 about risk adjustment. Is this the right place?
21 Or is that validity?

22 CO-CHAIR ASPLIN: That's validity.

1 MEMBER GARRETT: Okay.

2 CO-CHAIR DAMBERG: Bill?

3 MEMBER WEINTRAUB: Hi, so I have a
4 question for the developer and for CMS. So, at a
5 -- really at all the hospitals this looks
6 reliable.

7 But what can we say about the
8 individual hospital? Because we're looking at
9 thousands of hospitals. And some hospitals, and
10 this is more -- part of my comment this morning,
11 similar.

12 Some hospitals may stand out on a
13 stochastic basis either looking poor or looking
14 very good when it's inappropriate. Or just
15 looking like everybody else when really they
16 really should be -- they really are an outlier,
17 just on the basis of the number.

18 Especially for some of the hospitals
19 where the numbers are small. There are various
20 approaches to that. None of them are entirely
21 satisfactory.

22 And I just wonder the thoughts of the

1 developer and CMS?

2 DR. NAGAVARAPU: So real quickly. On
3 the original disability point. It wasn't noted
4 in this mission form. But we did use the
5 original reason for disability.

6 So, that -- yes. And so the
7 disability flag, wherever that's expressed, is
8 the original reason for disability.

9 CO-CHAIR DAMBERG: Actually, can I
10 follow up on that? Because that was my comment.

11 DR. NAGAVARAPU: Yes. Sure.

12 CO-CHAIR DAMBERG: So did you guys use
13 the enrollment database or the integrated data
14 repository?

15 DR. NAGAVARAPU: It's from the
16 enrollment database.

17 CO-CHAIR DAMBERG: Okay. So the
18 reason I raise this, because we've been, in work
19 that I do for CMS, been using that same variable.
20 And it turns out that at age 65 it resets to aged
21 into Medicare.

22 Whereas the variable that's in the

1 integrated repository, it's the OREC variable.
2 It retains their disability status beyond age 65.
3 So, it's an easy tweak for you guys.

4 But, I just wanted you to be aware of
5 that. So if you did your cost tabs, you wouldn't
6 find anybody over the age of 65 who is disabled.

7 DR. NAGAVARAPU: And just to make sure
8 about that, there is a current reason for
9 eligibility that's also included in EDB. And
10 we're not using that.

11 So, we're not using current
12 disability. We're using EDB disability.

13 CO-CHAIR DAMBERG: Yes. No, you want
14 the OREC. But you want it from the integrated
15 data repository.

16 And I don't know sort of all the ways
17 Medicare data flows. But somehow or other it
18 doesn't get reset in the IDR. It's kind of
19 strange.

20 DR. NAGAVARAPU: So, on the other
21 comment, so we did some additional numbers just
22 to get a sense of how much hospitals are moving

1 around in the type of comment that's being made
2 there.

3 Because the reliability numbers
4 reflect that in part in the sense that we're
5 calculating reliability. Kind of a signal to the
6 within metric for each hospital.

7 And trying to understand how much the
8 within variance is relative to the between
9 variance, and I think that's a point that maybe
10 Dr. Needleman and Dr. Naessens had brought up in
11 the last session. And so the reliability metric
12 speaks to that a bit directly in terms of how
13 much hospitals can be distinguished from one
14 another.

15 We've also done some examination of
16 quintile rank stability that was mentioned in the
17 summary by Dolores. We looked into that a little
18 bit more. We would expect some movement across
19 quintiles across years. And actually that's
20 desirable.

21 We want hospitals to be able to
22 improve on the measure. And so we would expect

1 rankings to change over time.

2 But, we also think there should be
3 some stability and not just noise. That we're
4 distinguishing something about these hospitals.
5 And we looked into one number where 94 percent of
6 hospitals that are in the highest quintile of
7 spending in 2014 are in the highest quintile
8 files in 2015.

9 So while there is some movement across
10 quintiles, the limited amount that Dolores
11 mentioned, there's not drastic movements across
12 time.

13 And then we have some information on
14 some simple calculations of confidence intervals.
15 I know some people asked about this.

16 We did some simple calculations. And
17 for example you can distinguish sort of high
18 performers from other hospitals.

19 So, about 75 percent of providers can
20 be statistically distinguished with a 95 percent
21 simple calculation of a confidence interval from
22 the 10th percentile. So, from high performing

1 providers. To give you a sense of that.

2 CO-CHAIR DAMBERG: Okay. So --

3 sorry.

4 MS. SPALDING BUSH: Can I -- oh,

5 sorry.

6 CO-CHAIR DAMBERG: That's okay.

7 MS. SPALDING BUSH: This is Kim. I
8 hope you guys can hear me. I would also just add
9 that we did set the case minimums in the interest
10 of protecting those smaller hospitals from having
11 one or two cases that, you know, sent their score
12 too far in one direction or another to protect
13 the stability there.

14 I mean, we also do a -- and Sri can
15 speak better to the actual way that we do this.
16 But we address outliers.

17 So we take a look at the difference
18 between the expected cost and the observed costs.
19 And when they're way off, they do dial that back
20 a little bit to help mitigate some of the impact
21 of those outlier payments for certain pieces.

22 But I think would also potentially

1 have a bigger impact on a smaller hospital.

2 CO-CHAIR DAMBERG: All right. Thank
3 you. Jack?

4 MEMBER NEEDLEMAN: This comment/
5 question sort of straddles the reliability/
6 validity dimensions. So, I apologize if I slide
7 into validity.

8 But, I think it's important to -- as
9 we think about the reliability here, to
10 understand what's being measured. And therefore
11 how we ought to be testing the reliability or the
12 validity.

13 This is fundamentally a price-weighted
14 measure of utilization. And because DRG is
15 included in the risk adjuster, all the
16 differences in prices that are associated with
17 the DRG are sopped up in the risk adjuster.

18 The DRG may also pick up any
19 differences across DRGs in the amount of non-
20 hospital use that is associated with specific
21 DRGs. But it ought to be sopping up the price,
22 the standardized price that is in -- that is part

1 of this estimate.

2 So, given that it's doing that, what
3 the measure is fundamentally measuring is all the
4 variations in non-hospital care associated with
5 that hospitalization.

6 And my -- so, given that, and given
7 the role of the DRG and the risk adjuster, I'm
8 wondering, have you done any analysis of the
9 reliability or any of the other measures of
10 variability taking the DRG price out of the
11 measure?

12 So we're really looking at just the
13 variability and the non-hospital components of
14 use. Which is really what the measure is
15 capturing in terms of the variability.

16 DR. NAGAVARAPU: Thanks for that. So,
17 that's exactly right. That DRGs used in risk
18 adjustment sort of net out the standardized cost
19 of DRG.

20 There is still some variation from the
21 inpatient stay in terms of Part B costs. So, the
22 extent to which physician services are used and

1 so on, will have an impact.

2 In terms of the results there, the
3 fraction of variation accounted for by that is on
4 the order of 15 percent. Whereas the fraction
5 accounted for by post-discharge spending is
6 higher.

7 What we have done is some basic
8 analysis as to where the post-discharge spending
9 is coming from. And to get a sense of what's
10 sort of driving the variation in that to speak to
11 the point about, you know, just focusing on post-
12 discharge. And it seems like a lot of that
13 variation is coming from particular post-acute
14 care facilities. So, it's skilled nursing
15 facility intensity of use, for instance, and home
16 health.

17 But we totally agree that the post-
18 discharge portion of this is a key aspect of
19 understanding what's driving the variation in
20 performance across providers. And there's
21 certain key post-acute care facilities rather
22 than later readmissions, for instance, that seems

1 to really be driving a lot of that variation.

2 CO-CHAIR DAMBERG: And I'm going to
3 turn to folks on the phone. John, do you want to
4 start?

5 MEMBER RATLIFF: Yes. Just a quick
6 question. You note that you use 25 episodes for
7 your reliability testing. That's kind of your
8 cutoff, like each facility having to have 25.
9 And that you also looked by restricting the
10 number of facilities.

11 So this is where you have 50 episodes.
12 And you note that you drop the number of
13 hospitals. And then you don't really give us
14 like a real -- reliability, excuse me, score,
15 when you increase the number of episodes.

16 And I was wondering what you saw with
17 that? Or if the developer would just like to
18 comment on that?

19 Like how much of an increase in your
20 reliability you reached by kind of decreasing the
21 number of hospitals? By going to hospitals with
22 a higher number of episodes?

1 DR. NAGAVARAPU: Yes. Thanks for
2 that. So, I have the numbers right here in front
3 of me actually that we can send everyone
4 afterwards.

5 But, if you look at the .7 threshold,
6 if you use a threshold of five episodes,
7 reliability is at 94 percent. And are between 93
8 and 94 percent for a lower episodes.

9 And then it stays fairly stable. So,
10 you know, it stays at 93 percent all the way
11 through to a case minimum of 75 episodes.

12 And it doesn't really show an increase
13 until you get to about 110 episodes as a case
14 minimum. Where it increases only slightly to 95
15 percent.

16 That's for .7 reliability. You know,
17 for .4 as well as .8 and .6, it's also very
18 stable across case minimums.

19 And I think what that's telling us is
20 that, you know, the measure is picking up
21 something real that's not sort of swayed very
22 dramatically by the exact sample that's being

1 included here.

2 CO-CHAIR DAMBERG: Bill, I think
3 you're next in the queue.

4 MEMBER WEINTRAUB: Did you say Bill?
5 I'm not listed as one of the people to be
6 speaking right now.

7 CO-CHAIR DAMBERG: Okay. Thank you.
8 Maybe your hand was still up on the site.

9 MEMBER WEINTRAUB: Oh, I never lowered
10 it. Sorry.

11 CO-CHAIR DAMBERG: Okay. Thanks. I
12 have one question regarding the reliability. So
13 if approximately 7 percent or below .7, does CMS
14 intend to use the measure results if it falls
15 below that reliability threshold?

16 MS. SPALDING BUSH: Yes. I think for
17 all of our payment and quality measures, we do
18 set the case minimum. And then we, you know,
19 kind of place where generally hospitals are
20 meeting an acceptable standard of reliability.

21 And they do use the measure then for
22 all hospitals that meet that case minimum.

1 CO-CHAIR DAMBERG: Any other comments
2 on this before we turn to talking about validity?

3 MS. SPALDING BUSH: Can I just add to
4 that? I'm sorry.

5 CO-CHAIR DAMBERG: Sure.

6 MS. SPALDING BUSH: It's hard to hear.
7 I'm really sorry. We also, you know, we split
8 that balance between being inclusive, capturing
9 enough hospitals. And then setting a threshold
10 so high that hospitals start to fall out.

11 So, I think that's where we -- I think
12 that's where we try to land. In that place where
13 we've got a reliable measure. Where we've not
14 had a whole lot of hospitals drop out.
15 Especially in something as important as measuring
16 costs.

17 CO-CHAIR DAMBERG: Great. Thank you.
18 Any other comments before we move to validity?

19 (No response)

20 CO-CHAIR DAMBERG: Sure. All right,
21 before everybody forgets what we just discussed,
22 let's take a vote on reliability.

1 MR. SINGH: Okay. So we're going to
2 begin voting on reliability for Measure Number
3 2158. Your options are one high, two moderate,
4 three low, and four insufficient.

5 Voting has now begun.

6 (Voting)

7 MS. O'ROURKE: Larry, if you could
8 submit your vote in the comment box, that would
9 be great. Thank you.

10 MEMBER BECKER: Did you get it that
11 time?

12 MS. O'ROURKE: Nope. Still not seeing
13 it. If you want, you can tell me right now if
14 you're comfortable doing that or you can email it
15 to me.

16 MEMBER BECKER: Reason it's not
17 working. Well, one.

18 MS. O'ROURKE: Okay. Thank you.

19 MR. SINGH: Okay. So we're going to
20 try that one more time because the other votes
21 did not come in.

22 So, bear with me while I reset it.

1 And I'll let you know when to resubmit the vote.

2 MS. O'ROURKE: Folks on the phone, we
3 have your votes. So, it will just be people in
4 the room will need to revote.

5 Apologies. We're having the same
6 issue where it's only capturing highs.

7 MR. SINGH: Okay. So, please resubmit
8 your vote again for those that are in the room.

9 (Voting)

10 MR. SINGH: Okay. So all votes are
11 in. And voting is now closed for reliability for
12 Measure Number 2158.

13 The results is as follows: eight
14 votes for high, ten votes for moderate, zero
15 votes for low, and zero votes for insufficient.
16 That accounts for 44 percent of the votes for
17 high, 56 percent of the votes for moderate, zero
18 percent of votes for low, and zero percent of
19 votes of insufficient.

20 This measure passes for reliability.

21 CO-CHAIR DAMBERG: All right. Now we
22 can turn to validity. Dolores?

1 MEMBER YANAGIHARA: All right. So,
2 the first part of validity is the specifications.
3 And I think there was a general sense that the
4 measure specifications were consistent with the
5 intent of the measure.

6 There was one question raise, or
7 concern raised about the ability of hospitals to
8 influence the total amount. Especially, I think,
9 the post-acute care piece.

10 In terms of testing, there was new
11 data that was used, empirical testing at the
12 measure score level.

13 The first test was looking at the
14 correlation with other measures of spending and
15 service utilization. And the second testing was
16 looking at cost variation by time period within
17 the episode.

18 So in terms of correlations, the first
19 one was correlated with risk-adjusted per capita
20 spending at the HRR level. The correlation there
21 was greater than .5. With a range, I believe of
22 like .51, .61 or something like that. I think

1 there was a range there.

2 And then the correlation with post-
3 acute -- not SNF, well I guess skilled nursing
4 and inpatient service per episode was .52. So,
5 moderate correlations there.

6 Variation by time period, 84 percent
7 of the variation was accounted for by post-acute
8 care. And 11 percent by the three days prior and
9 the in-depth admission length of stay.

10 So, there was a concern raised about
11 why you use different tests this times then the
12 first time around. Which I think focused on the
13 condition specific measures of utilization.

14 And there was a question raised about
15 whether a moderate correlation with the other
16 measures of utilization and spending were
17 sufficient. If they should be stronger.

18 And then again, the question of being
19 able to control the post-acute care. Because
20 that was where most of the variation in spending
21 occurred.

22 And then there was one question

1 raised, it may be more of a spec question. But
2 anyway, it was about in certain situations, I
3 think that's IRF, which I'm not sure if that's
4 inpatient rehab facility, I was guessing. Okay.

5 So, that that sometimes that can
6 actually extend beyond 30 days if they're in the
7 IRF longer than the 30 days after the whole
8 amount is included. And so there was concern
9 about that and the impact of that.

10 In terms of threat to validity, there
11 was some testing done on exclusions. It was
12 found that the -- there was minimal impact and
13 high correlation coefficients. Let's see, there
14 was -- I think, okay, so it's 1.6 percent of
15 cases excluded due to acute transfer. So that's
16 not too much.

17 And a high correlation, .95. About
18 eight percent of episodes were excluded due to
19 death during the episode. Very high correlation
20 with and without those of .99

21 For overlapping episodes, that
22 accounted for about 12 percent of exclusions.

1 And again, a very high correlation of whether you
2 include them or exclude them of .99.

3 Removing the top and bottom outliers,
4 there was a -- that was the one -- top and bottom
5 one percent. There was a correlation of .93. So
6 again, quite high correlations whether you
7 include or exclude those populations.

8 Some of the concerns raised were --
9 someone raised a concern about cancer hospitals
10 being excluded. But there may be some general
11 hospitals that have a lot of cancer patients that
12 might be included and that, you know, how would
13 that impact them? And that was the main concern
14 on exclusions.

15 In terms of risk adjustment, the risk
16 adjustment is based on the CMS-HCC model. But
17 there's no adjustment for sex in this one.

18 Let's see, it includes age disability,
19 ESRD status, long-term care status, severity of
20 illness, and the MS-DRG of the index submission.
21 And then ordinary least squares linear regression
22 is used.

1 In terms of discrimination, the R
2 squared for -- across all MBCs was .3. And then
3 overall was .48.

4 In terms of calibration, they looked
5 at -- there was a comment about the 90-day look
6 back period, and was that sufficient? So they
7 looked back 365 days to see what affect that had.

8 And basically the R squared of .3014
9 went to .2997. So, basically no impact there.
10 But it did cause 6.7 percent of the episodes to
11 be excluded because of the longer look back
12 period.

13 We looked at adding institutional
14 status. And there was minimal improvement to the
15 R squared. But it decreased the number of other
16 variables that were statistically significant.
17 And so that was not included.

18 Terms of predicted ratios, I think Sri
19 talked about this. By risk decile is very
20 consistent in all the deciles.

21 And then in terms of SDS testing, they
22 used income to poverty, and also race: black/non-

1 black. The F test showed both significant
2 predictors, both of those were significant
3 predictors.

4 But when they added it to the risk
5 model, it didn't have much impact at all. So, it
6 was a plus or minus .01 for 97 percent of the
7 hospitals. And nearly 100 percent correlation.

8 There were a lot of concerns raised
9 about the SDS. I think we heard some of that
10 from AAMC.

11 And then there was a question about
12 using zip code level. I think Sri explained that
13 the reason for doing that was to kind of find a
14 balance between individual income impact and
15 community income impact.

16 And let's see, oh, there was a
17 question about who were the three percent that
18 were affected more than .01 percent or .01. And
19 whether those were certain categories. For
20 example, like rural hospitals or something like
21 that.

22 And so I don't know if you have more

1 information about that. But if you do, that
2 would be great.

3 And then people raised the issue with
4 the connection to quality. And so the point was
5 that sometimes there's more services that are
6 provided that can actually lead to better
7 outcomes. But we don't know what the outcomes
8 are. In this case, it's just spending. So,
9 there was a question about that.

10 I'm almost done. This is a long
11 section.

12 (Laughter)

13 MEMBER YANAGIHARA: In terms of
14 meaningful differences, they stratified results
15 by hospital characteristics. So geography,
16 teaching hospitals and rural or urban. And the
17 results were as expected based on literature.

18 There was a request by a member, or
19 more then one member maybe, that they would like
20 to get information on the source of differences
21 for the higher and lower cost hospitals.

22 So, kind of understanding that more.

1 Like what was really driving that? And then,
2 again the link to quality was brought up.

3 In terms of missing data, I'm not sure
4 if this is actually missing data or not, but two
5 comments were that there's no Part D data. So,
6 that is true.

7 And then Medicare Advantage is not
8 included. And so you know, there may not be
9 missing data for Medicare fee for service, but in
10 terms of like understanding the context and the
11 whole market, that Medicare Advantage would be
12 missing.

13 So, those are my notes.

14 CO-CHAIR DAMBERG: Terrific. Yes,
15 Taroon?

16 DR. AMIN: Before we get into
17 conversation on this, Dolores, I think you did a
18 great job by the way. There were a few pre-
19 meeting comments that were submitted related to
20 this measure. As particularly related to this
21 section, that I just wanted to highlight.

22 We heard from the AAMC on this, from

1 the federation. There were some questions around
2 the variable that was used in the SDS evaluation
3 as it relates to the ASPE report.

4 And then from the AMA, some questions
5 around the level of analysis. And concern about
6 using this measure at a physician level. But
7 it's not specified as such.

8 So those are the only other two
9 comments that are related to validity that came
10 up. I just want to throw that into the
11 discussion.

12 CO-CHAIR DAMBERG: All right. So why
13 don't we start with Nancy.

14 MEMBER GARRETT: So I have a couple of
15 initial comments here. One is, to me the major
16 validity concern here is actually the title of
17 the measure.

18 I brought this up the last time we
19 reviewed it. And I'm sure when something's
20 written into statute, we can't change the title.

21 But, to me it's just ruining this
22 thing. I mean, this measure should be called

1 something like resource use per hospital episode.
2 It's not a true cost measure. And it's certainly
3 not a per beneficiary measure.

4 It's per episode. And so it just
5 seems really misleading. And given that, you
6 know, this is available to the public and it's
7 meant to be used by consumers, it seems really
8 important that the title is accurate.

9 So, I think that's a real validity
10 concern that the title doesn't match what the
11 measure is.

12 And then the second thing I wanted to
13 bring up is something that we noticed using the
14 data in Minnesota. Which is that there's a real
15 bifurcation between rural and urban hospitals on
16 these results.

17 And we find that the hospitals in the
18 more urban settings in the state have higher
19 scores. And then rural have lower scores on this
20 measure.

21 So like in Minnesota for example, the
22 Minnesota average is .9. And every single urban

1 hospital is .94, .95, .96. And every single
2 rural hospital is under .88.

3 And so I actually corresponded with
4 the measure developers about this a couple of
5 years ago. And one of their responses was, well
6 there's research showing that urban hospitals use
7 more resources.

8 And so, that could well be the
9 explanation. But it also makes me worry that
10 maybe there's something about the risk adjustment
11 that isn't picking up tertiary care and some of
12 the complexity of patients referred into some of
13 these facilities in the urban areas.

14 So, I don't -- I haven't done that
15 analysis across other states. So I don't know if
16 that is something that you've seen other places.
17 But to me, that's a real concern about how this
18 measure is actually playing out.

19 CO-CHAIR DAMBERG: Did you want to
20 comment on that?

21 DR. NAGAVARAPU: Yes. So, I'll let
22 Kim respond to the title issue. But the

1 rural/urban. On average rural hospitals do have
2 lower scores than urban hospitals.

3 I think in the materials that you all
4 saw, it sort of scores nationally. And the mean
5 for urban hospitals is 1.0. Whereas for rural
6 hospitals is .95.

7 However, the one thing I want to point
8 out, is if you look at the percentiles and the
9 distributions of rural hospitals and urban
10 hospitals, the distributions overlap a fair
11 amount. Right?

12 So, I wouldn't think of this as a
13 measure that's somehow segmenting off for urban
14 and rural hospitals. There are a large swath of
15 urban hospitals that are performing better than
16 the large set of rural hospitals.

17 So, I think what you're seeing in
18 terms of the difference in average is true.
19 Although the size of the difference seems to be
20 larger in Minnesota than nationally.

21 But those distributions are
22 overlapping a fair amount. So, I do think

1 there's something exclusive about the evidences
2 that's preventing urban hospitals from having
3 this source.

4 MS. SPALDING BUSH: So it -- oh, I'm
5 sorry.

6 CO-CHAIR DAMBERG: No problem.

7 MS. SPALDING BUSH: Just regarding the
8 title of the measure, you're right. It was
9 written in with the statute and for inclusion in
10 the Hospital Value-Based Purchasing Program.

11 When it displayed on Hospital Compare,
12 it does have a different name. Because that site
13 is for beneficiary consumption, theoretically
14 although a payment measure maybe of more interest
15 to others as well.

16 But, it's called like Medicare -- or
17 spending per hospital patient with Medicare, I
18 think. Something like that. It gives you the
19 sense that it is a hospital related measure and
20 it has to do with payment, so.

21 CO-CHAIR DAMBERG: Brent?

22 MS. SPALDING BUSH: We had the same

1 feeling about the title in CMS that you did.

2 CO-CHAIR DAMBERG: Brent?

3 CO-CHAIR ASPLIN: My question is about
4 the risk adjustment model and the 90-day look
5 back period. Could you just comment on that?

6 Is it -- either there's a benefit of
7 a look back period, in which case I don't think
8 90 days is enough if you apply how the HCC model
9 works for risk adjustment in Medicare Advantage.
10 You would never just look at a quarter. Or you
11 would miss a ton of risk in your population.

12 Or there's really no benefit in the
13 look back period and you're going to capture
14 whatever you're going to capture in the three
15 days prior to the episode. And you'll get your
16 HCC diagnosis there.

17 Would you just speak to that? Because
18 the 90 days to me just seems hung in the middle.
19 Sri?

20 DR. NAGAVARAPU: Yes. No, that's a
21 good question. So when we developed this, we
22 tested a variety of look back periods. As you

1 noted, Medicare Advantage looks at the previous
2 year.

3 What we did is look at sort of 90
4 days, 180 days, and so on. And up to 365 days,
5 to get a sense of how predictive power changes.

6 And the trade off there is potentially
7 improvements in predictive power versus losing
8 more beneficiaries because of people's move, they
9 get out of Medicare Advantage, you may lose
10 people the further you look back based on the
11 restrictions we have. Right?

12 However, what we found in the analysis
13 here, and what we found in previous analyses as
14 well, is that moving to a further look back
15 actually slightly reduces the R squared in moving
16 from 90 days to 365 days. And we think what's
17 happening is a problem with sort of false
18 positives in the sense that there are some
19 conditions that you would pick up if you look 365
20 days back that resolve by the time you get to the
21 inpatient stay.

22 And we think that's one possible

1 explanation for what we're seeing. That the 90-
2 day look back actually performs a bit better in
3 terms of predictive outcome.

4 But we have looked at a range of --
5 when developing the measure for exactly the
6 concern you have.

7 MS. SPALDING BUSH: Yes. And the
8 difference there being it's predicting just the
9 cost of this episode.

10 So that per -- it maybe that those 90
11 days pick up the conditions that are most
12 directly impacted, you know, the reason that
13 person was admitted, their, you know, their
14 current state at the time of admission.

15 And what we would expect the cost to
16 be for them post-discharge as a cur -- you know,
17 as compared to things we just pick up that they
18 happen to have as an acute condition that hasn't
19 been treated lately, you know, if we went back a
20 year.

21 CO-CHAIR DAMBERG: All right. I'm
22 going to turn to Jack. And I think we need to

1 try to wrap this up soon. So, --

2 MEMBER NEEDLEMAN: I actually have
3 just a few comments. I think the measure is, as
4 much as we looked at it originally, and it's as
5 worthy of endorsement as the first one was.

6 I think there are a couple of things
7 that should be noted here. Not necessarily for
8 the development of the measure. But for your
9 thinking about what you've got and how to analyze
10 it.

11 You show a fair amount of variability,
12 like 25 percentage points in your index between
13 the -- you know, the 10th and 90th percentile.
14 And that's a lot.

15 But it's even worse than that, because
16 you have standardized out about half the costs,
17 which are the hospitalization costs. So, the
18 variability around the non-hospital costs are
19 much larger.

20 And I think it's very important for
21 usability purposes, as well as for interpret
22 ability purpose that you do a lot more analysis

1 on where that -- what those variations in
2 spending are.

3 You mentioned readmissions as one of
4 the major potential sources of that variability,
5 and SNF use as the second major source. And we
6 need to understand that a lot better. We need to
7 understand that particularly if it's going to be
8 used in a value-based payment system, so we're
9 also going to be correlating with the outcome.

10 So, I would encourage you to think
11 hard about that. The second thing again, just a
12 general comment.

13 This is not a measure of resource use
14 because of the standardization of prices. To the
15 extent that you've got individual visits or
16 individual days in the SNF there, yes, you've got
17 some measure of differential resource use.

18 But within a hospital, you don't have
19 any variation in resource use. Because you've
20 used a standardized price for it. A little bit
21 on the Part B, but only a little bit on the Part
22 B.

1 And if we're going to understand how
2 hospitals influence those other costs, we better
3 have a better understanding of what's happening
4 in the hospital then this measure provides.

5 With regard to risk adjustment and SDS
6 risk adjustment, since Jan isn't here, let me
7 channel her. When your Yale colleagues were here
8 presenting some other measures, we raked them
9 over the coals over using zip code level measures
10 of income rather than census tract level
11 measures.

12 And we were told in subsequent work,
13 it's just really hard to get the beneficiaries
14 matched up to their census tracts. Even though
15 we supposedly have the address stuff.

16 So, it was not feasible. We just had
17 a measure, two measures earlier today in which
18 health partners managed to match their patients
19 up with census tracts.

20 I don't find the argument that the zip
21 code better captures the full range of resources
22 available, either to the patient or in the

1 community, as compelling as understanding better
2 the local circumstances in which the beneficiary
3 lives. Particularly if you're trying to apply
4 that as a measure of what resources the
5 beneficiary has.

6 So, I want you to -- I want to
7 strongly encourage you to go back and reconsider
8 the SDS analysis. We talked about the other
9 problems of, you know, high disparity, you know,
10 high disadvantage using facilities which are not
11 captured in your risk adjuster either.

12 But, I really do want you to go back,
13 if we're going to be doing risk adjustment around
14 SDS, you've got to figure out how to get the --
15 and you're going to use some geographic proxy for
16 the circumstances of individual beneficiaries.

17 You really do have to go back to the
18 census tract as the basis for that calculation,
19 not zip codes.

20 CO-CHAIR DAMBERG: Nancy, did you have
21 one last question before we wrap up?

22 MEMBER GARRETT: Yes. I just wanted

1 to second that comment. I feel like the approach
2 here to risk adjustment for SDS is really not
3 adequate for where we need to be.

4 And especially given the really big
5 impact that readmissions has on this particular
6 measure and all of the discussion that's been
7 going on around readmissions and the strong link
8 to socioeconomic circumstances of the
9 beneficiary.

10 So, I think that there's more we need
11 to do here.

12 CO-CHAIR DAMBERG: And jut to follow
13 onto that. I guess I was a little confused. And
14 maybe you could say more about the analysis you
15 did, adding dual status.

16 And it sounds like your results differ
17 a significant amount from what the IMPACT Act
18 analytic group found. And wondering if you could
19 say why you think that's the case?

20 DR. NAGAVARAPU: Thanks. So, let me
21 start with that point. And then I'll circle back
22 to all the other points.

1 So, on dual status. So we're very
2 familiar with the ASPE report. I came in,
3 actually was the support contract period to do
4 the analysis for ASPE. So we know those results
5 very well.

6 If you remember from the report, the
7 key distinction that they're making in the report
8 is a comparison between safety net hospitals and
9 non-safety net hospitals. Where safety net is
10 defined as greater than 20 percent dish.

11 When they look at the magnitude of
12 difference in measure scores in 2015 and fiscal
13 year 2015 between those two groups, the
14 difference is .01. And so the difference is
15 relatively small. Where we think of the standard
16 deviation here as .09.

17 So, that's the first point. I think
18 there is a question as to what is driving that
19 .01 difference between safety net hospitals and
20 non-safety net.

21 And so we did some analyses to look
22 into it that the ASPE report didn't get into.

1 And basically what we did is, we divided up
2 hospitals by the fraction of their episodes that
3 are in the -- that are for dual beneficiaries.

4 And looked at different thresholds to
5 compare hospitals that we would classify as
6 heavily dual. Like above a certain threshold.
7 Versus non-heavily dual.

8 Where the heavily dual are going to
9 correspond to some extent to the safety net
10 hospital. Because we want to understand what's
11 driving that .1 in the ASPE report.

12 And what we -- .01, sorry. And what
13 we saw in that, in the discrepancy there, is we
14 looked at the -- we calculated the measure for
15 non-duals in those hospitals.

16 And what you see is that even on non-
17 duals, the hospitals perform worse on the MSPB
18 measure than in the high dual concentration
19 hospital, as compared to the low dual
20 concentration. And so if you look at the number,
21 I have it written here. That's right.

22 So if you use the threshold of greater

1 than 50 percent for dual episodes as the marker
2 for what's a dual hospital and what's a non-dual
3 hospital, and then calculate the MSPB measure for
4 just non-duals in both of those fee sets of
5 hospitals, that measure is .04 larger for non-
6 duals in hospitals with greater than 50 percent
7 dual episodes versus others.

8 So, what that's saying is that both
9 for duals and non-duals, these hospitals seem to
10 be more expensive. It's not something that's
11 driven specifically by dual status.

12 Now, it could be some sort of
13 spillover type affect that everyone had
14 mentioned. That's a possibility. Another
15 possibility is that these are just inefficient
16 providers.

17 And so I think it's something that we
18 really do need to dig down into. I think more
19 research on that is required.

20 But, that seems to be what's driving
21 this result in the ASPE study to some extent.
22 And that's something we could dig into more with

1 the safety net definition.

2 For -- in terms of clarifying what we
3 did with dual status, we understand the concern.
4 The concerns about census track. We thought zip
5 code is a good way to get at sort of both of
6 these concerns at the same time. About the
7 individual level and the community level
8 attributes.

9 But we recognize that the people
10 wanted to focus more on the individual level.
11 That's why we went straight to dual status to
12 look at this.

13 And what we did is use a dual dummy in
14 the risk adjustment model for the MSPB measure.
15 Calculated the MSPB measure both with and without
16 the dual dummy and look at changes in the
17 measure.

18 And saw that greater than 98 percent
19 of hospitals have a change in magnitude less than
20 .201, so.

21 CO-CHAIR DAMBERG: So, I think the
22 challenge with risk adjustment is, you know, for

1 most providers, it's probably not going to make
2 much difference. But it's always, there's sort
3 of a handful of providers where the difference
4 can be quite large.

5 And I guess the question is, is have
6 you looked at that in terms of how much impact it
7 has on those that have a really large fraction
8 say of duals?

9 DR. NAGAVARAPU: Yes. No, that --
10 sorry, thanks. One way we've looked at that is
11 first to just see how many hospitals are sort of
12 moved by -- to sort of large changes in MSPB
13 measure score by including SDS factors or dual in
14 risk adjustment.

15 Looking at the table of numbers for
16 SDS, you know, we said the number that it's
17 something like 98 percent or 97 percent or so,
18 within .01. But, if you look at the other
19 hospitals, it's very rare that any hospital is
20 above .1 in the change in either direction.

21 There's only one hospital that's above
22 .03 and one hospital that's below minus .03 in a

1 change. So it's very tightly confined. For
2 duals it's similarly tightly confined in terms of
3 the numbers. Even the min and max are quite
4 tight. And I can pull the data up for you in a
5 second.

6 So if you look at the .1 percentile,
7 the change is minus .016. And if you look at the
8 99.9 percentile, the change is .029. So it's not
9 huge fluctuations for hospitals. It's like minor
10 fluctuations.

11 CO-CHAIR DAMBERG: All right. Thank
12 you. Sure, Helen?

13 DR. BURSTIN: I think there's been so
14 much attention to the ASPE report, I just want to
15 clarify one additional thing.

16 So, the actual table from the ASPE
17 report points out a four percent difference. Is
18 that what you're talking about, the .04? Four
19 percent difference using dual beneficiaries.

20 And then they specifically then looked
21 at this question of medical complexity using a
22 claims-based frailty index. Planning that half

1 of it's potentially addressed by in fact duals
2 isn't just poverty of course, it's for functional
3 status, it's disability, et cetera.

4 And so they then found about half of
5 that was taken up by these potentially unmeasured
6 clinical complexity. So at least their
7 recommendation was that this should potentially
8 be adjusted for.

9 So again, even if it's a small effect,
10 I just want to clarify the perspectives of both
11 CMS and the developer. Just because again,
12 there's this report that's now fresh out on the
13 street saying something that's slightly
14 different.

15 DR. NAGAVARAPU: Yes. So, the table
16 I had in mind for the .01 for the fiscal year
17 2015 is further down in the report. And I think
18 it's in the section where they talk about policy
19 simulations.

20 For this table they showed the four
21 percent total effect for social risk. What this
22 table is not doing that sort of the supplementary

1 results that we have help confirm, is that that
2 four percent could be something that's driven by
3 the types of hospitals that dual eligible
4 beneficiaries are in, versus themselves.

5 And so the four percent sort of
6 includes both of those effects. Now, they try to
7 get it that with that second column there with
8 the within hospital.

9 But if you look at what they do for
10 within hospitals, it's a random affects model.
11 And so it doesn't actually net out the mean
12 within a given hospital.

13 All it's doing is making adjustment
14 that's basically relating to sort of the
15 clustering. Taking into the account the air
16 structure.

17 And so really what they would want to
18 do in that second column to try and see how much
19 is due to which facilities people are
20 concentrated in versus the dual individuals
21 themselves, would be around like a fixed event
22 sort of specification. Which they don't have

1 here.

2 Now, the analysis we did that sort of
3 tries to look at these sorts of hospitals where
4 duals are more concentrated and look at what's
5 happening for non-duals, does provide some
6 indicative evidence that there's something going
7 on here. Where the types of facilities that
8 duals maybe clustered into, are facilities that
9 are inefficient not only for duals, but also for
10 non-duals in this measure.

11 DR. BURSTIN: Right. But part of what
12 this analysis is suggesting is that dual status
13 is an indicator of clinical complexity. So
14 inefficiency could be related to under-measure
15 clinical complexity, I think, is what the report
16 is urging. As you can see.

17 DR. NAGAVARAPU: Yes. No, and I think
18 it's possible. I think the HCC model that we
19 have now does a good job of taking into account a
20 lot of clinical factors that may affect dual
21 status.

22 And that's why I think that the MSPB

1 measure doesn't do that much when we risk adjust
2 for dual. Because a lot of those factors are
3 already captured by the existing HCC flags.

4 To the extent that there is additional
5 clinical complexity that's involved there, that's
6 a possibility. I think what goes hand in hand
7 with this decision though, is a policy decision
8 about, given these sort of very small size
9 effects, do we actually want to create a separate
10 standard for dual eligible beneficiaries?

11 Or do we create a lower standard of
12 care essentially by allowing that to enter into
13 this? I'm not sure.

14 CO-CHAIR DAMBERG: So, can I actually
15 comment on that?

16 DR. NAGAVARAPU: Yes.

17 CO-CHAIR DAMBERG: So, we also, full
18 disclosure, did some analysis, not on this
19 specific measure. But, one of the things that
20 we were asked to look at for the IMPACT Act was
21 within provider variation on a particular
22 measure.

1 And I'm curious for, let's say dual
2 versus non-dual within these hospitals if you
3 compute the same measures. Like how much
4 disparity is there? And is it sort of large and
5 consistently negative?

6 So, I think that's type of analysis,
7 if you haven't done it, and I'm happy to share
8 with you work that we did, that might be
9 informative in terms of your decision making
10 around adjustment.

11 DR. NAGAVARAPU: Thanks for that.
12 Yes, so we actually do have some results
13 comparing them.

14 And if you use that 60 percent
15 threshold in the preliminary results that we had
16 in order to respond to some of these pre-
17 evaluation comments, what we see is that the
18 measure score for non-dual episodes is around
19 1.04. And that's also the area that we see for
20 overall measure score as across all episodes.

21 And so that suggests that the dual and
22 non-dual is actually quite close. At least in

1 that segment of hospitals where duals are very
2 heavily concentrated.

3 CO-CHAIR DAMBERG: So, I'm mindful of
4 time But, I think what I've heard is probably
5 the socioeconomic demographic adjustment
6 conversation is not at an end. And we encourage
7 you to continue to work to evaluate the impacts
8 of SES factors on this measure.

9 Any other comments before we move to
10 voting?

11 (No response)

12 CO-CHAIR DAMBERG: All right. Seeing
13 none, let's tee up the voting.

14 MR. SINGH: Okay. Well, thank you
15 Cheryl. So we're going to begin voting on
16 validity for Measure Number 2158. Your options
17 are one, high; two, moderate; three, low; and
18 four, insufficient.

19 Please vote now.

20 (Voting)

21 MS. O'ROURKE: If you could submit
22 your vote through the comment. Or you could just

1 say it over the line too if you're comfortable
2 doing that.

3 MR. SINGH: We're about to break --
4 we're about to break our record because we're at
5 20 right now.

6 MS. O'ROURKE: Okay. So we'll have to
7 reset again. Sorry about that folks.

8 MR. SINGH: So, I'm going to reset the
9 voting. So please bear with us one second.

10 MS. O'ROURKE: Everyone else on the
11 phone, we have your votes. You don't need to
12 send them again.

13 Larry, we do need yours still though.
14 And Dr. Weintraub as well too.

15 MEMBER BECKER: This is Larry. I got
16 disconnected. Did you get my vote?

17 MS. O'ROURKE: No, Larry. So if you
18 could submit it again that would be appreciated.
19 And we need to revote in here too. So, you can
20 submit it when you get a chance.

21 MR. SINGH: Okay. So for those that
22 are in the room right now, please submit your

1 voted.

2 (Voting)

3 MEMBER BECKER: Did it come across?

4 MS. O'ROURKE: Yep, Larry. I got it.

5 MEMBER BECKER: Great. Thanks.

6 MS. O'ROURKE: And Bill Weintraub,
7 could you please enter your vote as well?

8 MR. SINGH: Okay. So all votes are
9 in. And voting is now closed for Measure Number
10 2058 with regards to validity.

11 The results are as follows: three
12 votes for high, nine votes for moderate, five
13 votes for low, and zero votes for insufficient.
14 With regards to percentages, that is 18 percent
15 for high, 53 percent for moderate, 29 percent for
16 low, and zero percent for insufficient.

17 This measure passes for validity.

18 MS. O'ROURKE: Just to be fair. We
19 need 60 percent, Elisa, Helen? Or at 53 are we
20 at consensus not reached?

21 DR. BURSTIN: High or moderate.

22 MS. O'ROURKE: Oh for -- sorry.

1 Apologies.

2 CO-CHAIR DAMBERG: All right. So, we
3 are now going to move to feasibility. And John,
4 I think you appoint to -- just a quick overview
5 on that.

6 MEMBER RATLIFF: So feasibility we
7 should be able to move through quite swiftly.
8 The staff recommendation was high feasibility.

9 The data elements that are utilized
10 for this measure are routinely generated already
11 by the developer. And routinely used in day to
12 day practice.

13 There won't be any kind of increased
14 demands on practitioners. Or any kind of
15 increased demands on the developer for use of
16 this measure.

17 One of the comments that was brought
18 up in the opening comment period from the
19 committee was that while these measures are
20 routinely developed, and it will be feasible for
21 CMS to do this, it will be difficult if not
22 impossible for independent calculation of the

1 measure.

2 Without presumably going through RSDAC
3 or going through another licensing agent for CMS
4 data and then obtaining that. So while this is
5 feasible for use by CMS, it may be difficult to
6 independently verify CMS' calculations or
7 independently calculate using the metric.

8 Otherwise, no one else had any
9 concerns with feasibility. And I would agree
10 that it's a feasible measure.

11 CO-CHAIR DAMBERG: All right. Any
12 comments?

13 (No response)

14 CO-CHAIR DAMBERG: I'm seeing none in
15 the room. Anyone on the phone?

16 (No response)

17 CO-CHAIR DAMBERG: All right. I think
18 we can move to vote.

19 MR. SINGH: All right. Thank you,
20 Cheryl. So we're going to be voting on
21 feasibility for Measure Number 2158. Your
22 options are one, high; two, moderate; three, low;

1 and four, insufficient.

2 Please vote now.

3 (Voting)

4 MR. SINGH: All right. We were so
5 close. But we're at 19. Which is over our
6 denominator.

7 So we're going to have to restart
8 again one more time. So please bear with me
9 while I reset the slide.

10 All right. So for those that are in
11 the room, please resubmit your vote.

12 (Voting)

13 MS. O'ROURKE: And is Bill Weintraub,
14 are you on the line still?

15 MEMBER RATLIFF: Perhaps you're on
16 mute?

17 MS. O'ROURKE: Bill, is that you on
18 the line?

19 MR. SINGH: I guess all votes are in.
20 And voting is now closed for feasibility on
21 Measure Number 2158.

22 With the results is as follows: 12

1 votes for high, five votes for moderate, zero
2 votes for low, and zero votes for insufficient.
3 And that gives us 71 percent of the votes for
4 high, 29 percent of the votes for moderate, zero
5 percent of the votes for low, and zero percent of
6 the votes for insufficient.

7 And this measure passes for
8 feasibility.

9 CO-CHAIR DAMBERG: All right. Thank
10 you. So, our last criteria, our lead discussant
11 had to leave early. So, I'm going to throw it
12 open to the committee to see if anyone has any
13 comments or issues related to the usability.

14 And let's start with Brent.

15 CO-CHAIR ASPLIN: So, the first
16 comment should not affect our voting today. But,
17 this just for CMS in the room.

18 You know, I don't think it's
19 appropriate for this measure to be used for
20 physician accountability in MIPS or a value
21 modifier program. It wasn't specified or built
22 for physicians.

1 But like I said, that's a quick
2 comment. And I don't think it really affects our
3 task today.

4 Two comments or suggestions for the
5 usability of the reports. One is state and
6 national averages are helpful. It would be great
7 to do a column on hospital referral region.
8 Which I don't think would be that difficult.

9 But, there's a lot of variation across
10 states. And to some of the comments around
11 rural/urban, et cetera, an HRR column in addition
12 to the state and national, I think would be more
13 informative in terms of your local marketplace.

14 And then the other comment is that the
15 subcategories of spend are really what's
16 important. It would be really great if you
17 could, kind of similar to the HealthPartners
18 total cost index and the resource use index, if
19 you could do utilization percentages within major
20 diagnostic classifications for the various levels
21 of post-acute care.

22 Because there may be good bench

1 marking data out there. But I'm frankly not
2 aware of good bench marking data to drive
3 performance.

4 And next site of care is the most
5 important decision in total episode spent for
6 people coming out of an anchor admission. And by
7 diagnostic category would be really great to help
8 guide clinicians around.

9 You know, 20 percent of beneficiaries
10 with diagnosis X or DRG X for this category need
11 skilled nursing care. And your average is 35
12 percent for example.

13 And the problem with the reports as
14 they are today, is it's just dollars spent.
15 Which is also helpful.

16 But it isn't granular enough to really
17 drive action or improvement in understanding
18 where you are relative to at least average
19 utilization for the various levels of care. Does
20 that make sense?

21 CO-CHAIR DAMBERG: Nancy?

22 MEMBER GARRETT: So, I also have, I

1 guess suggestions on how to make this more
2 usable. So, I think one of the reviewers
3 commented that in practice this measure is
4 difficult for hospitals to consume because the
5 data is not readily there to really understand
6 what's driving their score.

7 And I do appreciate the files that you
8 make available. What we found is that it takes a
9 lot of effort to get those files and put them
10 together in a way that gets you some answers.

11 And even then the answers aren't
12 complete, because all the data elements aren't
13 there. So you can see for example, what post-
14 acute providers are referring to most. But not
15 Prado it by where the biggest costs are.

16 And so just if there's a way to make
17 that system more usable, I think that would
18 really help the ability for people to -- for
19 providers to act on this.

20 As it is, it's kind of another data
21 point that we know we're being measured on. But
22 it's really hard to take that next step of, okay,

1 what are we going to do to improve? So.

2 CO-CHAIR DAMBERG: Thanks Nancy. Sri?

3 MEMBER SRIDHARA: Yes. So I'm
4 probably following up with somewhat -- just some
5 more comment. So it feels like a very helpful,
6 quick first measure.

7 That I think when we do our work we
8 usually try to implement it so that it's a good
9 measure you can get out the gates with. But it
10 doesn't help you say, what should be your action
11 steps next? So, it feels like a bit of a blunt
12 instrument is what it amounts to.

13 And so what we usually do is put this
14 in and then have some other episode measures to
15 where we can do some of this more refined parsing
16 of data to drive action. So, that's really it.

17 CO-CHAIR DAMBERG: Great. I'm not
18 seeing any more hands in the room or online. So
19 why don't we move to vote on this. Because I
20 know we have a few more agenda items to go before
21 the end of today.

22 MR. SINGH: All right. So we're going

1 to begin voting on usability and use for Measure
2 Number 2158. Your options are one, high; two,
3 moderate; three, low; and four, insufficient.

4 Please cast your vote.

5 (Voting)

6 MR. SINGH: We've gone over our
7 denominator this time. It's like a pattern here.
8 So, I'm going to reset the slide. So bear with
9 me for one minute.

10 MS. O'ROURKE: And just for the
11 record, our denominator is going to be 18 for
12 this count. Because Bill did email his votes to
13 us.

14 So, just FYI if you notice a change in
15 the denominator.

16 MR. SINGH: Okay. So if you'll please
17 submit your vote again. Those that are in the
18 room.

19 (Voting)

20 MR. SINGH: Okay. So all the votes
21 are in. And voting is now closed for usability
22 and use for Measure Number 2158.

1 And the results is as follows: five
2 votes for high, ten votes for moderate, three
3 votes for low, and zero votes for insufficient.
4 That gives us 28 percent of the votes for high,
5 56 percent of the votes for moderate, 17 percent
6 of the votes for low, and zero percent of the
7 votes for insufficient.

8 This measure passes for usability and
9 use.

10 CO-CHAIR DAMBERG: Okay. One more
11 vote to go. This is the overall.

12 MR. SINGH: Yes. So we're going to be
13 voting on the overall suitability for
14 endorsements for Measure Number 2158. Your
15 option is one yes, and two no.

16 So please cast your vote.

17 (Voting)

18 MR. SINGH: For those that are in the
19 room, can you please submit your vote one last
20 time. We're missing one.

21 (Voting)

22 MR. SINGH: Okay. So all votes are

1 in. And voting is now closed. For overall
2 suitability for endorsement for Measure Number
3 2158, the results is as follows: It's 16 votes
4 for yes, and zero votes for no.

5 Oh, so -- well 16 votes for yes and
6 one vote for no. That gives us about 98 percent
7 --

8 MS. O'ROURKE: Yes.

9 MR. SINGH: So 98 percent for yes.

10 MS. O'ROURKE: Could we redo that just
11 for the record? Just to be safe. People on the
12 phone, we have all your votes. So, in the room,
13 please?

14 Hopefully this is our last vote of the
15 day. And we'll try to find the source of the
16 gremlins or Russian hackers, whatever you want to
17 say they are.

18 MR. SINGH: Got some at NQF -- there
19 is -- okay. So for those that are in the room,
20 please resubmit your vote.

21 (Voting)

22 MR. SINGH: So the last one with

1 feeling this time. So, for overall suitability
2 for endorsement for Measure Number 2158 is as
3 follows: 17 votes for yes, and one vote for no.

4 And that gives us 94 percent of the
5 votes for yes, and 6 percent of the votes for no.

6 CO-CHAIR DAMBERG: All right. Thank
7 you. I just wanted to quickly see if there was
8 any additional member or public comment at this
9 time, both in the room.

10 And Operator, if you want to ask if
11 anyone on the phone has a public comment.

12 OPERATOR: Okay. At this time if you
13 would like to make a comment, please press star
14 then the number one.

15 (No response)

16 OPERATOR: And there are no public
17 comments at this time.

18 CO-CHAIR DAMBERG: Great. And there
19 are no comments in the room either.

20 We are going to take a very quick
21 break. And I would ask people if they could be
22 back in the room by 2:30. Because I know the NQF

1 staff have a few more items they want to get us
2 through.

3 But, they also know we need a leg
4 stretch. So, back in a few minutes.

5 (Whereupon, the above-entitled matter
6 went off the record at 2:23 p.m. and resumed at
7 2:33 p.m.)

8 CO-CHAIR ASPLIN: Good afternoon. What
9 we have left this afternoon is an overview of the
10 cost and resource use measurement landscape. And
11 then, some discussion about episode-grouper based
12 measures. And the overall project update for
13 cost and resource use. And the staff are going
14 to lead us through this conversation, so I will
15 turn it over to Erin.

16 MS. O'ROURKE: Thank you. And I want
17 to introduce Ashlie Wilbon, who has joined us at
18 the table. I think she's worked with many of you
19 in the past. So, Taroon, Ashlie, and I can kind
20 of drive the slides and we're going to skip
21 around a little, so feel free to jump in if you
22 have any comments.

1 So, if we could skip to Slide 28,
2 let's keep going, because Rachel went through
3 this in the morning. Again, you saw this slide.
4 So, again -- sorry, one back. We did just want
5 to quickly refresh you on what measures are
6 currently in the cost and resource portfolio.

7 We covered three of these today, the
8 others are the ones that we actually just looked
9 at over the summer, the episode of care for AMI,
10 heart failure, and pneumonia. Next slide.

11 So, to just give you an idea of where
12 these are used in federal quality initiatives, as
13 the team just was saying, the spending preventing
14 measure is used in the Hospital IQR program, as
15 well as the Hospital Value-Based Purchasing
16 Program. You can also see similar use of the
17 three episode of care measures, with the
18 exception of the pneumonia measure is right now
19 only for reporting. Next slide.

20 So, we're going to kind of combine the
21 next section, if that's okay, and then, open it
22 back up for any input the Committee might have on

1 gaps. So, I wanted to just briefly give you an
2 idea of some of the measures that are coming
3 through the pipeline. Next slide.

4 These are some that we've seen through
5 the MAP process, as well as in recent
6 legislation. Just to give you a quick refresher
7 on the MAP, the MAP is the body that NQF convenes
8 to provide input on the selection of measures for
9 federal value-based purchasing and public
10 reporting programs.

11 Each year, the MAP is given a list of
12 measures by HHS that they're considering
13 implementing through the rule-making process and
14 does a review, going measure by measure and
15 making a recommendation about whether they
16 support its use or not.

17 Similarly, MAP also does some work to
18 identify gaps in measure development and does
19 work to support alignment across the public and
20 private sectors, as well as settings, different
21 levels of analysis and populations to try to
22 promote care coordination and reduce the data

1 collection burden. Next slide.

2 We've been working to try to integrate
3 the MAP and CDP processes more closely. We know
4 that endorsement and selection are really two
5 processes that need to work in parallel and we
6 want to make sure that you're getting the
7 information that you need from the MAP work to
8 support your conversations about endorsing the
9 measures.

10 Similarly, we want to make sure we're
11 giving the MAP what the CDP standing committees
12 feel is the most relevant information about the
13 measures that are coming under consideration for
14 the various federal programs.

15 So, staff has started to undertake
16 some work where we will reach out to measure
17 developers who have measures under consideration
18 for MAP to encourage them to bring them in for
19 endorsement work.

20 We also, you may have noticed in the
21 preliminary analysis, include some information
22 about MAP's review of measures in the use and

1 usability section. Similarly, when we do a
2 preliminary analysis for the MAP committees, we
3 include relevant feedback from the CDP standing
4 committees and your reviews on any measures that
5 have come before a standing committee before they
6 go to MAP.

7 So, we do want to make sure that
8 information is flowing between the two processes
9 and both our endorsement and selection committees
10 feel supported by the information we're
11 providing. Next slide.

12 DR. AMIN: Erin, before you move on --

13 MS. O'ROURKE: Yes?

14 DR. AMIN: -- could we go back to that
15 slide for a second? So, I just wanted to
16 reiterate for the group, many of you have been
17 part of the standing committee since we
18 originally started our work in cost and resource
19 use measurement, and so, I wanted to just take a
20 second to reflect on the fact that we went from
21 having -- actually many of the measures that we
22 looked at today, these were the first measures

1 that we ever looked at. And so, now, three years
2 later, we have a significant number of cost and
3 resource use measures that are endorsed.

4 So, as Erin talked through, in terms
5 of the current measures that are in the
6 portfolio, what's really important for us is to
7 get some guidance, and we can get it today and we
8 can certainly get it from you all following the
9 meeting today, around where we want this domain
10 of measurement to go, in terms of, we sort of
11 describe it as gaps, but we've talked about,
12 actionability has come up a few times during our
13 conversation today, the use of these measures in
14 different settings, condition-specific measures,
15 but we also want to have a coherent portfolio.
16 This is an opportunity for an area of measurement
17 where we can be much more strategic in the types
18 of measures that we want to see.

19 Secondly, and as Erin described and
20 I'll just highlight, we have the opportunity in
21 the fact that this is a new area of measurement,
22 but also a really important area for use of these

1 measures in programs, where we have the
2 opportunity to see these measures, proposed
3 measures, early in the MAP process, sometimes
4 before they even get to the standing committee.

5 So, what Erin's going to walk through
6 is some of what we believe is going to be coming
7 down the pipeline for you to be evaluating in the
8 next several cycles of our work. And I say
9 several cycles, because it looks like there's
10 going to be quite a bit of work coming down in
11 this area of measurement.

12 But we want to make sure that you all
13 are familiar with the fact that, as we have these
14 conversations, the purpose of our discussion is
15 not only for our reports and for transparency
16 purposes, but it also feeds the MAP process as
17 the MAP committees think about using these
18 measures in programs.

19 And so, the preliminary analysis and
20 the scientific review that's done in these
21 committees have multiple uses and is really the
22 foundation for the MAP recommendations for the

1 various programs.

2 And so, we look at these two processes
3 as interconnected and the flow of information
4 going from one process to another, with the staff
5 really serving as that conduit. And so, with
6 that, I'll turn it back over to Erin, as we talk
7 through some of the measures that have been
8 proposed in the various MAP work groups.

9 MS. O'ROURKE: Sure. So, on that note,
10 next slide please. To just give you an update of
11 what we've seen through the MAP process that has
12 not really come before the Standing Committee
13 since you've last convened, in 2014-2015, MAP
14 took a look at a number of ACO-level measures for
15 the Medicare Shared Savings Program.

16 One is an application of 2158, the
17 Spending Per Beneficiary Measure you all reviewed
18 today, however, at the ACO level, not for the
19 hospital level of analysis as you reviewed today.
20 Also, the Total Per Capita Cost Measure that I
21 believe this Committee evaluated a few years ago
22 and was not endorsed. Similarly, MAP did not

1 support that measure for implementation in the
2 Shared Savings Program. Next slide.

3 So, this, I apologize for, the font is
4 rather small, but in the year before last, MAP
5 actually looked at quite a few measures under
6 consideration related to cost and resource use.
7 You can see there are a number of episode-based
8 payment measures for various conditions that were
9 under consideration for some of the hospital
10 programs, the IQR and the value-based purchasing
11 program.

12 There was also a spending per
13 beneficiary of post-acute care for the home
14 health, inpatient rehab facility, long-term care
15 hospital, and skilled nursing facility settings.
16 Next slide.

17 DR. AMIN: So, Erin -- sorry to keep
18 jumping in.

19 MS. O'ROURKE: No, no.

20 DR. AMIN: Can we go back to this
21 slide? So, one of the things that we wanted to
22 point out with this is, there is a real need,

1 again, just going back to my previous comments,
2 there is a need, as you can see with the number
3 of measures that are coming out for cost and
4 resource use and what they're focused on, there
5 really is a need for guidance around how and
6 which types of measures we're actually developing
7 for cost of care measures.

8 And you can see the myriad of
9 conditions that have been already proposed, and
10 they're all -- essentially, the recommendations
11 to the MAP were based on the question of whether
12 these are important areas for cost measurement.
13 They might be important clinical areas, but are
14 they really important cost drivers for the
15 system?

16 And so, again, we may need to really
17 think about, as part of our work, as we think
18 about the next phases of work, how do we really
19 think about breaking down these episode-based
20 measures and how do we come up with a conceptual
21 model for how we're going to be able to
22 prioritize?

1 And give some guidance to the field
2 about what types of measures we want to be seeing
3 here for cost of care, because some of these are
4 already being developed, there's a lot of
5 development dollars going into this, we want to
6 make sure we're really addressing some of the
7 high impact areas and in the last row, high
8 impact care settings, and making sure that we
9 have a level of harmonization of the measures
10 that we're seeing across these various settings.

11 MS. O'ROURKE: So, this is -- actually,
12 to go back to a point, Brent, you raised during
13 one of our orientation calls was, legislatively,
14 there have been quite a few updates around cost
15 and resource use measurement.

16 In particular, the Improving Medicare
17 Post-Acute Care Transformation Act of 2014. The
18 IMPACT Act required the development and reporting
19 of measures of resource use for LTACHs or SNFs
20 and home health agencies.

21 And then, the Medicare Access and CHIP
22 Reauthorization Act of 2015, MACRA, which

1 repealed the sustainable growth formula and
2 streamlined clinician quality reporting programs
3 and incentives into the Advanced Alternative
4 Payment Models requires the use of cost and
5 resource use measures. Those are included in
6 both tracks of the Quality Payment Program, both
7 the new Merit-based Incentive Program, as well as
8 the Advanced Alternative Payment Models.

9 So, just to give a very high level
10 overview of the MIPS Program, MIPS includes four
11 domains: quality, resource use, clinical practice
12 improvement activities, and advancing care
13 information.

14 The resource use domain will include
15 a number of measures, including the Total Per
16 Capita Cost for All Attributed Beneficiaries,
17 Medicare Spending Per Beneficiary, and up to
18 other 41 episode-based measures. These are still
19 in development, but focusing on acute care,
20 procedural, and episodic care. Next slide.

21 So, I want to kind of reframe some of
22 these questions here, pulling in some of Taroon's

1 points about not just what information the MAP
2 needs, that you can see on these slides, but also
3 to go back to the question about, does the
4 Committee have input on what are some outstanding
5 gaps in development?

6 Any guidance you'd want to put there
7 of where we should try to perhaps make
8 recommendations around where to put development
9 dollars, any outstanding gaps you see in the
10 portfolio. So, in combing the past two sections,
11 on both the MAP work and any gaps that remain in
12 the portfolio.

13 DR. AMIN: Recognizing that many of
14 these forty-some-odd episode measures may already
15 be in development.

16 MS. O'ROURKE: Yes.

17 DR. AMIN: So, some of that may already
18 be in development. So, I think, really, the
19 fundamental question here is, as we think about
20 these two important processes, are there any sort
21 of recommendations, observations that you have as
22 the Committee around how we can continue to

1 improve the information flow and also, where we
2 might, as a Committee, focus on prioritization of
3 guidance to the field for this area of
4 measurement?

5 If we're looking at doubling,
6 potentially even tripling the size of this cost
7 of care portfolio in the next three to four
8 years, how do we start to rationalize what we
9 really need to be looking at in this cost of care
10 domain?

11 CO-CHAIR ASPLIN: So, with that, we'll
12 open it up for discussion and comments from
13 Committee Members. Srinivas, do you have a
14 comment?

15 MEMBER SRIDHARA: Still up from --

16 CO-CHAIR ASPLIN: Cheryl?

17 CO-CHAIR DAMBERG: So, it seemed as
18 though, from that first slide that had all those
19 different conditions, there's pretty heavy
20 emphasis on the hospital setting. And I guess I
21 just need to understand better what's in the
22 measure development pipeline vis-a-vis cost for

1 ambulatory care and ambulatory care conditions.

2 MS. O'ROURKE: So, I think that is
3 something we haven't really seen yet, other than
4 the language in the proposed rules about the up
5 to 41 measures. I was just looking today,
6 there's some commenting open on the MACRA
7 website, with some information about the various
8 episode groups and the triggers.

9 But those measures are still in
10 development and we haven't really seen what they
11 might look like, they haven't come to the MAP
12 process yet.

13 CO-CHAIR ASPLIN: Jack?

14 MEMBER NEEDLEMAN: We spent a fair
15 amount of time talking about usability today,
16 even as we abbreviated it in some cases, but I
17 think that's critical. And I don't think the way
18 we're getting the data on these measures, either
19 we or the MAP, is facilitating our assessment of
20 the usability or the appropriateness of the use,
21 given the validity of the measure.

22 An awful lot of the payment measures

1 wind up in a grid system, with very sharp edges,
2 based upon your location in a distribution, not
3 the absolute level of your spending or resource
4 use.

5 And we have not been asking -- we got
6 told how many people changed quintiles, but we
7 didn't get told how many people, how many
8 hospitals or how many systems or how many
9 provider groups wound up being shifted from one
10 payment category to another, either a bonus to
11 nothing or to a penalty.

12 And yet, those are the way the
13 measures are being used in the systems that the
14 MAP is evaluating. And the assessment of how
15 well they perform needs to be done against use,
16 not more abstract levels of r-squares or anything
17 else.

18 So, I think that's one of the key
19 lessons I draw from this, for both our group, our
20 work, and the MAP work, in terms of enhancements
21 and guidance on how to do it and guidance for the
22 developers on what to provide.

1 I think one of the issues for us, we
2 are the Cost and Resource Use Committee, we often
3 don't measure resources because of standardized
4 pricing, the issue has been, in the value-based
5 payment, was the fact that people were looking at
6 value.

7 And I guess, one of the questions, in
8 terms of where the appropriate forum is, is, are
9 these grids, which integrate both information on
10 quality and information on resource use, a
11 measure in and of themselves or is it only the
12 separate components that the measures and,
13 therefore, how do they get evaluated?

14 And to the extent that the grid is the
15 measure, should the grid be coming into this
16 Committee with a broader mission of assessing
17 cost, resource, and value measures? So, those
18 are the issues I would raise for consideration.

19 CO-CHAIR ASPLIN: Martin?

20 MEMBER MARCINIAK: So, four years ago,
21 we came here and we had basically the same
22 conversation we had today and I made the comment

1 to a couple of you in passing as we went through
2 today, which caused me to kind of scratch my head
3 a little bit.

4 To Janis's point, the dialogue this
5 time seemed much the same, but the vote was very
6 different. Four years ago, I found, mistakenly,
7 in actually revoting at some point to sort out
8 where our true feelings were about the measures.

9 But at the end, we end up with a
10 conversation of, well, what are we measuring?
11 We're not measuring cost, we're not measuring
12 resource, and, thereby, we're not measuring
13 value.

14 And so, a couple of years ago, I got
15 excited about the fact that I actually started
16 seeing measures coming through that were what I
17 would call therapeutically-aligned, so, the
18 pneumonia one, right?

19 So, how can you measure cost without
20 context, was the conversation four years ago?
21 Once again, today we had a conversation of cost
22 without context, and that's the part that I have

1 a hard time resolving when I go back to the
2 office is, well, what do you share with people?

3 Well, we passed three resource
4 measures, that's what we're calling them. They
5 don't measure efficiency and they don't measure
6 value. And so, I would like to see, as we
7 continue to move forward with these conversation,
8 a degree of trying to drive the dialogue together
9 a bit more.

10 Because, at least at that point, it
11 will become more meaningful, because then you'll
12 understand what's happening in an ambulatory
13 setting, you'll understanding what's happening in
14 a hospital.

15 And, frankly, to the comment that
16 somebody had made about the group that was here
17 from Yale three years ago that got a really hard
18 time, and then, the young lady gave me a hard
19 time, because I explained that I couldn't
20 understand what she was doing well enough to tell
21 my parents, who use these systems.

22 There seemed to be, again, a lack of

1 congruency with respect to what the ultimate
2 pull-through ends up being. So, we approve
3 something here, we're not always sure exactly how
4 you differentiate what's the patient populations,
5 problematic, and then we approve it and it's used
6 broadly and we don't wrestle with that which we
7 have wrought, really.

8 So, that's my two cents for this. I
9 would like to see more communication, not less.
10 So, you tend to wax and wane based on the level
11 of activity, but there were some things that were
12 on the, I guess the chart, that I don't recall
13 having seen. Things that we had elected not to
14 recommend out to the broader group. Some of
15 them, again, were disease-specific, sort of
16 resource and cost total.

17 It would be nice to see a little bit
18 more of that, because that would allow me to
19 reestablish in myself some context of, that we
20 are trying to link the stories between cost,
21 resource efficiency, and value. Because most of
22 my day job is about talking to hospitals and

1 other groups about what value is and I still
2 haven't found a good definition of what that
3 means.

4 CO-CHAIR ASPLIN: Troy, and then,
5 Dolores.

6 MEMBER FIESINGER: Hello, this is Troy.
7 Appreciate hearing long-term care mentioned,
8 because the question for me and my practice and
9 being a family doctor is measures that look at
10 long-term treatment in the outpatient setting,
11 diabetes, heart failure, et cetera.

12 The sub-population that comes up very
13 often in our discussions with management of care
14 plans especially is, those high-cost, high-risk
15 acute patients.

16 And I don't know if there are any
17 measures looking specifically at that population
18 that have multiple illnesses, are in the hospital
19 often. Are there any benchmarks to compare how
20 we're doing with them? Do they just cost a lot
21 and that's the best we can do, or are there areas
22 to improve?

1 Second, in the post-acute care
2 setting, that are ACO, really looking closely at
3 SNF use versus LTACH use, home health PT versus
4 going to a clinic for PT, so care setting
5 measures addressing those subsets of use for
6 those services, but not just in the post or
7 discharge setting, but home health in particular.

8 A pattern I see is home health being
9 used and really -- care, but that's not covered.
10 I appreciate the comments that we just heard on
11 value with the care bill especially increased
12 risk for lower cost, but all we ask, do a good
13 job quality-wise. Measures that balance those
14 two with the value would be very helpful.

15 CO-CHAIR ASPLIN: Thank you. Dolores?

16 MEMBER YANAGIHARA: So, my comment is
17 related to feedback that we get from providers
18 all the time, in wanting to have a consistent set
19 of measures that they can be measured on across
20 their whole patient population.

21 And I know that there is lots of
22 reasons why that's challenging, because not every

1 measure is applicable to every population, but if
2 you think about it, the HealthPartners measures
3 were specific to commercial, and then, there is
4 the Medicare measure we just looked at, was
5 specific to Medicare.

6 And there may be reasons for that, but
7 it makes -- it drives the providers crazy to have
8 similar measures, and those two aren't exactly
9 similar, but that only apply to part of their
10 patient population.

11 So, I mean, I don't -- like I said,
12 there's lots of reasons why that gets very
13 challenging to do, but -- and then, that also has
14 to be balanced with, sometimes we start getting -
15 - so, we have total cost of care is not as
16 actionable, but it's applicable to everybody.
17 And then, you start drilling down into very
18 condition-specific thing that are maybe more
19 actionable, but then don't apply to as large of a
20 population.

21 So, like I said, I recognize there's
22 a lot of challenges, but I think to just keep in

1 mind that the more we do kind of payer-specific
2 kind of stuff, the less impactful it will be,
3 because the providers are trying to respond to
4 all these different signals.

5 CO-CHAIR ASPLIN: Larry?

6 MEMBER BECKER: Yes, thank you very
7 much. So, I wanted to reflect on a couple of the
8 prior comments and particularly Jack's. And
9 perhaps this is what Jack was saying, in that
10 there are a lot of measures and there are a lot
11 of measures outside of the cost and resource use
12 measures.

13 And understanding those may provide
14 context and a larger picture and fill in some of
15 the voids in maybe our perceptions, maybe our
16 realities about what we're looking at on cost and
17 resource use.

18 And that it would be helpful, perhaps,
19 to see where there may be complementary measures
20 that are sort of filling in those blanks, because
21 I have a sense that a lot of these measures are
22 aimed at trying to get a complete picture and

1 when we look at it from simply the cost and
2 resource use perspective, we're sort of getting a
3 narrow context, if you will.

4 And so, to the extent that other
5 things that are happening to fill in measures
6 could be complementary, I think it would be
7 helpful for us to at least see and understand
8 those in the context of the work you're asking us
9 to do.

10 CO-CHAIR ASPLIN: Thank you. Jim?

11 MEMBER NAESSENS: Thank you. Actually,
12 I was going to reflect back on more what Martin
13 said and also Dolores. And I was going to give
14 almost the opposite recommendation that Dolores
15 gave, that as measures proceed and as we're kind
16 of evolving down the path, and we look at the
17 usability for the providers or we look at the
18 usefulness for the consumer, global measures are
19 less useful.

20 They don't give us an idea of where we
21 can change, what's the best one. I'm coming in
22 with cancer, I really -- maybe the cancer

1 practice here is very different than all the
2 other practices.

3 So, the more and more we can move
4 towards measures, maybe not disease-specific or
5 certainly not payer-specific, but if we think of
6 a clinical domain, whether it's obstetrics,
7 whether it's primary care, whether it's
8 orthopedic surgery or some groups like this, and
9 recommend that measures be focused in those
10 fairly extensive, large domains, we should be
11 able to bring more of the quality measures with
12 the cost and utilization measures, get more
13 meaningful measures that are useful for providers
14 to make changes and also useful for consumers to
15 start selecting places.

16 CO-CHAIR ASPLIN: Srinivas?

17 MEMBER SRIDHARA: Yes, I think Jim
18 mostly said what -- similar comments. So, thank
19 you. If I could extend that, I think in terms of
20 a role for this group, in particular, is I think
21 the process being described, a lot of what's
22 coming and sort of how can we provide guidance,

1 and it almost seems like taking this conversation
2 and providing a framework to what is needed and
3 crafting that is what it's necessary.

4 Because it's -- to also go back to
5 something Martin was saying, in terms of aligning
6 with the therapeutic context, or if you think
7 about for, whether it's a hospital, a clinician,
8 anyone, they're operating in specific service
9 lines or categories of service that they're doing
10 in general, whatever that is, or specialities,
11 and we need something that aligns well with that,
12 so that it drives that action.

13 It could be that you still have
14 measures that are applicable across, like, these
15 cost of care measures, like the total cost of
16 care measure we looked at today, but there's
17 probably a push to say, in the coming time, we
18 want those to be applied in specific service
19 areas and contexts and bring that through, and
20 that's how we would like to approve it.

21 And that might be a way that, even for
22 CMS or others that are going to be using this in

1 how they, say, do MIPS or something else, then
2 they have a sense of how to tailor it to the
3 different service lines. But I think we could
4 probably help to provide that framework as a
5 group.

6 CO-CHAIR ASPLIN: Thank you. Kristine?

7 MEMBER MARTIN ANDERSON: I think when
8 -- so, what I struggle with is, whenever we have
9 these measures that have layers and layers of
10 algorithms, right, so they're going to have a
11 grouping algorithm, they're going to have a
12 measurement algorithm, they're going to have a
13 risk adjustment algorithm, et cetera, that it's
14 never true that it works equally well for all
15 populations.

16 And so, one thing that I struggled
17 with today and I think on this question of use,
18 that we need to continue to struggle with, is
19 that, if they don't work well for a particular
20 population, so a population-based measure does
21 not work well for individual physicians or
22 certain types of characteristics of individual

1 physicians or some places with a claims stream
2 really does not well represent the care process,
3 there isn't a way to articulate, here's where it
4 shouldn't be used.

5 And so, once they get endorsed, we
6 have these conversations, but once they get
7 endorsed, they can get used anywhere. And so, I
8 know that NQF has been hesitant to walk into the
9 -- down the road of appropriate for what use, but
10 when you get to these types of measures that have
11 so many layers of algorithms and they're reliant
12 on blunt information at the base, I think it's
13 important that that kind of conversation be had
14 in the endorsement process or the MAP process or
15 somewhere.

16 CO-CHAIR ASPLIN: Thank you. Nancy?

17 MEMBER GARRETT: So, one thing that
18 I've been thinking about in regards to this
19 portfolio is just about price. And so, whenever
20 I've been involved in total cost of care type
21 measurements across populations, I'm always
22 struck by how much price is a driver of the

1 results. Utilization is important too, but price
2 is really big, in terms of differentiating
3 performance.

4 And what role would NQF have there, in
5 terms of having more measures of price and having
6 more price transparency? So, that's kind of a
7 political question, but an important one, I
8 think, because it's a really key part of cost.

9 And there is some work in Minnesota,
10 where Community Measurement has created some,
11 really, price measures for several procedures
12 that are high volume, like MRIs, where we've
13 aggregated average allowed price across all
14 payers, so that for one -- you can compare the
15 cost of that procedure across all providers.

16 And that's on our website. That's
17 something we've done as a community, but it's not
18 a perfect measure by any stretch, but it is kind
19 of a baby step towards more transparency. So,
20 just something to think about.

21 CO-CHAIR ASPLIN: Thank you. I'm going
22 to make a quick comment and then, I'm going to

1 hand it over to Ashlie and we can move into some
2 of the grouper conversations, if that's all
3 right?

4 To me, the urgent area is around
5 physician accountability around resource use,
6 because we don't have any endorsed measures
7 there, and MIPS is coming up. And I just think
8 this whole process is way too labor intensive to
9 use the CDP to try to sort out MIPS.

10 And I don't know what level of
11 stakeholder engagement and dialogue there is
12 across CMS and MAP and physician groups, et
13 cetera, around, what is this resource category of
14 MIPS really going to look like, and Advanced
15 Alternative Payment Models?

16 We need a total per capita cost
17 measure in Medicare, we need one. I know it
18 didn't get over the bar when we talked about it
19 last time, the total per capita spending, but I
20 don't see primary care groups and physicians to
21 be accountable for episodes, it just doesn't make
22 sense.

1 And so, there needs to be some version
2 of the HealthPartners measures or something like
3 that in Medicare, I think. And where it fell
4 apart was on attribution, that's where it fell
5 apart.

6 And I think we have to sort through
7 that by having dialogue about use, which is not
8 part of the CDP, the Consensus Development
9 Process, but if CMS could clarify use and there
10 could be at least a modest amount of agreement
11 among physician groups and CMS about how the
12 resource use category of MIPS is going to move
13 forward, so that you could Pareto chart out all
14 the docs and this is generally who we're going to
15 use a total per capita measure for and these are
16 the physicians we're generally going to use an
17 episode-grouper for, and then some ambulatory
18 non-procedural specialists who are in single
19 speciality TINs are going to be left out.

20 And I don't know what to do about
21 them, right? So, what do you do about
22 rheumatology? Huge spend, not really going to

1 fit a grouper, and if you're a single specialty
2 rheumatologist group or solo practitioner, where
3 do you fit?

4 I don't know, but let's solve for the
5 20 after we get the 80 figure out, right? I
6 don't have the answer for everything, but I don't
7 want to go through 45 measures in this process
8 and then find out that that's not how they're
9 going to be used. Helen?

10 DR. BURSTIN: Yes. I think so many of
11 you raised great points and lots of work I think
12 we all need to collectively do for the future.
13 We do know that the measure we just talked about,
14 the MSPB Measure, is being respecified to the
15 physician-level, to the TIN-level, so that will
16 be coming back to you. And they'll adapt --
17 again, it may not answer all of that, but at
18 least that is one thing we know that is coming
19 down the pipe.

20 But, again, you've raised a lot of
21 really important issues about really thinking
22 about what's needed, frameworks, et cetera, that

1 I think are exactly what we'd like to have come
2 out of this incredibly smart Committee.

3 DR. AMIN: Yes. So, I think these are
4 excellent comments. I think there's a lot of
5 ideas here, in terms of -- Ashlie, did you have
6 some comments? I didn't mean to jump in.

7 MS. WILBON: No.

8 DR. AMIN: We're good. So, I think
9 there is a lot of work that we can do in terms of
10 just even thinking about how we start linking
11 these cost and quality measures, whether that's a
12 measure developer responsibility, as the Linking
13 Cost and Quality Expert Panel sort of
14 recommended, or based on Srinivas's sort of
15 proposal. That might be some activity that this
16 Committee can do, if we propose some additional
17 funding to be able to support that type of work.

18 So, Erin, if it's okay, we can move on
19 from this section, and I'll sort of move on to
20 the next slide. And this is a little bit of a
21 shift of gears and I appreciate everybody sort of
22 working with us.

1 And we have a few different conceptual
2 things that we wanted to talk about and we're
3 trying to stuff it all in the last hour here.
4 So, we're going to shift between multiple
5 different topics.

6 So, the next discussion, you have a
7 handout that's titled, it's on NQF letterhead,
8 that's titled Cost and Resource Use Measure
9 Evaluation Criteria Update Recommendations. So,
10 the purpose of this document is to review the CRU
11 criteria that are used for endorsement.

12 And over the past few years of
13 experience we've gained from deploying these
14 criteria in multiple CDP projects, there have
15 also been updates to the quality measure
16 evaluation criteria as well.

17 And so, the purpose of this document
18 in front of you is to -- there are several
19 recommendations that staff is making to update
20 the criteria for the Standing Committee to
21 consider. And from our perspective, these are
22 intended to simplify the criteria and make them

1 more precise.

2 In terms of, there are components that
3 are included here that are recommended for
4 removal, that we don't argue are important,
5 however, it is very unlikely that the Standing
6 Committee has ever made recommendations to not
7 endorse a measure based on these criteria.

8 And so, for us, they don't feel like
9 criteria if we're not really using them to
10 distinguish between different measures. So, the
11 first is on Criteria 1A, the measure focus.
12 Currently --

13 MEMBER WEINTRAUB: Bill, just a second.
14 For those on the phone, which one of the
15 documents is this?

16 DR. ROILAND: It should be the one
17 titled Cost and Resource Use Measure Evaluation
18 Criteria Updates. If you don't have it, we'll
19 send it out to you right now. Apologies about
20 that, if you can't access it.

21 MEMBER WEINTRAUB: I don't see that.
22 I'm looking one the website, I don't see that.

1 So, if you'll email it to me, I'd appreciate it.

2 DR. ROILAND: Okay.

3 CO-CHAIR ASPLIN: Maybe, can we also
4 bring it up on the screen for the webinar? Would
5 that be too much to ask?

6 CO-CHAIR DAMBERG: You can also post it
7 to the webinar.

8 MEMBER WEINTRAUB: That is too much to
9 ask? Okay.

10 DR. ROILAND: Yes, could we screen-
11 share this? Do we have it?

12 CO-CHAIR ASPLIN: Can we vote on it?

13 (Laughter.)

14 DR. AMIN: That was good Brent, that
15 was good. Sorry, Bill, we're pulling it up and
16 then, we'll also send it to you.

17 MEMBER WEINTRAUB: Great.

18 DR. AMIN: And I'll do my best to
19 actually walk through it in detail. So, the
20 first criteria, Criteria 1A includes two
21 components.

22 The first is that the measure focus

1 address a specific national health goal/priority
2 identified by HHS or the National Priorities
3 Partnership convened by the NQF. And we are
4 recommending removal of this component of 1A,
5 since, really, measuring costs conceptually is
6 very difficult to argue is not important to
7 measure.

8 And, really, it's the second half of
9 this criteria which is related to what we're
10 actually looking at, actually demonstrating that
11 it's a high impact aspect of healthcare, meaning
12 that it affects a large number of individuals,
13 that it's a condition, potentially, that's
14 affecting a large number of individuals, or a
15 leading cause of morbidity or mortality, or it's
16 just high resource use and severity of illness.

17 And so, this is really the component
18 that is of importance here. And so, this is
19 where we recommend that we continue to maintain
20 focus and remove the first component. The second
21 is around performance gap. Clearly, we've had a
22 lot of discussions around that today, I think

1 that stands.

2 And then, the third is, 1C, the intent
3 of the resource measure and the measure construct
4 are clearly described and the resource use
5 service categories that are included in the
6 measure are consistent with and representative of
7 the intent of the measure.

8 And so, the challenge here is that,
9 oftentimes with this section of the evaluation
10 criteria, is that, the importance to measure and
11 report criteria is intended to be conceptual in
12 terms of what the intent of the measure is
13 supposed to be focused on, whereas scientific
14 acceptability really gets us into the measure
15 specifications.

16 And so, 1C often has the tendency of
17 drawing us right into the most -- the heart of
18 the -- where people are really concerned about
19 the specifications, where really that's not the
20 intent.

21 And, quite frankly, it is repetitive
22 of what we're looking at with the reliability,

1 meaning the specifications are precise, and then,
2 the validity, meaning the specifications are
3 consistent with the intent.

4 And so, we are recommending removal,
5 since this is really repetitive and, quite
6 frankly, would be more structured if we included
7 it in the reliability and validity evaluation of
8 the measures.

9 And then, for reliability, we just
10 included, this is to be consistent with the
11 quality measures evaluation criteria, which is
12 looking at the specifications. We have not had
13 an eMeasure specified cost and resource use
14 measure yet, but it likely is coming. Cheryl
15 might be working on it.

16 (Laughter.)

17 CO-CHAIR DAMBERG: It's going to be a
18 hybrid.

19 DR. AMIN: Yes, or at least a hybrid.
20 But either way, at least just making it clear
21 that we're looking for ICD-10 specifications and
22 then, we're using the eMeasure specifications,

1 HQMF format.

2 And so, this is not really -- this is
3 just to be consistent with the rest of the
4 quality measure evaluation. And so, that really
5 is the bulk of what we wanted to bring in front
6 of you today.

7 We believe that these are relatively
8 minor recommendations, in terms of clarity and
9 just to make your work actually a lot simpler, in
10 terms of structuring our conversations. So,
11 those are the recommendations that are in front
12 of you for evaluation. Erin, is there anything
13 else that you wanted to add, as it relates to
14 this --

15 MS. O'ROURKE: No, I don't --

16 DR. AMIN: -- discussion?

17 MS. O'ROURKE: I don't think so. You
18 covered it.

19 DR. AMIN: And so, I would welcome any
20 discussion. And if there isn't any, that is
21 okay, we'll take that as agreement and then move
22 on. But I certainly welcome any conversation on

1 it.

2 MEMBER WEINTRAUB: This is Bill. To
3 me, this just does add clarity.

4 DR. AMIN: Thanks, Bill.

5 CO-CHAIR DAMBERG: Nancy?

6 MEMBER GARRETT: So, I just found under
7 1B, the disparities in care across population
8 groups, when we were going through that today, I
9 found that kind of confusing.

10 Because people interpreted that as,
11 should this be risk-adjusted for SDS? But then,
12 that was in the validity section. So, I don't
13 know if we're just not interpreting it the right
14 way, but it just doesn't seem to fit there.

15 DR. AMIN: We struggle with that as
16 well. The challenge is that this is -- yes. So,
17 the challenge is that the intent of this in the
18 quality measures evaluation criteria is that, one
19 of the reasons for including a measure is that it
20 might be sort of conceptually an area where there
21 is disparities of care. Now, whether the measure
22 is able to find the disparities is sort of the

1 validity question.

2 In our work, I don't know that it --
3 it is conceptually challenging to understand,
4 because, again, we have that same problem, where
5 we look at this and we're looking to see where
6 there's disparities and is that a validity
7 question?

8 That really is, that is a challenge as
9 well and I think that it does offer some
10 confusion as well. And it certainly added
11 confusion in our preliminary analysis work, in
12 terms of making sure that that was clear.

13 So, I mean, I would welcome additional
14 recommendations on that. We would have to
15 discuss with our measurement science colleagues
16 on the quality side to understand whether that
17 was an option to remove, but we certainly welcome
18 thoughts on that, if you have any, Nancy.

19 MEMBER GARRETT: Do they have to be
20 aligned to --

21 DR. AMIN: No, they don't --

22 MEMBER GARRETT: -- the cost and

1 quality measures?

2 DR. AMIN: They don't need to be.

3 MEMBER GARRETT: Okay.

4 DR. AMIN: They don't need to be.

5 DR. BURSTIN: It certainly would be
6 optimal, otherwise we have to explain why they're
7 different. So, if there's a reason to have
8 something in there, there has to be a compelling
9 reason why cost is different.

10 MS. WILBON: I wonder, too, if it would
11 just be an issue of just clarifying language. I
12 think this second bullet is really around, are
13 there such disparities in the population that
14 it's necessary to have this measure to help
15 illuminate that there are those disparities?

16 So, I think that disparities in care
17 -- exactly. So, I think it may be the wording of
18 it and the way that it -- so, maybe we can come
19 up with some new language, so that it's clearer
20 when we're going through the evaluation that the
21 context of the discussion is really around, is
22 this measure needed to help us understanding why

1 there are disparities in care?

2 Conceptually, that this measure is
3 needed, it's important to have this measure for
4 that reason. So, I think there may be ways that
5 we can massage that language a little bit.

6 CO-CHAIR DAMBERG: Any other comments?
7 So, did you want to take a vote on this or, like,
8 a show of hands?

9 (Laughter.)

10 DR. AMIN: I will just --

11 CO-CHAIR DAMBERG: No more electronic
12 anything.

13 (Laughter.)

14 DR. AMIN: No, I think we're -- unless
15 there is --

16 CO-CHAIR DAMBERG: Any objections?

17 DR. AMIN: -- any objections, we would
18 just take it that way, I think it's fine. And
19 then, I mean, this will have to go through other
20 bodies to look at, since it is a criteria review,
21 but we'll take that as input. Okay. So, Erin,
22 I'm going to turn it over to you on the SDS

1 slides. Or whatever topic you want to cover.

2 MS. O'ROURKE: Why don't we do the SDS
3 and then, I can turn it back to Ashlie for the
4 groupers? And that gets us on-schedule. We've
5 got attributions scheduled after the grouper
6 work. So -- yes.

7 MS. WILBON: So, which topic are we on?

8 MS. O'ROURKE: I'm going to just
9 quickly go through an update on our trial period
10 for adjustment for socioeconomic and other
11 demographic facts, or SDS as we've been referring
12 to it.

13 So, just to refresh everyone on the
14 last this Committee, really, heard of this, we
15 convened you over the summer to provide input on
16 the three measures from CMS, Yale, the episode-
17 based ones.

18 When we received an appeal about the
19 decision to inverse them without any SES factors
20 in the risk adjustment model, the Committee
21 recommended upholding endorsement of the measures
22 as-is. That decision was ultimately ratified by

1 the CSAC and the Board upheld the endorsement.

2 So, we did just want to close the loop
3 with the Committee on those. And thank you for
4 all the extra work you did to weigh in on those.
5 Next slide.

6 So, again, this is a topic that came
7 up throughout the conversations today, so I don't
8 really want to belabor it, but this is from the
9 ASPE report that we discussed quite a bit
10 already, just showing some of the challenges for
11 getting this data.

12 And as Helen said, it's really been
13 one of the major findings of our trial period is
14 just how challenging it is to get the data to
15 really link the empirical analyses to the
16 conceptual basis that we're seeing.

17 And as Helen said, NQF is committed to
18 continuing to do what we can to drive the better
19 data. We've been recommending at the annual
20 update that developers give us more information
21 about where they are.

22 So, I wanted to just highlight to the

1 Committee, that's one of the significant
2 findings, was this is still very challenging to
3 do and we are committed to doing what we can to
4 improve the underlying measurement science here.
5 Next slide.

6 So, again, what we found has really
7 been consistent with what's come out of ASPE.
8 Medicare patients with social risk factors tend
9 to have worse outcomes, regardless of provider.
10 Dual enrollment in Medicare and Medicaid can be a
11 powerful predictor of poor outcomes.

12 Providers disproportionately serving
13 Medicare patients with social risk factors have
14 worse performance on quality measures and
15 experience somewhat higher penalties in value-
16 based purchasing programs. And, really, tracking
17 with what's come out of our trial period is
18 better data and more study is needed here. Next
19 slide.

20 So, some initial results of our two-
21 year pilot. We really want to get the right data
22 to assess social risk, what we've got currently

1 is just not sufficient to show up in the
2 empirical analyses. We've probably only had ten
3 measures or so of all that we've looked at over
4 the past two years end up having SES factors in
5 their risk adjustment models.

6 We've seen a lot more come through
7 with a conceptual basis, but then it's really
8 just been a challenge to have that hold up when
9 you really crunch the numbers, similar to what, I
10 think, this Committee grappled with this morning.

11 Again, we do want to improve the
12 quality of care for social risk factors, this is
13 a key challenge I think the system is grappling
14 with. We need to find ways to better account for
15 the impact of social risk, so that value-based
16 purchasing programs reward providers fairly.

17 And we want to get to, really, the
18 next generation of measures that are assessing
19 healthcare equity. And this is something our
20 Disparities Standing Committee is tasked with,
21 they are actually meeting at the end of this
22 month to really start to consider what measures

1 of equity could look like. Next slide.

2 So, some key upcoming milestones. The
3 trial period will end in April 2017. During the
4 June 2017 meeting, we'll reconvene the
5 Disparities Standing Committee and ask them to
6 evaluate the trial period and make a
7 recommendation to the CSAC and the NQF Board
8 about whether or not we should continue to allow
9 SDS factors to be included in the risk adjustment
10 models of endorsed measures.

11 So, is there any reasons to put the
12 previous policy that prohibited standing
13 committees from consider this back in place? But
14 after the Disparities Committee makes their
15 recommendation, it will go through the CSAC and
16 the Board, I believe in July, for their input.
17 Next slide. So, again --

18 DR. AMIN: So, Erin --

19 MS. O'ROURKE: -- looking -- oh, sorry.

20 DR. AMIN: So, I think, there's the
21 Committee discussion around input to this
22 Disparities Standing Committee, there's been a

1 lot of conversation that we've had over the past
2 day related to this topic of SDS and risk
3 adjustment.

4 I just wanted to sort of reiterate
5 them as they relate to just input to the
6 Disparities Committee, in terms of what I've
7 heard so far. There's been a lot of discussion
8 around unmeasured risk, that Helen described
9 quite a bit in some of her comments, that really
10 needs to be explored by the field, in terms of
11 additional research.

12 Srinivas made the comment around, how
13 do we think about data, particularly data for
14 national measures, and what's actually available
15 for these measure developers to really use, if
16 we're expecting them to use for national
17 measurement and payment purposes?

18 Janis made some points around provider
19 and population-level adjustments, and what the
20 approach is that we might want to consider in
21 order to test the various measures that are in
22 front of us.

1 The last point, I think, that has come
2 up many times, both through our public comments
3 and then, through comments around the room as
4 well, is around the fact that, when we talk about
5 risk adjustment, the complexity of the
6 conversation is often very difficult for our
7 stakeholder groups to keep up with, quite
8 frankly.

9 The issues are so complex in terms of
10 the data that we're talking about, the way the
11 measures and variables are -- well, the way that
12 the variables are constructed to represent the
13 underlying construct, and then, the way that
14 these risk adjustment models work in analyzing --
15 just even our conversation earlier around, what's
16 in the ASPE report versus what measure developers
17 are finding.

18 And actually having a relatively clear
19 discussion in our reports and in our discussion
20 around why there's these different findings.
21 And, oftentimes, this complexity is really
22 creating a lot of confusion and I think

1 frustration among our stakeholders around
2 differences in what they're seeing in literature
3 versus what we're finding as a Committee.

4 So, I think all of those are
5 discussions that we've had today, in various
6 forms. I would certainly welcome other feedback,
7 but those are at least some of the key things
8 that I've heard today for the Disparities
9 Committee to consider.

10 MEMBER WEINTRAUB: I think something
11 that could really be very helpful would be a
12 white paper on the kinds of risk adjustment that
13 NQF is looking to use. Maybe you already have
14 it, but if you do, I haven't seen it.

15 And this can be written in a way that
16 people can understand. Now, not laypeople, but
17 that's not what we're really -- that's too heavy
18 a lift. But I think that the consumers of these
19 products can understand it, if it's well
20 explained. And if you go and try to just gather
21 that yourself from the literature, for most
22 people, that's a really heavy lift.

1 CO-CHAIR DAMBERG: Larry, did you have
2 a comment? I saw your hand up in the meeting.

3 MEMBER BECKER: Oh, sorry, no.

4 CO-CHAIR DAMBERG: Okay. Jack?

5 MEMBER NEEDLEMAN: I think this issue
6 of SDS adjustment is a complex one, we've already
7 figured that out. But I think one of the reasons
8 is, we're trying to capture at least three
9 different kinds of things with it.

10 And I believe that it would be helpful
11 for committees considering this and for the
12 developers to think about how well the way in
13 which they're doing the risk adjustment or how
14 well they're doing their analysis addresses the
15 three concerns that we have?

16 The first concern is the one that
17 Helen stated and that just got repeated, that
18 there is some unmeasured fragility or unmeasured
19 need for care in these populations that are not
20 captured in the current risk adjustment
21 variables, and we need to take that into account.

22 The second is a slightly different

1 issue, which is, even if there's no greater
2 fragility or unmeasured need for care, because of
3 the limited resources that these individuals have
4 or the neighborhoods that they live in have, the
5 healthcare system has to spend more on them to
6 meet their needs for care, because the resources
7 that we other expect them to have available are
8 not there.

9 So, the second issue is whether these
10 patients impose more demand on the system for
11 care. And if the system doesn't respond to that,
12 does it fall short in terms of the quality
13 outcomes? So, that's the second issue, which
14 needs to be articulated, frankly, better than I
15 just did it, but also needs to be examined when
16 folks are looking.

17 The third issue is the fact that we
18 are not completely measuring resources. And the
19 question is, whether the resources that are
20 available in systems that treat a
21 disproportionate number of the disadvantaged
22 population simply have fewer resources and,

1 therefore, part of the explanation for why they
2 are doing a poorer job is they don't have the
3 resources to do as good a job?

4 That's not giving them a bye on it,
5 necessarily, but it does recognize that there's a
6 difference between inefficiently using your
7 resources to deliver effective care and not
8 having the resources to deliver effective care.

9 And so, one of the issues we're trying
10 to deal with here is getting at that, getting
11 evidence or suggestions that that might be the
12 case. So, those are at least the three reasons I
13 see for wanting to have SDS kinds of adjustments
14 and SDS analysis.

15 And if people aren't responding to
16 those issues or if they aren't responding to
17 questions related to those three goals, then we
18 don't have usable data to assess whether or not
19 the SDS adjustments are needed or appropriate.

20 DR. AMIN: Those are excellent
21 comments, Jack. And I think, Erin, as you're
22 thinking about feedback back to the Disparities

1 Committee, the last point that Jack noted might
2 be particularly important for cost and resource
3 use different than quality measures, and
4 conceptually, the issue of disparities might be
5 different in our area of measurement for that
6 reason.

7 MEMBER WEINTRAUB: It might be
8 different, but it can be important in both. And
9 I think there's a real problem here, because the
10 resources available to less advantaged people is
11 really a latent variable, because it's not the
12 things that you're actually measuring. That's
13 pretty, pretty tricky, but I think Jack, once
14 again, raises an excellent point.

15 CO-CHAIR DAMBERG: So, this is Cheryl.
16 I think this kind of dovetails back to the
17 comment Kristine made, in terms of thinking about
18 how these measures are used. Because I know CMS
19 has been considering how much they need to do
20 what I call a front-end fix, which is risk
21 adjust, versus a back-end fix, which is to drive
22 more resources to providers who are in your third

1 bucket, Jack.

2 And so, I think kind of as these
3 measures get used in different applications, we
4 have to think about sort of the implications.
5 Because risk adjustment is fixing a
6 mismeasurement problem, but it still doesn't
7 address the resource disparity.

8 CO-CHAIR ASPLIN: Just a quick comment.
9 And maybe this is saying the exact same thing in
10 a slightly different way. I get the sense with
11 all the conversations, especially all the phone
12 calls related to the three measures as we went
13 through this trial period, that there's a belief
14 that there's some data out there that's going to
15 lead to the holy grail of figuring out the
16 differences.

17 That it's there, we just haven't found
18 the right data elements to put in the risk
19 adjustment model. I just don't think that's
20 where we're going to find it, because we're
21 really, at the end of the day, measuring the
22 outcome variable as cost to the payer, whether

1 it's Medicare or a private payer.

2 And the resources that HCMC is
3 expending to have the same level of readmission
4 with its population may be a lot higher than the
5 resources Mayo and St. Mary's are expending in
6 Rochester to have the same level of readmission.

7 And that's never going to be captured
8 by payments, and maybe that's exactly what
9 everybody else was saying, but I just don't think
10 it's in the risk adjustment model. It might be,
11 it's still open.

12 MEMBER WEINTRAUB: I think we're all on
13 the same page about that. There are things that
14 you'd like to measure, you know it's out there,
15 but can't.

16 DR. AMIN: Yes. Okay. Those are very
17 -- I mean, I don't mean to cut the conversation,
18 if there's additional comments, it doesn't sound
19 like there are any in the room, if there's anyone
20 on the phone on this topic? And then, I'd like
21 to ask Ashlie -- go ahead.

22 DR. BURSTIN: A couple people have

1 raised this question of the underlying resources
2 that go to different entities, now, that's not
3 measure at all, and I'm not saying necessarily
4 that's a performance measure, but I guess one
5 question as we think about balancing measures or
6 something along those lines, is that potentially
7 a gap to be able to understand the actual
8 resources of the entities being measured as part
9 of this effort? Just a thought to throw out
10 there.

11 MEMBER GARRETT: If I could just
12 respond quickly? I mean, I think it could be,
13 Helen. And, I mean, it's a really -- actually,
14 there's a simple way to measure it, which is
15 payer mix.

16 I mean, the percentage of commercial
17 patients you have, that's the way the healthcare
18 system is set up right now, to offset the costs
19 for other populations that don't have -- that
20 have, as HealthPartners said, half the
21 reimbursement or less.

22 And so, that's actually a simple way

1 to understand resources and how they're being
2 allocated. And then, you layer on top of that,
3 pay-for-performance programs and all the other
4 ways money is moved around, but that's kind of
5 the basis of the system of inequality we have.

6 DR. BURSTIN: That would certainly get
7 at the conceptualization of this that's about
8 poverty. I guess, the piece of this we still are
9 grappling with is whether there's truly just
10 something we're not measuring that's different
11 across hospitals that may get at this complexity
12 too.

13 We constantly get letters from
14 hospitals and others who have raised issues. A
15 recent appeal we just got clearly pointed out in
16 our hospital, a quaternary hospital, this would
17 not be captured. Things like that I think are
18 important to note as well.

19 MEMBER NEEDLEMAN: On that point, you
20 see, every few years, MedPAC comes out with its
21 report and it shows that hospitals -- there's a
22 Medicare deficit, right? Medicare payments are

1 less than cost in some hospitals than others, and
2 typically it's the hospitals with large numbers
3 of private payers.

4 So, you can reinterpret that as
5 saying, hospitals which have the option, have had
6 the option of receiving more funds from private
7 payers are using those to top-up payments beyond
8 those they get from Medicare. It's not a
9 Medicare loss per se, it's a decision to invest
10 resources above the payment level in the Medicare
11 patients.

12 And other hospitals that don't have
13 that private payer base don't have that
14 flexibility. The finances and the amount of
15 resources per Medicare patient at UCLA-Harbor
16 look very different from those at UCLA-Reagan.

17 And the issue is, does that affect
18 their ability to deliver quality care? So, some
19 of that was supposed to be equalized by the
20 disproportionate share payments and so forth, but
21 those are the kinds of issues, I think Helen has
22 got it exactly right.

1 It's not clear that it should be
2 covered in the measurement per se, but we need to
3 have better studies of the actual resources that
4 are being provided to patients versus the
5 standardized payments that are the basis of most
6 of the CMS cost and resource use measures that
7 we've been analyzing.

8 CO-CHAIR DAMBERG: Srinivas, did you
9 want to make a comment?

10 MEMBER SRIDHARA: Yes. I mean, I think
11 we're continuing to center around sort of claims-
12 based sort of analyses and so, for the
13 fundamental question I think Helen is asking and
14 Brent also mentioned, if we're talking about
15 actual costs, for health systems or anyone else,
16 that's everything from supply costs to personnel
17 costs.

18 I mean, there's costs and what we're
19 really talking about is this payment or spending
20 or something else that is unrelated. I think the
21 challenge is, you don't have standardized data
22 assets out there to get across everyone easily.

1 So, I think it is undoubtably valuable, the
2 question is, how would you do it and do it
3 systematically?

4 And I think, in as much as NQF has
5 leverage in sort of pushing towards encouraging
6 those sort of democratization of that kind of
7 data, I think that would be meaningful. But
8 without that, I don't know how developers would
9 really get access to that in a way that would be
10 helpful to everyone.

11 CO-CHAIR DAMBERG: Any other comments
12 on the phone? Okay.

13 DR. AMIN: So, yes, let's move on. So,
14 I think, just a quick time check, we have half an
15 hour for -- all right. Do you want to do
16 attribution or grouper? You want to do
17 attribution?

18 MS. O'ROURKE: All right. Let's head
19 to attribution.

20 DR. AMIN: Okay.

21 MS. O'ROURKE: So, again, this is
22 something that we just wanted to give you a quick

1 update on what our Attribution Expert Panel
2 found. Srinivas and Troy were actually on that
3 committee and have joined the Cost Committee, so
4 if there's anything we're missing, feel free to
5 chime in.

6 Since this has been such a theme
7 throughout this Committee's work, we did want to
8 update you on what this panel found. Again, this
9 slide is some background.

10 As we continue to see this push to
11 value-based purchasing, it's more imperative than
12 ever that we're able to accurately attribute
13 results to providers, as more and more payment is
14 determined by the results of cost and quality
15 measures.

16 However, we're finding it's also
17 increasingly challenging to do this, as we're
18 also trying to assess quality on outcome
19 measures, rather than process or structural
20 measures.

21 So, attribution, we've defined that as
22 the methodology used to assign patients and their

1 quality outcomes to providers or clinicians. And
2 attribution models can help to identify a patient
3 relationship that can be used to establish
4 accountability for quality and cost.

5 And then, as we aim to move the system
6 from fee-for-service payment to Alternative
7 Payment Models, it's really highlighted the need
8 to better understand how patient outcomes and
9 costs can be accurately attributed, as we also
10 aim to move to a system built on shared
11 accountability. So, next slide.

12 So, the purpose of this project was to
13 get multi-stakeholder guidance for the field on
14 approaches to issues of attribution. We aimed to
15 identify key challenges, develop a set of guiding
16 principles, identify the elements of an
17 attribution model and explore their strengths and
18 weaknesses, and then, make recommendations for
19 developing, selecting, and implementing an
20 attribution model. Next slide.

21 So, here you can see who was on the
22 committee. It was chaired by Ateev Mehrotra and

1 Carol Raphael. Next slide.

2 So, we began this project by
3 commissioning an environmental scan from a team
4 of authors out of the University of Michigan and
5 University of Pennsylvania. They found about 163
6 models that are in use or proposed for use, about
7 17 percent of those were currently in use. The
8 vast majority used retrospective attribution and,
9 again, the majority, to a single provider,
10 usually a physician.

11 They found quite a lot of variation in
12 how models are characterized, some of the
13 attributes are on the screen before you. Program
14 stage, the type of provider attributed, the
15 timing, clinical circumstances, the payer or
16 programmatic circumstances, the exclusivity of
17 attribution, the measure used to make attribution
18 as well as the minimum requirement, and the
19 period of time for which a provider is
20 responsible. Next slide.

21 So, what we found in the commission
22 paper was that largely best practices have not

1 yet been determined. New models are built off of
2 the previously used approaches and there hasn't
3 been a lot of exploration of the tradeoff of --
4 the pros and cons of different approaches and
5 that kind of thoughtful consideration of why one
6 model might be better in a given circumstances
7 than another.

8 One of the real challenges to doing
9 that was a lack of a standard definition for an
10 attribution model, makes it very difficult
11 currently to evaluate across models to determine
12 which one may be better in a given circumstance.

13 Next slide.

14 So, some key challenges that the
15 committee highlighted. First was that greater
16 standardization among attribution models is
17 needed to allow comparisons between the models
18 and to really allow best practices to emerge.

19 There's little consistency across
20 models, however, there is evidence that changing
21 attribution roles can significantly alter results
22 and how a provider may perform on a value-based

1 purchasing program.

2 And there is currently a lack of
3 transparency on how results are attributed and
4 providers have no way to appeal the results of a
5 model that may wrongly assign responsibility to
6 them. Next slide.

7 So, to start to address these
8 challenges, the committee came up with a number
9 of products. They first developed guiding
10 principles, they made a series of
11 recommendations, and they created the Attribution
12 Model Selection Guide.

13 These products allow for greater
14 standardization, transparency, and stakeholder
15 buy-in. And we're hoping to lay the groundwork
16 to develop an evidence base that will allow for
17 evaluation of attribution models in the future.
18 Next slide.

19 DR. AMIN: Erin, maybe I can jump in
20 here and just talk through some of the principles
21 -- no, you can continue on to the next slide --
22 just talk through some of the principles. And

1 then, I'll just walk through the guiding
2 principles and you can walk through the --

3 MS. O'ROURKE: Yes.

4 DR. AMIN: -- Selection Guide. And so,
5 some of the guiding principle preamble here was
6 to acknowledge the complexity and the
7 multidimensional challenges with implementing
8 attribution models.

9 And then, really grounding, and it
10 should be grounded in the National Quality
11 Strategy is, attribution models can play a
12 critical role in advancing these goals.
13 Recognizing attribution models can refer both to
14 the attribution of patients for accountability
15 purposes, but also the attribution of results of
16 a performance measure.

17 What was pretty critical was to
18 highlight the absence of a gold standard for
19 designing and selecting an attribution model.
20 And, really, the attribution model must
21 understand the goals of each use case.

22 So, key criteria for selecting an

1 attribution model are really actionability,
2 accuracy, fairness, and transparency. And I
3 think that's reflective of some of the
4 conversations we've had today around attribution.
5 So, moving on to the next slide.

6 So, the goals that were -- the guiding
7 principles that were discussed were that
8 attribution models should fairly and accurately
9 assign accountability. That attribution models
10 are an essential part of measure development,
11 implementation, and program and policy design.

12 And so, this obviously interacts with
13 the conversation we had early today around an
14 attribution model is still a guideline, as it
15 relates to our cost and resource use
16 specifications. That we should consider choices
17 among the available data are fundamental to the
18 design of attribution models.

19 Attribution models should be regularly
20 reviewed and updated. They should be transparent
21 and consistently applied and they should align
22 with the stated goals and purpose of the program.

1 And so, again, this relates to Jack's early point
2 around the use of a measure and the measure
3 specification.

4 And so, the Selection Guide noted that
5 in the current state that there's a tension
6 between the desire for clarity around attribution
7 models fit for purpose and the state of the
8 science related to attribution.

9 And there's a desire for rules to
10 clarify which attribution models should be used
11 in any given circumstances, but the problem is,
12 there's not enough evidence to support the
13 development of such rules at the current time.

14 And so, the goal of the Selection
15 Guide was really to aid measure developers,
16 standing committees, such as this, and program
17 implementers on the necessary elements of
18 attribution that should be specified a priori.
19 And it is intended to represent the minimum
20 amount of elements that should be shared with
21 accountable entities. So, Erin, can you just
22 walk us through the Selection Guide?

1 MS. O'ROURKE: Sure. So, really, the
2 Selection Guide asks a series of questions, and
3 if you look at the committee's final report,
4 there is a little more context here, they go into
5 some of the pros and cons and some of the
6 different things you might consider as you answer
7 each question.

8 So, Question 1 asks about the context
9 and goal of the program. Again, the committee
10 really stressed that how you're -- what you are
11 trying to achieve is fundamental to your
12 attribution model. And there's a need currently
13 to balance between aspirational goals as well as
14 what's feasible and practical.

15 So, again, you see in the second
16 column a series of questions that the committee
17 asked program implementers and measure developers
18 to consider as they weigh their choices around
19 attribution.

20 The next question is, how do the
21 measures relate to the context in which they're
22 being used? Particularly, asking some questions

1 focusing on the inclusion and exclusion criteria,
2 as well as, does the model attribute enough
3 individuals to draw fair conclusions?

4 The next overarching heading would be,
5 which units will be affected by the model?

6 Again, some additional questions here on what
7 units are eligible, the degree to which the
8 accountable unit can influence outcomes, again,
9 are there -- do the units have sufficient sample
10 size to meaningfully aggregate measure results,
11 and are there multiple units to which the model
12 could be applied?

13 And then, finally, how is attribution
14 performed? What data is used, do all parties
15 have access to that data? What are the
16 qualifying events for attribution, do those
17 events accurately assign care to the right
18 accountable unit? What are the details of the
19 algorithm used to assign responsibility? Have
20 you consider multiple methodologies to ensure
21 reliability of the model? And what is happening
22 of the attribution computation?

1 So, again, the final product, if you
2 will, that the committee came up is a series of
3 recommendations. They are designed to build on
4 the principles and the Attribution Model
5 Selection Guide. They're intended to apply
6 broadly to developing, selecting, and
7 implementing attribution models in the context of
8 public and private sector accountability
9 programs.

10 The committee recognized the current
11 state of the science, they considered what they
12 can achieve right now, as well as what's the
13 ideal state for the future regarding attribution,
14 and stressed the importance of aspiration and
15 actionable recommendations to drive the field
16 forward.

17 So, the first recommendation is to use
18 the Attribution Model Selection Guide to evaluate
19 the factors to consider in the choice of an
20 attribution model. The committee stressed that
21 currently there is no gold standard, different
22 approaches may be more appropriate than others in

1 a certain situation.

2 The model choice should be dictated by
3 the context in which it will be used and
4 supported by evidence. And developers and
5 program implementers should be transparent about
6 potential tradeoffs between the accountability
7 mechanism, the gap for improvement, the sphere of
8 influence of the accountable entity, as well as
9 the scientific properties of the measure. Next
10 slide.

11 Attribution models should be tested.
12 Attribution models for quality initiative
13 programs should be subject to some degree of
14 testing for goodness of fit, scientific rigor,
15 and unintended consequences, recognizing the
16 degree may vary on the states of the program.
17 However, given where we are now, models would be
18 greatly improved by rigorous scientific testing
19 and making the results of that testing public.

20 And when used in a mandatory
21 accountability program, models should be subject
22 to testing that demonstrates adequate sample

1 size, appropriate outlier exclusion, and/or risk
2 adjustment, to allow fair comparisons, and
3 sufficiently accurate data sources to support the
4 model. Next slide.

5 Attribution models should be subject
6 to multi-stakeholder review. Given that there is
7 no gold standard right now, the perspective on
8 which approach is best is really influenced by
9 stakeholder interests.

10 Attribution model selection and
11 implementation in various public and private
12 sector programs should use a multi-stakeholder
13 review to determine what model may best fit their
14 purposes. Next slide.

15 Attribution models should attribute
16 care to entities who can influence care and
17 outcomes. Right now, models can unfairly assign
18 results to entities who have little control over
19 the patient's outcomes.

20 And for a model to be fair and
21 meaningful, the accountable unit really must be
22 able to influence the outcomes that it's being

1 held responsible for, either directly or by
2 collaborating with others.

3 And as care is increasingly delivered
4 by teams and we're moving to a system of shared
5 accountability, models should reflect whether the
6 accountable entity can influence, rather
7 than directly control.

8 DR. AMIN: So, Erin, before we move on
9 from this, I just want to link this to our prior
10 conversation around, clearly the tradeoff between
11 an ideal state of what the care delivery system
12 looks like currently and then what our ideal
13 state is, and then, the culture of care delivery
14 that may exist in different communities.

15 So, that really came up in our total
16 cost of care discussion. But, ultimately, the
17 question of who should be attributed, there
18 should be some ability to influence the outcome.
19 And then, I'll just sort of finish off with the
20 last one.

21 Which is -- if we can move on to the
22 next slide? Which is, attribution models used in

1 mandatory public reporting or payment programs
2 should meet minimum criteria. And that goes back
3 to Jack's point earlier in this conversation
4 around, for several of these programs, we're
5 looking at the measure, but we're not looking at
6 the program.

7 And so, there is an element,
8 particularly for mandatory public reporting or
9 payment programs, that attribution models should
10 be clearly articulated, should be able to -- the
11 accountable entity should be able to meaningfully
12 influence the outcome, adequate sample sizes and
13 exclusions, and several other components.

14 So, the discussion item that we had
15 here for this conversation was really, as we
16 think about the implications of -- as we think
17 about the outcomes of this Attribution Committee,
18 what are the implications for our work for the
19 Standing Committee?

20 In particular, the question around,
21 how do we think about attribution models for
22 measure specifications going forward and how do

1 we think about these concerns in terms of measure
2 endorsement review?

3 And so, that's really sort of at a
4 very high level what this committee sort of
5 reviewed. I think what might be helpful is we'll
6 sort of share, again, the details of the Standing
7 Committee review and we can discuss it in more
8 detail at a later time. But those are
9 essentially the discussion items that we had for
10 today.

11 MEMBER BECKER: So, this is Larry, can
12 I ask a question?

13 CO-CHAIR DAMBERG: Sure. Go ahead,
14 Larry.

15 MEMBER BECKER: So, I couldn't read
16 through that slide where you had all the
17 committee members and the people I could read, I
18 didn't know all of them. So, pardon me for this.
19 But I wondered whether you had real patients who
20 use the system in various ways as real input and
21 as real partners in putting this work together?

22 Because it seems to me that

1 attribution and who has control over what happens
2 to the patient is in large measure what the
3 patient thinks in terms of who they think should
4 be either quarterbacking or whom they are getting
5 their advice, if you will, from.

6 So, while you might think that it's
7 the primary care doc, as an example, it might be
8 the surgeon or it might be some specialist or --
9 so, understanding and really working with the
10 patients to understand how they use the system of
11 healthcare, given various sort of types of
12 healthcare issues, I would think would be
13 incredibly important.

14 And now, you've put up the list and
15 I'm looking at this and virtually everybody on
16 this list has got multiple initials after their
17 names, which tells me that there aren't a lot of
18 patients involved here.

19 DR. BURSTIN: Yes, Larry, this is
20 Helen. I mean, it's certainly a fair point, we
21 had several consumer and purchaser reps at the
22 table, I guess all of us at some level have to

1 interact. But I certainly hear your point. The
2 committee did spend a lot of time thinking about
3 how you would actually think about it through the
4 patient lens.

5 In fact, even looking at some of the
6 newer coding CMS is putting out where it is
7 really assigning even those codes prospectively,
8 they very much said, at the end of the day,
9 ensuring that it's the patient, that's sort of
10 the key thing to always keep an eye on, that they
11 know who is accountable for them. But it's a
12 fair point, certainly more work to do in that
13 space going forward, without a doubt.

14 CO-CHAIR DAMBERG: Other comments from
15 those on the phone?

16 MEMBER RAMBUR: I have a question, this
17 is Betty. So, when Vermont was negotiating its
18 all-payer total cost of care model, attribution
19 not surprisingly was a huge issue.

20 And one of the things that really
21 confounded identifying who's accountable was
22 issues related to nurse practitioners and PAs not

1 being able to be attributed providers in
2 Medicare, but could in commercial and Medicaid,
3 but also the incident to billing. Did any of
4 that issue -- did that issue come up in this
5 committee's discussion?

6 MS. O'ROURKE: Yes. I think the
7 committee had quite a few conversations about how
8 you could appropriately include practitioners
9 like NPs or PAs and recognizing the shortcomings
10 that a lot of the current models only assign to
11 physicians. And as we're seeing other
12 practitioners increasingly deliver care, how to
13 appropriately include them in the attribution
14 models.

15 CO-CHAIR DAMBERG: All right. Any
16 other comments on the phone? Okay.

17 DR. AMIN: Thank you.

18 CO-CHAIR DAMBERG: Brent?

19 DR. AMIN: Oh, sorry.

20 CO-CHAIR DAMBERG: We have two comments
21 over here.

22 DR. AMIN: Oh, okay.

1 CO-CHAIR DAMBERG: Brent?

2 CO-CHAIR ASPLIN: Yes. So, the
3 framework is very helpful. It's a good
4 conversation. I think, this whole area could be
5 a thousand points of no for us, if we let it.

6 Because there's always going to be
7 tradeoffs for how granular it is and, I want an
8 episode around not just total knee replacement,
9 but right knee replacement, because that's my
10 sub-specialty.

11 And we could have a thousand different
12 resource episode measures of things like that.
13 And I just think, we can't let the perfect be the
14 enemy of the good in terms of moving forward in
15 general in this area.

16 And then, I would just add one other
17 comment around, just theoretically, if you step
18 back from it, a fee-for-service reimbursement
19 system isn't at all designed for accountability
20 around cost.

21 So, for those providers out there that
22 are really concerned about attribution, should

1 get themselves on Advanced Alternative Payment
2 Models, because almost all of them deal with this
3 through prospective assignment. Maybe Track One
4 Plus will be an exception.

5 And there are going to be enough
6 Alternative Payment Models that are specialty-
7 specific or are population-specific for total per
8 capita cost and use prospective assignment that
9 takes care of this.

10 And I think, just like there's a
11 theoretical limit to risk adjustment, there's a
12 theoretical limit to trying to get attribution
13 right in a fee-for-service environment. And I
14 just, I think if we're trying to get it too
15 perfect, you'll never satisfy everybody.

16 CO-CHAIR DAMBERG: I'm just going --

17 MEMBER RAMBUR: This is Betty, if I
18 could just quickly comment? I agree with that.
19 It's more about the base and the trend is often
20 set from the fee-for-service world and the fee-
21 for-service chassis, so that's sort of one of the
22 challenges in moving to real accountability for

1 cost and outcomes.

2 CO-CHAIR DAMBERG: I'll make this
3 quick, because I know we're running out of time.
4 I didn't see any mention of unintended
5 consequences. And I know some providers have
6 told me that, like, when the primary care is
7 assigned responsibility, they may offload
8 patients to the cardiologist or wherever. So, I
9 think we need to be cognizant of how attribution
10 rules affect behaviors, because these measures
11 are being used in accountability and payment
12 ways.

13 The second thing that I would note,
14 and I think in the context of wanting more care
15 coordination, even in this kind of fee-for-
16 service environment, is, I didn't see any mention
17 of multi-provider attribution.

18 And I think that this comment came up
19 once upon a time in this Medicare Spending Per
20 Beneficiary Measure, because so much of the cost
21 and variations happening in the skilled nursing
22 facility. So, I would, again, raise that.

1 And then, lastly, related to building
2 the science, I think I agree with that comment,
3 but I think measure developers and their sponsors
4 have to be committed to putting that information
5 out in the public domain.

6 And I know some measure developers and
7 their sponsors have been reluctant to do that,
8 because sometimes they think they're working in a
9 very policy-sensitive space. So, I would just
10 note that.

11 DR. AMIN: Okay. I -- Nancy, did you
12 have another comment?

13 MEMBER GARRETT: So, if I'm
14 understanding this correctly, one of the
15 questions is, whether the attribution algorithm
16 should be specified for measures in the cost and
17 resource portfolio, because we saw an example of
18 one where it was just recommended.

19 And looking at the guidance from the
20 committee, I really feel like it actually needs
21 to be, because -- a couple of reasons. It's such
22 a key part of how that measure ends up working

1 and is defined, that to not have guidance on
2 that, but the rest of the measure, you're missing
3 a big part.

4 But then, there's no standardization
5 around that. And then, also, to have
6 harmonization and standardization of measures
7 across populations, you really need that, to be
8 using the same algorithm.

9 I am sensitive to some of the previous
10 comments about how it doesn't allow you to take
11 into account local variation, so there is a
12 downside to that. But a lot of quality measures,
13 attribution is built into how you define that
14 measure, and so, I don't think it should be
15 different for the cost and resource measures.

16 DR. AMIN: So, I think we're going to
17 have to -- we'll take that comment and we'll have
18 to flag it for future Committee discussion.
19 We're going to have to discuss that probably in
20 more detail, but it sounds like there's enough
21 there that we should think about at least moving
22 it into specifications or -- yes, basically, I

1 think that's the proposal. But we'll have to
2 have a more thorough conversation, given that
3 we're at the top of the hour. Jack, last
4 comment.

5 MEMBER NEEDLEMAN: Just following up on
6 Nancy's comment. So, I don't have any -- two
7 questions that we need to think about some more.
8 I think Nancy's right, that we -- the attribution
9 is central to a lot of these measures.

10 So, the question is, two questions,
11 what do we expect the developers to present to us
12 to help us understand the performance, their
13 rationale for the choice of attribution measure
14 and its performance? And today, we simply had
15 somebody say, we used the current state-of-the-
16 art, which is plurality. Is that acceptable?

17 Which also raises the question, what's
18 our standard for -- can we develop some standards
19 or something beyond our gut feel for what
20 attributions look so questionable that we simply
21 would not accept them? And I don't think we have
22 that answer, we don't have standards right now or

1 a way to even think about that question.

2 CO-CHAIR DAMBERG: Troy, I know you
3 have your hand up.

4 MEMBER FIESINGER: So, this is Troy.
5 I just wanted to chime in to something on the
6 committee. I appreciate everybody's comments,
7 certainly we had proxies for patient
8 representation, we didn't have them -- we just
9 tried very hard to think of ourselves and our
10 patients in that scenario.

11 We did look at nurse practitioners and
12 physician assistants and Medicare certainly
13 incorporates them. This methodology, we were
14 very aware of the tension between the perfect
15 method and an adequate method, and that's why we
16 looked at minimum standards.

17 An issue that came up often is, what
18 attribution model is necessary for cost or
19 payment accountability versus what method might
20 be used internally to assign responsibility
21 within the organization?

22 We talked a lot about unintended

1 consequences, so that may not have come through
2 in the summary. And, certainly, a lot of
3 discussion about single attribution versus
4 multiple attribution.

5 The lack of data and research was
6 problematic, just not a lot of this is in
7 studies, a lot of that work was done by people in
8 the room. So, when we try to look at evidence
9 base, there wasn't enough there to draw some
10 conclusions. But I appreciate everyone's input,
11 your comments actually reflect a lot of what we
12 talked about at length in there --

13 DR. AMIN: Thanks, Troy. Thanks,
14 that's great. A lot of really thoughtful
15 feedback, so thank you all for sticking with us
16 in that marathon of various topics that were on
17 our minds as it relates to the measurement
18 science of cost and resource use. I'll turn it
19 back over to the Chairs for our public and Member
20 comment and then, closing remarks.

21 CO-CHAIR DAMBERG: So, are there any
22 final comments from the public or the Members?

1 OPERATOR: Okay. At this time, if you
2 would like to make a comment, please press Star,
3 then the number 1.

4 CO-CHAIR DAMBERG: Thank you.

5 OPERATOR: There are no public comments
6 at this time.

7 CO-CHAIR DAMBERG: All right. Thank
8 you very much.

9 DR. AMIN: So, I think this is closing
10 remarks from you all, from the Chairs. And then,
11 I think there was some timeline discussions that
12 Irvin's going to walk through

13 CO-CHAIR DAMBERG: All right. I just
14 want to say, on behalf of Brent, myself, and the
15 NQF staff, really appreciate you guys dedicating
16 not only today, a full day of working through a
17 lot of really complex issues, but also the time
18 you spent preparing for this meeting and
19 continuing to serve on the Committee.

20 MEMBER WEINTRAUB: Thanks for all the
21 work you guys have done putting this together and
22 making this easy for us.

1 MS. O'ROURKE: Sure. So, all right.
2 On behalf of the staff, I just want to thank
3 Brent and Cheryl for their leadership today and
4 as we prepared for this meeting. And, again,
5 thank you to all of you for your going above and
6 beyond to come here in person or to hang in with
7 us on a very long web meeting, and bearing with
8 us for the voting technology. So, thank you so
9 much and safe travels home, everyone.

10 Irvin is just going to quickly run
11 through some of our next steps. I'll steal his
12 thunder and give you the good news that we can
13 cancel next week's post-meeting call, since we
14 got through all of our agenda today. So, taking
15 that out of your next steps.

16 MR. SINGH: Yes. So, just to sort of
17 echo what Erin was saying, so we had our in-
18 person meeting, which was today. We just
19 canceled the March 22 and March 24 meetings, so
20 we're going to take that off the board.

21 So, the next active steps in terms of
22 the entire Committee getting together is going to

1 take place on June 6, 2017, from 2:00 to 4:30
2 p.m. Eastern Standard Time, and June 8, 2017,
3 from 1:00 to 3:30 p.m., where we're going to
4 discuss the comments that we have received during
5 the public and Member commenting period, which is
6 going to take place between April 20, 2017 to May
7 19, 2017.

8 MS. O'ROURKE: So, I think with that,
9 that is all we have today. So, again, thank you
10 so much, everyone. We really appreciate all the
11 time you took to attend and to prepare for the
12 meeting. So, we'll talk to you in June.

13 (Whereupon, the above-entitled matter
14 went off the record at 4:02 p.m.)
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Standing Committee

Before: NQF

Date: 03-15-17

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