NATIONAL QUALITY FORUM

Moderator: Sarah Fanta
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11:00 am CT

Operator: Good day everyone; welcome to today's Resource Use Steering Committee conference call. Today's call is being recorded.

At this time, I would like to turn the call over to Sarah Fanta. Please go ahead.

Sarah Fanta: Hi everyone. Thank you so much for making it on the call today to go over the comments that we received for Cycle 1.

This is Sarah Fanta and I'm joined here with Taroon and Ashlie by phone and Helen Burstin as well.

We also have Chad Heim from HealthPartners on the phone and Ben Hamlin from NCQA to answer any questions that we might have about the measures that were submitted.

Right now, we're currently having a problem with our webinar. So you won't be able to see anything on the screen right now. We're working on fixing it. So hopefully it will come up as the call progresses.

But if everybody has the documents that were emailed to them that's what we're going to be going over today. And I'll make reference to the documents as we go the call so you're looking at the same thing that we are. I'm sorry I apologize for this.

So the objectives for today's call are to go over the comments that we've received during the public and member comment period for Cycle 1 and for the Steering Committee to provide responses to those comments.

Male: All right, you're getting a considerable echo.

Sarah Fanta: I'm sorry about that. Carolyn?

Male: It's okay on my end.

Male: Yes same here.

Sarah Fanta: Okay. Carolyn I'm not sure if there's anything we can do about that but okay and this call's also an opportunity to provide recommendations on changes to the Cycle 1 Draft Report prior to the member voting period.

Real quick I'm going to go over the Steering Committee roster just to make sure we have everyone on the call that's supposed to be here. Tom Rosenthal?

Tom Rosenthal: Here.

Sarah Fanta: Okay, Bruce?

Bruce Steinwald: I'm here.

Sarah Fanta: Okay. Paul Barnett? Okay, Jack Bowhan?

Jack Bowhan: Yes.

Sarah Fanta: Okay. (Jeptda)? Okay. Kurt Elward? Bill Golden? Lisa Grabert? Ethan Halm? Ann Hendrich? Tom Lee? Jack Needleman?

Jack Needleman: Here.

Sarah Fanta: Thank you. Mary-Kay O'Neill?

Mary-Kay O'Neill: I'm here.

Sarah Fanta: Great thanks. David Penson? Doris Peter? Steve Phillips? David Redfearn?

David Redfearn: Present.

Sarah Fanta: Jeff Rich? Will Rich?

Will Rich: Yes here.

Sarah Fanta: Thanks great. Barb?

Barbara Rudolph: Yes I'm here.

Sarah Fanta: Great. Joe Stefanski? Jim Weinstein? And Dolores Yanagihara?

Dolores Yanagihara: Yes I'm here.

Sarah Fanta: Okay great. Thank you everyone.

Tom Rosenthal: Do we have a quorum? We've got a lot of people missing?

Sarah Fanta: Well let's see here we have one, two, three, four, five, six, seven, eight. We have eight people - nine people on the call.

Helen Burstin: This is Helen. And technically since you're not actually voting on anything today it's really just to discuss - what the staff will summarize it and send it to everybody so you're probably okay to proceed.

We also find a good number of people signed in the first 15 minutes or so. So for something like this you're probably okay.

Sarah Fanta: Okay.

Male: Okay.

Sarah Fanta: Okay and just to give everyone a brief recap of what we've done up to date, right now the Cycle 1 Draft Report public and member comment period has closed. It closed on September 28.

And just as a reminder that was on two HealthPartner measures and two NCQA measures.

The cycle two draft report will be posted for public and member comment on October 17 and will be closing on November 15.

And that will be on two Ingenix measures and two NCQA measures and the one diabetes measure from Ingenix where no consensus was reached.

So the next thing coming up for Cycle 1 is the member voting period which will be from October 24 until November 7. And it will also be reviewed by (Steve Sack) on November 2 and 3.

And then for Cycle 2 the public and member comment period will begin October 17 until November 15.

And the member voting period will take place from January 3 to January 16. It's little ways away.

So the most pressing thing that's coming up is the conference call taking place on December 5 from 12:00 to 2:00. And we'll send more information as that approaches to discuss the Cycle 2 comments and the draft report comments.

On October 24 - or I'm sorry October 26 we'll be having a pre-member voting Webinar for Cycle 1.

So that's just an opportunity for the project staff to present the comments that were received and just inform the members of what's going on in the project prior to their vote.

Committee attendance isn't required but if you would like to dial in that will be posted on the NQF site as well as emailed to you when exactly that's taking place.

And just as a reminder on November 2 and 3 CSAC will be going over the Resources project in the recommended measures so we can also send you the agenda and island information if you want to call in and listen to that.

Okay so for the Cycle 1 comment period we received 93 comments from 35 organizations. And you should have all received an email last week. So we have bucketed the comments from the report into theme. And those themes having captured in the memo like I said that was sent out last week.

The comments that require developer responses were then forwarded to the developer for them to provide a response. And those responses were inserted into the spreadsheet and were highlighted in green.

For the remaining responses which were the majority, the project team proposed responses for each individual comment. And that's reflected on the spreadsheet and to the themes that were identified which is in the memo.

The responses to the themes overlap with individual responses to the comments to the topic so we'll just go over them as themes and the committee responses.

So basically the goals for today is to discuss the comment themes and any other individual comments that the committee feels are important.

And like I said, because there were so many comments rather than go through each individually we should probably just start with the themes addressed in the memo and then circle back to any individual comments.

We also wanted to check and to make sure that the committee feels that our project team accurately represented the committee stance on the issues and anything that should be added or clarified.

We also need to identify any issues that should be actually reflected in the report itself. So anything that jumped out at you or any comments that you feel should be addressed in further detail we can go over.

We also need to confirm the committee's consensus on the recommendations on the four measures.

A revote is not required. We just need verbal agreement that consensus was reached because there was some division among the committee members on HealthPartners measures like 1598 and 1604 so if any of the comments changed any of the committee's opinions or if the committee's still comfortable moving these four measures forward.

Are there any questions before we begin?

Okay and Tom and Bruce I'm going to hand it over to you if you want to get started perhaps with the first theme?

Bruce Steinwald: Oh you're putting us to work.

Tom Rosenthal: Bruce, take it away Bruce.

Sarah Fanta: Okay. I can read them to. It's up to you guys.

Bruce Steinwald: I think you did a good job at summarizing the comments into the five buckets. Those it - I don't know that there were any others.

If any committee members think that there's a missing theme they should speak up at some point. But in general, Tom, why don't we alternate?

Tom Rosenthal: That's fine. Go ahead and get us started on theme one.

Bruce Steinwald: Okay. Important...

Tom Rosenthal: Is everybody comfortable with this agenda? Any - do we - is this - or is everybody happy with the agenda?

Sarah Fanta: Yes. It seems like the comments paralleled our discussion pretty well I think.

Tom Rosenthal: Okay. So we'll pound through the themes and I yes. So Bruce let's...

Male: I agree Tom. I think the comments were well summarized by the staff into the appropriate buckets.

Tom Rosenthal: Okay.

Bruce Steinwald: Well the first one is the importance of measuring at the individual and group practice level and - what was that?

Anyway the specific business group on health I think was hammered at that one pretty good and others did as well.

And I think our - the general response that you prepared I think is accurate that we generally think it would be important to have measures at the individual and small group level provided that they meet the criteria that we set forth for the scientific acceptability in particular.

I don't know that we need to go any further than...

Barbara Rudolph: Bruce?

Bruce Steinwald: ...this but would anyone like to add a comment on that?

Barbara Rudolph: Yes. Bruce this is Barb Rudolph.

Bruce Steinwald: Yes?

Barbara Rudolph: I think the concern was that in other kind of quality measures the level of applications, each level of application did not require testing of reliability and ability for that level.

So I'm just - I think the concern was that because somehow this was individually positioned that there was a higher bar for those measures to meet then in previous sort of endorsement processes.

Bruce Steinwald: I see.

Helen Burstin: Barb this is Helen if I could just jump in? We actually do require testing on the level analysis. It's actually quite standard.

You may recall a measure fairly recently on, you know, birth outcomes that a lot of the folks on the CSAC want that have pushed down to the lower level of analysis that just hasn't been tested yet. I don't think this is a different standard.

Barbara Rudolph: Okay.

David Penson: Hey guys; it's David Penson. Sorry I had some troubles getting here.

Jeff Rich: Hi and this...

Tom Rosenthal: We're glad you here now David.

Jeff Rich: Jeff Rich here too, sorry.

Tom Rosenthal: And generally we're going over the themes of the public comments. And we're on number one which is that the measures - there were a number of comments that the measures - all should be applicable to individual and group practice level.

And the staff response generally is in two sentences the committee agrees and the measures specified at that level should be able to demonstrate reliability and validity.

Does anybody else want to opine on the adequacy of the - I mean because we're not, you know, we discussed this rather endlessly in our meetings that was...

(Jack): Right. I would note that there's a link here to what I think is theme three, the attribution issue.

Tom Rosenthal: Right.

(Jack): ...that pushing down to the individual level also requires being - that the attribution algorithm be one that is acceptable.

That's simply - it is one of testing a reliability and validity at that low level, at the level of individual group or the group of physicians that are treating the patient or the individual physician that is - to whom that patient is attributed.

And that can be a sample size problem which is noted here. But it's also one of the - one of attribution. Have we - are we assigning the patient to the right individual?

Male: Well as we talked about in the last face to face meeting I - Jack and you're exactly right. And as we talked about in the last face to face meeting when we were trying to kind of tee up next steps I think one of the themes that got identified was the interrelationship between attribution statistical validity and what's being measured.

And that in our own conception of it and articulation of up till now these things have been siloed and that we needed to be more explicit perhaps in the final document of the interconnectedness to those things.

I think that to the extent that there's any confusion about this or lack of clarity it's because we could do one level better of articulating the - our view of the committees view of the interconnectedness of those.

Mary-Kay O'Neill: Well this is Mary-Kay And I think, you know, a piece of the, you know, importance or meaningfulness of the measures is that they're actionable and, you know, something needs to be actionable like a physician should be able to look at a measure and somehow or other figure what they should be doing differently.

But in terms of the measures that were submitted to us and the nature of their development, you know, we didn't have a huge amount to work with I didn't feel on that level. Maybe I missed something.

And I know this is, you know, I'm new to NQF in this cycle. So just to find measure developers work at that level, I don't know if that's a gap but that's a huge issue is my understanding.

And, you know, I think we did a good job looking at what we had to review and there just wasn't other than the HealthPartners very much it seemed to me really down at the level of, you know, giving the feedback to the individual physician of what they should do.

Bruce Steinwald: Right just as - this is Bruce. As a reminder that there is a huge program operating at the individual physician level that's at CMS at the direction of Congress to give individual physicians feedback, but...

Mary-Kay O'Neill: Yes.

Bruce Steinwald: ...obviously CMS didn't submit their measures to us so, you know, we're not in a position to comment.

Mary-Kay O'Neill: Yes.

Bruce Steinwald: Any more discussion? Staff do you feel like there you've gotten some guidance on maybe tweaking some of the language or do we need more?

Male: No I think it's about right. I - we're going to go back and take a look at least in - as updates to draft report due to try to make sure that we're capturing as Bruce you and Tom have noted, the interconnectedness of the reliability and validity at that level.

But I think what was clear for us was to make sure that the voice the committee of not stating a preference on a level of analysis was important. So I think we got it. Thank you.

Bruce Steinwald: Okay. Yes that was Tom...

Mary-Kay O'Neill: And everyone...

Bruce Steinwald: ...and Jack actually. But go ahead.

Male: Okay sorry.

Sarah Fanta: I'm sorry. Sorry everyone, this is Sarah again. I just restarted the Webinar so hopefully you should be able to see something on your screen. Is everyone seeing something?

Tom Rosenthal: Yes.

Sarah Fanta: Perfect. Okay thank you.

Tom Rosenthal: It looks like it's the memo though right so...

Sarah Fanta: It is yes.

Tom Rosenthal: Okay all right. Perfect.

Sarah Fanta: Thank you.

Tom Rosenthal: All right well if we're finished with that let's move to the costing approach. And here the general theme of the comments were the strong preference that both actual cost as well as standardize cost approach should be considered.

And I think again, staff response is generally we agree but that for national measures it particularly if what you're measuring is actual utilization then the utilization factors across the country would be preferable.

But this is not - this isn't a rejection of - this is not (manacheistic). There's should, you know, again we - the committee I think, you know, we discussed this almost ad nauseum.

But do people feel that the staff responses here are generally sufficient or do they need to be flushed out?

David Redfearn: This is David Redfearn. And I think this kind of misses the point.

An issue that I've been pushing and I noticed that one of David Hopkins comments hit the nail right on the head from my point of view.

It's not that one actual cost or synthetic costs are better than the other. They have different purposes. And like you said we've discussed that a lot.

But the NUF seems to be making an argument that any measure can only have one. You have to choose. You can't have both.

And the point that David Hopkins was making I strongly agree with is that we don't - I don't understand that. I don’t understand the necessity for that.

The measures complement each other and allowing measure developers to have both kinds of measures and both kinds of outcome measures included in their definition of the measure just adds value. It doesn't confuse anything at all.

So that's the problem for me is that the little section in the paper that discusses this frankly I just don't understand it. And just reading it literally I don't agree with it.

So that's my point. It's not that one is better than the other. I think the question is why can't we have both?

Bruce Steinwald: Well I think - and this takes us back to when we asked HealthPartners to split their measure, right?

Male: Yes.

Bruce Steinwald: Where the...

Male: Right.

Bruce Steinwald: ...sense was we could have two measures. We just - we wanted them to be submitted and evaluated as separate measures as opposed to one measure within either or switch.

So there - but there - I don't think there's any prejudice against one or the other way of measuring cost.

And in fact I agreed certainly with you David they can be complimentary. And we've learned from the developers and their customers that in fact they are often are complementary. They often are both utilized by the users.

So as long as we get that down on paper in a clear manner is there still a remaining issue for the committee?

Male: There is.

Tom Rosenthal: Well I'm not sure we specified in the words though that have been used because I think the - and I think it's a semantic problem, not a conceptual problem.

I think there's unanimity that for example a population-based measure that uses dollars could be used and exactly the same measure with standardized pricing could be used and in fact they would be complimentary.

I think what the staff was trying to articulate is that you can't have an either or and where it's random. And then just one person uses it with standardized pricing but the same measure whereas somebody else uses it with a dollar denominated measurement and you would have apples and oranges in the same measure.

That's I think what the staff is trying to articulate is the reason for specifying that an individual measure has to be one or the other.

But somebody could easily submit more or less the exact same measure but with the two different measuring tools but they would then be two measures.

Male: Right.

Tom Rosenthal: So there would be clarity. It's a matter of clarity, not a matter of prejudice. Am I saying that correctly?

Male: That's exactly correct Tom. It's true. And it's also to reflect the conversation that Bruce you noted on HealthPartners measure and that it was the will of the committee to separate the two - the individual measures into different ones based on a costing approach that there could only be one costing approach within an individual measure.

However there was no preference on one versus the other and they should be evaluated individually.

Tom Rosenthal: But maybe we could even add it in to say that in fact they are - they could very well be complementary to make it clear that what - we're again, we're not trying to articulate that only one is preferable.

David, does my rendition of it meet your concerns?

David Redfearn: I still have some concerns about it. I wrote comments to the language in the paper that I didn't really understand it.

I read the text and maybe again this is a matter of just flushing it out and communicating it a little bit clearer is that somehow having both alternatives destroyed the usefulness of the measure.

And I recall the Ingenix essentially - now Ingenix was the next stage but Ingenix was basically told well you can't do both. You have to choose one.

And frankly I think that put them at something of a disadvantage when they presented their measures.

So I - maybe it's a matter of clarity as your suggesting. But if that was...

Male: Yes.

Male: ...the case then I think we need to make it clearer.

Tom Rosenthal: Well I sort of well I'd agree with that actually on reflection because it shouldn't be confusing and yet apparently the way we've written it it's confusing.

But I do think it's a semantics thing because within a single measure it shouldn't be dealer's choice because that leaves ambiguity and the high probability in fact that one person will apply the measure one way and somebody else will apply it the other way and you will not have comparable outcomes which is bad. You have ambiguity.

Ashlie Wilbon: This is Ashlie. Hi everyone. I just wanted to clarify really quickly on David's last comment. Ingenix was given the exact same options in terms of splitting their measures as HealthPartners was.

They could either split it in two measures and so that both and actual and the standardized pricing approach or they could choose to supply one methodology. It was their choice to only resubmit using actual prices.

So I just wanted to clarify that both developers were given the exact same options in terms of splitting their costing approaches amongst the measures.

Tom Rosenthal: That's my recollection as well. And in fact it was surprising to me that they elected not to submit both because it would have been much, much stronger.

Male: Can I also ask a clarifying question to Tom and Bruce? It does seem like the comment that came from PBGH and what David is bringing up right now is actually trying to get at the question of that both costing approaches should be allowed in a single measure.

And it seems very clear from the committee's consensus that that should not be the case, that no particular costing approach should be - is preferred but yet no individual measure could have both costing approaches built into a single measure. I just want...

Tom Rosenthal: Only because it creates ambiguity.

Male: Right. I...

Female: Well the rules - the problem with the standardized pricing is that by itself it is communicating a dollar figure that is a hypothetical.

You know, I mean it's using the dollars to communicate the relative use of resources in an episode of care to kind of true up the relative size of an expensive and inexpensive endpoint and come out with some standard number that takes the form of dollars to be able to compare different systems and how they're utilizing something.

So if you use standardized pricing and some entity uses lots and lots of low cost inputs and very few high cost and the other entities with lots of high cost and very little low cost you can see the difference in this - the magnitude of the utilization of different kinds of input.

But the risk of using standardized pricing is people will interpret them to mean cost. So what we have to do is figure out a way to clearly communicate when we're using standardized pricing and when we're using actual cost.

And both of them have values for these different reasons because dollars are an actual resource that's utilized in healthcare, I mean real dollars.

And so it's according to what question's being asked and how it needs to be answered and we just have to make sure we're not modeling something that looks like a dollar figure with another thing that looks like a dollar figure that's on a totally different basis.

But the measures could be essentially the same in terms of how they're capturing data. It's just what unit they're being reported out in needs to be crystal clear.

Tom Rosenthal: Right. It's just an ambiguity issue not a preference issue. And you're exactly right, you could have two identical measures but one of them says that the outcome is measured in dollars and the other said it's measured in standardized pricing, otherwise exactly identical.

David Redfearn: Yes and this is David. I mean in my point - from my point of view splitting - having two copies of the same measure with a different outcome unit of analysis or a measures is the same thing as allowing the same measure to have both done and choose which one you use as long as you tell people what you've used.

Tom Rosenthal: Well accept in the one - well again the committee was pretty definitive about saying we preferred it to be done the other way and mainly because when we weren't that specific we ended up with it being ambiguous.

Female: Well I'm wondering if there's opportunity to note in the measure itself that this is the same measure as measure number blah, blah, blah except it's had a different method for pricing it.

And so that you make the link people know it's the same measure but with different costing methodologies.

So then you've got both the clarity but you also aren't trying to figure out is this the same or different? Is this - how is it different? It looks the same as the other one? You have a lot of clarity there just by stating that.

Tom Rosenthal: Right. But I think we have to explain it better in the report. I think the critique is and perhaps David was in every meeting and if he still read the thing and was uncertain as to what our intent was in the report or even in these comments it probably needs a little work to explain.

David Redfearn: Well honestly sometimes I think I'm in a different meeting than anybody else.

Tom Rosenthal: Oh well I'm not going to make any reference to the interpretation of that David.

Bruce Steinwald: This is Bruce. I'm certainly in agreement with the substance of what you said. The only area that sounds like there could be some disagreement is with the committee's decision that there should be two measures, not one measure with an either or in it.

And I'm also agreeing with Tom that we were fairly definitive about that. But I guess the contextual discussion needs to make it clearer that the reason for doing that was not to express a preference for one or the other.

It was to reduce ambiguity and make it clear what the measure was measuring as opposed to potentially incurring some risk of ambiguity.

Barbara Rudolph: This is Barb Rudolph. I just, you know, I totally agree with David Redfearn's interpretation actually.

And I had the feeling when I read the comments too that there was sort of a negative feel about the actual cost measures, you know, in the comments themselves saying, you know, that they shouldn't use nationally and so forth.

I think, you know, it would be better to be slightly more neutral in the remarks and at - I guess the one problem I have with the measures being separated -- and I don't think I was on the call that made the vote about this -- was that it's entirely possible that, you know, a measure could come through a Steering Committee and only one piece of it could actually get approved.

And then one really wonders what's happening because it, you know, it's essentially the same measure.

So I just think that we have to really think about, you know, how we're - what message we're sending for down the line for the maintenance committees and so forth who'll be looking at these things in the future.

Do we really want to do this separate always or can there be kind of different options within a single measure so that the measure developer who comes in and is using both parts in their work would not find themselves in the situation where one part of it, the standardized pricing got approved and then the alternative option was not approved leaving them hanging out to dry so to speak, you know, with their measurement activities.

Tom Rosenthal: Other comments?

(Jack): Well this is Jack. It strikes me is standardized pricing goes slightly beyond - its one additional level of analysis beyond the actual pricing because it requires having an additional set of algorithms for the producing it.

I didn't see us as having a preference for one over the other. It was my sense of the conversation was it was a sense that there was valuable and unique or distinctive information in each of the measures.

Standardized pricing told you one - let certain kinds of comparisons be easier and the actual pricing let other kinds of comparisons be easier.

And that there was a general feeling that we'd like to see measures with both. But to the extent you asked, so it was a matter of being clear about the labeling and making sure the labeling was - distinct enough that people knew what the measure was and what the numbers were telling them.

So if that sense that, you know, each has value and we'd like to see both and then the issue is simply how do you endorse them and define them clearly enough that what goes into the measure is clear it could get - it could be made clear in the report. I think that would help.

Tom Rosenthal: Well just to - there - in my recollection of some of the discussions the only negative notion know about costed from my recollection of the discussion was when it was going to be applied at an individual physician level where the conclusion would be is this physician was more efficient than that physician.

And at - in general the individual physician is only responsible for their utilization choices. They have very little control over their labor markets. They have very little control over, you know, the cost of items.

And therefore if one we're going to try to say physician X is in one part of the country is more efficient than physician Y in another part of the country by at least some notion of what efficiency means in relationship to physicians that standardized pricing was preferable.

I - so I do remember. But the counterargument is but some national employer really will want to know that Blue Cross in one part of the country, you know, dollar cost is different than in another part of the country and they don't really care why.

So but there are circumstances where one is going to make more sense than the other depending on the utilization. And it's - but there is a potential for misuse.

Bruce Steinwald: Okay. Well let's make sure that the language that describes that that is really neutral so that someone doesn't read it and come away with the sense that there's a bias and preference for one versus the other.

(Jack): Right.

Bruce Steinwald: Okay.

Male: I agree.

Bruce Steinwald: Can we go into theme three attribution, already have had a little bit of discussion that there's a relationship between attribution and other criteria.

I guess though as I read the comments and the summary of them the issue seems to revolve around attribution being guidelines as opposed to being more concrete requirements.

Is there any discussion of that? I don't know that I recommend any changes but others may feel differently?

Male: Certainly the (discussion) on attribution went way beyond implication ((inaudible)) document about excluding ((inaudible)).

It's much more complex than it actually ((inaudible)) statistical validity. If you recall a lot of bookings measures are because ((inaudible)).

It's a very, very complex issue and I think the answer and the ((inaudible)) response statistics I don't know how to ((inaudible)) any more than that.

Bruce Steinwald: Anything further?

Tom Rosenthal: Well it's interesting, CMS comment basically says they think the attribution should be more specific and the family physicians say we're happy that it's just a guideline. Go figure.

Bruce Steinwald: Well I guess they cancel each other out.

Barbara Rudolph: This is Barb Rudolph. And just from experience with some regional collaboratives frequently the physician groups who are measured in a regional area are likely to have input about the attribution process.

And so the form of guidelines is actually helpful to, you know, regional efforts in terms of getting physician buy-in to the measurement process.

So I'd like to see it stay as guidelines because I think, you know, it's an area where physicians have strong feelings about the attribution approach.

And there's usually a process in place. And I know HealthPartners left it as a guideline because they felt that, you know, they had gotten input from their physicians in terms of what the attribution approach should be.

So I think that part in terms of getting buy-in for measurement can be very important. So I'd prefer to see it left as guidelines as opposed to a, you know, specific standard.

Tom Rosenthal: Well we're not - our task here isn't to really change anything. Our task I think is to merely determine whether or not our responses to the queries are sufficient.

So I don't think - we're not going to change anything. And you make a very - Barb you make a really good set of arguments about why leaving it as a guideline is preferable.

But I think you can also see were CMS comes down of saying but if we really want to hold accountable. So in the of scenario you're describing is where doctors in fact want to use these for improvement opportunities, terrific. You want a guideline. You want flexibility.

But in the scenario where you're really going to hold this group of primary care doctors accountable for the difference in efficiencies from that one you'd probably want to be sure that in fact the same methodology was used.

Barbara Rudolph: Yes. Well one of the big problems about methodology and attribution in the commercial insurance world is that the tools you have to do the attribution vary incredibly based on the insurance product.

So if you're running an HMO product the attribution is almost inherent in the database of the plan. And if you're running a PPO product it's not at all. You have to make guesses and make rules and all of those kinds of things.

And so it's a little tricky out there in the real world to have something that's too restrictive. And what we found in our multi-payer project in Washington is when you start trying to get too

prescriptive about this, what you end up having is huge fallout and relatively small percentages of an individual physician's practice can be attributed at all.

So, you know, I think this is a work in progress and...

Tom Rosenthal: But maybe to the staff though that is a suggestion that our answers kind of really as I read the two competing ones we sort of say yes okay is kind of our answer.

And maybe our answers should reflect a little of this back and forth that we understand that for strict national comparisons it would be - it would probably be necessary or desirable to have a more proscribed attribution model.

The other point of view is that for all the reasons that Barb just enunciated guidelines can also be useful.

Barbara Rudolph: Yes.

Tom Rosenthal: And we elected at this moment in time given the state of the science which if we were honest about it is really got some room to grow that this is where the committee came down.

Barbara Rudolph: Yes.

Male: And I would just put that in as, you know, the (ANS) ((inaudible)) CMS requires specificity but it's in the insurance product it can't be private. You have to ((inaudible)) flexibility. So just put that in there to ((inaudible)) for the readers.

Tom Rosenthal: And that would also be a good idea because you're going to run head-on into this when we go into phase two and talk about the Ingenix approach in which they have about a half dozen different ways of doing attribution.

Bruce Steinwald: Right.

Tom Rosenthal: And that's certainly reflects way that product has been pushed out and sold to customers. I mean that kind of flexibility is sort of an inherent feature of the product.

Male: Yes again which is not a problem. We've been working with Ingenix so it's clearly not a problem when you're buying the product and you only intend to use it for improvement and in a way that Barbara describes.

The challenge is when you start to say I want to compare UCLA in California with some other group in Ohio.

And we the - and the attribution methodology is not specified. And so there's again, risk of ambiguity, there's a risk of apples and oranges and all the rest of it which is again I think the point of view that CMS is taking in this thing which is going to be we want a national standard, we don't want there to be ambiguity.

Male: ((inaudible)) statute they have.

Male: So I think we should acknowledge the tension between these two things and the fact is we came down on the side of tolerance in this first go around but we recognize the two poles of the argument.

Bruce Steinwald: Sounds good to me. Staff, do you have enough to work with there?

Male: Yes that's good. Thank you.

Bruce Steinwald: Okay. Any - if no further discussion then Tom we're on...

Tom Rosenthal: I guess were on to complexity of resource use measures. Anybody have any comments on this? I'm not sure even how to summarize it?

Resource - the resource use measures are inherently complex. And our response is we should - we would - we're striving to make them simple and transparent as possible but it's difficult.

Anybody have any suggestions on how to articulate that better?

Female: I'm just wondering if it's the measure? I mean the measure is mixed. The measure can be simple in the sense of, you know, there's a set of processes. The processes themselves are complex.

Does - do - does every single piece of the measure have to be completely understandable by all audiences?

I guess I don't know any other form of science where every single, you know, component is reduced to a simple statement.

I just think the expectation is rather high that some of these internal processes might, you know, not be, you know, quickly understood by everyone who looked at the measure.

Tom Rosenthal: So that's what the comments are. They're saying don't, you know, don't worry about it that they're complex, they're not easy and transparent.

But again I thought I did in fact hear from the committee with some regularity and I feel it myself at times.

Most of the quality - many of the quality - I shouldn't say most because every time you say most or all or something it's wrong.

But lots of the quality measures are in fact simple. You know, bloodstream infection rates you either have it or you don't, pressure ulcers you either have them or you don't. You know, ACE inhibitors with heart failure you either gave them or you didn't.

There's not a complex set of formulas residing behind them and yet here with particularly with these population-based methods there's a ton of complexity.

And I think the Ingenix or the other developers would tell you that it is true, there's a ton of complexity.

It's - it is - it tends to be easier to articulate to stakeholders and things what the meaning is when you don't have to spend, you know, two weeks explaining the methodology to where they go oh I see.

Now I'll except the fact I'm being measured this way. It just - it is what it is.

Barbara Rudolph: Right, I agree. And I think the issue is I mean there are some quality measures when I think of some of the hierarchical modeling that has occurred for the some of the - some of the more challenging measures.

And that your average person isn't going to understand hierarchical modeling and therefore, you know, should we not approve the measure because it's complex, so...

Tom Rosenthal: Right.

Barbara Rudolph: ...I think that the idea is is that the results should be understandable from the measure and that there ought to be, you know, well specified processes, but does everybody have to know exactly how every code is grouped or, you know, I don't know?

Tom Rosenthal: Right. Well did we overstate this in the report? Does anybody know? Does anybody think of the sort of language that's actually in the report that prompted these comments? I mean do we wail on about how awful it is that they're complicated?

Female: I'm - I don't think...

Tom Rosenthal: I didn't think we did actually.

Male: ((inaudible)).

Female: But we should...

Barbara Rudolph: There are a couple of statements. There were a couple of statements and I don't know if it was in this report or in the second one because I was reading both of them.

So there were statements about the complexity and that it wasn't to the Steering Committee what exactly what was happening in the measure, so...

Female: Well I do think we should strive to have the results interpretable.

Barbara Rudolph: Yes I agree.

Tom Rosenthal: Well then Barb would it be fair to say that one other difference between these and some of the quality ones is most of those quality ones ended up having a pretty substantial peer review literature to where not only was it - you're right, it may have been complicated and would've taken some degree of ability to sort through it but it was all out there for anybody to see. And much of this has not been out there for people to see.

Barbara Rudolph: True. It has not. And I - that may be an issue. But I just think that the average person isn't going to be able to take their data and run it, you know, unless they purchase the groupers unless they use the groupers they aren't going to be able to do this on their own period, you know, unless they have this - the tools, so the idea...

Tom Rosenthal: But that's part of the - of the lack of transparency that I think at least concerns some people on the committee that...

Barbara Rudolph: Right.

Tom Rosenthal: ...not only and with the exception of what I recall David Redfearn saying was you could get on Ingenix's Web site and if you had a PhD in economics you could over the course of several weeks work your way through ((inaudible)) to validate it.

(Crosstalk)

I'm exaggerating David but not by much. I'm exaggerating but not by much. But otherwise I think Barbara's right this - these are less transparent than some other measures have been. And there's a modicum of concern but I don't think it was overstated in the document.

But if somebody wants to go dig out the language I'm sure it could be tweaked and modified to make it, you know, more accurate of our sentiment.

Male: I would argue that the measure is no less transparent than any of the other measures because it's fully documented.

It is more complicated though and difficult to learn. But it's published. And so you have to argue about what's the definition of transparency. And I would argue that transparency means it's completely documented and it is. It's just very, very complicated.

Tom Rosenthal: Well I would submit that - and again at least in the quality realm transparent is more than published. It's published and subject to peer review.

And I guess the counterargument to that here with regard to say Ingenix is well the peer review has been relevant people have actually purchased it.

And in one regard is that just not as valid a kind of endorsement of the accepted scientific acceptability as having been published in peer reviewed literature?

Male: Well Tom I would also add to that that we just had a tap that thoroughly reviewed measures ((inaudible)) into all kinds of methodological issues and it as did we as a Steering Committee.

So you've been playing the role of peer reviewers to some extent in this?

Tom Rosenthal: Right, well we've endorsed them. The only question on the table here is staff's answers to the people who made comments about the complexity.

Are we satisfied with the staff answers or do we think they need to be tweaked or does the report itself need to be tweaked?

Male: Right. Well, you know, the one thing I would add we've been you know, this conversation and the response speaks a great deal to transparency which I think is very important.

But the other issue is usability. And we spent a lot of time thinking about whether these measures were produced numbers that were sufficiently clear that people could use them in - for appropriate use. And that gets us to aim - issue five which is the incompleteness of the measures is just measures of resource use and only some resources that.

But I would add usability is another measure of whether the measures are too complex. And I think we address that in our usability review.

Tom Rosenthal: All right well to sort of bring this to a close because again the purpose of the conversation isn't to rehash all the debates and back and forths that we had in the meeting.

It was to discern do we think the report is written satisfactory or needs to be modified based on the comments and/or that the comments of the staff to - are sufficient?

And I'm not hearing a dramatic proposition to change either one at the moment.

Female: I don't think so.

Tom Rosenthal: I'm going to interpret silence as agreement.

Male: Yes.

Female: Yes.

Tom Rosenthal: All right, okay.

Bruce Steinwald: All right let's go.

Tom Rosenthal: All right so then let's move onto theme five Bruce.

Bruce Steinwald: Theme five, yes. Linking quality and resource use measures.

You know, from our earliest first face to face meeting, you know, we have I think been pretty explicit that resource measures, resource use measures are not efficiency measures. They are weight station to arriving at efficiency measures.

And, you know, and maybe it's just because we've stated that point so many times and I thought it was pretty clear. So I guess I'm surprised to see that some commenters say that we need to make that clear.

Nonetheless if we're not clear enough, and we should be and we should be I think also a little careful about our language.

You know, I noticed in the response the word value has crept in. And I don't know that we need it.

I mean I think it's is reasonably understandable but I think it should be sufficient for our purposes to say yes resource use measures are not efficiency measures.

Yes, we would like to move in the direction of developing efficiency measures. Once we do, the concepts of quality and outcome need to be brought into the measurement process and leave it at that without trying to - without adding new concepts, let's put it that way.

Any but...

Dr. Rich: I would take out the word value and we've had this - robust discussions last year. And clear to us and the outside world that this is part of the equation but (based) on one side of that equation.

Bruce Steinwald: And Dr. (Rich) is that?

Dr. Rich: Yes.

Bruce Steinwald: You're breaking up a little bit. I think I agreed what you said if I only could have heard it, but...

Dr. Rich: If I don't say anything will you also agree with me?

Bruce Steinwald: Absolutely.

Dr. Rich: Maybe ((inaudible)) No I just said that it's - I think it is clear to us as you pointed out. And I just think I would just drop the word value from there and just emphasize this as an evolving process as you stated.

Bruce Steinwald: Okay. Anyone else? All right then I think we're done with...

Tom Rosenthal: Could I - I had - I was sitting here reading and I'm sorry, this is Tom again. I actually went back on the complexity thing and I was reading these complexity comments.

And the critique of us was that in fact somehow we dismiss things because they were too complex and that's just not true.

Bruce Steinwald: No it's not true.

Tom Rosenthal: I mean I'm reading this one from the National Partnership for Women's and they said we can't understand why the Steering Committee applied explained ability criteria to the measures. And we didn't really.

We're just saying that we think they should be explainable if they're going to be usable back to Jack's point.

So but I think the comments are mistaking what we did. I apologize for going back on the thing. But I - maybe on - in our staff responses we could clarify that I don't believe we rejected anything because it was too complex and not understandable.

We just believe that transparency and understandable - (understandableness) and clarity are important attributes or useful attributes. All right I'm done.

Bruce Steinwald: All right.

Female: Well it has to be understandable enough that different groups can take it and use it in different places. So I mean if it really was not...

Tom Rosenthal: Right.

Female: ...couldn't understand it. It's not useful.

Tom Rosenthal: Right. But the critique was as I went back and read several of these is you guys applied this and I don't understand why you applied it. That doesn't make sense.

Female: Yes.

Tom Rosenthal: Okay sorry.

Bruce Steinwald: That's okay.

Tom Rosenthal: I'm done.

Bruce Steinwald: Well I think that's probably useful to staff then. They can incorporate that thought into an elaboration.

So if we're truly done with the themes...

Male: Bruce I just want to add more thing which I think emerged in our conversations and it's implicit in theme five. And I just want to make sure it (gets worked) which is since our resource base measures consistently are based upon what's built or there are a great many resources that they're using ((inaudible)) people and measures that we reviewed.

And that's a long term issue, not a short term issue but a long term issue. It's important that we get - that people get information about the cost and value. I know we just decided to eliminate value, the cost and impact of resources which are currently not building, therefore not visible in the care process the way we've done - the way these measures are constructed.

Tom Rosenthal: Inputs are not accounted for.

Bruce Steinwald: Yes I think that those thoughts certainly were on the table many times at our meetings and out to be reflected in the report.

Tom Rosenthal: So Ashlie it looks like in the agenda the next steps are the next steps?

Sarah Fanta: Actually this is Sarah again. We did have one comment that we needed...

Bruce Steinwald: Right.

Sarah Fanta: ...the Steering Committee input on. And that was comment Number 14 on the spreadsheet that was submitted by Childbirth Connection.

Tom Rosenthal: Oh this is the one in gray?

Sarah Fanta: Yes.

Bruce Steinwald: Why don't you go ahead and present that Sarah.

Sarah Fanta: Okay. I'll just go ahead and read the comment.

Bruce Steinwald: And explain why you and staff thought that this was - this needed some committee discussion?

Sarah Fanta: Okay. So it says we support both 1557 and 1558 and strongly encourage - and strongly urge the committee to apply them to clinician and clinical group levels as soon as testing criteria are met.

It is difficult to justify excluding these levels. Is it customary for measure endorsers to specify minimum sample sizes?

This should be done consistently at the appropriate step in the development, endorsement and implementation process.

We understand that NCQA has been testing some relative resource use measures at the clinical group level with the Integrated Healthcare Association in California and found that physician groups have adequate sample sizes for the diabetes relative resources measure along with other promising results.

Male: And so the major question that's on the table here is with the NCQA guideline of the minimum sample size of 400 patients per measure the question is making sure that we have some consistency in Cycle 1 and Cycle two of NCQA of allowing measurement at the provider - at the group practice level in addition to health plan which is how the measure specifications read during the spring vote.

Bruce Steinwald: Okay.

Tom Rosenthal: So what's the question on the table for us in answering this? I'm a little unclear?

Male: The question on the table is there was a lot of conversation during the committee deliberations on whether the NCQA measure could be applied to the physician group practice level, whether it could or should or should not be. And it was - there was discussion on both sides of that.

The committee as we - the description of the committee discussions there was definitely some concern about applying it at the group practice level.

However we wanted to confirm and make sure that the committee was comfortable with applying the NCQA measure at the group practice level with a minimum sample size of 400.

Tom Rosenthal: And what did we - what was the actual vote when we did it and is there any confusion about what we think we voted on when we voted?

Ashlie Wilbon: Right Tom this is Ashlie. I'll just...

Tom Rosenthal: Yes.

Ashlie Wilbon: ...hop in here. So for the first cycle of review which was the cardiovascular and the diabetes NCQA measures it was - we went back to the transcripts and looked a little bit.

And it appeared that the committee's understanding even though on actual permission form NCQA had checked off both group practice and health plan level of analysis that the committee's recommendation was based on I think the understanding and the discussion was about recommending ((inaudible)) for use as the health plan level of analysis.

And then when - and there was some discussion about, you know, this use or this early testing at the group practice level in - with IHA.

And then but again as a recommendation appeared to be within understanding that the measure would be at the health plan level.

And then fast-forward to cycle two where you reviewed the COPD and the asthma measures from NCQA and there, you know, their positions are very similar to HI soft group practice level and health plan level analysis.

But the discussion of level analysis didn't come up specifically with those two measures. And so the measure would be moving forward with both group practice and health plan levels.

So we just - so to Taroon's point we just wanted to make sure that the committee was aware of how the level analysis that would be applied to the measure as it is recommended and that the - you're comfortable with that given the guideline for minimum sample size of 400.

Tom Rosenthal: I get it. So the discrepancy to the extent that there is one - and I do remember the discussion in the first one the way you described it which was this was meant to be at the health plan level because that's who they oversee. And I thought that was pretty explicit verbally.

But you're saying on the checkbox they had also checked group practice level. And this comment is saying they think it also should be at the group practice level as long as the sample size things are consistent?

Ashlie Wilbon: Correct.

Bruce Steinwald: Yes and that's...

Tom Rosenthal: Okay.

Bruce Steinwald: And that was my recollection is that what was important was meeting the criteria for scientific acceptability which would include sample size.

But I thought we were neutral on who the - what entities the measures would be applied to which would mean it's provided that the other criteria were met it could be group practice.

Tom Rosenthal: Is that the sense of the group on the phone? What do people want to do?

Male: That's my recollection too Tom.

Tom Rosenthal: Okay.

Female: I would like to support the group practice level. It's essentially the same measure developer. The measure's very similar. It's just a different, you know, condition whatever.

So if we're going to, you know, be consistent I would think we'd have to apply it to both what sort of group two and group one.

Tom Rosenthal: Okay.

Female: Yes I agree.

Tom Rosenthal: I think you guys...

Female: I would support that as well.

Male: I agree.

Tom Rosenthal: Okay so I think we have our answer there on that one staff.

Female: Okay.

(Crosstalk)

Female: Thank you.

Sarah Fanta: And so just based on the input that we were given we just want to make sure that they group as a whole is still comfortable maintaining their recommendations to move these measures forward.

So it sounds like that's the case but if anyone wants to just - if any of the comments changed anyone's opinion now would be the time to express that?

Helen Burstin: And I'd also add -- this is Helen -- that if there are specific comments that on the list you'd like us also call out and have it - and discussed that's fine as well.

Female: I presume we're going to talk about the Ingenix measure that didn't pass in a different call?

Sarah Fanta: Actually no, this is the opportunity for that as well.

Female: Okay.

Female: No Sarah, that's - not, this report - this call is only for Cycle 1 report. So you're...

Sarah Fanta: Okay.

Female: ...correct ((inaudible)) the next call for cycle two will include the Ingenix measures -- all the Ingenix measures...

Female: Okay.

Female: ...are in Cycle 2 so we're going to separate those out.

Female: Okay.

Female: And the report that we had just recently sent out. So in the input you have as far as, you know, the Ingenix review process would go into the report that we're going to post next week for comment. So if you have anything to add we're, you know, we could still take those for the next couple of days.

Sarah Fanta: Okay. Great, thank you. Are there any other specific comments anyone wants to pull out for discussion?

Bruce Steinwald: Hearing none...

Sarah Fanta: Okay and so at this time Carolyn if we want to open up the lines for public comment for anyone listening in? Carolyn, are you there?

Operator: Certainly. And all lines are now open.

Sarah Fanta: Okay.

Tom Rosenthal: Hearing none.

Bruce Steinwald: We're inviting public comment to anyone who is listening in on the call? Okay.

Sarah Fanta: Okay. So just moving along then for next steps, the next conference call will be on December 5. And that will be to discuss the Cycle 2 Draft Report comments.

And other important dates coming up as mentioned earlier October 24 November 7 NQS member voting for Cycle 1 measures will occur.

And you're all more than welcome to dial-in October 26 for the pre-member voting Webinar and November 2nd and 3rd for the CSAC discussion on the Resources Project and the recommended measures.

And either way we'll be forwarding you information on both of those events. Does anyone have any questions?

Male: No.

Sarah Fanta: Okay great. Thank you so much everyone for calling in today. We'll be sure to incorporate all of your comments into the draft report and to the responses themselves. And we look forward to speaking with you soon.

Bruce Steinwald: Good.

Sarah Fanta: Thank you.

Tom Rosenthal: Thanks everybody.

Bruce Steinwald: Staff you did a good job. And because you did you give us back 50 minutes of our time. Thank you.

Sarah Fanta: Very good.

Tom Rosenthal: All right.

Sarah Fanta: Thank you.

Tom Rosenthal: Bye everybody.

Female: Thanks.

Female: Bye-bye.

Male: Bye.

END