

NATIONAL QUALITY FORUM
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EFFICIENCY RESOURCE USE

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STEERING COMMITTEE MEETING
OPEN SESSION

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MONDAY, JULY 12, 2010

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The Steering Committee convened at 9:00 a.m. in Suite 600 South of the Homer Building, located at 601 13th Street, N.W., Washington, D.C., Doris Lotz and Bruce Steinwald, Co-Chairs, presiding.

PRESENT:

DORIS H. LOTZ, MD, MPH, CO-CHAIR

BRUCE STEINWALD, MBA, CO-CHAIR

PAUL BARNETT, PhD, VA Palo Alto Healthcare System

JACK BOWHAN, Wisconsin Collaborative for Healthcare Quality

JEPHTHA CURTIS, MD, FAAC, Yale University School of Medicine

KURTIS ELWARD, MD, MPH, FFAFP, Family

Medicine of Albemarle

WILLIAM GOLDEN, MD, MACP, Arkansas Medicaid

LISA M. GRABERT, MPH, American Hospital Association

ETHAN A. HALM, MD, MPH, University of Texas Southwestern Medical Center

ANN HENDRICH, RN, MSN, FAAN, Ascension

Health

THOMAS H. LEE, MD, Partners HealthCare System, Inc.

RENEE MARKUS-HODIN, JD, Community Catalyst
JACK NEEDLEMAN, PhD, FAAN, UCLA School of
Public Health

MARY KAY O'NEILL, MD, MBA, CIGNA Healthcare

DAVID PENSON, MD, MPH, Vanderbilt
University Medical Center

STEVE PHILLIPS, MPA, Johnson & Johnson
Health Care Systems, Inc.

DAVID REDFEARN, PhD, WellPoint

JEFFREY B. RICH, MD, Mid-Atlantic
Cardiothoracic Surgeons, Ltd.

WILLIAM RICH, MD, Northern Virginia
Ophthalmology Associates

TOM ROSENTHAL, MD, UCLA School of Medicine

BARBARA A. RUDOLPH, PhD, MSSW, The Leapfrog
Group

JOSEPH STEPHANSKY, PhD, Michigan Health and
Hospital Association

JAMES N. WEINSTEIN, DO, MS, Dartmouth
Hitchcock Medical Center

DOLORES YANAGIHARA, MPH, Integrated
Healthcare Association

NQF STAFF PRESENT:

HELEN BURSTIN, MD, MPH

JANET CORRIGAN, PhD

MAISHA MIMS, MPH

JENNIFER PODULKA, MPAff (Phase 1)

SALLY TURBYVILLE, MA, MS

ASHLIE WILBON, RN, MPH

ALSO PRESENT:

NIALL BRENNAN, CMS

ADRIAN HUSSAIN, HHS

RITA MUNLEY GALLAGHER, PhD, RN

C-O-N-T-E-N-T-S

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

(9:02 a.m.)

OPEN SESSION

MS. TURBYVILLE: Good morning. I want to welcome everyone here today and on the telephone to the NQF Resource Use Steering Committee meeting. We'll be meeting today, Monday, and tomorrow, Tuesday.

At this time we'll first introduce the staff, NQF staff, that are here today.

My name is Sally Turbyville. I'm a senior director in the performance measurement department.

We have Ashlie Wilbon who is the project manager in performance measurements; Maisha Mims, a research analyst in performance measurement; Jennifer Podulka, who is a senior director in strategic partnership.

DR. BURSTIN: Good morning, Helen Burstin, Senior Vice President for Performance Measures at NQF.

MS. TURBYVILLE: So at this time

1 I would request that we go around the room and
2 have the steering committee members introduce
3 themselves and the organization that they are
4 coming from.

5 CO-CHAIR LOTZ: I'm Doris Lotz.
6 I'm the New Hampshire Medicaid medical
7 director.

8 CO-CHAIR STEINWALD: I'm Bruce
9 Steinwald, I'm an independent consultant
10 living right here in Northwest Washington.
11 Until recently I was in the senior executive
12 service in the Government Accountability
13 Office.

14 DR. STEPHANSKY: Joe Stephansky.
15 I'm with the Michigan Health and Hospital
16 Association.

17 DR. ROSENTHAL: Tom Rosenthal,
18 I'm from UCLA.

19 DR. RUDOLPH: Barbara Rudolph. I
20 represent the Leapfrog Group.

21 DR. O'NEIL: Mary Kay O'Neil,
22 chief medical office for Cigna in the Pacific

1 Northwest.

2 MR. BOWHAN: I'm Jack Bowhan,
3 Wisconsin Collaborative for Health Care
4 Quality.

5 DR. BARNETT: Paul Barnett with
6 the VA Health Economics Resource Center.

7 DR. GOLDEN: Bill Gold, Arkansas
8 Medicaid.

9 DR. NEEDLEMAN: Jack Needleman,
10 UCLA School of Public Health.

11 MR. CURTIS: Jephtha Curtis, Yale
12 University Hospital.

13 MS. GRABERT: Lisa Grabert,
14 American Hospital Association.

15 MS. MARKUS-HODIN: Renee Markus-
16 Hodin, Community Catalyst.

17 MR. WEINSTEIN: Jim Weinstein,
18 I'm director of the Dartmouth Institute for
19 Health Policy and Clinical Practice and I'm
20 recently the president at Dartmouth Hitchcock.

21 MS. HENDRICH: Ann Hendrich,
22 Ascension Health vice president for quality

1 and patient safety.

2 MR. PHILLIPS: Steve Phillips,
3 director of health policy with Johnson &
4 Johnson.

5 DR. HALM: Ethan Halm, University
6 of Texas Southwestern in Dallas.

7 DR. REDFEARN: David Redfearn,
8 WellPoint.

9 DR. RICH: Jeff Rich, I'm a
10 practicing cardiac surgeon now, but in the
11 immediate past a director of the Medicare fee-
12 for-service program.

13 MR. YANAGIHARA: Hi, I'm Dolores
14 Yanagihara with the Integrated Health Care
15 Association in California.

16 DR. RICH: Bill Rich, practicing
17 ophthalmologist in Northern Virginia, and
18 director of health policy for the American
19 Academy of Ophthalmology.

20 DR. LEE: Tom Lee from Partners
21 Health Care System and Harvard Medical School
22 in Boston.

1 MS. TURBYVILLE: Thank you.

2 So briefly to talk about some of
3 the project goals and the status for today I'm
4 going to hand it over to Ashlie Wilbon, who is
5 the project manager.

6 REVIEW OF PROJECT SCOPE, STEERING COMMITTEE
7 CHANGE, PROJECT ACTIVITIES & PROJECT TIMELINE

8 MS. WILBON: Good morning,
9 everyone. Bear with us today. We are limited
10 on space so we are going to be playing a
11 little bit of musical chairs throughout the
12 day based on who is going to be leading the
13 conversation from the staff end. So thank you
14 everyone for being here.

15 A lot of this stuff you've seen
16 before. At this point we just want to kind of
17 set the tone and make sure everyone is on the
18 same page. Today is I think the first time
19 that everyone has been in the same place at
20 the same time, and we had a few absentees on
21 the calls sometimes, so it's just nice to
22 regroup and make sure everyone is aware of

1 what's going on.

2 So we are just going to review the
3 project scope, the steering committee charged
4 activities and timeline, what we've done so
5 far.

6 So the goal of this project again
7 is just to provide guidance, and Helen and
8 Sally have been through this already so I
9 won't dwell on it, but to provide guidance for
10 NQF committees, NQF members and measure
11 developers to make the process for reviewing
12 resource use measures transparent for when we
13 do a call for measures later on this fall.

14 Also for the resource use
15 measurement white paper to provide input for
16 that as well as the resource use evaluation
17 criteria, and then beginning with phase two
18 you will actually be evaluating the submitted
19 resource use measures for recommendation for
20 endorsement.

21 So again this project is divided
22 into two phases. The first phase that we are

1 in now is focused on the white paper and
2 actually deciding on what the evaluation
3 criteria will be for when the measures
4 actually come in.

5 Phase two we anticipate to begin
6 in the fall. We are looking at doing the call
7 for measures in October, and that will begin
8 the consensus development process. We will
9 talk a little bit more about that on day two
10 towards the end so you have an idea of what
11 that looks like.

12 We've got one steering committee
13 which is all of you for both of the phases,
14 and beginning in phase two we will have five,
15 at this point, five technical advisory panels,
16 based around the clinical areas of the
17 measures that we are expecting. Got 18
18 conditions, and then we've divided those 18
19 conditions into five lumps of clinical areas
20 that we'll have the TAPS focused on.

21 Each of the TAPS will be chaired
22 by a steering committee member, and most of

1 you guys already know who you are; again, we
2 can talk about that again on day two when we
3 get into phase two a little bit more.

4 So the roles of the steering
5 committee, to act as a proxy for the NQF
6 multi-stakeholder membership. Each of you
7 guys come from a different - bring a different
8 perspective and represent each of our various
9 stakeholders from different areas to work with
10 NQF staff to help us achieve the goals of the
11 project: evaluate the candidate measures
12 against the evaluation criteria; respond to
13 comments during the review period; and respond
14 to any directions from CSAC.

15 And at this point we're
16 anticipating that the evaluation criteria once
17 it's decided on will go to CSAC for review and
18 approval to be implemented.

19 The CSAC is the Consensus
20 Standards Approval Committee, and Helen may
21 want to give a little more detail, but
22 essentially they are the oversight body that

1 manages or kind of oversees a lot of the - all
2 the processes that - and procedures that NQF
3 implements. I'll leave it at that.

4 So all of the steering committee
5 members will be expected to review all the
6 measures, and each measure will be assigned
7 primary and secondary reviewers for more in-
8 depth review. And again we'll talk a little
9 bit more about how the measure review process
10 occurs when we get a little bit closer to
11 phase two. Right now this is just kind of to
12 give you an idea of how that will occur.

13 So each of the measures will be
14 evaluated against each of the evaluation
15 criteria, and you will review the measure
16 evaluations prepared by the staff, and
17 indicate the extent to which the criterion is
18 met for the rationale, and at that point, once
19 you've reviewed it you will be making
20 recommendations to staff whether or not they
21 should be moved forward for endorsement.

22 So the steering committee charge

1 for phase one is again to provide input on the
2 white paper, provide NQF operational guidance
3 for the evaluation criteria, and provide
4 guidance on the call for measures which we
5 will talk about tomorrow as well.

6 So this is just a high level
7 timeline for the project. We had our call on
8 June 18th where we talked about the evaluation
9 criteria. Today and tomorrow we'll be meeting
10 here for the in person meeting. We expect
11 that the white paper will go up for public and
12 member comments towards probably mid to late
13 August. That's a 30-day comment period. Once
14 we received those comments we will reconvene
15 you guys via conference call to discuss the
16 comments that come in, see if you'd like to
17 respond to them, how they should be
18 incorporated and so forth. That call we've
19 already scheduled based on majority
20 availability with the survey that we sent out
21 via email, and that is scheduled for October
22 5th.

1 We will begin the call for
2 measures again as I mentioned in October and
3 expect that the white paper will be finalized
4 in November of 2010.

5 And we will be simultaneously with
6 the call for measures we'll also be doing a
7 call for the remainder of the TAP members. We
8 do have the TAP chairs within the steering
9 committee, but the remainder of the TAP
10 members have not been selected yet so at the
11 time when we do the call for measures in
12 October we'll be doing the call for TAP
13 members. So between October and December
14 amongst all the holidays and stuff we'll be
15 empanelling those TAP measures, and then we'll
16 begin measure review in January of 2011.

17 DR. HALM: I'm just trying to
18 understand the role of the white paper beyond
19 just sort of getting people together on the
20 same page. You are doing a lot of public
21 disclosure and commenting on the white paper
22 as if it's sort of the final measure, or it's

1 sort of going to be the bible of resource use;
2 is that correct?

3 DR. BURSTIN: Basically because
4 this is such a totally new area for NQF, we
5 have never endorsed resource use measures
6 before, this is a pretty evolving field with
7 lots of people unsure what the terrain and the
8 definitions. We thought it was really
9 important to start with and actually it was
10 specifically requested as well by HHS as part
11 of this work that we do the white paper first
12 as sort of almost a grounding exercise, get
13 everybody on the same page and then do the
14 call for measures.

15 And again, because we're NQF,
16 everything we do is very transparent. We
17 learn a lot from public comment, routinely get
18 hundreds of comments for everything we put
19 out, and we get it from a very wide array of
20 stakeholders.

21 So we really value getting that.
22 We often learn a lot about things that

1 sometimes steering committees don't
2 necessarily think about. So that is the
3 purpose of it. We really see it as something
4 that may be also very useful for the measure
5 developers as they begin thinking about what
6 they want to put forward, how to bring that
7 forward.

8 MS. WILBON: And I think in a
9 broader sense to just kind of help lay the
10 ground and help people better understand how
11 the steering committee was led to coming up
12 with the evaluation criteria. So it's kind of
13 that background and the path leading into the
14 evaluation criteria and the measures. So
15 hopefully that helps.

16 DR. RUDOLPH: In terms of
17 resource use measures, I know we're going to
18 have probably a long discussion about what
19 these are, but NQF has endorsed measures on
20 length of stay, readmission, and probably
21 others that in my mind are resource use
22 measures as well as sort of quality metrics.

1 So just a clarification on that.

2 DR. BURSTIN: We'll have a lot of
3 discussion about that to follow. Those are
4 sort of classic efficiency measures. We've
5 had those before. But we haven't had sort of
6 the building blocks of ones that truly
7 represent cost resource use alone, which I
8 think is more to follow.

9 But you are absolutely right: we
10 really see this as building that overall
11 portfolio for efficiency measures to follow.

12 MS. WILBON: Does anyone else
13 have any questions?

14 MR. WEINSTEIN: There has been a
15 tendency for a lot of the national committees
16 to avoid the issues of cost. Whether it's
17 comparative effectiveness research through the
18 Institute of Medicine or others. Is this - it
19 creates controversy. People use different
20 kinds of language around that.

21 And I realize the intent here is
22 to get cost into the mix with measures. Do we

1 anticipate any problems with that publicly?

2 (Laughter)

3 DR. BURSTIN: Yes. I've now
4 been at NQF for three years and I actually now
5 say it, and Barb know this, the easy stuff is
6 kind of done. The hard stuff is to follow.
7 And we know cost is sort of the third rail,
8 but I don't think we can proceed without sort
9 of touching it. So that's why all you smart
10 people are here to help us do that wisely, and
11 avoid touching the rail if we can but doing
12 what is needed.

13 CO-CHAIR LOTZ: I think there is
14 something to be said too with just creating
15 some metrics. What people do with the numbers
16 once they get them is to some extent their own
17 affair, and what I've come to realize with a
18 fair amount of work, not so much with NQF, a
19 little bit of work with NQF, a lot more work
20 with AHRQ, is that while there is a desire to
21 talk about cost, a lot of costing is local,
22 and if we can just get some measures out there

1 that we can all agree to that start to
2 incorporate some concepts of cost, then the
3 folks local or at whatever level you play at
4 can figure out what they want to do with it.

5 MR. WEINSTEIN: I was just trying
6 to create the discussion, because I imagine
7 there will be a lot of discussion, and that
8 the committee probably realizes that and is
9 sensitive to that, was the reason for bringing
10 it up, publicly.

11 DR. LEE: You know, if I could
12 just interject, I mean I do think that though
13 I have questions and concerns about the
14 traditional NQF framework and public reporting
15 of these measures, I do think that some
16 clarity and standardization about how resource
17 use is measured would be very valuable right
18 now. I mean we and a lot of folks I know are
19 trying to develop value report cards with
20 outcomes over cost, and on the same reporting
21 framework, and having clarity and
22 standardization of what we are actually

1 putting in that bottom half of the page would
2 be very helpful for efforts to improve.

3 I'm not sure if public comparison
4 will be that straightforward. But for
5 improvement purposes this will be a very
6 useful exercise.

7 DR. GOLDEN: I don't know when
8 this would be appropriate in the framework,
9 but one of the questions I had as I read
10 through this is that we are kind of - we are
11 still lumping things that may not be lumpable,
12 in a sense for example when we go through this
13 we have Prometheus and the ABMS materials
14 together. And Prometheus is a payment
15 mechanism, and ABMS is a measurement
16 mechanism, and they may use common principles,
17 but I'm not sure that they are comparable in
18 terms of putting them into the same category.
19 And I'm not sure the white paper has done that
20 yet, and I don't know if that is going to be
21 discussed today. But that may help clarity as
22 we put this material forward.

1 MS. WILBON: We will actually
2 today be dedicated solely to the white paper.
3 We'll actually be going through section by
4 section. There are definitely sections of the
5 white paper that we have pulled out that we
6 want specific steering committee feedback and
7 decisions on so we will be calling your
8 attention to those and obviously everyone will
9 be bringing their own comments as well. So
10 there will definitely be opportunity to
11 discuss that and revisit that as well.

12 DR. GOLDEN: Just a quick
13 followup, it'd be nice when we start to have
14 a broad discussion before we get into the
15 details, because what I just brought up is
16 really kind of not in the paper but more a
17 conceptual framework.

18 MS. WILBON: Right. There will
19 be time.

20 DR. BURSTIN: Just one brief
21 response, Bill, it's a very good question.
22 We've just been through this and brought in

1 for example some of the Prometheus
2 complication measures as part of our outcomes
3 project. Again, what we would be bringing in
4 would not be the payment model; it would be
5 the measures they use as part of the payment
6 model. So I think we are trying to stay
7 consistent that we would only be looking at
8 the actual metrics themselves rather than the
9 payment model. But it sounds like for the
10 white paper and a lot of the discussions some
11 really useful principles that might be useful
12 to come out of this as well.

13 DR. NEEDLEMAN: I'd like to go
14 back briefly to Jim's comment and Tom's
15 comments and some of the implications for the
16 work. We are clearly entering another era of
17 where aggressive cost containment is going to
18 be one of the key drivers of what's going on
19 in health care. Bending the cost curve is
20 going to be the mantra for the next decade.
21 But it needs to be done in a way that quality
22 is actually not only protected but enhanced,

1 given the current levels of quality of care.

2 So in the long run the kinds of
3 issues that Tom mentioned, the effort to look
4 in an integrated way at how much we are
5 spending and how much quality we're getting
6 for that is critical. And I think in the
7 rubric we've been using in this committee,
8 that's where the efficiency measure is.

9 What's - what this paper is about,
10 and with the measures we are talking about
11 seem to me to be an important intermediate
12 step. We are going to be talking about
13 resource use at this stage of the game, not so
14 much efficiency measurement. We need to set
15 the stage for being able to measure efficiency
16 with the resource measures that are used, but
17 I've seen in the phone calls we've had, we
18 keep going back and forth between, are we
19 measuring efficiency or are we measuring
20 resources. We are going to need to be clear
21 about how far - the committee name is resource
22 use, and I think that's where we are, that's

1 where we have to begin. We need to be
2 thinking about how ultimately it may be used
3 in efficiency, but we should not be evaluating
4 whether these measures are adequate to measure
5 the efficiency of health care. They are not
6 going to be for all the reasons that we have
7 talked about on the phone.

8 MS. WILBON: Thank you, and
9 again, we'll have lots of opportunities to
10 discuss this later on today.

11 I am going to quickly move through
12 the rest of these slides so you guys can get
13 to your more important or more exciting
14 conversations.

15 This is just a summary of what we
16 have done so far. As most of you know we
17 started out working with a subcommittee of the
18 entire steering committee to help us get the
19 white paper to a point that we felt was ready
20 to go to the entire steering committee for
21 review. So the subcommittee reviewed the
22 paper in late May, and we had been working on

1 incorporating their edits and suggestions into
2 the paper prior to distributing it to the
3 entire steering committee.

4 We had the conference call on the
5 18th and the meeting today, obviously. And I
6 will actually hand it over to Sally. Thank
7 you.

8 WHITE PAPER DISCUSSION

9 MS. TURBYVILLE: Thank you,
10 Ashlie.

11 So as Ashlie mentioned and as is
12 indicated on the agenda, we are going to spend
13 much of today talking about the white paper.
14 We do have some key areas that we are hoping
15 to get some agreement on, but we realize that
16 there is going to need to be time for broad
17 discussions as well as discussions that may
18 stem from even some of the items that we want.
19 So we realize that there needs to be
20 flexibility. The slides are really just meant
21 as an outline to help guide us through the
22 day. But if they become no longer useful we

1 are prepared to continue to move forward.

2 So again we do want an open
3 discussion. We do want input on how to
4 improve the approach that we might take to
5 endorse resource use measures as well as on
6 the paper itself, and any recommendations on
7 key items that the committee may have.

8 The paper is currently in this
9 structure where we have our introduction, the
10 reason for the white paper. We talk about
11 what's going on in the real world, getting to
12 one of the comments below, perhaps needs some
13 expansion.

14 The type of resource use measures
15 on a continuum model, and then what the NQF
16 evaluation principles which we will have time
17 set aside for tomorrow to go through with you,
18 but we can bring them in today if we need to
19 as well as the evaluation criteria itself.

20 For some of you to make sure we're
21 all on the same page we did our best that we
22 could to get the various current measure

1 development approaches methods in the
2 appendix. We weren't able to get all of them
3 in there, 3M for example. But to the extent
4 that we could we put that in there.

5 The main reason was to demonstrate
6 how different fundamentally some of them
7 really are, and our sensitivity to that.

8 So I'm going to hand it over to
9 Bruce and Doris to lead this conversation. We
10 are here for questions or to respond to any
11 comments that you have that you need NQF
12 staff. But we really want this to be a
13 conversation amongst all of you to help guide
14 us through any improvements in the white
15 paper, things that are missing as well as the
16 evaluation approach itself.

17 CO-CHAIR LOTZ: Niall Brennan is
18 back in the room with us, and there was a
19 question that was asked when he was out, and
20 we said, oh we'll ask that when Niall is in,
21 so I did give him a heads up. But Niall, if
22 you could speak briefly before we begin

1 reviewing the paper as to how this project
2 bumps up against CMS' RFP requesting the
3 development of episode-based measures.

4 MR. BRENNAN: Sure.

5 DR. BURSTIN: Niall, could you
6 come up to a microphone.

7 MR. BRENNAN: Good morning,
8 everybody.

9 I suppose the first thing to say
10 is when we conceived of the NQF process the
11 notion of a requirement of a public domain
12 grouper wasn't exactly law yet. So the short
13 answer is, stuff happens. And we need to work
14 around it.

15 But I do think that the efforts
16 are very complementary. I mean it may seem a
17 little counterintuitive, but to tie into Tom's
18 point and some others specifically, the whole
19 purpose of this project is to try and
20 establish standards and consensus around how
21 resource use measures should be evaluated,
22 what's right, what's wrong, what's good or

1 bad. And I think a lot of the findings of
2 this process would hopefully feed into the
3 public domain grouper process.

4 There is an RFP on the streets.
5 We'll be evaluating proposals over the next
6 couple of months and hopefully making an award
7 or awards sometime in the early fall. So I
8 don't know if that answers the question to
9 everybody's satisfaction. So it's a little
10 difficult for me to state with certainty. But
11 fall of this year.

12 CO-CHAIR STEINWALD: Can I ask a
13 followup?

14 MR. BRENNAN: Yes.

15 CO-CHAIR STEINWALD: As you know
16 CMS has a huge task in front of it to
17 implement the provisions of what we are now
18 calling PPACA - just PACA?

19 MR. BRENNAN: PACA.

20 CO-CHAIR STEINWALD: PACA? Oh,
21 my gosh. I'm behind the times.

22 MR. BRENNAN: Affordable Care

1 Act, with the emphasis on affordable.

2 (Laughter)

3 CO-CHAIR STEINWALD: So you heard
4 it and I heard it here first, PACA, and man of
5 those provisions are oriented to moving away
6 from atomistic fee-for-service medicine into
7 different forms of health care delivery. And
8 some of us have wondered whether this project
9 could be complementary to these innovations
10 that you are going to need to identify and
11 implement in any case, and what most of us are
12 hoping that our health system will move in the
13 direction away from solely fee-for-service
14 medicine to more integrated delivery systems.

15 Do you see a complementarity
16 between that movement and this engagement?

17 MR. BRENNAN: Absolutely. You
18 know the move to value-based purchasing is one
19 of the key drivers of many many elements of
20 the bill. Accountable care organizations are
21 going to be evaluated against a whole range of
22 quality and cost of care metrics. You have

1 the expanded physician resource use report
2 program which will ultimately lead to the
3 value modifier provision where physicians will
4 be again evaluated on the basis of cost and
5 quality, and then a value modifier will be
6 calculated for their services.

7 And even if we do move away from
8 the old style fee for service, first of all,
9 ACOs are really sort of being lowered on top
10 of the fee-for-service structure, and over
11 time we may move to partial or full cap. And
12 there are certainly other models. And even if
13 we move away from payment per widget, we still
14 want to very closely track overall performance
15 and what patients are getting both in terms of
16 quality and quantity of care. So I view them
17 as very complementary. I don't know if that
18 answers your question or not, Bruce.

19 CO-CHAIR STEINWALD: While we
20 have Niall is here, anyone else like to ask a
21 question on this?

22 CO-CHAIR LOTZ: One more followup

1 before we open it up.

2 So you are seeing the development
3 of these resource use measures that will come
4 after the call up measures as being a
5 component of the assessment of that value and
6 would feed into the application of the value
7 modifiers. You have your quality measures
8 coming in from another pathway so to speak and
9 then these resource measures coming in from
10 this pathway and then leading into the
11 application of that value added modifier that
12 CMS is still discussing at this point.

13 Is that sort of where we fit in on
14 a bigger picture?

15 MR. BRENNAN: Yes, the only
16 clarification would be, and maybe it's
17 splitting hairs a little bit, I mean we don't
18 necessarily know and I can't always remember
19 all the dates, the value modifier is like
20 quite a way out there, and this process is
21 right now. So measures that are approved as
22 part of this process, they are the first

1 generation if you will of resource use
2 measures. So by the time we get around to a
3 value modifier or more aggressively evaluating
4 whatever entity based on quality and cost,
5 they may be different measures, but they will
6 still be based on a foundation of what's
7 happening now. We need to be addressing these
8 issues and developing prototypical standards
9 now and not waiting two more years or three
10 more years. Let's try and evaluate these,
11 get them out into the marketplace, even though
12 many of them are in the marketplace already,
13 and see how people react.

14 DR. RICH: Niall you saw our
15 timeline and workload. Is that going to be
16 adequate for you to help evaluate the RFP
17 proposals? When I reviewed it it looks like
18 the timelines are - your timeline is a lot
19 shorter than ours.

20 MR. BRENNAN: Our timelines are
21 somewhat shorter and some of our other
22 internal criteria may be different, but what

1 we're doing is we're approving work to begin
2 on development of a public domain group or we
3 would imagine that then those measures that
4 come out of that process, we could then look
5 at the evaluation criteria, evaluate them
6 against them.

7 DR. RICH: I just want to
8 reinforce what you are saying. There is a
9 sense of immediacy at CMS that we have to
10 appreciate, and I think some of the measures,
11 the resource use measures that we will come up
12 with will provide us with a picture of a holy
13 grail seven or eight years from now that we
14 could implement into the payment systems as
15 they evolve. But we have a really complicated
16 payment system now that's based on fee for
17 service, and I know this project is not all
18 about CMS, but the CMS fee-for-service program
19 is in dire need of resource use measurement,
20 and it needs to evolve in its payment
21 mechanisms, and resource use measurement needs
22 to be complementary along the way.

1 So I would say as we deliberate we
2 should remember that we might not pick the
3 perfect measure or have the perfect goal, but
4 have some intermediate steps and goals that
5 could be utilized by CMS as the payment
6 systems evolve.

7 DR. GOLDEN: To follow up on
8 that, just so I understand, in this process we
9 are looking at different mechanisms of
10 creating groupers and developing measures.
11 You get general principles which may or may
12 not be what the CMS goes into, and then you
13 have multiple different mechanisms of
14 performing tasks which can then create
15 different kinds of measures like a tangerine
16 or an orange. And I don't know quite what
17 we'll end up with. Will the system
18 accommodate six different silos of measures?
19 Are we looking at principles for different
20 systems, given that they have certain
21 assumptions going in. Even a creative grouper
22 system with certain assumptions and from there

1 you can create efficiency measures. But we
2 may not match up. So how are we going to put
3 all that together down the road.

4 MR. BRENNAN: Without wanting to
5 appear to not really answer the question, I
6 think only time will tell. We're both at the
7 beginning of two very complex processes, and
8 it's just difficult for me to state with any
9 certainty what may happen.

10 I do think one of the unique
11 challenges of this process in particular - not
12 that any of this is easy - is because so many
13 of the measures are different in slightly
14 different ways, and because so many of the
15 post-processing approaches that can be taken
16 can impact what a measure means and how it's
17 interpreted and accepted by people. I think
18 it's a very very tricky issue and area.

19 CO-CHAIR STEINWALD: Tom.

20 DR. ROSENTHAL: We can't separate
21 what we're trying to do in terms of
22 identifying some individual measures from what

1 we think is the long term goal, and the part
2 that I'm having trouble putting my head around
3 is this idea of sort of an individual value
4 for individual physicians, which sort of
5 relates to the grouper methodology, ranking
6 individual physicians with the perhaps more
7 ultimate goal of eliminating fee for service,
8 and driving towards accountable health care
9 organizations. I can't quite figure out how
10 one drives the other. And do you have some
11 thoughts on that based on how CMS is thinking
12 about it? Does the question make sense?

13 MR. BRENNAN: Could you try me
14 one more time, sorry?

15 DR. ROSENTHAL: Well, we have
16 this idea of individual doctors, and we are
17 going to rank individual doctors who are
18 practicing fee-for-service medicine and either
19 rank them by some value-based measure or what
20 CMS is developing, yet the real goal is in
21 fact to drive them into accountable health
22 care organizations, I think, and the

1 elimination of fee for service, and it's not
2 entirely clear to me how the ranking of
3 individual doctors or modifying their fee-for-
4 service payments based on a value purchasing
5 proposition drives the broader goal. A couple
6 of people are nodding their heads.

7 CO-CHAIR STEINWALD: Jim?

8 MR. WEINSTEIN: I guess -- just
9 to throw out some ideas on how I frame this,
10 and I don't know if it's helpful for CMS or
11 not. But as Tom said, lots of us are thinking
12 of ways to work within systems that are
13 actually is practical or pragmatic. So you
14 could imagine a grouper for something like
15 knee replacement, which is fairly simple,
16 versus diabetes or something, that people like
17 Ingenix and others have already come up with
18 grouper strategies that we have all read about
19 or are familiar with. And imagine testing
20 that. And I guess my question is, before we
21 jump into policy issues or changing the
22 payment structure, let me ask, is it CMS' goal

1 to actually test some of these methodologies
2 and measures to see if they actually deliver
3 what's proposed in some RFP or strategy,
4 rather than implementing a broad strategy that
5 ends up failing like the current strategy.

6 So is that where we're trying to
7 get?

8 MR. BRENNAN: I think it's a very
9 good point, Jim. And again just to, perhaps,
10 underline the earlier comments, when we
11 referred to ACOs, value modifiers, etcetera.
12 Those are, particularly the value modifier, a
13 very long way in the future. I don't really
14 want this conversation to be about payment
15 reform or payment policy in the short term.
16 I think it's about establishing standards and
17 criteria around getting to useful measures
18 that can eventually inform staff such as that
19 -- as long as we are confident that the
20 measures are giving us accurate information.
21 So I really appreciate that point.

22 CO-CHAIR STEINWALD: Jack.

1 DR. NEEDLEMAN: If I was
2 listening carefully enough, one of the things
3 I heard you say was one or several contracts
4 being let. And it ties in, I think, to some
5 of the conversation we've been having here --
6 which is, the decisions that are made today
7 are going to constrain the decisions that can
8 be made in the future. So if one is picking
9 a specific grouping methodology six months
10 from now, that will have important
11 consequences for the way data is organized,
12 data is collected, data is reported, that will
13 constrain what kinds of measures people use in
14 the future. So where in the -- but we've also
15 talked about, and the white paper makes very
16 clear, we've got a lot of uncertainty about
17 what conceptually is the right way to do this.
18 So where in terms of the development process
19 is CMS trying to hit with the call for
20 development of a public grouper? And is it
21 possible that you're in fact going to have
22 several contracts out there with very

1 different models being pursued so we have more
2 flexibility in the future to identify the
3 direction we want to go in, based on what
4 we've learned from the initial grouping work?

5 MR. BRENNAN: I think CMS faces
6 some short-term realities, and has long-term
7 goals. There needs to be a public domain
8 grouper, I believe, and I should be better
9 prepared, by January 1st, 2012. In order for
10 that to happen, CMS has employed a strategy --
11 as you are probably aware from the RFP -- of
12 pursuing both a short-term goal and a long
13 term goal, a short-term goal that looks
14 possibly at adapting some existing
15 methodologies to better account for measuring
16 these types of things in the Medicare
17 population; a longer term much more expansive
18 goal of: okay, if you had more time and more
19 resources to build a better resource use
20 measure, how would you build it.

21 CO-CHAIR STEINWALD: Jeff, go
22 ahead.

1 DR. RICH: Sure, I just want to
2 reflect on what Tom was saying. So just
3 remember that in the Medicare fee-for-service
4 program, there is a Part A and Part B. Part
5 A, the hospital side, already does a lot of
6 bundling, and has a prospective payment
7 system. So resource utilization is felt
8 already a little bit in that system. But on
9 the Part B side, the physician side, it
10 still -- you're paying for widgets, and it's
11 outside surgeons who get paid a 90-day global.
12 Everyone else in health care delivery on the
13 physicians' side is getting paid per diem for
14 what they do on a daily basis.

15 So in order to modify behavior,
16 you need to measure physician resource use and
17 then apply some payment mechanisms or
18 incentives to drive physicians from single
19 widget producing physicians to a more
20 integrated health care delivery system with
21 hospitals, and that's part of what the value
22 modifier will do. And part of the tiered

1 structure -- if you read Title III of this
2 program and the value-based purchasing parts -
3 - will be to provide the highest incentives
4 for physicians who are integrated into ACOs,
5 and the lowest to those who continue to remain
6 in the fee-for-service system, which will have
7 to remain. It's a part of the health care
8 delivery in the United States, and it will
9 take a long time to eliminate that. So there
10 has to be sort of multimodal ways of providing
11 incentives to create those organizational and
12 cultural changes in medicine.

13 CO-CHAIR STEINWALD: Okay, go
14 ahead.

15 DR. BURSTIN: Just one comment,
16 just to recognize that even as a measure is
17 endorsed at NQF, it is only endorsed for three
18 years, quite intentionally, because we
19 recognize that time changes, and knowledge and
20 experience moves on. So we really view this
21 as being sort of the initial set. I think
22 there will likely be a lot of evolution. If

1 you looked at the quality measures, for
2 example, even five years ago, compared to a
3 lot of the outcomes we have now, there's
4 already been that evolutionary change, and I
5 think we need to expect this will happen on
6 the research use side as well. We've got to
7 start somewhere. So I think that was our
8 expectation.

9 CO-CHAIR STEINWALD: All right,
10 then, one last one.

11 DR. GOLDEN: Just to understand
12 the NQF-CMS relationship, technically isn't
13 CMS supposed to use NQF endorsed activity,
14 unless proven otherwise or something? So how
15 does that relate here?

16 DR. BURSTIN: Sure. So NQF is a
17 voluntary consensus based organization; it's
18 a standard-setting organization. So we are
19 the measures that CMS needs to look to first
20 to use as consensus standards. So again, they
21 will look among the many measures we have
22 available and potentially select from that if

1 they have a program for which they need to use
2 it. It doesn't -- what we do is also not just
3 for CMS though. I mean, this is really a
4 diverse set of measures anyone can use,
5 systems, whoever chooses to, purchasers in
6 Bob's world. I mean, I just think having a
7 place to start is important, and it may be
8 that CMS won't even necessarily use these in
9 the short term, while they wait for the longer
10 experience to follow. We just don't know.

11 But I think from where you sit,
12 it's just really important to say, how do we
13 get this moving, how do we get this sort of
14 set of principles in place, get this Version
15 1.0 out there, and gain experience with it.

16 CO-CHAIR STEINWALD: Okay, we
17 will continue the discussion. I think we
18 should excuse Niall.

19 (Laughter)

20 CO-CHAIR STEINWALD: I want to
21 speak for the entire steering committee, and
22 thank you for taking the time that you have,

1 and also any continued guidance for us as we
2 go through our process from you or your
3 colleagues would be much appreciated.

4 MS. TURBYVILLE: Time to dive
5 into the white paper.

6 So certainly within Section 1, a
7 key area that we identified that we wanted
8 agreement from this steering committee and
9 thought -- we tried to do it over the
10 telephone and in person I think it's just best
11 -- there are many definitions of efficiency,
12 but to make sure we get agreement on what the
13 definition of resource use is in the context
14 of this project.

15 Now clearly I heard a call also
16 for a more broad discussion about the white
17 paper, so I'm going to hand it over to the
18 Chairs, and you can see what fits best. But
19 you'll notice in the slides that are in front
20 of you in the manila folder, we have at NQF
21 staff within most of the sections identified
22 key areas that we really hope to get agreement

1 on.

2 That aside, the broader discussion
3 is also certainly welcome and helpful.

4 CO-CHAIR STEINWALD: I'm going to
5 make a suggestion now. Since there are a lot
6 of people around this table, use this
7 convention of putting your tag card up on its
8 edge if you want to say something or ask a
9 question, and then the chairs can do a better
10 job of recognizing people.

11 DR. BARNETT: Isn't there
12 something on our microphone that says request.

13 DR. LEE: It's not hooked up.

14 DR. REDFEARN: It's a placebo.

15 (Laughter)

16 DR. BARNETT: It makes me feel
17 much better.

18 CO-CHAIR STEINWALD: Jack,
19 earlier you started to address this question
20 about what our focus is on, a resource measure
21 is different from an efficiency measure. It
22 seems that we're headed in the direction of

1 developing resource measures, but we need to
2 acknowledge what the difference is between
3 resource measures and efficiency, and the
4 staff have tried to capture that difference in
5 this slide, or these two slides.

6 Do you think they have captured it
7 reasonably well?

8 DR. GOLDEN: Yes. But as -- and
9 I think the world of the staff here. But as
10 Sally introduced this, she started a single
11 sentence which had efficiency and then slid
12 into resource. And I've got no -- I think
13 this definition is good. I think some of the
14 language that's in the paper is good. But we
15 need to be crystal clear in our thinking, if
16 not our presentation, about what the long-term
17 goal is in terms of measuring efficiency,
18 figuring out the value equation in health
19 care, and what this project is capable of
20 doing, which is focusing on how we measure the
21 resources devoted to caring for patients.

22 And we shouldn't be slipping and

1 sliding between language that talks about
2 efficiency and language that talks about
3 resource use. They are separate measures at
4 this point. And that's my only concern.

5 CO-CHAIR STEINWALD: Mary Kay.

6 DR. O'NEIL: So two things, first
7 on the efficiency point, and that is that
8 looking at the equation I think that we are
9 trying inform by this process is the number of
10 inputs or resources utilized per some defined
11 population or group of patients leading to a
12 given outcome, which would be the efficiency
13 I would say, is the only way that the resource
14 utilization data will have value in evaluating
15 things.

16 If we can't compare what this
17 entity putting in these resources here versus
18 this entity putting in this different mix of
19 resources there, then counting resources won't
20 have value. So the resources have to be
21 counted with an eye to efficiency, even though
22 it is a separate process.

1 And then the other thing I wanted
2 I guess from my industry's perspective, for me
3 resource utilization measures are measures of
4 counting. So you have to count office visits,
5 prescriptions, procedures -- whatever you're
6 counting is what the resource issues are. To
7 put some kind of standard dollar value on them
8 I think is dangerous, because costs vary
9 tremendously for all kinds of reasons. Now
10 at some point in time that exercise needs to
11 be done, but if we're counting resources and
12 looking at what resources it takes to properly
13 and efficiently take care of a condition or
14 group of patients, then putting what the costs
15 are has a lot of, like, geographic-specific
16 issues; it has contractually specific issues;
17 it has site-of-service specific issues, and
18 all of that kind of stuff.

19 So if we start putting dollars to
20 things early in the process, we're going to
21 get really, really muddy. Those are my
22 feelings.

1 CO-CHAIR STEINWALD: Jim, and
2 then Tom Lee, and then down --

3 CO-CHAIR LOTZ: Barbara.

4 CO-CHAIR STEINWALD: Barbara was
5 next? All right, go ahead, Barbara.

6 DR. RUDOLPH: I had two comments,
7 one being the resource use also. I agree with
8 the idea that it's really a count of resources
9 used, and then later on more -- as you get to
10 the value equation or the efficiency component
11 -- that you might assign dollars or some type
12 of standardized unit of money to it.

13 Second, somewhere in the white
14 paper it talks about efficiency, and right
15 below it talks about value being weights
16 assigned, the weight preferences assigned to
17 the various components of the efficiency
18 score.

19 And I guess I have a hard time
20 thinking about efficiency being without a
21 value, in the sense that no matter what you
22 are doing, depending on who's doing it, it's

1 going to turn out a little bit different
2 because of their own value preferences. I
3 don't know if you can isolate it. Maybe
4 theoretically you can isolate it -- that
5 efficiency is without any type of value
6 assignment by the parties who are creating the
7 efficiency score. But I just have trouble
8 thinking that that is possible. If somebody
9 has an example, I'd be happy to hear it.

10 CO-CHAIR STEINWALD: So Jim, Tom
11 and Tom.

12 MR. WEINSTEIN: Yes. I think
13 this is going to keep coming up, this issue of
14 efficiency and cost, because they are not
15 always related. And I guess whether you want
16 to use a golf analogy or baseball analogy,
17 somebody can swing efficiently, hit the ball
18 350 yards, but it's not straight, and it's
19 going to lead to another problem, and
20 eventually they won't get to the right score
21 on the hole or the ball game.

22 And yet we all understand the

1 issues of cost. All this is being driven by
2 cost in the sense that people are suggesting
3 we can't afford the health care system we
4 have. So we have sort of agreed to that being
5 on the table. Yet we haven't really
6 demonstrated what efficient care is for almost
7 any condition and then applied the cost
8 scenario to that. And sometimes I worry that
9 we are putting the cart before the horse a
10 little bit, and wonder if we need to do this
11 in phases, to be explicit, to develop measures
12 of efficiency or resource utilization around
13 sort of best practice, with measures of what
14 that looks like, and then applying costs, as
15 they are a differential across systems for all
16 kinds of reasons -- may be a better
17 methodological strategy.

18 And I'm not sure whether others
19 agree with that or not, but at least I'd like
20 to discuss it.

21 DR. LEE: I'm actually finding
22 that by forcing us to read this white paper

1 over and over again, it's been very helpful,
2 because it's made us sharpen our thinking
3 about what we are trying to accomplish. And
4 so what I'm hearing is that we are all seeing
5 that we are not talking about efficiency and
6 value at this stage. We are talking about
7 resource use. We should make it clear that
8 it's a building block that's necessary to get
9 to the phase where we can look at efficiency
10 and value.

11 And the other point I would make -
12 - which I think is resonant with yours,
13 Barbara -- is that we should say that as we
14 put together that building block we have to
15 understand that there are different
16 perspectives on value and efficiency. And
17 there is the purchaser perspective; there is
18 the delivery system that is trying to improve
19 perspective; and that there are going to be
20 different tools in different settings, like
21 there are going to be individual peer pressure
22 tools that folks like me need that are

1 probably never going to be useful to a
2 purchaser, because you can't measure things on
3 an individual doctor basis that are valid and
4 useful in that way for a lot of topics.

5 So I would say, make clear this is
6 a building block and that there are going to
7 be different perspectives, and that we need to
8 have a number of different types of building
9 blocks to prepare for that phase when we get
10 there.

11 CO-CHAIR STEINWALD: So Tom, Paul
12 and Jeff.

13 DR. ROSENTHAL: To weigh in on
14 this theme of sort of cost-versus-efficiency,
15 I'd like to suggest that a criteria for
16 picking a cost metric would be that there is
17 a corresponding outcome measurement that
18 already exists. That would be ideal and
19 preferable. But that we may in fact have
20 opportunities to measure cost in areas that we
21 really don't know anything at all or very
22 insubstantial developed quality metrics, and

1 we should not rule that out. Because we are
2 so nascent in our understanding of how to
3 measure cost and how we should count things
4 that, if we tie ourselves to having a
5 corresponding outcome metric, we may then end
6 up picking cost metrics that are the wrong
7 ones to experiment on.

8 So I think it should be a criteria
9 in the best of all possible worlds to have a
10 corresponding outcome measurement, but the
11 absence of a corresponding outcome measurement
12 should not dissuade us from picking cost
13 measurements that would head us down a path of
14 learning.

15 DR. BARNETT: Yes, just getting
16 back to the slide about resource use measures,
17 what I wanted to address is this issue of how
18 we turn our vector of services into dollars.
19 And the white paper, it seems to me, is a
20 little bit -- it talks about prices, and I
21 think that is careless language. Because --
22 are prices charges? I think it means

1 reimbursement. And I think it would be a
2 mistake for us to take the existing resource
3 base relative value scale as a given, and that
4 that actually does represent cost from the
5 view of the payer. But we think that maybe
6 that it wasn't based on it. It's based on
7 tradition. It's based on politics. It's not
8 really a measure of the resources or the
9 dollars that are being used. What we'd really
10 like to look at is what is the opportunity
11 cost, what is the long range marginal cost,
12 for each of these services that's used in the
13 health care system.

14 And there are vendors that are
15 selling these cost allocation systems used by
16 maybe 5 percent of the health care system to
17 try to actively get their costs attributed to
18 the services, and that we shouldn't just take
19 the existing current fee-for-service schedule
20 as a given. I think that's actually part of
21 the problem of why we are inefficient.

22 CO-CHAIR STEINWALD: Jeff, next.

1 DR. RICH: Yes. I think
2 generally I like the way the conversation is
3 going right now. And in particular I like
4 what Jim said and what Tom said, and I want to
5 reinforce that I completely agree that the
6 charge of the steering committee is to create
7 a building block for resource use measurement
8 which will lead to us understanding what
9 efficiency is to avoid cost. But to
10 personalize it, having sat and run the
11 Medicare fee-for-service program, I could see
12 and understand geographic variation in cost
13 very easily. I know that if DRG-1 is
14 \$300,000, heart failure with L-VADs in New
15 York, and it's \$130,000 in other geographic
16 areas, and I understand those differences in
17 the market, and that there are Medicare basket
18 of market indicators that we use to adjust
19 that.

20 What I didn't understand that is
21 that \$300,000 I was paying for that L-VAD to
22 be implanted in New York, were they using the

1 same basket of resources that somebody did in
2 Idaho, and were they efficient in the way that
3 they delivered care? Because we were
4 adjusting their prices based on their
5 Medicare cost reports and our historical look-
6 back on what it costs them to implant this.

7 What I would like to see come out
8 of the committee is to avoid cost but to give
9 payers, and particular CMS, a tool where they
10 can look at the care, the cost that they are
11 paying for it, and know that those particular
12 providers are efficient based on resource use
13 measurement and the quality that they are
14 delivering for their care.

15 CO-CHAIR STEINWALD: Steve and
16 then Bill.

17 MR. PHILLIPS: Yes. Thanks. I
18 just wanted to follow up, actually, on Tom's
19 point about -- and maybe I didn't understand
20 it completely -- but where you were saying we
21 shouldn't be constrained by whether there are
22 outcomes measures. And I guess I'm trying to

1 understand and need a little more elaboration
2 in terms of how you can evaluate costs and
3 resource use without some point that you are
4 trying to get to as far as an outcome.

5 Was I misunderstanding?

6 DR. ROSENTHAL: No, and I think
7 the example might in fact be the one that was
8 just alluded to about VADs. They are quite
9 good in the NQF domain outcome measures for a
10 variety of clinical areas, but not for 100
11 percent of them. We were chatting earlier
12 about glaucoma care. There aren't in the
13 public domain perfectly accepted outcome
14 measures. And I don't think we should be
15 constrained -- I think it should be a
16 principle that if in fact a cost measure and
17 an outcome measure are already coexisting,
18 that would be a criteria for picking the cost
19 measure, but I don't think we could learn an
20 awful lot about resource utilization by
21 picking something like VADs or glaucoma care.

22 And obviously somebody is then

1 going to have to go back and say, well, know
2 we know how to measure the cost realm of this
3 thing; somebody has now got to do the work to
4 get the outcome measure better understood and
5 in the public domain. That was I think the
6 point I was trying to make.

7 MR. PHILLIPS: Yes. I guess the
8 kind of missing link is, you can't really come
9 to a point where you say this is a deficiency,
10 because you can measure the cost but you don't
11 know exactly where you are trying to get to
12 until you have the outcomes piece.

13 DR. ROSENTHAL: I'm assuming that
14 eventually on anything we would pick to
15 understand the cost framework that somebody
16 then will be able to figure out how to measure
17 the outcomes well. I just don't think we
18 should be constrained on the cost side by
19 saying, well, but there are no good outcome
20 measures for VADs -- which I don't believe
21 there really are. I don't think we really
22 know how to say how the outcomes are different

1 in Idaho versus New York yet. But certainly
2 we could if we decided to use that as the
3 basis for understanding the cost and resource
4 input side of the thing. So that's all I'm
5 saying.

6 CO-CHAIR STEINWALD: Bill, and
7 then Ethan and then Jack.

8 DR. RICH: I want to go back to
9 Paul's comment; I'd like to reinforce Dr,
10 O'Neil's point about -- we should try to use
11 some relative scale as often as possible
12 because the variation of costs, even within
13 regions and among payers. And I think we are
14 going to have to have a hybrid system. If you
15 look at Jeff's analogy of the wide variation
16 of costs for VADs versus macular degeneration,
17 since 2002 the office-based inputs have been
18 standardized, okay, and there is no variation
19 in those relative values. You can do -- there
20 is a \$100 device in the office or a five-
21 dollar, you get paid the same. So there is no
22 difference to society.

1 The problem comes in the facility
2 or the use of device and drugs, and that is
3 where we are going to have to have some
4 standardized adopted Medicare payment for the
5 different drugs and devices. Because
6 certainly in the surgical realm, that's where
7 we see massive variation. And yet some things
8 like the physician side of things, in the
9 office or the facility, are very standardized
10 and have been since 2002. They've been
11 updated. But we are going to have to think of
12 a way of looking at cost variation in drugs
13 and devices, and we are going to have to look
14 at a dollar figure somehow.

15 CO-CHAIR STEINWALD: Ethan and
16 then Jack. Ethan?

17 DR. HALM: Yes. I'm still trying
18 to get my head around -- and I think I'm
19 hearing from the committee, that the scope of
20 this steering committee -- because I worry at
21 the margins that we are trying to blow the
22 oceans, and we are trying to be the efficiency

1 steering committee. And I wonder if it would
2 help -- it's hard enough to get the quality
3 metrics right in the poly steering committees,
4 and then there is this resource steering
5 committee. And I wonder from a process
6 standpoint if NQF is thinking that down the
7 road there would be sort of an efficiency use
8 steering committee, and we just need to worry
9 more narrowly about trying to get the resource
10 use piece right rather than -- right now we
11 are so wrapped up into all the problems with
12 resource use, but resource use in a vacuum
13 doesn't make sense, of course, to other
14 people. It only makes sense if you are a
15 payer. But I wonder if we can sort of
16 constrain -- help us think this through. If
17 there is going to be an efficiency steering
18 committee, then we don't have to -- that's
19 their problem.

20 CO-CHAIR STEINWALD: Jack?

21 MS. TURBYVILLE: So to respond to
22 the question, the scope of this project is to

1 focus on the resource use. We do often have
2 other projects that go on. We focus our
3 projects in on things that are manageable for
4 one steering committee. Our hope would be
5 that we would eventually have an efficiency
6 steering committee that is able to examine and
7 evaluate measures that incorporate outcomes,
8 etcetera, in a sophisticated manner. But we
9 think that right now where we are -- and we
10 are using you to make sure that our assumption
11 is correct -- but where the measurement world
12 is right now, where stakeholders are, that the
13 best kind of value that the steering committee
14 and NQF process could be, would be to focus in
15 on the resource use measures as a building
16 block, as you have heard some of the members
17 comment.

18 CO-CHAIR STEINWALD: Jack.

19 DR. NEEDLEMAN: Two things -- one
20 on this issue of: do we reduce things in some
21 ways to costs. Whether we call it costs or
22 something else, ultimately I think we have to.

1 There is no way to understand the tradeoff
2 between using drugs versus psychotherapy if we
3 are talking about depression, unless we put
4 them into some kind of common metric. We've
5 got lots of different resources that are being
6 used, each of which have their own natural
7 measurement: hours for people's time, dollars
8 or prescriptions for drugs, physical units for
9 different kinds of supplies, but if people are
10 making tradeoffs in the use of supplies versus
11 drugs versus people we will not see that
12 unless we produce some common metric of the
13 resource use.

14 So I think while it's going to be
15 important to look to keep in mind the natural
16 units, we also have to think about whether the
17 resource measures are effectively aggregating
18 them up so we can understand total resource
19 use; so that is one element.

20 The other element is, as we think
21 about the use of the resource measures, we've
22 got two different directions I think we are

1 going to wind up going with, both of which are
2 complementary to each other. One is the
3 issue of: are we getting value for money, the
4 whole issue of what is the outcome, how is the
5 quality, how does that compare with the amount
6 of resources that are being devoted. The
7 other -- which is related to that but is its
8 own analytic effort -- is understanding the
9 sources of variation in resource use. And
10 those are two separate uses of the resource
11 measures that we are going to wind up seeing
12 people use, and whatever we are going to wind
13 up endorsing is going to have to enable people
14 to pursue both research agendas down the road.

15 CO-CHAIR STEINWALD: I want to
16 agree -- it's always a good idea to agree with
17 Jack, just as advice to the rest of the
18 steering committee. I think we use dollars
19 because it's a way of aggregating across
20 different kinds of services. Now how we do
21 that and what adjustments we make to the
22 dollars for differences in what you pay a

1 nurse in Boston versus Iowa City, those are
2 important details. But we can't get away, I
3 think, from dollars as the common metric for
4 aggregating across different kinds of
5 resources.

6 And resource use measures also
7 have a denominator, and that's where all the
8 different kinds of resource measures that
9 we've talked about -- specific services or
10 episodes per capita can be a population of
11 patients or a population at large. So we are
12 talking about measures that have both a
13 numerator and a denominator. Where they fall
14 short of being efficiency measures -- and I
15 think this is kind of what Jack was suggesting
16 too -- is that it's not until you bring health
17 or some other outcome measure into the measure
18 that you've really got a measure of
19 efficiency.

20 So if we are content with
21 concentrating on resource measures, we don't
22 need to worry too much, or at least it's not

1 within our charge to say to the measure
2 developers, well, you have to tell us how this
3 resource measure contributes to the
4 improvement, maintenance or restoration of
5 health -- for example.

6 Tom.

7 DR. ROSENTHAL: And did we agree
8 that cost is not that same as what's paid?

9 CO-CHAIR STEINWALD: Yes.

10 DR. ROSENTHAL: Okay.

11 CO-CHAIR LOTZ: So then if we go
12 back to the specific charge in front of us
13 now, to look at this definition and create a
14 definition that both guides us and the next
15 several pages of the white paper and in the
16 call for measures, what needs to be amended in
17 this definition to reflect our conversation?
18 Is resource use, for instance, a measure then
19 of the costs for various services? Or does it
20 need some structure -- as Bruce suggested, the
21 cost per something -- which becomes the
22 denominator? It seems to me that a lot of

1 our conversations up to this point have
2 struggled with what the task is in front of
3 us. And having allowed us to voice some of
4 that struggle, how do we bring it altogether
5 now in a definition that is going to guide the
6 rest of our day's conversation?

7 CO-CHAIR STEINWALD: Another
8 question, I guess, is -- well, I don't know
9 how close we are to a consensus. The staff
10 needs to tell us that. Do you have enough
11 input on this issue to frame what you believe
12 is the steering committee consensus, or do we
13 need more conversation?

14 MS. TURBYVILLE: I would say no.
15 (Laughter) Because I see some people throwing
16 out the word cost, others thinking to resource
17 use as just the most obvious example. I've
18 heard some say no to dollars, just
19 utilization; others that we understand the
20 weights. So I think it warrants spending the
21 time now to make sure there is some kind of
22 agreement across the steering committee as we

1 move forward.

2 CO-CHAIR STEINWALD: This is
3 pretty fundamental, isn't it.

4 All right. Those who are putting
5 their cards up, you need to have your name
6 facing this direction, otherwise you don't get
7 called on.

8 All right, Mary Kay, Barbara, Bill
9 Golden and Tom, and Jim.

10 DR. O'NEIL: I was not meaning to
11 say we not use dollars. What I was saying is,
12 for us to have a broadly valuable process that
13 we can use in a number of different settings,
14 markets, we need to start with counting
15 inputs, resource utilization, and then have a
16 mechanism by which we monetize it in a given
17 setting.

18 And obviously, to Jack's point, we
19 need to be able to do relative value of
20 different levels of input -- we need to do
21 that. But I think fundamentally our product
22 needs to be able to accurately count inputs if

1 we're really going to do resource measurement.

2 CO-CHAIR STEINWALD: But -- but
3 summarize them using dollars as a common
4 metric, once we've got them.

5 DR. O'NEIL: Well, I mean there's
6 maybe different purposes for that, so we
7 should be able to do both. But I think the
8 fundamental measure is that we can accurately
9 count what resources have been used, I guess,
10 by a delivery system, whether that's a single
11 doc or something else, on a given population.

12 CO-CHAIR STEINWALD: Okay.
13 Barbara?

14 DR. RUDOLPH: I guess I was just
15 planning on speaking to the need to say:
16 according to some sort of population or sample
17 of a population. Otherwise it's just kind of
18 hanging out there, you don't know what you are
19 applying it to.

20 CO-CHAIR STEINWALD: Okay. I
21 think -- Bill Golden.

22 DR. GOLDEN: Yes, multiple

1 thoughts. But getting back to Jack's comment,
2 has the staff -- and I have a followup -- has
3 the staff looked at the thinking that went
4 into the whole RBRVs, because that broke
5 resource use down into different components.
6 And I only have two with that kind of thought.
7 Have you looked at that just from the
8 documents, to look at that kind of elements of
9 what goes into the price of a charge?

10 MS. TURBYVILLE: Yes, we thought
11 about how different resource use units are
12 defined or weighted. But I think our thinking
13 was that some of that would come through,
14 depending on the measure and the perspective.
15 And Jennifer, maybe you want to add to that,
16 but it certainly was part of the thinking or
17 consideration.

18 MS. PODULKA: We wanted to make
19 sure that the measures -- remember, again,
20 they are not just going to be used by CMS, so
21 many other payers rely on a similar RBRVs
22 system. But we want to ensure flexibility.

1 We need to potentially endorse measures, but
2 different payers, different purchasers, can
3 use those for different purposes, and it
4 possibly is entirely valid for a payer who
5 negotiates very different payment rates or
6 prices with different providers in their
7 network to continue to carry along that
8 information. So you might provide fewer
9 resources, considering RBRVs, but have them
10 negotiated at a much higher price point, and
11 thereby overall cost more than comparative
12 physicians.

13 DR. GOLDEN: And the other
14 thought I had was as we go through this, early
15 in the meeting we talked about the world is
16 maybe going away from solo fee-for-service
17 into more aggregate type of mechanisms. And
18 that has sort of a bearing, because as we
19 consolidate or we get into more global kind of
20 payments, you end up not having to deal with
21 as much complexity, because then the local
22 administration has to deal with how to do its

1 own metrics, and then you can deal with all
2 the uniqueness of Omaha versus Sacramento.
3 And that is not our problem; it's their
4 problem. That's I guess how the DRGs worked
5 in many ways. So as we go through this, do we
6 focus on a disease -- which gets very micro --
7 or do we focus on patients? So, patients with
8 diseases, and then you can figure out how a
9 system can manage patients with multiple
10 diseases, and you just get costs. So it seems
11 we want to work toward a simplified system
12 rather than getting real detailed, because I
13 think we can get ourselves lost in the weeds
14 very quickly.

15 CO-CHAIR STEINWALD: Tom, Steve,
16 Jim and then Jack.

17 Tom.

18 DR. ROSENTHAL: I actually think
19 there is consensus. And I think Jack
20 described it pretty well. We can go around
21 the table one more time. But it seems to me
22 the consensus is: count first, monetize

1 second. And if one were trying to sort of
2 tweak the statement that you've got there, it
3 says resource use measures are measures of
4 input, usually in terms of dollars. And I
5 think if you in fact just rewrote that to talk
6 about this concept of count first, monetize
7 second, and that the monetization is a sort of
8 standardized thing that is separate and apart
9 from the markets, you will have captured what
10 I believe is the consensus of the group,
11 unless I'm missing something.

12 CO-CHAIR STEINWALD: Steve, and
13 Jim and then Jack.

14 MR. PHILLIPS: Yes. I was just
15 going to put out there that I think this does
16 capture, as has been said, what generally is
17 out there that you can look at as far as
18 measuring resources. I think the value of NQF
19 going through this is to draw upon creativity
20 and innovative thinking beyond these. But I
21 guess the principle I would raise to maybe add
22 to this is just that the challenge, I think,

1 is going to be that anything that is maybe
2 more creative in terms of measuring resources,
3 can it be consistently applied across provider
4 groups or physician offices, let's say. You
5 may have some of the more sophisticated groups
6 that can do more sophisticated tracking of
7 their costs. But is whatever measure that is
8 being applied something that can be
9 universally or at least widely used? CO-CHAIR

10 STEINWALD: I think that is one of your
11 global principles. Yes.

12 Okay, I have Jim and then Jack.

13 MR. WEINSTEIN: I was just
14 thinking to keep this in the context of the
15 value equation so that we don't get off on too
16 many tangents, but quality will be important,
17 at some point those measures will fit into
18 this resource, which I'm going to call the
19 denominator here. And I like the notion of
20 counts and then monetize, as was suggested,
21 when you do diagnoses, because people have
22 specific -- multiple -- diagnoses more often

1 than not, especially in the Medicare
2 population. Or do you do it in a capitated
3 sort of population base? But I think the
4 context as suggested is important. People who
5 have to manage populations tend to do that
6 much more efficiently when they have fixed
7 dollars than people who don't. So I think
8 that matters.

9 But I think that if we as a
10 committee could stay within the value equation
11 and just assume that we are going to deal with
12 resources in the denominator around counts and
13 then monetize, then you start to put the
14 pieces together. Because as the subgroups
15 come together around the different domains --
16 of cardiac or whatever -- they are going to
17 want to understand value in terms of quality.
18 Because they are going to argue, we are doing
19 something really good as measured by X. And
20 so we want to be able to work with them to fit
21 these pieces together at the end of the day,
22 so that is the comment.

1 CO-CHAIR LOTZ: So just to jump
2 in to the list here, adding some comment about
3 they should be able to use two, linked with
4 quality in some respect, which is missing
5 still from this definition; not something we
6 acknowledge we are going to work on over the
7 next day and a half, over the next couple of
8 months, but clearly should be reflected in the
9 definition as this guide is moving forward.

10 You're shaking your head?

11 MR. WEINSTEIN: Yes, I mean you
12 have to leave quality as the numerator however
13 we're going to measure it, just to stay
14 consistent with everybody else's work, IOM,
15 the Congressional language, etcetera,
16 etcetera. To leave quality out would, I
17 think, make the subgroups and the various
18 subspecialties very uneasy if it's all about
19 eventually cost.

20 CO-CHAIR STEINWALD: Well, I
21 think it depends on what you mean by leaving
22 quality out. My own view is that, when one

1 looks at performance measures, one --
2 historically, we've looked at quality measures
3 more than cost measures, and now maybe they're
4 on an equal footing. Many payers evaluate
5 providers on a cost dimension and a quality
6 dimension separately and have separate
7 thresholds that have to be met for each, as
8 opposed to having a composite measure. And I
9 could imagine that our work says something
10 about how our resource measures should be used
11 in combination or extended to incorporate
12 quality. But in and of themselves, not do
13 that.

14 MR. WEINSTEIN: That's the
15 notion, just that people realize we haven't
16 forgotten about that.

17 CO-CHAIR STEINWALD: Okay. Jack.

18 DR. NEEDLEMAN: Some of what
19 we're doing here is inherently complex, and I
20 think we are going to have to carry some of
21 that complexity through our thinking for a
22 while. I'm a little concerned about premature

1 closure to get clear definitions when in fact
2 we are not dealing with clear concepts.

3 So we've talked about the prices
4 that are charged for the final service may not
5 be a good measure of resource use; I've got no
6 problem with that. But we are also going to
7 be talking about input prices for the things
8 that are purchased in order to deliver that
9 care, and there we are going to be dealing
10 with the concept of prices.

11 We've talked about payments not
12 necessarily as a good measure of resource use.
13 But we often standardize across different
14 places by using the same payment rates
15 regardless of -- even as we make adjustments.
16 So there is a standard DRG rate, even though
17 the actual DRG rate paid to hospitals in
18 Manhattan, New York, are different than the
19 amounts we pay to hospitals in Manhattan,
20 Kansas, because of the wage differentials,
21 which are input price differences.

22 Sometimes when we are trying to

1 compare resources we use standardized costs to
2 try to get out some of the regional
3 differences. But when we do that, we ignore
4 some of the reasons for differences of
5 resource use. A community in which advanced
6 practice nurses, nurses that are doing
7 basically primary care, are 90 percent of the
8 cost of primary care docs, and where nurse
9 diabetes educators or other diabetes educators
10 are 40 percent of the cost of primary care
11 docs, is going to have a very different mix of
12 primary care physicians, advance practice
13 nurses, and nurse educators than a community
14 where you've got the advanced practice nurses
15 being 70 percent of the cost of primary care
16 docs, and other nurse educators or diabetes
17 educators being 60 percent of the cost of
18 primary care docs.

19 Those differences in the relative
20 cost of inputs are going to affect the
21 decisions about what the mix of inputs are
22 going to be. And when you apply standardized

1 pricing to each of those inputs, you lose
2 that.

3 So I think we're going to wind up,
4 as we go through this process, having to be
5 thinking about what the advantages are of
6 using standardized input prices or
7 standardized costs for comparisons, versus the
8 actual costs for different communities in
9 comparison. And that, as I said -- I think
10 some of the complexity we have in thinking
11 about this, we just are going to have to live
12 with and carry through, rather than trying to
13 reach premature closure on which group to go
14 in.

15 CO-CHAIR STEINWALD: Fair enough.
16 I've been told it's time for a break.
17 Dolores, why don't you take the last comment,
18 and then we'll come back and be very consensus
19 minded.

20 MS. YANAGIHARA: Actually, Jack
21 just touched on what I was going to talk
22 about. But I feel uncomfortable saying that

1 we should take actual payments made off the
2 table, because I think there is definitely a
3 place for that. And so I'm fine with saying
4 count first, monetize second. Two ways to
5 monetize: standardized pricing, actual
6 pricing. But I think there is a place for
7 each of those, and to say we are not going to
8 go into actual pricing at all just doesn't
9 make sense, because there are times when that
10 is really important.

11 So to acknowledge there are two
12 different ways, but to not completely take it
13 off the table.

14 CO-CHAIR STEINWALD: Okay, how
15 much time do we have? Fifteen minutes. All
16 right, this will be an 11 - 15 minute break.

17 (Whereupon the above entitled
18 matter went off the record at 10:34 a.m. and
19 resumed at 10:50 a.m.)

20 MS. TURBYVILLE: We'll get
21 started again. At 12:10 we do open this call
22 up for public comment and questions. So I

1 want to get us started up again so we can
2 finish what we hope to get done this morning,
3 if at all possible. I think we've made good
4 progress so far. So I'm going to go ahead and
5 hand it back over to Doris and Bruce.

6 RESOURCE USE MEASURE EVALUATION CRITERIA

7 CO-CHAIR STEINWALD: Well, the
8 consensus out during the break is that we are
9 close to a consensus.

10 (Laughter)

11 So Sally has put something up for
12 us to look at, so why don't we take a look.
13 Then if we want to comment on it positively or
14 negatively, please do.

15 MS. TURBYVILLE: Just to note, I
16 didn't try and change the actual definition
17 too much in that short amount of time. What
18 I did try to do is capture the approaches that
19 we will then want to make sure the definition
20 clearly expresses. But I think we have a few
21 minutes; if there are some wordsmithing
22 suggestions, that's completely welcome.

1 MR. MARKUS-HODIN: Could you
2 enlarge this slide a little bit?

3 MS. TURBYVILLE: Oh, sure.

4 MR. MARKUS-HODIN: Thank you.

5 CO-CHAIR LOTZ: And we can, as
6 was suggested, move forward in our
7 conversation and then revisit this later on,
8 revisit it over the next couple of days
9 through email.

10 CO-CHAIR STEINWALD: Mary Kay.

11 DR. O'NEIL: Well, I like this,
12 and I think the resource inputs as the
13 numerator, the population -- whether it be a
14 geographic population or a single physician's
15 population -- as the denominator, makes
16 perfect sense, but the product has to be the
17 value of the health outcome. Right? The
18 input to the population leads to a result, and
19 that result is better or worse health for
20 value, right? So that's how we're relating --
21 this is a building block of the equation for
22 value.

1 CO-CHAIR STEINWALD: A building
2 block?

3 DR. O'NEIL: Yes.

4 CO-CHAIR STEINWALD: Dolores, you
5 still have your card up? No?

6 Okay, anyone else? Go ahead.

7 DR. RICH: I think I was just
8 reflecting on what Jack said earlier, that
9 some accounts of resources I would see as
10 inputs, and some inputs are already monetized,
11 for instance, wages. So there may be a gray
12 zone between one and two, where some resources
13 are already monetized. And we'll have to deal
14 with how you demonetize something. Do you
15 take the cost of labor and turn it into an
16 FDE? And is that the resource that we're
17 going to look at, number one. And then
18 monetize it in order to compare across
19 providers.

20 CO-CHAIR STEINWALD: Tom.

21 DR. LEE: The truth is, I think
22 we need them all. I think that -- in my

1 organization, which is trying to improve but
2 also dealing with the marketplace, being
3 criticized in the marketplace, we basically
4 are using all of the measures on the spectrum
5 of measures that are described later on in the
6 white paper, and we use them monetized, non-
7 monetized. So I think there are different
8 customers for all of the different frameworks
9 that we might consider here. And I think
10 actually one of the best contributions we can
11 make is help people understand which
12 structures are most useful and appropriate for
13 which settings.

14 CO-CHAIR STEINWALD: Based on
15 that, would you want to modify the number two,
16 and monetize as appropriate or -- ?

17 DR. LEE: Well, that is a good
18 point, because there are different approaches
19 to monetize, what you adjust for -- what you
20 adjust for like, do you adjust for GME and
21 teaching hospital status? People at teaching
22 hospitals say, yes, of course you should.

1 Other people say, we don't care. And both
2 perspectives are understandable.

3 CO-CHAIR STEINWALD: Right, we
4 don't care because you cost too much.

5 Anyone else? Oh yes, Ann, sorry,
6 and then Paul.

7 MS. HENDRICH: I just have a
8 question about number one, which is the count
9 of resources. If it assumed that that is
10 across the environments of where care is
11 provided? Because currently I think that's
12 one of our greatest challenges -- that it's in
13 a very defined portion or episode of illness
14 within that continuum, and we really can't get
15 to number two and the outcomes, as we've been
16 talking about. So that counter resources
17 definition, how are we viewing that?

18 CO-CHAIR STEINWALD: Barbara, you
19 were an advocate for that. Go ahead.

20 DR. RUDOLPH: Yes. I wasn't sure
21 in the paper whether or not it was about --
22 all of this was about within an episode, or

1 whether it was more broadly aimed. And if
2 it's within an episode, then he could say
3 resource use within an episode. Otherwise,
4 then somewhere along the line you define who
5 the population is and the time period covered.
6 But I'm not sure how to fix that.

7 CO-CHAIR STEINWALD: Well, I'm
8 for broad-based, personally. And I think the
9 way we've got it there, it seems to me, allows
10 for a lot of different applications of the
11 concept of resource measurement. And the hell
12 part of it that you are referring to, Ann, I
13 think is down the road a bit, or up to the
14 measure developers: if you want to use the
15 measure for this purpose, here's how. At this
16 stage, I think we're at a higher level than
17 the hell.

18 Jim.

19 MR. WEINSTEIN: The only thing I
20 would add is, I think we all would say the
21 people are going to do the measures, et
22 cetera, what are they going to adjust for?

1 That will be a big question. And so just
2 "with appropriate adjustments" somewhere in
3 this will be important.

4 CO-CHAIR STEINWALD: Well, the
5 monetizing -- the adjustment can be, it seems
6 to me, at any level. But why don't others
7 contribute? Jack and then Tom.

8 MR. BOWHAN: The way it's written
9 now -- with "count and monetize resources" --
10 I don't know if there is supposed to be an
11 "or" in there. And to Tom Lee's point, this
12 is supposed to be kind of high level, right?
13 And we haven't figured out what the best way
14 to go is, whether it's counting units or it's
15 dollars. So can there be an "or" in there --
16 that the resource measures are inputs of
17 dollars or units of service? So we cover the
18 options that people want to go down with
19 building measures, rather than saying it has
20 to be one way or the other.

21 CO-CHAIR STEINWALD: Tom.

22 DR. ROSENTHAL: I'm assuming also

1 that there are going to be a variety of other
2 principles added to this, like attribution and
3 risk adjustment, and a variety of things that
4 we do not have to capture in this definition.

5 And back to your point, Bruce --
6 it seems at this stage we could continue
7 probably to sit here all day and wordsmith
8 this thing, but maybe to no particular -- the
9 marginal utility of improvement here is going
10 to decline pretty rapidly.

11 CO-CHAIR STEINWALD: Steve.

12 MR. PHILLIPS: I hope this isn't
13 a decline. (Laughter) Or a wordsmith. But
14 maybe more of a conceptual thought. I guess
15 when I think about what we're trying to get at
16 here, there are situations where maybe it's
17 not so much of an input count or cost as, say,
18 you've got a piece of expensive equipment that
19 is sitting there, otherwise would be unused,
20 maybe to test the use of it is not that
21 necessary. But the real resource use is in
22 the payment that's made, for what may

1 otherwise be a rather low marginal cost. So
2 I don't really see that fitting in there, but
3 I just throw it out there -- that it's not
4 necessarily an input in cost or count, but
5 it's a system cost, as far as the payment is
6 made.

7 DR. HALM: Sort of a capital
8 expenditure.

9 MR. PHILLIPS: Well, the capital
10 expense may actually be minimal. So your
11 input cost is minimal, but there is a payment
12 that's made for a test that maybe doesn't have
13 significant marginal benefit.

14 CO-CHAIR STEINWALD: David. Do
15 you want to introduce yourself?

16 DR. PENSON: Sure, my name is
17 David Penson. I'm a urologist by training.
18 I am at Vanderbilt and head our Center for
19 Surgical Quality and Outcomes Research. And
20 I'm sorry I was late.

21 My comment is just, I don't see
22 counting the resources and monetizing the

1 resources - I think we are building consensus
2 here - as mutually exclusive. And since we
3 are trying to be at this sort of very high
4 level overview the question is when would you
5 use one or when would you use the other. And
6 it strikes me that what we are really trying
7 to do here is come up with measures that are
8 broadly applicable across populations. And
9 maybe that's the verbiage we need to add. I
10 know we are wordsmithing, but I think that
11 people would prefer to have counts, because
12 costs are different between say Nashville and
13 New York. But the fact of the matter is you
14 want to be able to make comparisons. So maybe
15 the idea here is to wordsmith it in such a way
16 that it basically says to make it broadly
17 comparable across populations, if that
18 resonates with people.

19 CO-CHAIR STEINWALD: Any
20 resonating in the room here? Since there does
21 seem to be a consensus that you don't always
22 need to monetize then maybe you'd add a little

1 bit of language that says monetize it if
2 necessary or desirable; something like that.
3 And then add the broad usage concept, and we
4 might be done. What do you think?

5 I don't know that we need all of
6 our refinement right at this moment.

7 MS. TURBYVILLE: No, but I'm just
8 trying to make sure I capture some of this
9 final silence of resonation.

10 CO-CHAIR STEINWALD: All right.

11 Tom has something.

12 DR. ROSENTHAL: I just want to go
13 back to the note for a second. Because I
14 agree as a principle the resource use is a
15 building block to bring us closer to value or
16 efficiency, but that we may select measures
17 that don't yet have a significant quality
18 component that we currently understand to be
19 developed later. So I don't want this thing
20 to be again implying that we can only select
21 cost measures for which there are existing
22 well developed quality measures.

1 MS. TURBYVILLE: And we will look
2 at all the principles together. So this is
3 just to note that there is this principle, an
4 opportunity to have the outcome portion, and
5 then also as the group discusses it whether or
6 not to add this other idea to those
7 principles.

8 CO-CHAIR STEINWALD: Are we good
9 to go? Okay, let's move on.

10 MS. TURBYVILLE: Let me hit save.

11 (Laughter)

12 Okay, so I think the next portion
13 of the discussion we were hoping to have the
14 steering committee focus on was what is
15 section two, I believe, or three, which is
16 looking at the real world implications. We
17 also talk about other NQF efforts that are
18 ongoing to help drive home this idea that we
19 realize that we are just focusing on one
20 portion of some very important things that
21 need to be grappled with.

22 And then kind of this conceptual

1 model that we put forth about the approaches
2 to resource use measurement and what they
3 span, and I think it makes sense to talk about
4 this in the context of what we've heard from
5 the definition discussion here today as well.
6 So clearly all of section two and any tie-
7 backs et cetera, are open to comment. But
8 this is an area that we really wanted to make
9 sure the steering committee felt comfortable
10 with our final model, what do we need to add
11 to it, delete, et cetera.

12 CO-CHAIR STEINWALD: Comments.

13 Ethan? I'm sorry, are you going to make your
14 first?

15 CO-CHAIR LOTZ: Well, you had
16 wanted me to drive that section, so -

17 CO-CHAIR STEINWALD: Oh, yes, yes.

18 CO-CHAIR LOTZ: But you can drive
19 it.

20 CO-CHAIR STEINWALD: No, no.

21 CO-CHAIR LOTZ: You're on a roll.

22 CO-CHAIR STEINWALD: No, I'll

1 listen this time.

2 CO-CHAIR LOTZ: All right. I'm
3 shorter though, so that might be a little bit
4 of a challenge.

5 DR. HALM: So in thinking about
6 the continuum, in the document there I'm
7 wondering if there is a piece of the continuum
8 between per capita and per episode that we may
9 want to articulate in the document? People
10 talk about diabetes care for a year or health
11 care for diabetics for a year. And I often
12 think per capita is the big picture smoothie
13 of Medicare spending per beneficiary in a
14 year. And so I'm wondering if other people
15 sort of think where that kind of construct of
16 diabetes care for a year, or care of a
17 diabetic, for a year, fits in that continuum?

18 CO-CHAIR LOTZ: Some of the
19 background reading looked at it from an acute
20 and chronic point of view. But I'll just
21 throw that out there. Bill, you're next.
22 Bill, you didn't turn your table tent, but

1 fortunately I know you.

2 MS. TURBYVILLE: And just
3 quickly, apparently some people on the phone
4 are having a hard time hearing us, so if you
5 can remember to speak as close to the
6 microphone or closer to the microphone that
7 would be helpful. Sorry for the interruption.

8 DR. GOLDEN: It just helps me as
9 we go through these technical documents, and
10 your eyes start crossing, I'd like to hear a
11 very succinct distinction between per patient
12 and per capita, a little example.

13 CO-CHAIR STEINWALD: I'll offer
14 one. I think we're going to run into how the
15 terminology in the field has developed. Per
16 capita as I understand it in the Medicare
17 context was a term that was used to contrast
18 with episode where a lot of the investment had
19 already been made, and for the most part it
20 refers to a population of patients, whereas
21 we're also interested in per capita being a
22 population at large or a population served by

1 a health plan, or the population of Medicare
2 beneficiaries. So there are two kinds of per
3 capita I think that are of interest. And
4 whether we need to distinguish them with
5 different terms or not I'm not sure.

6 DR. GOLDEN: I think that the
7 document will be strengthened for other
8 readers by having a little box distinguishing
9 the two. Because I think it's not clear, it's
10 still not clear, when you go over that.

11 Because you start saying, per capita, you
12 start talking populations and it gets real
13 blurry for me. I'm thinking one is a disease
14 state and the other is more global in terms of
15 multiple disease states. Is that correct, or
16 am I wrong there?

17 CO-CHAIR STEINWALD: Line 277.

18 DR. GOLDEN: Two seventy seven?
19 For example per patient measures may be the
20 best choice. Physicians performance for the
21 patients. Again, I'm having a hard time
22 distinguishing whether it's a disease state

1 versus a population within a practice. I'm
2 not sure.

3 DR. BARNETT: So what I read that
4 to mean was per capita was per covered life,
5 and per patient was per covered life that
6 actually came to see the doctor that year, and
7 that was the jargon that was in the document.

8 CO-CHAIR LOTZ: Barbara.

9 DR. RUDOLPH: I just want to
10 remind everyone that there are going to be
11 other users. For example a number of the
12 states are now beginning to collect all payer
13 data systems that cross plans, cross Medicare,
14 cross Medicaid, et cetera. And that we have
15 to really think about not just thinking about
16 specific plan populations or specific payer
17 populations, but across the population as
18 well.

19 CO-CHAIR STEINWALD: I think Bill
20 wants a return.

21 CO-CHAIR LOTZ: Bill, are you up
22 again?

1 DR. GOLDEN: The other question I
2 have is on lines 253 to 255. You have an
3 interesting statement that says, relying on
4 either measure alone could mask differences
5 between physicians and even allow gaming by
6 affecting the physician practice pattern, such
7 that it generates more discrete episodes to
8 appear more efficient on a per episode basis.

9 Help me out with that. I would
10 think that if you built the concept of time
11 into the concept of an episode you would avoid
12 that problem. So I'm a little confused as to
13 why episodes would necessarily make somebody
14 look more efficient if he has multiple
15 episodes, if you have time built into it.

16 CO-CHAIR STEINWALD: The back
17 story here, as I understand it, and CMS, you
18 can contribute if you like, this derives from
19 some work that MedPAC did on resource
20 measurement in episodes where they were
21 contrasting different metropolitan areas. And
22 their initial measures showed Miami to be

1 significantly more efficient if that is the
2 right word than Minneapolis. And the second
3 level of analysis was, well, that's not
4 possible, so what's wrong with our analysis.
5 And it turned out there were many, many more
6 trivial episodes in Miami than there were in
7 Minneapolis. So it was partially a
8 recordkeeping and coding phenomenon that led
9 MedPAC to decide that putting all of one's
10 eggs in the episode basket was not a good idea
11 because it could lead to misleading results.

12 And that's another reason I think
13 that CMS, while the Medicare improvements,
14 MIPPA, required CMS to develop physician
15 feedback measures based both on episode
16 measurement and what we are calling per capita
17 measurement, in part because of the growing
18 belief that either approach could contribute
19 information that would supplement the other,
20 and provide - and in fact -- I know I'm
21 jumping around, but the document that the
22 staff sent us on CMS' report on their early

1 experience with physician feedback has both
2 per capita and episode measures constructed in
3 a way that it looks like both contribute to
4 the profile of the physician in a way that
5 neither by itself would accomplish.

6 DR. GOLDEN: But a followup, was
7 that a problem though of the notion of using
8 episodes or in the definition of an episode,
9 because I was on a committee with Jim that we
10 talked about what is an episode. And unless
11 you expand the timeframe of the episode, you
12 might conclude that, I don't know, unless you
13 have multiple different diseases.

14 DR. LEE: From the cardiology
15 examples I know well is that in Miami, where
16 they have a low threshold for catheterizing
17 people, that leads to creation of a tremendous
18 number of episodes of unstable ischemic heart
19 disease, of fairly straightforward patients
20 who are basically in and out very quickly. So
21 it's low cost per episode. But they just have
22 many, many more episodes than anywhere else in

1 the country, or many other places in the
2 country.

3 CO-CHAIR LOTZ: Jeff.

4 DR. JEFFREY RICH: I agree, and
5 another example is heart failure. So if you
6 are looking at the cost for heart failure as
7 we did, it's huge. So to become more
8 efficient you discharge your patients earlier
9 but admit them more often. So if you look at
10 the total cost of heart failure over a year -
11 so the point here is you need to have a time
12 element. And this is just an example of
13 racing too fast and you get beyond where you
14 want to be.

15 CO-CHAIR LOTZ: Ethan.

16 DR. HALM: So between per capita
17 and per episode can we add per condition.
18 Because you have per procedure at the end, but
19 per condition would capture some of the
20 chronic disease care that people are talking
21 about now.

22 DR. LEE: And it's not just

1 disease, but it's also like the high risk
2 population, like the dual eligible population
3 which are in PMPM arrangements in many
4 populations. So there is something in
5 between.

6 CO-CHAIR LOTZ: Mary Kay.

7 DR. O'NEIL: I think some of the
8 problems - maybe I'm not understanding this
9 correctly - are if you are counting by how
10 many procedures are done per patient with a
11 condition, versus how many times a given
12 physician or health care system does the
13 procedure to people with that diagnosis, we're
14 going to come up with somewhat different
15 numbers, right?

16 CO-CHAIR STEINWALD: But part of
17 the problem there is that the frequency of the
18 diagnosis is not independent of the propensity
19 to treat.

20 Well, guidance to staff, it sounds
21 like some elaboration of this continuum would
22 be helpful. Do we need the per

1 hospitalization there as a separate element on
2 that. It seems to me that is covered by per
3 procedure - in my mind it is at least.

4 DR. O'NEIL: If you define a
5 hospitalization as a procedure, but for
6 medical conditions that's the part that gets
7 muddy and has the highest degree of
8 variability.

9 CO-CHAIR LOTZ: I think what you
10 are looking for is per some sort of an event
11 that is smaller than an episode, or some
12 building block that perhaps leads into a
13 episode.

14 Tom.

15 DR. ROSENTHAL: Well, these also
16 get into to whom you are attributing these
17 things. So there is this cross intersection
18 with attribution that it may be at the end of
19 the day that there will be hospital-oriented
20 kinds of things that will want attribution,
21 and then the per hospitalization thing will
22 make sense. In the absence of that it may not

1 make sense.

2 CO-CHAIR LOTZ: Jeff.

3 DR. JEFFREY RICH: That's where I
4 was confused was, what's the difference
5 between per episode and per hospitalization?
6 I always think of episodes of care at least in
7 cardiovascular disease as hospitalizations.
8 And so is hospitalization part of an episode,
9 or is an episode part of a hospitalization?

10 CO-CHAIR LOTZ: Bill.

11 DR. GOLDEN: I'm a little
12 concerned, and again, I'm going to flip it
13 back at Jim also, because the committee -
14 there was a previous efficiency steering
15 committee. We got it, and there's a white
16 paper that NQF published that broadens the
17 definition of episode considerably from what
18 Jeff just said. And it talks about
19 timeframes, and getting away from acute
20 events. And I think we're in conflict with
21 what was developed in the previous workgroup.

22 MR. WEINSTEIN: I also think the

1 Institute of Medicine did the same thing with
2 some other language around the value equation,
3 quality over cost over time, and to save that
4 longitudinality. And I think the notion is
5 there are a lot of procedures that are
6 hospitalized today, more and more even in
7 cardiac. So I don't know if that captures
8 it. But this issue of time is important, and
9 I think in the text here at least we put
10 diabetes as a one year for the episode
11 potentially. I mean in that time period there
12 are going to be a lot of measures and
13 utilization of resources. And is that an
14 episode? Is that per episode? Is that per
15 procedure? Is it per capita? I mean all of
16 those things are sort of a continuum, right?
17 That's what I thought this line was, was
18 potentially a continuum of services. I didn't
19 think of it as all different. Because you are
20 looking at per capita expenditures. For
21 somebody who may have had one procedure, or
22 one hospitalization, or multiple

1 hospitalizations, or multiple episodes for
2 different diseases.

3 And then there is a per capita
4 spending on all of that for that person over
5 time. Is that not what you mean by this?

6 MS. TURBYVILLE: I think that is
7 right. We are trying to show the breadth of
8 how resource use measures may present
9 themselves for the endorsement process, but
10 not to say that a particular patient isn't
11 going to be within a per capita, or that you
12 are not going to look at episodes. I think we
13 were actually trying to be more broad than
14 narrow in how we are bucketing them.

15 MR. WEINSTEIN: And the
16 efficiency group that David and I were on, you
17 actually sent that paper out as well, which
18 sort of captured some of this language. So I
19 agree it should be similar.

20 CO-CHAIR STEINWALD: I think if
21 the message here is that the - that resources
22 measures can be broad based, they can be very

1 discrete and narrow. They can at the other
2 end be oriented to the care of entire
3 populations, then what we put on the bar
4 doesn't matter that much. And whatever we put
5 there, actually it should be consistent with
6 what NQF has developed in the past.

7 CO-CHAIR LOTZ: Now is this
8 intended to have the resource use measure
9 developers assign themselves into one of these
10 buckets? Or is this purely for
11 conceptualization for the reader of this white
12 paper?

13 MS. TURBYVILLE: I think in the
14 end we are going to need to know what kind of
15 resource use measure they intend for us to
16 evaluate. But potentially - and Jennifer, do
17 you want to add something to that?

18 MS. PODULKA: Well, I think it's
19 going to be helpful to give a signal to the
20 measure developers as to what we might be
21 looking for. It's going to be helpful to the
22 steering committee as well, once you have

1 those measures submitted and you are
2 considering issues like best in class. A per
3 capita measure at one end of the continuum
4 wouldn't necessarily compete with or crowd out
5 a per procedure measure at the other end of
6 the continuum. So you might want to sort the
7 measures you get into buckets, according to
8 the continuum, and then compare them just
9 within the buckets. Because you might want
10 measures from different buckets.

11 CO-CHAIR LOTZ: Mary Kay. Some
12 of these table tents are still up from before.
13 Jeff, is yours up new? Or you just want to
14 continually be up, is that what you're -

15 DR. JEFFREY RICH: No, I put it
16 down, and I put it back up. So all the way to
17 the right is per procedure, also per
18 encounter? I mean procedure sounds to me like
19 a visit to a physician, or a surgeon. But an
20 encounter? Is that where a visit to your
21 family doctor would be, at the very far right?
22 I don't see where on a continuum that would

1 go.

2 MS. TURBYVILLE: In my experience
3 it's often part of the definition of a measure
4 that they submit, like a patient must have had
5 an encounter. But if there were a measure
6 like that it would fit somewhere on that
7 continuum. And I think you're right, but I'm
8 having a hard time thinking of an example.
9 You mean just a count of encounters?

10 (Simultaneous speakers.)

11 DR. JEFFREY RICH: Just going to
12 your gynecologist for your annual. That's an
13 encounter, isn't it?

14 CO-CHAIR LOTZ: Paul.

15 DR. BARNETT: Just trying to
16 understand the context of this, we have in the
17 white paper this thing about applying the
18 unitive measurement and unitive measurement.
19 And it was a little bit hard to understand.
20 In the interest of transparency might be worth
21 thinking about, talking about services and -
22 it was previously the numerator, previously

1 the denominator. And I found that a little -
2 the numerator and denominator actually I
3 understood. (Laughter) But it is sort of
4 like services - and these are sort of what
5 we're talking about, are they outputs? I'm
6 just thinking that we need to have a little
7 bit better jargon to make it easy for people
8 to understand. So I don't know if these are
9 approaches for measuring resource use as much
10 as they are the buckets that we put the
11 services into, the denominator.

12 CO-CHAIR LOTZ: Bill.

13 DR. GOLDEN: Instead of asking a
14 question, I was going to say, I would hope
15 that our steering committee could make
16 comments on preferred measures that we would
17 like to receive. And I think as we go toward
18 the right side of that slide, we are getting
19 into the weeds. And frankly, I don't think,
20 given the past work the NQF has done, I don't
21 think we really want to encourage cost per
22 cath, or cost per ER visit. I think we really

1 want to get more measures looking at broader
2 measurement and management of conditions. And
3 I would be reluctant to endorse multiple
4 buckets that get into a lot of these very
5 small, very narrow events. I think we'd end
6 up spending a lot of time with measures that
7 are not that interesting and potentially not
8 that useful.

9 CO-CHAIR LOTZ: Tom.

10 DR. ROSENTHAL: Well, I think
11 generally I would agree that there is value
12 being more to the left side broadly. But I
13 think we miss real opportunities if we don't
14 leave the whole spectrum on there. Because I
15 don't think the state of the art is such that
16 we really know. And I actually think if we
17 had some measurement that said the cost of
18 cath here and the cost of cath there, at some
19 really prescribed level that we understood
20 well, I mean we have all kinds of innovation
21 projects going on around the country on
22 bundled pricing. I don't think we have a clue

1 yet really how that is going to shake out. So
2 I don't think we should sort of chop off the
3 right-hand side of that thing, even though I
4 take the point about the broader virtue of per
5 capita measures and global measures and the
6 value. The problem with the per capita
7 measures is that the risk-adjusting
8 methodology becomes so much more challenging
9 and difficult to get your hands around, and
10 will be divisive, and we'll be fighting over
11 it. Whereas on the right-hand side you really
12 can get down to a very prescribed level and
13 it's harder to quibble over what you get at
14 the end of the day.

15 So I think they are complementary.

16 I don't think that we should sort of say,
17 let's carve off one side or the other.

18 CO-CHAIR LOTZ: Bill Rich.

19 DR. WILLIAM RICH: I agree with
20 Tom. Because if large - ideally we should be
21 on the left, I agree with that Bill, but the
22 reality is some of the more clearcut measures

1 that will address variation can be procedure
2 specific. And there is some suggestion that
3 these can be extrapolated across that
4 physician's provision of more complex
5 services.

6 So I agree with that, and some of
7 the work that has been done shows huge
8 variation, 100 percent attribution, very
9 clearcut things on very powerful measures that
10 have a great deal of financial impact. So I
11 would not like to see us get rid of those,
12 since we avoid a lot of the problems of
13 attribution.

14 CO-CHAIR LOTZ: Thomas Lee.

15 DR. LEE: It's great watching the
16 eye surgeon keep knocking over his water.

17 (Laughter) But that is in the numerator part.

18 But I think to make a comment that directly
19 goes against the interest of my organization,
20 because we do get paid better than our
21 competitors, and we get criticized a lot for
22 it, the truth is most of the world is not

1 organized enough for the left side as yet.
2 And on the right side, it's actually very
3 complicated to get into prices. We've been
4 trying in Massachusetts, part of our health
5 care reform effort, and of course every payer
6 pays different for a CT scan, for an office
7 visit, and so on. So what in Massachusetts
8 we've done, we've actually organized baskets
9 of service for what you would expect a
10 diabetic to get in the course of a year. And
11 we've said, based upon the median of the fees
12 paid to Partners Health Care and Beth Israel
13 and so on, this is what that basket would cost
14 you for a diabetic; for a routine
15 hypertensive; and so on.

16 We are not even looking at the
17 question of how efficient we actually are
18 taking care of hypertensives and diabetics,
19 but it's just a basket service, it's two
20 visits, eye exam, that kind of that thing.
21 What would it cost if you got your care within
22 the system? And the truth is, it does put

1 some healthy pressure on providers to have
2 that out there. Really it's just price. It
3 doesn't reflect what is actually happening to
4 the patients. It's just given the prices in
5 the contracts, what would it cost for a
6 typical basket of services. Because it's not
7 that helpful to say, here are the prices for
8 CT, echo, and that kind of thing.

9 CO-CHAIR LOTZ: Jack.

10 DR. NEEDLEMAN: Two things. One,
11 Tom's discussion of looking at the median
12 prices and then applying them to a bundle of
13 goods is a classic example of what we were
14 talking about earlier about the issue of
15 standardized prices versus nonstandardized
16 prices. And there is value for some
17 comparisons in having standardization, and
18 other value for other reasons in not having
19 the standardization. So it's not either/or,
20 it's and/both. And that is going to be an
21 important component of all this work.

22 As I look at the continuum here,

1 the most ambiguous part is the per episode.
2 And I read the original, the earlier NQF
3 report on efficiency measures, and I've read
4 what's here, and I've looked at the
5 definitions of episodes. And they are
6 remarkably ambiguous. And they have, as has
7 been noted, very important consequences for
8 estimating who's high, who's low, what's being
9 included or not.

10 So I think - I don't think the
11 answer to what the right way to do this is
12 necessarily in the documents yet that we have
13 received. And I think one of the issues for
14 looking at what measures are more effective
15 than others is in fact going to turn on how
16 thoughtfully the episode definitions are in
17 fact defined and implemented in the measures
18 to capture the gaming, to capture the
19 aggregation, but also to capture the
20 challenges we have in both attribution and in
21 doing comparisons that make sense.

22 CO-CHAIR LOTZ: Jeff.

1 DR. JEFFREY RICH: I just wanted
2 to reinforce what Tom and Bill had said. From
3 a very practical and functional standpoint the
4 payment systems live to the right, per
5 hospitalization per episode. And if this
6 committee is going to have any value to
7 society and to payers and to others, then we
8 are going to create measures that begin there,
9 that are living and dynamic and can move with
10 the payment systems as they move to the left.
11 And that will be our challenge, to pick the
12 right measures that don't stay to the right,
13 but can move to the left.

14 CO-CHAIR LOTZ: I think as well
15 is where CMS was the sponsor of this steering
16 committee and this effort, that they were
17 looking for specific measures in all three
18 areas - per procedure, per service, per
19 capita, and also per episode. So we can never
20 get too far away from who's paying the bill
21 and what do they expect for that payment from
22 this project. Not to limit ourselves to that,

1 but I don't think we can get too far away from
2 that. If you want to take something out of
3 the equation as not being doable right now it
4 certainly has to float back to CMS to say,
5 listen, we don't think there is any value in
6 doing this; here's the reason why. And allow
7 them to comment further.

8 So please bear that in mind as you
9 are thinking about this.

10 Final comments before we move on?
11 Yes, go ahead, Tom.

12 DR. ROSENTHAL: Just to the last
13 comment you made. I'm all for leaving these
14 all on here, even though I think we'll find
15 interesting questions about each one of those
16 things. But based on your last comment, we
17 are not obligated to take a measurement in
18 each one of those realms, I assume, despite
19 CMS' imprimatur. Because I share with Jack
20 some of the concerns about the episode basis.
21 I'm not sure the science is where it needs to
22 be right now to pick one of those. But we're

1 okay with this being broadly permissive as
2 Sally said, but we are not obligated to take
3 one from each area necessarily.

4 CO-CHAIR LOTZ: And we may not
5 receive one from each area either. So Jeff.

6 DR. RICH: I'm sorry, I just
7 wanted to clarify my comments. I didn't meant
8 that we should stay to the right. We should
9 be across the spectrum. But we need to be
10 attentive to the right as well, because that's
11 where a lot of the payment systems live and
12 breathe right now.

13 CO-CHAIR LOTZ: Yes, and there is
14 another directive in our vast amounts of
15 background reading, most of which I have here
16 in front of me in case anyone wants to
17 refresh, is this idea to be actionable as
18 well, and accountable. And I think that it's
19 hard sometimes, depending on who you are to
20 think about accountability at a per capita
21 level, you really do have to get down to
22 something that is a little bit more smaller

1 unit driven.

2 Jim.

3 MR. WEINSTEIN: I guess the
4 question is, to me, one of the other
5 committees, I think it was nebulous for good
6 reasons. I don't think they tried to get into
7 the weeds on every diagnosis. But the notion
8 that there was a population at risk that had
9 a particular diagnosis and then had some
10 followup. But the issue of appropriateness
11 which is where we all sort of fall off, and
12 lots of people have studied this issue, but
13 measures of resource use for things that
14 patients don't want if they were well informed
15 are a problem. And I guess the first
16 committee discussed that a lot, that assuming
17 we are going to use measures that when
18 patients were well informed would actually
19 want what's being offered to them, I don't
20 know where that comes into this definition
21 independent of per capita or procedure. It
22 involves both. Because I think we know from

1 our own work that over 30-plus percent of
2 people when well informed wouldn't choose what
3 they've gotten in health care. So I don't
4 care how you measure it, but I'd like to see
5 that as part of the measurement of this
6 strategy which goes along with the previous
7 committee.

8 CO-CHAIR STEINWALD: Let me
9 comment. In a previous conversation I think
10 this was Jack Needleman raised the distinction
11 between technical and allocative efficiency,
12 and not wanting to go into it too deeply, but
13 if you are talking technical measures you can
14 measure the resource use or even the
15 efficiency of performing a procedure whether
16 it's needed or not, right, which is kind of
17 what you're getting at. Whereas if your
18 broader based measure needs to bring in the
19 contribution to health that the procedure once
20 performed makes, and that gets at the problem
21 that you are raising.

22 So we talked earlier about the

1 building block concept that we are confining
2 ourselves to resource measures but with the
3 understanding that those measures are intended
4 to be a building block that gets you further
5 down the road at gauging both quality and
6 outcome.

7 MR. WEINSTEIN: Well, is not a
8 resource measure whether you engage the
9 patient in the decision making? Right now
10 that's paid for very differently, depending on
11 the payers. But it's a resource use that's
12 not traditionally there that affects the
13 utilization a lot.

14 CO-CHAIR STEINWALD: I think the
15 patient engagement really gets at the concept
16 of health. To me it's, the patient would not
17 undergo 30 percent of procedures if they fully
18 understood the value of the procedure in
19 contributing to their own health. To me the
20 patient preference is indistinguishable from
21 the contribution of the procedure to human
22 health.

1 MR. WEINSTEIN: I'm just arguing
2 that the resource - it's an important point to
3 me personally, obviously. I don't have any
4 stock or anything, but I think the notion of
5 if we are going to create resource use
6 measures, I'd like to know that the patient
7 involvement as a resource in some active
8 engagement was a resource, part of the
9 measurement. If they're not engaged, that's
10 interesting. In fact we end up spending more
11 money when they're not engaged.

12 CO-CHAIR LOTZ: Helen is going to
13 trump Ethan and Paul, so hang in there.

14 DR. BURSTIN: Oh, I didn't mean
15 to trump anybody. I just pulled up the
16 efficiency report, because I think it's
17 actually really useful. And if nothing else
18 probably should just hand out a hard copy of
19 the executive summary; it's just a few pages.
20 Just wanted to make the point that the
21 committee very explicitly said there were
22 domains for performance measurement to get at

1 the patient-focused episode, the broader view
2 of episodes. And they clearly laid them out
3 as health outcomes important to patients,
4 which includes health status, healthy quality
5 of life, patient experience, cost and resource
6 use as well as the more classic quality
7 measures.

8 So I think what really still gets
9 back to is this issue of building blocks. I
10 still think we are seeing, we still need the
11 domain of the cost and resource use measures
12 that would then get packaged together into a
13 broad-based view of an episode.

14 But I think we are still in the
15 case of today at least trying to focus in on
16 again trying not to boil the ocean as somebody
17 said earlier, the piece about cost and
18 resource use, understanding that when you look
19 at the patient-focused episode, our hope is
20 you will pull in the patient experience of
21 care, you will pull in patient preferences,
22 you will pull in outcomes. But what we are

1 talking about today is the cost and resource
2 use piece really in a more narrow way.

3 DR. BARNETT: So just to follow
4 up on what Jim just said, so there are
5 important things that need to be done in the
6 health care system that are either
7 inadequately reimbursed or not reimbursed at
8 all. And I'm just still stuck on that last
9 point. It says, if we use the reimbursement
10 schedule to say what things cost, then we're
11 missing the boat.

12 CO-CHAIR LOTZ: Ethan.

13 DR. HALM: I don't mean to
14 playing like the 12th angry man role here, but
15 I think, I like the picture and the continuum
16 I think will be extremely helpful because it
17 will help ground and anchor sort of things
18 that are out there, and then things we hope to
19 see happen. And especially moving towards the
20 left. I think we have a little more work to
21 do to make that visual more representative of
22 the discussions. So to me semantically per

1 episode suggests something happening. So I'm
2 still arguing that we need to come up with
3 something visually to put between per capita
4 and per episode. Because the words say per
5 capita measures which are total health care
6 spending per person. It doesn't say total
7 diabetes cost per year, or think about mental
8 health carve out. So you have the costs of
9 depression for a year, and then you have an
10 acute episode of acute depression involving
11 hospitalization or ED visits and other stuff.
12 And just the semantics of a per episode, we
13 are not going to want to use per episode to
14 mean, well, an episode could be a year of
15 acute and chronic care altogether. Because
16 all the technicalities, and how you define the
17 episode as looking for sort of quiet periods
18 before and after, and this and that, and I
19 think maybe we can do this more offline, but
20 that is going to be - we've already heard
21 several people talking about, people are
22 actively thinking about measures that are in

1 between that per capita and per episode part
2 of the spectrum, and coming up with some
3 language to describe that on the diagram I
4 think would be really helpful.

5 CO-CHAIR LOTZ: Lisa.

6 MS. GRABERT: I like the spectrum
7 of different measures, and I appreciate that
8 CMS may want to have different measures from
9 each of those buckets.

10 I have a question in terms of the
11 call for measures that goes out, and whether
12 or not there is going to be an intent to focus
13 on just one of those buckets, or if the intent
14 would be to determine best in class from a per
15 episode measure versus a per procedure
16 measure.

17 MS. TURBYVILLE: So when we think
18 about best in class we think about selecting
19 measures that are measuring the same thing.
20 So theoretically I would assume that a per
21 capita measure and a per procedure measure
22 are measuring different things as measures;

1 not that they are not potentially looking at
2 similar types of costs. But it is something
3 to think about.

4 And then further the steering
5 committee will help us frame and inform that
6 call for measures. So if as we think about
7 how broad to be during a first call for
8 measures, perhaps we go across the whole
9 spectrum and see what we get, and then maybe
10 future efforts would be more narrow. I don't
11 know. So this meeting here today and tomorrow
12 will help us frame that call for measures more
13 concretely. So that is right on question.

14 MS. GRABERT: I think that is
15 helpful. Then I'll express my strong
16 preference for a per episode scope, because I
17 think that that is where we need the most help
18 right now overall for measures. We certainly
19 have per procedure measures. We certainly
20 have handfuls of per hospital plus days and
21 readmissions measures. I do think that we
22 need a lot of help with per episode now.

1 CO-CHAIR LOTZ: Mary Kay.

2 DR. O'NEIL: I was just thinking
3 about the - and this may be semantic as much
4 as anything - but we're kind of looking for an
5 annualized care per individual type measure,
6 whether somebody has a chronic condition. I
7 from a kind of business perspective consider
8 what should be the run rate for a diabetic,
9 what should be a run rate for an asthmatic,
10 what kind of care is the proper level of care,
11 and even the proper level of care for somebody
12 who is well.

13 But when per capita is utilized I
14 think most people think of measuring
15 populations. They don't think of looking at
16 what is the proper allocation of care for an
17 individual through a timeframe. And that
18 seems maybe the one that is missing between
19 per capita and per episode. I understand per
20 episode can be defined to include that. But
21 I think it's not easily understood to mean
22 that.

1 CO-CHAIR LOTZ: Jephtha.

2 MR. CURTIS: So I just want to
3 follow up on Lisa's point. Where I think this
4 is useful is as a construct for understanding
5 the full spectrum of different ways that you
6 can measure resource use. But what is
7 missing I think, what particularly measure
8 developers are going to need is sort of a de
9 facto judgment over which are preferred and
10 which are not preferred. And that's missing
11 at least from my reading of the text
12 currently. And so you may end up with, and I
13 know we'll craft a call for measures later on,
14 but it's easy to say that I think a heart
15 failure should be measured as an episode of
16 care over not just the acute hospitalization;
17 and that is in fact superior to a pure
18 procedural or per hospital measure.

19 And I think we can make those
20 judgments, and to the extent we can now it
21 will be better in terms of setting it up for
22 actually judgments, measures, as they come

1 forward.

2 CO-CHAIR LOTZ: Bill.

3 DR. GOLDEN: I think this is a
4 very important section, and it's not an easy
5 section to write. So I have my sympathies.
6 It is a little wonky. And I think if we have
7 other readers - if we are having trouble
8 teasing it apart. I think that a lot of
9 readers - this will be read a lot I'm sure by
10 many people - I think it'd be really useful to
11 have a box of just examples of what we are
12 talking about, concrete examples. Otherwise
13 we're going to I think lose some folks. I
14 think it's a good start, but we need a Readers
15 Digest version and some examples.

16 CO-CHAIR LOTZ: Tom, you don't
17 have your table tent, Thomas Lee, up, but you
18 just drew a box that you shared with Helen,
19 and Helen is nodding and there is a
20 conversation going on down here. So why don't
21 you share your conceptualization in a box?

22 DR. LEE: This is like my sort of

1 line about we need all these things. So my
2 table is like those four columns - per capita,
3 per episode, per hospitalization, per
4 procedure. Although I agree with Ethan that
5 there are things in between those categories,
6 but then the rows I have are unadjusted
7 dollars, like what purchasers value. The
8 second row is adjusted dollars, adjusting for
9 pair missed wage inputs, and people will
10 disagree what you adjust for, but it's for
11 policymakers, and then the third row is
12 nonmonetized utilization data which is what
13 providers need for actual improvement.

14 And the truth is, I actually think
15 we need things in all 12 of those cells.

16 CO-CHAIR LOTZ: Could you add a
17 row to deal with the patient perspective in
18 some way or other, and then maybe we've got
19 everyone's focus.

20 DR. LEE: My assumption is that
21 patients care most about the first row which
22 is unadjusted dollars. They may be shielded

1 right now from the unadjusted dollars. But
2 ultimately I think they are bearing more and
3 more of it.

4 CO-CHAIR LOTZ: Additional
5 comments before we close out this section?
6 Jim.

7 MR. WEINSTEIN: I guess I'm
8 probably not being very clear about what I'm
9 trying to suggest as a resource. There is a
10 unit of service that requires patients to
11 engage like a laboratory around decision
12 making that is currently not paid for that is
13 not in the system. And because it's not there
14 we are spending 30 percent more than we need
15 to potentially. That is just a potential.

16 How do we account for those kinds
17 of resources, independent of the one I'm
18 suggesting, patient decision tools?

19 CO-CHAIR LOTZ: Jack.

20 DR. NEEDLEMAN: If I understand
21 what Jim is saying, let me try to add some
22 concreteness to it. So we've got patients

1 with prostate cancer who are trying to decide
2 what treatment to take. And some practices
3 have hired people - some practices rely on the
4 physician to provide that counseling, and
5 there is more time required of the physician
6 visit, and maybe that gets reflected in the
7 way the physician has - the CPT code the
8 physicians use to bill that, so it looks like
9 they are using higher resources, or maybe it
10 isn't. Some practices have hired individuals
11 with expertise in talking to patients about
12 counseling them about their options. And that
13 will not be a billable service; it will not
14 show up in our resource use.

15 Other practices have put together
16 online programs to enable patients to look at
17 the literature, hear discussions that other
18 patients have had about the different
19 procedures, and the cost of developing that
20 and of making it available to the patients are
21 also not billable directly and may or not be
22 showing up in our resource measures. Each of

1 those represent three - and then some
2 practices because it's not billed well will
3 not be doing very much of that in any
4 organized way.

5 So we've got four different models
6 about how patients get educated about their
7 choices about prostate cancer. Each of us
8 have very different resource profiles, only
9 some of which are being shown up in our
10 billing, and if we are using billing methods
11 to capture resource use, only some of which
12 will be showing up in our measure of how much
13 resources are being devoted to the treatment
14 of prostate cancer.

15 So I think Jim's issue is, down
16 the road we want to sort out whether - which
17 of these are better methods, which of them are
18 better methods for which patients. But in -
19 even if we are in the realm of resource use
20 how do we capture the differences in the way
21 practices have organized themselves to provide
22 information to patients around decisions the

1 patients have got to make.

2 Have I got your problem and a
3 concrete enough example?

4 MR. WEINSTEIN: You're hired as a
5 resource.

6 CO-CHAIR LOTZ: Inasmuch as I put
7 out there for folks to recall, you know CMS
8 has these buckets. They are not precluding
9 the idea of being somewhat aspirational and
10 creating new buckets. So that may be part of
11 the framework that is put out there, and it
12 may be that when the calls for measure go out,
13 no one populates that with any measures. But
14 putting it out there I think brings in an
15 important point. And I'm speaking personally
16 now, I think it is an important point.

17 MR. WEINSTEIN: There are
18 measures that IOM and others have been looking
19 around, patient values, knowledge-based
20 measures about the decisions. People are
21 working on those kinds of measures. The
22 notion of it being a resource that currently

1 is not in our normal thought process to me
2 doesn't exclude it as a resource. And I think
3 we need to think out of the box about that if
4 we are actually going to have some benefit for
5 the future going forward.

6 CO-CHAIR LOTZ: We'll have to be
7 a little concrete in the use of our resources.
8 I know from the perspective of where I sit, we
9 create all sorts of programs. And I not
10 infrequently ask myself, does anyone want
11 these programs?

12 All right, next I have Jack, but
13 you're down. Mary Kay.

14 DR. O'NEIL: Well, speaking of
15 out of the box, in my company we have
16 purchased intellectual property to decision
17 support processes for 12 different conditions,
18 and we deploy them on our membership as the
19 insurer. And so in part because we have a
20 patchwork of capabilities across the country
21 in terms of different delivery systems and
22 physicians. So in fact that is being invested

1 in and done as a resource. And if we look at
2 the whole big global per capita spending in
3 the U.S. on health care, I mean the stuff
4 we're spending money on is an expense and an
5 investment. And we can argue whether we
6 should be doing that or not, and whether we
7 should be paying people to do that. But that
8 is currently being done for the 12 million
9 people that have their coverage through us.

10 DR. NEEDLEMAN: Immediate follow
11 on to that, and once again it goes to, those
12 costs will be showing up in the ASO cost, the
13 administrative cost of the insurance, that
14 wasted portion rather than in direct patient
15 care expenditures in terms of direct billed
16 services. So again we've got to understand
17 what we are trying to measure, and we've got
18 to appreciate that some of the things we're
19 trying to measure right now are not being
20 billed for explicitly, and the question is,
21 how well will any measures of resource use
22 that people are putting forward take into

1 account these kinds of variations in the way
2 care is delivered that are important in terms
3 of patient decision making.

4 CO-CHAIR LOTZ: Ann.

5 MS. HENDRICH: This was the
6 reason for my question earlier about counting
7 of resources, because I think the field is so
8 trained to not give credit for the types of
9 innovations that we just heard that I think a
10 question that we're all seeing perhaps in a
11 different way is, is part of the role of this
12 paper to help discover the innovations that
13 are out there, and frankly stir up the
14 measures and have them come forward in a way
15 that can get connected to outcomes eventually.

16 So I think these two dots, as I
17 think we're all saying in different ways, have
18 a very important real connection of getting at
19 quality and cost.

20 CO-CHAIR LOTZ: Paul.

21 DR. BARNETT: So I think the
22 question about, for example, the unreimbursed

1 prostate cancer counselor, is whether we want
2 to put in the call for measures that we are
3 seeking a measure that would involve actually
4 figuring out what things cost as opposed to
5 what we actually reimburse for them. And
6 there are products, activity-based cost
7 allocation systems, I'm sure, that people
8 would be interested in submitting them as
9 potential measures.

10 On the other hand I could see this
11 as falling into one of those categories of
12 things that is not immediately feasible, and
13 something that we ought to kick forward to the
14 next committee. But somewhere we need to at
15 least acknowledge that limitation if we don't
16 address it and acknowledge the limitation and
17 say this is to be accomplished.

18 CO-CHAIR LOTZ: Ethan.

19 DR. HALM: Yes, and I wonder if
20 one way to solve this issue of what to do
21 about things that we know take real inputs but
22 aren't currently reimbursed for, if we ought

1 to have a section that directly addresses
2 that. So as a primary care doctor, a big
3 chunk of what I do is not currently reimbursed
4 for. So a lot of the coordination, counseling
5 and other services, the extent to which it
6 doesn't show up in E&M coding and email and
7 phone stuff, whereas in some of the new pay
8 reforms they are trying to acknowledge that as
9 inputs that are real, that need some other way
10 to sort of recognize that. And so the shared
11 decision making is one area, but there are
12 other examples as well. And I wonder if in
13 the document we may want to comment on the
14 fact that there are real inputs out there
15 right now that we just don't have very good
16 ways of measuring or counting, and that we
17 need to do so so that people understand that
18 it is not just - if it ain't being charged for
19 now it's not important or doesn't exist.

20 CO-CHAIR LOTZ: Renee.

21 MS. MARKUS-HODIN: So I just
22 wanted to as probably the only consumer rep on

1 the committee, I wanted to just echo - I feel
2 like we are reaching consensus around that.
3 I agree that we should be using this process
4 to kind of drive the - to attempt to drive the
5 kind of behavior we'd like to see in the
6 system.

7 And so paying for the kinds of
8 counseling that we have talked about, the use
9 of shared decision making tools and the like
10 I would absolutely support. I'd add another
11 one, and I think it absolutely should be in
12 this paper, which would make this I think for
13 consumers a much less inscrutable paper to
14 read.

15 So I would add that we might want
16 to include other things, more proactive
17 things, like evidence-based programs such as
18 chronic disease self management programs,
19 things like that, that those could also be
20 things that we would count as resources.

21 CO-CHAIR LOTZ: I just want to do
22 a real quick time check. We've got 15 minutes

1 before we'll open up the lines for any of the
2 public that are listening in on this to
3 comment. So right now I have teed up David,
4 Tom, Joseph and Bill. That might be all we
5 can get through in about 15 minutes. So bear
6 that in mind.

7 David.

8 DR. REDFEARN: I'll be quick. I
9 just kind of agree with some of the comments,
10 that just the practical issue is, a lot of
11 these services, there are no codes for them.
12 The example we ran into in California is
13 telemedicine, which got to be supported by the
14 Medical program in California, and there were
15 some codes developed but nonstandard codes,
16 and you are always struggling with them. And
17 from a prospective payer point of view, if you
18 don't have a code you can't pay it, so it
19 doesn't exist; that's part of it.

20 The other thing that just occurred
21 to me is, the rules that are being pushed out
22 now about loss ratios for carriers is going to

1 push the - we are going to start developing
2 codes for these kinds of services because we
3 want them to be in the admin costs when we
4 calculate our loss ratios. So that is
5 actually going to push in the right direction
6 I think. Right now there is a huge gap but
7 it's going to move in the right direction
8 fairly quickly, I would suspect.

9 CO-CHAIR LOTZ: Tom.

10 DR. ROSENTHAL: Well, we've
11 identified kind of a generalizable problem it
12 seems, that the way we count things is by
13 billed services or, in a capitated system,
14 encounter data. And how do you account for
15 things that aren't billed? And so this is
16 certainly one that we've seen about these kind
17 of patient teaching kinds of services. But
18 the other one is there are entire health
19 systems that don't generate bills, and
20 wouldn't it be nice if in this thing you'd be
21 actually able to know how well is Kaiser doing
22 in relationship to the commercial world, or

1 how well is the VA doing in relationship to
2 the commercial world. And this may be a
3 bridge too far as I think it was Paul alluded
4 to. But it certainly is a problem that we
5 might want to think about, because we've made
6 an assumption that the only way we're going to
7 count things is by, whether it was paid or
8 not that actually somebody has generated a
9 billing slip which drives the accounting.

10 CO-CHAIR LOTZ: Joe.

11 DR. STEPHANSKY: I think we need
12 to be aware that there are actually quite a
13 few payers, insurance companies, that are
14 experimenting with sets of codes for these
15 kinds of services. On Blue Cross Blue Shield
16 in Michigan for example has developed some
17 codes for social worker contact; for group
18 educational sessions; for different kinds of
19 nursing assistant contacts that other
20 insurances may not be recognizing at this
21 point, but there is going to be a lot of data
22 there, potential measures that we can learn

1 from.

2 CO-CHAIR LOTZ: Bill Golden.

3 DR. GOLDEN: Again, very briefly,
4 again, talking about the left side versus the
5 right side of the curve, as we start going
6 toward the right, we start really focusing the
7 system on paying for widgets. You pay for it
8 now; therefore we can continue to measure it.
9 And we really want to move away from paying
10 for widgets, and moving in more broad kind of
11 service packages, which is just a whole other
12 dynamic as we move forward.

13 CO-CHAIR LOTZ: Bill Rich.

14 DR. RICH: Well, actually a lot
15 of these services that are not quote counted
16 now, the codes exist and they are valued, they
17 are just not paid for, including consultation,
18 email consultations, coordination of care.
19 And I think what we are going to find is you
20 are going to have successful economic models
21 of delivering quality of care, and if you do
22 a look back then you will see what comprises

1 those things. That's what happened with the
2 medical home. The Medicare demonstration care
3 project for chronic care, there were four or
4 five sites that had really, they did quite
5 well. So you go back and you look
6 retrospectively what were the components of
7 Michigan, Dartmouth, and Geisinger, and you
8 put those inputs together, and that's how you
9 can actually value and define what is an
10 effective medical home. And I think that's
11 what we are going to find here. I don't
12 think up front we're going to be able to count
13 these things. Because there is now way of
14 accounting - even though there are codes for
15 them, they are not valued.

16 DR. STEPHANSKY: They are being
17 paid for as part of the developing medical
18 homes.

19 DR. RICH: But that is just in
20 Michigan. But there are many parts of the
21 country where there is no way of capturing
22 that work being done by primary care now.

1 CO-CHAIR LOTZ: All right, I'm
2 going to try to summarize a little bit, and
3 the point of doing it is just tell me where
4 I'm wrong.

5 So what I've heard was is that
6 there is a desire to take this continuum that
7 is up there and relate it to prior work that
8 NQF has done, in particular the model that
9 came out of the evaluation of episodes very
10 recently. And Helen said we can get the
11 executive summary. So hold on to that thought
12 if you want to look at that, and then comment
13 on it again tomorrow. But clearly the list
14 needs to be a little bit broader, so we need
15 to create some new buckets. Some of these new
16 buckets may be somewhat aspirational, but
17 should include the patient decision making as
18 a resource that we should capture. Care
19 coordination was mentioned, and maybe there
20 are even some other things that we haven't
21 quite articulated them in a nice sound bite,
22 but what else is happening in medicine that

1 should be incorporated here.

2 So thinking about it also in terms
3 of a linear continuum or possibly a box as Tom
4 Lee put out there. And I think that
5 summarizes what I wrote along the margins of
6 my paper. What do you have, Sally? What else
7 is missing? Or from the group, what else
8 wasn't captured in that summary?

9 MS. TURBYVILLE: I would just add
10 that we would, as we in particular I heard the
11 requests to add something in between per
12 capita and per episode. And that's mainly to
13 address the way people think of the two as -
14 that there is something in the middle. But I
15 think we do want to continue to present this
16 as a continuum and not just a series of
17 buckets, so that we don't back ourselves into
18 a corner. I see people nodding their head,
19 okay. And then making sure whether it shows
20 up in the continuum or the language within
21 this section that there are very important
22 resources, whether it's through innovation or

1 which have been ongoing for awhile that are
2 not currently reimbursed that can affect
3 resource use. And we need to make sure that
4 we are putting that in this section, because
5 that is real world, and we need to make sure
6 that we are addressing that, along with all
7 the other comments that I heard including
8 taking a look at how to further add
9 information for the users and readers of this
10 document so it's not this continuum at a very
11 high level; that they can actually think about
12 how it applies to the measures that they have
13 been exposed to.

14 CO-CHAIR LOTZ: Well, you guys
15 are models of efficiency, because we are
16 actually 10 minutes before we open up the
17 lines. I don't know what the NQF dynamic is
18 about that. Can we open up the lines
19 early? Do we have to talk about our children
20 for 10 minutes until we open up the lines? Or
21 where do we go from here?

22 MS. TURBYVILLE: Well, I'll

1 defer to Ashley and Helen, but we do need to
2 make sure it's open at 12:10, because there is
3 an agenda that is posted to our website that
4 said at 12:10 we'll be open to public
5 comments. So and without knowing how many
6 questions will come in, I don't know what your
7 experience has been.

8 So we'll just go ahead and open
9 them up for public questions of the steering
10 committee.

11 Could the operator please open the
12 line for public comment or questions?

13 OPERATOR: If you do have a
14 question or comment from the phone line you
15 may press star zero and then a voice will
16 prompt you on your phone line to indicate when
17 your line is open to make your comment or a
18 question. We ask that you state your name
19 before you pose your question or comment. And
20 once again if you want to ask a question or
21 make a comment, you may press star one.

22 DR. MUNLEY GALLAGHER: This is

1 Rita Munley Gallagher for the American Nurses
2 Association. May I get in the queue please?

3 MS. TURBYVILLE: You're in the
4 queue. We can hear you loud and clear.
5 Please go ahead with your question or comment.

6 DR. MUNLEY GALLAGHER: Thank you
7 for the opportunity to comment. I would
8 respectfully request that the steering
9 committee utilize more inclusive language as
10 appropriate throughout their process and also
11 within the white paper which would be
12 reflective of clinicians, practitioners, and
13 health care as opposed to referencing
14 physicians and doctors and medical care.

15 In addition, while I've not had
16 the benefit of the white paper to review, I
17 believe that I heard reference to gaming
18 during the steering committee's discussion.
19 And I would call the committee's attention to
20 earlier comments sent to NQF by the then
21 presidents of the American Medical Association
22 and the American Nurses Association opposing

1 the reference to gaming by clinicians within
2 NQF documents.

3 Thank you.

4 MS. TURBYVILLE: Thank you. We
5 have taken note of your comment.

6 Any other questions or comments?

7 OPERATOR: We have no one else on
8 the phone lines at this time.

9 MS. TURBYVILLE: So at 12:10
10 we'll open it back up just to make sure that
11 there isn't a public comment that was going to
12 call in specifically at 12:10 based on the
13 materials they've seen. Otherwise we'll just
14 keep it on hold for now.

15 DR. GOLDEN: Doris, I have a
16 question. There are some comments about the
17 text - I only got the text in the last couple
18 of days, and there were some comments about
19 some of the trials that I didn't want to spend
20 during the meeting. Who do I send comments
21 to?

22 CO-CHAIR LOTZ: Sally. If

1 they're handwritten.

2 DR. GOLDEN: You probably want me
3 to type something to you?

4 CO-CHAIR LOTZ: It would be
5 easier for us to manage and track. We do want
6 to share all the comments across the board.
7 And I don't have the whole timeline in front
8 of me right now but I think it's mid-August
9 that the white paper gets done. So you have
10 a couple of weeks after this to continue to
11 write.

12 MS. TURBYVILLE: So for the white
13 paper the next two weeks will be devoted to
14 comments preceding this meeting and after this
15 meeting incorporated those, and then we do
16 have to send it to our publication department
17 who does an excellent formatting, editing,
18 making sure we are using the appropriate NQF
19 language that they prefer. And then it gets
20 posted for public comment . Then we have
21 another opportunity with all of you to review
22 that public comment, and again, make the paper

1 better and better. In the end the final paper
2 will be in November. But this next two weeks
3 really is critical to get it to a point where
4 the steering committee feels it's ready for
5 public comment. So in particular for red
6 flags, please let us know if there is
7 something you think we must address or we
8 can't go forward. And then all edits of
9 course and suggestions we will be paying very
10 close attention to.

11 CO-CHAIR LOTZ: Bill - I'm sorry,
12 I've lost the order. Jack, you're up next and
13 then we'll go to Steve.

14 DR. NEEDLEMAN: Two things.
15 First, in terms of the comment we did receive
16 about using more inclusive language,
17 particular as we began to think about this
18 work, is supporting efforts to find more
19 appropriate, more integrated ways of
20 delivering care. I think the comment about
21 using more inclusive language about who is
22 delivering the care is absolutely appropriate,

1 and we should be looking, making sure that we
2 are being rather aggressive in broadening the
3 language as we do the revision.

4 The second thing is in the
5 discussion of all the comments I think Sally
6 mentioned this but I don't want it to get
7 lost, we've got a whole variety of individual
8 practices and integrated systems, sometimes
9 working with the insurers that are in fact
10 delivering many of these services right now;
11 the total amount that they are compensation
12 from whatever services they bill for are in
13 fact being used to pay for a variety of these
14 services.

15 So I think as we write the paper
16 and as we think about editing it, we need to
17 draw the distinction between the resources
18 that are used to deliver care, some of which
19 are paid for explicitly and some aren't,
20 versus the specific services that people are
21 being billed for and reimbursed for. And to
22 draw the distinction as we measure resource

1 use between measuring on the basis of billed
2 services and measuring on the basis of the way
3 care is organized and delivered, and some of
4 the tensions between those two things is
5 appropriate measure of resource use. And we
6 should not - again I think it was implicit in
7 what Sally added to the things that were on
8 her list, but we need to make very sure that
9 that is clear and it's communicated in the
10 paper.

11 CO-CHAIR LOTZ: Steve.

12 MR. PHILLIPS: Thanks. Maybe it
13 was at the end of the previous section, but
14 it's just a specific comment on the language.
15 I didn't have a lot of written comments, so
16 I'll just offer this up now. At line 229 it
17 talks about some of the specific objectives of
18 these measures. And I wanted to insert the
19 note, because it doesn't mention there - it
20 was mentioned I think earlier in the
21 discussion this morning that they should be
22 useful to the health care providers in terms

1 of the information that comes out of these
2 measures. And I thought that that should be
3 mentioned in that section as well.

4 CO-CHAIR LOTZ: Tom Lee.

5 DR. LEE: You know the more you
6 think about this stuff, the more complicated
7 it gets. One thing which hadn't occurred to
8 me was, to what extent do we imagine adjusting
9 for the type of insurance products that make
10 up the patient population of whoever is
11 measured, you know, PPO versus HMO.

12 CO-CHAIR LOTZ: So you're
13 thinking about benefit design or the
14 composition of physicians?

15 DR. LEE: Well, I think in
16 benefit design and in high deductible. I mean
17 it takes you down a road that frankly probably
18 just gets you feeling lost. But these are
19 variables I think that I know that when we
20 start showing this kind of data to other
21 people out there they are going to go, well,
22 if it's just for this and that. We might as

1 well at least anticipate those questions and
2 prepare a response.

3 CO-CHAIR LOTZ: Again, I'm
4 thinking that as we think of our building
5 blocks strategy, that that is something when
6 you are building you have to consider what
7 resources a patient may have by way of their
8 benefit design.

9 Mary Kay.

10 DR. O'NEIL: It's not even
11 benefit design as much as like the consumer-
12 driven model of health care, and how that
13 drives individual decision making. It really
14 changes things that we know in our industry
15 from an actuarial standpoint, we have
16 actuarial data on the impact of those
17 different types of products. So it's really
18 product type and benefit design.

19 The other issue that could get you
20 really crazy about benefit design is in the
21 commercial insurance world the trend over the
22 last number of years, I don't know when it

1 really started for increasing percentage of
2 our business being self insured. That means
3 somebody comes to me and says, does CIGNA
4 cover this, I can't hardly answer the
5 question. I mean I can say what we do on our
6 fully insured book of business, what we do on
7 a consumer driven, and what we do on our own
8 policy for our own employees. But given the
9 array of plants that we have, we have a lot of
10 different plants, so there is a lot of
11 complexity out there.

12 DR. LEE: I just want to say that
13 contemplating it I think that we might want to
14 decide up front it's hopeless to adjust for
15 these things, and just make it clear that it
16 is hopeless. You'd never get the information
17 on their deductibles and that, and that the
18 data might end up being biased, but I think we
19 have to accept that there are going to be
20 issues that we can't adjust for.

21 CO-CHAIR LOTZ: But at least
22 acknowledge it.

1 DR. RUDOLPH: Well, just a couple
2 of different things on that. One might be a
3 stratification process like we do with race,
4 ethnicity, those kinds of things. Because I
5 think we don't want to adjust away differences
6 when consumers are able to make choices; they
7 should be able to see what those differences
8 are, and thereby make a rational choice.

9 So if we are going to do
10 something, I would propose stratification as
11 opposed to adjustment.

12 CO-CHAIR LOTZ: All right, we're
13 going to pause here again to see if there are
14 any public questions.

15 MS. TURBYVILLE: Operator, at
16 this time we would request that you open the
17 line again for any public comments or
18 questions.

19 OPERATOR: Again, as a reminder,
20 if you would like to pose a question or
21 comment, you may press star one on your
22 telephone keypad at this time.

1 (Pause)

2 It appears that we have no
3 questions or comments at this time from the
4 phone lines.

5 MS. TURBYVILLE: Thank you.

6 All right, so we'll put it to the
7 group. We've got a few table tents up. We
8 can take the three that are up right now -
9 oops, two that are up right now, or move to
10 lunch.

11 David, and then Kurt.

12 DR. REDFEARN: I'll be fast in
13 the interests of the food.

14 We have an interesting experience
15 with ACO in California with some pilots that
16 are starting up right now that reflect on
17 these issues of benefits. First, the issues
18 that came up -- I think stratification makes
19 sense in terms of looking at this - I don't
20 think you can adjust it away, stratification.

21 There's been some push back from
22 the medical groups in terms of looking at

1 individual enrolled business, because of high
2 deductibles, policies that are sold commonly
3 in that industry, and if you are going to take
4 responsibility for managing the whole care,
5 and you have this huge gap in the benefit
6 structure, it makes it harder for the medical
7 groups.

8 The other comment about ASO which
9 I thought was very appropriate, essentially
10 we've taken essentially all the ASO business
11 off the table for the very practical reason is
12 that you have to go back to the groups and get
13 permission to do that. That's not insured
14 business which we sort of control.

15 So again it's like a
16 stratification. It's what populations go into
17 your analysis. And I think it makes sense to
18 think of it in that context.

19 CO-CHAIR LOTZ: Kurt.

20 DR. ELWARD: Yes, I'd just echo
21 those, and also mentioned that to your point
22 about the number of self-insured business on

1 one hand, those self-insured policies can
2 provide a lot of innovation, because the self-
3 insured groups will do some things that you
4 just don't get done otherwise.

5 At the same time it really does
6 complicate things, and we're - I think benefit
7 design is one thing, this person does the
8 surgery for this policy is really really
9 cheap, but I guess we do want to include
10 anesthesia, if you don't have that. Or it may
11 go to diabetes. I'd think it'd be very
12 important for an employer or a purchaser to
13 know that when they are buying diabetes care
14 from X, it includes a package of services that
15 they really want their employees to have, and
16 that extra resource input may be worthwhile.
17 So I think it'd be really helpful to people.

18 CO-CHAIR LOTZ: Well, we are
19 actually on schedule. So Sally, do you want
20 to see if there are any last public comments
21 before we break for lunch? Just go ahead and
22 break for lunch? When do you want us back?

1 MS. TURBYVILLE: So we will break
2 for lunch now. And for those on the phone we
3 will reconvene at about 12:50. So thank you.

4 (Whereupon the proceeding in the
5 above-entitled matter went off the record at
6 12:16 p.m. and resumed at 12:57 p.m.)

7 CO-CHAIR LOTZ: Steering
8 committee, lunch is officially over.

9 You may now sit down and digest,
10 but please do sit down so we can begin. Our
11 afternoon is very, very ambitious, so the
12 sooner begun, the sooner done.

13 MS. TURBYVILLE: And to the
14 operator, if you could please make sure that
15 the line is open, though not open for comments
16 or questions at this time, just in case you
17 disconnected during lunch.

18 CO-CHAIR STEINWALD: All right,
19 we're on to Section 3, types of resource
20 measures. We've already had some discussion
21 of this right before lunch. But before we get
22 onto the next topic, would anyone like to say

1 anything more about types of resource
2 measures?

3 One thing I guess I'd like to
4 emphasize, what I said before is that when the
5 per capita terminology has been applied as I
6 understand it at CMS and elsewhere to mean a
7 population of patients. But we I believe
8 intended to incorporate more than just a
9 population of patients. It could include
10 populations at large, populations served by a
11 health plan, the population of the state of
12 New Hampshire.

13 And I'm not sure whether we need
14 to have new terminology or just make it clear
15 in the text of the paper that per capita means
16 more than just one thing.

17 Anyone else? We talked about it
18 enough? Okay, that we can go on.

19 MS. TURBYVILLE: So this is still
20 within Section 3, and what we want to have the
21 steering committee discuss and then come to
22 some agreement, is, is there a way to classify

1 what we called phases of resource use
2 measures. And it's steps that a measure
3 developer and an implementer of those measures
4 would need to take in order to successfully
5 then roll out the resource use measure.

6 And the way we classified three
7 phases, and we could call them modules as
8 well, include data preparation, which would be
9 steps that are taken in order to make sure
10 that the data are in a form or robust or
11 sufficient enough in order to support the
12 resource measure. A creation of the unit of
13 measurement which in essence could be the
14 creation of the denominator for the resource
15 use measure the way we've defined it. We
16 shied away from the term, denominator, because
17 we felt that there was some disagreement on
18 whether or not you can call them denominators.
19 But we're very open again to what these are
20 called. And then how you apply those, and
21 that includes once you've defined your unit
22 that you want to measure, whether that is a

1 population, or is it an episode, et cetera,
2 you have your clinical logic that is in that
3 second step; you have your creation of an
4 episode if it's an episode measure, or your
5 creation of the population, whether it's those
6 patients with diabetes; and then how you apply
7 that unit of measurement which would include
8 which resource units you want to measure. So
9 those would potentially include the
10 reimbursable and as we have stated
11 acknowledging that there are unreimbursible
12 units. So your ED stays. Your evaluation and
13 management, et cetera. And then also whether
14 or not and how you would monetize those. And
15 all those steps are outlined in the paper.

16 But we would like some general
17 agreement on this attempt to put resource use
18 measurement into these three phases, and then
19 that will help us discuss with all of you
20 which phases and which steps within phases are
21 subject to evaluation by this steering
22 committee.

1 So it's an attempt to make sure
2 that as you think about evaluating these
3 measures, recovering all the various steps
4 which are quite numerous, what is true is that
5 these are not all mutually exclusive steps
6 that would happen only for resource
7 measurement. You might find them in quality
8 measurements. But we think it's really
9 important to send the signal to the measure
10 developers and others what exactly we will be
11 evaluating, and how we are bucketing those
12 particular steps.

13 So with that I'm going to hand it
14 back over to the chairs to either further add
15 to that or just kick off the discussion.

16 CO-CHAIR STEINWALD: The chair is
17 looking for names being turned up to the
18 vertical position.

19 Tom

20 DR. LEE: I think that those
21 steps work, chronologically and logically. I
22 think that the middle one is where there is a

1 lot of intellectual work to be done. I think
2 that looking over the white paper draft, I
3 think the one section within that number two
4 that I think really probably warrants some
5 more discussion is the risk adjustment
6 section. Because a na<ve reader might look at
7 it and think that risk adjustment is something
8 you do and it's done like scanning a computer
9 for viruses, which of course isn't that
10 straightforward either. (Laughter) But risk,
11 it's more like a philosophical or religious
12 experience than something you just do, it's
13 not a commodity. So the risk adjustment
14 approach of Prometheus is quite different from
15 other kinds, like the DxCG. Under Prometheus
16 they've taken the approach that if you do more
17 procedures to a patient it must mean the
18 patient needed more, and you move into a
19 different bucket, because they wanted
20 providers to be comfortable that this wasn't
21 something that was going to punish them for
22 taking care of sick patients.

1 So it's a spectrum. And I think
2 the risk adjustment section should probably
3 include some longer discussion so that readers
4 can be realistic about it.

5 CO-CHAIR STEINWALD: Whenever
6 I've dealt with risk adjustment issues in the
7 work I've done, mostly at GAO, the question or
8 the issue of the best being the enemy of the
9 good always comes up. And if you can't
10 achieve perfection, how much do you need to
11 achieve in order to go forward, even if risk
12 adjustment is imperfect.

13 And I don't know if that is worth
14 some discussion among the steering committee,
15 but it might be, because some guidance to the
16 developers about how good is good enough
17 might be helpful to them.

18 DR. LEE: Just to jump out and
19 say, I agree with you completely. It can
20 never be perfect. There is no completely risk
21 adjusted status. You can't adjust for all the
22 socioeconomic factors either, and so I think

1 that's like being, having perspective on the
2 data knowing that they are not going to be
3 perfect. There may be biases that we have to
4 live with.

5 CO-CHAIR STEINWALD: Paul, and
6 then David, and Bill.

7 DR. BARNETT: So I think that the
8 phases are right; I'm a little worried about
9 the units for measurement. It's just the
10 nomenclature; I think I mentioned that before.
11 It's a little bit hard to understand what is
12 meant. And I appreciate you're trying to make
13 a generic term. But it's not real clear to
14 folks.

15 Just in terms of, in the document
16 itself, everywhere I saw the word, price, I
17 circled it, and I thought, I wonder what
18 really they mean here. And I think in many
19 cases it meant reimbursement - you know we had
20 that issue this morning about that.

21 There was also mention in the data
22 cleaning part about removing high cost

1 observations. And I think Winsorizing is one
2 thing, removing them altogether is quite
3 another. So I thought that might be just a
4 little editorial comment. I don't think you
5 probably meant that.

6 And then I think vis-...-vis the
7 risk adjustment, I think there is a whole
8 category of people alluded to about pay
9 status, socioeconomic status, that are not
10 really developed much in the document. And at
11 some point we might want to think about the
12 issue of teaching status of the provider, and
13 disproportionate share status of the provider,
14 and how that enters into these efficiency
15 measures, and how do we credit those things,
16 or do we ignore them; important things to
17 think about.

18 CO-CHAIR STEINWALD: David.

19 DR. REDFEARN: Per the risk
20 adjustment, I think one thing that might be
21 prudent is to make sure that there is no
22 implication that somehow when you do risk

1 adjustment you adjusted away risk. The thing
2 I just keep in mind is, and I've had a lot of
3 experience with the models, like the DxCG
4 model and the symmetry ERG model, is that
5 prospectively those models predict about 25
6 percent of future cost variation. That seems
7 to be - there is no danger of getting
8 something perfect, because we are stuck with
9 something that is actually fairly crappy.
10 (Laughter) And in my social science training
11 when you account for 25 percent of the
12 variation you've failed.

13 So they certainly help, but they
14 don't solve any problems. You say, well okay
15 you do risk adjustment; you set categories;
16 you apply these models; and risk goes away.
17 No, it does. Some of it goes away, but not
18 much.

19 CO-CHAIR STEINWALD: Bill.

20 DR. GOLDEN: As we go through
21 this, I think it'd be useful to have somewhere
22 in there that the risk adjustment should be

1 based on the total universe of the patients'
2 claims, and not just on the claims of the
3 entity being looked at.

4 What do I mean by that? Well, for
5 example, if there is a diabetic or a heart
6 failure patient in my practice, I may not code
7 for mental illness issues. In fact if I did
8 code for mental illness issues I'd be
9 penalized because I get paid less because I'm
10 caring for the depression. However everybody
11 knows if they have mental illness
12 comorbidities, their costs go up. So I think
13 it'd be a useful principle that it should not
14 be just based on the narrow diagnoses being
15 cared for but all the diagnoses that the
16 patient carries in the claim set.

17 CO-CHAIR STEINWALD: Tom.

18 DR. ROSENTHAL: On the risk
19 adjustment question, my observation would be,
20 it sort of depends. I would say that to the
21 extent possible we should in fact include
22 socioeconomic status. Because as I've learned

1 in about the last year in a half it's an
2 incredibly important driver of cost of care,
3 and to not include it would be a major
4 mistake.

5 But to the question of how good is
6 good, and when is perfect the enemy of good,
7 I think it depends on what use the data is
8 going to be put to. If the use is going to be
9 to publish the names of every hospital or
10 every provider in a state, region or country
11 on the front page of the New York Times, I
12 have a feeling that all of those individuals
13 so arrayed are going to be very much
14 interested in as good a risk adjusting thing
15 as we could possibly come up with.

16 If on the other hand the goal of
17 the exercise, and what we are trying to get,
18 is performance improvement, I suspect that
19 good enough is generally good enough for most
20 organizations to look at and say, it may not
21 be perfect but we'll work on this because it's
22 probably directionally correct.

1 So I think the answer is, it's
2 going to depend on the uses as to how much
3 risk adjustment is going to be viewed as
4 believable.

5 Jack Needleman and I were talking
6 the other day, and there are two criteria for
7 this entire exercise it seems to us. It's got
8 to be believable and actionable. Believable
9 and actionable are going to then depend on how
10 the data is collected and to whom it's
11 portrayed for action.

12 CO-CHAIR STEINWALD: Bill, Rich
13 and then Lisa.

14 DR. RICH: On the point on risk
15 adjustment that Tom raised, it depends on what
16 part of the spectrum you are, working left to
17 right. If you are all the way on the left
18 where Bill Golden is you need more and more
19 granularity, and it's very important that you
20 do I think look at race and socioeconomic
21 status.

22 When you get over to the right-

1 hand side for procedure specific, I think that
2 the risk adjustment should be, the measure
3 should have a very finite endpoint, so there
4 is not - almost have a clear line and a little
5 granularity. Now I don't know how you
6 verbalize that, but I think you can develop
7 some pretty powerful measures on the right-
8 hand side where you don't want granularity.
9 And on the left-hand side you need that
10 granularity if you're ever going to have
11 meaningful risk adjustment over there.

12 So I think there is a continuum of
13 risk adjustment, depending on what kind of
14 measures we are looking at. I don't know if
15 that makes sense.

16 CO-CHAIR STEINWALD: It makes
17 sense to me.

18 Lisa and then Ethan.

19 MS. GRABERT: I just had a
20 comment about how we're discussing this. The
21 last bullet says, later discuss the extent to
22 which each phase is subject to evaluation. I

1 actually think we need to have that
2 conversation first, because I don't know what
3 parts of the methodology I should put into
4 which bucket unless I know whether or not they
5 are a sufficient or necessary part of the
6 overall evaluation process.

7 Previously in the earlier draft
8 that we had, data preparation and creation of
9 the unit for measurement were both necessary
10 and sufficient, Part 3, applying it to
11 measurement was not necessary. And there are
12 certain things that are in that bucket that
13 you might argue are more or less necessary
14 such as attribution, once you know what you
15 plan to do with each of those buckets.

16 MS. TURBYVILLE: So what was
17 previously put forth was just to get the
18 steering committee talking about it; there was
19 no assumption that three would not be subject
20 to evaluation. It was like here was an
21 example, you wouldn't have to include them
22 all.

1 Right now, the thinking after we
2 heard the comments based on the webinar is
3 that potentially all three are subject to
4 evaluation, and maybe there are steps within -
5 honestly we don't know. We really want the
6 steering committee to inform this piece -
7 which parts will be subject to the evaluation
8 and which parts will not. And there are many
9 reasons and implications for those decisions.

10 DR. HALM: Nothing stops
11 providers quicker than the risk adjustment
12 issue. And there have been lots and lots of
13 thoughtful discussions of this, and I wonder,
14 obviously 15 lines on this doesn't capture
15 what's already known and been talked about
16 with risk adjustment. So I wonder since there
17 is an element of the white paper that is to
18 educate people and somewhat aspirational as
19 far as encouraging your more sophisticated
20 measures if that's what's indicated, if
21 either NQF or their other well endorsed sort
22 of policy descriptions of the different

1 domains, or sort of goodness in the pursuit of
2 the perfect with regard to risk adjustment
3 that are out there that we can articulate so
4 that people can kind of see in the hierarchy
5 of the kinds of domains that are sort of
6 optimal, okay, and not so good.

7 I'll also comment that in the era
8 of electronic medical records there is going
9 to be much more that people are going to be
10 able to do. So even like in our center we are
11 coming up with measures of social chaos and
12 adherenceness using electronic means.

13 CO-CHAIR STEINWALD: I'm going to
14 pretend this is for the benefit of the guys
15 with earphones. Would you repeat what you
16 just said? Social chaos and?

17 DR. HALM: Adherences.

18 CO-CHAIR STEINWALD: Adherences.

19 DR. HALM: But I wonder if we can
20 sort of amplify or have an appendix of just
21 some - a lot of the thoughtful work that's
22 been done on risk adjustment so that we don't

1 have to see that as the purpose of the
2 resource use steering committee, but really
3 sort of reference that or educate people about
4 what's already been known and done on that.

5 CO-CHAIR STEINWALD: Right. So
6 you're saying let's not even try to create the
7 wheel, but let's point to where the wheels
8 exist elsewhere.

9 I'm sorry?

10 DR. HALM: We need to have more
11 than 15 lines in the document that reflects
12 that current state on that, and that would
13 help.

14 CO-CHAIR STEINWALD: Lisa, your
15 card is still up. Did you intend it to be?

16 All right, I'm not sure we've
17 given enough guidance to staff on this. One
18 question is, are these the three distinct
19 phases that need to be identified as such? Do
20 we agree with the phases and how they are
21 described?

22 Data preparation I think, it

1 sounds a little bit more techy that we
2 intended it to be. That is, it's not just the
3 preparation, it's identifying what data will
4 be used for a resource measure, and then
5 putting those data in a form that meets the
6 scientific acceptability criterion, I would
7 guess. Did you mean it to mean more than
8 that?

9 MS. TURBYVILLE: Kind of diving
10 into what we have within, so the data
11 preparation is to determine any changes that
12 might need to be made to the data, and some
13 would be optional; others would be mandatory.
14 And some of that could depend on whose
15 resource measure you are using. So for
16 example an Ingenix episode-based measure may
17 have suggestions on how you might want to set
18 up your data. Are there certain claim line
19 outliers that you would want to either
20 Winsorize or actually eliminate? And what we
21 are proposing is what steps need to be taken
22 in order for the resource use measure to be

1 valid based on the measure developer's
2 experience be explicitly included in the
3 specification. So that if there are steps
4 that a user of a measure needs to take in
5 order for the end measure to be valid and
6 reliable, that they make sure that they're
7 explicitly telling the measure developers what
8 those steps are.

9 DR. LEE: Although this part
10 isn't the sexiest part of the document, it's
11 important for states that have developed all-
12 payer databases, like Maine, Massachusetts -
13 we actually outsource it to Maine, because
14 they actually had experience working through
15 these issues, and wanted our data to be
16 comparable at least to Maine. So there really
17 are some methods - there should be clarify and
18 consistency in the methods used here. So
19 this is important methodological stuff.

20 CO-CHAIR STEINWALD: Jack, Bill,
21 Barbara.

22 DR. NEEDLEMAN: The goal of the

1 work is to produce comparisons that are
2 informative, whatever we're comparing folks
3 to. And the whole purpose of risk adjustment
4 is to eliminate things that say, yes, but you
5 can't compare that. That's apples and
6 oranges. So we've got lots of methods for
7 adjusting our comparisons so that they are
8 informative and I'll use the word believable
9 as a condition. And we've got methods
10 specified in here that risk adjustment
11 typically means some sort of additive or
12 multiplicative adjustment process, or - but
13 we've got those methods. We've got
14 stratification. We've got truncation. We've
15 got exclusion rules. And ultimately when you
16 are looking at a measure you've to look at
17 the combined way that all the things they have
18 done to create comparability in the numbers.
19 And that I think is the most important thing
20 to communicate here.

21 And then I would agree that some
22 of the specific methods, and some of the

1 things that NQF has already learnt, looking at
2 other kinds of measures about how those
3 comparisons are made might very fruitfully be
4 in an appendix or a more extended discussion.

5 But the essence of what we are
6 trying to get at is important, and then the
7 mechanics of the kinds of things we've seen in
8 other measures to do that are also important.
9 And in that regard, just again at the risk of
10 nitpicking on the language, around line 524 it
11 says, unlike quality measures which normally
12 compare performance to an agreed upon
13 standard, and it talks about the lack of
14 agreement here. Well, we've got some quality
15 measures that are process measures, and there
16 we tend not to risk adjust. Because once
17 we've decided that for this population
18 something should happen, it either happened or
19 it didn't; we don't need to risk adjust it.

20 But we've got other measures,
21 particularly anything that falls into the
22 realm of outcome measures, where risk

1 adjustment is absolutely essential. So we've
2 got mortality measures for cardiothoracic
3 surgery, and we risk adjust the hell out of
4 those measures precisely to produce this
5 informative comparison basis. So I think that
6 language is a little bit too strong and
7 doesn't capture the full range of measures
8 that we actually are using, some of which are
9 risk adjusted, some of which aren't.

10 CO-CHAIR STEINWALD: Bill.

11 DR. GOLDEN: If you want to
12 technically get into what we are doing here,
13 I'm not sure that we are capturing it. Data
14 preparation is really, I think you are looking
15 at really, you are trying to describe an
16 analytic protocol as opposed to just - and I
17 don't think we're capturing it. I mean I've
18 seen the material on 313, 318. I've seen
19 people make substantial errors here. And
20 really what you're trying to say to folks is
21 that they need to make sure that they know
22 what they're looking at, and they have

1 competent people doing the analysis. And I'm
2 not sure that's truly data preparation. It's
3 really preparing the dataset. It's making
4 sure you have done the right basics before you
5 can get started. And putting in an inclusion
6 or an exclusion as the next step, that
7 actually shouldn't happen I think until after
8 you've defined your measures. So I think
9 you've kind of put some things in a funny
10 order there. But let's - I mean basically you
11 have all the material there, but I'm not sure
12 you have the right steps put together.

13 And what you are trying to do here
14 I think is put together a roadmap for the
15 analytic team to make sure they don't make
16 fundamental errors.

17 CO-CHAIR STEINWALD: Barbara.

18 DR. RUDOLPH: I was doing to talk
19 about some similar things. The data selection
20 really, there should be a basis for why that
21 particular data is being utilized, given this
22 is by other parties. And if it's something

1 new that has never been done, then I think
2 there needs to be a rationale as to why that
3 might be a viable option, things like that, in
4 addition to then when you start to prepare the
5 data.

6 But I really like the idea that
7 all the steps must be explicit. And having to
8 do that is so torturous, because you make a
9 million decisions when you are analyzing data.
10 But for the end user unless that is made
11 explicit you aren't going to be able to really
12 know what happened or replicate it.

13 For risk adjustment I agreed with
14 what Jack was saying, depending on where you
15 are on that sort of measure continuum, if
16 you were doing just a procedure or a clinic
17 visit you may not need to risk adjust it. So
18 if there is risk adjustment necessary or not
19 necessary, it should be at least discussed in
20 the data submission, and a rationale should
21 be given for sort of the extent of that
22 adjustment activity.

1 And I actually on page 47 of the
2 report, I liked what was in the exhibit, risk
3 bifurcation, and then Prometheus model where
4 they actually came up with some criteria for
5 the predictors that were selected. In this
6 case it was like greater than or equal to 30
7 episodes per category of positive coefficient;
8 a low variance inflation factor; a high
9 partial r square; and clinically plausible.
10 Because what I see happening oftentimes is,
11 those decision points aren't made explicit.
12 Why was that predictor included? I look
13 through for a little private project that I
14 did, I looked through all the public reports
15 on CABG procedures, and the risk adjustment
16 models for all of them and found that about 80
17 percent of the risk predictors actually
18 weren't significant, yet they were still being
19 used. And to me that just muddies the water.
20 I mean if you are going to have predictors
21 they ought be actually contributing to the
22 model as opposed to just additional factors

1 that people think might contribute but
2 actually don't.

3 CO-CHAIR STEINWALD: Tom, then
4 Kurt then Jim.

5 DR. ROSENTHAL: I had a
6 clarifying question is, this discussion about
7 data presumes that somebody submitting a
8 measurement will have very carefully
9 identified the populations that are being
10 talked about, and to whom it would be
11 attributed, and all of that kind of stuff, and
12 now we are only talking about the data
13 elements that would be necessary and how you
14 would get them and all that.

15 Have we assumed that that step is
16 done, or have I missed that?

17 MS. TURBYVILLE: If I'm getting
18 your question right we would have assumed that
19 they have specified the measure and tested it
20 in some way or another, and so clearly
21 identified which elements a user needs in
22 order to support the intent of the measure

1 they are putting forward. So if it's an
2 overall resource use, and they say pharmacy
3 data is critical to this metric, you would
4 assume that they have a rationale for that.

5 DR. ROSENTHAL: So if, in fact,
6 somebody were saying I'm going to measure
7 Blue-Cross-capitated populations in California
8 across organized medical groups, and then this
9 is only relevant to them. Here's the
10 datasets, here's how I get the data; here's
11 how I risk adjust the data, and so forth. The
12 presumption is all the other descriptive stuff
13 would have been done.

14 MS. TURBYVILLE: Correct.

15 DR. ROSENTHAL: Okay.

16 CO-CHAIR STEINWALD: Kurt.

17 DR. ELWARD: Just following on
18 Bill's comment on what we're trying to do.
19 Unless data preparation is a formal term that
20 we always use, I'm wondering if we might think
21 more about data protocol or development of
22 data design, something like that. When I read

1 data preparation I almost think of data
2 cleaning, like you've got the data and now
3 you're going to prepare it. And maybe it's
4 just me, but perhaps we could be a little bit
5 clearer about what we actually mean by data
6 preparation.

7 CO-CHAIR STEINWALD: Data
8 development?

9 DR. ELWARD: Data development or
10 data protocol.

11 CO-CHAIR STEINWALD: Jim.

12 MR. WEINSTEIN: If I could follow
13 up a little bit, so these are resource use
14 measures that are data elements I guess. And
15 then is it implied that the IT people in
16 either the payer world or in the provider
17 world will actually have the ability to do
18 this in their systems?

19 CO-CHAIR STEINWALD: Is that a
20 rhetorical question?

21 MR. WEINSTEIN: Well, I guess the
22 question is, we're running up against what

1 meaningful use is for IT strategies. And is
2 it a recommendation of the committee then that
3 these become meaningful use measures or not?
4 Because it does create a cost to systems to
5 have to do these things, and we should be
6 cognizant of that.

7 CO-CHAIR STEINWALD: What do
8 others think about that issue?

9 DR. ROSENTHAL: Doability was a
10 component of what --

11 CO-CHAIR LOTZ: Feasibility.

12 DR. ROSENTHAL: I don't know all
13 the lingo yet. Obviously, feasibility has got
14 to be a component of the thing. Of if it is
15 a profoundly important bit of data that is not
16 in fact currently feasible then we'd have to
17 make some judgment of -- this ought to be part
18 of meaningful use even if it's not. But I
19 think we've got to adjudicate that against
20 what comes. I don't think we should lay it
21 out prospectively yea or nay.

22 DR. RUDOLPH: To add on to that,

1 I think one of the questions has been over the
2 last couple of years in the CSAC is, if data
3 is available to only one party and to no one
4 else, is that really a feasible measure, and
5 I'll raise that here.

6 CO-CHAIR STEINWALD: A tree falls
7 in the forest and --

8 Would anyone like to respond to
9 that? Well, I guess we will discuss the four
10 criteria and what constitutes feasibility.
11 Should we defer that? Go ahead, Tom.

12 DR. ROSENTHAL: Well, I think that
13 is a very important question, because some of
14 the materials that we've seen hasn't been
15 validated by anybody and isn't particularly
16 transparent. And I think on any of these
17 there has to be at least a certain element of
18 transparency, and ability for independent
19 replication before it can be put into place.
20 So I think your point is well made.

21 CO-CHAIR STEINWALD: Helen, go
22 ahead and jump in.

1 DR. BURSTIN: One clarification,
2 though: I think there is a distinction between
3 the measure and all the details of the
4 measure, and how you do the measure being
5 fully transparent which is an absolute
6 paramount thing for NQF. That's clear, you
7 guys will get to evaluate the insides -- there
8 are not black boxes. You guys will get to set
9 the insides of any box submitted, should boxes
10 come in.

11 The issue I think Barbara is
12 raising is slightly different, which is, what
13 if the measure is fully transparent but the
14 data are not? And this has been a continuing
15 issue we are going to talk about again this
16 week with the CSAC of you know the ultimate
17 goal of NQF-endorsed measures that they are
18 publicly reported to the public at large. But
19 we recognize this as a continuum of public
20 reporting, so if a measure is only reported
21 for example to the health plan or only
22 reported to CMS, that is potentially along

1 that path on public reporting.

2 But the point Tom is raising I
3 just want to make very clear, the measure
4 itself must be fully transparent. And we
5 actually even have a carder that we have
6 created for submission of measures by
7 proprietary groups where it is fully
8 transparent to the steering committee
9 completely, all the details. We will then
10 have a limited license to view. If it's
11 endorsed they will have to provide a limited
12 license to view so that anybody who wants to
13 look at using that endorsed measure will have
14 the capacity to again go under the hood, but
15 potentially the issue of costs involved in
16 paying for a proprietary system would get
17 woven in under feasibility.

18 CO-CHAIR STEINWALD: Lisa and
19 Bill, you both have your cards up. Did you
20 intend them to be? Yes, okay, go ahead.

21 MS. GRABERT: This may be just
22 splitting hairs, but I think that the NQF

1 project team may be interested in my specific
2 comment that I think pricing methodology
3 should be included in the data preparation
4 bucket. That is certainly the way that I've
5 always thought of it when I managed the
6 physician resource use reporting program for
7 CMS, that was definitely a data preparation
8 step before we did anything else with the data
9 in terms of putting it into a measure.

10 CO-CHAIR STEINWALD: Ethan.

11 DR. HALM: Yes, I think there are
12 a lot of good steps in the analytic process
13 that are listed out here. I'm hearing
14 comments that I don't know that these three
15 phases make the most sense as a way of
16 classifying them or chunking them. And I'm
17 trying to figure out from a process standpoint
18 how to handle that as far as advising people
19 with regard to the white paper. We would see
20 maybe some additional important analytic steps
21 in there, and then we can think conceptually
22 of how we would chunk these things and name

1 them. Because I think there is a lot of
2 great content here in the steps, but the names
3 themselves, I think, are less informative than
4 the individual pieces. And I hear us
5 struggling with that a little bit. And I
6 don't know that we can solve that in real
7 time.

8 CO-CHAIR STEINWALD: I don't hear
9 or see disagreement. I guess again, could the
10 best be the enemy of the good? Do these three
11 work for purposes of providing guidance to
12 measure developers, let's say, that there is
13 some value in trying to disaggregate a process
14 into components, and we've got, as Sally said
15 earlier, that calling them phases implies that
16 they are sequential in time and don't actually
17 necessarily mean that, so they could be
18 modules or something else. But if - can
19 anybody suggest any modifications or
20 improvements to - other than what we've
21 already talked about in data preparation?

22 Do you think you have enough

1 guidance for the time being?

2 MS. TURBYVILLE: I do, thank you.

3 DR. RUDOLPH: Can I make one
4 suggestion?

5 CO-CHAIR STEINWALD: Sure.

6 DR. RUDOLPH: I think this is
7 where it kind of threw me off. I think it'd
8 be helpful to have a category above data
9 preparation called "measure specification" so
10 that people would then realize some of the
11 things that we've talked about, that would be
12 already - that you would start out with this
13 package of measure specs, and then you'd do
14 data preparation, and then creation of the
15 units for measurement and explaining it that
16 way. I don't know how others feel, but --

17 DR. PENSON: What do you mean by
18 that? I'm over here, sorry. I'm not too sure
19 what you're driving at with that so help me
20 out.

21 DR. RUDOLPH: The measure
22 developers have to provide to NQF the set of

1 specifications including all the coding, the -
2 et cetera, all the description of the data,
3 blah blah blah. And then, as an end user you
4 get that description. But then there is also
5 - you'll have to do data preparation
6 activities which would include some of the
7 things that - the next steps, the data prep,
8 the creation of the units for measurement, the
9 applying the units.

10 DR. PENSON: I see where you are
11 driving at. I mean, I think it's all implied
12 there because effectively your phase two and
13 three are your numerator and denominator for
14 your measure specifications. So I'm wrestling
15 with the same thing everyone else is wrestling
16 with which is - I think it's semantics. I
17 don't know if adding a fourth helps. I see
18 what you're getting at. But it strikes me
19 that these are not - they are not sequential,
20 they're concurrent. I mean they are
21 components, but you sort of - maybe the whole
22 thing is measure specifications; maybe that's

1 what this is, which is each measure has to
2 have certain specifications. The numerator is
3 the unit of measurement, the denominator - and
4 you're going to have to do certain things with
5 the data to get there and you've got to tell
6 us what they are. Maybe that's the right way
7 to do it, maybe.

8 CO-CHAIR STEINWALD: Bill Golden,
9 your card is up? All right, then Bill Rich.

10 DR. RICH: You know one of the
11 things we're struggling with and we're talking
12 around, when you look at this white paper and
13 then you read the McGlynn Thomas paper and the
14 acumen things, are any of these steps, they're
15 going to give us transparency, but are we
16 going to have a product that is going to be
17 different and useful and meaningful? Or are
18 we going to have to have a retrospective
19 analysis like those papers do? I think what
20 we'd like to do is try to, in this process,
21 try to identify the things that would make
22 these things actual, reasonable, reliable, and

1 do a better job than explaining 25 percent of
2 their variation.

3 And then I struggle with the whole
4 white paper. I'm not sure that any of these
5 steps are going to predict whether these
6 things are going to be reliable measures or
7 not.

8 CO-CHAIR STEINWALD: An even more
9 fundamental question, I think, is, will any
10 measure developers develop measures that meet
11 all the requirements that we're laying out
12 here? And what can we do to turn that around?
13 How can we have the white paper be a resource
14 that encourages measure developers to innovate
15 a bit? I'm not sure that's very responsive to
16 what you just said. But if the white paper
17 reads as if it's full of requirements and
18 restrictions, then you can't view it as
19 something that's encouraging, and how can it
20 be framed in such a way that we're trying to
21 encourage measure developers to think a little
22 bit outside the box and doing something

1 different from what they've done before.

2 Yes, sir.

3 DR. BARNETT: I am not sure - I
4 saw in the appendix that one of the measure
5 developers had distinguished the inessential
6 care, the care that is not indicated, not
7 appropriate. And I don't think that that, as
8 being a criteria or a part of it, is in the
9 front part of the white paper, that whole
10 issue of appropriateness. And of course we
11 very much care about - we want to see
12 resources used on things that are appropriate
13 and not on things that are inappropriate, and
14 to the extent that that can be incorporated
15 into a measure is certainly desirable.

16 CO-CHAIR STEINWALD: Well, do you
17 think that the way the white paper is written
18 now it's precluding that?

19 DR. BARNETT: No, I just think
20 it's an oversight. That could be another
21 attribute that some measures have that others
22 don't and that hasn't been articulated.

1 CO-CHAIR STEINWALD: Tom.

2 DR. ROSENTHAL: I think the point
3 that you raised about encouraging development
4 is a really important one. Because it's not
5 entirely clear that any of the things that
6 might really - that are currently phrased in
7 the thing are quite ready for the front page
8 of the Washington Post test that I hold it
9 against. And maybe this is a situation where
10 the NQF's success over the last 10 years might
11 work a little bit against this effort, in the
12 sense that we're at the 10th or 12th year of
13 quality measures and sort of a little bit of
14 maturity to them. And maybe the notion that
15 could be incorporated into the white paper is
16 that the notion of pilot measurements would be
17 solicited in addition to those that would get
18 the full NQF treatment, and I don't think that
19 that concept is in there yet, and - or at all,
20 and maybe that's a way to address the notion
21 that this is going to be a multi-year process
22 to identify things that are really fully ready

1 for the whole full-scale NQF treatment.

2 CO-CHAIR STEINWALD: Your
3 Washington Post - I know I heard New York
4 Times earlier.

5 Ethan.

6 DR. HALM: Just thinking, I
7 wonder if - I'll just throw it out there as a
8 suggestion. You know perhaps the - if we
9 called things measure specification creation,
10 and application, would that potentially fit?

11 CO-CHAIR STEINWALD: You're
12 suggestion renaming --

13 DR. HALM: Or just playing with
14 it a little bit. Because I'm hearing now
15 it's all about the measure so rather than
16 putting the word data or unit - I mean the
17 word data and unit, I get confused on. But I
18 know what you mean by a measure. So maybe
19 playing around with measure specification,
20 creation and application or further kind of
21 brainstorming about making it a little bit
22 more intuitive.

1 CO-CHAIR STEINWALD: All right.

2 Go ahead.

3 DR. RICH: Yes, that was a little
4 bit where I was confused here, because when I
5 saw data preparation, when I think about data
6 preparation, I think about application of the
7 measure that's already specified. And I think
8 I'm stuck where Barbara was, you know, trying
9 to figure out, is this a measure specification
10 for developers section? Or is this talking
11 about how you take data that you've collected
12 and apply to an already specified measure?

13 CO-CHAIR STEINWALD: Go ahead.

14 MS. TURBYVILLE: And I appreciate
15 this conversation. We did struggle with the
16 language and we still are, which is one reason
17 that I'm very thankful that you are being
18 thoughtful about this. It is intended to
19 parse out the measure specification. And the
20 signal that we are hoping to drive through
21 this process, whether it's painful or not, is
22 to make sure the measure developers understand

1 that they can't just submit to us some high
2 level specification and think that that is a
3 done deal. They need to be very explicit
4 about what data are needed, what needs to
5 happen to the data protocol. It's not how you
6 collect the data necessarily. But it would be
7 implicit because it would tell you what types
8 of data need to be there. You need to tell
9 them explicitly -them being the users - how to
10 create your denominator or your unit for which
11 you are going to apply the resources.

12 You need to then say which units
13 of resources are relevant to that denominator.
14 Because there is a huge menu of potential
15 resource units that could be applied to any
16 measure. So we want the measure submitter,
17 the developer, to say, for this measure it is
18 valid to measure ED use, to measure monetized
19 evaluation management. That all should be
20 part of the specification. So, in essence,
21 this is the specification as was mentioned
22 earlier, broken out because we don't want any

1 one step to be ignored, realizing that a lot
2 of these developers have not going through
3 this type of endorsement process before. So
4 to the extent that we can make it more clear
5 and use better language, and whether or not
6 three -

7 CO-CHAIR STEINWALD: Mary Kay.

8 DR. O'NEIL: I'm new to this
9 process as well, so I guess there is the
10 tension between being inviting, to want people
11 to actually submit things, and being clear
12 about what's required to participate. And so
13 perhaps it is in the wording to just say
14 things the way that you've said them.

15 I did come to this meeting with
16 some local feedback that the NQF measure
17 requirements are too expensive for many
18 entities to participate in, and obviously we
19 don't want just anybody in here doing things
20 that are meaningless and nonreproducible. But
21 maybe there does need to be a little bit of
22 balance if part of the message is to invite

1 people to participate in that.

2 CO-CHAIR STEINWALD: The remark
3 that someone made earlier is that NQF's past
4 success may work against it. So the ability
5 to get measure developers to do something they
6 haven't done before may be something that
7 should be confronted right up front, and the
8 notion that a measure doesn't need to be a
9 completely developed measure, let's say.

10 Well, let me rephrase that.

11 (Laughter.)

12 I obviously misspoke.

13 Well, then, rather than get fired
14 again, language that would be more inviting
15 and encouraging, I think would be very helpful
16 if we can figure out a way to do that.

17 DR. BURSTIN: I'd just make a
18 point, I think in some ways some of this is
19 just the different lexicons that these
20 different fields use. As I read through that
21 section again, this whole data preparation-
22 data cleaning looks like the algorithm that a

1 company lists of our measure specifications.
2 So it may even be sort of a side by side of
3 this is what we usually think about in terms
4 of a measure, numerator, denominator,
5 exclusions, the algorithm that accompanies it,
6 and then link it to what would happen, because
7 in some ways what they are actually saying in
8 the paper here is that the data piece is
9 actually somewhat distinct and precedes the
10 measure calculation. So there is almost a
11 pre-phase in this that doesn't exist with most
12 measures unless you sort of -- so they just
13 need --

14 PARTICIPANT: It really should.

15 DR. BURSTIN: Hmm?

16 PARTICIPANT: It really should be
17 for all measures, all the time.

18 DR. BURSTIN: Right, but this
19 degree of specificity, I think, is somewhat
20 unique to this area, and I don't think we want
21 to lose that specificity when these things are
22 submitted to us. I think we can work to try

1 to make some - help the lexicons connect.

2 CO-CHAIR STEINWALD: Okay.

3 Anything else on this matter? Let's go
4 forward.

5 DR. BARNETT: One brief thing is,
6 I think that everything is here and that what
7 people are struggling with is, they want to
8 change the headings -- the names on the
9 headings and the order of the text. And so
10 that suggests there is not really a lot to
11 worry about.

12 DR. BURSTIN: That was such a
13 simply stated comment. Does she feel like she
14 has enough in terms of what should the
15 headings should be changed to and how they
16 should be reordered? But suggestions on paper
17 are welcome as well.

18 MS. TURBYVILLE: So we did start
19 out with denominator and numerator. We have
20 been having conversation with many of the
21 measure developers to get their feedback along
22 the way, and quite a few did not like that at

1 all and felt that it was trying to force them
2 into the quality measure domain, and our
3 measures are really different. This language
4 came from one of their suggestions, but I
5 still think it's really important that we are
6 clear to our readers as well. So it is kind
7 of this interesting development of what is
8 going to be the best nomenclature. And since
9 we are a little bit ahead of schedule it might
10 be worthwhile to spend a little bit of time on
11 it now rather than just through email, since
12 we are not behind schedule yet. Is that okay
13 with you?

14 CO-CHAIR STEINWALD: Paul and
15 then Barbara.

16 DR. BARNETT: So Ethan had
17 something he said earlier. He said what were
18 good headings. But I think the one thing
19 we're struggling with is that word "unit,"
20 when what you mean is per capita or per
21 episode. And it would be more transparent,
22 isn't it?

1 MS. TURBYVILLE: Right, that is
2 the challenge, because at that point it's not
3 - and maybe it's a different way to think
4 about it, but that's prior to applying the
5 resource unit, so there is no "per" at that
6 point. It's just defining either the clinical
7 logic, the episode construction would be -
8 which would be like a trigger, whether it's an
9 event or a procedure or a diagnosis, and then
10 the end data for a population, it would be
11 whether based on demographic descriptions or
12 belonging to a certain health plan or whether
13 it's this other in between, which is that per
14 patient, like someone with diabetes, just
15 identifying what in essence is the
16 denominator, and then the third piece was
17 intended to not apply as an implementation,
18 but now that you have that unit or that
19 denominator, which was the way I was thinking
20 about it, and I got pushback on the concept of
21 a denominator, to that numerator, then you say
22 which resources, whether or not they need to

1 be - have a cost method applied to them,
2 whether it's standard or allowable charges, or
3 some other - and then from there you get your
4 -- exactly as you described, Paul, is it at
5 that point per patient per this, is it a per
6 episode? Is it average, episode costs, et
7 cetera. There are all those steps that that
8 third place, that third bucket has the most
9 steps of all, at least the way we presented it
10 to all of you.

11 DR. BARNETT: So what is the
12 definition of unit?

13 MS. TURBYVILLE: It's the core
14 defining features which include the clinical
15 and temporal logic of the claims that identify
16 a distinct and homogeneous - though they may
17 not be completely homogeneous - units for
18 measurement.

19 DR. BARNETT: But don't you
20 really mean there episode or case or person,
21 patient?

22 CO-CHAIR STEINWALD: If you do

1 doesn't the word, unit, kind of cover all of
2 those things?

3 DR. BARNETT: But unit could be,
4 you know, dollar, it could be emergency room
5 visited. It's so generic that it doesn't say
6 anything, and that's why people are having
7 trouble understanding it.

8 CO-CHAIR STEINWALD: Barbara and
9 then Tom.

10 DR. RUDOLPH: Okay, I was going
11 to talk about something else, but it sort of
12 fits in here too. I think that for these
13 types of measures, many of the people
14 developing them do not come from an
15 epidemiologic framework. They come from a
16 different - either economic or business logic
17 or sociologic framework. So numerators and
18 denominators aren't really part of that way of
19 thinking. So I can see where a lot of them
20 would be resistive to that kind of
21 nomenclature for it.

22 The other thing is that oftentimes

1 when you do numerators and denominators, you
2 simplify things that are much more complex
3 than that. Like some of the methodologies
4 used for risk adjustment, you really can't
5 even think about it in terms of numerators and
6 denominators; it doesn't make sense. Based on
7 techniques and other kinds of things.

8 So I just think it's probably best
9 not to do numerator/denominator. And I don't
10 know what the correct - how you would define
11 it exactly, but this more complete definition
12 helps me a lot.

13 CO-CHAIR STEINWALD: Tom and then
14 Dolores.

15 DR. ROSENTHAL: I think the thing
16 we're struggling with a little bit is, again
17 back to the question I posed earlier, the
18 presumption is that somebody has already
19 thought, what am I going to prepare to what?
20 I want to compare the cost of glaucoma surgery
21 where I'm going to measure every
22 ophthalmologist in the country or I'm going to

1 measure heart failure at the individual doctor
2 level using an episode grouper, these units
3 are, well, what are those costs that you would
4 include in whatever the episode is? But it
5 presumes that you've got the episode
6 categorized in your head, and now you are just
7 getting people to put the data together is the
8 way I see it. And if I were you, I'd push
9 back to the pushback.

10 I mean, here we're all sitting and
11 saying, when you describe what you think we
12 are trying to get them, anybody who would
13 develop one of these things, to do, it makes
14 perfect sense to us. And the only reason it
15 sounds like you are sticking with those title
16 headings is, well, some of the developers
17 didn't like it or didn't understand it.

18 I'd just push back, I'd push back
19 the pushback.

20 CO-CHAIR STEINWALD: Dolores.

21 MS. YANAGIHARA: I'm just
22 wondering if -- I like the idea of bucketing

1 it, but it seems like different methodologies
2 might bucket different things in different
3 places. So that gets kind of messy. But I'm
4 just wondering, I mean this is really all part
5 of the specification. So instead of trying to
6 bucket it into different categories, I'm
7 wondering if we just say, here are the
8 requirements of the specification and describe
9 - instead of trying to figure out what terms
10 to use to bucket them. Just say, these are
11 the things that we need, and you have to use
12 some terms obviously, but then the
13 description, I think, makes it more clear. So
14 it's all part of the specification. I don't
15 know if that helps or not, but I think, to try
16 to figure out how to bucket it, and what terms
17 to use for the bucketing, it just may be more
18 complicated in the end than just making a list
19 of what needs to be included in the
20 specifications.

21 DR. HALM: You've used the word
22 "steps" several times. So even just thinking

1 about steps for measure specification and
2 creation and application may get away from -
3 may get closer to what people really do.

4 CO-CHAIR STEINWALD: David.

5 DR. PENSON: I think, from
6 hearing the comments from across the table
7 before, I don't want to use the term
8 "denominator," Barbara. But on the other
9 hand it goes back to something we were talking
10 about this morning, which was that spectrum on
11 left and right per episode, per capita. The
12 first step is deciding what your "per" is
13 going to be.

14 PARTICIPANT: The per is not --
15 they don't do it in terms of denominator

16 DR. PENSON: But effectively it
17 is, because it's a rate. Whether it's for the
18 population, for the - but however you want to
19 word it, that's the first step. Because that
20 defines - I mean the first step in measure
21 specification is what is your 'per', for lack
22 of a better way to put it. Because that then

1 is going to determine everything that goes on
2 afterwards, whether it's risk adjustment,
3 whether you count, whether you monetize, what
4 it is, it's all what your `per' is. I don't
5 know the right term to use, it's
6 categorization, how you are going to -- unit,
7 I don't know, but that's really what we're
8 trying to say here if I'm reading it right.

9 CO-CHAIR STEINWALD: Paul and
10 then Jack.

11 MR. BOWHAN: I hate to disagree
12 with my colleague from Wisconsin, but I think
13 it does come down to keeping it simple,
14 because we are directing this toward people
15 who are going to create performance measures,
16 as I understand it. Let's keep it simple:
17 it's a measure specification, and in that
18 specification you need something that
19 describes a numerator and a denominator, and
20 you need the specifics behind that. And I
21 think we are trying to make it too
22 complicated, and each of these paragraphs or

1 sections almost always talk about defining a
2 population. Well, you are repeating that same
3 kind of language through all the sections. We
4 are making it too complicated, I think.

5 CO-CHAIR STEINWALD: How are you
6 feeling about this?

7 MS. TURBYVILLE: Like I did last
8 week.

9 CO-CHAIR STEINWALD: Well, I do
10 hear something that sounds like a consensus at
11 work. We're talking broadly about the
12 specification of a measure. And that
13 specification has a number of components to
14 it, whether you call them steps or units or
15 whatever else.

16 Now I heard someone suggest that
17 rather than have three buckets and try to
18 defend them it might be better just to go on
19 to discuss about them, in some detail as you
20 have done, the elements without trying to
21 create and defend that there are three
22 buckets, and here's how they are defined.

1 Does that work? In other words -- can you
2 live with that?

3 MS. TURBYVILLE: Is there
4 anything missing in this step? We've talked
5 about what is there, but is there anything
6 that is not there that ought to be?

7 CO-CHAIR STEINWALD: Go ahead,
8 Ethan.

9 DR. HALM: I think Tom earlier
10 brought up the sort of all payers perspective,
11 but in the section on inclusion and exclusion
12 there's some nice subtlety talked about,
13 people moving in and out of different plans or
14 payment systems. But I would just amplify
15 that, because there are plenty of people who
16 are just in more than one and stay in more
17 than one. So we have dual eligible Medicare
18 and Medicaid people. We have people in the VA
19 and Medicare.

20 So the extent to which we really
21 want developers to have all inputs in relating
22 to a patient I might just add a few sentences

1 about the reality of acknowledging and
2 handling sort of dual eligible individuals.

3 CO-CHAIR STEINWALD: That makes
4 sense to me. Do you want to move on?

5 MR. PHILLIPS: Could I, just on
6 the question of whether there was anything
7 missing, I guess when I was looking through
8 here I was trying to find - oh here it is -
9 just as far as the general NQF measure
10 evaluation criteria. And looking through here
11 and maybe this isn't the place that we would
12 touch on these, but the first one on the
13 importance of measuring this whatever it is
14 you're trying to measure, and is that
15 something that needs to be touched on here, as
16 we talked about the mechanics of developing
17 the measure, but we should also include in
18 here something on is this an important area to
19 measure.

20 CO-CHAIR STEINWALD: Well, that
21 is one of the four criteria - go ahead.

22 CO-CHAIR LOTZ: I was just going

1 to say, I'm looking through some of the notes
2 from our earlier conversation. We brought up
3 the issue of perspective and how perspective
4 changes, is that something that should be
5 spoken to as part of this development. Does
6 that change the steps you would take?

7 CO-CHAIR STEINWALD: Payer,
8 patient, provider.

9 CO-CHAIR LOTZ: Policy.

10 CO-CHAIR STEINWALD: As long as
11 it begins with a P.

12 CO-CHAIR LOTZ: Yes, we're okay
13 with that.

14 MR. PHILLIPS: I guess my thought
15 is just as the developer going through the
16 thought process, it might be worthwhile just
17 to include something here in terms of the
18 steps, to assess the importance of the
19 measure.

20 MS. TURBYVILLE: So our approach
21 has changed a couple of times where we have
22 the evaluation, criterion discussions as part

1 of the white paper, and then where we've
2 broken it apart and it's become it's own
3 separate deliverable. But we are managing the
4 timeline such that any revisions to the
5 current submission form and the evaluation
6 criteria for which the measures will be
7 evaluated by the steering committee and the
8 technical advisory panels will be available to
9 the measure developers before they submit. So
10 that call for measures that is coming out of
11 here, and we are going to talk a lot more
12 about the evaluation criteria tomorrow, and
13 the evaluation criteria will go out to them at
14 the same time. So, excellent point, thank
15 you, and you will have the opportunity to make
16 sure that we are hitting everything that needs
17 to be on those subcriteria.

18 CO-CHAIR STEINWALD: Well, do we
19 need a discussion and decision on all of these
20 things? Or have we covered - you've got a lot
21 of the details. I don't know that we need
22 complete discussion of all of those details,

1 what do you think?

2 MS. TURBYVILLE: We don't as long
3 as you go through it or if you see today
4 anything that's missing or you think doesn't
5 belong on the list we certainly need to know
6 that and provide the group an opportunity to
7 respond to those comments.

8 What we would be moving onto next
9 - we had bucketed them but now maybe thinking
10 of all of these as components of a resource
11 use measure specification which pieces will be
12 subject to evaluation. So will the measure
13 developer have to submit, and when way say
14 specifications, that is like following a very
15 clear recipe. It's not like your peer
16 comparison is something very vague. So when
17 we are requesting them to submit a
18 specification on a peer comparison or how you
19 would estimate your comparison benchmarker
20 expected that they would have to be explicit,
21 and that you would evaluate them. So there
22 may be things as you work through that you

1 might want it to be an explicit
2 specification, or options for the users, or
3 what have you, and we need that guidance so we
4 can make sure we get that guidance to the
5 measure developer. So we are ready to move on
6 to that next step.

7 CO-CHAIR STEINWALD: Rich.

8 DR. RICH: So as a measure
9 developer, am I going to develop a measure for
10 data or for patients from any dataset? Or do
11 I have to specify the data source? Because if
12 you create a measure that has sophisticated
13 risk adjustment like the STS mortality CABG
14 measure, that has a lot of chart abstraction
15 associated with it, whereas if you have just
16 a resource measure that is coming from an
17 administrative database, risk adjustment can't
18 be as strong within that measure. So are we
19 assuming that a measure has to apply to all
20 populations, or can people submit measures for
21 a specific population, administrative data set
22 only or for more comprehensive data sets?

1 MS. TURBYVILLE: So I mean they
2 certainly can submit a measure for a specific
3 population. One of the four criteria that the
4 steering committee will evaluate will be
5 feasibility of a measure. However if you
6 think that the data that they are requiring is
7 so narrow in scope that it is not very usable,
8 or at this time perhaps it's ahead of itself,
9 you would weigh that in your evaluation of the
10 measure. So one might specify a measure for
11 a Medicare population and perhaps it wouldn't
12 work as well in another population. That
13 would be part of their specification, and you
14 would evaluate it as such. But you also may
15 look if they specify a population that is so
16 narrow that you are not really sure how useful
17 it will be. So it's a balance in the context
18 that you have put in between usability and
19 feasibility as well and importance to the
20 industry as a whole.

21 CO-CHAIR STEINWALD: Bill.

22 DR. GOLDEN: Just a direct

1 comment, on page 17, lines 478 through 483 or
2 482, I don't think that - you've made things
3 way too simple. In the private sector some
4 plans such as HMOs that use gatekeepers, which
5 very few do anymore, assign patients for
6 primary care physician making the attribution
7 of patients' resources relatively
8 straightforward.

9 I would warn you that is a gross
10 understatement. And especially in PPO plans
11 where there is an assigned primary care doc,
12 attribution is still a nightmare. So I would
13 significantly tone that down.

14 CO-CHAIR STEINWALD: I think the
15 issue gets to usability, feasibility, I
16 certainly wouldn't want to reject a measure
17 just because it requires chart abstraction.
18 Even if it was based on a database where chart
19 abstraction had already been done on a small
20 subset of patients, if the measure seems to
21 have great promise, then it may convince other
22 users that it's worth the cost of chart

1 abstraction. Of alternatively as electronic
2 health records become more prevalent, then
3 there is an alternative to actually going to
4 paper charts and obtaining the data from
5 electronic records.

6 Go ahead.

7 DR. RICH: So then I think when
8 we do our call for measures we should give
9 some specific guidance and language regarding
10 that. Because if I'm a measure developer, I'd
11 like to know that you are willing to accept
12 measures that have a lot of chart abstraction
13 or measures that aren't only associated with
14 administrative databases, et cetera. You may
15 have a different response. Invitation and
16 participation, I think has been said, so you
17 may not want to participate if you think the
18 invite is too strong or too prohibitive.

19 CO-CHAIR STEINWALD: Helen would
20 like to respond.

21 DR. BURSTIN: Just to briefly
22 weigh in, feasibility is one of the four

1 criteria, so the ability to collect data
2 through the routine byproduct of care or
3 administrative data is one component. So it's
4 already built into our process that you can
5 bring in anything. But I've got to tell you,
6 having sat through enough steering committees
7 in the last year the appetite for true chart-
8 based measures unless they are in a very
9 focused area like a registry or something like
10 that is just plummeting.

11 CO-CHAIR STEINWALD: Just like
12 the value of my portfolio.

13 (Laughter)

14 Kurt.

15 DR. ELWARD: One question, too,
16 while we are talking about EMRs, it's clear to
17 me that a lot of the EMRs aren't designed at
18 all for this kind of data provision, and how
19 are we thinking about how we can make this set
20 of measures interface with EMR manufacturers
21 to say this is what you need and this is how
22 you get the data out of there? Because in

1 some ways I don't see it any easier on an EMR
2 than I do a paper chart.

3 CO-CHAIR STEINWALD: Bill or
4 David, you both have your cards up.

5 DR. REDFEARN: This is a comment
6 starting on 494. You quote the MedPAC article
7 that said the attribution method did not
8 significantly affect physician's resource.
9 There's an Annals of Internal Medicine paper
10 that just came out that says exactly the
11 opposite. This implies that this is easy.
12 I'm more inclined to say it's really hard.
13 This kind of dismissed it. You can't do that.
14 I think there is a lot of credible evidence
15 that it's really hard to do attributions, and
16 attribution methodology does make a difference
17 in terms of the scores and how the physicians
18 come out on these things as the providers.

19 CO-CHAIR STEINWALD: Bill.

20
21 DR. GOLDEN: Comment on page 20,
22 line 543ish, 541, talks about peer groups and

1 that kind of material about comparing docs.
2 And I would just be cautious here, it may not
3 be true for all specialties, when you start
4 getting into things like internal medicine,
5 probably family practice, others, you can have
6 somebody with a specialty, but somebody who is
7 a hospitalist versus an outpatient doc,
8 somebody is a nursing home doc or a palliative
9 care doc, and the - they get all put in the
10 same bucket. And I was one of the people who
11 got one of the 300 Medicare profiles. It was
12 one of those things, I'm a pack rat, and I had
13 it in my hand about a week or two ago, and I
14 think I threw it away after having it in a
15 pile somewhere. Otherwise I would Xerox and
16 send it to you all. But it was interesting,
17 the data for internal medicine was remarkably
18 flat. The difference between the 10th
19 percentile and the 85th - 90th percentile was
20 about \$100 a year, \$200 a year. But then
21 there were some interesting tails, and I think
22 the tail at the far end I think were clearly

1 misattributed docs who had atypical practices.
2 They may have been internal medicine doc who
3 worked for an oncologist, and there are people
4 like this, and I'm not sure how you get around
5 that, but you have to be careful. Not
6 everybody who is an internist is an internist.

7 DR. BARNETT: That's the fear,
8 correct, not the attribution.

9 DR. GOLDEN: Sorry, that's -
10 well, yes okay. That's right, the peer group
11 argument. It was an inappropriate peer.

12 DR. REDFEARN: We even have a
13 name for them - people practicing outside
14 their specialties. Zebras. We find them all
15 over the place. And I tried to do a little
16 statistical work trying to impute specialties
17 going backwards from episode data, trying to
18 impute the specialty. And there are some
19 statistical tools you can use right now that
20 kind of help you do that a little bit. But
21 then at the end result you get this
22 reattribution, reclassification. You say,

1 well, what's right? I know in California the
2 Blue Shield plan actually hired 20 temps and
3 had them call every one of the doctors in the
4 list and said, what are you. It's not like,
5 how do you want to be listed in the directory.
6 They said, we are going to compare you to a
7 peer group. What peer group would you like to
8 be part of, and ask them point blank. I tried
9 to get our own people to do it in the company,
10 and they said no way, too expensive, and they
11 didn't do it.

12 DR. GOLDEN: Let me follow up on
13 that, because I've had experience with my
14 Medicaid program, and every now and then
15 somebody will send me a data analysis of
16 outliers, and you look at these docs, they
17 charge them by level five. They're an
18 outlier.

19 And there are some docs who are
20 charging level fives for head colds, but half
21 of them or more were people who were running
22 a foster care clinic. Where somebody who was

1 running a tertiary GI clinic, and you almost
2 have to - before you go out and publish these
3 things, all you're doing is identifying
4 outliers, and very often or a good percent of
5 the time there is a reason that they are an
6 outlier, a perfectly legitimate reason they
7 are outliers. And I think we ought to build
8 that in at some point. Outlier status does
9 not necessarily mean that there is something
10 wrong.

11 CO-CHAIR LOTZ: I want to ask
12 another part of the section that we're looking
13 at here talks about determining the expected -
14 specifically this page we were on before, 20,
15 talks about the observed to the expected but
16 this concept of benchmarking is something
17 we've talked about on our conference calls.
18 And does the committee have anything that it
19 wants to tell measure developers or
20 incorporate into our evaluation tool about how
21 to come up with an expected or benchmark or
22 comparison group. We haven't brought that out

1 in conversation yet. Are we just leaving it up
2 to them and whatever they provide? Will it
3 stand? Are there some guiding principles or
4 some fundamental aspects that need to be
5 brought out? Because I didn't see them when
6 I read through the paper, sort of the must-
7 have criteria.

8 CO-CHAIR STEINWALD: Thank you
9 for that contribution.

10 (Laughter.)

11 CO-CHAIR LOTZ: Yes, well, just
12 invite me to any party and that will put a
13 quick end to it. No, I mean, I was very
14 concerned about that --

15 DR. O'NEIL: But being a kind of
16 new area it would be kind of hard - I'm trying
17 to think of where we would get that benchmark
18 from the get-go. I mean I think that's
19 something that over a couple of years you
20 might be able to start seeing if you have a
21 clear definition of these measures. I mean it
22 just seems like unless there is a bunch of

1 data out there from a particular system that -
2 which there very well may be that I don't
3 know about, I don't know where you would start
4 today.

5 CO-CHAIR STEINWALD: I've been
6 sort of thinking, maybe this is along the
7 lines of what you're saying, how can the
8 measure developers be encouraged to be
9 innovative if that's what we would like them
10 to be? And we're in a relatively new area,
11 and a health system that is evolving, a
12 delivery system, and so how can we either - if
13 we're not going to provide them guidance and
14 invite them to be innovative in developing
15 their own benchmarks, or benchmarking in a way
16 that hasn't been done before, or even using
17 foreign data for that matter, how do we do
18 that and at the same time say you have to meet
19 specifications in order to satisfy NQF, but at
20 the same time we'd like you to be forward
21 thinking and think about how measures might be
22 utilized, not only tomorrow but five or 10

1 years from now when our health care system
2 looks a bit different than it does now.

3 I think that is a dilemma. I'm
4 not sure how to solve it, but it seems to come
5 up in a lot of the individual comments that
6 people are making.

7 Yes?

8 DR. BURSTIN: Just to go back to
9 a comment I made earlier, that's a really
10 important point, the reality is these measures
11 are going to be called for in just a few
12 months in October, so if they haven't
13 developed them yet or if they are not in their
14 sort of ultimate testing, they ain't going to
15 be submitted. But I think it's critically
16 important that part of what this steering
17 committee does is say what should be developed
18 and what should be the next generation of
19 measures, while in the interim we kind of deal
20 with what gets submitted in November. I just
21 think nothing is going to happen between now
22 and November in new de novo measure

1 development. You might for example spark an
2 interest in a developer to maybe modify the
3 way they were thinking about it for
4 submission, but what you are really talking
5 about is informing the next generation. And
6 that's a critical role for steering
7 committees; we really value that. We'll put
8 that out there and hopefully that will then
9 bring the next generation to measures we
10 really want.

11 CO-CHAIR STEINWALD: I see some
12 cards up. Jack.

13 DR. NEEDLEMAN: It's not clear to
14 me that at the moment we know enough to be
15 able to specify what a good risk adjustment
16 model looks like or what the right peer groups
17 are. As Helen has said these are questions
18 that the folks who are developing these
19 measures are not unaware people are asking,
20 and we are going to see measures come in that
21 attempt to deal with all of these issues. And
22 I think I'm expecting to learn a hell of a

1 lot from looking at how they have tried to do
2 it, and what documentation they provide about
3 how successful they are. To be able to
4 critically assess whether I think they have
5 successfully dealt with them.

6 So Prometheus we already see in
7 the documents we've got a very clear model of
8 what we include in our risk adjustment model
9 and so forth. So we - I think the level of
10 information to the developers at this point is
11 adequate. We're worried about these issues
12 and we're looking to see how you have solved
13 them is about where we are I think in terms of
14 the guidance we can offer.

15 CO-CHAIR STEINWALD: Lisa.

16 MS. GRABERT: I think I really
17 agree with the remarks that Jack just made.
18 I think I would feel most comfortable if a
19 developer went through every single one of
20 these steps and then applied to the measure.
21 The reality is, they're probably not going to
22 go through every single one of them. But I

1 would like to know what they've thought about
2 applying each of these portions of the
3 methodology behind it to their measure, and
4 where they decided to not do something let us
5 know why.

6 CO-CHAIR STEINWALD: Bill.

7 DR. GOLDEN: In the zone of
8 limitations, unresolved questions, et cetera,
9 a potential unintended consequence, what
10 happens, what do we do with folks who work at
11 multiple clinical sites with different
12 profiles? So a private practicing physician
13 works in a teaching clinic a half day, two
14 half days a week or spends two days in a
15 underresourced clinic or a charity clinic.
16 They may have very different kinds of outcomes
17 and resources, and they may have less control
18 over what gets attributed to the patients
19 they're taking care of.

20 Can people opt out? Or are we
21 going to potentially incentivize people to no
22 longer do those activities?

1 So I don't know how you play with
2 that, but I'm just throwing it out there as
3 something to put on the table as a potential
4 consequence of this kind of profiling.

5 CO-CHAIR STEINWALD: Mark Kay,
6 one more and then we'll break.

7 DR. O'NEIL: Well, in this sort
8 of whole new field of resource utilization
9 measurement, I mean basically when we're
10 talking about benchmarking and whatnot, I'm
11 not sure that we have real baselines. I mean
12 these measures are being developed to see how
13 people are doing, which is essentially a
14 baselining operation. It's not really to see
15 quite yet if this intervention changes
16 resource utilization.

17 Are we at a baselining, or at we
18 at the changing of the system point with this?

19 DR. BURSTIN: I'm not really sure
20 we can make that distinction. But I do think
21 we are beyond just baselining. I think we
22 want to put something out that people can

1 begin to use to compare providers. And the
2 question is what comfort zone is there,
3 depending on the level of attribution and the
4 level of comparisons.

5 DR. O'NEIL: But working on all
6 these definitions of how we're describing
7 these things, this data doesn't currently
8 exist out there; is that correct? Or it does?
9 So utilization data is out there currently?

10 DR. BURSTIN: There is a lot of
11 it out there.

12 DR. O'NEIL: There is a lot, I
13 know, but in this sort of systematic way. I
14 mean I know we have utilization data in our
15 system, but it's not generally applicable to
16 other systems. I mean we can say a lot about
17 what's going on in our population, but we are
18 trying to come up with measures that are more
19 generally applicable, right? I'm just
20 struggling with using these things - you can
21 rank, order, if you are counting or monetizing
22 something, you can say this doc is driving all

1 these expenses for this category of care, or
2 this system is driving all this utilization
3 for this defined population. I'm just - but
4 in terms of benchmarking, because every
5 subcomponent of the system has different data
6 there isn't a benchmark out there that's
7 generally applicable to these measures; is
8 that correct?

9 CO-CHAIR STEINWALD: A single
10 benchmark, yes.

11 MS. TURBYVILLE: I think what we
12 were thinking is the measure developers as
13 part of their submitting their specifications
14 would either have to describe to the user how
15 to estimate or create a benchmark, and if they
16 had some external benchmark available they
17 would have to make it available.

18 CO-CHAIR STEINWALD: All right,
19 Barbara, and then Jeff, and then we break. No
20 more cards.

21 DR. RUDOLPH: Just a statement on
22 the history of some of these groups, they've

1 been doing this a long time. I know I went
2 to presentations back in 2003 by a variety of
3 vendors who were already doing this kind of
4 work. So they are going to be ahead of where
5 we are in terms of their experience with this.
6 That doesn't mean that they have done
7 everything right, because they probably
8 haven't. But I think anybody who will have
9 had to be doing this for awhile in order to
10 meet the submission requirements, for testing,
11 reliability, validity, all those kinds of
12 things. So I think we are going to learn a
13 lot from what they are able to tell us, and
14 many of them have had access to physicians'
15 claim data for a long time.

16 CO-CHAIR STEINWALD: Jeff.

17 MR. CURTIS: This may be just
18 restating what people have said already, but
19 I think the important thing is that it's the
20 expectation that the measure developers will
21 specify how it will be implemented, which I
22 think is what this is getting to. How will

1 outliers be identified? How might this
2 information be conveyed? And I think at least
3 from my work on the outcomes measure, that is
4 something that developers are oftentimes on
5 purpose - or purposely vague about, and this
6 is trying to get them to put their nickel
7 down.

8 So I think we don't need to set
9 the benchmark for them. We just need them to
10 tell us what their proposed benchmarks are, so
11 we have an idea if there is face validity to
12 it.

13 CO-CHAIR STEINWALD: Very good.

14 All right, let's break until what
15 time?

16 MS. TURBYVILLE: 2:40?

17 CO-CHAIR STEINWALD: 2:40, okay,
18 see you then.

19 (Whereupon the proceeding in the
20 above entitled matter went off the record at
21 2:23 p.m. and resumed at 2:49 p.m.)

22 MS. TURBYVILLE: So as I've been

1 saying throughout the day thank you again for
2 all your thoughtful inputs thus far. We think
3 at this time we can move onto the next section
4 which is Section 4. It is still labeled
5 Section 5 in the white paper, I apologize,
6 starting on line 621, unless there are any
7 other absolute must-share items for the
8 sections that we've been talking about, not
9 that there won't be future opportunities to
10 circle back. But I know we kind of abruptly
11 stopped for break. So are we all ready to
12 move on to the next section of the white
13 paper? Please?

14 MS. YANAGIHARA: Did we determine
15 which of the aspects are going to be part of
16 the purview of this group and which are not?
17 I'm not really clear on it if we did?

18 MS. TURBYVILLE: No, because we
19 are going to discuss that more again. So we're
20 not getting away from that, and then we are
21 going to open that conversation up later on
22 today, and then as we go through the criteria,

1 kind of rethink any thinking we've had before
2 that to make sure that we are meeting the
3 needs of this measurement effort.

4 So I will go ahead and hand it
5 back over to our co-chairs.

6 CO-CHAIR LOTZ: All right, we're
7 going to discuss Section 5 - it's labeled
8 differently in different places, but it's
9 Section 4 or Section 5, and this is talking
10 about limitations, implications, unresolved
11 questions. Sally has written a few things on
12 the slide here, but open forum. Barbara, did
13 you want to say something already?

14 So again, analogous to our prior
15 conversation, much has been suggested based on
16 the emails and calls today about what some of
17 the limitations might be. They are baked
18 into the white paper. Did we capture them
19 correctly? Is there something missing? Is
20 there something that needs to be amplified,
21 clarified? What kinds of limitations will we
22 communicate or what kind of considerations of

1 limitations do our measure developers need to
2 communicate to the steering committee when
3 they submit their measures?

4 Jim.

5 MR. WEINSTEIN: I was just
6 curious, in this section I don't know if this
7 is part of the black box methodology section
8 as well, but I didn't have those specific
9 references that you had in Ingenix and Reuters
10 and didn't know if the measurement developers
11 will have access to those kinds of things or
12 not.

13 CO-CHAIR LOTZ: Jim, what kinds
14 of things? Could you just elaborate?

15 MR. WEINSTEIN: You have in here
16 - I'll get the page number - on page 27,
17 anyhow, the reference is 17 to 18.

18 DR. REDFEARN: Ingenix at least
19 it's a website, once you go into the website
20 all you do is agree not to steal their
21 proprietary information and the entire
22 documentation is available; it's completely

1 open. I haven't looked at the Med Stat one
2 but I assume it's similar.

3 MR. WEINSTEIN: So the question
4 is, are we going to require people who work on
5 measures to provide that kind of detail.

6 MS. TURBYVILLE: So yes, anyone
7 who wants to submit a measure for endorsement,
8 is that what you might mean?

9 MR. WEINSTEIN: Yes.

10 CO-CHAIR LOTZ: Yes. The answer
11 is yes.

12 Paul.

13 DR. BARNETT: Actually I think
14 David is in front of me.

15 CO-CHAIR LOTZ: All right, David.

16 DR. REDFEARN: Just the
17 discussion starting on 636 about standard
18 error of a mean. I might be really confused,
19 but I think there is something missing here.
20 I think the variability of the mean for the
21 physician or the provider that you are
22 comparing is also important to the confidence

1 interval. It's not just the standard
2 deviation of the norm; it's the distribution
3 or the variability. So I just would - maybe
4 I don't understand the calculation, but I
5 always think about it as terms of the
6 variability of the physician being compared,
7 not the variability of the norm or the peer
8 group.

9 CO-CHAIR LOTZ: Paul.

10 DR. BARNETT: So one of the
11 problems of all this, I notice in the
12 description of the Prometheus they talk about
13 adjusting for regional variation. And so
14 there are these regional level variations in
15 practice that are quite profound, and it
16 doesn't seem like something we want to adjust
17 out. We want to ding them if they are in a
18 region that's bad and get everybody in the
19 region to do better. But that is part of the
20 evaluation problem is to detect what's
21 regional and what's not.

22 CO-CHAIR STEINWALD: My response

1 to that is, everyone is favored; it depends.

2 A lot of the measures so far in use of
3 resource are confined to metropolitan areas.
4 And part of the reason for that is lack of
5 confidence in being able to compare across
6 metropolitan areas.

7 And so you might - a lot of the
8 measures are, well, Dr. X compares to his
9 peers in Phoenix; he's 20 percent above. And
10 Dr. Y in Sacramento is 20 percent below the
11 average for the peers. But the median may be
12 very different in those areas.

13 And I think that's kind of been
14 the evolution of the measure development. If
15 you are taking small steps before big steps
16 you do the comparisons within geographic areas
17 before you then try to compare across. At
18 least that is my observation. Not that we
19 shouldn't eventually want to compare across.
20 But I think again going back to the measure
21 developers and their specification and
22 justification for the measure they need to

1 tell us whether this is a measure that can be
2 used within geographic areas or it could be
3 used across, and the criteria might be a bit
4 more stringent for comparing across.

5 CO-CHAIR LOTZ: Barbara.

6 DR. RUDOLPH: I guess I was
7 wondering if we should talk at all about using
8 different Bayesian methodology to address
9 issues like small cell size, and whether that
10 is going to be acceptable as understandable to
11 the physicians being compared. And if in fact
12 it is going to be acceptable, then what types
13 of information should the measure developer
14 provide that would support that use.

15 CO-CHAIR STEINWALD: CMS, when it
16 was developing its physician feedback protocol
17 addressed that issue, and I don't know all the
18 details, but there was a tradeoff between
19 providing all the information that you would
20 want, that someone might want to know right up
21 front and making it look very complicated
22 versus keeping it simple and understandable

1 but not satisfying the people who wanted all
2 the details.

3 So I think what they did is they
4 used drill downs. They have a report, a
5 feedback report for a physician that gives the
6 basic information on how you compare to a peer
7 group. And then for those who want all the
8 details of the methodology whether it
9 involves Bayes theorem or not, if it's an
10 electronic report, then they can drill down or
11 they can call the telephone number of the
12 expert who developed it and actually have a
13 conversation.

14 And so I think there are I'm sure
15 many users and maybe even some developers who
16 wouldn't feel comfortable having to explain
17 the methodology to every person or provider
18 who is likely to be compared as a requirement,
19 but as an option, maybe so. Does that make
20 sense?

21 Others have more experience with
22 these measures, that issue I know gets

1 addressed all the time, I think. Go ahead.

2 DR. ROSENTHAL: Well, when CMS
3 measures hospitals and looks at things like
4 congestive heart failure and mortality
5 outcomes, they end up with quite a number of
6 the measured entities not being statistically
7 different. I don't see any problem with that,
8 if you end up with a big chunk of the measured
9 being not statistically different, you have a
10 little bit around the small N problem. The
11 other way to approach it is, let's not pick
12 something that has a small N.

13 But if you do you are going to end
14 up with a bunch of them being not being
15 statistically different, and why is that not
16 okay? Maybe all we're looking for is to
17 define some very high and low end outliers,
18 and again it gets down to what's our purpose
19 in the measurement.

20 CO-CHAIR LOTZ: David.

21 DR. REDFEARN: The only comment
22 I'd make is that I think you need to do

1 statistical comparisons when you are reporting
2 this kind of data. I think that is kind of a
3 requirement. What we have found is that
4 confidence intervals presents in a way that
5 it's more understandable than using some of
6 the fancier statistical techniques. It seems
7 to work better; it seems to be understandable.

8 And I'll tell you frankly that in
9 our work we have - I generate three
10 classifications of a physician: efficient,
11 don't know, and inefficient. The "don't know"
12 category is real big. And it's a byproduct
13 of doing a 95 percent confidence interval on
14 the data, and the small sample sizes, and the
15 extreme variability you see in the performance
16 of the doctors because of presumably changes
17 in medical practice, variability in the
18 underlying patient that we have not measured;
19 severity differences that we can't measure;
20 all those kinds of things. But we get a big
21 "don't' know" category.

22 And in terms of reliability across

1 time, you see people moving between the
2 efficient and don't know and inefficient and
3 don't know. You very rarely see somebody
4 moving from efficient to inefficient across
5 time. So it's a fairly conservative approach.
6 And I've presented this to a couple of medical
7 groups in California, and they seem to get it.
8 So that's just personal experience.

9 CO-CHAIR LOTZ: Tom.

10 DR. LEE: I think that the way
11 this plays out in real life is that you end up
12 with situations where you have a small
13 hospital or small volume practice that seems
14 way off the average, but they are described as
15 statistically within the expected range. And
16 then you will have a bigger hospital or a
17 bigger practice that actually has performance
18 which is better or worse. Because they will
19 be an outlier, because they have - a
20 statistical outlier because they have more
21 volume. And people will go, hey, wait a
22 minute, we're better or worse than them, but

1 we're statistically significantly different.

2 But the price of not using
3 statistical analysis is too great. You just
4 get clobbered. So you just have to explain
5 that these little outliers are going to be
6 classified within the statistical norm because
7 of statistics. Because the alternatives are
8 worse. That is our experience in reporting
9 in Massachusetts so far.

10 MR. CURTIS: Let me just follow
11 up on that because we bump up on this
12 continuously with the outcome measures that we
13 develop with heart failure and pneumonia, and
14 in terms of the choice of presenting it.
15 Obviously there are pros and cons for
16 hierarchical or regular logistic regression in
17 different approaches to the statistical
18 modeling. And I think everyone agrees that
19 you need to have some form of risk adjustment.

20 The problem is and one that we've
21 run into time and time again now is that there
22 are such extreme opinions on it yet there is

1 no external truth out there that this is the
2 right way to do it or not. And I know that NQF
3 has continuously struggled with this as well,
4 but I think what we are going to see are a
5 huge range of different approaches, and unless
6 we establish an external gold standard for
7 better or worse, it's going to be very
8 difficult to make good comparisons across the
9 validity of these different measures and
10 different approaches. This is a larger issue
11 than the steering committee here, but I think
12 NQF really needs to develop a format or a form
13 by which we can get to consensus on this,
14 because it's I think tearing outcomes
15 measures apart.

16 CO-CHAIR LOTZ: Jack.

17 DR. NEEDLEMAN: On that point I
18 think one of the issues that we see is that
19 people have adopted a specific method, and the
20 impact is somewhat blinded. So CMS when it's
21 doing hospital compare uses a Bayesian
22 shrinkage model which moves people - small

1 places get their numbers averaged with the
2 mean based on the relative size. So we start
3 out in all of these methods with some raw
4 data. Including standard errors around
5 estimates and standard errors around
6 individual estimates for subunits that have
7 numbers. And then things get done with them.
8 So I think at this point since we don't have
9 a gold standard, and we don't have an agreed
10 upon method, it will be helpful to understand
11 what the raw numbers are that emerge from
12 these systems, and how the statistical
13 adjustments that the methods developers prefer
14 change what is being reported from raw. So if
15 we got Bayesian shrinkage, let's see what the
16 original number looks like and what the shrunk
17 number looks like. And so in the face of
18 this, rather than our having to decide ex ante
19 what the right method is, I'd like to see us
20 get enough raw data from the folks who are
21 submitting that we can understand how their
22 methods change the interpretation of the

1 analysis that is being presented out of their
2 measure.

3 CO-CHAIR LOTZ: So a requirement
4 to provide both basically.

5 Tom.

6 DR. ROSENTHAL: Well, it seems to
7 me ultimately this is not a trivial
8 philosophical point in regard to how the
9 information is going to be used, and the
10 example I would give relates to some of the
11 AHRQ quality measures that are now getting
12 incorporated into practice, and one of the
13 people in our system has been heavily involved
14 in the validation of those, gave a
15 presentation to our group recently and said,
16 well, this particular AHRQ measurement has
17 been validated to 50 percent reliability. And
18 was pleased that this was going to be put into
19 public practice. And my response was, it
20 seems to me doing something that is
21 potentially significantly wrong is actually
22 quite harmful, and that we should err on the

1 side of actually knowing something, and
2 knowing it pretty affirmatively before we
3 start using it in pretty substantial ways
4 either for public reporting or for - and now
5 we are talking about money. So for payment
6 differences, and that's where I come back
7 David to your comment of, you know, I
8 understand the Bayesian methodologies and you
9 can manipulate things. But I think we want to
10 err on the side of being affirmatively right
11 and being able to demonstrate that it's
12 affirmatively right than being able to come up
13 with something that by some manipulation we
14 can jigger into something that may be
15 statistically valid.

16 So I think this is a not
17 unimportant philosophical debate that we will
18 likely see played out as we get these thing
19 in.

20 DR. RUDOLPH: If that were
21 Bayesian they would have taken out the random
22 error, so it would be on the positive side at

1 50 percent correct, after they removed the
2 random error you would be in the positive
3 zone, so you would know something more than
4 just a guess.

5 CO-CHAIR STEINWALD: One
6 criterion that might be applied, I am getting
7 at the sample size issue is, if there is a
8 difference between two groups or between a
9 group's performance and a benchmark, that is
10 economically significant, then the sample size
11 and the power that goes with it ought to be
12 able to detect that difference as being
13 statistically significant. One often uses the
14 same criterion in clinical trials, a
15 clinically significant difference ought to be
16 statistically significant. And in this case
17 since we are developing resource measures, I
18 think the criterion would be economically. So
19 if there is a difference in the resources
20 associated with hospitalization of \$10 between
21 two groups, that's not economically
22 significant. But you as the user need to

1 decide well, what is economically significant?
2 Is it \$1,000? If that's what it is, then our
3 power including the sample size ought to be
4 good enough to detect that difference as being
5 statistically significant.

6 CO-CHAIR LOTZ: Lisa.

7 MS. GRABERT: I can sort of let
8 you know what methodology we use for the
9 physician resource use measurement program
10 when I was at CMS for a minimum threshold, or
11 to get around small N. We had a minimum
12 threshold for each and every benchmark that we
13 had, and the benchmark was defined as
14 specialty condition and geographic area. And
15 if you changed one of those three factors,
16 you'd have a different minimum threshold. So
17 each time you had to calculate a new
18 threshold. The rate of reliability that we
19 used was point five, and we felt comfortable
20 with that for purposes of confidential
21 feedback reporting.

22 For other levels such as public

1 reporting and possibly payment, the rate of
2 reliability we always felt needed to be much
3 higher than that.

4 CO-CHAIR STEINWALD: How did you
5 determine where the threshold was? If each
6 threshold was different how did you determine
7 the threshold?

8 MS. GRABERT: As long as you hit
9 a rate of reliability of point five, depending
10 on those three parameters of the benchmark,
11 that would define what your minimum case
12 number had to be. So for example for any
13 given specialty in a given geographic area,
14 for just diabetes, your minimum threshold to
15 hit a reliability of point five from everyone
16 underneath that benchmark might need to be 25
17 cases. But if you were to change the
18 geographic location to a different part of the
19 country, because there may be more variation
20 in that geographic area, your minimum caseload
21 - minimum threshold might be 55 cases. So it
22 changes depending on what your benchmark looks

1 like.

2 CO-CHAIR LOTZ: Jim.

3 MR. WEINSTEIN: It's a little
4 interesting how you determine what your
5 meaningful clinical difference is. Given that
6 we don't have data that allows us to
7 understand what change we are looking for, to
8 calculate some sample size et cetera. I think
9 it's a good discussion, but I worry about the
10 implications. Who is going to determine what
11 is meaningful, what a meaningful difference
12 is? Is it geographically defined? Is it
13 individually defined? Is it case defined?
14 And then you are talking about dollars, in
15 this last example. Geez, I don't know is
16 \$100,000 too much for a transplant difference?
17 Is it \$50,000? In the Bayesian models what's
18 cost effective? Is it \$100,000 in the U.S.
19 system? Is it the U.S. Euro qual versus the
20 European Euro qual measure? This whole area
21 of measurement, for all of you who are better
22 at it than I am, is not so simple. And

1 depending on the measure du jour and how you
2 use that you can find an answer. The nice
3 thing about Bayesian is you do some
4 sensitivity analysis, and sort of look at the
5 model, and you do some bootstrapping and
6 things like that to help. But I guess I just
7 - I don't know enough about resource
8 utilizations to say what is right for a given
9 diagnosis.

10 There is a commonality of resource
11 use that we'd like to look for, but then with
12 some outcome, again, how is that determined
13 what is good or bad, and what's that change
14 score? So we all realize around the table the
15 limitations, and we realize the altruism of
16 what we are trying to do. But I think not
17 stating that is problematic.

18 CO-CHAIR STEINWALD: Well, would
19 it be sufficient from your point of view just
20 to require that the measure developer address
21 that issue, rather than us trying to say here
22 is what the threshold is?

1 MR. WEINSTEIN: Yes. Yes.

2 MS. GRABERT: I think so, because
3 I'll just add, in order to do what we did
4 with CMS, we had \$12 million and several FTEs,
5 and I think that that is a level (laughter) to
6 expect from a measure developer that may be
7 too high.

8 CO-CHAIR LOTZ: That's Helen's
9 next budget for the steering committee.

10 Ethan.

11 DR. HALM: I was just going to
12 add, since we see the resource use as a
13 building block to another committee who is
14 going to worry about efficiency that small
15 differences in money, in the denominator, or
16 even the same amount of resources spent, when
17 you start looking at different outcomes, you
18 might in fact be from a patient's or society's
19 perspective become big differences. So I
20 would stay away from trying to specify that,
21 because I think in a vacuum it's not going to
22 be as useful.

1 CO-CHAIR LOTZ: Mary Kay.

2 DR. O'NEIL: I was going to make
3 a similar point to look at what the
4 significance of the different amounts being
5 spent without an outcome is a little big
6 dangerous just to rank order people. In our
7 system we will look at characteristics of
8 physician practice not just by how much
9 they're spending at a particular time but the
10 impact on the cost to the system or the
11 individual over a longer time frame. So that
12 if you are seen by a physician with a
13 particular cost and utilization profile, that
14 will predict the trend of cost for somebody
15 with that diagnosis. And it's a much longer
16 timeframe for evaluation.

17 But I was a little concerned about
18 some of the language in this section about
19 making sure that the measures all have the
20 performance of the individual physician as
21 required for the measures, because I think
22 that the way things are going with health care

1 into accountable care organizations, and the
2 organization of care, and the variation of
3 what kind of services are available if you go
4 to different organizations, and I think those
5 differentiations are increasing right now, to
6 require that every measure starts with just
7 the individual physician's performance is a
8 little bit limiting, and maybe not exactly
9 really where we want to go. And then of
10 course if you are talking about individual
11 physicians you get the small N problem.

12 So I think that there are some
13 important characteristics of practices that
14 really change outcome even if somebody is
15 being seen for maybe a limited service, just
16 because certain systems prospectively look for
17 different characteristics of patients and
18 address them, and that is increasingly
19 emphasized in how people develop their
20 practices.

21 CO-CHAIR LOTZ: Helen

22 DR. BURSTIN: This is more a

1 question than an answer, but it sounded like
2 part of what we were also hoping to do as part
3 of this white paper was to also identify what
4 were the unique issues around testing these
5 measures. And it sounds like it might be
6 useful for this committee to come up with a
7 list of the key things you'd want people to
8 report on in terms of the testing of the
9 measures to get at some of these analytic
10 issues.

11 The other thing I wanted to
12 mention that I think is also an important
13 question is, one of the things that also kind
14 of plagues us at NQF and probably in the real
15 world as well is the issue of when does the
16 measure specifications end and implementation
17 guidance begin. So there is oftentimes a lot
18 of discussion about you may for example put an
19 implementation guidance, sample size,
20 statistical significance, things like that
21 that aren't necessarily uniquely part of the
22 measure specification itself. I think it'd be

1 really helpful for this group to also help us
2 think through when do some of these issues
3 become - this is core to the measure versus
4 these are sort of ways you can potentially
5 vary it as you use it in practice. Things
6 like level of analysis would be baked into the
7 measure because scientific reliability is so
8 dependent on for example where you would look
9 at that. But things like sample size for
10 example, sample size is sometimes baked in,
11 not always. But there are many issues in
12 terms of the way the data are actually
13 reported out, for example using stars or above
14 or below or things like that, choosing a level
15 of statistical significance that sometimes are
16 actually outside of the measure
17 specifications, and more so in the realm of
18 how the end user uses the measure.

19 So this would just be helpful,
20 just a series of questions, but things that I
21 think would really be useful for us to try to
22 get a handle on before we even go out with a

1 call for measures here.

2 DR. GOLDEN: You wanted ideas
3 about testing. Two ideas here. One would be,
4 I think you want to document that there really
5 is variation; no point in having the measure
6 if there is no variation. Or then the
7 question is, if there is variation, then how
8 much variation? So if you profile 500 people
9 and you find out three person variation, is
10 that meaningful?

11 I guess the followup to that,
12 something we mentioned earlier, have you
13 looked at who the outliers are? So are the
14 outliers true outliers? Or did you actually
15 analyze the outliers and find out that there
16 was a reason for the outliers?

17 CO-CHAIR STEINWALD: I'm thinking
18 of, Helen, what you just said, you've got the
19 measure and then we've got the use of the
20 measure. And the question is what is required
21 of the measure developer to provide guidance
22 to the user? And that is where issues of

1 small N and outliers and other things come in.
2 But I think it's a good question though as to
3 how responsible is the measure developer for
4 a potential user's misuse of the measure. And
5 I think it's a good question, but I don't have
6 a good answer personally.

7 CO-CHAIR LOTZ: Going back to the
8 way Helen teed up these two questions, issues
9 of testing we've talked earlier today about
10 multiple sites of service. We've talked about
11 limitations of administrative data sets. Do
12 we want to bring any of the aspects of those
13 conversations into this part of our day to
14 include that in an emerging list of guidelines
15 to developers?

16 Bill, is your card up still?

17 Kurt.

18 DR. ELWARD: It might help to
19 have them submit known issues that they would
20 anticipate, some of which have just been
21 mentioned, but potential problems with the
22 measure, potential variations in how well it

1 would work in different settings, ways a
2 measurement might actually vary based on the
3 setting which is being evaluated. I think
4 giving people some idea initially that they
5 have thought about these things and they can
6 anticipate certain problems in various
7 settings I think would be very helpful.

8 CO-CHAIR LOTZ: Tom Rosenthal.

9 Oh, I'm sorry, Tom Lee.

10 DR. LEE: I was just going to
11 raise a question: is it too high a hurdle to
12 ask them to actually analyze reliability the
13 way the RAND folks did in the New England
14 Journal paper? I mean I know it's actually a
15 hard thing methodologically to read, but the
16 actual formula itself is not that difficult.
17 That might be actually something that could
18 help people put measures in perspective. They
19 need real data.

20 CO-CHAIR LOTZ: Sally is
21 thinking; she's just not thinking out loud.

22 What about that is making you

1 uncomfortable, Sally?

2 MS. TURBYVILLE: I guess my
3 question would be, is that the only way, or is
4 that a suggestion that respected colleagues
5 have produced as an approach to examine
6 reliability but that there may be other
7 avenues. So being - it's rather new. We
8 would be going out for a call for measures in
9 October. Is that something that if you have
10 done this this might be a way to demonstrate
11 reliability but not be so narrow? That was my
12 discomfort reaction, kind of thinking how new
13 it is and how much people have actually had a
14 chance to practice it in the real data arena.
15 But that is not to say no.

16 CO-CHAIR LOTZ: All right, well
17 that inspired a lot of conversation.

18 David.

19 DR. REDFEARN: That particular
20 measure of reliability is fairly
21 controversial. Ingenix for example says it's
22 absolutely the wrong measure to use when you

1 are using this kind of methodology to evaluate
2 performance. So I would say that is
3 controversial. I think what Sally was sort of
4 implying is that that is not a standard;
5 that's a suggestion. Perhaps a suggestion
6 that the developers consider statistical
7 reliability in terms of analyzing their
8 results would be appropriate without being
9 terribly specific.

10 I personally, I think I agree with
11 Ingenix, I think a statistical test is a
12 better fit for doing this kind of evaluation,
13 so I would - I don't think reliability works
14 in this context, but that is an opinion.

15 CO-CHAIR LOTZ: Steve.

16 MR. PHILLIPS: This is probably I
17 think more of a question than a comment
18 necessarily, but the idea of linking with
19 electronic medical records has been mentioned
20 a couple of times and I guess this discussion
21 makes me think of it. If I recall it seems
22 like there is an effort within NQF to try to

1 look at the issue of measures that are - can
2 be incorporated within electronic medical
3 records, and I was just wondering, does that
4 overlay with what we are talking about here?
5 And maybe it falls within the just the general
6 evaluative criteria which is I understand
7 going to be a separate document? But I was
8 just curious about that question.

9 DR. BURSTIN: It's an interesting
10 area, just because so much of the data here is
11 actually claims based, at least in terms of,
12 on the cost side. So I guess the real issue
13 is getting at the interoperability issues, how
14 do these data relate to perhaps some of the
15 richer clinical data you could pull out of an
16 EHR for risk adjustment to get a better handle
17 on the patient population. I don't think we
18 know yet, but I would suspect if you think
19 about the meaningful use trajectory, these are
20 likely more like 2015 rather than 2010 or
21 2013. But I think we will wait and see.

22 CO-CHAIR LOTZ: Tom Rosenthal.

1 DR. ROSENTHAL: A couple of quick
2 points. On this business about the acceptance
3 of these things, given that there is almost no
4 science, at least not any peer reviewed
5 science, unlike when we started on the quality
6 measurement realm there was at least some peer
7 reviewed basis that you had to start out,
8 coming back to the idea of encouraging the
9 developers, I'd still put out the idea that
10 maybe there are two levels of acceptance.
11 Level one would be, it's not been validated.
12 There is not statistical proof. It has not
13 been tried in populations, but boy it sure
14 sounds intriguing and likely to get us to
15 something in 2015, and the sort of phase one
16 endorsement by this group would enable those
17 entities potentially to get grant money
18 and other sorts of things to actually do the
19 science to get to the next phase.

20 So I'd put back the idea that
21 there might be sort of two levels of
22 acceptance where there may be other things

1 that are perfectly ready for primetime and
2 ready to roll out.

3 And the other point that I wanted
4 to come back to was the thing that Mary Kay
5 said a minute ago that I wanted to be sure -
6 I didn't hear any validation of, which is that
7 even in this white paper document we are not
8 going to insist upon physician level
9 attribution; that we would in fact solicit a
10 wide swatch of potential attributions,
11 possibly hospitals, possibly individual
12 physicians, possibly physician groups, et
13 cetera. And I didn't hear any validation of
14 Mary Kay's point which I think is really
15 critical.

16 DR. STEPHANSKY: Hear hear on
17 that.

18 CO-CHAIR LOTZ: David, your card
19 is up as well.

20 DR. PENSON: So I wanted to build
21 on Tom's comment and get back to David's
22 comment, the issue of reliability. And we

1 keep dancing around validity. And if you look
2 at the criteria which NQF has used for quality
3 measures, validity has always been there.
4 There is even a line, and I pulled it up
5 because I've been on these TAPS as everyone
6 else has, if face validity is the only
7 validity addressed, it should be
8 systematically addressed. I think you have to
9 have validity for these resource use measures,
10 and I do think you have to have reliability.
11 It doesn't necessarily have to be what the
12 RAND group used, but there has to be some sort
13 of assessment. We may be early here. But I
14 think Tom's point is very well taken. And I
15 think that actually it is worth explicitly
16 saying that validity has to be assessed and
17 reliability should be there too. I'm not
18 hearing that. People are saying reliability
19 doesn't have to be there.

20 CO-CHAIR LOTZ: Barbara.

21 DR. RUDOLPH: I was just going to
22 say that I wouldn't want to prescribe the

1 exact tests of reliability or validity, but it
2 certainly is part of the endorsement process,
3 and if you didn't have reliability and
4 validity the measure would be unlikely to
5 pass.

6 CO-CHAIR LOTZ: Bill Rich.

7 DR. RICH: Again this addresses
8 some of my initial concerns that the way the
9 white paper is constructed gives us no way to
10 evaluate how effective these things are going
11 to be. And I think we may have an out if we
12 have some direction for implementation and put
13 it up front as one of the criteria, some
14 measure or intent to look at reliability and
15 stability. And again I don't feel confident,
16 as David pointed out, in specifying what that
17 should be. But I do think we have to address
18 either up front or in the directions for
19 implementation that there be some measure of
20 the stability and reliability of the measures.

21 CO-CHAIR LOTZ: Barbara, did you
22 go back up again?

1 David? Mary Kay?

2 DR. O'NEIL: We've come around in
3 a circle from this morning. If we are talking
4 about the resource utilization building block
5 of really counting resources that have been
6 used, we do have to have a reliable way of
7 counting those things, but I think we get a
8 lot more nervous about counting it when we
9 start rank ordering docs by how many resources
10 they are using, and then we get nervous by
11 rank ordering them without a outcome of
12 product of quality or medical outcome at the
13 other end.

14 I guess being in my end of the
15 business, I feel like we can count resource
16 uses pretty reliably, but I guess the other
17 reliability part is the significance of any of
18 this or the attribution of it to a physician
19 implying clinical decision making and quality
20 of practice and all of those kinds of things.
21 So the counting I think we can do, but if it's
22 just that building block and nothing else,

1 then it's hard to figure out what the
2 significance of that activity is.

3 CO-CHAIR LOTZ: Bill Rich, are
4 you up again, or are you still up from the
5 first time?

6 CO-CHAIR STEINWALD: It's fun to
7 do that.

8 CO-CHAIR LOTZ: I haven't tried
9 it yet.

10 CO-CHAIR STEINWALD: I've been
11 trying to figure out how we could implement
12 the spirit of what Tom suggested about sort
13 of different level of standard without
14 actually putting it that way. Because again
15 if we want to be inviting and encouraging to
16 measure developers to develop measures that
17 are new, in essence, it seems to me that the
18 standard that one would apply should be
19 somewhat different than the standard that one
20 would apply if we are talking about measures
21 that are incremental improvements in the
22 technology that has existed for years. But

1 how we present that to measure developers in
2 a way that doesn't make it seem like we have
3 a double standard, because I know NQF doesn't
4 have a double standard, I think is a bit of a
5 challenge. But I would hope we could find a
6 way to do that. And any suggestions for the
7 staff on how to present that I think might be
8 very helpful.

9 Well, let me add to that. One of
10 the four absolute criteria than NQF has,
11 importance is first, scientific acceptability
12 is second. But scientific acceptability might
13 have some wiggle room to it.

14 CO-CHAIR LOTZ: David.

15 DR. REDFEARN: The only thing I
16 would suggest is that you could, without being
17 specific about how the evaluation was actually
18 done, you could ask that the developers do
19 some sort of separate sample validation on
20 their method, or split half validation. I
21 mean to get to this point of reliability, you
22 can think of reliability in a general sense

1 is: if you take a doctor and you take half his
2 cases and run your methodology and you take
3 the other half and run your methodology and
4 compare the two scores, and you would expect
5 the scores to agree.

6 So in a general sense of
7 reliability that is absolutely a standard for
8 what we have, and I think it's not
9 unreasonable to ask these developers to
10 document and demonstrate that level of
11 reliability using the data. Any of the
12 developers that I think are going to come to
13 this and are going to propose this are going
14 to be sitting on tons of data, developmental
15 data, huge amounts of data, so it's not
16 ridiculous to ask them to go back and document
17 this with their sample data they used to
18 develop it. I mean that's how you do
19 development: you develop the model, you hold
20 back some samples, you run your model again
21 and you see what happens to your R squared.
22 Does it stay the same or does it go down? And

1 I mean that is routine in terms of the
2 developmental process. And when they do a
3 developmental process they should be able to
4 document what happens when they do that. I
5 don't think that is unreasonable.

6 CO-CHAIR LOTZ: Kurt.

7 DR. ELWARD: I would agree. And
8 as much as I think we'd all like to imagine it
9 wouldn't happen, I think the reality some
10 people if they developed a measure that is
11 particularly to their advantage will use this
12 for commercial advantage. There is a lot of
13 gamesmanship that can be done. I think if
14 they - support them being required to go back
15 and say this has some validity. Or if they
16 don't, but if it's a promising measure, they
17 should at least be able to say, we have this
18 plan of evaluation. So that at least we have
19 an evaluation plan in place. So we know that
20 if this seems to be a very very promising
21 measure that there is some kind of - we will
22 know eventually whether it's valid or not.

1 CO-CHAIR LOTZ: Dolores.

2 MS. YANAGIHARA: This is a
3 question for NQF. I seem to recall that for
4 the quality measures that there are two levels
5 of endorsement, is that right? There is like
6 a full endorsement and then there is a time-
7 limited endorsement for those that haven't
8 been kind of tested in the real world? Is
9 that the differentiation? I mean could that
10 sort of differential apply and be what Bruce
11 is looking for in terms of kind of different
12 levels of endorsement or whatever?

13 DR. BURSTIN: To date we do have
14 a time limited endorsement category. It is
15 really intended for measures that otherwise
16 would completely pass all the NQF evaluation
17 criteria except for the fact that it hasn't
18 been adequately field tested. There is
19 actually a testing task force that just put
20 out a draft report on our website currently
21 that really much more specifically outlines
22 what we really mean by testing reliability and

1 validity.

2 But I think that in the last year
3 or so there has been increasing discomfort
4 with bringing in untested measures, especially
5 untested complex measures. So in May the
6 Board of Directors narrowed the scope of what
7 could be brought in under time limited
8 measures. It has to be an area where there is
9 clearly a gap. It has to be where there is a
10 legislative mandate or a clear need to bring
11 in untested measures because of a quick need
12 to get measures in. And the third thing is
13 they can't be complex measures. And I think
14 many would argue these are fairly complex,
15 risk adjusted, things like that, composite.
16 So I think - and again I'd be curious to
17 potentially get CMS' perspectives on this.
18 But I think the idea of an untested resource
19 use measure getting through the process I
20 think at this point are low.

21 CO-CHAIR STEINWALD: I don't know
22 that anyone, even Tom, or me, was suggesting

1 untested. The question is what standards of
2 testing might you apply to different methods
3 at different levels.

4 DR. BURSTIN: What might be
5 useful the testing report is still - actually
6 closes for comment tomorrow. There is a very
7 nice table of their proposed evaluation
8 ratings of high, medium and low for testing
9 for measures, that I think might be useful to
10 share for the committee for our discussion
11 tomorrow. And the question would be, how
12 would you look at this in light of these kinds
13 of measures? Do you have to modify this
14 rubric slightly? But it really gets into the
15 level of sort of testing both at the data
16 element level or the measure score level. And
17 I think these seem like the kind of measures
18 that really gear toward measure score as
19 opposed to testing of the data elements. But
20 we'll have to - we'll share that with you
21 tomorrow as we sit down and think that
22 through.

1 CO-CHAIR LOTZ: Go ahead, Tom.

2 DR. ROSENTHAL: Of those criteria
3 that you listed, the one that would seem to
4 offer some possibility here is the notion of
5 gap. Because in a way there is a gap entirely
6 here. And it seems to me part of the gap
7 isn't being able to just do the statistics.
8 It's to have a group of people who have given
9 some deep thought to the problem and say, right
10 now I've got this array of numbers. Does this
11 really tell me something about the difference
12 between this physician and that physician, or
13 this group and that group, and that group and
14 the other group. And I think that's where
15 there is a tremendous gap, with the exception
16 of a few of the health plans and maybe a
17 little bit of the Medicare demonstration
18 project, I don't think those - I mean there
19 are value judgments implicit and explicit in
20 that. But it may be that we are going to have
21 to do some of those. But until you do those,
22 you don't want to have the thing out there as

1 a fully endorsed measure. So I think that is
2 where it maybe even not as much a statistical
3 methodologic problem as it is a value judgment
4 problem in assessing the thing for, is this
5 really likely to play out in real life as
6 being a meaningful difference between these
7 doctors' practices.

8 But the gap piece would maybe -
9 the complexity piece is what doesn't give us
10 any room in that formulation.

11 CO-CHAIR LOTZ: Paul.

12 DR. BARNETT: I'm a little
13 dismayed by the direction we are heading here,
14 because I think that this whole topic of
15 efficiency in health care is a political
16 lightning rod, and that anything we do that is
17 half baked is going to be a real problem. And
18 that what we ought to do is find a few things
19 that are extremely well validated and start
20 with that. That's all.

21 CO-CHAIR STEINWALD: Well, okay.
22 You know if we truly believe we are on an

1 unsustainable path and we need to get control
2 of health care spending in this country, and
3 we want to do it in a way that is as efficient
4 as possible, I don't want to ignore the
5 politics, but I also don't want to acquiesce
6 to the knee-jerk reactions that often occur,
7 that we are going to have rationing, we are
8 going to have death panels if we develop
9 comparative effectiveness data. I think we
10 can be above, or if not above, in a different
11 place than that political discussion. And
12 again I wouldn't want to discourage a measure
13 developer from being somewhat innovative
14 because they would worry that their measure
15 would immediately be put in a political
16 context and trashed if it weren't completely
17 validated in an - to the extent that
18 expectations would be unreasonable.

19 Now and so for example if someone
20 were to develop a measure of - a resource
21 measure that was suitable for let's say
22 medical home, and yet we don't have a whole

1 lot of medical homes and the ones that we have
2 are different from each other, maybe the
3 measure developer can only test it in one or
4 two sites, and yet we think that the concept
5 is going to grow and develop nationally so
6 that having a measure of resource use for
7 medical homes would be a very useful thing to
8 have now, but especially five years from now,
9 I think we would want to encourage measure
10 developers to go that route even knowing that
11 their ability to completely validate the
12 measure might be very constrained.

13 I don't know, what do you guys
14 think?

15 DR. PENSON: You know I think we
16 can learn a few things from the experience
17 with quality measures. You don't want to stop
18 people from doing this; you want to encourage
19 innovation. But let's be honest: a lot of
20 our quality measures, which are process
21 measures, are nonsense. They are not tied to
22 outcomes, and while they have some face

1 validity, when you look at it in the end when
2 you look at it a lot of them are kind of
3 meaningless.

4 So Bruce, I think we have to
5 balance it, and I think there is something to
6 be said for saying, you have a responsibility
7 with this measure. We don't want you - you
8 don't have to come here with a full
9 statistical validity reliability assessment,
10 but on the other hand you have some
11 responsibility to show that this is a
12 meaningful measure.

13 I'm concerned that if we just sort
14 of say, well, it seems like it might be a good
15 idea and it might be a great idea in five
16 years, and we let it in the door, then we'll
17 end up with nonsense. And I do think a lot of
18 the quality measures we have now, the process
19 measures, are problematic. So I think we can
20 learn from our prior errors.

21 CO-CHAIR STEINWALD: I'm
22 completely with you on the meaningful measure.

1 And I guess where I am though is not wanting
2 to have unreasonable expectations, especially
3 for the development of innovative measures
4 that are not sort of incremental improvements
5 of what already exists.

6 CO-CHAIR LOTZ: Jim.

7 MR. WEINSTEIN: I guess there is
8 lots of data out there, that I know we have
9 done and others have done, predictors of
10 utilization as just sort of what people have
11 been doing for the last 10 years. And if you
12 look at what they are going to do the next 10
13 years, you probably can project that with
14 pretty good confidence intervals and
15 reliability and Bayesian modeling. I think
16 that - I want to agree with you that I think
17 we need to go out a little bit further on the
18 limb here, but I do think there are some
19 groupers that we can look at that are fairly
20 simple compared to others and do the
21 experiment, whether it's like the pay for
22 performance activities that use mostly process

1 measures. And we were able to do 2 percent
2 better than others and get some benefit and
3 some cost sharing, or shared savings. I think
4 that is an interesting experiment.

5 I think the same thing can happen
6 here, and I don't imagine that we actually
7 know the measures. But I know that in large
8 databases you can find predictors of
9 utilization of resources by various provider
10 groups all across the country, and we have
11 seen that over and over and over again. The
12 question is, what are we going to do about it?
13 So now we have the models. Now we know what
14 the resources are. Are we going to change the
15 payment system, which does get into politics?
16 And that's what people are afraid of.
17 They are actually afraid that you are going to
18 use that information to change their payment
19 structure, and therefore not have the same
20 number of resources to spend for the resources
21 that they have been using.

22 So that context is out there. So

1 let's not shy away from it, but let's take
2 some pretty good examples where we can get
3 fairly confident measures of use of resources,
4 and yes eventually tie them to outcomes so
5 that we can get to the value equation, and yes
6 eventually change the payment system. Because
7 unless we are going down that pathway, I'm not
8 sure why we are sitting here. The fact of the
9 matter is, we do have to change what we are
10 doing. I think the voice at the table is,
11 let's do that in some rational way with some
12 experimentation that suggests by the providers
13 that are in those experiments that that does
14 make sense, and yes we can do it better and
15 differently.

16 CO-CHAIR LOTZ: Bill.

17 DR. GOLDEN: You know as we
18 evaluate these materials that come in, we
19 might even want to, over and above passing a
20 judgment or commentary on a particular measure
21 or measure set or developer, look at their
22 methodology and actually take some lessons

1 learned from the methodology in general, and
2 since you are from Dartmouth I can beat up on
3 Dartmouth. When you looked at the payment
4 models, one of the Dartmouth model as
5 presented at a meeting I was at talked about
6 using historic costs and taking a percentage
7 of the historic costs. Which made me very
8 nervous, because if you were a traditionally
9 over-utilizing region or you were a
10 traditionally - you were an early adopted of
11 technology, you got locked into that pattern
12 as opposed to somebody who hadn't adopted the
13 technology. And so I was kind of very
14 uncomfortable with that approach.

15 Now that would mean we could have
16 a discussion about do we like that measure
17 with historic costs as the basis. But we
18 might even want to pull that out and just
19 discuss the notion of historic costs as a
20 method that has its positives and negatives,
21 and perhaps inform the rest of the community
22 about when they design further measures.

1 CO-CHAIR LOTZ: Dolores.

2 MS. YANAGIHARA: One comment, and
3 one question.

4 Comment is, I think we would be
5 better served to have fewer really usable
6 tested well vetted measures than a bunch of
7 ones that are maybe not quite so solid. So I
8 just think we need to make sure that the
9 science is behind it.

10 The question, though, is, because
11 I also agree that we want to encourage
12 innovation, how - so we've got this initial
13 call for measures. What happens next? So the
14 developers that aren't ready to go out in
15 October with their measures, when is the next
16 time that they would be able to submit? Is
17 there a certain cycle? Is it ongoing?
18 Because if a measure is not ready it is not
19 ready. And so when would the next opportunity
20 be so that we can let people know that
21 process?

22 MS. TURBYVILLE: There are two

1 answers to that question. One is we do have
2 a standard three-year maintenance cycle in
3 which the developers would know that in three
4 years there is an opportunity to resubmit and
5 measures that have been currently endorsed are
6 reexamined and compared to the new generation
7 of measures. And that is true for all the
8 measures that we have.

9 But if another project were to
10 come about that's another opportunity too. We
11 could have another project that comes forward
12 and says, okay, you kind of got the very first
13 little building block. Now it's time to go to
14 the next building block. So there are at
15 least two opportunities. And Helen, did I --

16 DR. BURSTIN: I think, again,
17 this is such a new area for us, so that what
18 we often do with new areas like this is, we'll
19 have a group help us think it through. What
20 we really want to do is mainstream it. So we
21 had a composite steering committee a couple of
22 years back set up an evaluation framework.

1 How do we look at composites? What are we
2 going to ask for? What is the measure
3 submission look like?

4 The reality is, now, any project
5 we do, composite measures are welcome. And I
6 think the idea would be, going forward, once
7 we get past this initial hump, big hump,
8 little, whatever it is, I don't know, we will
9 ultimately as we go through all of our
10 endorsement maintenance projects over the next
11 three years, as a condition comes up or as
12 cost counting error comes up, resource
13 measures would be welcome as would any other
14 kind of - any other sort of parts of quality
15 measures, et cetera.

16 So I think that is the way we'd
17 ultimately want to say if for example in
18 September we are doing surgery and
19 cardiovascular. That's a little soon
20 obviously right now. But if we did a call for
21 measures on anything related to cardiovascular
22 care, we would within two or three years say,

1 sure, bring in resource use or efficiency, if
2 we get to the next level we hope by then,
3 going back to Ethan's point. We would say,
4 please bring in your efficiency measures to
5 the topical area as well. We won't have them
6 pigeon holed into these measurement type
7 projects any more.

8 CO-CHAIR LOTZ: Tom.

9 DR. ROSENTHAL: I would agree
10 with the proposition that given the full NQF
11 criteria that we will be lucky to come up with
12 two or three that pass the full spectrum of
13 things, and that that ought to be our focus.
14 So I agree with that completely. And the only
15 thing I thought we were discussing was how not
16 to close the door at this stage of the game on
17 people who are thinking about other things,
18 and I would hope that it is not a sort of
19 taste-great-less-filling conversation, but
20 just how do we keep the doors open at this
21 point. I agree that we will be lucky if we
22 come up with two or three, and they need to be

1 perfecto, they can't be - oh, maybe they were
2 okay, but maybe they hadn't been tested. That
3 would be a catastrophe. But it may also be
4 the case that we could also learn from the
5 quality thing that maybe this is an
6 opportunity to accelerate the field. Because
7 again I think we are starting at a different
8 place than the quality conversation started
9 where again there is not a lot of public
10 science about the thing.

11 And I saw somebody frown when I
12 said there is no science about this, but there
13 is not a lot of published science. What we
14 saw last week in the New England Journal
15 article was about the first thing I'd seen
16 that anybody - and I've Googled it and I
17 couldn't find much more that really gave me
18 what you would classically get from the
19 science. So I don't think this is a taste-
20 great-less-filling conversation yet.

21 CO-CHAIR LOTZ: Mary Kay.

22 DR. O'NEIL: It's a question, if

1 in the measures that are submitted it's clear
2 that there are significant gaps in issues that
3 are not being addressed by those, is there a
4 process or method to go after getting those
5 gaps filled without waiting for a three-year
6 cycle? If a couple of measures addressing one
7 part of the question come up, and everything
8 else is kind of ignored?

9 DR. BURSTIN: We are faced within
10 this project measures that are submitted to
11 the project. Part of what we also rely on
12 steering committees to do is to say where are
13 the good pockets of measures out there; find
14 them; bring them in. So if you can work with
15 whoever your stakeholders are, whatever the
16 group is, if there are some good things out
17 there, we would also hope you would identify
18 those for us, and we can get them into the mix
19 early.

20 The other thing is that there is a
21 fair amount of back and forth between steering
22 committees and developers as well, so it may

1 be that - and Jeff knows this as well. But as
2 measures come into us, there is often a sort
3 of back and forth saying this measure probably
4 could make it through but there are
5 significant concerns with the following, and
6 these are the conditions. So you will have a
7 little back and forth. We can't wholesale
8 rewrite measures or make them really different
9 than they started out to be. But again I
10 don't think it's a three-year cycle. Because
11 I think again once we get comfortable with
12 this area of measurement we would expect these
13 kinds of measures to flow into every single
14 one of our - whether it's cancer or pulmonary
15 or cardiovascular or care coordination. I mean
16 there may be ways to bring these kinds of
17 things in regardless of the topical area.

18 CO-CHAIR LOTZ: Paul.

19 DR. BARNETT: The other thing I
20 was just thinking about, and this was said in
21 the morning, but in terms of the criteria, I
22 think these resource measures are going to be

1 more acceptable if they can somehow be linked
2 to a quality measure. And I heard this great
3 quote, I don't know where it originally came
4 from, but that efficiency without quality is
5 unacceptable and quality without efficiency is
6 unsustainable. And so I think that whole
7 idea of efficiency without quality being
8 unacceptable is something that we have to
9 realize and that we would love it if there
10 were criteria that - you know one of these
11 resource criteria was linkable or really tied
12 in with some quality metric too, and it was a
13 value for money thing. So obviously we would
14 rate that much higher if we had that linkage.

15 CO-CHAIR LOTZ: Helen.

16 DR. BURSTIN: This is a really
17 interesting question, and one we've actually
18 spent a lot of time thinking about. The
19 question is, at this point in the game, do we
20 know enough about these resource use measures
21 to say, you should use this resource use
22 measure with this outcome X? Or is that

1 something that might be evolutionary over the
2 next couple of years. And again if we sort of
3 stick to the idea these are building blocks,
4 the NQF measurement framework couldn't have
5 said more clearly that resource use measures
6 should only be used when coupled with quality
7 measures. We are saying that; that is up
8 front; that is a given. But I think the idea
9 of necessarily saying that, going back to the
10 point somebody was raising earlier, we may not
11 have the right - your point - we may not
12 always have the right outcome measures we want
13 to put in front of it. But certainly Jim
14 would recognize that there are some great
15 issues around joint replacement. We've got
16 really crappy, at least to date, quality
17 measures around knee and hip replacement, yet
18 such an important area, really high cost, high
19 variability. So I think again if we kind of
20 stick to the building block approach, knowing
21 we can frame it in the context of at least
22 from where we sit the measurement framework

1 has already clearly said, only use when
2 coupled with quality, that is probably the
3 best approach for us at this point. But I'm
4 certainly open to other ideas and suggestions.

5 One thing Sally and I were talking
6 a little bit about is, it might be useful when
7 we do the measure submission to at least ask
8 the developers to indicate which quality
9 measures they have coupled these with, just so
10 we can begin to learn. But I don't think
11 again making it the requirement, or
12 automatically saying this resource use measure
13 goes with this outcome measure, I'd be curious
14 to know your take on it, but it's an
15 interesting question.

16 DR. BARNETT: Just to make clear
17 what I was proposing is not that we make it
18 mandatory, but that we include it as another
19 criterion, and if somebody meets it then
20 obviously we are going to rate that measure
21 higher.

22 CO-CHAIR LOTZ: Kurt.

1 DR. ELWARD: Yes, I appreciate
2 Helen's comments, and I just want to make sure
3 that that's something that will get past the
4 board, too. You were talking about things
5 that haven't actually been proven yet. So
6 that would pass - your sense is what you were
7 saying would pass the board? I'm trying to
8 make sure that I'm following you. When
9 measures haven't been truly proven yet,
10 earlier I thought you were saying that that
11 would have problems getting past the NQF
12 board.

13 DR. BURSTIN: I still think these
14 would be tested resource use measures. I'm
15 just trying to make the point that I'm not
16 sure we necessarily want to say we absolutely
17 know at this point for certain that these
18 resource use measures should go with outcome
19 B. In terms of the coupling piece of it.
20 Separate, I think the resource use measures we
21 are still saying we want them to be reliable
22 and valid.

1 DR. ELWARD: I think from my
2 point of view, also, we almost have to couple
3 them with some kind of quality measure.

4 DR. BURSTIN: We are absolutely
5 saying they must be coupled with a quality
6 measure. The question is the level of
7 specificity. Do we say for example this
8 resource use measure on hip and knees must go
9 with the Oxford hip and knee functional tool.
10 Or must go with the Ottawa tool. I mean this
11 is where I think it maybe fuzzy. I'd just be
12 curious about the committee's perspective on
13 that, because I think that's a tough issue.

14 CO-CHAIR LOTZ: Okay, we started
15 this section talking about limitations and
16 implications. We actually drifted a little
17 bit into our next section, which is supposed
18 to be - I'm going to ask Sally to say it the
19 way she said it over the break, because it's
20 really getting to the point where it's got
21 some useable and actual information out of our
22 conversations. So what are must-have

1 criteria, what are things for us to continue
2 to think about? How can we take the day's
3 conversation and distill it into a ranking or
4 a sense of importance of what we have talked
5 about that will then tomorrow inform how we
6 actually turn those comments into criteria and
7 into our call for measures. Kurt. Oh, I'm
8 sorry, Jim.

9 MR. WEINSTEIN: Are you into the
10 discussion?

11 CO-CHAIR LOTZ: Yes.

12 MR. WEINSTEIN: Because I think
13 as you mentioned like line 806 et cetera gets
14 into the resource use measures as building
15 blocks toward the future around quality and
16 appropriateness performance, and I just - I
17 think quality and appropriateness are
18 different.

19 And then maybe examples in this
20 text of how these things might be measured.
21 And then as you go through the next several
22 bullets like 816, 818, it might be nice to

1 have some specific examples as well as 824,
2 resource use scores, et cetera, for the
3 reader. And the reference 20 doesn't really
4 reference anything. But I was just - or if it
5 does I don't know what it is. But those are
6 my comments. I think this could have been
7 helped a lot by some examples of actually in
8 use systems that are doing these measures that
9 would help the people who want to submit
10 measures understanding what kind of thing we'd
11 be looking for in submitting.

12 CO-CHAIR LOTZ: Do you want to
13 reframe the conversation the way you did over
14 the break?

15 DAY 1 RECAP

16 CO-CHAIR LOTZ: Again, just doing
17 a time check, we've got about half an hour, a
18 little more than half an hour before we open
19 up the lines for public comment. We are
20 supposed to have a break in between then, but
21 I'm also told that we should wrap up by about
22 4:50, so if you all feel you need a break, or

1 if we - it's 3:55 right now, so we have a
2 little less than an hour total, part of which
3 includes some time for public comment.

4 Bill, go ahead.

5 DR. GOLDEN: Since we have a
6 little time, I was just curious, maybe we
7 could hear, and you might not want to say, on
8 page 32, there was a talk about direction for
9 a physician compare website. And with the
10 problems of getting that granular, are there
11 any thoughts as to what that may or may not
12 look like?

13 CO-CHAIR LOTZ: Or would you
14 rather actually stay with the agenda and just
15 take that afterwards?

16 DR. RICH: I'll sort of answer
17 that for you, it was going to be based on
18 PQRI, people who successfully participated in
19 PQRI used that measure set. Not a process
20 measure as was said before, but that's what it
21 was going to be based on.

22 DR. GOLDEN: That helps.

1 MS. TURBYVILLE: So knowing that
2 we were going to have a very full day, my hope
3 was that prior to adjourning this first day
4 that we at least start to get the steering
5 committee to think a little more concretely in
6 the application of evaluating the resource use
7 measures as they come in based on the
8 conversation that had happened.

9 I think you guys have actually
10 already started down that path prior to the
11 formal kickoff of this section. So in
12 thinking about the evaluation criteria that
13 exists now, in thinking about the evaluation
14 criteria that we had as a straw man during the
15 webinar where we started playing around with
16 how we might expand language to just reframe -
17 we've done away with what we were calling the
18 phases, but there are certain components that
19 we have identified, and I'm just going to
20 throw this one out there as being one of those
21 hot topics, like attribution, that would or
22 would not be subject to the evaluation

1 process.

2 And this is not meant to come to
3 decision today because we will actually go
4 through the principles and evaluations
5 tomorrow. But make sure we've answered
6 questions or kind of really dove deep enough
7 into the various topic areas to inform that
8 conversation tomorrow.

9 So I don't think we are trying to
10 get to decisions unless it's absolutely not,
11 let's not look at that, and then get the group
12 to respond to that.

13 CO-CHAIR LOTZ: Jim, are you up
14 again? Not yet? Okay.

15 CO-CHAIR STEINWALD: Well, just
16 to make sure I understand context, we have
17 four criteria, four main criteria. They are:
18 importance, scientific acceptability,
19 feasibility and usability, right? And so we
20 are not arguing those four. Those four are
21 etched in stone. So what we are discussing
22 is, okay, how much granularity do we need

1 underneath those four?

2 MS. TURBYVILLE: Well, my vision
3 which may not have been right a week ago given
4 that we are now in play was that that would be
5 tomorrow. But today thinking about what we've
6 discussed about the components as far as
7 measures, are there any things that are off
8 the table, things that would help us prepare
9 what you need tomorrow to really dive in.

10 And putting it into context, it's
11 almost you guys help us do a wrap up for today
12 and bringing it down to the more concrete
13 slice in which - affects evaluation. Which I
14 really do think you already had naturally
15 started having that conversation about.

16 And yes, tomorrow when we go
17 through the actual sub-criteria, I mean a lot
18 of the sub-criteria we saw are still
19 applicable. Validity is still applicable.
20 Reliability is still applicable. Some of the
21 things that you started talking about. How
22 will we guide the measure developers in what

1 do they need to submit to us that would
2 demonstrate that they are meeting those sub-
3 criteria. We will have those conversations
4 certainly in more depth tomorrow as well. Or
5 we can choose to go down another path.
6 Honestly these slides are just meant to help
7 guide us and make sure that we are getting
8 everything we need, but not meant to be
9 restrictive to the steering committee at all.

10 CO-CHAIR STEINWALD: What's the
11 next slide? Oh okay.

12 MS. TURBYVILLE: We could also
13 just kind of - staff could present to you some
14 of the criteria and considerations that we
15 know have to happen. And then maybe that will
16 allow you to think through the conversation
17 today. And then tomorrow we can dive more
18 into the steering committee discussion. We're
19 open to that, because this is kind of canned,
20 already, pre-canned. If everyone is wearing
21 out.

22 DR. HALM: You know the extent to

1 which you can highlight from the discussion or
2 the email comments of some suggested additions
3 to kind of the standard canon that people have
4 suggested we might need to include for
5 resource use specifically beyond just the four
6 horsemen.

7 CO-CHAIR LOTZ: Barbara, go
8 ahead.

9 DR. RUDOLPH: Well, I was just
10 going to talk about the first criteria is
11 importance. And it might be under the
12 criteria for evaluation of measures. And I
13 think there might be something extra that
14 would be valuable there. Right now you need
15 to meet the sort of one of the important areas
16 that the priority partners have decided upon
17 needs to be high volume or high cost, I'm
18 trying to think what the other ones are. But
19 I have a feeling that this area, particularly
20 pertaining to efficiency -- as it relates to
21 efficiency, might need a little more
22 specification on the importance side. Because

1 I'm thinking about like how do you select the
2 - say if you were going to do procedure
3 specific, or you were going to do a condition,
4 if you were going to do an episode, where do
5 you start with this? And what would drive
6 your choice about which area to measure? And
7 I guess there as representing purchasers of
8 commercial populations, I might have an
9 interest in for example deliveries, and that
10 might not be on a priority partners' list of
11 important things, yet it's say 20 percent of
12 the consumer spend or the commercial spend is
13 on deliveries. So I mean I'm thinking that
14 there might be some other criteria that may or
15 may not match with the existing criteria for
16 importance to measure.

17 MS. TURBYVILLE: So just to maybe
18 aid a little bit more in this discussion, I
19 forgot to mention, in your manila envelopes
20 are in a table that is the thickest document
21 in there, on the right-hand side, are the
22 current NQF evaluation criteria, and on the

1 left-hand side would be what we have proposed.
2 It looks like the memo is the one that is in
3 landscape on the front page.

4 DR. BURSTIN: Let me just put
5 this in context for a minute, Sally, if that's
6 okay.

7 So the idea here was that we
8 already have a set of NQF evaluation criteria
9 that we use. A couple of them are being
10 updated as I mentioned. There is a testing
11 task force, and I've got that table for you
12 that I'll share around reliability and
13 validity, as well as a group that is really
14 focusing on sub-criteria 1(c) which is the
15 evidence for the measure focus. But the idea
16 was, how these resource measures still feel
17 like a bit of a round peg in a square hole.
18 And so the idea was, how do we adapt, not
19 create new ones, but adapt the current
20 criteria or perhaps add a subcriteria or two
21 to make it work best to evaluate these
22 measures, since they are kind of a bit of a

1 different beast.

2 DR. GOLDEN: A question for you.

3 I was going to put this in writing, but I'll
4 make it a statement now. There are two
5 aspects of the paper that I thought got a
6 little on the editorial side as opposed to a
7 little more analytic. And I thought - and I
8 just think as we go through this there are
9 ways of producing a compelling document
10 without necessarily turning off audiences we
11 want to reach.

12 So the first paragraph I thought
13 was a little strong in terms of going after
14 the health care system. You can go over
15 things, but I don't think we have to - I think
16 the approach was a little - I think we can
17 make it a little more value neutral in some
18 ways.

19 But the whole notion of the term -
20 and I think it's in the first page here on the
21 document - the third page - poor performance,
22 the term poor performance, especially when it

1 deals with resource use, it might be better to
2 use the term, inferior performance. You are
3 implying a value judgment on the performance
4 on the basis of the data without necessarily -
5 it's all comparative. And I'm not sure we
6 can state that it's truly "poor performance."
7 It's definitely a lesser performance; it's an
8 inferior performance. But it's not
9 necessarily a poor performance, depending on
10 the circumstances.

11 CO-CHAIR LOTZ: Barbara.
12 Dolores?

13 MS. YANAGIHARA: I was just going
14 to go back to the question I started with this
15 afternoon. So there are these lists of things
16 that are supposed to be part of the
17 specifications, and which ones are we going to
18 be responsible for, and which ones are - it's
19 kind of the question that I think Helen was
20 asking. So which are part of the evaluation
21 criteria, and which are the implementation?
22 And I don't know that we answer that. I don't

1 know if we should answer it now or tomorrow or
2 what, but it might be helpful to go through
3 that list of all of the things that we talked
4 about and ask, is it in or out as part of the
5 evaluation or not at some point. I don't
6 know if it's now in preparation for tomorrow
7 so we can think about how all these criteria
8 would apply, or if it's tomorrow. But I think
9 that needs to be done still.

10 CO-CHAIR LOTZ: Ethan.

11 DR. HALM: I'm not sure if you
12 are asking us to kind of wade into this table
13 now and comment on the different pieces. But
14 in heading into the discussion I think on the
15 importance side, I think the perspective seems
16 different for this resource use steering
17 committee than some of the quality measure
18 ones. So sort of proportion of heart attack
19 patients getting an aspirin, you don't have to
20 worry about what the perspective is there in
21 generally. But here we have heard
22 conversations about, is it the prospective

1 society, of the payer, the provider, the
2 organization, the patient. And so I think
3 this is going to come up particularly in the
4 importance that people need to talk about
5 things being important, from which
6 perspective. And I'm not sure thinking ahead
7 on these other dimensions what about resource
8 use is inherently different than the more
9 traditional quality measure construction
10 issues are. That seems like one of them to
11 me.

12 CO-CHAIR LOTZ: Bill, are you up
13 again? Mary Kay.

14 DR. O'NEIL: I'm thinking back to
15 that spectrum that we discussed earlier from
16 procedures and episodes and things like that.
17 So when you look at those things you can say
18 who does the most efficient job of doing a
19 knee replacement from inputs or costs of
20 inputs. On the other hand if you go further
21 to the other end of the spectrum when you are
22 looking at the application of resources to a

1 population, the outcome can be looked at as
2 what the costs are, what the medical trend
3 costs are for that population over a longer
4 time horizon, and that can be the surrogate
5 for how healthy they are, in terms of what
6 their medical needs are on a going-forward
7 basis. So in other words what kind of inputs
8 are most efficient in producing health over
9 time. And of course in our industry we are
10 also interested in productivity over time,
11 because we are mostly looking at working age
12 adults. So there are some really different
13 ways of looking at what the outcomes are, what
14 you are measuring and the impact that you are
15 tracking that is pretty different than more
16 narrow very time-restricted interaction of the
17 patient with the health care system.

18 MS. TURBYVILLE: I wish there was
19 an easier way to pull up the various
20 components because what we had thought was to
21 think about the phases and the steps, but now
22 it's just pretty much the steps. So let me

1 see if I can - they are all included in here,
2 but just separately. So if we don't think of
3 them as just kind of specification. (Pause)
4 Bear with me for one second. (Pause)

5 So this may seem obvious, but for
6 example would there be any of these steps of
7 a specification that would not be subject to
8 evaluation? And then we can just, there are
9 a few others. So would there be any reason
10 why there wouldn't be an expectation as we go
11 through the evaluation criteria and we're
12 helping guide this through, that the measure
13 developer could step away from clearly
14 defining the unit of measurement, et cetera.

15 And so just kind of quickly in the
16 last few minutes, it doesn't mean that it's
17 all in cement or anything, but are there any
18 things - and I'll pull up the rest of the list
19 - are there any things in these steps that you
20 do not consider to be subject to evaluation
21 when we start thinking about the criteria in
22 more detail tomorrow?

1 CO-CHAIR LOTZ: Bill.

2 DR. GOLDEN: Do you want me to
3 react to what's up there? Or do you want to
4 have comment on one of the measures, or just
5 see whether it should be there or not?

6 MS. PODULKA: I'm sorry.

7 DR. GOLDEN: I'll flip it. The
8 first item, the first bullet, I'm not sure is
9 what you are trying to capture. The issue of
10 acute versus chronic is not as important as
11 the timeframe. So I mean you could have acute
12 episodes that last five days or last - for the
13 same issue - last two months. And I think we
14 need time in there as opposed to adjectives.

15 MS. TURBYVILLE: Does that work?

16 DR. GOLDEN: I'm just making the
17 comment.

18 MS. TURBYVILLE: So would that
19 address your concern a little bit better, if
20 the group agrees?

21 DR. GOLDEN: It goes to a similar
22 thing we did before.

1 MS. TURBYVILLE: Right. Okay.

2 CO-CHAIR LOTZ: Paul.

3 DR. BARNETT: I'm not sure when
4 we evaluate measures we are sort of - we want
5 to look at something, and I think the top
6 level, the four horsemen as it were, are the
7 right place to start, and that drilling down
8 to this level, if someone has a measure and we
9 are convinced it's important and it's valid
10 and it gives actionable information, I don't
11 really care to second guess how they got to
12 that point, or drill down and say hey, should
13 it be tweaked a little bit. I really want to
14 focus on those top level things. Is it
15 important? Are there are a lot of costs
16 involved? A lot of people involved? Have
17 they done some validation that it works? And
18 can we do something with it once it comes out?
19 I think those are all the things that we
20 should be looking at and not so much how they
21 got there.

22 CO-CHAIR LOTZ: I don't

1 understand it as a how we got there, but as a
2 refining or clarification as it's to be used
3 in this particular application. I'm thinking
4 about the scientific acceptability. And
5 someone earlier mentioned the idea about the
6 difference between clinically significant and
7 statistically significant, and the analogy
8 here being economically significant versus
9 statistically significant. And do we -
10 telegraph that in the call to measure, and
11 consider that when actually looking at the
12 measure. So as I have kind of understood this
13 exercise it's to take those four essential
14 criteria that NQF has used and intends to
15 continue to use and refine them or amend them
16 for this particular process. Is there
17 anything else we need? Or do we need to be a
18 little bit clearer on how to apply those to
19 this particular project? Tell me if that is
20 wrong.

21 DR. BURSTIN: I think that is
22 right, but I guess the question would be,

1 would it make more sense to start with the
2 criteria and the suggestions for ways to flex
3 them, and then come back?

4 MS. TURBYVILLE: I think that is
5 a good question. I think the challenge is
6 even - and so maybe this will come out more
7 naturally tomorrow - is when speaking to
8 measure developers about these types of
9 measures and submitting measures, it's not
10 clear to them what the specification would be
11 that they need to submit for the steering
12 committee to evaluate.

13 And so while it seems like it's
14 getting into the details, that's because it
15 is. So what are they just going to submit the
16 description of their measure and we use a
17 clinical logic that we have tested but you
18 don't need to see it because we'll just let
19 you know that it was tested? These are the
20 kinds of things I'm trying to push the
21 steering committee to think about so that as
22 we develop the call for measures and the

1 submission form, et cetera, that we are able
2 to clearly tell them what to submit, that we
3 are also not getting volumes and volumes of
4 things that you might not be interested in
5 evaluating.

6 So it is the details, and that's
7 kind of what the thinking was behind it.

8 MS. PODULKA: It has an
9 implication not just for the signal to the
10 measure developers about what you want to see,
11 but it has an implication down the road for
12 the users of our measures. And for instance
13 we want to keep abreast of whether users are
14 using actual NQF-endorsed measures or if they
15 are tweaking or somehow changing those in
16 their implementation. But there could be
17 changes or tweaks that you as a steering
18 committee are agnostic or indifferent about.
19 For instance in one of those pre-steps
20 whatever we are calling them now about data
21 cleaning. There is a step for Winsorizing or
22 excluding certain claims. If some measure

1 developers Winsorize to the 1st and the 99th
2 percentile, and another measure developer
3 Winsorizes to the 2nd and the 98th, you might
4 be agnostic or indifferent, and you might say,
5 well users could choose what they want there.
6 Or you might say, this step is integral to the
7 measure, and needs to be considered in view of
8 our four criteria.

9 CO-CHAIR LOTZ: Mark Kay? Tom?

10 DR. ROSENTHAL: I mean I think
11 this is pretty good. I mean this is almost a
12 recapitulation of the discussion we had a
13 little earlier, trying to define what it is,
14 and how much detail are we going to insist on.
15 I have a question and a comment.

16 The question is, when we have
17 defined the unit episode, let's say for the
18 sake of discussion that that was going to be
19 a bundled payment for joint replacement, are
20 you saying that we do or don't have to ask for
21 any greater degree of specificity about what
22 kinds of things they would put in there? For

1 example in the working group that we had on
2 this, the question is, do you include rehab
3 services or don't you include rehab services?
4 And it's a fairly important question. Is that
5 the kind of specificity that you are looking
6 for in the definition of the unit? And if so
7 you may want to provide a little more
8 guidance.

9 And the comment I have is, I think
10 the attribution question is maybe more
11 important in this business than it has been in
12 the quality realm, maybe it didn't matter
13 quite as much, but here I think it matters a
14 lot. And maybe that needs to be its own
15 something up there that guides people as
16 saying we really want to be very certain to
17 whom you are attributing this, because I think
18 our selection of one measurement over another
19 may hinge upon the degree to which the
20 attribution is really clearcut and not
21 ambiguous. And so that may be the only thing
22 that I don't see on there that might be worth

1 spelling out, unless again that's implicit in
2 your idea of defining unit construction logic,
3 but now we are back into, will everybody
4 understand what you meant exactly by that.

5 MS. TURBYVILLE: I just haven't
6 cut and pasted it on there yet. So yes that
7 would come from - you are absolutely right,
8 when we go back to the PowerPoint, you were
9 right to say it's getting back to the earlier
10 discussion. So when we started talking about
11 applying, that's when you see this list is
12 quite long, 29 and 30, when we start talking
13 about the attribution, et cetera, absolutely.
14 So the question was if there are any of these
15 steps in here that would not be part of
16 evaluation.

17 CO-CHAIR STEINWALD: So we are
18 not explicitly excluding anything, but we are
19 giving a lot of discretion to the measure
20 developer about what really needs to be
21 highlighted. In other words, it may not be
22 important - there may be a measure where

1 attribution is not an important dimension; but
2 some will. And they might need to say why
3 that's true. But that could be a paragraph as
4 opposed to 10 pages.

5 MS. TURBYVILLE: Just to comment,
6 not to necessarily - to add to your comment -
7 how we handled it on the quality measure,
8 there are times where it's - risk adjustment
9 is a required component, or you must provide
10 your justification of rationale of why it is
11 not applicable to this measure. So you could
12 latch on to that kind of language for some of
13 these where it is a required criteria, and
14 where they don't do it it must be an
15 intentional well thought out rationale that
16 then the steering committee thinks is an
17 acceptable rationale.

18 CO-CHAIR LOTZ: What I've noticed
19 as kind of a common theme, or what I think has
20 been a common theme throughout our discussion
21 is that there is a lot of these criteria where
22 we say, just explain to us what your thinking

1 is, but we are not creating any absolute
2 thresholds like you have to do your
3 statistical analysis in this way. What I've
4 heard is, we have to do some kind of
5 statistical analysis. Just tell us what it
6 is, and tell us why you chose it, and tell us
7 what kind of strength comes along with that.

8 Paul, Barbara and Jack in that
9 order.

10 DR. BARNETT: So now you have
11 convinced me of the need to get into all of
12 the detail. But I think that the last two
13 comments are exactly right. So if I'm peer
14 reviewing one of these, I'm not going to have
15 any independent information whether a 60-day
16 or a 30-day or a 90-day clear period is the
17 best way to define an episode. But I want to
18 be convinced that they knew why they chose the
19 one that they did.

20 CO-CHAIR LOTZ: Barbara.

21 DR. RUDOLPH: I was just looking
22 at one of the comments on the criteria, and it

1 was discussing like laboratory and I think
2 pharmacy as well. And so I can see situations
3 where either laboratory costs and/or
4 drug/pharmacy costs are included, and in other
5 cases perhaps the measure developer didn't
6 include it because either they didn't have
7 access to the data or whatever. Again I think
8 that might be something that there would need
9 to be a rationale for not including some of
10 those costs. If they were relevant.

11 And again maybe it's this
12 discussion of relevancy is, because if you got
13 two groups in, and they -- one group included
14 both lab and pharmacy and the other said, well
15 we tested that but it really didn't make any
16 difference, I could live with that. But
17 things like that would certainly be a
18 consideration here.

19 CO-CHAIR LOTZ: Jack.

20 DR. NEEDLEMAN: Barbara's comment
21 raises the issue of understanding not only
22 what the unit of measurement is intended to be

1 but what the scope of the measure is, what
2 costs, what resources, have been taken into
3 account, which have not been taken into
4 account. So I think where that fits in the
5 description of what we want is not completely
6 clear to me, but we certainly need to make
7 clear we want that.

8 Missing from this list is
9 something we talked about right at the
10 beginning of the day, which is what kinds of
11 cost adjustments or cost standardizations have
12 been introduced into the measure. And that
13 should probably be made explicit.

14 The other thing that I had a
15 question about is whether the flow on this
16 list is important to our consideration,
17 because the attribution problem is going to be
18 a major issue as we think about the
19 application of this. It's post-attribution
20 that the physician comparisons and the Adams
21 McGlynn paper come up in particular, and
22 reliability issues come up. But right now

1 it's on the top of that second page, and I
2 actually think the attribution issue,
3 attribution goes down after we have measures
4 of resource costs either at the episode or the
5 patient level. Then we need to figure out who
6 we are assigning these to for the purposes of
7 making any cross-provider, cross-clinician
8 comparisons, and what the appropriate level
9 is.

10 But if it's relevant about the
11 flow here, I'd want to see that move down in
12 the flow. And if it's not relevant at the
13 moment then it's not relevant at the moment.
14 But we should be thinking about the flow of
15 the analysis and which numbers we get early
16 and which numbers we get late in the course of
17 understanding what the measure is doing.

18 CO-CHAIR LOTZ: Additional
19 comments? Should we just go ahead and open
20 up the phones?

21 MS. TURBYVILLE: Operator, at
22 this time we'd like to open the call up to any

1 public comments or questions for the steering
2 committee.

3 PUBLIC COMMENT

4 OPERATOR: Press star one for any
5 questions or comments.

6 We'll take our first question.
7 Caller, please go ahead.

8 DR. MUNLEY GALLAGHER: Hi, this
9 is Rita Gallagher. May I comment?

10 MS. TURBYVILLE: Yes, please.

11 DR. MUNLEY GALLAGHER: This is
12 Rita Gallagher. May I comment?

13 MS. TURBYVILLE: Yes, you can.
14 Can you hear us, Rita? Because we can hear
15 you?

16 DR. MUNLEY GALLAGHER: I can now.
17 Thank you.

18 Again thank you for the
19 opportunity to comment. The efficiency
20 resource use steering committee has been
21 eloquent in its discussion of what the measure
22 developers are to be doing in specifying and

1 submitting measures for consideration for NQF
2 endorsement. I would respectfully suggest
3 that there is a parallel need for NQF to
4 ensure that the members of the various
5 technical advisory panels and steering
6 advisory committees have the necessary
7 expertise and time, and are adequately and
8 uniformly prepared to fully engage in the
9 evaluation of those measures once they are
10 submitted.

11 Thank you.

12 MS. TURBYVILLE: Thank you. Any
13 other questions or comments?

14 OPERATOR: No further comments or
15 questions on the phone.

16 CO-CHAIR LOTZ: All right, there
17 is a desire to wrap it up. So one last time,
18 final comments? Otherwise we will talk about
19 the logistics of reconvening in the morning
20 and how we'll spend our time.

21 So according to our schedule we
22 are back in this building I guess - why am I

1 doing logistics, I have no insight into this.

2 Ashley, actually Ashley I think is our
3 logistics person.

4 MS. TURBYVILLE: We are indeed
5 back here tomorrow. And day two starts at
6 8:45 for a continental breakfast. We start at
7 9:00. We dive right in, we do our best to do
8 a recap to make sure that we haven't
9 inadvertently gone down the wrong path. We
10 will talk about some external market
11 implications and give everyone a chance to
12 discuss that, so we can learn from all of you.
13 And then we will dive right into the
14 evaluation criteria table.

15 Now the slides are set up to go
16 through what we have seen with the
17 subcriteria, and we'll talk a bit more in
18 detail as being different. But I do want to
19 make sure we spend time on what we have,
20 because we may have missed something. So we
21 will think about how best to approach that
22 tomorrow. And that includes a discussion by

1 the way of the evaluation principles which are
2 reflected in the white paper and will also be
3 maintained in the evaluation criteria
4 documents.

5 So that I think will be the
6 starting point before we dive into the more
7 detailed discussion.

8 Please.

9 DR. BURSTIN: I'd just mention,
10 she said Table 2 is the draft table from our
11 testing task force report. It might just be
12 useful as a starting point for our discussion
13 tomorrow to look at this and see how that
14 would work, not work, need to be modified
15 potentially for the resource use measures.

16 MS. TURBYVILLE: Thank you
17 everyone.

18 (Whereupon at 4:33 p.m. the
19 proceeding in the above-entitled matter was
20 adjourned.)

21
22

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