

NATIONAL QUALITY FORUM

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RESOURCE USE CARDIOVASCULAR/DIABETES
TECHNICAL ADVISORY PANEL MEETING

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WEDNESDAY

MAY 11, 2011

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The Technical Advisory Panel met at the National Quality Forum, Suite 600 North, 601 13th Street, N.W., Washington, D.C., at 8:30 a.m., Jephtha Curtis and James Rosenzweig, Co-Chairs, presiding.

PRESENT:

JEPHTHA CURTIS, MD, FACC, Co-Chair, Yale
University School of Medicine

JAMES ROSENZWEIG, MD, Co-Chair, Boston Medical
Center and Boston University School of

Medicine

MARY ANN CLARK, MHA, Neocure Group

CONSTANCE HWANG, MD, MPH, Resolution Health,
Inc.

THOMAS MARWICK, MBBS, PhD, Cleveland Clinic

DAVID PALESTRANT, MD, Cedars-Sinai Medical
Center*

BRENDA PARKER, PharmD, GlaxoSmithKline

KATHERINE REEDER, PhD, RN, University of
Kansas

School of Nursing

WILLIAM WEINTRAUB, MD, Christiana Care Health
System

NQF STAFF:

TAROON AMIN, MPH

HEIDI BOSSLEY, MSN, MBA

SARAH FANTA

SALLY TURBYVILLE, MA, MS

ASHLIE WILBON, MPH, BSN

ALSO PRESENT:

BEN HAMLIN, MPH, National Committee for
Quality

Assurance (NCQA)

TODD LEE, PharmD, PhD, American Board of
Medical Specialties (ABMS)*

TOM LYNN, MD, Ingenix

ROBIN WAGNER, RN, MHSA, American Board of

Medical Specialties (ABMS)*

KEVIN WEISS, MD, MPH, American Board of
Medical Specialties (ABMS)*

* Participating via telephone

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

8:30 a.m.

1
2
3 MS. TURBYVILLE: I wanted to go
4 over quickly some of the parking lots and
5 recurring themes. There is just a few, to
6 make sure I've captured them from yesterday,
7 and then because we're starting with the ABMS
8 measures, we thought it would be a good idea,
9 especially in areas where the specifications
10 are similar across the measures which include
11 the data protocol steps, which is the data
12 cleaning, and others, kind of recap that.

13 So hopefully then the focus,
14 without ignoring how your evaluation today
15 will influence that, would be on the clinical
16 components and what's different about the
17 measures that you're going to review today,
18 and we had talked about that with Jamie and
19 Jeptha.

20 So I'm hoping everyone is in
21 agreement with that, kind of built on
22 efficiencies our of what we learned yesterday.

1 Yes? Okay, great.

2 So in addition to some of the --
3 I'm going to start with the parking lot
4 issues. Give me one second, to pull it up.
5 Yes, please?

6 DR. MARWICK: Could I just ask
7 something?

8 MS. TURBYVILLE: Yes.

9 DR. MARWICK: Just in relation to
10 the stroke Ingenix document, it has the same
11 problem that we dealt with yesterday with the
12 acute MI document. The third Ingenix, the
13 chronic coronary disease, I think, is less of
14 an issue.

15 But I wonder if we should have a
16 discussion with them as to which they would --
17 if they wish to proceed. I'm not the primary
18 spokesperson on that, but it's just an
19 observation.

20 MS. TURBYVILLE: We could really -
21 - I mean, I think it's worthwhile for us to
22 examine how to prevent reviewing a measure

1 that we feel is not going to make it much
2 further through the process. However, the
3 problem that you identified there really is
4 what we rely on the clinicians to do.

5 So maybe if you guys have a side -
6 - you know, maybe if you and the lead
7 discussant or the lead -- I can't remember who
8 the lead discussant is, feel that it really
9 has these flaws, then, yes, I'll need your
10 input, and at least the lead discussant, in
11 order to then share that with Ingenix. Does
12 that make sense?

13 CO-CHAIR CURTIS: I think since
14 we're not going to anticipate getting to that
15 today --

16 MS. TURBYVILLE: We can do it
17 today.

18 CO-CHAIR CURTIS: -- anyway, maybe
19 offline --

20 MS. TURBYVILLE: Yes.

21 CO-CHAIR CURTIS: -- and then we
22 can discuss how to address that --

1 MS. TURBYVILLE: Yes.

2 CO-CHAIR CURTIS: -- and get --
3 pull the measure developer into that
4 discussion.

5 MS. TURBYVILLE: Yes, okay.

6 DR. PALESTRANT: I'm the lead
7 discussant on that. I think that there are
8 certain issues, but I guess the question is,
9 are we going to review things that we have --
10 that may have issues, that may not get full
11 endorsement or pass on those until they come
12 back, but from what I understand, we need to
13 give some guidance of why we're not endorsing
14 them.

15 MS. TURBYVILLE: We're having a
16 hard time hearing you, David, again. I'm
17 sorry.

18 DR. PALESTRANT: Okay, can you
19 hear me now?

20 MS. TURBYVILLE: Yes, that's much
21 better.

22 DR. PALESTRANT: Okay, I think the

1 stroke based resource one, there were a lot of
2 interesting components to it, but there were
3 certainly issues. My sense is that we're here
4 to -- we're not just here to endorse. We
5 should be reviewing things that even though
6 we're not endorsing them, I guess because
7 they're in front of us, we should be reviewing
8 them.

9 CO-CHAIR CURTIS: Okay, so let's
10 put that in the parking lot for right now, but
11 definitely we'll have some discussions and
12 engage both primary reviewers.

13 DR. PALESTRANT: Just one other
14 thing on the Ingenix thing. We haven't
15 reviewed an Ingenix one in full, and I
16 reviewed two of them and they are -- once
17 again, I think -- requires reviewing one in
18 full because they're all essentially based on
19 the same kind of -- they're all exactly the
20 same, essentially, in terms of their
21 methodology.

22 MS. TURBYVILLE: Great, thank you,

1 David.

2 So some of the parking lot issues
3 are recurring themes. These are not measure
4 specific that we heard yesterday, is a request
5 that the NQF Steering Committee provide
6 additional guidance and statement that the
7 resource use measures that are publicly used
8 should include sound statistical approaches in
9 their estimation and be transparent.

10 That administrative data lacks --
11 acknowledging the administrative does lack
12 clinical detail. This type of lacking of
13 clinical detail can affect the risk
14 adjustment, reliability, and, potentially,
15 ultimately, the validity of the measure. No
16 real solution, but it was a recurring theme.

17 Disparities by socio-economic,
18 race and ethnicity and resource use and
19 literature really does not currently overlap.
20 So we may need to -- what we had been doing
21 towards the end of the meeting is getting not
22 -- rating, a "not applicable" in the disparity

1 sub-criteria.

2 The measures submitted are not
3 providing options for data sources in general,
4 so that sub-criteria has also been a "not
5 applicable," so far.

6 There was a broad question about
7 all measures relying on coding and
8 administrative data. This goes back to one of
9 the earlier points, and that potentially, any
10 source of data that may be influenced by
11 measures, can then also, in some ways,
12 influence their continued validity.

13 There was also a request, as we
14 move forward, to think about the number of
15 sub-elements that map back to the broad
16 criteria and think about how we might parse it
17 out or reduce that.

18 So any other over-arching themes
19 or parking lot issues that I may have missed
20 or should be -- now that you've had a chance
21 to think about yesterday, that should be
22 added?

1 Okay, great. So in thinking about
2 -- do you want -- we can go over what we
3 heard, as kind of the over-arching themes --
4 do we have the voting of the ABMS measure
5 summary?

6 Okay, while Sarah pulls it up,
7 staff can summarize what we heard. Overall,
8 as we reviewed the ABMS measures, or Jephtha or
9 Jamie as co-Chairs, if you prefer us to do it,
10 that's fine.

11 CO-CHAIR CURTIS: You can do it.

12 MS. TURBYVILLE: Okay, so just
13 give me one minute, and Sarah is going to pull
14 up the -- you know what?

15 Okay, so, for the ABMS measures,
16 there was -- for all of them, a request for
17 the information on the risk adjustment
18 fitting, how it fit, R-squareds to be
19 submitted.

20 So while they described some of
21 their risk adjustment approach, there was a
22 request to clarify that in general for the

1 specifications, including components of the
2 pricing, some time frames that didn't quite
3 always synch up to the amount of data that
4 they requested, that those need to be synched
5 up, for example, in the cardio measure, making
6 sure that they're specifying three years of
7 data because that's what the measure actually
8 requires, and actually when we've reviewed
9 across all of those measures, that was
10 something staff noted, as well, that needed to
11 be more consistent.

12 I'm just going to -- so, all the
13 issues in the data protocol were similar, and
14 as well as the specifications, really, a need
15 for more clarity on the specifications, as
16 well.

17 Usability consistently was not
18 applicable across the ABMS measures because
19 they had not provided any information in that
20 section, and feasibility issues -- what was
21 the -- can you scroll down?

22 So an agreement that because there

1 aren't administrative data, they are routinely
2 generated. The data elements were available.

3 There was some concern about
4 susceptibility, the inaccuracies. It wasn't
5 really clear how much they had done to respond
6 to that, and the data collection strategy also
7 had some concerns from the members because it
8 had not been implemented as of yet, and I
9 think it also reflected the need for the
10 specifications to be clarified better, in
11 order for it -- for you to have more comfort
12 in it being implementable.

13 CO-CHAIR CURTIS: But in general,
14 I think it's fairly consistent across the two
15 measures that we've reviewed, at least with
16 usability, feasibility --

17 MS. TURBYVILLE: Yes, and
18 feasibility --

19 CO-CHAIR CURTIS: -- and were
20 there any --

21 MS. TURBYVILLE: Yes, I think
22 where we saw the biggest difference, if you

1 could scroll up -- is the specification.

2 When we went into the -- when we
3 went into the second measure, it was uncovered
4 that there was a need for clarity, and they
5 would have been issues that would have been
6 included, for example, the costing method, in
7 the previous ABMS measure.

8 It wasn't so much about the
9 components that are actually different from
10 clinical area to clinical area, and importance
11 was also, I think, quite similar, in your
12 findings, yes.

13 So it was really around uncovering
14 the fact that some of the specifications were
15 not as clear as they should be, and I think
16 that influenced some of the voting, and the
17 need -- yes, because the risk adjustment and
18 the need for the goodness of fit of that was
19 discussed in the first measure.

20 CO-CHAIR CURTIS: Okay, so I think
21 with that review, maybe we should move on to
22 the zero to 30 days. Mary Ann, if you could

1 take us through that.

2 MS. CLARK: Okay, this measure is
3 acute myocardial infarction episode of care
4 for 30 days following onset, and the statement
5 is even a little bit fuzzy, but they go
6 further down and explain what they mean by the
7 time frame. So I'll get into that in a
8 minute.

9 This is, as we mentioned, by the
10 American Board of Medical Specialities
11 Research and Education Foundation. So the
12 description of the measure is resource use and
13 costs associated with acute myocardial
14 infarction episode during the acute period,
15 and the acute period being defined as, and
16 again, a little bit fuzzy here, but 30 days
17 following initial hospitalization for an AMI
18 event.

19 An index AMI event identified in
20 all AMI related services are identified in the
21 30 days following the onset of the acute
22 event. Total AMI related services are

1 calculated for each patient and summarized at
2 the attributable hospital level, and observed
3 costs are compared to risk adjusted expected
4 costs.

5 DR. WEINTRAUB: So this includes
6 the initial hospital?

7 MS. CLARK: Yes, I believe it
8 does. If we go down to the time frame, that
9 sounds like that -- it does include that. So
10 it's not really 30 days post-discharge. It's
11 30 days from --

12 DR. WEINTRAUB: The onset?

13 MS. CLARK: Yes, right.

14 CO-CHAIR ROSENZWEIG: It's the
15 onset of the admission or the onset of the
16 event?

17 MS. CLARK: The admission to the
18 hospital, yes.

19 CO-CHAIR CURTIS: Can the measure
20 developer just confirm that because that's
21 pretty critical?

22 MS. CLARK: Yes.

1 DR. WEISS: Yes, it's from the
2 date of admission.

3 CO-CHAIR CURTIS: Thank you.

4 MS. CLARK: Okay.

5 DR. WEINTRAUB: So that would
6 include what happens in --

7 MS. TURBYVILLE: Microphone.

8 DR. WEINTRAUB: My problem
9 continues. So that includes what happens in
10 the emergency department, yes?

11 DR. WEISS: That is correct.

12 CO-CHAIR ROSENZWEIG: Oh, I'm
13 sorry, and if the patient comes into the -- to
14 see a physician and it's determined that an
15 acute myocardial infarction has occurred at
16 some in-determinant time prior to that out-
17 patient visit, that -- those people are not
18 included in this -- in this particular
19 protocol, I assume, is that correct?

20 DR. WEISS: Yes, that's correct.
21 This is -- this episode is triggered by an in-
22 patient event.

1 CO-CHAIR ROSENZWEIG: Okay.

2 DR. WEINTRAUB: Suppose someone
3 has an MI as a complication of non-cardiac
4 surgery. So they have gallbladder surgery and
5 then have an MI, is that included?

6 DR. WEISS: If the event ends up
7 as a hospitalization with a diagnostic -- set
8 of diagnostic codes that meet our entry
9 criteria, it would. But if the primary
10 diagnosis is for gallbladder procedure -- or
11 sorry, for something else, and then the
12 myocardial infarction happens, it's possible
13 that that event would not be captured. It
14 depends on the set of codes that are used as
15 part of the hospitalization.

16 MS. CLARK: Yes, I think it's the
17 principal diagnosis code.

18 MS. BOSSLEY: Is it just the
19 principal, though?

20 DR. WEISS: Yes, it has to be the
21 first. I'm sorry, I didn't clarify that. It
22 has to be the first.

1 DR. WEINTRAUB: So then we are a
2 little subject to the variations in coding,
3 though.

4 MS. CLARK: Well, yes, I mean,
5 according to the way they're supposed to code
6 it, they're supposed to code it based on the
7 discharge diagnosis, the main thing that
8 occurs during the hospitalization.

9 CO-CHAIR CURTIS: And I think the
10 instructions of the -- the principal diagnosis
11 for which the patient was admitted to the
12 hospital?

13 MS. CLARK: No.

14 CO-CHAIR CURTIS: No?

15 MS. CLARK: No, that's on
16 discharge.

17 CO-CHAIR CURTIS: It's determined
18 on discharge, but I think --

19 MS. CLARK: Not the main reason.

20 CO-CHAIR CURTIS: Okay.

21 MS. CLARK: Well, anyway.

22 CO-CHAIR CURTIS: Anyway, every

1 measure of MI has the same --

2 MS. CLARK: Yes.

3 CO-CHAIR CURTIS: -- that uses
4 administrative data, it uses the same
5 approach. So I don't think we can distinguish
6 on that.

7 MS. CLARK: Okay, so, let's see, I
8 guess we'll move on down to the data, the area
9 of high impact, I guess. What page is this
10 on? This is on -- oh, it starts on page --
11 well, I guess I have it on page four.

12 But anyway, high impact,
13 obviously, this is a high impact area, and
14 they support that with their same literature
15 that was in the other measures, in terms of --
16 let's see, you know, high impact.

17 So in terms of opportunity for
18 improvement and the data on that and summary
19 of variation across providers and variation
20 across population groups. You know, again,
21 this is the same information, really, that was
22 presented in the other measures, I believe.

1 So there was, you know, quite a
2 bit of -- of data on different disparities by
3 population group, and then they had some
4 citations, also, for variation and costs
5 across providers, as well. So it's the same
6 citations.

7 Let's see, moving on to 1C, which
8 is the measure intent, the purpose and
9 objective of the resource use measure and the
10 components, and the construct for the resource
11 use and costs are clearly described.

12 Let's see, so, that's on page
13 eight, I believe, and I think that -- let's
14 see, so, the intent is that the measure will
15 be used along with the measure of the 30 day
16 re-admission -- re-admissions to -- to examine
17 the overall efficiency of health care being
18 provided to patients with an AMI.

19 It will help to identify hospitals
20 that may be undertaking best care practices
21 through identification of those facilities
22 that provide efficient care by examining the

1 resource use as well as the re-admission
2 rates. So they're saying that these two
3 measures would be put together to really
4 examine the whole AMI episode.

5 The resource use service
6 categories, I believe they're the same ones,
7 as on the other measure.

8 Let's see, where are we, now?
9 This is kind of out of order. Let me scroll
10 through the -- well, anyway.

11 I think the -- what page is --
12 does anyone know what page that is on because
13 it's not the same?

14 DR. HWONG: The categories are
15 listed at the bottom.

16 MS. CLARK: Okay.

17 MS. TURBYVILLE: So that would be
18 the last sub-criteria for importance.

19 MS. CLARK: Yes, 1D, right, but
20 it's not in order, on the --

21 CO-CHAIR CURTIS: It doesn't
22 correspond to any specific elements within the

1 -- MS. CLARK: Okay.

2 CO-CHAIR CURTIS: -- application.

3 It's sort of --

4 MS. CLARK: Yes.

5 CO-CHAIR CURTIS: -- measure
6 intent, combined with construction logic.

7 MS. CLARK: Just a general
8 overview of the logic, yes.

9 Okay, so I think that's about it
10 for resource use evaluation, resource use
11 measure evaluation criteria, the 1A, B, C, and
12 D. Should we --

13 CO-CHAIR CURTIS: Let me just ask
14 a clarification.

15 MS. CLARK: Yes.

16 CO-CHAIR CURTIS: So the measure
17 intent here is different than what we've seen
18 for their other measures, and it's odd because
19 it's -- to me, it specifies that it's paired
20 with the 30 day re-admission measure, and I'm
21 not sure --

22 MS. CLARK: Yes.

1 CO-CHAIR CURTIS: -- what that is.
2 To me, that's two different measures of
3 resource use, one of which is embedded in the
4 other.

5 So I guess they're complementary.
6 I wouldn't see them as being additive, but --

7 MS. TURBYVILLE: And just as a
8 process clarification, we're not evaluating
9 paired measures. So they would have to be
10 evaluated independently and complementary may
11 be a more appropriate way to frame it.

12 DR. WEISS: So I can clarify that
13 they are not intended to be paired. It was
14 simply our intent that they could eventually
15 be put together to evaluate efficiencies.
16 This measure is simply intended to focus on
17 the resource use during the 30 day period
18 following an initial hospitalization.

19 MS. CLARK: Right, and it seems
20 like they would have to be -- almost have to
21 be independent because in the other measure,
22 which is the 31 to 365 days, the -- all of

1 those events would be related to the first --
2 the first AMI hospitalization, and whereas in
3 this case, each individual AMI hospitalization
4 is looked at separately.

5 So there is kind of like, some of
6 the ones that -- some of the ones in this
7 measure could be in that 31 to 365 day period,
8 you know, there would be an overlap, right?
9 That's a question for the developer.

10 DR. WEISS: I guess I'm confused.
11 Can you just --

12 MS. CLARK: Sure, so in the other
13 measure, we're looking at patients who have an
14 -- an AMI, and let's say, it's in 2009, and
15 then we're looking from 31 days to 365 days
16 out to look at their costs.

17 So if they happen to have another
18 AMI episode within that 31 to 365 days, their
19 costs are captured within that first measure,
20 and then independently we're also counting the
21 cost of that -- that second AMI episode, as a
22 separate episode, only a 30 day episode,

1 right? Is there any issue with that?

2 CO-CHAIR CURTIS: So you're
3 basically just saying could the same patient
4 enter this measure more than one time?

5 MS. CLARK: Yes.

6 CO-CHAIR CURTIS: And then cross-
7 cut it in a separate measure, of 31 to 365?

8 I think potentially, depending on
9 how it's specified, unless there is a --

10 MS. CLARK: Yes.

11 CO-CHAIR CURTIS: I guess we get
12 into that in the data specifications, if there
13 is an exclusion for one per calendar year.

14 MS. CLARK: But it doesn't seem to
15 be an issue, probably.

16 CO-CHAIR CURTIS: Okay.

17 MS. CLARK: So any other
18 questions? Well, are we ready to vote then?

19 1A, which is the measure focus
20 addresses a specific national health goal
21 priority identified by DHHS or the National
22 Priorities Partnership convened by NQF or a

1 demonstrated high impact aspect of healthcare.

2 Okay, 1B is demonstration of
3 resource use or cost problems and opportunity
4 for improvement. Data demonstrating variation
5 and the delivery of care across providers
6 and/or population groups. So, again, these
7 were the same citations as in the other
8 measure.

9 DR. HWONG: I think the comment
10 from the previous measure was that a lot of
11 the citations were not specifically about that
12 31 to 365 day period. Were the citations more
13 relevant to this 30 day period?

14 MS. CLARK: No, I think they were
15 the same.

16 DR. HWONG: Okay, that's fine,
17 then.

18 DR. WEINTRAUB: I think the --

19 MS. TURBYVILLE: Microphone.

20 DR. WEINTRAUB: -- the evidence --

21 MS. TURBYVILLE: Microphone.

22 DR. WEINTRAUB: I think the

1 evidence for variation here is probably less.
2 I mean, we know that when people go home all
3 kinds of things happen that are variable.

4 When people are treated for MIs
5 today, the course of treatment is so firmly
6 within guidelines that to step out of that is
7 a little more unusual. I think that there's
8 probably less concern here than there would be
9 in some of the other measures.

10 Now, that doesn't mean there is
11 zero, but I'm not sure that they've
12 demonstrated -- that they have demonstrated
13 that this is -- this is a critical national
14 need to look at resource variation and
15 treatment for acute MI.

16 MS. CLARK: Okay, shall we vote,
17 then?

18 CO-CHAIR ROSENZWEIG: Well, there
19 were some, actually, some references that did
20 --

21 MS. TURBYVILLE: Microphone.

22 CO-CHAIR ROSENZWEIG: I'm sorry.

1 They did cite some references that referred to
2 variation in care for the MI in the hospital,
3 which actually is within that 30 day period.

4 They talk about -- there is some
5 references related to utilization of coronary
6 angiography, variations and -- and
7 institutional variations in length of stay,
8 and complications of -- of MI, as well.

9 So they do address some of that,
10 at least, if you consider that to be -- you
11 know, it is -- since the actual clinical in-
12 patient event is actually a part of this area
13 of study. So they're a little more specific
14 to that than in the other protocols, I would
15 believe.

16 CO-CHAIR CURTIS: So we have to
17 re-vote on that?

18 MS. TURBYVILLE: We're going to
19 re-vote on that.

20 MS. CLARK: The timer got started
21 before you -- so we're going to re-vote?

22 MS. TURBYVILLE: We're going to

1 re-vote on 1B.

2 MS. CLARK: Okay, 1B re-vote.

3 MS. TURBYVILLE: Okay.

4 CO-CHAIR CURTIS: So moving to 1C?

5 MS. CLARK: 1C, the purpose
6 objective of the resource use measure,
7 including its components and the construct for
8 resource use and costs are clearly described.

9 CO-CHAIR CURTIS: The only
10 feedback I would personally give to the
11 measure developers, I think that in the
12 measure intent, describing it as being paired
13 with the re-admission measure is what lowered,
14 at least, my vote on this particular one.

15 MS. CLARK: Finally then, 1D,
16 which is the resource use service categories
17 that are included in the resource use measure
18 are consistent with the -- and representative
19 of the conceptual construct represented by the
20 measure.

21 So, again, these were the same
22 resource use categories as before.

1 CO-CHAIR CURTIS: And just how do
2 we vote on this -- for the other two measures?
3 I think it's probably the same.

4 DR. HWONG: I think it was --

5 CO-CHAIR CURTIS: Sorry, did we
6 complete the vote?

7 MS. WILBON: I started it and then
8 --

9 CO-CHAIR CURTIS: Okay.

10 MS. WILBON: -- you started
11 talking so I restarted it. Sorry.

12 CO-CHAIR CURTIS: Ashlie is trying
13 to move it along. Appreciate that.

14 Okay, so moving on to scientific
15 acceptability.

16 MS. CLARK: Okay, the long one.

17 CO-CHAIR CURTIS: Walk us through.

18 MS. CLARK: Okay, so S2 -- sub-
19 category S2, I guess, general approach.

20 So when I was reading this and the
21 other ones, as well, I was maybe -- maybe
22 people have approached this differently, but

1 the general approach that they describe is
2 really more of a process for how the measure
3 was created, and not a general approach to the
4 method. So I don't know if that's really what
5 was supposed to be put in this group -- in
6 this -- as an answer to this question, or not.

7 But they talk about, you know,
8 consensus panels and clinical input and all of
9 that, as the way that they got to develop the
10 measure. But I was, I guess, assuming that it
11 was going to be more of a general description
12 of how the measure worked. So I don't know
13 which one -- is it -- does it matter?

14 MS. TURBYVILLE: Yes, I would
15 focus more on the other data elements.

16 MS. CLARK: Yes.

17 MS. TURBYVILLE: We can work with
18 them to --

19 MS. CLARK: Okay.

20 MS. TURBYVILLE: -- update that
21 document, but it won't necessarily --

22 MS. CLARK: Yes.

1 MS. TURBYVILLE: -- affect the
2 specs of the submitted --

3 MS. CLARK: Okay, so the general
4 approach --

5 MS. TURBYVILLE: Good point,
6 though.

7 MS. CLARK: -- you know, again, is
8 basically exactly the same as the other one.

9 Type of resource use measure. So,
10 again, they just say per episode, which I
11 guess I would like a little more description,
12 there. So it's really, what is an episode
13 because an episode can be anything.

14 So I would recommend a little bit
15 more description on that, that it's within
16 that certain time period, the initial
17 hospitalization through 30 days.

18 MS. WILBON: Mary, just a quick
19 note. That -- there is a few options that we
20 give them in the form, on the electronic
21 submission form, that are just check boxes
22 that help feed our database so we could kind

1 of search for them at a later time. That's
2 one of those fields.

3 So just so we can kind of have an
4 identifier for the measure.

5 MS. CLARK: What are the other
6 choices?

7 MS. TURBYVILLE: So S41, S42, S3 -
8 -

9 MS. CLARK: No, no, the other
10 choices --

11 MS. WILBON: No, the other choices
12 --

13 MS. CLARK: -- per capita --

14 MS. TURBYVILLE: What are the
15 other choices of S3?

16 MS. WILBON: Type of measure, type
17 of resource use measurement.

18 MS. TURBYVILLE: Per capita, per
19 episode, procedure, so it's different types of
20 resource use measures that they might be
21 focusing on. These are episode based
22 measures.

1 MS. CLARK: Target population,
2 they left blank, but I guess we'll get to
3 that.

4 CO-CHAIR ROSENZWEIG: It seems
5 like it's left blank in most of them.

6 MS. CLARK: Yes.

7 MS. TURBYVILLE: Yes, again, it's
8 a standard list, and some of them just don't
9 touch on --

10 MS. CLARK: Okay.

11 MS. TURBYVILLE: -- and it's a
12 list that goes across all measures, that's for
13 kind of out-facing NQF tool, and these
14 measures don't necessarily just focus on one
15 of them listed.

16 So I would -- that is --

17 MS. CLARK: Okay.

18 MS. TURBYVILLE: -- intentionally
19 left blank, by some.

20 MS. CLARK: Okay, data dictionary
21 or code table, I mean, I think this was pretty
22 much the same as the other ones, as well. I

1 mean, I kind of was wishing there would be a
2 little bit more description in that table in
3 terms of definitions of the variables. I
4 mean, it was pretty generic. So that was my
5 only comment there.

6 Let's see, data protocol, so
7 preparing the data for analysis. So this is,
8 again, on the data cleaning, and they're
9 suggesting a guideline, as opposed to a, I
10 guess, specification. So standard approach to
11 cleaning the claims data that payers are using
12 today, I guess.

13 Let's see, I don't think they're
14 really recommending any -- let's see, if
15 organizations impute missing data, they're
16 saying to not use imputed data. So that would
17 be one recommendation that they make.

18 DR. WEINTRAUB: And that's the
19 same as the --

20 MS. CLARK: Yes.

21 CO-CHAIR CURTIS: I think just
22 highlighting the different --

1 MS. CLARK: Okay.

2 CO-CHAIR CURTIS: You know, the
3 differences would be --

4 MS. CLARK: Yes, so it's the same
5 -- so do we need to -- well, when we get to
6 the ratings, we can go through those.

7 Okay, data inclusion criteria, so
8 it's the same type of thing. I think it's
9 exactly the same, right? Paid claims with
10 non-missing enrollee identification numbers,
11 blah, blah, blah.

12 So data exclusion criteria, those
13 are the same, as well.

14 DR. WEINTRAUB: What page are you
15 on?

16 MS. CLARK: This is on page 11,
17 S63. Missing data, I believe that's the same,
18 as well, and then the data type, and the
19 administrative claims, as we know, and then
20 they also have "other" because of these
21 pricing files that they're using, I believe.

22 Data source or collection

1 instrument, we already talked about. Data
2 source, okay, so, now, we're getting into the
3 clinical framework.

4 Okay, the brief description is
5 that resource use and cost associated with the
6 AMI during the acute episode, and, again,
7 defining that as the 30 days following initial
8 hospitalization.

9 So, again, I think maybe if they
10 want to be a little bit more specific here,
11 that it includes the initial -- the index
12 hospitalization, as well.

13 So it's really 30 days from
14 admission for the AMI, I believe, right?

15 CO-CHAIR ROSENZWEIG: It looks to
16 me like they're saying -- maybe I'm wrong, but
17 the way I read it, is that it's 30 days
18 following -- well, oh, I'm sorry, they say
19 hospitalization for an MI event.

20 MS. CLARK: Yes.

21 CO-CHAIR ROSENZWEIG: Okay, I'm
22 sorry. But then they say the event is

1 identified in all AMI related services that
2 are identified in the 30 days following --

3 MS. TURBYVILLE: You need to speak
4 up.

5 CO-CHAIR ROSENZWEIG: What?

6 MS. TURBYVILLE: Use the
7 microphone.

8 CO-CHAIR ROSENZWEIG: What?

9 MS. TURBYVILLE: Your microphone
10 is back on. You're good.

11 CO-CHAIR ROSENZWEIG: Okay, all
12 right. It's just that there is a little
13 confusion here.

14 MS. CLARK: Yes.

15 CO-CHAIR ROSENZWEIG: In one case,
16 they're saying 30 days following the
17 hospitalization, but then in another case
18 they're talking about 30 days following the
19 onset of the acute event, and, as we know, the
20 onset of the acute event might occur a few
21 days prior to the hospitalization, or it might
22 occur after the hospitalization, right? I

1 mean, the --

2 CO-CHAIR CURTIS: Right, so but I
3 think the --

4 CO-CHAIR ROSENZWEIG: So the 30 --

5 CO-CHAIR CURTIS: The
6 clarification that they gave us was that the
7 triggering event was the date of admission.
8 So I assume that their calculations start at
9 the -- from the emergency department through
10 that initial hospitalization.

11 CO-CHAIR ROSENZWEIG: All right,
12 well, then they need to change the --

13 CO-CHAIR CURTIS: Right.

14 CO-CHAIR ROSENZWEIG: -- the way
15 they write it here.

16 CO-CHAIR CURTIS: Yes.

17 CO-CHAIR ROSENZWEIG: Okay, it's
18 not that -- if they clarified it as such,
19 that's fine. It's just that it's not written
20 as such -- CO-CHAIR CURTIS: Yes.

21 CO-CHAIR ROSENZWEIG: -- in the
22 specifications of the measure.

1 DR. WEINTRAUB: That's correct.

2 CO-CHAIR ROSENZWEIG: And that has
3 to be clarified.

4 MS. CLARK: Yes.

5 DR. HWONG: Mary Ann, I had -- and
6 also for the measure developer, some questions
7 in terms of this clinical framework, in terms
8 of the eligibility criteria, and I'm wondering
9 if there are some ways to make this a little
10 bit clearer because I think they mentioned
11 that eligibility, you know, has to be for the
12 previous year and the current year.

13 Like, there is -- I think there is
14 a statement somewhere that, you know, you need
15 to be eligible, yes, in the prior year and the
16 current year. And so the question I have is
17 if you're looking at an event that's happening
18 in the measurement year, and you're only
19 looking at 30 days following that, why would
20 you need to have the eligibility criteria be
21 a full year?

22 I mean, it's just sort of a

1 question. You'll -- in so doing, you end up
2 decreasing your sensitivity. You'll lose, you
3 know, potential cases that you'd want to
4 include because that eligibility criteria for
5 the measurement year becomes too stringent.

6 So I'm just -- you know, maybe for
7 -- I don't know if you had some perspective on
8 that, Mary Ann, or the measure developer could
9 answer that. But you potentially are losing
10 cases that you could count.

11 MS. CLARK: Right, yes, I think
12 we're -- that's a good comment. Does the
13 measure developer want to comment on the
14 reason for requiring a full year worth of
15 data?

16 DR. HWONG: Or eligibility, yes.

17 DR. WEISS: Yes, sure. This is
18 actually a topic that we debated quite a bit
19 within our development group, for not only
20 this measure, but for some other measures that
21 focus on a non-365 day period.

22 The decision ultimately came down

1 to try to be consistent across all of our
2 measures, to make it a bit easier on folks
3 that would be implementing these measures, in
4 that if you're assessing eligibility criteria,
5 you can do it -- across all of the ABMS-REF
6 measures.

7 And we realize that we're going to
8 lose sample size and exclude cases because of
9 this eligibility criteria, but it was more a
10 decision of pragmatism than anything else.

11 DR. HWONG: Got you. You know, my
12 only feeling on that, you know, again, coming
13 from, you know, health plan and understanding
14 sort of enrollment, and having someone with
15 two years of continuous enrollment, actually,
16 you know, is not an easy thing.

17 You will actually lose, you know,
18 a large number, and especially if the measure
19 period of interest is only 30 days, you really
20 have a chance to gather a lot more cases.

21 So, you know, if the measure
22 developer could contemplate that and think

1 about maybe, you know, reducing the stringency
2 of that criteria, I think you could actually
3 apply this to a lot more individuals.

4 So the other thing, one other
5 thing in terms of, again, this is sort of the
6 eligibility and sort of measure construction,
7 but you know, if the measure event, you know,
8 the triggering event is supposed to occur
9 between January 1 and December 31st, it can't
10 really be December 30th because you still need
11 that 30 days follow up to actually assess, you
12 know, the resource use during that period of
13 time.

14 So I would ask maybe the measure
15 developer to clarify that, that you would have
16 to set that, you know, to like, you know,
17 December 1st would be the final date that you
18 could actually submit a triggering event.

19 Is that how you -- you know, maybe
20 that would --

21 DR. WEISS: Yes, we can make that
22 clarification. You're absolutely right, you

1 have to have full capture of the 30 day follow
2 up period, within the dates.

3 DR. HWONG: Okay.

4 MS. CLARK: Yes, usually, when I -
5 - I've done a lot of these claims and analysis
6 studies, I always do it from the time period
7 from the -- you know, each patient has an
8 index date.

9 So you're doing it from their own
10 index date. So, I mean, that's another
11 approach, as well.

12 CO-CHAIR ROSENZWEIG: Just with
13 respect -- I have a question, maybe other
14 people know more about this than I. But now
15 with the new healthcare law that specifies
16 that you don't -- you know, that you can't be
17 prohibited from joining a plan due to a pre-
18 existing condition, so will there be a lot of
19 patients who actually join a plan on the --
20 you know, when -- with the onset of an acute
21 MI, and would there be a bias related to
22 individual -- you know, which plans people

1 decide to join, or is that -- this is not an
2 issue, here?

3 CO-CHAIR CURTIS: I think the
4 requirement that you have at least a year
5 before probably makes that not relevant to
6 this, and that you'll have equal amount of
7 time for risk adjustment. I don't know how
8 often people do that or would want to do that,
9 but I don't think it's necessarily relevant.

10 CO-CHAIR ROSENZWEIG: So that is a
11 good reason for having the patient in the plan
12 for a year, prior to?

13 CO-CHAIR CURTIS: Right, you have
14 to have a stable, you know, time of -- for
15 which you can obtain the information --

16 CO-CHAIR ROSENZWEIG: Okay.

17 CO-CHAIR CURTIS: -- about co-
18 morbidity and cardiac status.

19 CO-CHAIR ROSENZWEIG: So that's a
20 good rationale for that, okay.

21 MS. CLARK: Let's see, so going on
22 then in terms of the in -- the clinical frame

1 work. So, basically, the age range is the
2 same as the others, 18 to 85, during the
3 measurement year.

4 DR. WEINTRAUB: In the re-
5 vascularization one, there was no upper age.
6 In the MI one, there was. So you have some
7 variability.

8 MS. CLARK: Right, and I think our
9 comments on the previous AMI measure was that,
10 why? Why have the upper end, and it was
11 because, I believe, the response was because
12 the costs could be higher for elderly.

13 CO-CHAIR CURTIS: The sample --
14 process might be different.

15 MS. CLARK: Yes.

16 CO-CHAIR CURTIS: With a clinical
17 decision.

18 DR. WEINTRAUB: Well, the sampling
19 -- it doesn't entirely makes sense to me. MI
20 and revascularization, they're in -- pretty
21 much in the same age range, and you have
22 plenty that are in the upper age range.

1 The reason for not including them
2 in the super elderly was because this was --
3 this was aimed at private plans, rather than
4 Medicare. So the issue, to me, is the same,
5 here.

6 MS. CLARK: So in this --

7 DR. WEINTRAUB: Hardly the most
8 important thing in the whole world, but --

9 MS. CLARK: In this commercial
10 database, though, they're including Medicare
11 Advantage. So is that -- was that excluded?
12 Well, it was, according to this criteria, I
13 guess.

14 I mean, is this measure intended
15 to be applied just to a commercial under --
16 non-Medicare population, or is it including
17 the Medicare Advantage population, which is
18 commercial?

19 DR. WEISS: In testing, it was
20 primarily in a non-Medicare commercially
21 insured population. There were very few
22 people that were over the age of 65.

1 However, we did test this and the
2 post acute AMI measure in a sample of Medicare
3 data, so it's not the intent that it should
4 only be applied to commercially insured
5 populations.

6 MS. CLARK: No, I think in this
7 measure, when they do the testing, they also
8 tested it in Medicare claims.

9 DR. MARWICK: Could we just clarify
10 that the emergency room costs are incorporated
11 in this?

12 People admitted to hospital, after
13 their emergency room stay because there may be
14 -- for example, with use of CT, there may be
15 significant costs there that might not be
16 captured.

17 MS. CLARK: Normally, if they're
18 admitted after an ER visit, that's included in
19 the hospitalization.

20 DR. WEINTRAUB: That is what they
21 said in response to -- I think one of the
22 places you could have problem is if someone

1 dies in the emergency department. They're not
2 actually admitted.

3 So with -- when people who
4 actually don't get as far as being admitted,
5 are they included?

6 DR. WEISS: No, you have to be
7 discharged alive.

8 DR. WEINTRAUB: Oh, that's
9 interesting. Why that choice because that's
10 going to take out for approximately five
11 percent who die?

12 DR. WEISS: Those people don't
13 have costs in the 30 day follow-up period, and
14 I understand that they might have very high
15 hospital costs, but we're trying to look at a
16 population of patients that might consume
17 resources over that post-follow-up period.

18 DR. WEINTRAUB: Yes but, you know,
19 that creates quite a bias.

20 DR. WEISS: It's the same bias,
21 though. There is no differential bias.
22 Everyone is discharged alive.

1 So, we understand that we may be
2 underestimating overall resource use, but this
3 isn't a measure intended to say, "Hey, how
4 much do in-patient events totally cost?"
5 We're trying to figure out if there are
6 differential resource uses across entities,
7 and in this case, hospitals.

8 DR. WEINTRAUB: All right, let me
9 explain why there might be a bias. If you
10 have hospitals that aren't that -- that aren't
11 doing a good job, and their sick people dying,
12 they're taken out, those are the people that
13 might use a lot of resources.

14 DR. WEISS: Yes, I agree -- I
15 acknowledge that fully.

16 CO-CHAIR CURTIS: And I'll just to
17 ask the comparing question, if someone is in
18 the hospital for 30 days, thus not discharged,
19 they would be excluded?

20 DR. WEISS: I'm sorry, I couldn't
21 hear that question.

22 CO-CHAIR CURTIS: All right, in

1 the case where a patient is in the hospital
2 for 30 days post-MI, rare, but it does happen,
3 they would be excluded?

4 DR. WEISS: Yes, you know what,
5 our measure specification does not do a good
6 job of dealing with that instance. So, the way
7 that we've written it, it would be excluded --
8 well, you know what? I would have to -- we'll
9 have to clarify that.

10 It wasn't the intent that those
11 individuals would be excluded, but I could see
12 in operationalizing our specifications, how
13 there could be variability around that case,
14 because if that person is discharged alive, we
15 would want to capture their costs.

16 CO-CHAIR ROSENZWEIG: What if they
17 die in the 30 day period, even if they're
18 discharged alive?

19 DR. WEISS: They're included.

20 CO-CHAIR ROSENZWEIG: They're
21 included.

22 MS. CLARK: Any other questions,

1 there?

2 Okay, let's see, so, again,
3 they're excluding hospitalizations that were
4 subsequent hospitalizations, so the diagnosis
5 code with the 410-X2.

6 Let's see, there are other -- same
7 exclusions as in the other measure, in terms
8 of patients with active cancer, end-stage
9 renal disease and let's see, what else? Some
10 of the other organ transplants, HIV.

11 Also, discharges to a skilled
12 nursing facility, excluded, which in this
13 case, I'm wondering if that really makes
14 sense.

15 CO-CHAIR CURTIS: I think this is
16 the reason why it was in the other one, is
17 that they thought that they couldn't
18 adequately or accurately capture the resources
19 used in that setting.

20 And so, it's a challenge, but I do
21 -- we questioned it on the last one, I think,
22 I personally would question it, on this one,

1 but it's no different.

2 But given the variation in
3 discharge across the nation, I kind of wonder
4 if we're attributing this to the hospital
5 level, if that's appropriate, and I think
6 ultimately this is attributed to the hospital
7 level, not to the physician.

8 MS. CLARK: Yes.

9 DR. MARWICK: The impact of that is
10 much greater with this, obviously, isn't it?

11 CO-CHAIR ROSENZWEIG: Would
12 hospice care be an exclusion?

13 DR. WEISS: No.

14 MS. CLARK: Can you just remind us
15 of why -- you know, why do you think skilled
16 nursing is going to be difficult, as opposed
17 to hospice, for example? I mean, what's the
18 difference there?

19 DR. WEISS: Well, hospice, you can
20 still, in most data systems, observe the care
21 that's being provided, if they're seeing
22 physicians, if they have an area home nursing

1 agency coming in. Those are claims that are
2 submitted and observable.

3 If individuals are admitted to a
4 SNF, often times that may result in them
5 moving outside of the data stream that we're
6 able to capture, especially in our test data
7 set, and then they have this large,
8 immeasurable period.

9 And so, with that immeasurable
10 period, we're potentially, again, introducing
11 another bias, and so our approach was then to
12 exclude that in-measurable period.

13 I mean, this is the same concerns
14 around the sicker patients that die. Maybe
15 sicker patients that were admitted to a SNF,
16 and if those are the higher resource patients,
17 then they're a potential directional bias.

18 MS. CLARK: So, the market --

19 DR. WEISS: So we wanted to try to
20 avoid that.

21 MS. CLARK: The market scan data
22 doesn't have skilled nursing claims. That's

1 basically what you're saying.

2 DR. WEISS: That is correct.

3 MS. CLARK: So, the --

4 DR. WEISS: But similarly, if you
5 were using Medicare data and they were put
6 into -- admitted to a skilled nursing
7 facility, and then Medicaid became the primary
8 payer, it may be difficult, measuring that, as
9 well, unless you had a combined data set.

10 This was more of, again, an
11 ability to measure costs during that period
12 than anything else.

13 MS. CLARK: Right. Okay. Let's
14 see, in terms of again, identifying the event,
15 it's an AMI diagnosis code on admission,
16 principal diagnosis code, right?

17 The events within the 30 days
18 would be anything related. Again, that's the
19 same, I think, definition of AMI related
20 codes.

21 So, it's going to be the same
22 diagnosis codes and DRGs, if they were

1 admitted to the hospital, including anything
2 for unstable angina, arrhythmia, pace makers,
3 heart failure, atherosclerosis and procedures
4 that would be related, as well.

5 And so we had some comments on the
6 coding that needed to be updated here. So,
7 that would need to apply to this, as well.

8 Pharmacy related -- AMI related
9 medications, I think those were the same ones,
10 as well, right, and we had some comments on
11 those, before? Yes.

12 Okay, so, let's see, anything new
13 here? First event, includes any 30 day period
14 as a triggering event for the episode.

15 Again, I think this needs to be
16 further clarified or defined here.

17 Length of stay --

18 DR. WEINTRAUB: What page are you
19 on?

20 MS. CLARK: I'm on page 14. Length
21 of stay; for an event to qualify for
22 initiating episode, the length of stay needs

1 to be more than one day.

2 Is that something that is --

3 DR. WEINTRAUB: Well, if they're
4 going to stick with the idea that they have to
5 be people who are discharged alive --

6 CO-CHAIR CURTIS: Microphone.

7 DR. WEINTRAUB: If they want to
8 include people who are -- only people who are
9 discharged alive, it's reasonable.

10 If they -- if we -- if they change
11 it to include people who die, then this
12 doesn't work.

13 MS. CLARK: Right. Okay. Yes,
14 and then the next paragraph is the discharge
15 alive. It only includes people that were
16 discharged alive.

17 CO-CHAIR CURTIS: I guess, I'm
18 just having -- and we discussed it. I just
19 want to touch on it one more time.

20 But it doesn't necessarily make
21 sense to me that, specifically, also given
22 variation and length of stays across hospitals

1 and aggressiveness of pushing people out, that
2 if someone is in the hospital for two days and
3 gets discharged on day four, or sorry, gets
4 discharged and dies on day four, how is that
5 different conceptually, than someone who is in
6 the hospital and dies at day four?

7 And you could have -- so, I think
8 the problem of deaths doesn't stop at
9 discharge, and if you're going to include
10 them, once you are discharged, I think you
11 probably have to consider including them
12 during the admission, recognizing -- and I
13 understand that -- your rationale on that you
14 don't want to reward high mortality hospitals
15 for looking really good on not using a lot of
16 resources.

17 But on the other hand, that's why
18 ultimately, once these are moved towards
19 value, you would look -- you know, it would
20 hopefully be offset in that regard.

21 DR. WEISS: Yes, so, let me
22 respond to that, if I can, because I agree

1 with you, completely.

2 One of the complexities of
3 measuring this and identifying that death on
4 day four is that a lot of especially
5 commercial claims data, do not do a good job
6 of identifying mortalities.

7 It does do a good job of
8 identifying mortality in hospitals. So, there
9 is ways to say, "Hey, look, this person died
10 in the hospital," through discharge codes.

11 We cannot reliably identify
12 mortality that happened outside of the
13 hospital, in a lot of these commercial claims.
14 That's an exception, if you move to a database
15 that does have mortality information, and
16 perhaps, that's something that we should
17 reconsider, in light of those type of
18 databases.

19 But again, there was a balance
20 here, in what we can measure and still try and
21 be consistent within the measure.

22 DR. WEINTRAUB: That's true, but

1 I'm not sure that's a good reason for -- that
2 particular issue is not a good reason for
3 excluding the deaths in the hospital. That
4 would be --

5 DR. WEISS: No, no, I'm sorry --

6 DR. WEINTRAUB: That would be an
7 argument for including them, seeing is you
8 have other people that are dying.

9 DR. WEISS: I was just speaking to
10 the rationale for not excluding somebody that
11 died day four, post-discharge.

12 We can't measure it in the data
13 that we tested our measure in.

14 CO-CHAIR CURTIS: The other thing
15 I noticed on the exclusion criteria, that sort
16 of varies across the different measures, is
17 the exclusion or inclusion of pregnant
18 patients.

19 So, on the repost
20 revascularization measure, it looked like you
21 were trying to exclude pregnant patients, and
22 in the MI measures, both of them now, you are

1 including that population.

2 Obviously, it's a low frequency
3 event, but just didn't quite understand the
4 difference in decision making.

5 DR. WEISS: So, that's driven by
6 separate clinical work groups, across these
7 two measures.

8 Our AMI measures were one clinical
9 work group. Our CAD measures were a separate
10 clinical work group, and they made separate
11 clinical decisions and we did not try to
12 reconcile some of those clinical decisions
13 across measures.

14 DR. WEINTRAUB: So, I mean, there
15 is a clinical scenario in which this occurs,
16 in young women, and that's coronary dissection
17 in the peripartum period.

18 They can present with MIs, and
19 they both could be revascularized.

20 CO-CHAIR CURTIS: We'll just
21 accept that at, you know, decision and we'll
22 take each measure separately. Thank you for

1 the clarification, though.

2 CO-CHAIR ROSENZWEIG: Your
3 rationale for excluding patients with end
4 stage renal disease? I mean, that seems to be
5 a condition in which you have a high incidence
6 of acute MI.

7 I know there are much higher cost
8 patients, in general, but shouldn't -- is
9 there a clear cut reason for excluding them?

10 DR. WEISS: Again, this is one of
11 our standard exclusion across all of our
12 measures, because of concerns about
13 differential resource use.

14 We really were following along
15 with what NCQA does, as part of their HEDIS
16 measures, and their relative resource use
17 measures, because of the concerns around
18 differential costs.

19 DR. WEINTRAUB: How are you
20 handling transfers?

21 DR. WEISS: That topic is later on
22 in the specification. I don't know if you

1 want to talk about it now.

2 DR. WEINTRAUB: All right.

3 MS. CLARK: So, in terms of co-
4 morbidities, they're basically handling that
5 through the risk adjustment, the HCC risk
6 adjustment, except they're separating out the
7 heart failure patients.

8 So, that's the same as in the
9 other measure.

10 Let's see. Severity -- no
11 severity adjustments. Let's see, no -- yes,
12 now, I'm going onto 17.

13 Concurrency of clinical events.
14 There is nothing provided there. Measure
15 construction, logic. So, again, you know, the
16 brief overview of the construction logic,
17 identifying the population, related resources,
18 assigning standard prices and creating the
19 episode strata.

20 CO-CHAIR ROSENZWEIG: Just going
21 back to page 14, with respect to pharmacy, it
22 seems like you have a fairly limited number of

1 medications that are listed. You're not
2 including anti-arrhythmics?

3 CO-CHAIR CURTIS: That is
4 consistent across the two measures.

5 I think we asked them about that
6 on the first 31 to 365, and the response was
7 that they really wanted to focus on the ones
8 that were most likely AMI-related, for
9 something like amiodarone, for instance.

10 It's a little hard to say, is that
11 AMI-related or afib-related and -- it's
12 complex. So, I think they opted to try and
13 take the most focused list possible, within --
14 you know, but there are limitations to that
15 decision.

16 DR. WEINTRAUB: Yes, I think here,
17 it's more problematical.

18 Atrial fibrillation can occur, as
19 a complication of acute myocardial infarction,
20 and certainly, on a v-tach.

21 You're going to be giving anti-
22 arrhythmics that are -- that I think are

1 clearly related. I think excluding them here
2 is a bigger problem.

3 CO-CHAIR CURTIS: I think it's the
4 same issue. I don't know. I don't think it's
5 different than what we voted on before, or our
6 discussion before.

7 MS. CLARK: Okay, then moving on,
8 we're on page 18.

9 So, this is where they do talk
10 about -- let's see, it's identifying patients
11 that are transferred between two in-patient
12 facilities.

13 Information is used when reporting
14 the results as findings or stratified, by
15 those that were and were not transferred.

16 So, I guess that's explained in
17 the stratification. We're not to that, yet.

18 DR. WEINTRAUB: So, I'm not sure
19 what you do with that, though.

20 Is the -- and how about the
21 receiving facility? Is the receiving
22 facility not included for the MI, at all, and

1 what happens to -- so, what happens? How do
2 you handle that, analytically?

3 DR. WEISS: How do we handle what,
4 analytically?

5 DR. WEINTRAUB: So, someone has an
6 MI, they come to a hospital that doesn't
7 perform revascularization. They're
8 transferred to a hospital that does. How do
9 you attribute that MI? Whether it's
10 stratified or not stratified, how do you
11 attribute it?

12 DR. WEISS: Yes, so, our
13 attribution logic focuses on the hospital with
14 the majority of the length of stay.

15 So, if that person stayed for six
16 days and was -- five of them were in the
17 receiving hospital, the attribution would be
18 to the receiving hospital.

19 MS. CLARK: Page 23, it has this
20 method.

21 So, if someone gets transferred,
22 then the cost of the initial hospital are just

1 included -- if the second hospital had the
2 longer length of stay than the initial
3 hospital, those costs would be assigned to the
4 second hospital?

5 DR. WEISS: That is right.

6 MS. CLARK: Okay.

7 DR. WEINTRAUB: So, I mean, there
8 is no perfect way of doing this. But you can
9 see what happens, how you can have a problem.
10 Someone is admitted to a community hospital
11 that doesn't have revascularization, they're
12 there for four days, especially if it's a non-
13 STEMI.

14 They're transferred -- they
15 transfer, they have the STEMI at the receiving
16 -- they have the PCI at the receiving
17 hospital, and go home the next day.

18 But it's all attributed to the --
19 the community hospital. Maybe that's okay,
20 but you know, it becomes a little peculiar.

21 MS. CLARK: So, in terms of
22 identifying that initial event, if they both

1 had a principle diagnosis of AMI, are you
2 looking at the same patient, and then -- and
3 looking at like the admission source and the
4 discharge status, because you would need to
5 look at -- to try to determine which one was -
6 - or is that necessary? Maybe you don't need
7 to do that.

8 DR. WEISS: We look at the
9 discharge status and the fact that two events
10 might be -- there might be a discharge date
11 and an admission date that are exactly the
12 same.

13 So, we've identified transfer
14 status and then the fact that there is an
15 admission and discharge date that are common,
16 we identify that individual as having been
17 transferred.

18 MS. CLARK: Okay, all right.
19 Let's go back up to -- so, this is, just
20 again, talking about the specification of the
21 logic. We already talked a bit about this,
22 discharged alive, transfers, eligibility and

1 continuous enrollment.

2 So, this is where you had the
3 comment about whether there really needs to be
4 a full year post-AMI. So, just a comment, I
5 guess.

6 Let's see, anything else that
7 stands out here? I don't think so. Those
8 were -- exclusion criteria, again, I think
9 were fairly similar.

10 Related resources, we already
11 talked about that, but in-patient
12 hospitalization events, out-patient events,
13 procedures and lab, you know, all the costs
14 associated within that 30 period that would be
15 related to AMI, according to the codes that
16 they identified, and need to be updated.

17 Measure trigger and end
18 mechanisms, we already discussed that, but
19 some clarity needs to be put around that.

20 Redundancy and overlap, that is
21 not applicable here, I guess. Complementary
22 services is not specified here, either.

1 Then we have resource use service
2 categories, those are the same ones.
3 Inpatient facility, evaluation and management,
4 so on.

5 So, okay, so, emergency
6 department, I think is added here, right? I
7 don't know that -- was that in the previous
8 one, ambulatory services?

9 Can the developer comment on that?
10 I can't remember whether, on the other AMI
11 measure -- I'm assuming it was, but was
12 emergency department services a specified
13 resource use category?

14 CO-CHAIR CURTIS: I believe it
15 was. We can confirm. But I think it was
16 consistent.

17 MS. CLARK: Okay, I just didn't
18 remember seeing that one.

19 So, let's see, in terms of
20 identifying the categories, they're doing this
21 based on the, you know, codes on the claims,
22 once again.

1 So, I still have a little bit of a
2 -- an issue with this, because I don't think
3 it's very specific.

4 I mean, you talk about BETOS
5 categories, which apply to the HCPCS codes and
6 the -- I don't know, it's just not quite --
7 very clear on how the assignments are being
8 made to the various resource groups, that's
9 all.

10 I would like a little more
11 clarification, unless everybody -- it's
12 perfectly clear for everybody else.

13 Care setting, so, here we have,
14 again, ambulatory care, which includes ASC,
15 urgent care, clinician office.

16 So, I guess I would ask -- these
17 are probably standard categories, is that
18 right, the care settings?

19 MS. WILBON: Yes, those are
20 standard.

21 MS. CLARK: So, is there one for
22 out-patient hospital?

1 MS. WILBON: I don't believe so.

2 MS. CLARK: And that is not on
3 here, just acute -- it just says hospital
4 acute care facility, so, I guess, in this
5 grouping, is everything done at a hospital
6 just considered hospital? Because they have
7 different settings.

8 MS. TURBYVILLE: I'll find the
9 list and clarify. Heidi, do you have any, for
10 the taxonomy or care setting, it's out-
11 patient? I'm sure out-patient is on there,
12 right?

13 MS. BOSSLEY: Yes, it's
14 ambulatory.

15 MS. TURBYVILLE: It's ambulatory?

16 MS. BOSSLEY: Yes.

17 MS. TURBYVILLE: All right.

18 MS. BOSSLEY: Then there is three
19 sub-settings underneath it, ambulatory,
20 surgical center --

21 MS. TURBYVILLE: Okay.

22 MS. BOSSLEY: -- clinician office

1 and something else. I'm blanking on the third.
2 I'll look it up. I've got it.

3 MS. CLARK: So, the reason I'm
4 asking is there is a definite, you know, for
5 Medicare, anyway, there is a whole different
6 payment system for hospital outpatient versus
7 ambulatory surgery, free standing ambulatory
8 surgery.

9 So, you know, the costs are
10 different for those, right?

11 MS. WILBON: Okay, we'll check on
12 that list and let you know.

13 MS. BOSSLEY: We didn't
14 distinguish between the two. We had many
15 discussions on the best way to do it, and
16 right now, we don't distinguish between the
17 two, if I remember correctly.

18 MS. CLARK: Because the cost
19 structures are really different, between the
20 two.

21 MS. BOSSLEY: Yes.

22 MS. CLARK: Yes.

1 MS. BOSSLEY: It was one that we
2 went back and forth on, and probably, I
3 suspect we'll be updating the taxonomy again,
4 to --

5 MS. CLARK: Okay.

6 MS. BOSSLEY: -- add it back in,
7 yes. It's not there, now.

8 MS. CLARK: Okay, let's see, so
9 then moving onto S10, I think we already
10 talked a little bit about that, risk
11 adjustment method, S10.1.

12 So, this is the same risk
13 adjustment method as in the other measures.

14 So, it's -- I guess it's again,
15 using -- starting off with using the Medicare
16 HCC method, but then doing some adjustments
17 for -- that are specific to AMI, I guess, and
18 then several different models were tested, and
19 I think we already provided comments on
20 getting better clarity around those models in
21 the R-squareds.

22 Let's see --

1 DR. WEINTRAUB: I think they
2 actually lack calibration, as well, but I
3 think that is true of all of their --

4 CO-CHAIR CURTIS: Right, so, I
5 think we can just sort of have this similar
6 feedback across this.

7 MS. CLARK: Yes, okay, and then
8 onto page 23, down to 10.2, the stratification
9 method.

10 Here again, we talked about this,
11 but the CHF group and then the transfers to
12 other hospitals.

13 So, again, I guess, is there any
14 discussion on why does CHF need to be called
15 out separately? I mean, there could be other
16 groups. Is that something --

17 CO-CHAIR CURTIS: Right, I think
18 that's the same --

19 MS. CLARK: Same comments?

20 CO-CHAIR CURTIS: -- comment we
21 had, is why heart failure as opposed to any
22 one of other comorbidities, I think it's

1 consistent, without empiric evidence, that
2 this is --

3 MS. CLARK: Yes.

4 CO-CHAIR CURTIS: -- the absolute
5 one that had to be adjusted for, it seems
6 somewhat arbitrary.

7 MS. CLARK: Yes, okay, and then
8 the costing method, I think they are the same
9 comments that we've had on others. They're
10 using the same methodology.

11 CO-CHAIR ROSENZWEIG: When we talk
12 about stratification method, does it always
13 assume that there has to be adjustment for it?
14 I mean, or in certain cases are they just
15 stratifying to look at different categories?

16 CO-CHAIR CURTIS: I think there
17 are different reasons for stratification, as
18 we've sort of discussed.

19 You know, it might be something
20 that helps you drill down on the data. It
21 might be something that you don't think risk
22 adjustment alone can account for. It might be

1 related to a disparity in care that you don't
2 want to obscure.

3 But the rationale isn't really
4 provided here, as to why heart failure, as
5 opposed to any --

6 DR. WEINTRAUB: I mean,
7 theoretically, from a mathematical point of
8 view, the reason for stratification is you
9 believe that there is going to be an
10 interaction with other covariates.

11 So, for instance, if you believe
12 that the effect of age is greater in patients
13 with heart failure than without heart failure,
14 and you don't want to build a model with
15 interaction terms, since they're always very
16 confusing, then that's the reason for
17 stratifying and doing it, from a mathematical
18 -- doing an analysis.

19 I don't think they've gotten into
20 that, but in modeling that I've done, these
21 kinds of conversations are very intense, go on
22 for months, trying to figure out what you're

1 going to do.

2 CO-CHAIR ROSENZWEIG: Okay, well,
3 earlier on they mentioned that they were going
4 to consider NS STEMIs and N STEMIs separately,
5 so, would that be -- should that be included
6 in this section, as well?

7 CO-CHAIR CURTIS: Well, they said
8 that they can't, because they can't
9 distinguish between the two, in the data that
10 they have.

11 DR. MARWICK: But that's even more
12 of problem --

13 CO-CHAIR CURTIS: It's a very big
14 problem --

15 DR. MARWICK: -- in this group,
16 than it is in the later group.

17 DR. WEINTRAUB: Because there, you
18 really do, you may very well have
19 interactions, but you have other things going
20 on, because of cost of care is so very
21 different for STEMIs, and it -- and in the N
22 STEMIs, and if they can't distinguish it, it

1 is a limitation of this whole process, there
2 about.

3 CO-CHAIR CURTIS: But again, one
4 that's consistent across all the outcomes
5 measures for MI.

6 DR. WEINTRAUB: So, you know, I
7 think that they ought to try and justify what
8 they're trying to accomplish a little bit
9 better, within that stratification. I
10 wouldn't particularly stratify heart failure.

11 The other thing is, heart failure
12 can be a complication, and they make it clear,
13 it's heart failure on admission, or heart
14 failure when -- prior heart failure, if it's
15 heart failure as a complication, it's the same
16 kind of problem they had with stratification
17 that we saw before, the revascularization
18 model, where they were stratifying on events
19 downstream, which makes no sense.

20 CO-CHAIR CURTIS: So, I believe it
21 was specified, as in the previous 12 months,
22 but could the developer clarify that?

1 DR. WEISS: It's heart failure
2 identified in the period prior to the index
3 event.

4 DR. WEINTRAUB: If you're going to
5 do it.

6 CO-CHAIR CURTIS: Much better.

7 MS. CLARK: Okay, then moving onto
8 the -- let's see, attribution approach, which
9 is page 28.

10 CO-CHAIR CURTIS: So, for the
11 costing method, we'll have, again, the same
12 comments that we had before.

13 MS. CLARK: Yes, and so,
14 attribution method is at the hospital level,
15 as we discussed, with the hospital with the
16 majority of the length of stay during the
17 index AMI, having the -- getting it attributed
18 there.

19 Peer groups, they don't specify
20 guidelines, or have the guidelines for
21 identifying or defining peer groups. So,
22 nothing is defined there.

1 So, there is a comment there,
2 though, that says we do not think it's
3 feasible for most users to link with databases
4 that contain hospital information, such as
5 number of beds, teaching status or other
6 criteria. That seems pretty reasonable to me.
7 I do that all the time.

8 CO-CHAIR CURTIS: Would the
9 measure be helped, in terms of the
10 interpretability or usability of it, down the
11 road, if you did have a peer group?

12 I, personally, would think that if
13 you had CABG capable hospitals as a peer group
14 --

15 MS. CLARK: Right.

16 CO-CHAIR CURTIS: -- that would
17 make sense, or primary for --

18 MS. CLARK: Yes, right.

19 DR. WEINTRAUB: Absolutely.

20 MS. CLARK: I would think so.

21 DR. WEINTRAUB: Hospitals that are
22 doing revascularization --

1 MS. TURBYVILLE: Microphone.

2 DR. WEINTRAUB: Hospitals that are
3 doing revascularization and hospitals that are
4 not are going to have very different cost
5 structures.

6 CO-CHAIR CURTIS: Yes.

7 DR. WEINTRAUB: Necessarily so.

8 MS. CLARK: Yes, okay, let's see,
9 so, now, we're onto what, 11-3, which is level
10 of -- oh, no, we talked about that.

11 Outliers and thresholds, I guess.
12 So, guidelines, not specifications. I think
13 they did the same thing, here.

14 Let's see, provider reports, the
15 observed episode cost Winsorized at the second
16 and 98th percentile.

17 Claim line outliers are not
18 removed, and the use of risk adjusted results
19 are intended to correct for extreme outliers.

20 So, I guess a question here is
21 then, when you're talking about Winsorizing
22 these outliers, is that at the -- that is at

1 the episode level? Is that -- it's not at the
2 claim level, right?

3 DR. WEISS: I'm sorry, Winsorizing
4 happens at two levels.

5 For hospitalization, it happens at
6 the 99th percentile, for episode, and then it
7 happens again at the episode level, at the
8 second to 98th percentile.

9 MS. CLARK: Okay, sample size
10 requirements, no specifications there. Anyone
11 have comments on that? Same ones? Same
12 comments?

13 What did we say about sample size,
14 before? I don't remember.

15 CO-CHAIR CURTIS: I think it was a
16 little different kettle of fish, because it
17 was at the hospital -- it was at the physician
18 level, previously.

19 MS. CLARK: Okay.

20 CO-CHAIR CURTIS: And that's, I
21 think, a different -- you know, I mean, the
22 same sample size issues are -- so, it would be

1 nice to have a --

2 MS. CLARK: A number?

3 CO-CHAIR CURTIS: -- some sort of
4 assessment, a threshold, with some empiric
5 evidence to back up why they selected that,
6 that threshold.

7 However, there isn't that
8 threshold met for the outcomes measures, where
9 they just arbitrarily chose 25.

10 MS. CLARK: Okay, all right, and -
11 -

12 DR. WEINTRAUB: It certainly can
13 be done, per the comment from Carlos,
14 yesterday, some modeling -- not modeling,
15 simulation exercise could help in the sample
16 size.

17 MS. CLARK: Let's see, then the
18 last one in this section, defining, bench
19 marking or comparative estimates.

20 So, these, again, are provider
21 level summaries, and they go through the
22 method of calculating the cost at the provider

1 level, looking at observed to expected cost
2 ratio.

3 Now, I think there might be a cut
4 and paste problem here, too, though, because
5 it's kind of mixing physician attribution in
6 with this hospital.

7 So, this is --

8 DR. WEINTRAUB: You're at the page
9 --

10 MS. CLARK: -- needs to be cleaned
11 up, here.

12 DR. WEINTRAUB: The top of page 30
13 is what you're talking about?

14 MS. CLARK: Yes.

15 DR. WEINTRAUB: Yes, I see it.

16 MS. CLARK: So, that would be the
17 comment here, I guess.

18 DR. WEISS: I'm sorry, are you
19 talking about 12.2?

20 MS. CLARK: This is -- no, this is
21 11.6, and it's the top of page 30. It's the
22 last paragraph in this, in 11.6.

1 So, it's talking about -- the very
2 last -- let's see, where is that?

3 CO-CHAIR ROSENZWEIG: Provider
4 summary reports.

5 MS. CLARK: Yes, I mean, you're
6 talking about, for example, if the provider
7 for which the summary statistics are being
8 calculated, as a general internist, and it's
9 the --

10 DR. WEISS: Okay, yes, thank you.
11 We can fix that.

12 MS. CLARK: Okay, yes.

13 CO-CHAIR CURTIS: And similar for
14 the sample report that you provided, it's at
15 the physician level.

16 DR. WEISS: Yes, we can make that
17 change, too, sorry.

18 MS. CLARK: Okay, so, should we go
19 onto the reliability piece, or go ahead and
20 vote on this part?

21 CO-CHAIR CURTIS: I think we
22 should, again, go with 2A1 and 2B1 --

1 MS. CLARK: Two-B1?

2 CO-CHAIR CURTIS: -- voting, which
3 considers these criteria S11 to S11.6.

4 MS. CLARK: Okay.

5 CO-CHAIR CURTIS: So, I don't know
6 if you can put up the table of previous votes,
7 it would be kind of useful.

8 I think we've identified unique
9 aspects of this one, that are worth
10 consideration, or different than the previous
11 measures. But there is a lot of overlap, as
12 well.

13 So, for 2A1, the measure is well
14 defined and precisely specified, so that it
15 can be implemented consistently within and
16 across organizations.

17 Before we put up the vote, any
18 other further comments or general summary
19 comments? Mary Ann, do you want to tell us
20 what your thoughts are on this?

21 MS. CLARK: Well, I mean, I think,
22 you know, we've discussed, there are quite a

1 few issues that need to be corrected here.

2 So, I mean, I don't know that we
3 can go forward, you know, I would either say
4 medium or low, on this measure.

5 CO-CHAIR CURTIS: Okay, let's go
6 ahead and vote on that.

7 So, three medium and five low.

8 And then for 2B1, the measure
9 specifications are consistent with the
10 evidence presented to support the focus of
11 measurement under criteria in 1B. The measure
12 is specified to capture the most inclusive
13 target population indicated by the evidence,
14 and exclusions are supported by the evidence.

15 I'll editorialize a little bit,
16 that I think the exclusion of the SNFs and in-
17 hospital mortalities makes me more concerned
18 about this than I was on the previous measure.
19 Are there any other comments?

20 MS. CLARK: No, I think that's --
21 I agree.

22 DR. WEINTRAUB: Yes, I agree, as

1 well. I think those are problematic.

2 CO-CHAIR CURTIS: Okay, go ahead
3 and vote.

4 And so, then you want to go to
5 reliability and validity? I'm sorry, it was
6 eight low, is that right?

7 MS. CLARK: See if we can find
8 that. So, that's on page 31.

9 Okay, so, here is where there are
10 -- they're doing the testing on the Thomson
11 Reuter's database, as well, they say, a sample
12 of CMS Medicare data.

13 So, I believe the same type of
14 testing was used on the Thomson Reuter's
15 database, and then they talk about testing on
16 the Medicare database, a sample of 100 percent
17 of the Medicare population in 12 metropolitan
18 areas, and I guess that's kind of the one I
19 was most interested in.

20 They said it was necessary to make
21 some modifications to the analytic
22 methodologies, in the Medicare analysis,

1 Medicare testing, and I don't know that those
2 are really specified, though.

3 CO-CHAIR CURTIS: Isn't that
4 probably around the pharmacy, absence of the
5 Part D, or is that separate from that?

6 MS. CLARK: They did that, but
7 they also did something with costing, too,
8 which I think they changed a costing method.

9 DR. WEINTRAUB: They say what the
10 modifications are on the top of page 33.

11 MS. CLARK: Yes, developing a new
12 set of prices, to be applied to individual
13 services and hospitalizations.

14 So, that's a mystery. You know,
15 what does that mean?

16 DR. WEISS: I can clarify that.
17 Sorry for the lack of clarity in here.

18 There wasn't a one-to-one cross-
19 mark from our average -- our standardized
20 price data that we created from the Thomson
21 data sets, to what we had in the Medicare data
22 sets.

1 So, we just created a new
2 standardized price table.

3 MS. CLARK: How?

4 DR. WEISS: Same way that we did
5 it for the Thomson data, which we talked about
6 a little bit yesterday, where at the hospital
7 -- we do it at the hospitalization level, and
8 then we do it for other events at the CPT or
9 procedure code and modifier level, creating an
10 average cost for those events, and then
11 applying that every time we see that event in
12 the data set.

13 MS. CLARK: In this case, I'm
14 wondering why, you know, the Medicare
15 methodologies weren't used.

16 You know, there is some specific
17 methods that CMS uses to cost out services,
18 which could have been employed here. Just an
19 idea.

20 So, and also then the SNF claims
21 were dropped, as well, or was that -- those
22 were not included here, either, right?

1 DR. WEISS: Right, same exclusion
2 criteria.

3 MS. CLARK: And I see that also
4 there were -- analyses were dropped of
5 resource use -- well, by individual provider,
6 that wasn't part of this, but -- and provider
7 specialty, but you're talking also, about
8 dropping analysis of individual hospitals, as
9 well, but hospitals are in the Medicare data.
10 So, why would those have been dropped?

11 DR. WEISS: Well, this statement,
12 we were, at the time, investigating whether or
13 not this was -- this measure was going to be
14 able to be attributable at the team level,
15 within a facility, so that we could identify
16 the group of providers that were providing
17 care to the patients.

18 We attempted to do that. We found
19 that we were unsuccessful in doing that, both
20 in the Thomson data and in the Medicare data.

21 I don't know how many hospital
22 identifiers were missing, when we went to

1 hospital level attrition in the Medicare data.
2 That is something that we can provide
3 additional information on.

4 MS. CLARK: Well, you should have
5 had all the hospital identifiers, because that
6 is how they get paid. So, okay.

7 So, testing results, market scan
8 testing, do we want to go to the slides that
9 present the results?

10 Let's see, where are those
11 located? Those are a separate slide?

12 MS. TURBYVILLE: They're in the
13 PDF.

14 MS. CLARK: Yes.

15 MS. TURBYVILLE: They are the
16 fourth bookmark.

17 MS. CLARK: Fourth bookmark,
18 scientific acceptability attachment? Okay,
19 same slides?

20 DR. WEINTRAUB: Same sort of
21 orientation slides we've seen before.

22 MS. CLARK: Anything new here?

1 DR. WEINTRAUB: Actually, there
2 is.

3 MS. CLARK: Okay.

4 DR. WEINTRAUB: The distribution
5 of costs is not as problematic as we've seen
6 before.

7 MS. CLARK: In terms of the -- the
8 distribution, in terms of what? The related,
9 AMI related services, or the non-related
10 services, or just in general?

11 DR. WEINTRAUB: Actually, I don't
12 think they lay them out quite the same way,
13 unless I'm missing something.

14 MS. CLARK: Yes.

15 DR. WEINTRAUB: So, they're not
16 related to four. They had, within that, they
17 had related and non-related. I don't see
18 that distinction.

19 MS. CLARK: They're separate
20 slides, it looks like.

21 DR. WEINTRAUB: And one thing
22 that's going to make that analysis a little

1 bit easier, if you go to slide 15, which is 63
2 in the PDF, you see the overall distribution
3 and cost is not as skewed.

4 MS. CLARK: Well, yes, because
5 everybody had a hospitalization --

6 DR. WEINTRAUB: Yes, right. So,
7 it does make it a little bit easier.

8 But the outpatient costs, on the
9 other hand, are -- it's a smaller piece, and
10 there is more skew.

11 MS. CLARK: Yes, well, that's,
12 again, a question, because I mean, out-patient
13 facility cost, where is that even coming from?
14 I don't know. Is that --

15 DR. WEINTRAUB: I agree.

16 MS. CLARK: That wasn't one of the
17 resource use specifications. Is it a BETOS
18 category? I don't know.

19 CO-CHAIR CURTIS: Could the
20 developer just clarify that?

21 DR. WEISS: Yes, we categorized
22 it, based on the category -- we know, for our

1 -- I'll say this with a caveat that we know,
2 in the data set, we have a difficulty
3 identifying all of the outpatient facility
4 costs that occur, and appropriately grouping
5 them.

6 We don't have a problem finding
7 the costs that occur, but we have a problem
8 appropriately putting them in this cost
9 bucket.

10 So, while some of the facilities,
11 you may be able to do a good job of
12 identifying the facility costs, others may
13 show up in the procedures bucket, or
14 potentially in the physician services bucket,
15 under E&M.

16 So, while we are relatively
17 confident we're capturing the full spectrum of
18 costs, there may be some mis-classification,
19 in terms of these descriptors.

20 DR. WEINTRAUB: The one I'm a
21 little concerned about is other services,
22 quite skewed. It's only two percent of the

1 overall, but it's zero from the 75th
2 percentile, and then it goes up to \$2,500.
3 What is that?

4 DR. WEISS: It's a mix of stuff.
5 I mean, it's a bucket that captures lots of
6 different things.

7 I mean, I can get you the BETOS
8 list, to show you the groups there. The
9 problem is, it may be capturing some of our
10 outpatient facility costs, and again, I'm
11 going to fully admit that we have some problem
12 in appropriately categorizing costs into all
13 of these buckets.

14 The biggest thing here is that 81
15 percent of all costs are on the inpatient
16 side.

17 CO-CHAIR CURTIS: So, I think,
18 just -- it's a similar approach to reliability
19 and validation that we've seen, you know, the
20 specific data, probably a little bit less
21 problematic, given that we have the inpatient
22 admission for all patients.

1 MS. CLARK: Right.

2 CO-CHAIR CURTIS: It's less skewed
3 by subsequent admissions.

4 But you know, partly in the
5 interest of time, I kind of want to make sure
6 that we're focusing on the differences, as
7 opposed to going through entirely de novo.

8 MS. CLARK: Okay, so, let's see,
9 what page are we on, there?

10 So, that was reliability testing,
11 and validity, right?

12 So, are we ready to vote on those,
13 or do we need more review?

14 MS. TURBYVILLE: You could also
15 look at any of the other commenters on this
16 sheet, that you have, maybe, and --

17 MS. CLARK: Sure.

18 MS. TURBYVILLE: For 1570, it
19 would have -- I think -- though, you may have
20 been the only one p-

21 MS. CLARK: Was I the only one --

22 MS. TURBYVILLE: Yes.

1 MS. CLARK: Yes, I don't think I
2 have anything to add to myself. I mean --

3 MS. TURBYVILLE: Well, you could
4 have changed your mind.

5 MS. CLARK: Yes.

6 MS. TURBYVILLE: Yes, let's see.

7 CO-CHAIR CURTIS: I think if
8 everyone is comfortable with what we're doing,
9 I think we should go ahead and vote.

10 We have the -- on the screen, the
11 comparison of the two tables, of the prior
12 measures, and how we voted on reliability and
13 validity in those cases.

14 We would start with 2A2,
15 reliability testing demonstrates that the
16 results are repeatable, producing the same
17 result a high proportion of the time when
18 assessed in the same population and that the
19 measure score is precise.

20 And in looking at that, we have
21 definitely directed from 2A2 in the first one,
22 to the second, where we would move from mostly

1 moderates to all lows.

2 DR. HWONG: I think it had much
3 more to do with the actual measure construct,
4 right?

5 CO-CHAIR CURTIS: I agree, agreed.

6 DR. HWONG: Yes, right.

7 CO-CHAIR CURTIS: So, I think that

8 --

9 DR. HWONG: Reflective of that.

10 CO-CHAIR CURTIS: Yes, and then
11 specifically --

12 DR. HWONG: As opposed to the
13 approach.

14 CO-CHAIR CURTIS: -- that missing
15 of the -- or the combination of the -- in
16 relation to the specification.

17 So, let's go ahead and vote on
18 that one, and we're -- okay, there it is,
19 okay.

20 MS. WILBON: Two moderate -- I'm
21 sorry, seven moderate and -- seven moderate
22 and one low.

1 CO-CHAIR CURTIS: So, 2B2,
2 validity testing demonstrates the measure data
3 elements are correct and/or the measure score
4 correctly reflects cost of care and resources
5 provided, adequately distinguishing higher and
6 lower cost or resource use. And it was again
7 moderate for 2B2 in the first, and eight on
8 the low.

9 I would say that the -- in my
10 opinion, this is more likely, or closer to the
11 first measure that we would be within the
12 second.

13 That being said, there are also
14 new caveats of the issues that we raised. So,
15 go ahead and vote on that.

16 Four, sorry, six moderate and two
17 low. So, for 2B3, exclusions are supported by
18 the clinical evidence, otherwise, they are
19 supported by evidence of sufficient frequency,
20 but mainly, focusing on the measure
21 specifications and how to specify the
22 exclusions.

1 So, in the previous ones, for the
2 first measure, it was a range around moderate
3 and the second, it was five lows and two
4 mediums.

5 MS. TURBYVILLE: Is this one
6 influenced by the discharge question?

7 CO-CHAIR CURTIS: In my opinion,
8 it's influenced by the exclusion of in-
9 hospital mortality and the discharge to SNF.
10 That's eight low.

11 For 2b4, outcome measure, more
12 resource use when indicated, evidence-based
13 risk adjustment strategy is specified, based
14 on clinical factors, and for that we were
15 fairly consistent with the range around
16 moderate, for both measures, and I think it's
17 consistent with that.

18 Go ahead and vote. So, that's
19 eight moderate.

20 For 2b5, data analysis
21 demonstrates that methods for scoring at the -
22 - the analysis has specified measure allowed

1 for identification of statistically
2 significant and practically clinically
3 meaningful differences in performance.

4 For the previous ones, we had
5 mainly -- well, insufficient on the second
6 measure, post-revascularization, and more
7 moderate to low on the first measure, the 31
8 to 365.

9 Mary Ann, do you have a thought as
10 to kind of where this would fall?

11 MS. CLARK: You know, the testing
12 they did was -- or creating a score, this one
13 -- this one was at the hospital level.

14 So, you know, I'm not -- I wish we
15 had our statistician here, but so, you know,
16 I'd say this was probably more of a moderate
17 to me.

18 DR. WEINTRAUB: So, the testing
19 shows some range to it, but they really don't
20 have model characteristics. They haven't done
21 validation. They haven't done calibration, I
22 mean, they're not -- they haven't tested in

1 external data sources.

2 I mean, it seems to me a lot of
3 them could be done.

4 CO-CHAIR CURTIS: Okay, let's go
5 ahead and vote on that. That is three
6 moderate and five low.

7 Then, 2b6 is actually I think
8 relevant for this, because of the --
9 potentially, because of the CMS data, but let
10 me think about that. Probably not, because
11 it's the same administrative data.

12 DR. HWONG: Yes, I don't think
13 they're saying that there is options for use.

14 CO-CHAIR CURTIS: So, I don't
15 think we'll vote on that, and for the
16 disparities, similar to the other ones, we do
17 not vote. So, keep that consistent.

18 DR. WEINTRAUB: We're not going to
19 vote?

20 CO-CHAIR CURTIS: We're not going
21 to vote on those two, for reliability, not
22 applicable for this measure.

1 So, I think what we discussed
2 yesterday was, in the interest of time, for
3 usability and both feasibility we would
4 anticipate that this would have a similar
5 score, basis of similar issues.

6 Eventually, this will be voted on
7 formally by the TAP, or those -- that
8 information will be captured, as we
9 anticipated for all these measures, there will
10 be the opportunity for a re-vote, via a
11 SurveyMonkey or other device.

12 So that the formal opinion of the
13 TAP will be captured, but we will save a few
14 minutes, at least, in terms of going through
15 and getting the vote and the delays with the
16 reply key.

17 So, just to clarify that for the
18 measure developer, this will be officially
19 done. We would anticipate that it would be
20 the same voting at this time.

21 There were some efficiencies
22 captured in this. I think we should continue

1 our plan, move to the ABMS diabetic measure,
2 and then go to the Ingenix measures to follow
3 that.

4 But let me ask you, should we take
5 a break now, or do you want to --

6 CO-CHAIR ROSENZWEIG: Yes, let's
7 take a --

8 CO-CHAIR CURTIS: Maybe a five
9 minute break?

10 CO-CHAIR ROSENZWEIG: Five minute
11 break just for restrooms.

12 (Whereupon, the above-entitled
13 matter went off the record at 10:09 a.m. and
14 resumed at 10:15 a.m.)

15 CO-CHAIR CURTIS: Why don't we go
16 ahead and reconvene?

17 CO-CHAIR ROSENZWEIG: Yes, in the
18 interest of time, let's get started.

19 We're now considering review
20 number 1576, I believe, episodes of care for
21 patients with diabetes over a one-year period,
22 and Brenda Parker will be the -- is the

1 primary reviewer.

2 Do we have any comments by the
3 measure developer first, before we start an
4 introduction?

5 DR. WEISS: I'll just give you a
6 very brief introduction.

7 The measure is developed in the
8 same manner as the other measures that you
9 reviewed from us.

10 The intent of this measure was to
11 focus on patients that were not newly
12 diagnosed with diabetes nor were at the end
13 stage part of their disease.

14 We were trying to focus on a group
15 of patients that our work group sort of termed
16 in the management phase of diabetes, and we
17 did this by identifying homogenous patients,
18 in an attempt to capture all of their
19 diabetes-related resource use over a one-year
20 period.

21 CO-CHAIR ROSENZWEIG: Okay, thank
22 you very much. Brenda, would you like to

1 start?

2 MS. PARKER: Sure, thank you.

3 Thank you to the measure developer for the
4 brief overview.

5 So, with that, we will jump right
6 into the importance to measure and report.

7 Regarding impact, there is, in my
8 opinion, sufficient evidence that the measure
9 developer has provided, in terms of high
10 impact, regarding the epidemiology of
11 diabetes, as well as some of the care
12 considerations and the economic consequences
13 of diabetes, in terms of co-morbidities.

14 So, for that, I think that they
15 did a great job, there. Also, a note to them
16 for identifying the IOM as ranking this as a
17 top 20 priority, in general.

18 In terms of opportunity for
19 improvement, regarding variation across
20 providers, as well as disparities in
21 population groups, it was definitely
22 sufficient evidence to support that practice

1 variation does exist, as well as racial
2 disparities, within diabetes care.

3 However, racial disparities were
4 really the only variation that were targeted.
5 There were no other discussions of other
6 population groups where disparities may exist,
7 as far as age, gender, socio-economic status.
8 So, I think that was a deficiency there,
9 within that section, because again, it did
10 concentrate primarily on race, which, there is
11 a lot of data to support that focus, but I
12 think, you know, in terms of being a well
13 rounded measure, you should probably attempt
14 to address multiple disparities.

15 With regards to -- sorry, I got
16 ahead of myself here.

17 With regards to the purpose and
18 the intent, and that is on -- starts on page
19 six, my apologies for not keeping everyone
20 along as we go, with the bulk of that being at
21 the top of page seven.

22 The intent of the measure was

1 clear, however, after going through the AMI
2 intent, or measure this morning, I'm wondering
3 if -- because the question of re-admission
4 came to mind, and why this was included, as it
5 wasn't included in the previous literature, as
6 it being a large issue in patients with
7 diabetes.

8 So, I'm wondering if this was,
9 because essentially, it's the exact same
10 language from the AMI, so, I'm wondering if
11 that may have been a copy and paste, or if the
12 measure developer could provide some evidence
13 or support of why, in addition to resource
14 use, re-admissions were mentioned specifically
15 within this section.

16 Would the measure developer care
17 to comment on that?

18 DR. WEISS: I'm sorry, can you
19 point me to the page? I'm trying to find it.

20 MS. PARKER: Sure, it's on page
21 seven, at the top of the PDF, and there is, I
22 believe it's in the second sentence, provide

1 efficient care, third line, by examining both
2 the resource use, as well as the re-admission
3 rates.

4 DR. WEISS: Yes, this partially
5 would be a problem with the copy and paste,
6 and I apologize, I thought when we were
7 looking at this, hospitalization -- and re-
8 admission is probably the wrong term; it's
9 more hospitalization ends up being an
10 important cost driver within this episode.
11 So, we can clarify this language.

12 MS. PARKER: Well, and so, is
13 there really the need to include something
14 more specific when later on, in the construct,
15 you mention that in-patient hospitalization is
16 included in there?

17 So, I would think that that would
18 fall under the blanket umbrella of resource
19 use.

20 DR. WEISS: Fair enough.

21 CO-CHAIR CURTIS: And I think
22 there is a fair intent here, to compare the

1 relative research used by different providers
2 to examine patterns in diabetes.

3 MS. PARKER: Right.

4 CO-CHAIR CURTIS: And compare the
5 healthcare costs, so, I think --

6 MS. PARKER: Yes, and in my notes
7 --

8 CO-CHAIR CURTIS: So, I don't
9 think we should cut down too much --

10 MS. PARKER: -- it's fine, yes,
11 it's fine, just wondering if I missed
12 something, or if there is something that the
13 measure developer cared to elaborate on.

14 And then finally, within the
15 importance to measure and report category,
16 evaluation of the resource-use categories,
17 which seemed to be relatively consistent with
18 some of the other measures that have been --
19 and I'm trying to get to that section, my
20 apologies.

21 Trying to get down there. It
22 seemed to be consistent with some of the other

1 measures, given that this was in -- a chronic
2 condition.

3 One thing that came to mind,
4 perhaps that relates to this, sort of is
5 within the care setting, and I didn't find
6 those individual care settings. That seemed
7 to be a very short list.

8 So, I'm not sure if that's
9 something that, as mentioned earlier, the care
10 setting categories that are provided, the
11 taxonomy there, if those are more of the broad
12 categories, and a lot of the sub-categories
13 may roll into that, because there were only
14 three care settings identified: either
15 hospital, primary care or pharmacy, I think.

16 And there seemed to be a lot more
17 granularity in some of the other measures, or
18 at least more granularity.

19 So, that may be an NQF question,
20 or a measure-developer question, but I think
21 that gets at the resource-use categories.

22 My question is not clear, is it,

1 because you're looking at me.

2 MS. TURBYVILLE: I just want to
3 make sure, so, is it that you felt that
4 perhaps, they weren't inclusive enough of the
5 resource-use categories for this measure?

6 MS. PARKER: The resource-use
7 categories themselves, as indicated in S96 --

8 MS. TURBYVILLE: Okay.

9 MS. PARKER: -- seem to be
10 adequate, but they don't match up to what I
11 expected to see in the care setting.

12 So, just trying to reconcile that,
13 while we're at this point.

14 MS. TURBYVILLE: Okay.

15 CO-CHAIR CURTIS: So, is that a
16 function of, again, they're sort of doing
17 diabetes-related resource use?

18 MS. PARKER: It doesn't seem to be
19 that it would be a function of that. It's
20 merely a function of what they chose, or maybe
21 what they had an option to choose from.

22 CO-CHAIR CURTIS: And are you

1 concerned that there are specific areas that -
2 -

3 MS. PARKER: That may be missing
4 in the care setting.

5 CO-CHAIR CURTIS: So, which ones
6 do you -- well, maybe we'll come back to that.

7 MS. PARKER: Sure, but that
8 doesn't mean you can look at --

9 MS. TURBYVILLE: Well, we'll have
10 to look at our list and --

11 MS. PARKER: Yes, perfect and
12 we'll get to that later.

13 MS. TURBYVILLE: Okay.

14 MS. PARKER: So, that concludes
15 kind of my overall cursory review of the
16 importance to measure and report.

17 So, if there are no further
18 questions or no further comments from the
19 measure developer, I think we could go ahead
20 and vote.

21 CO-CHAIR ROSENZWEIG: Sure, any
22 comments or questions? All right, so, let's

1 vote on 1a.

2 MS. PARKER: And within this
3 category, I'm happy to kind of give my input
4 in how I ranked this, as I was reviewing it.

5 Again, 1a is the importance of it
6 and the impact and again, that provides
7 sufficient evidence. So, I ranked that
8 actually as high.

9 CO-CHAIR ROSENZWEIG: All right,
10 eight, high, and it's in the right color, it
11 fits in this time.

12 MS. PARKER: That's helpful.

13 CO-CHAIR ROSENZWEIG: All right,
14 and then the second, 1b is demonstration of
15 resource use or cost problems and opportunity
16 for improvement.

17 MS. PARKER: Sure, and with that
18 one, as I mentioned previously, I think that
19 they did a good job, as far as practice
20 variation.

21 But, and Jamie, you could probably
22 comment to this, if there is sufficient data,

1 as far as disparities regarding age or gender
2 or socio-economic status, because I think
3 there was a real deficiency there in the
4 development of their case.

5 So, I ranked that as moderate,
6 because again, they did a great job on
7 practice variation and the literature of the
8 racial disparities was thorough. I just think
9 they kind of missed an opportunity.

10 CO-CHAIR ROSENZWEIG: And there
11 were also opportunities for resource use that
12 they didn't mention --

13 MS. PARKER: Sure.

14 CO-CHAIR ROSENZWEIG: -- related
15 to actual appropriate resource use --

16 MS. PARKER: Right, yes.

17 CO-CHAIR ROSENZWEIG: So, there
18 were a lot of -- for instance, absence of eye
19 exams and the various other things.

20 So, there is -- we're not just
21 talking about saving money, here, we're also
22 talking about appropriately using resources.

1 MS. PARKER: Exactly.

2 CO-CHAIR ROSENZWEIG: And there
3 are clear disparities that have been
4 identified.

5 MS. PARKER: I agree. So, again,
6 I chose to kind of rank this as moderate.

7 CO-CHAIR ROSENZWEIG: Two high and
8 six moderate, okay. Then the third is 1c.

9 The purpose objective of the
10 resource-use measure and the construct for
11 resource use are clearly described.

12 MS. PARKER: And for what it's
13 worth, because of the re-admission piece, it
14 confused me a little when I was reviewing it,
15 and I ranked this moderate.

16 I'll leave it up to the panel, to
17 decide, you know, based on the conversation
18 here, what they would like to do with that.

19 CO-CHAIR ROSENZWEIG: Two high,
20 five moderate and one low.

21 Okay, and then the fourth one, 1b,
22 the resource-use category that are included in

1 the resource measure consistent with and
2 represented of the conceptual construct,
3 represented by the measure.

4 So, they want to make sure that
5 the categories that are being used are
6 coherent and consistent with the purpose of
7 the measure.

8 MS. PARKER: Sure, and this
9 specific resource-use categories that they did
10 identify are comprehensive and specific,
11 regardless of the care setting.

12 CO-CHAIR ROSENZWEIG: Okay.

13 MS. PARKER: I ranked that high.

14 MS. TURBYVILLE: Can I ask one
15 clarifying question for our notes?

16 For the purpose and intent, we had
17 a little bit, you know, the moderates and the
18 lows.

19 I just want to make sure that we
20 captured the feedback, which is that they're
21 pointing to some resource use and not other,
22 which others, which may signal that some are

1 more important and others ought to -- other
2 than just being broad, and thinking about
3 resource use and measurement of diabetes.

4 For example, re-admissions was
5 mentioned, and it didn't really seem to --

6 MS. PARKER: I think the two
7 statements you have are crossing. I think the
8 initial statement you had relates more to the
9 lb, so, regarding variation and practices.

10 MS. TURBYVILLE: Okay.

11 MS. PARKER: The re-admission
12 piece was perhaps, a copy and paste error or
13 an element that the measure developer said
14 that they would modify and/or remove all
15 together.

16 MS. TURBYVILLE: Sounds good,
17 okay.

18 CO-CHAIR ROSENZWEIG: Okay, let's
19 move on to scientific acceptability.

20 MS. PARKER: So, if it's okay with
21 the panel, for scientific acceptability of the
22 measure properties, what I did in reviewing

1 this again last night was, I kind of called
2 out the things that were similar to the other
3 proposed measures, and I'd like to just review
4 those.

5 So, it may seem like it's jumping
6 around a bit, but I think it's helpful to go
7 ahead and review what we've kind of already
8 processed, if that is acceptable.

9 CO-CHAIR ROSENZWEIG: Sounds good.

10 MS. PARKER: Great. So, the
11 general approach is the same, as far as
12 establishing a working group to kind of weigh
13 in on these different measures.

14 The data protocol itself, again,
15 is very consistent, as far as they do not
16 recommend imputation of missing data, that
17 only closed claims, or those that have been
18 paid are utilized and that the quantity values
19 for resource use and the frequency are set to
20 one, when missing an order, to capture costs.

21 The data type is administrative,
22 as are all of the proposed measures. The co-

1 morbidity risk adjustment used is the HCC,
2 which they've proposed in previous measures.

3 Costing, again, uses the NCQA
4 standardized price tables and their
5 modifications to such tables.

6 And so, I think all of those are
7 pretty consistent, and what they've presented
8 is consistent, but also, the feedback in the
9 context of diabetes is consistent, as well, in
10 my opinion.

11 CO-CHAIR ROSENZWEIG: Okay.

12 MS. PARKER: As far as the
13 relation to -- let me get the overall, broad
14 category here.

15 The detail attribution peer group,
16 outliers, table size, bench marking, that
17 grouping, the attribution is 70/30.

18 This is a chronic disease state,
19 as far as, you know, most of the care, in my
20 experience, and anyone can weigh in, is that,
21 you know, a primary care provider does
22 typically manage patients with diabetes and

1 refers those on who need further follow up or
2 have more severe disease.

3 So, it makes sense that the
4 majority of this would be attributed to where
5 most of the care takes place, versus with some
6 of the other events in cardiology, where it
7 may be that it's referred -- the patient is
8 referred to a cardiologist, and this may
9 increase costs, and therefore, the attribution
10 may be a little skewed, in terms of that.

11 I think the attribution method
12 here, in the context of diabetes, makes sense.

13 Anyone have any comments?

14 CO-CHAIR ROSENZWEIG: Yes, I would
15 just propose some caveats, and that is that
16 patients with more complex and more expensive
17 diabetes tend to be referred to
18 endocrinologists for care, if they need to --
19 usually, those people who are on insulin or
20 are on multiple daily injections and who have
21 multiple complications.

22 So, the attribution of those

1 patients is more likely to be to the
2 endocrinologist, since once they refer to an
3 endocrinologist, it's usually not for a single
4 visit, it's for multiple visits.

5 And whereas, the attribution for
6 the other patients who might be -- might have
7 lower costs, might stay with the primary care
8 doc.

9 One of the reasons they're
10 actually referred to an endocrinologist is
11 when they need more care.

12 MS. PARKER: Absolutely.

13 CO-CHAIR ROSENZWEIG: So, there
14 may be issues related to case-mix adjustment
15 that this particular model may not fully take
16 into account.

17 MS. PARKER: And if the measure
18 developer could address that, I think that
19 would be very appropriate -- an appropriate
20 request.

21 They do mention and acknowledge
22 that the more severe patients will be referred

1 to an endocrinologist. So, they do note that
2 that does occur.

3 CO-CHAIR CURTIS: That seems like
4 it should have been covered at least at -- if
5 the primary comparisons are within peer group,
6 and the peer groups are appropriately defined,
7 then it would be less of an issue.

8 But it has to do with, I guess,
9 how the measure is used at the end of the day.

10 CO-CHAIR ROSENZWEIG: Correct,
11 it's just that, yes, diabetologists are not --
12 it's interesting, but there are some
13 diabetologists who are not endocrinologists.

14 And so, there is a -- it's a bit
15 of a -- it's not as clear as the attribution
16 issues that apply to chronic CAD.

17 MS. PARKER: Sure. The level of
18 analysis is at the individual clinician level,
19 or proposed that way.

20 Winsorization, as in the other
21 proposals takes place, and there are no sample
22 size recommendations and finally, the bench

1 marking is, in terms of the provider
2 summaries.

3 I had no objection to it being a
4 provider level, but I wanted to throw that to
5 the actual providers to weigh in as that's not
6 really my area of expertise.

7 DR. MARWICK: How is the
8 attribution made?

9 If somebody, for example, has a
10 coincidental identification of diabetes in the
11 midst of another problem, is the diabetes
12 attributed -- presumably, the diabetes is
13 attributed to the person looking after the
14 other problem? I just see that as a potential
15 issue, here.

16 MS. PARKER: And if it helps, we
17 could go ahead and go through the clinical
18 framework, so, that you know, kind of, how the
19 population is identified, or if the measure
20 developer would like to kind of comment, on
21 that request, at this time.

22 DR. WEISS: Sure, I mean, the

1 attribution logic function around the E&M
2 codes that have a diagnostic code but groups
3 different episodes.

4 So, we identify all of the
5 physicians and -- the provider interactions
6 with an E&M code that have eligible ICD9 codes
7 for this episode, and then, make the
8 attribution rules, based on the proportion of
9 those codes that are -- the proportion of
10 those digits that are acting within a provider
11 or multiple providers.

12 So, in the example, if the person
13 has another problem, and they're going to a
14 cardiologist, for example, and the
15 cardiologist also includes a diabetes code on
16 that claim, there is a possibility that the
17 cardiologist would be the one that is
18 attributed in the episode.

19 MS. PARKER: Does that clarify the
20 --

21 DR. MARWICK: Yes, it does. It was
22 kind of what I was afraid of.

1 So, you know, the risk there is
2 that the cardiologist may not be the primary
3 person looking after the diabetes, and it may
4 not be wise to attribute subsequent
5 interactions to them.

6 MS. PARKER: Sure, and is there a
7 way that this -- this may have been tested,
8 and I just didn't see it, but is there a way,
9 from the measure developer, to give us an idea
10 of how often that happens and/or maybe a
11 proposed approach to how this can kind of be
12 addressed, or minimize it, at best?

13 DR. WEISS: So, in our testing,
14 cardiology happens to be the sixth most common
15 specialty for which episodes are attributed
16 to, but it's a -- only 3,000 episodes versus
17 family practice, which is 41,000 and internal
18 medicine, which is 33,000.

19 So, the absolute number being
20 attributed to a cardiologist is much, much
21 lower than other types of providers.

22 CO-CHAIR ROSENZWEIG: Correct, but

1 the costs may be much higher, knowing that
2 cardiologists tend to cost more.

3 DR. WEISS: Understand, and that's
4 why we would not propose comparing episodes
5 attributed to a cardiologist, compared to some
6 -- and episode attributed to a family practice
7 physician.

8 We'd only want to compare episodes
9 that are attributed to cardiologists with
10 other cardiologist-attributed episodes, those
11 providers.

12 MS. PARKER: And that seems to be
13 a sufficient and adequate comparison.

14 DR. MARWICK: I think there are
15 going to be statistical issues there, that's
16 part of the concern, and I wonder if the more
17 sophisticated approach would be to look at,
18 for example, if a patient has had multiple
19 visits, maybe there is a threshold number of
20 visits with the attribution -- with diabetes
21 linked that would be a better means of doing
22 this.

1 As I currently understand, it will
2 be possible for somebody to see a cardiologist
3 once, and have that listed, and then the
4 cardiologist be linked to that patient in
5 subsequent events.

6 MS. PARKER: Is that something the
7 measure developer would be willing to do
8 and/or potentially address here?

9 DR. WEISS: Would we be willing to
10 change our attribution logic? Is that the
11 question?

12 I think we're well beyond our
13 ability to change our attribution logic right
14 now.

15 MS. PARKER: Well, I think more
16 so, it's just maybe a proposed -- you know,
17 really, the burden is on you to kind of
18 identify what that appropriate number would
19 be, I believe, or if that makes sense -- and
20 either it does or it doesn't for your proposed
21 measure -- but that's something that only you
22 can kind of decide, if that's something that

1 makes sense, and if that's something that you
2 could do.

3 CO-CHAIR CURTIS: I guess to me,
4 it just doesn't -- there's going to be noise
5 in this --

6 MS. PARKER: Sure.

7 CO-CHAIR CURTIS: There's going to
8 be mis-classification, but as we said, the
9 sample sizes are going to be extremely low,
10 and I guess if I got that report back, of
11 characterizing the care of my diabetic
12 patients, and I was signing it, I guess it
13 depends on the consequences of it.

14 But I would ignore it, whereas, I
15 think the people -- the primary care doctors
16 and the endocrinologists, diabetologists,
17 would be the ones who would really focus on
18 it.

19 So, I'm just -- I wish that it
20 were completely precise, but I think it might
21 be an impossible threshold to set.

22 MS. PARKER: Well, and I believe

1 NQF has committed to providing a statement, a
2 caveat statement, regarding the statistical
3 significance or the power behind this.

4 So, I would just charge the
5 Steering Committee with making sure that that
6 statement is accurate, and make sure that it
7 definitely reflects the intent, because I
8 think statistical significance may not be
9 necessarily the most appropriate terminology.

10 But I trust the Steering Committee
11 will make the appropriate decision.

12 DR. WEINTRAUB: I want to go back
13 to your original question about whether we can
14 -- will have adequate power to look at the
15 individual provider level, and in this measure
16 compared to others. I think for most
17 providers, we probably can.

18 It looks like, first of all, there
19 are lots of patients with diabetes.

20 MS. PARKER: Sure.

21 DR. WEINTRAUB: And family docs
22 and internists will see a lot of them.

1 So, if we believe that the
2 attribution, even if imperfect, is okay, or at
3 least acceptable, probably most of the time,
4 we're going to be okay on power.

5 The other thing, we're looking at
6 the distribution of costs, it's not as skewed
7 as it is, because we're dealing much more with
8 out-patient care rather than hospitalizations.

9 MS. PARKER: Sure.

10 DR. WEINTRAUB: So, most of the
11 time, it's going to work out okay.

12 I do worry that low-volume
13 providers, or providers that have a couple of
14 hospitalizations, may find all of the sudden,
15 that they're lying outside the boundaries,
16 here and there.

17 MS. PARKER: And that may be
18 something that the measure developer can
19 consider for the next step in the process, as
20 NQF mentioned, the three-year revisiting.

21 Maybe by that time, you know, if
22 the measure is approved, or if they have

1 adequate time to develop an adequate sample
2 size, that they can test and make sure, you
3 know, with this many -- not necessarily number
4 of providers, but as NCQA uses, but maybe
5 number of visits or -- et cetera -- getting
6 back to the general comment of cardiology, but
7 also, kind of the concept of adequate power.

8 CO-CHAIR ROSENZWEIG: Yes, I think
9 adequate power may be an issue, even though
10 diabetes is a common disease, still
11 represents, you know, in many plans, only
12 about four to five percent of the population,
13 okay, because they exclude the elderly, and
14 that's not enough, necessarily, in a typical
15 primary care practice, or in -- you know, to
16 really necessarily achieve good power.

17 And this has already come up in
18 quality improvement measures, okay. So, there
19 is no reason why it shouldn't come up here,
20 and physicians with part-time practices as
21 well: that will be even a bigger problem.

22 And since measures like this might

1 be used for things like physician tiering,
2 which we already have in Massachusetts, I
3 don't know if you have it in your states, this
4 is an important issue.

5 MS. PARKER: Absolutely, and that
6 kind of rounds out the -- what was similar.
7 So, I think this was very good context for
8 diabetes.

9 I also think we land kind of in
10 the same general area, with a few exceptions.

11 So, now, I'm going to go
12 specifically to the clinical framework, which
13 is specific to diabetes. So, it obviously, is
14 different from the other proposed measures
15 that are specific to cardiology.

16 And just walking through, I'm
17 going to walk through the clinical framework,
18 before I kind of digest it for you, and for
19 the measure developer, please feel free to
20 jump in and correct my interpretation of what
21 you have here, if that applies.

22 So, essentially, the way that the

1 patients are going to be identified, and there
2 are two methods, if you will. The first one
3 is really using the oral medications, in terms
4 of identifying patients. So, there are no age
5 restrictions within the first criterion.

6 Essentially, patients are required
7 to have at least one out-patient visit with a
8 diagnosis of diabetes, within the first six
9 months of the identification year.

10 So, again, 24 months is within the
11 document. Within the first year, where the
12 patients are identified, they need to have a
13 diagnosis of diabetes within the first six
14 months, at least one prescription for an oral
15 hypoglycemic medication in the first six
16 months, as well, and at least one diabetes-
17 related resource-use event in the measurement
18 year.

19 That could be anything from a fill
20 at the pharmacy, a visit to the doctor, even
21 a hospitalization. So, just one measure.

22 Again, I think similar to one of

1 the measures yesterday, you know, just making
2 sure that these patients are -- have not left
3 the Earth, I believe is the exact phrase from
4 yesterday. So, that's the first criteria.

5 The second criteria is looking
6 more -- using insulin as kind of the
7 differentiator.

8 So, again, within the first six
9 months of the identification year, needs a
10 diagnosis of diabetes. No oral hypoglycemic
11 medication in the first six months of the
12 year, rather, they would have one insulin
13 claim in the first six months of the year, and
14 there is an age restriction here, and it's
15 restricted to those patients who are 30 years
16 and older during the identification year, and
17 at least one diabetes resource-use event in
18 the year of measurement. That's the inclusion
19 criteria.

20 So, I'll go ahead and go through
21 the exclusion criteria, then maybe we can
22 discuss both, or does it make more sense to go

1 ahead and discuss the inclusion criteria and
2 concerns that I have?

3 DR. HWONG: I was wondering if we
4 could --

5 CO-CHAIR ROSENZWEIG: Let's just -
6 - go ahead.

7 DR. HWONG: -- pause for a second
8 and -- go ahead.

9 CO-CHAIR ROSENZWEIG: No, go
10 ahead.

11 DR. HWONG: I was thinking, you
12 know, I have a couple sort of questions --

13 MS. PARKER: Okay.

14 DR. HWONG: -- in terms of the
15 inclusion, and sort of, how they've -- because
16 I'd expect it this way, right?

17 So, one of the -- yes, I guess I
18 would love to get some clarification on, you
19 know, the alternate path to get into this
20 measure, where -- yes, if you're an insulin
21 user, so, I'm assuming that's probably going
22 to help you identify a lot of your Type 1

1 diabetics.

2 But why is this 30 -- why for that
3 path, do you have to be 30 or older?

4 MS. PARKER: Which, I would think
5 is -- I was thinking the same thing, until I
6 got to the age 30, and that's counter-
7 intuitive, because Type 1s, you know, are --
8 could be younger, usually more healthy, not
9 your typical Type 2s.

10 So, I thought that was a -- and
11 there is no real rationale, in my mind, of why
12 30 is an appropriate cut off.

13 So, I was hoping that, again,
14 either the practicing docs here could help or
15 the measure developer could weigh in.

16 CO-CHAIR ROSENZWEIG: Yes, I was
17 concerned about this, too. Could the measure
18 developer comment on this?

19 DR. WEISS: Yes, sure. Our
20 clinical work group pushed this forward, the
21 identification, the focus of this measure
22 being on patients with Type 2 diabetes.

1 We realized that through our
2 specification criteria, for inclusion, there
3 will be some Type 1 diabetics that enter into
4 our population.

5 The second inclusion criteria was
6 an effort to identify the insulin-only Type 2
7 diabetics, and that's why the age restriction
8 was placed on the second pathway.

9 MS. PARKER: And so, here are my
10 thoughts. I automatically identified that
11 there was no separation of Type 1 and Type 2.
12 You just talk about diabetes in terms of the
13 measurements.

14 So, that is not clear, and could
15 be made more clear, and there are specific
16 ICD9 codes that help with that diagnosis,
17 assuming that they are not mis-classified.

18 So, I think there could be a
19 combination, but you know, helping to clarify
20 that earlier on, probably would have taken
21 care of this concern, at least as it stands
22 now, of why that was the case.

1 But I'm still not sure that if --
2 that you would want -- I don't -- I wrote down
3 two things, as far as this, that relate, that
4 Type 1 and Type 2 could potentially be
5 stratification, because they are different to
6 your point, Type 2 being, I think, 90 to 95
7 percent of the population with diabetes.

8 And then also, the exclusion of
9 the newly diagnosed, as well as the end stage,
10 again, being kind of stratification measures,
11 because they still all have diabetes, and we
12 still all want to know about their resource
13 use, and match them to quality, so, that we
14 really understand the efficiencies of care in
15 diabetes.

16 So, I'm not sure that the measure
17 is specific to Type 2, I don't know if that
18 was a request or that is just the general
19 consensus, that that's where we need it. But
20 if we have the opportunity to include some of
21 these other perspectives in care, I think that
22 it is wise to take advantage of that

1 opportunity without a lot more effort.

2 CO-CHAIR ROSENZWEIG: Yes, I would
3 just comment, if indeed, the focus then is on
4 Type 2 diabetes, then it should be included in
5 the title of the measure very specifically, if
6 actually, you want to exclude Type 1 patients
7 that are known.

8 Now, with respect to -- I do
9 understand, though, that there are differences
10 in the various coding for Type 1 and Type 2,
11 but those are often misused, and I think
12 that's the rationale --

13 MS. PARKER: Absolutely.

14 CO-CHAIR ROSENZWEIG: -- for their
15 not using them that specifically.

16 MS. PARKER: Sure.

17 CO-CHAIR ROSENZWEIG: Because it's
18 extremely common for physicians, once a
19 patient is on insulin, to classify them as
20 Type 1 --

21 MS. PARKER: Type 1.

22 CO-CHAIR ROSENZWEIG: -- even

1 though they may not really be Type 1.

2 MS. PARKER: Sure.

3 CO-CHAIR ROSENZWEIG:

4 Nevertheless, I think it's -- I think that if
5 the focus really is suppose to be Type 1, and
6 you're not -- you don't want to have to
7 include Type 2 in this population -- excuse
8 me, Type 2, and you don't want to have to
9 include Type 1 in the population, then it
10 definitely should be part of the actual title
11 of this protocol.

12 DR. HWONG: Right, and I would say
13 even beyond the actual title, that if this is
14 truly the intent, and that's fine, you know,
15 if the measure developer wants to submit it to
16 be sort of Type 2 diabetes, but just as Brenda
17 has pointed out, there are a lot of other
18 types of criteria you can put in there, to
19 just try and be more stringent.

20 I understand that there is, you
21 know, some problems with this mis-coding, but
22 I think, you know, there are -- again, sort

1 of, if that really is the focus, I think you
2 could spend -- a measure developer could spend
3 a little bit more time to try and tighten that
4 up.

5 CO-CHAIR ROSENZWEIG: Exactly.

6 Now, the other issue is that they don't
7 include all of the various medications.

8 MS. PARKER: And I was actually
9 getting to that lower down. So, I think
10 that's a great point.

11 CO-CHAIR ROSENZWEIG: Now, I
12 suppose, for the purpose of -- now, there are
13 two issues.

14 For the purpose of actually
15 looking at cost, there is -- you need to
16 include all of them, but for the purpose of
17 looking for -- to -- for determining the
18 denominator, I understand why they wouldn't
19 put metformin in, as we --

20 MS. PARKER: Sure.

21 CO-CHAIR ROSENZWEIG: -- discussed
22 in previous protocols.

1 But they have left out a whole
2 number of other medications that are used for
3 treatment of Type 2 diabetes.

4 MS. PARKER: And I actually had
5 some of my bias from my previous work as, you
6 know, DPP4s, it's a new class, but it's a new
7 class that's being used a lot.

8 I mean, Januvia is being used
9 quite a bit. So, that's a great point, and I
10 actually have that listed more further down.

11 MS. CLARK: I just had a question.

12 CO-CHAIR ROSENZWEIG: In addition,
13 injectable non-insulin medications, like --

14 MS. PARKER: Yes, Byetta.

15 CO-CHAIR ROSENZWEIG: -- like
16 sitagliptin, yes, Byetta, Onglyza.

17 MS. PARKER: Yes, exactly.

18 CO-CHAIR ROSENZWEIG: Victoza,
19 excuse me.

20 MS. PARKER: Victoza, yes.

21 CO-CHAIR ROSENZWEIG: Yes.

22 MS. CLARK: I just had a question

1 about the criterion of a diagnosis of diabetes
2 within the first six months of the
3 identification year. What does that mean?

4 MS. PARKER: It was kind of odd,
5 that it was six months, but --

6 MS. CLARK: Yes.

7 MS. PARKER: -- maybe that's
8 again, due to the time frame of having enough
9 claims following the identification. I don't
10 know if anyone else can --

11 DR. HWONG: I think their mention
12 of the identification year is the year
13 previous -- prior to the measurement, if I'm
14 not mistaken.

15 MS. PARKER: Right, but why the
16 six months, rather than the full year?

17 MS. CLARK: Yes.

18 DR. HWONG: That is a good
19 question.

20 MS. PARKER: I mean, that may be -
21 -

22 MS. CLARK: I would have

1 identified patients in the measurement year
2 with diabetes, and then looked back to see --
3 if you're trying to identify a person that is
4 constantly managed, then you look back in the
5 previous year to identify somebody that, if
6 they had another claim, back then.

7 MS. PARKER: Well, then it may be
8 to rule out, kind of that new -- that new
9 diagnosis.

10 MS. CLARK: Well, that is what I'm
11 saying --

12 CO-CHAIR ROSENZWEIG: They're
13 trying to exclude newly diagnosed patients
14 with diabetes, because they're -- there are
15 a lot of additional costs that occur with
16 newly diagnosed patients, that don't occur in
17 -- subsequently.

18 MS. CLARK: It just seems like an
19 odd way to do it.

20 MS. PARKER: Does it make sense to
21 exclude them all together, or to stratify by
22 them?

1 I mean, to the point yesterday,
2 stratification is a measure used to separate
3 groups that have sort of the same outcomes,
4 but may be different based on that
5 stratification measure, which would be newly
6 diagnosed versus more of the management-based
7 --

8 DR. HWONG: Yes, I actually
9 thought that might be a good thing.

10 Like, when I sort of step back and
11 looked at this measure, and I think it's, you
12 know, again, about diabetes management, and I
13 understand, you're trying -- I understand,
14 measure developer, you know, is trying to sort
15 of create this very homogenous group, if
16 you're going to compare across providers, et
17 cetera, to this sort of like, you know,
18 ongoing management of diabetes.

19 So, but I -- you know, I sort of
20 think about all the individuals that are sort
21 of newly diagnosed, right, and I understand
22 that, you know, costs could be, you know,

1 potentially higher for these individuals, but
2 it's sort of like without a companion
3 resource-use measure about this group, I think
4 that in some ways, it's -- you know, I would
5 like to see that, right.

6 If I'm thinking about sort of
7 overall management or care of diabetics, you
8 know, I think that is sort of an important
9 group.

10 So, you know, since you're saying
11 -- I understand, they're trying to do this
12 sort of homogenous area, but like, you know,
13 something for consideration, I think it might
14 be -- it would have been interesting if they
15 could include those, you know, newly
16 diagnosed, and then, you know, stratify on
17 them.

18 But like I said, because I could
19 imagine down the road, you can have a whole
20 bunch of resource measures where you're
21 getting to sort of these narrower and
22 narrower, sort of specific --

1 MS. PARKER: Sure.

2 DR. HWONG: -- groups, and then
3 that sort of leaves, you know -- in terms of,
4 I think, what it's actually trying to tell
5 you, I think could be, you know, more limited.

6 DR. REEDER: Are the diagnostic
7 tests and the time involved in creating a new
8 diagnosis for a patient on diabetes, such that
9 there -- it's a long time span, or that the
10 costs are high enough that this particular
11 group, maybe by the developer, was considered
12 an outlier and rightly so excluded?

13 CO-CHAIR ROSENZWEIG: I think that
14 --

15 DR. REEDER: I don't know, I'm
16 asking.

17 CO-CHAIR ROSENZWEIG: I don't
18 recall reading specifically the rationale, but
19 -- in here. Brenda, I don't know, you may --

20 MS. PARKER: It has to do exactly
21 with what you stated. That's why I thought
22 you read it, because you quoted it perfectly.

1 CO-CHAIR ROSENZWEIG: Okay, fine.

2 MS. PARKER: High use of costs.

3 CO-CHAIR ROSENZWEIG: No, no, but
4 I mean, but I didn't think that -- they didn't
5 regard them as outliers, as much as sort of a
6 separate high cost item.

7 I don't think they thought of them
8 as totally outliers, because there are so many
9 of them, and diabetes diagnosis is so common.

10 So, I thought that they -- it was
11 like, they couldn't compare them with the rest
12 of the population, since they are really
13 trying to -- this is a chronic care measure,
14 okay.

15 CO-CHAIR CURTIS: Let me ask you
16 then, so, to the -- I mean, it sounds like
17 ideally, you would want to stratify it by new
18 onset of diabetes, but you're not going to be
19 able to have that.

20 So, if you look at these criteria,
21 as a simple cardiologist, I need you guys to
22 tell me, is the passing the sniff test? Is

1 this a reasonable set of decisions that
2 they've made to identify population with --

3 MS. PARKER: In the management
4 phase.

5 CO-CHAIR CURTIS: In the
6 management phase --

7 MS. PARKER: -- of diabetes.

8 CO-CHAIR CURTIS: -- of diabetes?

9 MS. PARKER: That is their intent.
10 I think they do that.

11 CO-CHAIR ROSENZWEIG: I think they
12 actually have thought this through, and I --
13 I don't disagree with them on -- at least,
14 with respect to this particular measure.

15 One would like to know about the
16 data on costs, on patients who are newly
17 diagnosed.

18 One thing I should clarify is that
19 newly diagnosed patients with Type 2 diabetes
20 are not the same as patients with new onset of
21 diabetes.

22 The average patient with diabetes

1 is diagnosed four to five years after the
2 onset of the disease.

3 So, there is a tremendous amount
4 of undiagnosed diabetes out there. So, I
5 would just -- I don't really object, myself,
6 to their rationale for excluding these people.

7 MS. PARKER: Great.

8 CO-CHAIR ROSENZWEIG: There is a
9 lot of diabetes education issues. There are
10 a lot of counseling issues. The frequency of
11 visits is much more frequent in the first six
12 months after diagnosis of diabetes for most
13 people.

14 MS. PARKER: So, just to
15 summarize, it sounds like the inclusion
16 criteria that they have proposed within the
17 document is appropriate.

18 CO-CHAIR ROSENZWEIG: Except for,
19 they've left out medications --

20 MS. PARKER: Well, they get to
21 medications, later. So, we'll --

22 CO-CHAIR CURTIS: No, but they

1 used specific inclusion medication.

2 CO-CHAIR ROSENZWEIG: There are
3 certain medications that could -- that should
4 be included for --

5 MS. PARKER: Oh, you're saying the
6 non-insulin injectables, perhaps, because they
7 just say one oral hypoglycemic or one insulin
8 --

9 CO-CHAIR ROSENZWEIG: Yes, I think
10 they may have left them out because they are
11 not usually first-line agents.

12 MS. PARKER: Sure.

13 CO-CHAIR ROSENZWEIG: They're
14 usually second- or third-line agents.

15 MS. PARKER: But it is the
16 maintenance phase of the --

17 CO-CHAIR ROSENZWEIG: But we're in
18 the maintenance phase, anyway.

19 MS. PARKER: -- for diabetes, so,
20 yes.

21 CO-CHAIR ROSENZWEIG: Yes.

22 MS. PARKER: So, that needs to be

1 clarified within the inclusions.

2 CO-CHAIR ROSENZWEIG: Right, yes.

3 MS. PARKER: Okay, perfect. So,
4 now, we go to the exclusion criteria.

5 No surprises here: PCOS,
6 gestational diabetes or steroid-induced
7 diabetes, cancer, ESRD, renal failure,
8 HIV/AIDS and organ transplant.

9 Now, on the flip side of the newly
10 diagnosed patients who have a lot of costs,
11 they've excluded kind of the other end of
12 patients with diabetes, as far as renal
13 failure, end stage renal disease, and my
14 recollection of diabetic nephropathy is that
15 it's -- diabetes is the leading cause of liver
16 failure, liver issues, in general.

17 And so, it's interesting that, as
18 you'll see later on, they include other
19 conditions that are kind of linked with the
20 microvascular conditions, retinopathy,
21 neuropathy, but they leave out nephropathy.

22 So, that was just kind of

1 something that stood out to me, and again, in
2 the context of yesterday's conversation,
3 where, you know, in diabetes, why was end
4 stage renal failure left out? Why was organ
5 transplant left out, when they have pancreas
6 and kidney transplant?

7 So, just opening that up to the
8 panel, to discuss, and I don't remember where
9 we landed yesterday, with kind of keeping
10 those out of the proposed -- I think it was
11 the NCQA measure.

12 So, it may help to know kind of
13 where we landed there to guide where we should
14 land here.

15 DR. HWONG: I think in general,
16 for that, it was really just about sort of the
17 high costs, in terms of the ESRD population --

18 MS. PARKER: Right.

19 DR. HWONG: -- in terms of those
20 cost outliers. I think what is interesting
21 here is that they also include this category
22 called renal failure.

1 MS. PARKER: Right.

2 DR. HWONG: So, you know, maybe,
3 you know, Brenda, you know, looking at this,
4 maybe the measure developer can answer, but
5 what -- how are you defining renal failure?

6 Like, what chronic disease stage
7 is included in that exclusion criteria?

8 MS. PARKER: And I don't know off
9 the top of my head. I don't know if they --
10 I don't know --

11 DR. HWONG: Yes, maybe it's been -
12 -

13 MS. PARKER: -- the codes well
14 enough, to know what the codes mean.

15 DR. HWONG: Sure, if the measure
16 developer maybe could help us out with that.

17 DR. WEISS: Yes, it's three
18 specific ICD9 codes. You know what? I'm
19 going to have to look them up to be able to
20 tell you exactly what they are.

21 DR. HWONG: Okay.

22 MS. PARKER: So, I think that is -

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DR. WEISS: It's 585.2, 585.3 and
585.4. I mean, I don't know if that helps
anybody, but I can get you a --

DR. WEINTRAUB: Those aren't
ICD9s.

DR. HWONG: Yes, 585 point what?

DR. WEISS: It's 585.2, 585.3 and
--

CO-CHAIR CURTIS: Five-eighty-
five-point-four is chronic kidney disease
stage four.

MS. PARKER: Okay, so, that makes
sense, as far as being on the more severe
spectrum.

CO-CHAIR CURTIS: But then why
wouldn't end stage diabetic retinopathy or
blindness be excluded?

MS. PARKER: And that was --

CO-CHAIR CURTIS: So, the ESRD, I
understand, and we accepted it --

DR. HWONG: Yes.

1 CO-CHAIR CURTIS: -- for the NCQA
2 measure, because it's such a high cost area.

3 This is more trying to homogenize
4 the clinical severity of diabetes with fairly
5 arbitrary thresholds.

6 MS. PARKER: Well, yes, and then -
7 -

8 DR. HWONG: Yes, this gets to --

9 MS. PARKER: -- kind of, somewhat
10 of a normal -- I mean, the very first stage of
11 CKD, I believe, from recollection, is -- I
12 mean, it's not a terribly low creatinine
13 clearance.

14 So, it's something that I would
15 assume would be relatively common, perhaps.

16 DR. HWONG: Right.

17 MS. PARKER: More so then it
18 warrants being excluded.

19 So, I think -- and that was my
20 concern again, not including nephropathy, when
21 neuropathy, retinopathy are included and
22 nephropathy would seem to be one of the most

1 important aspects of diabetes, and maybe
2 that's a stratification or sub-group or
3 something.

4 CO-CHAIR ROSENZWEIG: Well,
5 they're including nephropathy, they're just
6 not including the ESRD.

7 MS. PARKER: Well, they actually
8 don't mention diabetic nephropathy
9 specifically as they do -- and this is by
10 words only -- as they do in the identification
11 of related services, they mention diabetes,
12 poly-neuropathy, diabetic retinopathy and
13 diabetic cataract.

14 CO-CHAIR ROSENZWEIG: They don't
15 mention any aspects of -- where are you?

16 MS. PARKER: I'm sorry, I am on
17 page 11, the fourth paragraph from the bottom,
18 the first and second lines.

19 CO-CHAIR CURTIS: So, the
20 identification of diabetic related services?

21 MS. PARKER: Yes, exactly.

22 DR. HWONG: I sort of mentioned

1 this point before, and again, sort of it
2 causes -- you know, me to be a little bit
3 concerned, again, sort of adding this renal
4 failure category and sort of opens this
5 question about what other types of
6 complications would you want to add.

7 But you start to sort of whittle
8 down this population a bit, especially if one
9 of the codes, I think I just put in there, I
10 can be wrong, it's -- you know, I'm looking
11 ICD9 look up on the internet.

12 But if it's like CKD stage three,
13 as well, I mean, you're going to -- so, you're
14 sort of truncating this group and again, I
15 understand it's in the effort of being
16 homogenous and that's all good, I love things
17 that are comparable.

18 But I just -- you know, I sort of
19 wonder, in the end, so, you're taking away,
20 again, these newly diagnosed folks.

21 You're taking away, you know, on
22 the other end of the spectrum, you know, some

1 individuals, not only sort of extreme costs,
2 but also, you know, individuals with some
3 evidence, you know, of moderate chronic kidney
4 disease and it just starts to get -- starts to
5 feel like a much sort of smaller, narrower
6 group.

7 MS. PARKER: Sure.

8 CO-CHAIR ROSENZWEIG: Well, later
9 on, they do mention diabetes and renal
10 complications. I'm looking at page 12, which
11 is what, I guess, you were referring to.

12 CO-CHAIR CURTIS: I think we're
13 referring to the exclusion of these patients,
14 and it -- and 585.2 is mild.

15 So, you know, they are excluding
16 the gamut of patients with renal
17 insufficiency, at least as diagnosed by these
18 specific ICD9 codes, and I agree, it's sort of
19 -- you know, why not exclude heart failure
20 patients? You know, it's sort of --

21 CO-CHAIR ROSENZWEIG: Well, this
22 is -- CO-CHAIR CURTIS: How

1 homogenous does the population have to --

2 CO-CHAIR ROSENZWEIG: -- there is
3 end stage renal disease, and then they have
4 including dialysis, but where are they
5 excluding --

6 CO-CHAIR CURTIS: Well, it's --

7 CO-CHAIR ROSENZWEIG: Where are
8 they excluding --

9 MS. PARKER: Renal failure is
10 directly below end stage renal disease and --

11 DR. HWONG: On page 16.

12 MS. PARKER: -- and dialysis.

13 DR. HWONG: It's one of the
14 bulleted --

15 MS. PARKER: On page 11.

16 DR. HWONG: I'm sorry, I see it in
17 another area, too.

18 MS. PARKER: Yes, and I think from
19 my research experience, you know, renal
20 disease is an important -- I mean, we always
21 look at it in terms of the sub-groups and the
22 different classifications of CKD and that was

1 important.

2 It may be because my research was
3 sort of looking at that sub-group
4 individually, but it's always been something
5 important.

6 CO-CHAIR ROSENZWEIG: Yes, I would
7 say that chronic kidney disease certainly
8 shouldn't be excluded.

9 I think one of the issues that
10 does come up with end stage renal disease, and
11 dialysis is that those patients tend to go to
12 a different pool --

13 MS. PARKER: Sure.

14 CO-CHAIR ROSENZWEIG: -- insurance
15 pool. They end up in Medicare.

16 MS. PARKER: Right, right.

17 CO-CHAIR ROSENZWEIG: And so, they
18 are pulled out of the -- the costs are
19 actually pulled out of -- if this is designed
20 mostly, let's say, to apply to commercial
21 insurance, they're in a different category.

22 So, but I'm not justifying that,

1 necessarily, but the other basic issue is that
2 the two biggest cost drivers for diabetes are
3 chronic renal disease and -- but even -- and
4 cardiovascular disease.

5 So, we're not excluding
6 cardiovascular disease.

7 MS. PARKER: We don't. They
8 actually mention hypertension and
9 hyperlipidemia, as important areas within this
10 population to address.

11 CO-CHAIR CURTIS: I guess, we
12 would ask the developer, then, is to sort of
13 provide a more complete justification of this
14 decision as to what -- and specifically, you
15 know, I think it might affect kind of how our
16 take on the measure is, so it's fairly
17 important.

18 CO-CHAIR ROSENZWEIG: And later,
19 in their accounting of the costs, they do
20 include diabetes, renal-related codes.

21 So, if they're excluding them up
22 on top, why are they including them later on?

1 MS. PARKER: Yes, and my next
2 notes, actually, just confirming the accuracy,
3 consistency of the codes that they recommend.

4 MS. CLARK: Yes, I actually had a
5 question about all these exclusions, anyway,
6 because if you're risk-adjusting the costs
7 anyway using the HCC scoring, then do you need
8 to exclude them?

9 You know, they are already
10 addressed in the --

11 CO-CHAIR CURTIS: Well, I think
12 we've already sort of accepted the template of
13 the NCQA saying --

14 MS. CLARK: Yes, I know, I'm just
15 --

16 CO-CHAIR CURTIS: -- you know,
17 like saying these are reasonable high-cost
18 areas that can't be really adjusted for, on
19 the basis of the HCC's or other risk-
20 adjustment methodology.

21 So, I think where -- there needs
22 to be specific rationale, is to where they

1 diverge from that preset cohort, which may not
2 be complete, but at least explain why you're
3 adding onto that.

4 CO-CHAIR ROSENZWEIG: Yes, I mean,
5 if they want to exclude ESRD and dialysis,
6 that's one thing, but they cannot really
7 exclude the large proportion of these patients
8 that have microalbuminuria or pre-ESRD -- up
9 to pre-ESRD.

10 MS. PARKER: I agree, and just to
11 the earlier point of making sure that the list
12 of medications that are to be evaluated are
13 complete, and that's something that we have
14 identified as a deficiency within the
15 medications listed.

16 One question I did have for NQF
17 is, with all of these measures, how are they
18 updated when new medication classes or
19 products are -- or codes, even, I mean, how
20 are these kind of maintained to update?

21 CO-CHAIR CURTIS: Let me just --

22 DR. HWONG: Yes.

1 CO-CHAIR CURTIS: I think you
2 would -- that would fall under measure
3 maintenance in the three year reviews.

4 If, in the interim, however,
5 events occur, such as the release of a whole
6 new class or some other key thing, which
7 changed the measure definition, there are --
8 we can do it on a more frequent than three
9 year basis.

10 MS. PARKER: Okay, perfect.

11 MS. TURBYVILLE: Right, and we
12 actually just started a continuous annual
13 update process, as well --

14 MS. PARKER: Okay.

15 MS. TURBYVILLE: -- in addition to
16 the maintenance review.

17 MS. PARKER: Okay, sorry, I've had
18 that question all along. I just waited until
19 my turn to speak.

20 So, moving along, I won't belabor,
21 again, I just think that all of the codes need
22 to be confirmed to be accurate and consistent,

1 in the inclusion/exclusion and the codes they
2 have listed, and --

3 CO-CHAIR CURTIS: Did you feel
4 like any class of outcomes or costs were
5 missing, in this current data set, any, I
6 guess broad costs, is --

7 MS. PARKER: Nothing that jumped
8 out at me, but again, I don't manage patients
9 with diabetes often, so, there may be some
10 nuances that I did not capture, based on my
11 unfamiliarity of management of patients with
12 diabetes.

13 CO-CHAIR ROSENZWEIG: One thing
14 that came up, that is a high cost item is
15 bariatric surgery.

16 MS. PARKER: And is that in here
17 or not in here?

18 CO-CHAIR ROSENZWEIG: It's now
19 indicated -- it should -- it's not in there,
20 not that I could find.

21 MS. PARKER: Okay.

22 CO-CHAIR ROSENZWEIG: I don't -- I

1 checked the codes, to the best of my ability.

2 MS. PARKER: Okay.

3 CO-CHAIR ROSENZWEIG: But it is
4 now approved for use in patients with diabetes
5 and a lower obesity category, than those
6 without diabetes.

7 MS. PARKER: Okay, perfect, thank
8 you. One question I had, with regards to kind
9 of our concern with the medications, that was
10 kind of where I'm comfortable, in those
11 instances, is that hypertension,
12 hyperlipidemia are called out as being
13 important, in terms of identifying patients
14 with diabetes and their co-morbidities.
15 Nephropathy was not.

16 However, and you could argue that
17 this is in terms of hypertension, you know,
18 ACEs and ARBs are included, that prevents
19 nephropathy, but while neuropathy was called
20 out as an important -- and this is -- it gets
21 confusing, neuropathy was called out as
22 important, I don't really see any medications

1 that are specific to neuropathy.

2 There aren't that many that are
3 approved specifically for diabetic neuropathy.
4 There are some that are used off-label for it,
5 and are very effective, however, the one that
6 came to mind was Lyrica, I believe, is the
7 specific product drug that is approved for
8 diabetic neuropathy.

9 So, just kind of, again, a
10 disconnect between what we're saying is
11 important in the medications that were
12 indicated, that there seems to be kind of a
13 difference that jumped out at me.

14 I don't know if that is important
15 or it's just something that the --

16 MS. TURBYVILLE: Do you want to
17 ask the measure developer?

18 MS. PARKER: Sure, that's --

19 MS. TURBYVILLE: If that was
20 intentional.

21 MS. PARKER: Yes, measure
22 developer, was that intentional?

1 DR. WEISS: To exclude those,
2 right? Our expert panel, our clinical work
3 group, identified the medications that they
4 were interested in including, and those drugs
5 were not on their list.

6 So, there is not an intentional
7 exclusion. They didn't come out and say, "We
8 don't want to include these drugs." They did
9 not show up on our frequently used medication
10 list, that were not grouping to our episodes.

11 MS. PARKER: And perhaps in the
12 interest of time, this is just another
13 statement, or another scenario that
14 underscores the difficulties of identifying
15 diabetes related, rather than just taking all
16 of the resources, as was proposed in a
17 previous measure.

18 So, it's a casualty of the method
19 selected, perhaps.

20 CO-CHAIR ROSENZWEIG: There are a
21 whole variety of medications for, yes,
22 treatment of painful diabetic neuropathy, that

1 are not included here.

2 MS. PARKER: So, that just may be
3 a deficiency that the Steering Committee will
4 need to decide, if it's acceptable or that we
5 would ask that they go back and address, I
6 think.

7 CO-CHAIR CURTIS: But as the
8 expert reviewer here in this --

9 MS. PARKER: I think they need to
10 be --

11 CO-CHAIR CURTIS: -- do you think
12 it's a --

13 MS. PARKER: I think if they're
14 going to say, "These are the diabetes specific
15 medications," then you need to make sure that
16 you have every diabetes specific medication on
17 the list, in my opinion.

18 CO-CHAIR CURTIS: Or rationale for
19 the exclusion.

20 MS. PARKER: Exactly.

21 CO-CHAIR CURTIS: Okay.

22 CO-CHAIR ROSENZWEIG: And there

1 is, you know, at least one medication for
2 treatment of peripheral vascular disease.

3 MS. PARKER: Yes, and again, that
4 is diabetes related, so, I think that this
5 warrants a revisit.

6 Then lastly, and I know it seems
7 like it's hard to say lastly, within this
8 section, is the stratification.

9 So, this gets back to, you know,
10 are there sub-groups that should be stratified
11 or -- because there are no stratification
12 measures proposed, no stratification at all.

13 At the very least, with some of
14 the others, we've seen stratification based on
15 populations, disparities, you know, some sort
16 of stratification, and maybe this again --

17 DR. WEINTRAUB: You don't need to.

18 MS. PARKER: -- this goes back to
19 the need for perhaps, a clarifying definition
20 for stratification, because there seems to be
21 some confusion on is stratification something
22 that you do in the very beginning or

1 essentially, you have this full group and you
2 stratify on one variable that could impact
3 outcomes, or does stratification refer to the
4 sub-grouping afterwards, where you report the
5 information, based on different sub-groups
6 that have been identified?

7 DR. WEINTRAUB: Well, you know, I
8 think --

9 MS. PARKER: And it's used both
10 ways, unfortunately, in the public domain,
11 honestly.

12 DR. WEINTRAUB: Clarification of
13 why you would want to stratify is needed.

14 Again, the real reason for -- I
15 guess you could come up with two reasons for
16 stratify.

17 One reason would be that is
18 aesthetic. So, if you consider Type 1 and
19 Type 2 diabetes, you might not want to have
20 them together --

21 MS. PARKER: Exactly.

22 DR. WEINTRAUB: -- or ST segment

1 elevation or non-ST segment elevation, but
2 that is aesthetic.

3 The other reason is analytic, that
4 you -- in developing your model, you may want
5 to stick with main effect models, and not have
6 interactions, specific interactions are very
7 confusing to people.

8 MS. PARKER: Absolutely.

9 DR. WEINTRAUB: And so, if you
10 have interactions, you can still put them all
11 in one pot, and deal with it that way, and
12 mathematically, it will work out.

13 MS. PARKER: Right.

14 DR. WEINTRAUB: But you may choose
15 not to do that. Those are the only reasons
16 for stratify.

17 Looking at sub-groups, on the
18 other hand, is something that's perfectly fine
19 to do.

20 So, for instance, in dealing with
21 patients with diabetes, you may want to look
22 at the sub-group with peripheral vascular

1 disease, or look at the sub-group with heart
2 failure or what have you, or want to look at
3 them all together.

4 In all of these measures, this
5 kind of analytic approach, none of them -- in
6 none of the ones we've discussed here, has
7 this been laid out as a kind of analytic
8 strategy.

9 MS. PARKER: Right, I would agree.

10 CO-CHAIR CURTIS: But for the
11 specific measure, they're not specifying any -
12 -

13 MS. PARKER: They said nothing.

14 CO-CHAIR CURTIS: --
15 stratification necessary, based on the --
16 their efforts upstream, to make this --

17 MS. PARKER: Right.

18 CO-CHAIR CURTIS: -- a more
19 homogenous population.

20 MS. PARKER: Right.

21 CO-CHAIR CURTIS: Okay.

22 MS. PARKER: Which again, is my --

1 some of my confusion is just the intense case
2 they made for the disparities in race.

3 So, but again, I think we need to
4 clarify, because I think it's been confusing,
5 and this has come up, is the intent of the
6 question, stratification from an analytic
7 perspective, or is it a sub-group from
8 reporting.

9 CO-CHAIR CURTIS: Not to
10 interrupt, but I think what we've heard and I
11 think what we have to take back to the
12 Steering group level, and maybe even higher --

13 MS. PARKER: Sure.

14 CO-CHAIR CURTIS: -- within NQF
15 is, is it important to address --

16 MS. PARKER: Right.

17 CO-CHAIR CURTIS: -- disparities
18 within resource use --

19 MS. PARKER: Right.

20 CO-CHAIR CURTIS: -- and you could
21 see it as being part of something that
22 exacerbates disparities, but is it something

1 that you need to report separately? I'm not
2 sure.

3 I think it's more important for
4 process or outcomes measures, but we'll take
5 that up to the next level.

6 MS. PARKER: Yes, and not a deal
7 breaker, from my perspective. Again, I think
8 it's very ambiguous, as to what the definition
9 is and the intent is, and I think it would be
10 helpful, though, for measure developers in
11 general to kind of weigh in as to how they
12 think that this would be reported beyond some
13 broad provider summary category.

14 You know, is it -- and that would
15 demonstrate a true, I think, understanding of
16 the disease state, and that they did use kind
17 of key opinion leaders or experts in the
18 field, to understand how this would be
19 reported, or how the user may find it useful
20 to look at this, just beyond the peer group,
21 but maybe also within the disparities or the
22 sub-groups.

1 That's my opinion. I don't think
2 it makes or breaks this --

3 MS. CLARK: I like the idea that
4 the NCQA had, of providing information on
5 percent of patients or the number of
6 procedures along with the cost information.

7 So, you know, for example, if
8 you're going to create a report, looking at
9 the different cost categories, why not also
10 provide a report looking at the distribution
11 of patients within -- you know, within these
12 certain categories that you're talking about,
13 at least?

14 I mean, that might be helpful,
15 additional information.

16 CO-CHAIR ROSENZWEIG: It's 2a2 and
17 2b2, is that correct?

18 MS. PARKER: Yes, I believe so.

19 CO-CHAIR ROSENZWEIG: Okay.

20 CO-CHAIR CURTIS: And 2b1.

21 MS. PARKER: Did we want to let
22 the measure developer comment, or ask anyone

1 else for any questions, before we move on to
2 voting?

3 CO-CHAIR CURTIS: I propose we
4 just move to vote on these two. I think you
5 did a nice job of leading us through the
6 differences, and I think we have a good
7 understanding.

8 MS. PARKER: Okay, great.

9 CO-CHAIR ROSENZWEIG: Okay, so,
10 2b1 is the measure specifications are
11 consistent with -- MS. TURBYVILLE: Two-a1.

12 MS. PARKER: Two-a1.

13 CO-CHAIR ROSENZWEIG: I'm sorry.

14 MS. TURBYVILLE: That's okay.

15 CO-CHAIR ROSENZWEIG: Two-a1 is
16 the measure is well defined and precisely
17 specified, so it can be implemented
18 consistently within and across organizations
19 and allow for comparability.

20 MS. PARKER: Can we see the
21 comparison on the screen, of the --

22 MS. TURBYVILLE: Sure.

1 MS. PARKER: I know it's a
2 different disease stage, but within the
3 context of the disease stage.

4 MS. TURBYVILLE: So?

5 CO-CHAIR CURTIS: Do you want to
6 bring that up over -- what you recommend for
7 this?

8 MS. PARKER: Sure, I was actually
9 on the sense of moderate to low, just based on
10 what we've discussed previously, with regards
11 to the similarities.

12 But given the concerns within just
13 the clinical framework itself and the
14 construct of the measure, I would probably
15 vote low on this, at this time, because I
16 think there is some room for improvement.

17 CO-CHAIR CURTIS: So, maybe I'm --

18 MS. PARKER: No, go ahead.

19 CO-CHAIR CURTIS: I think low is a
20 specific threshold that sort of -- it's a --
21 well, it's a --

22 MS. PARKER: I can vote moderate.

1 CO-CHAIR CURTIS: It's a barrier
2 to moving forward and I mean, I just -- this
3 is my opinion.

4 MS. PARKER: Sure.

5 CO-CHAIR CURTIS: I feel like,
6 we've identified ways that they could improve
7 it or refine the measure.

8 MS. PARKER: Sure.

9 CO-CHAIR CURTIS: But I don't
10 think we've found anything that we could
11 characterize as a fatal flaw.

12 MS. PARKER: As a critical flaw,
13 sure.

14 CO-CHAIR CURTIS: Again, my
15 opinion, but --

16 MS. PARKER: And so -- go ahead.

17 DR. MARWICK: The chronic kidney
18 disease issue is a significant piece.

19 CO-CHAIR CURTIS: I think it's
20 significant, not ignorable, but I don't know
21 if it's --

22 MS. PARKER: But you think that

1 that's very easier --

2 CO-CHAIR CURTIS: That's fixable.

3 MS. PARKER: That is easily --

4 CO-CHAIR CURTIS: It's easily
5 fixable.

6 MS. PARKER: Okay.

7 CO-CHAIR CURTIS: Or they could
8 just clarify --

9 MS. PARKER: Sure, and that was
10 what I was thinking, was that the kidney issue
11 was a serious concern, but if it's -- if the
12 addressability of it means that we could vote
13 moderate, because it is something that's
14 easily fixed, then I think that's --

15 CO-CHAIR CURTIS: We could respond
16 to it and --

17 MS. PARKER: That's fair.

18 CO-CHAIR CURTIS: Yes.

19 MS. PARKER: That is a fair
20 assessment.

21 CO-CHAIR ROSENZWEIG: So, we're
22 not -- we're not really commenting on errors

1 in their definition? It's whether it can be
2 defined? Is that it? I'm a little confused
3 here, because --

4 MS. PARKER: Well, they haven't
5 defined it, really.

6 CO-CHAIR ROSENZWEIG: Really,
7 we've identified a whole variety of things
8 that --

9 CO-CHAIR CURTIS: I mean, I'm not
10 saying how we should -- how you should vote.
11 I just think --

12 CO-CHAIR ROSENZWEIG: Type 1
13 versus Type 2, those kinds of issues are --

14 MS. TURBYVILLE: That is validity,
15 I think. This is about -- so, just to -- this
16 is really about how precisely the
17 specification is written, and then you'll get
18 into whether or not they included the right
19 codes more and the validity and -- right, so -
20 -

21 MS. PARKER: But the specification
22 of diabetes is --

1 CO-CHAIR CURTIS: It's along the
2 sort of --

3 MS. PARKER: It's pretty broad.

4 MS. TURBYVILLE: Okay, okay.

5 CO-CHAIR CURTIS: We're including
6 that, as in part of the specifications.

7 MS. PARKER: Right.

8 CO-CHAIR CURTIS: It's like, not
9 just how well -- how precisely specified it
10 is, but how accurately that reflects the
11 population, the target population.

12 CO-CHAIR ROSENZWEIG: But we are -
13 -

14 CO-CHAIR CURTIS: So, we've
15 identified it --

16 CO-CHAIR ROSENZWEIG: We're
17 identifying the -- we were telling them to
18 change the title of this, the Type 2 diabetes.

19 MS. TURBYVILLE: Right, but you're
20 going to want to make sure that that comes up
21 again, then, in 2b1, which is about, is it
22 consistent with the evidence, and 2a2 is

1 really about how it's written and can it be
2 implemented consistently?

3 CO-CHAIR CURTIS: Okay.

4 MS. PARKER: Two-a1, you're saying
5 is implemented?

6 MS. TURBYVILLE: Yes, is it
7 written clearly enough, which I think you guys
8 have identified themes across measures, to be
9 implemented consistently, and 2b1 definitely
10 is the place where you're saying, you know,
11 we're talking about people with diabetes, some
12 are being carved out, some are -- you know,
13 all of the conversations that you have had.

14 MS. PARKER: And that makes sense
15 within the context of reliability, as we
16 discussed yesterday, that it has been tested
17 and it can do it, with its testing. So, that
18 makes sense, in the reliability, in looking at
19 it in the broad sense.

20 MS. TURBYVILLE: Not that it
21 doesn't influence.

22 MS. PARKER: Sure.

1 MS. TURBYVILLE: Clearly, what
2 you're looking and the precision, I completely
3 agree. I just want to make sure you also
4 think about that in 2b1.

5 MS. PARKER: Okay.

6 CO-CHAIR ROSENZWEIG: All right,
7 so, for 2a1, what is your recommendation?

8 MS. PARKER: After the very
9 thorough explanation by NQF, I think I would
10 still go with moderate, because I still think
11 that there is some room for improvement.

12 CO-CHAIR CURTIS: Let's go ahead
13 and vote.

14 CO-CHAIR ROSENZWEIG: Let's vote.
15 Six moderate and two low.

16 All right, then 2b1, is that
17 correct, is the next one?

18 MS. TURBYVILLE: Yes.

19 CO-CHAIR ROSENZWEIG: The measure
20 specifications are consistent with the
21 evidence presented, and support the focus of
22 measurement under criterion 1b, and the

1 measure is specified to capture the most
2 inclusive target population indicated by the
3 evidence, and exclusions are supported by the
4 evidence.

5 MS. PARKER: So, here, I think
6 it's more of the issue of distinguishing
7 between Type 1 and Type 2, as well as the
8 exclusion of renal failure.

9 I think those are our two major
10 issues. Can they be easily fixed? I don't
11 know, that would be something that the measure
12 developer would have to weigh in on, but at
13 this time, I think moderate to low is going
14 to, for me, go to low.

15 Again, that's not a judgment or an
16 indictment on anyone else, that they need to
17 do the same.

18 CO-CHAIR CURTIS: Okay, let's
19 vote. I'm becoming more like a surgeon.

20 CO-CHAIR ROSENZWEIG: All right,
21 two moderate and six low.

22 MS. PARKER: So, going back to

1 2a2, reliability, again, this gets at not if
2 what they necessarily have is right, but if
3 what they have currently was tested
4 sufficiently, to demonstrate repeatable
5 results, and they use the Market Scan
6 database, which is a large database, that has
7 lots of patients with diabetes.

8 So, they had a large population to
9 work with, and for me, I think that based on
10 the consistency of the results, that they were
11 -- that they presented in their -- even, you
12 know, removing some of the pieces and
13 modifying the measure some, produced
14 consistent results.

15 I was okay with this. I don't
16 know if within some of the other measures
17 we've looked at, their slides, if there would
18 be any need to go through those with the
19 panel, given that it's kind of the consistent
20 -- the same reports, the same slides, the same
21 data presented, just in the context of
22 diabetes.

1 Is there anything the measure
2 developer would care to add to the discussion?

3 DR. WEISS: The only additional
4 piece of information on testing is that we
5 also tested our diabetes measure in a large
6 data set in Wisconsin, that we have data --
7 have found that similar performance within
8 that data set as we feel was in the Market
9 Scan data.

10 MS. PARKER: That was in a
11 Wisconsin specific database? Was my reading
12 of that correct, that it's Wisconsin, which I
13 don't think is a largely populated state.

14 So, I would just -- I didn't think
15 that was as strong as -- and I could be wrong.
16 I'm not from Wisconsin, I don't claim to know
17 much about Wisconsin, other than Brett Favre.

18 So, you know, I'm definitely
19 limited. So, I didn't just see that as kind of
20 an overwhelmingly credible database. Maybe
21 it's just my lack of knowledge.

22 CO-CHAIR CURTIS: No, it's 3.4

1 residents, million residents, 207 million
2 claims against -- I mean, it's not ignorable.

3 DR. WEINTRAUB: That's not bad.

4 MS. PARKER: So, there are a lot
5 of cheeseheads, clearly.

6 DR. WEINTRAUB: This has been
7 tested in a good size program.

8 COURT REPORTER: Use your
9 microphone.

10 DR. WEINTRAUB: This has been
11 tested in several good size cohorts.

12 MS. PARKER: So, if there are no
13 further comments, we'll --

14 DR. WEINTRAUB: Well, so, they
15 haven't the --

16 MS. PARKER: Microphone.

17 DR. WEINTRAUB: Yes, they have the
18 same kind of problem with related/non-related
19 services that we've seen before.

20 If you go to slide eight, it will
21 -- you will see for, right at the top, routine
22 gynecological examine, they have related/non-

1 related services, routine medical exam,
2 related/non-related, chest pain, related/non-
3 related.

4 And I think that they have some
5 problems here, in making sense out of that,
6 same kind of thing that we saw before.

7 CO-CHAIR CURTIS: And I think
8 that's, you know, not that we're parking
9 lotting it, but that it's consistent with the
10 other ABMS --

11 MS. PARKER: Exactly.

12 CO-CHAIR CURTIS: -- or REF
13 measures that we've addressed.

14 But specifically, with regard to
15 2a2, results are repeatable. In fact, this is
16 actually the highest test, where they've
17 looked at kind of --

18 MS. PARKER: Yes, exactly.

19 CO-CHAIR CURTIS: -- looked at
20 comparable data sets.

21 MS. PARKER: Exactly.

22 CO-CHAIR CURTIS: Not having to

1 redefine the costs, based on --

2 MS. PARKER: And I looked at this,
3 after this morning's discussion, just to
4 confirm that yes, they didn't have to change
5 anything, but they also weren't using
6 necessarily different -- commercial and
7 Medicare populations are different.

8 So, it kind of makes sense that
9 they would to perhaps, change methodology. It
10 doesn't make it easy, but intuitively, I get
11 it.

12 Here, there really was no obvious
13 difference in the databases that would warrant
14 potential changing.

15 So, no, I think they did a great
16 job of testing the reliability of the measure.

17 DR. WEINTRAUB: Yes, so, the other
18 thing that makes that -- that will make this
19 work is the distribution is pretty reasonable,
20 if you go to slide 17.

21 MS. PARKER: Sure.

22 DR. WEINTRAUB: But drug charges

1 is,
2 by far and away, the number one cost.

3 But E&M, not a durable medical
4 equipment -- and I think the other medical
5 equipment was a little more of a problem, but
6 they're really not too bad.

7 CO-CHAIR ROSENZWEIG: Which slide
8 are you referring to?

9 DR. WEINTRAUB: Slide 17. The
10 other things we're very concerned about in
11 developing the measure was thinking about in-
12 patient facility charges, but the 99
13 percentile is still zero dollars. Not a lot
14 of -- not a lot of hospitalizations in these
15 folks.

16 MS. PARKER: And I believe that
17 that comment was made earlier, that this is
18 mainly an out-patient sort of disease, and
19 that that wouldn't be terribly high, although
20 requiring an in-patient -- no, an in-patient
21 wasn't required for this, my apologies.

22 CO-CHAIR ROSENZWEIG: No.

1 MS. PARKER: It was just, it could
2 be counted as one of the resource use
3 requirements.

4 So, I think we're okay, with 2 --

5 CO-CHAIR ROSENZWEIG: Actually,
6 I'm surprised that there was a zero in-patient
7 facility charge.

8 MS. PARKER: Well, the mean was --

9 CO-CHAIR ROSENZWEIG: Somebody was
10 --

11 MS. PARKER: -- terribly low.

12 CO-CHAIR CURTIS: Well, it doesn't
13 say no, but it means that --

14 MS. PARKER: The mean is \$215, so,
15 you don't have to --

16 DR. WEINTRAUB: This is 95 percent
17 comparable, so the --

18 MS. PARKER: And this normally
19 rounds down and up.

20 DR. WEINTRAUB: That means it's
21 still a couple -- a couple of percent of the
22 people that are hospitalized, and that is not

1 unreasonable.

2 CO-CHAIR CURTIS: But it would be
3 nice if we could see the range on that, to see
4 if that improves, or what percent were
5 actually hospitalized, might be useful
6 feedback.

7 MS. PARKER: Well, and that might
8 be, again, back to the point earlier, by
9 looking at frequencies, as well as costs, and
10 how NCQA did it, as well. So --

11 CO-CHAIR ROSENZWEIG: So, this is
12 very different from the Medicare population?

13 MS. PARKER: Absolutely.

14 CO-CHAIR ROSENZWEIG: Where the
15 big cost drivers are actually
16 hospitalizations.

17 MS. PARKER: Okay, so, do we vote
18 now on 2a2, or do we go to 2b2 and vote on
19 those, together?

20 CO-CHAIR CURTIS: Let's keep
21 going.

22 MS. PARKER: Keep going, okay,

1 great. So, 2b2, I think this validity gets
2 back to 2b1, and the concerns that we have
3 there, with it being that the data elements
4 are -- there are some significant room for
5 improvement with the clarification of the data
6 elements with 2b2.

7 CO-CHAIR CURTIS: But what about -
8 - so, if you look at 17, to me, at least,
9 there is some face validity to that, as to
10 that they are clinically meaningful and
11 important differences in cost?

12 MS. PARKER: And granted, I
13 actually rated that as moderate, because of
14 the concerns that I had within the data
15 elements being correct. But yes, it does seem
16 to be valid.

17 CO-CHAIR CURTIS: Okay.

18 MS. PARKER: Any other comments or
19 questions?

20 Okay, 2b3, exclusions are
21 supported by clinical evidence, measure
22 specifications for scoring include computing

1 exclusions, so that the effect on the measure
2 is transparent, and patient preference.

3 I don't think that that
4 necessarily applies here. So, if -- and I'll
5 kind of walk everyone through that, if --
6 quickly, if that's desirable.

7 But essentially, I just noted that
8 they have not sufficiently -- I mean, they've
9 tested it in the cohorts, in the databases
10 that they have, but there were still some
11 concerns with the exclusion criteria of renal
12 disease and that being impactful.

13 So, I still ranked that as
14 moderate, being that they could improve that,
15 and based on the previous discussion that
16 improving the criteria would be a relatively
17 easy thing that they should address.

18 And then 2b4, if there are no
19 questions, moving along here, risk adjustment
20 method.

21 It seems to be that the risk
22 adjustment methodology is widely accepted

1 among all the measures, no difference here in
2 my opinion, and getting back to the
3 stratification issue, I think that's still
4 something that has been put in the parking
5 lot, as something that will be addressed, as
6 to if this is really important.

7 So, here, I would rank this still
8 as moderate. Oh, actually, I think it would
9 probably change that to high, given that we
10 have agreed on HCC, and with the caveat that
11 the stratification issues are still something
12 to be determined by the Steering Committee.

13 DR. WEINTRAUB: So, we have some
14 kinds of modeling issues here, that we don't
15 see in our -- unless I'm missing it, we don't
16 see that R-squared here, not only that, they
17 could the R-squared in the validation
18 population, which would really be nice, and
19 they don't have calibration here.

20 MS. PARKER: And that's something
21 that they've been requested to provide, is
22 that correct?

1 DR. WEINTRAUB: Yes.

2 MS. TURBYVILLE: For all the
3 measures.

4 DR. WEINTRAUB: For all the
5 measures.

6 MS. PARKER: For all the measures,
7 okay.

8 DR. WEINTRAUB: But here, I'm
9 going to say that they can do a -- they've got
10 the second cohort, so, they can do proper
11 validation of the models --

12 MS. PARKER: Sure.

13 DR. WEINTRAUB: -- to be -- step
14 up, yes.

15 DR. MARWICK: Once they're familiar
16 with the risk adjustment process -- is heart
17 failure a part of that, do you know?

18 MS. PARKER: I'm not sure if it is
19 included.

20 CO-CHAIR CURTIS: Yes, it is.

21 DR. MARWICK: It is?

22 CO-CHAIR CURTIS: It's one of the

1 HCCs.

2 MS. PARKER: Okay. Okay, 2b5,
3 here, I interpreted this a little differently
4 than I think most people have, in that I
5 looked at the type of score you're using, as
6 well as the interpretation of the score, and
7 it looks like, you know, based on what I've
8 read is that the score they're using is
9 actually the observed to expected ratio, which
10 has been accepted with all of the other
11 measures, that have been proposed.

12 So, in my opinion, I thought that,
13 you know, based on the consensus of the panel
14 of previous measures, that it was an
15 acceptable way to identify these, and it did
16 provide a meaningful comparison among the
17 groups, that they have provided in their data,
18 whether it's region, provider, state, et
19 cetera.

20 So, unless I missed something
21 significant, I thought that was completely
22 appropriate and that they did valid that and

1 make sure that that does provide meaningful
2 information.

3 CO-CHAIR ROSENZWEIG: Any
4 comments? Okay.

5 MS. PARKER: Two-b6 doesn't really
6 apply, and 2c, I think here, it is going to be
7 a similar vote, as to the other proposed
8 measures by the measure developer.

9 CO-CHAIR CURTIS: Right, so, we'll
10 take that up to the Steering Committee.

11 MS. PARKER: Exactly.

12 CO-CHAIR CURTIS: And vote on it,
13 yes.

14 CO-CHAIR ROSENZWEIG: Okay, let's
15 do the voting on these measures, on these
16 components. I guess we start with 2b2?

17 MS. PARKER: Two-a2.

18 CO-CHAIR ROSENZWEIG: Two-a2, I'm
19 sorry, I keep on forgetting.

20 MS. TURBYVILLE: Two-a2.

21 CO-CHAIR ROSENZWEIG: All right,
22 so, 2a2 is reliability testing demonstrates

1 the results were reproducible, producing the
2 same results in a high proportion of time,
3 when assessed in the same population, in the
4 same time period, and that the measure score
5 is precise.

6 MS. PARKER: Yes, and they did
7 demonstrate that it is reliable, the way that
8 it is, using the two databases.

9 CO-CHAIR ROSENZWEIG: Yes.

10 MS. PARKER: So, I voted high for
11 that one.

12 CO-CHAIR ROSENZWEIG: Especially
13 if you live in Wisconsin.

14 MS. PARKER: That's right.

15 CO-CHAIR ROSENZWEIG: Okay, now,
16 2b?

17 MS. TURBYVILLE: Two.

18 CO-CHAIR ROSENZWEIG: Okay,
19 validity testing demonstrates that the measure
20 data elements are correct and the measure
21 score correctly reflects the costs of care for
22 resources provided, adequately distinguishing

1 higher and lower cost resource use.

2 MS. PARKER: So, in their results,
3 they did show that it was valid, the way that
4 it was tested, but there are some existing
5 concerns with some of the data elements in the
6 definitions and inclusion and exclusion.

7 So, based on that, I would rank it
8 as moderate.

9 DR. WEINTRAUB: Now, you know, we
10 don't see a formal calibration.

11 MS. PARKER: Right.

12 CO-CHAIR ROSENZWEIG: All right,
13 so, they're all moderate, okay.

14 Okay, 2b3, that's where we are on
15 the next one?

16 MS. TURBYVILLE: Yes.

17 CO-CHAIR ROSENZWEIG: Exclusions
18 supported by the clinical evidence, otherwise,
19 they are supported by evidence that sufficient
20 frequency of occurrence of the results are
21 distorted with the exclusion.

22 MS. PARKER: I think the exclusion

1 criteria makes sense, for the most part, based
2 on the latter part of that, and that they have
3 some of the other ESRD's, high cost.

4 However, the inclusion of renal
5 failure as an exclusion criteria did raise
6 some concern with the panel.

7 So, I will still vote them -- or
8 rank this as moderate, noting that there is
9 room for improvement.

10 CO-CHAIR ROSENZWEIG: One high and
11 seven moderate.

12 DR. HWONG: That's me, I'm sorry,
13 I miscounted. Could I hear it back?

14 MS. TURBYVILLE: I agree.

15 CO-CHAIR ROSENZWEIG: Sorry, which
16 one?

17 DR. HWONG: I forget which one I
18 was, by accident.

19 MS. TURBYVILLE: Okay, you guys
20 ready? Go ahead.

21 DR. HWONG: Sorry about that.

22 CO-CHAIR ROSENZWEIG: That's

1 interesting. Brenda, I was going to say that
2 you were doing as well as Kim Jong-il, but I
3 don't think so.

4 All right, okay, so, we're up to
5 2b?

6 MS. TURBYVILLE: Five.

7 MS. PARKER: Four.

8 CO-CHAIR ROSENZWEIG: Four? Four,
9 the risk adjustment strategy, 2b4.

10 Evidence based risk adjustment
11 strategy is specified and is based on patient
12 clinical factors that influence the measured
13 outcome, but not factors related to
14 disparities in care.

15 MS. PARKER: And so, again, just
16 to reiterate, kind of our general consensus on
17 the HCC being an accepted risk stratification,
18 or adjustment method, I think this would be
19 high, except for the fact that I still have
20 some concerns with stratification and not
21 understanding it completely, and I understand
22 it will be parking lotted.

1 So, I still think based on what
2 comes from the Steering Committee on that,
3 there may be room for improvement. So, I
4 would go with moderate, on this one.

5 So, there were three high and five
6 moderate, and we will go to 2b5.

7 CO-CHAIR ROSENZWEIG: Yes, and
8 this is the data analysis demonstrates that
9 the scoring and the method -- the measure
10 allows for identification of statistically
11 significant and practically significant
12 meaningful differences in performance.

13 MS. PARKER: And similar, and in
14 my opinion, again, at least to 2b4, the OE
15 ratio and its interpretation has seemed to be
16 fairly accepted by the panel, and as presented
17 in other measures, as it is here.

18 So, I personally ranked this as
19 high, given its consistency with the other
20 measure developers.

21 DR. WEINTRAUB: But they haven't
22 done this.

1 MS. PARKER: They did. They
2 provide the ratio and they provide the --

3 DR. WEINTRAUB: No, but the --

4 MS. PARKER: They do in the --

5 DR. WEINTRAUB: Say they do it.
6 Say they do it, and then it comes --

7 MS. PARKER: No, if they look at -
8 -

9 DR. WEINTRAUB: But do they
10 actually --

11 MS. PARKER: If you look in the
12 slides, maybe -- and this would be great,
13 because if I'm misunderstanding it, then that
14 would obviously impact my interpretation, as
15 well as my ranking.

16 However, if you look in -- let me
17 get there, and measure developer, if I'm mis-
18 representing you one way or the other, please
19 let me know.

20 CO-CHAIR CURTIS: Slide 36 of the
21 PDF.

22 MS. PARKER: Thank you. So, it

1 actually starts on 34, with -- they present
2 their ratio, as they've calculated, by region,
3 by state, by specialty, as they've done in all
4 of the previous measures, and I thought that
5 was meaningful, in looking at those values.

6 CO-CHAIR ROSENZWEIG: But wouldn't
7 the issue of the fact that they're measuring
8 at the provider level --

9 MS. PARKER: Well, we said earlier
10 that that would --

11 CO-CHAIR ROSENZWEIG: -- and
12 statistically significant issues, related to
13 that part of this measure --

14 MS. PARKER: So, that was -- yes,
15 that was something that NQF said that they
16 would kind of look at, as making a blanket
17 measure, as far as the interpretability and
18 applicability of these, in the absence of
19 statistical power.

20 Also, I believe that we recommend
21 that perhaps, valid sample sizes could be
22 calculated in the three year period, where

1 this is in use, and there is enough data to
2 obtain that.

3 So, based on what we have here, I
4 still think that the values are -- the way
5 that it's scored, and the interpretation of
6 the score, is meaningful, and it's something
7 that's easily understood by most.

8 CO-CHAIR CURTIS: Also, just
9 looking at this does make me a little bit more
10 concerned about the peer group evaluations and
11 the accuracy of the assessment of specialty,
12 if they're -- you know, I don't know what the
13 ratio of endocrinologist, internal medicine
14 and family practice doctors is, but 5,000
15 seems low, and then if you have 5,000
16 endocrinologists and 3,000 cardiologists being
17 captured by this measure, you do wonder if
18 it's more of an issue than I had initially
19 expected.

20 MS. PARKER: Well, and I think
21 that still goes to kind of the sub-group and
22 the -- not necessarily the score itself, but

1 as it is reported.

2 CO-CHAIR CURTIS: Yes.

3 MS. PARKER: So, I still rank this
4 as high, because I think it makes complete
5 sense.

6 CO-CHAIR CURTIS: No, they just
7 raised that other issue.

8 MS. PARKER: Exactly.

9 CO-CHAIR ROSENZWEIG: Okay.

10 CO-CHAIR CURTIS: We're waiting
11 for one response.

12 MS. TURBYVILLE: One more.

13 DR. WEINTRAUB: Everyone, hit your
14 button six times.

15 MS. TURBYVILLE: There you go.

16 MS. PARKER: So, there were six
17 high and two moderate, and I believe, correct
18 me if I'm wrong, that the remaining measures,
19 2b6, 2c, all usability and feasibility fall
20 along the same lines as before, is that
21 correct, or am I --

22 CO-CHAIR CURTIS: I think we

1 should -- MS. TURBYVILLE: Yes.

2 CO-CHAIR CURTIS: -- yes, take the
3 same approach as we took for the other.

4 MS. PARKER: Okay.

5 CO-CHAIR CURTIS: Either not
6 applicable or we'll formalize the vote at the
7 future date.

8 MS. PARKER: Okay, perfect, thank
9 you.

10 CO-CHAIR ROSENZWEIG: Okay, thank
11 you very much, Brenda.

12 MS. PARKER: Thank you.

13 MS. TURBYVILLE: Now, can we just
14 get a statement from the TAP, about usability
15 and feasibility for this measure, just so that
16 we have it for --

17 CO-CHAIR CURTIS: So, just to
18 formally state it, we would expect that, like
19 the other ABMS area measures, that it's not
20 been formally tested for usability, and we
21 would likely have similar scores, but we'll
22 formalize that in the future, similarly for

1 feasibility.

2 So, we have 11:45 a.m. So, I'm
3 not sure if --

4 MS. TURBYVILLE: Yes, so, we'll
5 open it up to public comment, now.

6 Operator, if you could open the
7 line for any public input or questions at this
8 time, we would really appreciate it.

9 OPERATOR: Certainly, that is *1,
10 if you have a question or comment.

11 DR. LEE: This is Todd Lee. Can I
12 make one comment that I think is relevant for
13 all of our measures, that I've sort of learned
14 through this process, over the last day and a
15 half, while we're waiting for public comment,
16 that I think we failed to do a good job
17 communicating in our measure specifications.

18 The actual overall intent is to be
19 able to provide actionable information with
20 our measures and that's the reason that we
21 focus on conditions that set the resource use.

22 So, that once you will provide, or

1 once a provider received a report that said
2 maybe they're high or low on an O to E ratio,
3 it would be able to go and use the data to
4 find out why, and that's sort of the reports
5 that under-ly the episode report at the O to
6 E ratio for the position.

7 And so, we'd be able to certainly
8 look, there is a lot -- we've got a lot of
9 hospitalizations, so, you've got a lot of high
10 cost medication use, or alternatively, if
11 you're a low cost provider, then you're
12 partnering that with a quality measure.

13 Now, this is -- you know, you
14 compared our diabetes measure a lot to NCQA,
15 and our group is completely different. Our
16 measure is intended to say, "Look, here is the
17 topic of diabetes," and what can you change
18 possibly, if you're a high cost provider?

19 And I just think we did a good job
20 -- or did a poor job, of communicating that to
21 the panel, and I just wanted to be sure that
22 we said that, as you consider our next couple

1 of measures.

2 CO-CHAIR CURTIS: I think that is
3 fair. I mean, I do feel like we discussed
4 that, certainly, and some of the previous
5 measures have -- this is trying to be more
6 actionable.

7 I think the concern has always
8 been, you know, the specificity of the outcome
9 and how complete it is.

10 So, but your point is well taken
11 and acknowledged.

12 Are there any public comments?

13 OPERATOR: No, public comment at
14 this time.

15 CO-CHAIR CURTIS: Okay, so, we're
16 at a little bit of a crossroads. We have
17 slightly less than four hours, before 3:30
18 p.m.

19 I'm not sure if people have to
20 catch planes, or not, but we would like to
21 respect that deadline, and we have at least
22 two Ingenix measures that we would like to go

1 through, in that time frame.

2 So, what I would propose is sort
3 of a natural break, but early lunch, and keep
4 it as a very short lunch, and hope to be back
5 by slightly after noon, 12:10 p.m., to get
6 restarted, and that should give us a solid,
7 almost three and a half hours to get through
8 the two Ingenix measures.

9 (Whereupon, the above-entitled
10 matter went off the record at 11:09 a.m. and
11 resumed at 12:09 p.m.)

12 CO-CHAIR CURTIS: So, in the
13 interest of maximizing our time together, is -
14 - why don't we go ahead and get started on the
15 Ingenix measure, on diabetes, that Jamie is
16 going to take us through? Do you have the
17 measure number?

18 CO-CHAIR ROSENZWEIG: Sure, this
19 is measure number 1595, and the title of the
20 measure is ETG-based diabetes resource use
21 measure, and the measure steward is Ingenix,
22 or how do you pronounce it? Is it Ingenix?

1 DR. LYNN: Ingenix.

2 CO-CHAIR ROSENZWEIG: Ingenix,
3 okay, and the measure developer is here, and
4 so, could you give us an introduction to the
5 measure set?

6 DR. LYNN: Sure. Again, this is a
7 measure that's been extracted from an
8 application that tries to group all claims to
9 episodes of disease.

10 Our approach with diabetes is to
11 create year long episodes of diabetes, by
12 gathering claims to the episode of diabetes,
13 and then using comorbidities and what we call
14 condition status factors for diagnostic
15 information that's part of the diabetes
16 episode itself, to do a -- create a severity
17 score for that diabetes.

18 The measure then goes on, like all
19 of our measures do, to use the severity of the
20 diabetes to create expected values for our
21 metrics that are all part of the measurement.

22 CO-CHAIR ROSENZWEIG: Okay, thank

1 you very much. Okay, yes?

2 DR. REEDER: I'm not familiar with
3 Ingenix. Could you give me a time line? How
4 long has this been going on? How rich are
5 your data?

6 DR. LYNN: Ingenix is a -- has
7 been around for 15 or 20 years. The product
8 ETG is -- was originally a product of a
9 company called Symmetry, which was purchased
10 by Ingenix, maybe six years ago, and the
11 product has been around for you know, 15
12 years.

13 DR. REEDER: Thank you.

14 DR. LYNN: That is the episode,
15 the ETG product has been. You know, some of
16 these other products that use it for these
17 sorts of measurements are more recent.

18 CO-CHAIR ROSENZWEIG: And yet,
19 Ingenix is a subsidiary of United Healthcare,
20 is that correct?

21 DR. LYNN: United Healthcare is
22 our sister. Our parent company is United

1 Healthcare, yes.

2 CO-CHAIR ROSENZWEIG: Yes, okay.

3 Okay, so, this particular measure basically,
4 to start out, is -- it focuses on the
5 resources that deliver episodes of care with
6 patients with diabetes, and they use a
7 specific methodology that was developed by
8 Ingenix, that's called the ETG methodology,
9 episode treatment groups, and I'll get into
10 how this is described, and I will probably ask
11 our developer for more details, in
12 relationship to this.

13 But largely, it's a grouping
14 methodology that takes groups of visits and
15 based upon an anchor visit, essentially
16 creates an episode of care, and this is
17 actually -- the applicability of this to
18 diabetes is -- will be very interesting,
19 because diabetes is such a chronic disease.

20 It actually is a mirror -- the
21 review of this is, in a sense, a mirror of the
22 previous Ingenix protocol that we started

1 reviewing, where there was clearly an event
2 related problem, and this is quite the
3 opposite.

4 This is a diabetes, which is a
5 chronic disease, which involves lots of
6 ongoing care, but they're able, through their
7 methodology, to create episodes, distinct
8 episodes of care for which they then are able
9 to look at costs related to those episodes of
10 care.

11 DR. HWONG: Jamie, one quick
12 thing.

13 CO-CHAIR ROSENZWEIG: Yes.

14 DR. HWONG: And maybe also, with
15 the measure developer here.

16 So, my -- in sort of reading this,
17 in terms of the episode of care, because
18 diabetes is, you know, classified as a chronic
19 condition, it essentially is just one episode
20 for the entire year, is that correct, or am I
21 mis-interpreting that?

22 DR. LYNN: That is exactly

1 correct. We often use multiple years of data,
2 of course, and then we create one long episode
3 of diabetes, then go back and divide it into
4 year long segments.

5 DR. HWONG: So, that sort of makes
6 it conceptually a little bit easier to handle,
7 right, that we don't --

8 CO-CHAIR ROSENZWEIG: Exactly.

9 DR. HWONG: -- have to worry
10 about, you know, sort of these discreet
11 episodes. It essentially becomes like a one-
12 year, you know, service, you know, accounting
13 of services.

14 CO-CHAIR ROSENZWEIG: Yes, in my
15 review of this, it appeared to me that that
16 one long year period was going to account for
17 the majority of, certainly, the vast majority
18 of the actual episodes.

19 But it didn't -- it wasn't clear
20 that it would account for all of them. There
21 seemed to be certain situations that might
22 arise, where an episode of care could be

1 shorter than a year.

2 DR. LYNN: Right, so, what can
3 happen, of course, the grouper itself can be
4 configured in a number of ways.

5 But for the purposes of this
6 project, it was configured in a way, so that
7 all of the years end on the anniversary date
8 of the end of the member's eligibility date.

9 You can -- depending on certain
10 situations, you can configure it different
11 ways, but that's how we configured it for the
12 purposes of this project.

13 What that means is that the
14 benefit is that your complete years tend to be
15 at the end of your reporting period.

16 However, somebody could have, say,
17 joined in June of one year, and then went
18 through the end of the next, the following
19 year. So, the last year would be a complete
20 episode, but the year prior to that would be
21 what we would call an incomplete episode
22 because the member was only eligible for six

1 months.

2 And so, in this particular
3 analysis, we have different folks that treat
4 that different ways, and some people try to
5 create -- try to basically, use that
6 incomplete episode, but in this particular
7 analysis, we did not do that. We only
8 included complete year long episodes.

9 CO-CHAIR ROSENZWEIG: Okay, that
10 clarifies it, actually. So, with respect to
11 the first IM1, the summary of the evidence for
12 high impact, this, I think, actually is
13 summarized reasonably well, indicating that
14 diabetes is an important disease, as I would
15 certainly think so.

16 It involves a lot of patients, and
17 they actually, also, do some analysis of their
18 benchmark data from their own organization of
19 about seven-million individuals, non and
20 elderly, so that the diabetes represented 4.5
21 percent of the total population, of their
22 group.

1 But that's largely because they
2 were non-elderly. If you include the elderly,
3 it will go up to like nine percent.

4 And they were able to look at,
5 actually, the total cost per member per month,
6 for these individuals was actually by most
7 criteria, looking at other populations of
8 people with diabetes was quite low, and that
9 is largely probably because of the younger age
10 of these patients, I would assume.

11 If you look at the average cost
12 for patients with diabetes nationwide, it's
13 much higher, either that, or just Ingenix is
14 doing a good job, in keeping the costs down.

15 DR. LYNN: Let me make a comment
16 about that, actually, because -- well, I just
17 want to -- this is not just Ingenix data, by
18 the way.

19 CO-CHAIR ROSENZWEIG: Okay.

20 DR. LYNN: This is not just United
21 Health Group data.

22 CO-CHAIR ROSENZWEIG: Okay, so,

1 it's not just your own clients. It's a much
2 larger database that you're looking at.

3 DR. LYNN: Right, so, Ingenix, it
4 basically has a deal with all of the clients
5 of ETG, that for decreased contracted rate,
6 they share our -- their data with us.

7 So, it's all of our clients' data,
8 not just United Health Group.

9 CO-CHAIR ROSENZWEIG: Okay, and
10 they actually give some data, as well, on the
11 number of prescriptions, costs per --
12 specialty visits, and various other
13 encounters, as well.

14 So, I thought this was pretty well
15 presented, okay.

16 The next section is opportunity
17 for improvement. This particular section
18 largely talks about the fact that there is
19 fairly significant variability -- well,
20 actually, no. No, that's the next section.

21 So, this basically is a fairly
22 short section that indicates that obviously,

1 that there are lots of costs associated with
2 diabetes, and that includes the ability to
3 lower costs.

4 But actually, doesn't give much
5 specific rationale for it, but indicates that
6 this kind of methodology might be able to help
7 with that.

8 Okay, and then the next section
9 that describes the summary of the data,
10 showing variation across providers.

11 Now, in this particular section,
12 they are largely looking at variation by
13 geographic areas, and indicating that certain
14 areas have much more resources available, and
15 that there seems to be a correlation, at least
16 with respect to care that -- areas where there
17 are more resources available tend to have more
18 costs, more resource utilization, which has
19 been demonstrated in a number of disease
20 states.

21 I wasn't aware that this was -- I
22 don't know if this is specific to diabetes or

1 not, at least in their discussion here,
2 entirely. It's mostly chronically ill,
3 patients who have chronic illness, in general.

4 DR. HWONG: Right, I think the
5 only one, in terms of the references. So, I
6 agree, it's like very broad.

7 I think there was one, in terms of
8 the ambulatory care sensitive conditions,
9 where one of the highlighted, at least in the
10 blurb, one of the highlighted conditions is
11 sort of looking at poorly controlled diabetes,
12 and sort of the utilization rates of like
13 hospitalization and ER afterwards.

14 So, I thought that was probably
15 the only one that was very specific to
16 diabetes, at least from, again, the quick
17 review of the blurbs, I can't say, you know,
18 if you dove deeper into some of these other
19 ones, they break out diabetes or not.

20 CO-CHAIR ROSENZWEIG: Okay, so,
21 but it largely discusses it in comparison to
22 specific -- into geographic areas and into

1 areas where -- they are saying that certain
2 geographic areas have high resources and
3 others have low.

4 I would have liked to have seen a
5 little more of a discussion of other issues,
6 related to types of providers, issues related
7 to variation -- on other issues than
8 geographic.

9 But I thought it was reasonably
10 well presented, as well, okay, and then they
11 include citations for the variety of data, on
12 their variation, and once again, using their
13 ETG based condition, they come up with an
14 observed to expected ratio of their costs per
15 episode.

16 Do you want to comment on that, at
17 all?

18 DR. LYNN: Well, I mean,
19 eventually, the measure will look at other
20 metrics besides costs and utilization metrics,
21 as well, ER visits, hospital days, I think.

22 CO-CHAIR ROSENZWEIG: Okay, and

1 then there is a summary of the discussion of
2 disparities by population group, and this
3 particular area also discusses efforts to
4 improve healthcare delivery in various areas.

5 It doesn't really specifically
6 discuss underserved populations or socio-
7 economic issues. It is mostly looking at
8 areas where expenditures are higher versus
9 other areas related to overuse, misuse and
10 waste.

11 So, the focus, I thought, was very
12 much related to that, rather than other
13 issues.

14 MS. PARKER: Yes.

15 CO-CHAIR ROSENZWEIG: That I
16 thought could have been included.

17 MS. PARKER: Right, I think in
18 this section, they kind of fall short, and
19 they acknowledge that there are disparities,
20 but they don't really go into what those
21 disparities look like.

22 It's kind of a more general

1 discussion on yes, they exist and they exist
2 here, but they don't go into it.

3 So, I think again, it could be
4 improved, to support the need for the measure.

5 CO-CHAIR ROSENZWEIG: But the
6 focus a little more then, on the -- in the
7 other ones, as it related to efforts to try to
8 eliminate waste, duplication of services,
9 things of that sort, which is perfectly
10 reasonable, it's just a little different in
11 its focus than some of the other proposals
12 that we've had.

13 Then, the measure rationale for
14 analyzing variation, basically, they say that
15 they want to reduce unwarranted variation and
16 eliminate unnecessary services, but they don't
17 really -- and but they don't really describe
18 how the measure relates to this, as much as
19 sort of the use of robust -- as they say, a
20 robust approach, including medical homes,
21 value based payment and accountable care
22 organizations.

1 So, they see this as a foundation
2 for the use of those kinds of approaches.

3 So, it's not very specific, at
4 least, with respect to the rationale for
5 analyzing the variation, at least from my
6 point of view.

7 DR. HWONG: Jamie, I had the
8 impression, again, not so much about like
9 diabetes, per se, but sort of the two things
10 is, you know, allowing, you know -- having
11 this sort of assessment, to allow sort of
12 this, you know, classification of efficiency
13 of, you know, providers and sort of that
14 second blurb down there, I felt like it was
15 interesting, here, is -- you know, Ingenix, in
16 terms of this ETG grouper methodology, you
17 know, it says that you can use the output on
18 individual providers, roll that up.

19 And you know, so, this is one of
20 the things that it's not like it's for a
21 health plan. It's for provider group. It's
22 for an individual physician. It's sort of

1 saying that it actually should be able to
2 serve you well, in all of these
3 categorizations, from individual, up to
4 provider group, up to full delivery systems,
5 you know, in particular, I think there is this
6 focus on ACOs and you know, how that may be
7 more relevant moving forward, right, in terms
8 of having these types of statistics for those
9 groups.

10 So, you know, I thought that was
11 interesting, a little different --

12 CO-CHAIR ROSENZWEIG: Yes.

13 DR. HWONG: -- you know, the
14 intent of the measure.

15 CO-CHAIR ROSENZWEIG: Yes, we get
16 into that a little bit later -- go ahead.

17 CO-CHAIR CURTIS: Yes, I was going
18 to say, but I think this is where I picked
19 this up on the AMI measure, is that would
20 measure developer one have to consider this
21 from one or two of these perspectives, or do
22 you want to get us to consider it across the

1 broader spectrum?

2 And I think it's relevant because
3 the sensitivities at the physician level may
4 be different than they are at the payer level
5 or ACO level.

6 CO-CHAIR ROSENZWEIG: They're
7 currently in use to evaluate providers,
8 provider groups, and health plans, as well,
9 all three. Is that correct?

10 DR. LYNN: That is correct,
11 employers, although, at the level of
12 providers, it's you know, aggregated with
13 other diseases, not just diabetes.

14 CO-CHAIR ROSENZWEIG: Okay, and
15 then the next section, the resource use
16 categories, I did review the additional table,
17 and it looked like that, in fact, it was a
18 pretty comprehensive list of a whole variety
19 of different categories that they included.
20 It's a very robust huge list, in fact of
21 various categories that they use for
22 evaluation of the criteria, and it certainly

1 looked adequate to me.

2 I didn't know what all the numbers
3 were, frankly. I mean, they don't -- you
4 don't categorize them by ICD9 codes. You have
5 your own map codes, for all these various
6 services.

7 DR. LYNN: Yes, this is --

8 CO-CHAIR ROSENZWEIG: That are
9 different from ones -- the ones that we
10 normally use, but they're very, very
11 extensive.

12 DR. LYNN: Yes, it's a roll-up of
13 procedure codes.

14 CO-CHAIR ROSENZWEIG: Yes. Okay,
15 so, do you want to stop here and vote on
16 those, this whole group of measures?

17 So, with respect to the first one,
18 the importance of the measure, summary of
19 evidence of high impact, I basically -- that
20 is 1a, I don't know if we have to read what
21 that means, after doing this over and over
22 again.

1 But I gave this a high score. I
2 thought this was reasonably well presented.

3 (Off mic comment.)

4 CO-CHAIR ROSENZWEIG: You'll never
5 forgive me for that. At least some people
6 have selective memory.

7 Okay, all right, so, everyone --
8 okay, I'm glad that we have agreement on that
9 one.

10 Now, with respect to the benefits
11 envisioned by the use of the measure and the
12 opportunity for improvement, I thought their
13 case was a little bit skewed towards dealing
14 with issues related to duplication of
15 services, unnecessary services in regions and
16 making too much medical care available.

17 And I guess because of that, and
18 because it didn't consider all of those other
19 issues, I gave it a moderate score. But I
20 think it was adequate, let's put it that way.

21 Okay, three high and five
22 moderate, okay.

1 Now, the demonstration -- the data
2 -- the next one is --

3 MS. TURBYVILLE: One-C.

4 CO-CHAIR ROSENZWEIG: -- 1c, which
5 is --

6 MS. TURBYVILLE: Measure
7 objective.

8 CO-CHAIR ROSENZWEIG: Okay, yes,
9 the measure -- the construct -- the objective
10 is -- and the construct for resource use costs
11 are clearly described.

12 I didn't think they were that
13 clearly described in this particular. It was
14 kind of a fairly brief description. So, the
15 purpose, I guess, is described reasonably
16 well.

17 So, I have given it a low reading,
18 but the purpose is described in a fairly short
19 manner, so, I probably -- I think I'd probably
20 move that up from low, to moderate, frankly,
21 from my recommendations, with respect to this
22 particular section, after thinking about it a

1 little bit more.

2 Okay, so, three high and two --
3 and five moderate, okay, and then, I did
4 believe that they were -- they had a really
5 quite extensive and complete -- with respect
6 to 1d, the objective and resource use and
7 construct for resource use are clearly
8 described.

9 I thought they actually did a good
10 job, of summarizing that. I gave them high
11 marks on that one.

12 Okay, good, all right, eight high.
13 Now, we'll move onto the scientific
14 acceptability, yes, scientific acceptability
15 of the measure properties, the extent to which
16 the measure produces consistent, reliable,
17 credible valid results.

18 Basically, they described their
19 methodology, with respect to the foundational
20 of the episodes of care. It's a different
21 methodology that we've encountered, with
22 respect to the other protocols.

1 We actually had a meeting about a
2 year or so ago, that I attended, that was
3 sponsored by NQF on the whole -- how to define
4 the diabetes episode of care. It was actually
5 an interesting issue, because it's so
6 difficult to be able to come to agree to a
7 common, sort of -- how to interpret the
8 episode of care because of the nature of how
9 diabetes is cared for in the fact that care of
10 patients with diabetes is so shared among
11 multiple providers.

12 So, it seems that although they
13 use the episodes of care methodology, they're
14 largely really talking about a time based,
15 from what you're telling us, a year long -- in
16 a sense, even though the methodology is
17 different, you're coming, basically, to the
18 analysis of a year long grouping of diabetes
19 related costs, much like the other protocols
20 that we've encountered. Is that correct?

21 DR. LYNN: Yes, that is correct.

22 CO-CHAIR ROSENZWEIG: Yes, okay.

1 CO-CHAIR CURTIS: Just so, I think
2 -- just had to clear my head.

3 So, for the vast, vast majority of
4 patients, the episode is a year. There could
5 be instances where it would be slightly less
6 than a year or is it 100 percent at a year?

7 DR. LYNN: You could have episodes
8 that are less than a year, but for the
9 purposes of the measures that are at the end,
10 those get eliminated.

11 CO-CHAIR CURTIS: Got it, thank
12 you.

13 DR. PALESTRANT: Can I just ask a
14 question about the general methodology?

15 MS. TURBYVILLE: Is that David?

16 DR. PALESTRANT: Yes, it is.
17 David Palestrant.

18 MS. TURBYVILLE: Go ahead, please.

19 DR. PALESTRANT: Yes, the issue I
20 allude to the other measures, but and they're
21 all exactly the same, with respect to the
22 verbiage, and let's say, very impressively

1 written. It could almost be a textbook, in
2 terms of the different issues that come up.

3 The question I have is, this
4 specific methodology, has it been validated
5 externally, in the literature? It seems like
6 it's proprietary, but my question is, I guess,
7 has this been scrutinized outside of the
8 company?

9 DR. LYNN: Not really sent the
10 methodology outside of the company to be
11 validated, per se.

12 The methodology is made available
13 for folks in academia, to use for various
14 studies, some of which are around the episode
15 grouper, itself.

16 So, the short answer is, probably
17 no, but it had -- it's obviously, used by a
18 lot of entities external to Ingenix, some of
19 which are academic.

20 DR. PALESTRANT: So, some of the
21 experts in the panel in this area -- can you
22 comment on this methodology, or do you have a

1 comment on the -- at the end, about what you
2 think?

3 DR. HWONG: So, when I was looking
4 a little bit at sort of trying to understand,
5 because it's a fairly complex system, right,
6 this ETG methodology?

7 CO-CHAIR ROSENZWEIG: Yes.

8 DR. HWONG: You know, just looking
9 around, getting some background information,
10 but I want to say, CMS, there is, you know, I
11 have this article, but CMS, in 2008, you know,
12 did an extensive study on ETG's versus MEG's,
13 two proprietary systems, in terms of, you
14 know, evaluating kind of like the differences.

15 And it turns out, I mean, you
16 know, the article is totally not particularly
17 relevant to this, but you know, in terms of
18 like, there are sort of just subtle
19 differences.

20 So, in the sense of, just to
21 answer that question, I think, you know, this
22 problem has been around for a long time, and

1 there have been, you know, public entities
2 that have, you know, evaluated that for their
3 purposes and compared it to other existing,
4 you know, grouper of methodologies.

5 So, I think there is some level of
6 familiarity, you know, with that in the
7 external space.

8 CO-CHAIR ROSENZWEIG: You turned
9 me off?

10 CO-CHAIR CURTIS: I think it's
11 easier to hear the phone, when the microphones
12 are off. I think if we adjust the volume and -
13 -

14 CO-CHAIR ROSENZWEIG: Okay, I see,
15 I have a sensor next door to me, okay, all
16 right.

17 Okay, all right, so, they
18 basically take a fairly wide range of data,
19 including, you know, basically, a claim on --
20 claims, they use diagnosis and NDC codes,
21 HCPC's, ICD9, CPT -- I don't even know what
22 NUBC revenue codes are, I'll have to be

1 honest.

2 DR. LYNN: Those are the hospital
3 codes that -- the line items.

4 CO-CHAIR ROSENZWEIG: Okay, and
5 even non-standard other local codes are taken
6 in and are cross-walked, and actually, added
7 to valid comparable codes.

8 And they look at a wide variety,
9 including in-patient facility, out-patient
10 facility, pharmacy benefits and a variety of
11 other things.

12 They are fairly -- and they list a
13 whole -- a number of them on page 12, okay.

14 They're fairly comprehensive, in
15 terms of all of these features, but they're
16 also fairly -- the data inclusion is fairly --
17 I mean, they're basically, fairly specific for
18 diabetes related, in a more narrow sense than
19 certainly, was given to us for the NCQA and
20 even -- and also, it's more narrow than what
21 was given to us for the ABMS.

22 They're more focused on clearly,

1 treatment of diabetes related -- treatment of
2 diabetes itself, as opposed to all of its
3 complications, am I correct in that?

4 DR. LYNN: Yes, that's correct.
5 Again, you know, this is an extraction from a
6 methodology that groups into many different
7 diseases and conditions, and you know, our
8 philosophy is always -- has, for the most
9 part, has been, you know, you can put things
10 together, but it's hard for folks using the
11 product, to take them apart.

12 So, we do look at diabetes in a
13 narrow way, and you know, we have folks that
14 use it in a broader way, and then include
15 multiple episodes related to diabetes to do
16 that.

17 But then we have other folks that
18 would say, "You know, well, I don't want to
19 include diabetic retinopathy in there, because
20 I want to be able to pull that out, and look
21 at how my ophthalmologists are handling that
22 separately."

1 DR. HWONG: You know, I got the
2 sense in -- I'm sorry, I got the sense in my
3 review, you know now, that we've seen sort of
4 the three different measure developers, right,
5 you know, NCQA, clearly, the broadest.

6 You find the diabetics and you
7 throw all the -- the claims associated, or
8 services associated with the diabetic patient.

9 The ABMS versions are -- they get
10 down to be very specific, I felt like, in
11 terms of, here are the meds, here are the, you
12 know, E&M visits, that are associated, you
13 know, with this diagnosis code, et cetera.

14 The Ingenix system, as far as I
15 could tell, it felt like it was in between,
16 for me, in the sense that, they have specific
17 codes that have to be sort of the -- for the
18 anchor or the primary diagnosis, but in terms
19 of the actual episode of what claims get
20 counted, in terms of the cost, you can
21 actually start to associate a lot of things
22 that, you know, wouldn't -- weren't

1 necessarily included on the ABMS, you know,
2 criteria, in terms of being specific.

3 So, you know, probably this may
4 come up a little bit later, if we looked at
5 the data dictionary and some of the clinical
6 logic, but there is some services in there,
7 like, I don't know, like anesthesia, you know,
8 and there is some kind of like, somewhat
9 little bit random kind of stuff, that
10 sometimes kind of gets captured in there, for
11 better or for worse.

12 I mean, somewhere -- I'm saying it
13 is somewhere in between. Clearly, we've
14 looked at, you know, again, methodology that
15 takes all claims, and then we look at things
16 that are very sort of clinician picked and
17 very focused on ABMS.

18 I kind of felt like this sort of
19 fell somewhere in between.

20 CO-CHAIR ROSENZWEIG: Well, the
21 range of the curves was broad, but it seemed
22 like all of them had to be related to a

1 diabetes episode.

2 CO-CHAIR CURTIS: But that's my
3 question, and that's where it becomes a black
4 box, here, is that if you go through the
5 spreadsheets, which are extensive, of whether
6 or not a particular claim was -- the strength
7 of association, I can't remember, I'm going to
8 get the nomenclature wrong.

9 But that seemed potentially,
10 completely arbitrary, and that is supported,
11 in a sense, by the noise that you identified,
12 Connie.

13 And so, that is the validation
14 that I actually want, right, that's why I have
15 a hard time evaluating the quality of this
16 measure, without knowing and feeling confident
17 that this was something that made clinical
18 sense, and because there were so many
19 episodes, where it couldn't make clinical
20 sense to a group that -- with diabetes, or it
21 just didn't make -- I couldn't figure out the
22 clinical sensibility to it. That troubled me,

1 and that is true for all of the measures.

2 I think probably something we
3 should take back to the Steering Committee, or
4 I would propose, is that the Ingenix measures
5 are, as you pointed out, very hard to
6 disentangle and look at in isolation, and it's
7 almost like you need an entirely different
8 approach to look at Ingenix, and sort of the
9 ETG grouper methodology, and evaluate it as a
10 whole, as opposed to piece by piece, because
11 I think we're going to run up against this
12 same thing in all the measures.

13 DR. PALESTRANT: I just wanted to
14 second what you said. I think that falls from
15 these categories, which are chronic, so, one
16 of the other ones I reviewed was coronary
17 arteries, which I guess, the ongoing disease
18 and could be episodic and also be chronic.

19 There are so many different areas
20 where this would fit into and how to you make
21 sure that this is, you know, that you're --
22 you need to be -- it was hard to get specific

1 on how that code is actually captured and
2 defined, how that -- but what is the criteria,
3 for actually measuring? What are the actual
4 things that you're trying to measure?

5 CO-CHAIR ROSENZWEIG: Yes, I would
6 agree with those previous two comments, and I
7 was going to get to that a little bit later,
8 with respect to the black box issue of this.

9 But with respect to the -- they
10 have this section on missing data. There were
11 some parts of this that I really just didn't
12 understand.

13 When they said missing pharmacies
14 data for some members and populations,
15 pharmacy data can be missing, generally, due
16 to different factors, including not having a
17 pharmacy benefit with the entity collecting
18 the data used for measurement or pharmacy
19 services being managed by a pharmacy benefits
20 manager for the measurement entity.

21 Where pharmacy data are not
22 generally available for a member, adjustments

1 are required to ensure valid comparisons.
2 What are these adjustments? I mean, I just
3 didn't -- you know, and the next section, it
4 said that in fact, the methodology didn't
5 require pharmacy data at all, but somehow,
6 there would be adjustments that would be
7 thrown in there.

8 I just didn't understand, how that
9 would work.

10 DR. LYNN: Yes, we're moving
11 beyond the ETG, but it's definitely part of
12 its measurement, which is, you know, how do
13 you deal with a group of members, where some
14 of them have pharmacy data and some of them
15 don't?

16 And we've looked at a lot of
17 approaches on this, but what we've come down
18 to is basically, when you -- once you've
19 grouped the data and you start to create the
20 O to E ratios, the critical part in the
21 denominator is, you know, what is the expected
22 value and how is that sort of stratified?

1 And so, what we've done is, we've
2 added to that stratification, whether the
3 member had pharmacy benefits during that time
4 or not, and then that drives the expected
5 value, obviously, drives the expected value
6 down, when they don't have pharmacy benefits
7 and increases it when they do.

8 So, that is that approach that
9 this measure has taken, to be able to combine
10 folks that have pharmacy data with folks that
11 do not.

12 CO-CHAIR ROSENZWEIG: But the
13 devil, to a certain extent, is in the details,
14 as to how -- you know, how that -- you know,
15 how you compensate for that.

16 DR. LYNN: Well, I'd be happy to
17 discuss the details.

18 You know, so, let's take a
19 stratification of diabetes around how it might
20 be done.

21 So, you might -- it's not -- it
22 might not be how it's done in here.

1 You take a member, all of the
2 cases around a peer group, that have diabetes,
3 a peer group of providers or groups, or you
4 can do it in a larger setting, and the -- the
5 stratification would be, you go into that peer
6 group and look at all of the episodes of
7 diabetes, and they're basically eight
8 stratifications, the four severity levels, and
9 each one, whether or not they had a pharmacy
10 benefit or not.

11 And therefore, you create the
12 expected values, based on those eight buckets,
13 and use those expected values, so, when you
14 have a member -- when you have -- and I'm just
15 using three, not that we would ever use three,
16 but just sort of to be simple.

17 You had a member that -- a
18 diabetes episode that was severity one with
19 pharmacy benefit of the diabetes member --
20 episode, severity one without, and diabetes
21 episode that was severity level two and had a
22 pharmacy benefit, and then you calculate --

1 use the -- in the denominator, use the
2 expected value from the appropriate strata,
3 and that is how we account for that.

4 CO-CHAIR ROSENZWEIG: Okay, and
5 then there is a fairly lengthy discussion in
6 the protocol, under the clinical framework,
7 which discusses how these ETG's are created,
8 based upon anchor visits, anchor records, or -
9 - and then episodes that are created from the
10 anchor records, and then non-anchor records
11 that are then grouped together to the
12 episodes.

13 And then the co-morbidities and
14 complicated factors are added, subsequent to
15 that, or treatment of those issues are added,
16 subsequent to that.

17 To a certain extent, this is moot
18 because with respect to at least this diabetes
19 protocol, you're really considering all
20 episodes -- I mean, all events of care within
21 a specific year. Am I correct, in assuming
22 that?

1 DR. LYNN: Your assumption is
2 right. I don't understand what part is moot,
3 because of that.

4 CO-CHAIR CURTIS: Well, I think
5 from my read, it was like, if you have an
6 episode that's six months long, and comparing
7 that to the resource use of a year long
8 episode, would make comparisons difficult.

9 So, in that sense, it's easier or
10 more intuitive to understand, since they are
11 all at least one year, or they are all one
12 year.

13 CO-CHAIR ROSENZWEIG: Yes, yes,
14 that is what I was trying to get at, yes.

15 DR. LYNN: Yes, that is correct.

16 CO-CHAIR ROSENZWEIG: I mean, I
17 still think, yes, you know, you may be able to
18 stratify or be able to analyze the costs,
19 based upon what goes to the anchor and what
20 goes to the others separately, but to a
21 certain extent, the total costs are all lumped
22 together, as a part of this whole process.

1 Okay, and then there was about --
2 the issue of finalizing the episodes. What
3 does that exactly mean? I just had a question
4 about that.

5 It says, "Finalizing an episode of
6 diabetes involves determining whether or not
7 the episode is complete, assigning co-
8 morbidity and conditions status factors and
9 calculating a severity score and an associated
10 severity level."

11 So, how are the severity scores
12 and severity levels determined?

13 DR. LYNN: So, for each episode of
14 diabetes, there are a number of markers that
15 occur during the year long episode.

16 CO-CHAIR ROSENZWEIG: Yes.

17 DR. LYNN: There are co-morbidity
18 markers. These are, in the case of ETG, these
19 are episodes that occur outside of the
20 diabetes, that have an indirect effect on the
21 cost of the diabetes.

22 And then we have what we call

1 condition status factors, which are -- and
2 these are all by the way, diagnostically
3 driven, factors inside of diabetes that
4 directly affect the cost of diabetes, because
5 these are claims that are actually grouping to
6 the episode.

7 And each one of those, we've taken
8 these markers and we have, you know, put them
9 in a -- a linear regression model, to look at
10 the direct effects -- I'm sorry, the effect of
11 the markers, as well as the effect of
12 interactions of the markers, and as well as
13 the demographic information.

14 And so, all the grouper really has
15 to do -- once that difficult modeling is done,
16 the grouper is just going to a table and
17 saying, this marker adds this much severity to
18 the episode, and adds up all of those scores,
19 to create a severity score for the episode of
20 diabetes itself.

21 Finally, we put episodes that have
22 similar -- that have severity levels that are

1 similar into buckets, called severity levels.

2 So, we take that real number that
3 goes from zero to five or six, or something
4 like that and we divide it into buckets of
5 four severity levels, one, two, three, four
6 where low is the highest -- low is the -- low
7 is definitely not the highest.

8 One is the lowest, and four is the
9 highest, and then, that's how we create our
10 sort of statistical unit right along with,
11 whether you have pharmacy or not, to figure
12 out what the expected value is inside that
13 level.

14 CO-CHAIR ROSENZWEIG: Your basis
15 for your severity scores are all based upon
16 cost data, that you've accumulated?

17 DR. LYNN: Yes, that is a great
18 question. You wouldn't be surprised,
19 probably, to hear that if we have another
20 insurance company that we get data from, that
21 they don't give us the cost. They give us
22 everything else, but not the cost.

1 So, we have a standard priced
2 methodology -- this is for the actual modeling
3 purposes, with a standard price process that
4 goes through and standard prices all of the
5 claims, and then uses the standard price cost
6 as the dependent variable in the model, that
7 is exactly right.

8 But because it is standard priced,
9 the dependent variable is actually -- is more
10 like resource utilization than cost, because
11 the contracted rate has been taken out.

12 CO-CHAIR ROSENZWEIG: Okay.

13 DR. HWONG: Jamie, I wonder if we
14 can go back, you know, in terms of the black
15 box comment that you brought up earlier, and
16 the same with Jephtha, in term of the -- again,
17 I want to sort maybe get a little bit more
18 clarity, in terms of the types of claims that
19 get ultimately put into this one year long
20 episode, right.

21 So, I think it makes a lot of
22 sense, in terms of the primary, you know, the

1 primary anchor dates, no problem. You have a
2 very highly specific list of codes for
3 diabetes. You look at it and say, "That is
4 diabetes. That is good."

5 The problem, or the concern, I
6 mean, it's not necessarily a problem, but you
7 know, is when you get to those incidental
8 diagnoses codes, right, which can,
9 essentially, they're ranked or not ranked,
10 they're tagged as being specific, non-specific
11 sign or symptom, right.

12 And so, if it's specific, right,
13 to diabetes, it can get pulled in, it can get
14 pulled into the overall evaluation of the cost
15 of that episode.

16 So, this is the list. Again,
17 primary diagnosis codes, no problem. That
18 looks fine. This one has just some really
19 funny things, in terms of the specific --
20 like, what you consider specific, and I'm just
21 reading about that point. You can --

22 DR. LYNN: Yes, yes --

1 DR. HWONG: Yes, okay, maybe you
2 can just --

3 DR. LYNN: Yes, because you were
4 going down a little bit of wrong path.

5 DR. HWONG: Okay, good, yes.

6 DR. LYNN: So, the specificity is
7 a description -- is a description of the
8 diagnosis code, not the relationship between
9 the diagnosis code and the episode.

10 DR. HWONG: Okay.

11 DR. LYNN: The primary and
12 incidental is the relationship, and incidental
13 can have a rank associated with it.

14 DR. HWONG: Okay.

15 DR. LYNN: But the specific is
16 basically -- it's like -- it's describing the
17 diagnosis codes.

18 So, you're basically saying, this
19 diagnosis code seems to describe a specific
20 disease, not necessarily diabetes, okay.

21 DR. HWONG: Okay.

22 DR. LYNN: And that a non-specific

1 is just trying to get a specific -- trying to
2 get at describing disease, but it's non-
3 specific, in other words, it could describe a
4 number of diseases, and these are usually what
5 they call mis-codes, right, the three and four
6 digit codes.

7 DR. HWONG: Okay.

8 DR. LYNN: And then we have the
9 signs and symptoms, that don't describe
10 specific diseases.

11 So, then it's the relationship
12 between that code and diabetes that's
13 incidental, which means it doesn't have as
14 much power to join the episode, as a primary
15 diagnosis code.

16 But the diagnosis code itself has
17 a higher priority because it's specific, as
18 opposed to non-specific sign and symptom.

19 DR. HWONG: Okay, so, I guess, you
20 know, and I think this conversation sort of
21 highlights it, it is a little it's -- so, it's
22 a little challenging to kind of wrap one's

1 brain, kind of around that, right.

2 I get the sort of, the primary
3 diagnosis codes and I guess sort of, you're
4 saying sort of specific/non-specific is
5 different than primary versus incidental, like
6 you know, they're sort of slightly different
7 concepts there.

8 So, if you could explain, like, in
9 terms of -- you know, I understand, you've got
10 an anchor, right, you've got an anchor that
11 comes in, primary diagnosis code, looks good,
12 it's diabetes, whatever procedure gets counted
13 in there.

14 What else gets put into that
15 episode, then?

16 DR. LYNN: Then once that episode
17 is started, then other primary diagnoses can
18 join that episode, and there is a higher
19 priority there.

20 Incidental diagnosis codes can
21 join that episode, and the -- and again, this
22 is where we're -- you know, we have a little

1 trouble, because we're sort of showing you how
2 diabetes works, but it works in context with
3 other diseases, in that these claims have to
4 compete with other episodes that it could
5 potentially start or join.

6 And so, we're sort of casting a
7 wide net, from the incidental standpoint, and
8 from the procedure standpoint, in order to try
9 to drive -- because there is a competition
10 going on, and you know, even if it's eligible
11 to go to diabetes, it might not, and in some
12 cases, probably will not, because there are
13 other episodes that are competing.

14 DR. HWONG: Got you, so, when I
15 look at this incidental diagnosis code list,
16 this concept here is that, you know, it will
17 be viewed in the full context of how many
18 other primary diagnoses or ETG's or episodes
19 are being -- you know, ETG's, separate ETG's
20 are being opened, and you know, that code may
21 go to the diabetes episode, or it may not,
22 right.

1 So, and that's fine. That's just
2 the system. It's just, you know, we're
3 evaluating it, when I'm looking at it, when I
4 saw it on the spreadsheet, you know, it was
5 like, oh, is that specific/non-specific to
6 this group?

7 You're just saying that this is
8 this general bucket of, you know, services
9 that generate cost, that in the end -- and so,
10 this is where it was the little black box, but
11 in the end, where it's kind of all weighed
12 out, some will go to the diabetes episode,
13 others will not.

14 DR. LYNN: That is correct, and
15 that is why there is, you know, an extensive
16 discussion of the tie breaking logic in this
17 document, and I -- believe me, I know, I
18 understand how that, you know, is difficult to
19 sort of wade through.

20 But we tried to put it in there
21 and -- DR. HWONG: It's not a
22 bad thing, just it is a challenge, that's all.

1 CO-CHAIR ROSENZWEIG: So, with
2 respect to your risk -- your severity of --
3 your severity score, your severity scoring
4 system that you've developed, is it -- is the
5 methodology for that available, to others, or
6 is it proprietary for Ingenix?

7 DR. LYNN: Sorry, I don't mean to
8 turn my mic on at the same time.

9 You know, it's proprietary. We've
10 obviously shared it here, in great detail,
11 greater detail than we -- I really don't know,
12 to the extent that we sort of share it.

13 But it is proprietary. It was
14 developed by us. You know, we haven't always
15 shared the actual weights on the different
16 markers.

17 We've always shared the markers,
18 but we've only shared the weights, in certain
19 circumstances.

20 CO-CHAIR ROSENZWEIG: Okay.

21 DR. MARWICK: Can I ask a specific
22 question?

1 CO-CHAIR ROSENZWEIG: Sure.

2 DR. MARWICK: I'm still not sure I
3 have my head around this.

4 Say I have a patient who is
5 admitted to the hospital with diabetes and
6 heart failure. That patient might end up
7 going to the heart failure ETG, presumably.

8 If I have a patient who has a
9 background history of heart failure, but
10 presents with a diabetic problem, so that
11 their primary problem is diabetes, I take from
12 what you are saying that they will probably
13 end up in the diabetes bucket.

14 But then they may not be terribly
15 different entities.

16 DR. LYNN: That is true. You
17 know, there is no question that when you have
18 -- you know, the hospital admission is a
19 little bit different because the hospital
20 admission, when you look at the diagnosis code
21 list, there is a meaning to the fact that some
22 -- that the diagnosis is primary, the first

1 one. It's less clear cut, in other sorts of
2 claims.

3 So, you know, the grouper, in the
4 case -- in the special case of an in-patient
5 stay, the primary ICD9 code drives, always
6 drives where that episode groups, which is not
7 the case in others.

8 They are equal, except for the
9 order on the claim, as the final tie breaker.

10 So, you know, in the case of an
11 in-patient claim, you know, it's, you know,
12 really very consistently going to go to what
13 was the primary reason for the admission.

14 I mean, I think it's a shared sort
15 of problem that a lot of these things have,
16 that someone who presents to the hospital with
17 a primary diagnosis is diabetes, and the
18 secondary diagnosis is CHF, might not be that
19 different from someone who presents with a
20 primary of CHF and a secondary of diabetes.

21 But you know, it's an issue that a
22 lot of folks sort of struggle with, and we --

1 our current methodology does not really split
2 up claims. We don't split claim costs in
3 multiple episodes, although, we're actually --
4 not that this really matters, but we've always
5 been worried about that, thinking about it,
6 and looking at ways that you could divide up
7 the costs.

8 In addition to that, in the cases
9 where -- so, you know, looking like, how the
10 claim lines group, looking at what the co-
11 morbidities are, from say, an MS-DRG
12 standpoint, and dividing up the costs that
13 way.

14 Looking at the professional claims
15 that occur during the hospitalization and
16 seeing if that can help you divide up costs,
17 when you do have these cases, where it's
18 diabetes and congestive heart failure.

19 But the product right now, that
20 you're evaluating, will take that cost for
21 that admission and group it to a single
22 episode.

1 CO-CHAIR CURTIS: I would say,
2 it's precisely defined, as to what bucket it
3 ends up in, in the black box is the
4 appropriateness of that decision, right?

5 CO-CHAIR ROSENZWEIG: Okay, so,
6 moving onto page 21, they talk about how the
7 major condition factors that are defined for
8 their diabetes, at least for their anchor,
9 they have five categories.

10 You know, basically, they're
11 talking about this very specific diabetes
12 diagnosis, either diabetes Type 1 or Type 2,
13 diabetic coma, which presumably, or
14 hyperosmolar state or ketoacidosis.

15 I was wondering why you didn't
16 include hypoglycemia, as -- which is certainly
17 a -- would be an appropriate very specific --
18 you know, specific diabetes related
19 complication, not a complication, but an
20 element related to diabetes and I just was
21 curious, if that should be included, as well.

22 Also, the co-morbidity factors are

1 very broad. So, basically, any complication
2 of diabetes, which normally would be
3 considered very closely related to diabetes,
4 is considered as a co-morbidity, at least in
5 this methodology.

6 DR. LYNN: Yes, we didn't look at
7 hypoglycemia as a marker. I mean, I think
8 maybe we should have, but we did not.

9 We do look at those other markers
10 and this is -- as far as this, you know, the
11 co-morbidities, they are broad, that we put a
12 lot of things in the model. They all had --
13 there was obviously, a lot of things that have
14 an effect on the diabetes.

15 But the co-morbidities, again,
16 have an indirect effect, right, because
17 they're -- the cost for that co-morbidity is
18 captured in a different episode.

19 So, the effect it has on the cost
20 of the diabetes itself, is not the obvious
21 fact that it increases the cost to the
22 patient. But the indirect effect that, you

1 know, because there is this other disease
2 occurring, it's making the diabetes harder to
3 treat, from a utilization standpoint.

4 CO-CHAIR ROSENZWEIG: Okay.

5 CO-CHAIR CURTIS: Let me just, I
6 think it's related, correct me if -- I
7 apologize if I'm wrong.

8 But the risks, or the severity
9 levels in the identification of the co-
10 morbidities is taking place concurrently with
11 the -- within the episode, within the year,
12 correct?

13 And the problem, or the question I
14 have for you is, there is specific guidance
15 from NQF criteria in 2b5, to be very specific,
16 talking about how we're -- sorry, 2b4, that
17 for risk -- and this gets into risk
18 adjustment, that it's -- you're suppose to
19 adjust for factors that are present at the
20 start of care, and could not represent
21 complications, and so, maybe I'm getting ahead
22 of myself, here.

1 But I just want to ask for some
2 clarification, as to why you took that
3 approach, and again, it's very different than
4 what we do for outcomes measures and to me,
5 could -- is potentially, could be problematic.

6 DR. LYNN: You know, we do
7 consider co-morbidities that occur during the
8 measurement year, that don't -- they're not
9 limited to those that occur before the
10 measurement year.

11 DR. WEINTRAUB: Then per Dr.
12 Curtis' point, how do you set the product --
13 to that point, how do you separate out
14 complications from co-morbidity?

15 DR. LYNN: I guess we don't.

16 CO-CHAIR ROSENZWEIG: Yes, it
17 looks like, I mean, like they say, example for
18 co-morbidity groups for diabetes included
19 ischemic heart disease, congestive heart
20 failure, and COPD. Well, ischemic heart
21 disease certainly is a complication -- can be
22 considered more closely related to diabetes as

1 diabetic retinopathy or diabetic nephropathy
2 or something like that.

3 COPD is something sort of often a
4 different realm.

5 So, and certainly, there are other
6 examples, like you mentioned, multiple
7 sclerosis, so, even there, that would be a co-
8 morbidity, but it's not sort of part of the
9 diabetes care episode.

10 And I didn't quite understand, are
11 you taking -- are you considering all of the
12 costs for all of these things, or is it -- no,
13 you're not?

14 DR. LYNN: No, it's a marker,
15 right, it's a marker that has an indirect
16 effect on the cost -- all of these markers
17 have indirect effects on the cost of caring
18 for the very specific diabetes episode.

19 CO-CHAIR ROSENZWEIG: Okay, all
20 right, and you use Moody's examples, and
21 actually, there is a lot of data to support
22 issues related to --

1 DR. LYNN: Yes, and the --

2 CO-CHAIR ROSENZWEIG: -- co-
3 morbidity of depression, being associated with
4 increased cost, okay.

5 All right, now, I had already
6 asked -- I guess, I didn't quite understand
7 how the severity scores were elucidated, but
8 according to what you are saying, it is
9 basically weighted, based upon comparable
10 codes in your database, that are associated
11 with similar levels of cost, or were there
12 other issues -- other elements that go into
13 them, in addition to cost?

14 DR. LYNN: Again, the weights come
15 from a model that uses standard price as the
16 dependent variable.

17 CO-CHAIR ROSENZWEIG: Okay, all
18 right, so, I'm going to move onto page 27, and
19 you're listing a lot of resource use
20 categories, and most of these seem pretty
21 straight forward.

22 I wondered why you didn't include

1 diabetes education, at all, as one of the
2 resource use categories that might enter into
3 the picture here.

4 (Off mic comments)

5 CO-CHAIR ROSENZWEIG: We're on
6 page 27 S9.7.

7 MS. PARKER: Jamie, that was
8 actually a question that I had on the previous
9 one that I missed in my notes, is that exact
10 thing.

11 I wasn't sure if how it's coded or
12 if it was even -- I guess it wouldn't matter
13 in NCQA, since they kind of group everything
14 together.

15 But I think that's a very valid
16 point, that is something is billed for, it
17 does happen, and it is part of the standard of
18 care for patients with diabetes.

19 CO-CHAIR ROSENZWEIG: It's
20 definitely part of the standard of care, and
21 it is billed for, the actual amount of
22 diabetes education is -- that is billed for

1 between plans is very variable.

2 So, but it actually represents,
3 you know, a cost component that should be
4 taken into consideration, with respect to
5 episodes of care, and I suppose, you know,
6 whether or not it -- you can subsume it under
7 evaluation and management services, I'm not
8 sure.

9 DR. LYNN: We can definitely pull
10 that out, as a separate category.

11 CO-CHAIR CURTIS: But you are
12 suggesting that it's already in there, it's
13 just not broken up?

14 DR. LYNN: I think that is
15 correct.

16 CO-CHAIR CURTIS: Okay, so, if you
17 could just check back with us.

18 DR. LYNN: Yes.

19 CO-CHAIR ROSENZWEIG: Okay, all
20 right, and they describe in quite detail, the
21 various -- how they define the various types
22 of services.

1 I'm not sure I need to get into in
2 depth, in describing it to the committee, but
3 it also goes into -- I mean, once again, it --
4 I don't pretend to fully understand how these
5 calculations are done, in order to create the
6 scores, okay.

7 CO-CHAIR CURTIS: But the top line
8 message here is that only the costs that are
9 associated with claims that have an adequate -
10 - that are mapped to diabetes get captured,
11 correct?

12 DR. LYNN: Those are the only ones
13 that get captured in the episode.

14 CO-CHAIR CURTIS: In this
15 particular --

16 DR. LYNN: Yes.

17 CO-CHAIR CURTIS: Right.

18 CO-CHAIR ROSENZWEIG: That is why

19 I -- CO-CHAIR CURTIS: So, the
20 admission for heart failure, that's grouped to
21 heart failure, would be invisible in this
22 particular measure.

1 CO-CHAIR ROSENZWEIG: That is why
2 I thought it was --

3 DR. LYNN: That is correct.

4 CO-CHAIR ROSENZWEIG: Yes, that is
5 why I thought -- yes, that was the basis of my
6 interpretation, that this was more diabetes --
7 that the costs that were being evaluated in
8 this were more diabetes specific and less
9 related to total medical costs, than in other
10 situations, that you were trying to actually
11 eliminate costs for the variety of co-
12 morbidities, or a lot of co-morbidities.

13 However, some of the co-
14 morbidities do affect your diabetes costs,
15 statistically.

16 DR. LYNN: Right, so, the ones
17 that are outside of diabetes are markers for
18 the severity of the diabetes, itself.

19 But that's correct, we're looking
20 at the direct cost of diabetes, again, you
21 know, if we have folks that want to analyze
22 that unit, they can. If we have folks that

1 want to analyze the aggregation of diabetes
2 and all of its sequela, they can add our
3 episodes together, to do that.

4 CO-CHAIR CURTIS: So, one
5 clarifying question, then. Does the intensity
6 of coding variations, by region, physician,
7 whatever, influence this, in terms of that tie
8 breaking methodology?

9 So, I would assume that the more
10 codes you have, or that, you know, how many
11 ICD9 codes I check off, provides a different
12 set of potential number of episodes that it
13 could be attributed to.

14 So, one might be heart failure.
15 One might be diabetes. One might be CAD, and
16 so, I could see that there would be problems,
17 based on that known variation and just the
18 number of codes that are submitted.

19 DR. LYNN: So, two comments about
20 that. We had done studies about looking at,
21 you know, claims that have three ICD9 codes on
22 it versus four, versus two, versus one, and

1 when you go from three to four, you're only
2 changing grouping, like, less than a percent
3 of the time.

4 So, it doesn't have an effect on
5 grouping. But it could have an effect on co-
6 morbidity identifications and markers.

7 But it only takes one diagnosis
8 code to mark a co-morbidity. So, you know,
9 that effect is relatively small, too.

10 CO-CHAIR CURTIS: So, for future
11 applications, it would be very good to have
12 that information, because persistently, in all
13 my evaluations of the Ingenix measures, that
14 was the biggest concern I had, is that
15 stability of the assignment.

16 DR. LYNN: The stability of the
17 assignment of the claim to the episode?

18 CO-CHAIR CURTIS: Right, that
19 again, if I happen to click on heart failure
20 one day, and heart failure and diabetes, the
21 next time I see the patient, because I have
22 two more seconds to think about what I saw the

1 patient for, you know, just that possibility
2 of arbitrary assignment, or maybe I'm
3 perseverating, so, I'll stop.

4 DR. LYNN: No, I think, you know,
5 I -- we can probably -- we actually probably
6 have that data someplace, because I know we've
7 done that before.

8 I don't know if this is the data
9 you're looking for, but you know, how do
10 things change from one diagnosis to two to
11 three to four?

12 (Off mic comments)

13 DR. PALESTRANT: Can I ask just
14 ask one question, please?

15 DR. WEINTRAUB: He's just trying
16 to show who is boss.

17 DR. PALESTRANT: Sorry, can I just
18 interrupt for one second?

19 MS. TURBYVILLE: Please.

20 DR. PALESTRANT: Yes, so, say the
21 one of the issues I don't quite understand is
22 where -- it was in this -- this example, there

1 is the specialty care service, and there is
2 the Excel spreadsheet that goes through all
3 the different potential specialty services
4 that could be attached.

5 Some of these things, I would not
6 think that it -- it's basically, every
7 specialty service that could be offered to any
8 patient or any time, not diabetic specific at
9 all. Some of them would be, of course, but
10 some of them wouldn't.

11 So, I mean, to the trauma codes,
12 which I don't think would be probably be due
13 to diabetes, unless someone became
14 hypoglycemic and drove their car off the road.

15 So, I'm not quite sure if we get
16 into the value -- because I mean, what
17 concerns me here is, there is suppose to be
18 value -- resource use per episode, but it
19 seems to be almost resource use per patient,
20 because there are so many different attached
21 episodes, so many attached episodes to each
22 diagnosis.

1 DR. LYNN: What spreadsheet are
2 you looking at?

3 DR. PALESTRANT: I'm looking at
4 the Excel spreadsheet, it's the one that's in
5 the red posting, that's 1595, and it's line
6 seven, which is what I think is being
7 referenced on page 30.

8 DR. LYNN: Yes, this is a
9 comprehensive list for -- that's used for all
10 measures. So, it is p- includes a lot of
11 stuff that's not related to diabetes.

12 CO-CHAIR CURTIS: But what I did
13 see for the AMI measure, previously, was that
14 it had the more specific assignments -- that's
15 a bad term, but it had the assignments and I
16 think it was S5, which I didn't see in this
17 web-based.

18 So, there may be a missing
19 spreadsheet, that might be more specific to
20 this measure.

21 DR. PALESTRANT: The specialty
22 code services, if I'm reading it correctly, is

1 -- because this is actually in each of the
2 other measures for Ingenix, and it is this
3 broad, unless I'm not understanding it, that
4 these are all included, which makes me think
5 that it's services per year, per patient, not
6 services per diagnosis.

7 DR. LYNN: It's broad because it's
8 used across all of these episodes, not just
9 diabetes.

10 When it would be used for
11 diabetes, only those procedures that were
12 related to these categories would be included.

13 CO-CHAIR ROSENZWEIG: The way I
14 interpreted it was that that big table, and in
15 deed, the fairly lengthy listing of specialty
16 care services and radiology and so forth, that
17 only -- you know, that -- this is their entire
18 list of things that they actually collect data
19 on, but only certain percentages are actually
20 -- only certain ones of these are going to be
21 actually specifically assigned to diabetes.

22 You're not going to have too many

1 allergy tests or -- that are going to be
2 assigned to diabetes, unless they have insulin
3 allergies, for example.

4 DR. PALESTRANT: Yes, that would
5 be the assumption, but I'm not sure we can
6 make that assumption.

7 CO-CHAIR ROSENZWEIG: Okay.

8 DR. LYNN: We can narrow this list
9 down specifically for diabetes, if you'd like.

10 CO-CHAIR ROSENZWEIG: Okay, it's
11 just -- yes, it's a huge list it seems fairly
12 generic, not just specific to this particular
13 protocol.

14 All right, and then getting onto
15 page 32, is that -- I'm just moving ahead a
16 little bit, here.

17 There is a fairly lengthy
18 discussion -- well, it's a discussion of their
19 -- of how they use the risk adjustment method,
20 to compare -- basically, they have their
21 severity of illness system, which as they
22 indicate, is proprietary, but then they use it

1 to be able to compare different providers.

2 So, whereas the previous material
3 was discussing mostly comparing large groups,
4 this is -- they can use the risk adjustment
5 methodology to compare providers, as well.

6 They have, you know, Dr. Jones and
7 Dr. Smith, and Dr. Jones is more expensive
8 than Dr. Smith.

9 DR. WEINTRAUB: You know, it's
10 always going to depend on sample size and
11 probably for diabetes, it probably can be
12 done, given the relative p- frequency of
13 diabetes and the distribution of costs are
14 quite clear.

15 Do you know what the R-square is
16 of your model?

17 DR. LYNN: No, I've heard you ask
18 the other -- I've already written that in my
19 notes, to bring the R-square for this severity
20 model.

21 DR. WEINTRAUB: Okay.

22 DR. LYNN: Yes, I don't know what

1 you're looking at with the physicians,
2 comparing.

3 CO-CHAIR ROSENZWEIG: Okay, and
4 then on S10.2 stratification method, it says
5 ETG stratifies episodes by intensity of
6 service or total cost. Is it both or one or
7 the other?

8 DR. LYNN: So, if you use -- if
9 you re-price the data set that you're doing
10 the study in, or I should say standard price,
11 my boss gets really mad at me, when I say re-
12 price, standard price, the data set, then what
13 you're looking at is intensity of service,
14 because you've taken out the contracted rate,
15 and if you actually use the actual cost, then
16 you're -- then there is total cost, which
17 includes not only the utilization, but
18 potentially higher contracted rates.

19 So, you know, depending on what
20 you're trying to do, you would use either one
21 of those methods.

22 CO-CHAIR ROSENZWEIG: Okay.

1 DR. WEINTRAUB: I don't understand
2 what you're trying to do here with this
3 stratification.

4 You said a bottom line is -- the
5 severity level can then be used to stratify
6 episodes by severity, measured as resource
7 consumption. I don't understand what you are
8 doing.

9 DR. LYNN: Yes, so, again, this is
10 where we're assigning the severity level to
11 the severity score.

12 So, the severity score, which is a
13 real number, maps to a severity level, where -
14 - that's the one through four, thing.

15 DR. WEINTRAUB: So, are you
16 developing -- are you developing models by
17 severity? Are you really stratifying, or are
18 do you mean something else than stratifying?
19 I suspect you don't mean stratify.

20 CO-CHAIR CURTIS: This is risk
21 adjustment methodology.

22 DR. LYNN: Yes.

1 CO-CHAIR CURTIS: Like, there is
2 no other -- essentially, right?

3 DR. LYNN: There is no other
4 stratification, yes. So, that -- okay, what
5 we're using to stratify is the severity score.

6 So, there is no clinical
7 stratification.

8 DR. WEINTRAUB: So, you're
9 actually not stratifying, using -- you're
10 looking at -- what you're saying is, we can
11 look at severity.

12 You can look at it like a sub-
13 group -- what it is, is you're developing a
14 separate model.

15 DR. LYNN: No.

16 DR. WEINTRAUB: So, you're not
17 truly stratifying. They're really sub-groups.

18 DR. LYNN: Okay, they're not
19 clinically stratified.

20 DR. WEINTRAUB: No, I didn't mean
21 clinically. I mean, by statistically. I
22 mean, in terms of modeling, they're not really

1 strata.

2 DR. LYNN: Let me tell you what
3 they are, and you can tell me whether they're
4 really strata or not, because I --

5 Again, you take a severity score
6 of an episode and then each of these severity
7 levels is a severity score that maps to a
8 range, and you know, from zero to .5 is
9 severity level one, that is what is being
10 done, and if that's not strata, then it
11 doesn't belong here.

12 DR. WEINTRAUB: So, what you're
13 really doing is, what you're saying is, we
14 can look at different sub-groups, by how
15 severe they are, and look at -- and develop O
16 to E ratios for those separate sub-groups.

17 DR. LYNN: Right, but you -- but
18 also, you can combine O to E ratios, right?

19 DR. WEINTRAUB: Sure.

20 DR. LYNN: Okay.

21 CO-CHAIR ROSENZWEIG: All right,
22 so, going on to S11.1, the attribution

1 process, it sounds like you basically look at
2 all the various visits and you assign a
3 specific provider to each of them.

4 Now, you're talking about
5 physicians here, only. Diabetes is
6 specifically a condition which a large portion
7 of visits are actually done by people other
8 than physicians.

9 So, I assume you're talking about
10 all sorts of providers, and not just
11 physicians, is that correct? Like, nurse
12 practitioners, PA's, diabetes educators,
13 podiatrists, things like that.

14 DR. LYNN: Yes, so, for the
15 purpose of this, with this project, there are,
16 you know, inside of the grouper, you can
17 actually map different specialities to
18 different -- to whether they're sort of
19 considered ancillary or clinicians, and for --
20 when we did this, nurse practitioners and PA's
21 were included in the clinician grouping, which
22 would have the power to create an anchor.

1 But the nurse educators and the
2 diabetes educators would not have been, and
3 part of that may be a limitation to
4 identifying that specialty in the data that we
5 had.

6 CO-CHAIR ROSENZWEIG: I see, so,
7 that could create problems, to a certain
8 extent, because the way you're setting this up
9 is, at least as I understand it, you know,
10 with respect to attribution, is that
11 obviously, it's hard to -- you know, as I
12 said, personal diabetes may be seen in the
13 course of a year, by eight or 10 different
14 providers.

15 Some of them may be NP's, working
16 with the primary care doctor. Some of them
17 may be NP's working with a specialist.

18 But I assume, the way you're
19 lumping all of the primary care guys together,
20 as a group, okay, so, suppose a person sees
21 more than one primary care doctor in the
22 course of a year, they would be lumped

1 together as a group and then, at least as I
2 interpret it from this fairly lengthy
3 discussion here, and -- that you would lump
4 all of the, let's say, endocrinologists
5 together, all of the cardiologists together,
6 and somehow, attach the NP's to each of these
7 providers, or would the NP's also be sort of
8 a separate group, as well?

9 DR. LYNN: The nurse practitioners
10 would be a separate group, although we don't -
11 - they're not commonly evaluated, but they
12 would be a separate group, and again, you can
13 -- you know, inside the grouper, you can not
14 group the nurse practitioner to the physician
15 assistants, to clinicians, and you get a
16 slightly different result.

17 But we want to create, you know --
18 they should have the ability to create the
19 anchor. So, we're not trying to aggregate the
20 PA's to the primary care provider. You can,
21 of course, do this at a group level, in which
22 they would be aggregated to the group level.

1 CO-CHAIR CURTIS: So, it seems
2 like you've created rules for attributing to
3 individuals as one option, but you're retained
4 the option of rolling it up to groups or other
5 payer, or other levels, right, and then
6 actually, I thought the one that was most
7 appealing was actually the panel approach,
8 where you sort of assign, you know, within
9 that type of payer system, if you have a PCP
10 assigned, you could attribute everybody and
11 that information is, in my opinion, most
12 actionable.

13 DR. HWONG: Yes, I mean, what I
14 liked about, in terms of this measure,
15 compared to let's say, the ABMS, and it's
16 fine, I mean, ABMS has sort of one attribution
17 logic, right, and you know, has its positives
18 and negatives.

19 But this, it looks like you have,
20 you know, four different kinds, right. You
21 can sort of specify, you know, if you want it
22 to be a PCP attribution, like who was just

1 identified as like the gate keeper in some
2 ways, or who is the MD who has the most cost,
3 who has the highest number of clusters, you
4 know, within an episode, and or who has just
5 the most face-to-face visits.

6 So, you know, I don't think
7 they're not that -- it's nice to have that
8 flexibility, right, to be able to sort decide
9 kind of how -- what you feel like is -- you
10 know, who you want to call responsible, let's
11 say, for that episode and for those costs.

12 So, the one question I have,
13 though, so, even with all those four variance,
14 right, the episode only ever gets attributed
15 to one -- like, a given episode and a cost for
16 that, only ever gets attributed to one
17 provider. I mean, you can roll them up, but
18 like it's responsible by one provider, right?

19 DR. LYNN: That is correct, we
20 don't -- the methodology does not divide the
21 responsibility of episodes across multiple
22 providers.

1 DR. HWONG: Okay.

2 CO-CHAIR ROSENZWEIG: That's
3 within a peer group.

4 DR. LYNN: There is a possibility
5 that rarely, if the peer groups have two
6 different methodologies for determining the
7 responsible provider, that very rarely, the
8 episode would occur in one peer group and
9 another.

10 But those groups would never be
11 compared to each other. So, you wouldn't
12 really be double counting the dollars, and
13 it's very rare, and again, only if you assign
14 different rules to different peer groups, as
15 far as attribution goes.

16 If you don't assign different
17 rules to different peer groups, then it won't
18 happen.

19 CO-CHAIR ROSENZWEIG: Okay, so,
20 it's more than just those four categories,
21 you're dealing with -- within those categories
22 of physicians, you know, on the physicians, on

1 an individual level, you're dealing with
2 physicians in different peer groups.

3 So, it gets very, very detailed
4 and very granular. You're dealing with
5 cardiologists, primary care doctors, at least
6 as I interpreted S11.2, you know,
7 cardiologists, general surgery, and so forth
8 and so on.

9 DR. LYNN: Yes, let's talk about
10 that. I don't know if this is -- when we
11 create the peer groups, part of the exercise
12 is, you know, mapping episodes that are
13 related to that peer group.

14 So, you know, if in the broader
15 context, you know, if you fall down and break
16 your foot, and your next door neighbor happens
17 to be an endocrinologist, and he ends up with
18 a foot fracture episode, we don't assign that
19 to him, even though he may have been the
20 responsible provider.

21 So, there is a map inside here
22 that says, this peer group is responsible for

1 these episodes, and even if they get an errant
2 episode outside of their area of speciality,
3 it's not used to evaluate the provider.

4 So, general surgeon would not be
5 in that map for diabetes, and cardiologist,
6 you can debate it, but you know, I think
7 usually, it's not.

8 CO-CHAIR ROSENZWEIG: Okay, but
9 you say internal medicine, cardiology or
10 general surgeon within a certain geographic
11 area are examples of a peer group.

12 CO-CHAIR CURTIS: I think that
13 might apply across the measures, as opposed to
14 being specific for this one.

15 DR. LYNN: That is correct, and it
16 should have been more specific, but it's
17 something we missed, when we created specific
18 documents out of that.

19 CO-CHAIR ROSENZWEIG: All right,
20 okay.

21 DR. LYNN: So, I apologize for
22 that.

1 CO-CHAIR ROSENZWEIG: That's okay.

2 All right, and then sample size, or outliers,
3 you do the Winsorization, like everyone else
4 does, and then, with respect to sample size
5 requirements, could you explain what you --
6 why a sample size of 30 is chosen?

7 DR. LYNN: Well, I think, you
8 know, the sample size of 30 is --

9 MS. TURBYVILLE: Microphone.

10 DR. LYNN: Thank you. The sample
11 size of 30 is really, you know, it's what is
12 used, but it's not the important part, as far
13 as we're concerned.

14 What's important is that you show
15 a statistically significant difference to the
16 threshold.

17 We used 30 because, you know,
18 numbers lower than that start to get sort of
19 ridiculous, even if you're statistically
20 significantly different, and you have five
21 cases or 10 cases, you know, I'm not sure, how
22 really meaningful that is.

1 But the important thing is that,
2 you know, whether you have 30 or 100 or 50,
3 that if your score is statistically different
4 than the threshold, then that's what should
5 matter.

6 DR. WEINTRAUB: Well, you really
7 should assign that in advance, rather than
8 saying, well, now, it's statistically
9 significant, but the problem then is that if
10 you find something that's a trend, what do you
11 -- how do you handle that?

12 So, the right way is to think in
13 terms of power, and are you going to have
14 enough power, with 30, to see a difference, if
15 there is one?

16 DR. LYNN: Yes, I think, I mean,
17 that's a good point. I mean, I think you
18 could go back and say, "We're looking for
19 differences that are -- you know, we want to
20 find differences that are 25 percent or 20
21 percent, or something like that," and
22 therefore, you would need a certain number to

1 do that.

2 DR. WEINTRAUB: That's correct.

3 DR. LYNN: Although, you know,
4 there are -- the -- the issue that I guess, we
5 have when we look at this is, suppose you're
6 looking for differences that are 25 percent,
7 and you -- and therefore you want to pick --
8 you would pick a number, like 50, but they
9 have some providers or provider groups, that
10 maybe have 35 or 40, but are sort of way out
11 there, and you know, are statistically
12 different from your threshold. Wouldn't you
13 want to include those?

14 DR. WEINTRAUB: One way of doing
15 that would be not just to have one number for
16 power, but we could find a 50 percent
17 difference at 30, and a 25 percent difference
18 at 100, or whatever.

19 But I have trouble just saying,
20 "Well, if it's statistically significant, it's
21 statistically significant," and what do you do
22 with the next guy, when there is a trend, when

1 you haven't set up your rules in advance?

2 CO-CHAIR CURTIS: Right, and so, I
3 think we're getting a little off target, but
4 I think it's an important point, in terms of
5 the public reporting and the interpretation
6 and use.

7 But I think we're probably
8 unresolvable at this situation, but I would
9 ask you to sort or take that under advisement,
10 to sort of define what is clinically
11 significant, before you -- in terms of the
12 differences in cost, and that's something we
13 haven't ask any other measure developer to do.

14 So, it would be sort of a little
15 unfair.

16 CO-CHAIR ROSENZWEIG: But most of
17 them haven't come up with a specific number,
18 like 30.

19 CO-CHAIR CURTIS: Well, NCQA had
20 the 400.

21 CO-CHAIR ROSENZWEIG: Four-
22 hundred?

1 CO-CHAIR CURTIS: I mean, it
2 really has to do -- it has to do more with the
3 -- now, I'm getting philosophical again.

4 It's the statistical property of
5 reliability, which is different than the other
6 types of reliability that we've talked about,
7 and that is testable, to say, "Okay, well,
8 this is the number that you have to have,"
9 again, sort of a more stable case mix, if you
10 sort of randomly sampled from the universe of
11 diabetic patients.

12 We don't know what that number is,
13 but that would, I think, influence the
14 appropriate number for making categorizations
15 and comparisons.

16 CO-CHAIR ROSENZWEIG: Okay, and
17 then on page 38 and 39, they discuss the bench
18 marking process, which we've actually
19 discussed already and is outlined in S10.1, in
20 more detail.

21 Okay, so, I think we've gone
22 through this section, up to 'testing and

1 analysis', so, maybe we should -- or let's
2 see, should we continue from there, or keep
3 going?

4 CO-CHAIR CURTIS: We should, yes,
5 I think following our lead, go through 2a1 an
6 2b1.

7 CO-CHAIR ROSENZWEIG: All right,
8 okay. CO-CHAIR CURTIS: So, I
9 think -- so, with regards to --

10 CO-CHAIR ROSENZWEIG: So, 2a1 is
11 the measure is well defined and precisely
12 specified, so that it can be implemented
13 consistently within and across organizations
14 and allow for comparability. EHR measure
15 specifications are based on quality data set.

16 Well, it's probably defined within
17 Ingenix. The question is, is it defined for
18 us?

19 DR. WEINTRAUB: Hard to tell.

20 CO-CHAIR ROSENZWEIG: That's hard
21 to tell, as far as I'm concerned.

22 DR. MARWICK: Is the fact that it's

1 proprietary a problem, in that respect?

2 CO-CHAIR ROSENZWEIG: I don't know
3 what the rules are for NQF with respect to --

4 DR. HWONG: That's a really good
5 question, right.

6 DR. LYNN: Let me clarify that.
7 Folks that use this product do have access to
8 the weights. The weights are actually on a
9 website, and all of how the grouper works and
10 all of that stuff is available. I was just
11 wrong when I said that.

12 CO-CHAIR CURTIS: Well, let me --
13 but so, is it available to any clinician off
14 the street, who is being measured by this
15 methodology?

16 DR. LYNN: Yes, there is a
17 transparency website for ETG, where you can
18 get all this information.

19 DR. PALESTRANT: Is your database
20 used for -- in other words, is this database -
21 - is this system being used for measuring
22 value for conditions, or is it being used for

1 other purposes?

2 CO-CHAIR CURTIS: You were kind of
3 breaking up there. If you could repeat it.

4 DR. PALESTRANT: Yes, it seems to
5 me that this -- the database and this system
6 is designed to measure the general usage per
7 patient, and maybe by physician, but not usage
8 per diagnosis, which is what we're getting at.

9 So, it seems that, and I may be
10 wrong, I need this clarified then, is this
11 database being used currently, and your
12 system, for what we want to do with it, in
13 other words, use it in this case for measuring
14 diabetes over the course of a year, currently?

15 DR. LYNN: We're trying to measure
16 diabetes. We're not -- you know, the unit of
17 analysis is -- even when you take on the
18 entire grouper, episode treatment groups, the
19 unit of analysis is not the patients. The
20 unit of analysis is the episode of disease.

21 CO-CHAIR ROSENZWEIG: Isn't that
22 correct?

1 DR. LYNN: Yes, right.

2 DR. PALESTRANT: And you're
3 currently being used -- I mean, are you
4 currently using it -- are you currently using
5 a diabetes episode treatment group as a
6 commercial product, and giving this data out
7 to your subscribers?

8 CO-CHAIR CURTIS: So, basically,
9 is it currently in use?

10 DR. LYNN: The product is in use,
11 that people -- you know, occasionally use it
12 to measure solely diabetes, although they
13 don't usually do that in the context of
14 measurement.

15 They use it when they use -- look
16 at only diabetes, they're looking at, you
17 know, employee costs or health system costs or
18 things like that.

19 But we do -- you know, it is --
20 and the grouper, as a whole, is used in its
21 different conditions, to do exactly this, and
22 has been used for a while.

1 CO-CHAIR ROSENZWEIG: The question
2 is, is it well defined and precisely
3 specified, so that it can be implemented?

4 My concern would be the fact that
5 I don't feel it's precisely specified within
6 the structure of this.

7 I mean, it's specified in a
8 variety of ways, but --

9 DR. HWONG: But -- oh, go ahead,
10 yes.

11 CO-CHAIR ROSENZWEIG: Yes, go
12 ahead.

13 DR. HWONG: You know, it's --
14 there is where I sort of have that, you know,
15 a hard time with this, right.

16 But I think I'm leaning towards
17 one direction. I think it's precisely
18 specified, like, the product itself and
19 understanding how it's suppose to work, and
20 how you've laid out the logic and even -- you
21 know, to the extent of transparency that you
22 provided to us, you know, in the measures, I

1 get the sense, if I bought the product, and I
2 was using it, I know exactly how that works
3 and you know, I can kind of look these things
4 up.

5 I think, getting to Jamie's point,
6 where it might be tough is if we -- if someone
7 didn't buy a product and I, with my
8 development team, wanted to try and build
9 this, right, we'd probably get like a good
10 distance, but I think there would be some --
11 you know, like, so, in terms of, is it spec to
12 this point, where I could sort of reproduce,
13 you know, this? I think there is probably a
14 little, you know -- it would take a little
15 work, and you know, you'd have to sort of
16 build that.

17 So, I think I'm sort of leaning
18 towards -- you know, this is just me, just
19 sort of, just for conversation, but like, in
20 terms of, do I think these are precisely
21 specified, you know, in terms of the use of
22 the product, and this sort of system? I do

1 think that.

2 I think, sort of, this whole sense
3 of like, you know, is it enough that some
4 outside, you know, group or entity who want to
5 try and build this, right, you know, could do
6 it or reproduce this, right, you know, may be
7 a little bit more tricky.

8 DR. WEINTRAUB: I think that's
9 very well said. I think you got right to the
10 heart of it.

11 CO-CHAIR ROSENZWEIG: All right,
12 so, I don't know, I would give it a moderate
13 score.

14 DR. WEINTRAUB: But if you bought
15 into what Connie said, you would give it a
16 high.

17 CO-CHAIR CURTIS: So, let's go
18 ahead and vote.

19 DR. WEINTRAUB: Electronics?

20 MS. TURBYVILLE: We're missing
21 one, now.

22 (Off mic comments)

1 DR. LYNN: I didn't vote.

2 CO-CHAIR CURTIS: Did Brenda?

3 MS. TURBYVILLE: Brenda Marie is
4 not at the table right now.

5 CO-CHAIR ROSENZWEIG: Okay, the
6 next one is 2b2, is that correct?

7 CO-CHAIR CURTIS: 2b1.

8 CO-CHAIR ROSENZWEIG: 2b1, okay,
9 measure specifications are consistent with the
10 evidence presented to support the focus of
11 measurement under criterion 1b. The measure
12 is specified to capture the most inclusive
13 target population, indicated by the evidence,
14 and exclusions are supported by the evidence.

15 To me, it seems like that in fact,
16 yes, that the measure specifications are
17 consistent with the evidence presented, and it
18 certainly does -- it captures an inclusive
19 population. It has a lot of data in it.

20 CO-CHAIR CURTIS: So, just my
21 opinion is still, that the -- it's very
22 precisely defined, as to what goes into the

1 outcome, but I'm not sure if it's capturing
2 everything or -- and if it's arbitrary
3 assignment or not. I think that's restating
4 whatever the --

5 DR. WEINTRAUB: So, the question
6 is, is this -- does it capture the most
7 inclusive target population?

8 CO-CHAIR CURTIS: Not so much the
9 population, because I think the population is
10 okay. It's the outcome.

11 DR. WEINTRAUB: Well, but it's
12 still consistent with --

13 CO-CHAIR ROSENZWEIG:
14 Specifications are consistent, yes.

15 DR. WEINTRAUB: Yes.

16 CO-CHAIR ROSENZWEIG: Whether
17 they're accurately represented, I can't tell
18 you.

19 DR. PALESTRANT: Can I make just
20 one more comment?

21 MS. TURBYVILLE: Go ahead.

22 DR. PALESTRANT: Just asking the

1 group, if you were to -- knowing what you
2 know, which is actually more than what most
3 people would know, when they get a report from
4 this, and they issue a new received report
5 with these numbers, would you know what went
6 into generating that report, in any great
7 depth?

8 DR. LYNN: Who is that question
9 for?

10 DR. PALESTRANT: Just for the
11 group, it's my concern. Even having studied
12 this, gone through these a few times, trying
13 to read it, trying to understand how this was
14 all generated.

15 I'm still not clear, what the
16 metric that would be -- would you get as your
17 answer, what it would actually mean, and
18 therefore, this comes to -- at least the heart
19 of the problem, I mean, we know more than what
20 most users of this will know, and that could
21 be a course for the report.

22 CO-CHAIR CURTIS: I'd just say

1 that I have moderate confidence in my ability
2 to understand what exactly, the numbers would
3 mean, all right. I think you could decipher
4 it. I think this -- this is complex. It's
5 been generated over years and years, and
6 clearly, a lot of thought has gone into it.

7 It's hard for us, in a two hour
8 span of time, to unwind it and make sure we
9 understand.

10 DR. PALESTRANT: So, you're really
11 endorsing it for general use, correct? I
12 mean, most of us get confused, we're endorsing
13 this as a metric.

14 CO-CHAIR CURTIS: We're endorsing
15 it as a measure of resource use.

16 DR. PALESTRANT: Yes, correct.

17 DR. WEINTRAUB: This is a generic
18 problem, right? I mean, this is a problem
19 with all of these, that we're struggling to
20 figure out what they mean, as fairly
21 sophisticated people, and putting more time
22 into it than most.

1 If the person who is getting this
2 in a report in a hospital, gets back one of
3 these reports, and I deal with this on the
4 other side, the NCDR, and we developed these
5 reports for people and I'm constantly saying,
6 "These reports are no good. We've got to get
7 better reports."

8 And I can tell you, people don't
9 understand the reports.

10 DR. PALESTRANT: Correct, and that
11 was the number, and that's significant,
12 because there is a number for this, and that's
13 the part of the responsibility of -- at least
14 from my perspective, of what we're trying to -
15 - when we make judgments on these metrics, you
16 have to understand how it will be used, and
17 whether it will be useful, when that data is
18 generated.

19 And I'm not sure that anybody who
20 gets the score will actually know what it
21 means.

22 DR. HWONG: So, you know, from my

1 perspective, coming again, from an analytics
2 company within a health plan, and the health
3 plan, we do support, you know, somebody's
4 physician quality profiling efforts, and
5 generate reports, and although my group isn't,
6 you know, formally involved in the efficiency
7 fact, you know, calculation side, right, you
8 know, for example, within Well Point, you
9 know, a different analytic group actually does
10 use these ETG, you know, the ETG
11 methodologies.

12 So, what I would -- from my
13 experience, in looking at this, I think
14 whenever sort of scores go out, you have a
15 huge amount of feedback on the quality
16 measures, the process measures, because that's
17 very, in some ways, you know, for physicians
18 and in terms of just training, or whatever,
19 it's just sort of easier to kind of get into
20 and sort of, you know, find issue with, number
21 one.

22 So, we get a lot of feedback that

1 way. I think the efficiency side,
2 historically, you know, you do get a lot of
3 frustration about that. You get more of this,
4 you know, sort of -- yes, just not only
5 frustration, because it is difficult to kind
6 of wrap your -- again, sort of wrap your brain
7 around it. It's, you know, sophisticated,
8 right.

9 But that being said, I think there
10 have been a lot of efforts, certainly from the
11 health plan perspective, you know, when
12 implementing these programs, to try and break
13 it down. I think Ingenix also has, you know,
14 like you said, this website for transparency,
15 to try and explain some of these weights,
16 etcetera.

17 So, maybe part of this, in terms
18 of, I mean, maybe I'm sort of standing on too
19 much of a soap box, but maybe part of this, in
20 terms of being able to endorse or sort of
21 raise the awareness on a national level about
22 these sort of methodologies is to try and help

1 -- you know, as they -- as they are used, you
2 know, a lot of these programs, to try and kind
3 of highlight, you know, sort of awareness of
4 it, and I think maybe, you know, we're sort of
5 moving in that direction.

6 So, the only thing I would say, I
7 recognize, I think you know, it is difficult
8 to understand. I don't think it's impossible
9 to understand. It's going to take a lot of
10 time and a lot of education, but you know,
11 given sort of use of these, and especially
12 sort of the importance, in terms of
13 characterizing sort of resource use, you know,
14 this may be a good step in that direction.

15 DR. PALESTRANT: That does seem to
16 speak to the black box, and part of what the
17 idea is here, at least from my understanding,
18 is that you'll get a number, or you'll get a
19 score, and then the idea would be in order to
20 contain cost, is that people will make
21 adjustments and then go forward, and hoping
22 their score improves and bring at least,

1 standard throughout the country to be similar,
2 or at least the same utilization of resources,
3 and that way, we can reduce costs.

4 If I get this number, as a
5 practicing physician, or as a health group, or
6 as an ACO, what I actually know, how I can
7 change or improve, what I know what this
8 number actually means, so that I can effect
9 changes in my organization, and I would argue
10 that I'm not sure anybody receiving this
11 report would have any notion of what to do
12 about it.

13 CO-CHAIR CURTIS: But I think
14 you're getting towards the usability issue,
15 which I actually think they do have some
16 better response to, than most.

17 So, I think for this particular
18 group of votes, we're really just saying, how
19 reliably can they count up the resource use in
20 the population of interest and does it meet
21 that threshold?

22 So, that is, at least for what

1 we're voting on right now, and we will get
2 back to the usability, and that's why I
3 brought up at the start of this review, is
4 this really -- do you want us to review this
5 from the perspective of physician profiling,
6 or at the level of the payer or some other
7 population based level, because I think that's
8 again, sort of has different sensitivities.

9 Well, we did vote on 2b1, so, I
10 think we should go through the reliability and
11 validity.

12 CO-CHAIR ROSENZWEIG: Are we up to
13 testing and analysis?

14 CO-CHAIR CURTIS: Yes.

15 CO-CHAIR ROSENZWEIG: Okay, all
16 right. Okay, so, the reliability testing,
17 they basically had -- used a large health
18 services benchmark database, 25-million
19 covered lives for the calendar year 2009, and
20 4-million member sample, 7-million member
21 sample used for reliability evaluation.

22 But this is not specifically for

1 diabetes, is it?

2 DR. LYNN: No.

3 CO-CHAIR ROSENZWEIG: All right.

4 DR. LYNN: These are all -- these
5 are not just people that have diabetes. It's
6 everybody.

7 CO-CHAIR ROSENZWEIG: Okay, all
8 right, and okay, and they found that it was
9 internally consistent, and there was a -- and
10 they were also able to look at reliability
11 across HCO's, showing measures of resource use
12 for nine healthcare organizations.

13 CO-CHAIR CURTIS: What I liked
14 about the description of reliability is that
15 they actually described the internal QI
16 process, which was absent from, I think, the
17 other measure that we've evaluated.

18 But they have a whole peril
19 process with making sure that it's truly
20 getting to the same result. So, I have a much
21 higher confidence of the internal reliability
22 of this, as opposed to the others.

1 CO-CHAIR ROSENZWEIG: Yes, okay,
2 and then the validity testing, there again,
3 large number of patient samples for which this
4 review, 7-million member sample in nine
5 healthcare organizations used for reliability
6 assessment, and they were able to process
7 comparisons between ETG and resource
8 utilization software, and got -- DR.

9 WEINTRAUB: So, you developed -- did you -- in
10 one group, you had a delegation, and another
11 group of validation, is that what you did?

12 CO-CHAIR CURTIS: Microphone.

13 DR. WEINTRAUB: I'm sorry, did you
14 do a standard delegation and validation study,
15 developing model in one group and testing in
16 another?

17 DR. LYNN: No, I think what was
18 done here, and I'm not exactly the person who
19 has done it, but I think what was done here is
20 that we looked at -- just looked at metrics
21 across multiple health plans for a
22 consistency.

1 I don't think it was -- this is
2 different than developing the model of
3 severity. This is not where we develop the
4 model of severity, which we're trying to show
5 that -- some reliability.

6 We did not do sort of the
7 statistical measure of how close these
8 different health plans were.

9 DR. WEINTRAUB: So, then this is
10 not truly validity testing, right? All you
11 did is see that you have measures that can be
12 applied in some kind of way, in different
13 populations.

14 [overlapping voices]

15 DR. REEDER: I think they're in
16 the beginnings of content and construct
17 validity here.

18 DR. WEINTRAUB: Well, I mean --

19 DR. REEDER: In what I'm reading.

20 DR. WEINTRAUB: I mean, that's
21 sort of a different kind of issue.

22 What I'm talking about is validity

1 testing of your model.

2 CO-CHAIR CURTIS: So, the focus is
3 really not so much on the validity testing of
4 the risk adjustment, but it's really in the
5 reliability of which you can specify the
6 population, and the validity is in the
7 repeatability of the ranges across payers, I
8 think, and I think that is more on --

9 DR. WEINTRAUB: I think we have to
10 be careful of what we mean.

11 CO-CHAIR CURTIS: So, I think it's
12 face validity is being supported by that
13 output.

14 DR. WEINTRAUB: Okay.

15 CO-CHAIR CURTIS: If I could speak
16 for the measure developer.

17 DR. LYNN: You're doing great.

18 (Off mic comments)

19 DR. REEDER: Just for the record.

20 DR. WEINTRAUB: Yes, again, I
21 would agree, it looks to me like there is face
22 construct validity, but validity -- there

1 isn't this formal statistical validation,
2 which could be done.

3 DR. LYNN: Right, but I don't
4 think we -- we haven't done that.

5 DR. WEINTRAUB: It's easier.

6 DR. LYNN: Maybe I'll, you know,
7 get my boss, Dan Dunn, in touch with you.

8 CO-CHAIR ROSENZWEIG: So, they
9 also describe how they deal with exclusions.
10 They eliminate outliers and they also
11 eliminate a variety of incomplete episodes,
12 okay, and how do you exactly describe an
13 incomplete episode?

14 DR. LYNN: Again, in the case of
15 diabetes, an incomplete episode is a member
16 who has not been eligible for the year in
17 which there was a diabetes episode.

18 CO-CHAIR ROSENZWEIG: Okay, and
19 they've also tested this, with respect to
20 resource use between 2006 and 2010. Was
21 diabetes specifically addressed, in this
22 population -- in this particular testing,

1 analysis of exclusions?

2 CO-CHAIR CURTIS: You're on page
3 43, now?

4 CO-CHAIR ROSENZWEIG: I'm on page,
5 yes, the bottom of page 42 and the top of page
6 43.

7 CO-CHAIR CURTIS: Okay.

8 DR. LYNN: Let me see, I happen to
9 have, I think it's diabetes specifically, but
10 -- this is 9.7.

11 CO-CHAIR CURTIS: Your microphone.

12 DR. LYNN: I'm talking to myself.
13 I'm just looking to see if these are different
14 for the two different -- for another one that
15 I have open. It will just take me a second.
16 Sorry for the delay.

17 CO-CHAIR CURTIS: Maybe we can
18 keep moving forward with the description.

19 CO-CHAIR ROSENZWEIG: All right,
20 okay, and the analytic method, I think we've
21 kind of discussed this already. I think we've
22 gone through this particular point, as well,

1 and -- okay, and so, I think we're sort of at
2 the -- I think we're ready to vote on this, on
3 the validity section.

4 CO-CHAIR CURTIS: So, I'll just
5 the liberty. So, 2a2, reliability, testing
6 demonstrates that the results are repeatable,
7 producing the same result a high proportion of
8 the time, when assessed in the same
9 population, the measure score is precise.

10 So, in the absence of additional
11 conversation, why don't we go ahead and vote?

12 CO-CHAIR ROSENZWEIG: Yes, I gave
13 this a high value.

14 DR. LYNN: Just, that was overall
15 diseases, not just diabetes.

16 CO-CHAIR ROSENZWEIG: Okay.

17 CO-CHAIR CURTIS: That's seven
18 high.

19 DR. WEINTRAUB: Have we lost
20 someone?

21 CO-CHAIR CURTIS: Brenda.

22 MS. TURBYVILLE: Brenda Marie is

1 next door.

2 CO-CHAIR ROSENZWEIG: The person
3 on the phone, does he vote, too?

4 CO-CHAIR CURTIS: So, 2b2,
5 validity testing demonstrates the measure data
6 elements are correct, and the measure score
7 correctly reflects of care, resources
8 provided.

9 CO-CHAIR ROSENZWEIG: Yes, it
10 looked to me like it was -- you know,
11 internally, it certainly seemed like they were
12 measuring costs and comparing them between
13 groups.

14 So, here, again, gave it a high
15 rating.

16 CO-CHAIR CURTIS: I gave it a
17 moderate, just based on that heart
18 failure/diabetes example that -- again, I
19 don't know if it's capturing the true total
20 costs, but that's my take.

21 DR. WEINTRAUB: Well, I mean, we
22 haven't seen formal evidence of discrimination

1 and we certainly haven't seen calibration,
2 unless I'm missing something. I can't give
3 more than a moderate.

4 MS. TURBYVILLE: One more vote?

5 CO-CHAIR ROSENZWEIG: Okay, so the
6 next one is 2b3, exclusions are supported by
7 the clinical evidence, otherwise, they are
8 supported by evidence of sufficient frequency
9 of occurrence, so that results are distorted,
10 within -- with the exclusion.

11 You know, there is a discussion of
12 exclusions here, but a lot of it is very much
13 based to whether or not it fits within the
14 grouping.

15 So, I didn't give it a high
16 rating. I gave probably either moderate -- I
17 started -- when I originally reviewed it, I
18 thought it was low, but I'll move it up to
19 moderate, from my recommendation.

20 CO-CHAIR CURTIS: Waiting on one,
21 and seven moderate, okay.

22 CO-CHAIR ROSENZWEIG: Okay, and

1 the risk adjustment strategy, here, we're
2 getting into a certain amount of data analysis
3 that does demonstrate that the methods for
4 scoring and analysis of the specified measure
5 allow for identification of statistically
6 significant and practically, clinically
7 meaningful differences in performance.

8 See, this is sort of an area in
9 which Connie comes from one end of the
10 spectrum, in which she's looking at physicians
11 and they're getting scored okay, and from
12 their perspective, there is -- they're getting
13 data that seems internally consistent and is
14 reliable.

15 I don't know, as a physician being
16 judged, I tend to be a little more skeptical
17 about these scores, that when I get them, and
18 I think -- I agree, that they really put a lot
19 work into this and that I'm not being able to
20 totally judge methodology, from my own
21 perspective.

22 So, I can't give it a one. I

1 would either give it a moderate or -- probably
2 a moderate score, or perhaps a low -- I mean,
3 because frankly, physicians are much more --
4 when they get scoring related to quality care,
5 it's much -- it appears much more transparent
6 to them, because it shows the number of --
7 their percentage of patients that get A1C's
8 done and percent, and what their average A1C
9 is and so forth.

10 But here, we're getting basically,
11 a score that gives you sort of an estimate of
12 your costs related to other physicians costs
13 in diabetes, and it does -- and absent of the
14 clinical -- and of course, we're not expecting
15 this from the developer, but absent some
16 quality assessment, that maybe your costs were
17 deservedly so, or not deservedly so, it has a
18 certain -- less amount of meaning, to a
19 certain extent.

20 DR. LYNN: I just want to make one
21 comment, and that is about how, you know, it's
22 -- it's hard for this stuff to be actionable,

1 and it is hard for this stuff to be
2 actionable, but one of the things that we've
3 tried to do is include these other measures,
4 not just the cost, but you know, number of ER
5 visits per episode and hospitalizations per
6 episode, to try to help get at some of these
7 drivers.

8 You know, there is a lot more that
9 needs to be done, but you know, we are trying
10 to provide some drivers of cost.

11 DR. HWONG: And as far as like
12 2b4, so, Jamie, I think your points are well
13 taken.

14 You know, for this, is this really
15 that sort of risk adjustment methodology? Are
16 we ranking that, 2b4, or --

17 CO-CHAIR ROSENZWEIG: This is 2b5.

18 DR. HWONG: I'm sorry.

19 MS. TURBYVILLE: No, we're on 2b4.

20 DR. HWONG: We are on 2b4?

21 CO-CHAIR ROSENZWEIG: I'm sorry.

22 DR. HWONG: I'm sorry, yes, I was

1 looking at the screen and getting kind of
2 confused. Yes, we're voting on risk
3 adjustment or -- and then I was thinking about
4 -- I was thinking he was talking about the
5 next sort of topic.

6 CO-CHAIR ROSENZWEIG: All right, I
7 will address that, I apologize.

8 DR. HWONG: So, I'll hold that
9 thought.

10 CO-CHAIR ROSENZWEIG: I skipped
11 one of the measures. Okay, so, for outcome
12 measures and other measures, when indicated,
13 an evidence based risk adjustment strategy,
14 risk models as specified and is based on
15 patient clinical factors that influence the
16 measured outcome, but not related to
17 disparities of care.

18 I would give this, yes, a high
19 rating. I'm sorry, I apologize to the rest.

20 DR. WEINTRAUB: Really, I mean,
21 this has problems here. First of all, you
22 automatically distinguish between

1 complications and co-morbidity, and then I
2 think that we haven't seen enough, in terms of
3 specification of the model.

4 So, I think was going to give it a
5 low. You could talk me into a moderate, but
6 you'll have troubling telling me it's high.

7 CO-CHAIR CURTIS: I share those
8 concerns, particularly, you know, without a
9 very strong explanation or rationale for why
10 you're identifying -- can't distinguish
11 between complications and co-morbidities, it
12 flies in the face of most measures.

13 It might be still as accurate, I
14 don't know, but it certainly violates our
15 principles. So, maybe too strong.

16 DR. WEINTRAUB: I mean, you know,
17 talk about colinearity, I mean, complications
18 predict complications. If you have heart
19 failure, you have heart failure. You
20 absolutely cannot make sense of putting into
21 a model, complications to predict the outcome.

22 DR. LYNN: I think it's a

1 different question, slightly. You know, are
2 you going to hold physicians responsible for
3 the greater difficulty of caring for diabetes,
4 because they have something else that's going
5 on, that whether it occurred before or after,
6 is it "their fault"?

7 And again, the model does not
8 include the cost of caring for the heart
9 failure. It includes only the cost of caring
10 for the diabetes.

11 DR. WEINTRAUB: All right, so, if
12 you take it out and you don't count it,
13 because that admission for the studies have
14 nothing to do with diabetes, no problem.
15 They're not getting dinged on it.

16 CO-CHAIR ROSENZWEIG: All right,
17 you know, considering all the complicated
18 issues related to co-morbidities, yes, I'll
19 lower my recommendation from high to moderate,
20 yes.

21 CO-CHAIR CURTIS: I think the
22 other piece, though, is that if we are pairing

1 this with quality measures in the future, you
2 can't really have two different approaches to
3 risk adjustment, and no one is ever going to
4 modify, to identify complications as co-
5 morbidities.

6 DR. WEINTRAUB: The last thing you
7 want to do is have a measure out there with
8 complications, as part of the model.

9 I mean, we criticize from here to
10 eternity.

11 CO-CHAIR CURTIS: So, let's go
12 ahead and vote.

13 CO-CHAIR ROSENZWEIG: Okay, so,
14 people were more skeptical of this than I was,
15 okay.

16 And then the next one, data
17 analysis -- I'm sorry, this is 2b5, data
18 analysis demonstrates that methods for scoring
19 an analysis of the specified measure allowed
20 for identification of clinically significant
21 and practically clinically meaningful
22 differences in performance.

1 Well, you know, since you're
2 looking at these differences on so many
3 different levels, it's hard to say.

4 I suspect that probably the data
5 analysis for large groups could really show
6 differences in performance, within the
7 spectrum of what is being measured here.

8 I wonder about the number 30, that
9 was given to us, with respect to looking at
10 individual physicians, especially since many
11 physicians may not have that many patients
12 with diabetes in their practice, and so, I
13 would be a little skeptical about that one and
14 I'd probably give it a low reading.

15 CO-CHAIR CURTIS: Let's go ahead
16 and vote then.

17 CO-CHAIR ROSENZWEIG: Two moderate
18 and -- excuse me, four moderate and three low.

19 MS. TURBYVILLE: Could I make sure
20 I capture the rationale, here? I was still
21 working on the risk adjustment rationale,
22 quickly, so, I didn't hear what Jamie said.

1 So, is it -- was is, going back to
2 the issue of the physicians, or -- I
3 completely missed what was said.

4 CO-CHAIR CURTIS: It's
5 insufficient evidence of a threshold number,
6 or that the -- that the results are clinically
7 useful at the end of the day, at the level of
8 the physician, less so for higher levels.

9 MS. TURBYVILLE: So, unlike the
10 other measures, because it's recommending the
11 physician level of analysis?

12 CO-CHAIR ROSENZWEIG: I'm sorry?

13 DR. LYNN: This is kind of an
14 interesting issue. I mean, you know, if you
15 give it a different rating, if you use the
16 group or -- MS. TURBYVILLE: Right,
17 so, I just want to make sure I'm capturing
18 that.

19 So, is it -- so, unlike the other
20 measures, this one, in looking at physician
21 profiling, it's a concern that it wouldn't be
22 actionable by an individual physician, or is

1 it also about something else that I've missed?

2 CO-CHAIR ROSENZWEIG: Yes, I have
3 a certain amount of skepticism about the
4 individual profiling of individual physicians.

5 MS. TURBYVILLE: Okay.

6 CO-CHAIR ROSENZWEIG: With respect
7 to this, because of the number of patients
8 with diabetes within a specific panel that
9 physicians tend to have, and so forth.

10 I have less skepticism with
11 respect to analyzing the data and like NCQA
12 does, to look at plans, since they -- it's
13 likely that they're probably -- those are more
14 consistent.

15 MS. TURBYVILLE: Okay.

16 CO-CHAIR CURTIS: But looking at -
17 - there needs to be consistency across, right,
18 because the ABMS measures also specific the
19 level of the physician, and I don't know if we
20 have a similar low range.

21 MS. TURBYVILLE: But I'm wondering
22 if there is a little change in the tone of the

1 --

2 CO-CHAIR CURTIS: So, we can look
3 at that, when we get to the comparisons.

4 MS. TURBYVILLE: We'll revisit, as
5 long as it's captured here.

6 CO-CHAIR CURTIS: Well, do we want
7 to re-vote on that, with that consideration,
8 because I don't think it's different.

9 CO-CHAIR ROSENZWEIG: Well, but
10 the ABMS also used a very widely recognized
11 system that's been in place -- you know,
12 that's, at least from my perspective, is a
13 little more not proprietary and is more
14 transparent.

15 So, I don't know, I can't remember
16 what we actually voted on for the ABMS value
17 for this particular measure, but --

18 DR. WEINTRAUB: Can we look at it?

19 CO-CHAIR CURTIS: It will be from
20 this morning, for the diabetes measure,
21 specifically.

22 CO-CHAIR ROSENZWEIG: The diabetes

1 measure, specifically, yes.

2 CO-CHAIR CURTIS: Not the NCQA,
3 just the --

4 MS. WILBON: The diabetes measure
5 is not --

6 MS. TURBYVILLE: Yes, it's not.
7 This is --

8 CO-CHAIR CURTIS: It's not in
9 there?

10 MS. TURBYVILLE: This software
11 tool does not allow us to easily summarize
12 after it's run, sorry.

13 MS. WILBON: I can read it out
14 loud, hold on one second.

15 MS. TURBYVILLE: Okay.

16 CO-CHAIR ROSENZWEIG: Okay, then
17 if multiple data sources are specified, and
18 there is demonstration that they produce
19 comparable results, I don't think that was
20 addressed here, specifically.

21 CO-CHAIR CURTIS: Right.

22 CO-CHAIR ROSENZWEIG: It's all

1 from the -- yes, yes, yes.

2 CO-CHAIR CURTIS: So, I summarily
3 move that we dismiss 2c.

4 CO-CHAIR ROSENZWEIG: That being
5 non-applicable.

6 CO-CHAIR CURTIS: Yes.

7 CO-CHAIR ROSENZWEIG: I suppose.

8 CO-CHAIR CURTIS: Right.

9 CO-CHAIR ROSENZWEIG: Okay, and
10 then so, I think we're onto usability.

11 MS. WILBON: So, just a quick
12 follow up to the request before.

13 I think you wanted your ratings on
14 the ABMS diabetes measure.

15 CO-CHAIR ROSENZWEIG: Yes.

16 MS. WILBON: Specifically on 2b5?

17 CO-CHAIR ROSENZWEIG: Yes.

18 MS. WILBON: Around statistical
19 meaningful differences. Six high and two
20 moderate.

21 CO-CHAIR CURTIS: Unless we can --

22 DR. HWONG: You know, I mean, I

1 think I wonder if it's there, with ABMS.
2 Remember, they sort of specified very clearly
3 in sort of clinical terms, like what services
4 are going to be included, whereas, maybe
5 what's getting -- maybe -- potentially, there
6 was a difference, like, you know, here, it's
7 still, there is that interplay with different
8 episodes and kind of what ultimately ends up
9 inside.

10 You know, may be less
11 interpretable to a physician at the end, even
12 if I were to hypothesize what might be some of
13 that difference.

14 That being said, I do recognize
15 that the Ingenix developer, especially when
16 you stratify -- not stratify, but like, when
17 you -- well, that's sort of strata, but like,
18 pull out, in terms of the different resource
19 categories, right, but you know, I mean, I
20 think that does go part of the way to address,
21 you know, it being a meaningful, something
22 that potentially could be meaningful, in terms

1 of someone's practice or a group practice.

2 CO-CHAIR CURTIS: And I think it
3 also does get into the risk adjustment
4 methodology, as Jamie said, is different and
5 there are more significant questions about
6 that risk adjustment methodology, you know,
7 years prior or within the year, and that may
8 be affecting people's votes, certainly.

9 CO-CHAIR ROSENZWEIG: The other
10 issue is that the other group also specified
11 that they would only use it to compare
12 physicians when there was statistically
13 significant differences, as least as I recall.
14 That's not the case?

15 CO-CHAIR CURTIS: I think that's
16 how they specify here. I don't think that
17 they're applying it differently.

18 CO-CHAIR ROSENZWEIG: They're just
19 saying 30.

20 CO-CHAIR CURTIS: No, no.

21 MS. TURBYVILLE: That's just an
22 example.

1 CO-CHAIR ROSENZWEIG: That's just
2 an example?

3 CO-CHAIR CURTIS: No, that's just
4 an arbitrary number.

5 CO-CHAIR ROSENZWEIG: Okay, all
6 right.

7 MS. TURBYVILLE: So, we'll just
8 revisit that when we get more feedback from
9 all the measure developers, including their R-
10 squared for their risk adjustment method.

11 CO-CHAIR CURTIS: Okay.

12 DR. WEINTRAUB: Ask him to give
13 calibration, as well, not just discrimination.

14 MS. FANTA: We've got it down.

15 CO-CHAIR CURTIS: So, then we're
16 on usability?

17 CO-CHAIR ROSENZWEIG: Yes. Okay,
18 we're on page 45, and -- I think that -- they
19 certainly have reports that seem to be
20 readable and logical, and seem to be
21 reasonably current, and they compare -- but
22 what they're doing, at least with respect to

1 their discussion of this, they're really
2 talking about comparing healthcare
3 organization one versus various others, and
4 they're not specifically talking about
5 diabetes.

6 CO-CHAIR CURTIS: Do you want to
7 comment on that, Tom?

8 DR. LYNN: Let me look at it,
9 before I do, because -- is this still --

10 CO-CHAIR ROSENZWEIG: I'm talking
11 about U11 and U12.

12 CO-CHAIR CURTIS: Page 45 and 46,
13 I think is the predominant, and -- the other
14 piece of this is that they talk about how the
15 payers are using it. They're not talking
16 necessarily, about individual providers, but
17 they don't state that they payers are not
18 looking at the individual providers.

19 So, you know, it's a little bit of
20 a black box, but this is the first time that
21 we've really gotten to usability, to a large
22 extent.

1 DR. HWONG: Right, and the only
2 thing I would add to that, in terms of coming
3 just from one payer, you know, especially
4 where the symmetry, in an ETG product that's
5 used, so, as far as where it's used for like,
6 community, you know, public reporting, there
7 are listings, in terms of the provider
8 directory, you know, there is program that
9 looks at sort of overall cost and quality
10 rankings and so, that is the driver of that.

11 So, in some ways, like,
12 physicians, the community at large, actually
13 sees that. So, if this category is really
14 about like, you know, are these performance
15 results sort of made public? Are they seen?
16 Are they used in programs? I know of at
17 least, like, personally, like one example
18 where that is being done.

19 DR. LYNN: This is not
20 specifically talking to that, overall.

21 DR. HWONG: Right.

22 CO-CHAIR CURTIS: Is there an

1 overall Ingenix measure under evaluation in
2 this process, one that rolls up all the
3 individuals?

4 DR. LYNN: We had to -- there is
5 actually a bug on my -- you guys are bugging
6 my stuff.

7 There is actually -- we had a
8 measure, but there were complications that
9 were not technical. They were more -- other
10 complications that we had to take, that went
11 down.

12 MS. CLARK: I have a question
13 about this public reporting. I mean, it says
14 public at large. I mean, does this really
15 mean that it needs to be -- it's widely
16 available to the public, right?

17 I mean, all of these uses are
18 really internally within the health plans, as
19 the examples. So, is that considered public?

20 CO-CHAIR CURTIS: What Connie just
21 referred to is private.

22 DR. HWONG: Granted, it's not in

1 the application, but like, I can just from my
2 experience, right, and just one single example

3 -- MS. CLARK: Okay.

4 DR. HWONG: -- but the rankings
5 for physicians are placed on the website for
6 the provider directory.

7 So, you can see the results, and
8 then there is information about the program,
9 as to how those scores, or how those symbols,
10 the blue ribbon, gold star kind of stuff,
11 right, you know.

12 But, you know, it's certainly out
13 there, that someone, you know, a lay person
14 can go to the website, take a look, right, and
15 see, you know, look up their physician, that
16 sort of thing.

17 MS. CLARK: But that's -- is it
18 the same report, type of reports that are
19 here? I mean, it's a different report?

20 DR. HWONG: Right, yes, I hear
21 you. So, for the one example I'm giving in
22 that regard, that -- the full report isn't

1 available to patients at large, that way.

2 That being said, in the other
3 programs that we do, in terms of, it is
4 available to the physicians, to the
5 physicians, in terms of their individual
6 reports.

7 So, yes, it may not get at, Mary
8 Ann, you know, at this sort of wide spread
9 public, you know, dissemination, maybe, but
10 there is some --

11 MS. CLARK: Was that the intent,
12 though?

13 MS. TURBYVILLE: That's a
14 conversation that continues to occur at the
15 CSAC level, our committee for standards
16 setting that oversees all of the Steering
17 Committee work, and there is discussion about,
18 you know, is it public at large? Does it have
19 to be the General Joe, and Heidi might want to
20 add to it, but I'm not sure that that is, you
21 know, 100 percent where we are right now.

22 MS. BOSSLEY: I think this is

1 evolving, and in fact, the Board will be
2 looking at a recommendation, and we have a
3 task force that specifically looks at, when we
4 talk about usability, what does that mean, the
5 first time you see that measure, what kind of
6 use are we looking for, and the usefulness,
7 because there is two pieces to it, and then at
8 maintenance, what are you going to?

9 So, hopefully, as you're going
10 through this, you will have a group that is
11 advising, and it will probably help you refine
12 your criteria on that, as well. But this is
13 one of the more loose ones we have, right now.

14 CO-CHAIR ROSENZWEIG: Okay, so,
15 with respect to demonstration of usability,
16 you have used this in public reporting, in a
17 variety of settings, at least you say here,
18 but they ask, at least the -- NQF asked for
19 the names of the programs, the locations and
20 web URL's and you're just basically telling us
21 HC-05, HC-06, and so forth.

22 Is there -- is that proprietary

1 information that you can't divulge?

2 DR. LYNN: I actually don't know
3 the answer to that question. I can find out,
4 and get back to you about that.

5 CO-CHAIR ROSENZWEIG: Are there
6 specific -- is there any data that -- the use
7 of these, you know, this reporting has
8 actually resulted in quality improvement or in
9 cost reduction?

10 CO-CHAIR CURTIS: Well, that
11 really gets to the effectiveness, which I
12 don't think was the criteria.

13 The criteria is whether or not
14 it's being used by --

15 CO-CHAIR ROSENZWEIG: Okay.

16 CO-CHAIR CURTIS: -- people for
17 quality, attempts to improve quality, and I
18 think that they do meet that threshold.

19 CO-CHAIR ROSENZWEIG: Okay, it's
20 been used?

21 CO-CHAIR CURTIS: It's being used
22 by --

1 CO-CHAIR ROSENZWEIG: Not
2 specifically for diabetes, at least as a
3 diabetes stand alone.

4 CO-CHAIR CURTIS: Right.

5 DR. WEINTRAUB: That's important.
6 There are examples here, are things entirely
7 different, Caesarean section, for instance.

8 CO-CHAIR CURTIS: But that gets
9 back to this sort of artificial, the
10 construction of the overall ETG methodology
11 and to its component parts.

12 So, you know, they don't ever
13 report out diabetes without the larger
14 context. So, it might be impossible.

15 DR. LYNN: It's not that we don't
16 ever do it, but that is not what is usually
17 done.

18 CO-CHAIR CURTIS: Well, right.

19 CO-CHAIR ROSENZWEIG: But the plan
20 is, in the future, to. That's why you're
21 coming to us with this measure, right?

22 DR. LYNN: Honest, we see this as

1 a part of a bigger effort. You know, we
2 assume that this is going to continue to go
3 and there are going to be more diseases and
4 more diseases added, and we recognize that you
5 need -- you know, part of increasing the end
6 here is increasing the number of diseases that
7 are sort of certified, and I know that's time
8 consuming and difficult.

9 DR. MARWICK: I think if that's the
10 goal, then dealing with the ambiguity about
11 how people get allocated from bucket to
12 bucket, that's something I personally would
13 feel much more comfortable about, and still
14 feel some disquiet about that.

15 CO-CHAIR ROSENZWEIG: Okay,
16 testing of interpretability, this is
17 interesting. I mean, the interpretability has
18 been looked at by the medical advisory board
19 of Ingenix and also, the user.

20 Could you explain who the user
21 forums are? I mean, have you done any
22 testing, like, actually sent out

1 questionnaires to the physicians who are being
2 rated by this?

3 DR. LYNN: We probably have not
4 sent out questionnaires -- You know, being
5 that we're not the organization that actually
6 measures the physicians, we haven't gone out
7 to the physicians.

8 These are probably -- this is
9 basically input from the intermediary, who are
10 using the methodology.

11 So, our users are, you know,
12 health plans, large provider organizations and
13 groups like that, that use this methodology.

14 CO-CHAIR ROSENZWEIG: Okay, you're
15 not giving us any specific details on the data
16 that's been reported to you. You're just
17 saying that they were --

18 CO-CHAIR CURTIS: Is this in
19 contrast to the NCQA diabetes measure? I know
20 we talked about how they -- I think they
21 specified that they have focus groups and
22 commented on the usability of the measures and

1 things like that.

2 But again, I don't know if it was
3 that specific to say, this company said that
4 this was useful for these reasons.

5 But I agree, that as a product, as
6 it matures in this arena, it might be useful
7 to do that type of testing in the future.

8 CO-CHAIR ROSENZWEIG: Okay, and
9 resource use data and result can be decomposed
10 for transparency and understanding.

11 DR. WEINTRAUB: Can be.

12 CO-CHAIR CURTIS: Actually, in the
13 sense, I feel like I'm on the promotion
14 committee now, but if you couple it with the
15 ER visits, with the individual service lines,
16 I think there is that potential for enhancing
17 the interpret-ability and the decomposition of
18 the total costs, to the component elements.

19 Again, I don't know if that's been
20 adequately demonstrated for our group, but --

21 CO-CHAIR ROSENZWEIG: I wasn't --
22 I mean, it -- I suppose it could be, whatever

1 decomposing means.

2 Okay, and if this measure has
3 either the --

4 CO-CHAIR CURTIS: I worry about
5 Brenda, it might still --

6 CO-CHAIR ROSENZWEIG: Has either
7 the same measure focus or same target
8 population as NQF endorsed measures. Are
9 these measure specifications completely
10 harmonized?

11 DR. HWONG: I think we're leaving
12 that off the table right now, the
13 harmonization.

14 CO-CHAIR ROSENZWEIG: I think
15 that's off the table, yes, I wouldn't -- I had
16 it as insufficient or not applicable. So,
17 let's make it not applicable, so, we don't
18 have to -- okay.

19 All right, do we want to go over
20 these now, or we can just continue through the
21 --

22 CO-CHAIR CURTIS: I think I'd stop

1 at usability --

2 CO-CHAIR ROSENZWEIG: All right.

3 CO-CHAIR CURTIS: -- and then
4 maybe go through it, yes.

5 CO-CHAIR ROSENZWEIG: All right,
6 so, for 3a?

7 DR. HWONG: Yes.

8 CO-CHAIR ROSENZWEIG: This is for
9 the use and quality improvement. They
10 certainly listed a series of organizations.
11 They haven't specified what they are, and
12 haven't specifically indicated that there is -
13 - that there is specific benefit from them.

14 But it certainly seems like they
15 are probably pretty usable, from my
16 perspective. I had the sense that they would
17 be usable. So, I gave this a moderate.

18 CO-CHAIR CURTIS: So, I don't
19 believe this is for quality. This is for the
20 public reporting aspect.

21 CO-CHAIR ROSENZWEIG: This is for
22 the public reporting, as opposed to whether or

1 not it actually -- whether or not it -- yes,
2 as you -- I'm not -- there is no -- there is
3 not a lot of evidence that it specifically
4 produced better quality, but there is evidence
5 that it was usable, okay.

6 DR. WEINTRAUB: In that sense, it
7 benefitted the public?

8 DR. HWONG: I got a sense that
9 this was more about just, is it out there,
10 right? Is it publically available? Is it
11 somewhere? It's not just hidden in a closet
12 somewhere for some private purpose, but that,
13 you know, that there is some opportunity,
14 potentially for some feedback on the actual,
15 you know, structure and method.

16 CO-CHAIR CURTIS: And I think
17 we're voting on our understanding of overall
18 Ingenix measure, and not necessarily the
19 specific line within it.

20 I think you have to have that,
21 because it's --

22 DR. PALESTRANT: I think my

1 concern is publically reported occurrence --
2 it was really isn't to any great extent, and
3 could it be in the future? Sure, but it's
4 not, and then does the report look like, is
5 also a big question.

6 If you publically report it, then
7 it has to have the details of how this measure
8 was devised, and not -- and so, is the company
9 then prepared to sort of -- release a lot of
10 data to the public about how they came to
11 these numbers, and I don't think we have the
12 answers for those questions, right now at all.

13 CO-CHAIR CURTIS: So, it seems
14 like it might default back to non-applicable,
15 or --

16 DR. PALESTRANT: Well, no, no, no,
17 well, first of all I think it's either high,
18 not low --

19 CO-CHAIR CURTIS: Or insufficient,
20 one of the two.

21 CO-CHAIR ROSENZWEIG: Your point
22 is well taken, because none of these are

1 diabetes specific, so, they're not really
2 addressing the specific measure.

3 DR. HWONG: I guess, I sort of
4 look at it, again, you know, understanding
5 this carved out from the overall methodology,
6 and then I look at the sort of sub-sub-
7 criteria, right, the -- is it currently in
8 use? You know, is it used in public reporting
9 initiative, which I am hearing from everybody,
10 that, you know, I feel like less confident
11 about that.

12 Is it used in quality improvement
13 efforts, that I see, that that is, you know,
14 based on sort of the responses, you know,
15 placed in the application, and used for other
16 accountability functions, as well, you know,
17 in terms of the QI and if there was sort of
18 accountability, you know, at a physician
19 level.

20 So, yes, I guess when I look at
21 the actual, sort of the sub-sub-criteria, I
22 think there are, you know, some aspects, you

1 know, maybe not all, right, but some aspects
2 that might be fulfilled.

3 CO-CHAIR ROSENZWEIG: As I said,
4 it's not the diabetes measure. It's the ETG
5 methodology.

6 CO-CHAIR CURTIS: I just think
7 it's hard to separate it out, because that is
8 the evidence that they've given us.

9 MS. TURBYVILLE: Right.

10 CO-CHAIR CURTIS: If it's evidence
11 of the diabetes, it's got to be insufficient,
12 by definition, right, because they haven't
13 provided that level.

14 So, I guess we could vote, either
15 way, we could choose -- I mean, we should
16 probably be agreeing as a group, as to which -
17 - you know, and I'm comfortable voting on the
18 overall, as long as that's in the annotation
19 to the Steering Committee, that that is how we
20 took this.

21 Sally, so, do you want to -- do
22 you have a thought, as to which direction we

1 should go?

2 MS. TURBYVILLE: Well, we are
3 charged with evaluating this as an independent
4 measure. The current text and the background
5 of the ETG system is clearly, critical to
6 understanding the measure, and how it might be
7 used.

8 But the endorsement process, as we
9 have is structured, and we had similar comment
10 to ABMS, when they were stating paired
11 measures, really is an independent evaluation.

12 CO-CHAIR CURTIS: Okay, so, I
13 think that's adequate guidance. So, okay,
14 let's vote. One moderate and one low, four
15 insufficient.

16 CO-CHAIR ROSENZWEIG: Okay.

17 CO-CHAIR CURTIS: So, for 3b, this
18 is where the results are meaningful,
19 understandable and useful to the intended
20 audience.

21 CO-CHAIR ROSENZWEIG: So, they
22 showed a mock-up of what the report looks

1 like. They've used -- for the purposes of
2 this, I don't think it'd need diabetes
3 specificity as much, at least that's the way
4 I would interpret it.

5 They have had sort of a -- sort of
6 reviewed by their medical -- their own medical
7 advisory board, an Ingenix user forum, but it
8 hasn't really be tested for interpretability
9 by -- at least, they haven't given us
10 evidence that it's been tested for
11 interpretability by outside groups.

12 CO-CHAIR CURTIS: Okay, so, should
13 we go ahead and vote on that?

14 Okay, four moderate, one low and
15 one -- two insufficient, and 3c, data and
16 result details and maintains such that the
17 resource use measure, including construction
18 logic could be decomposed to facilitate
19 transparency.

20 So, I think we talked about how
21 one could, but it takes an awful lot of
22 effort.

1 One high, two moderate and four
2 low.

3 CO-CHAIR ROSENZWEIG: And then the
4 fourth one--

5 CO-CHAIR CURTIS: Harmonization,
6 we can --

7 CO-CHAIR ROSENZWEIG:
8 Harmonization, we can punt on.

9 CO-CHAIR CURTIS: Yes.

10 CO-CHAIR ROSENZWEIG: Okay.

11 MS. TURBYVILLE: Can I take a step
12 back for the rationale on 3c, because I think
13 there are a lot of moderate and lows, if I
14 remember correctly, the one that we just did.

15 CO-CHAIR ROSENZWEIG: Okay.

16 MS. TURBYVILLE: Okay, so, I just
17 want to make sure, as we capture the
18 rationale, so, unlike for example, the NCQA
19 measure, there ABMS measure, the challenges
20 for the user or the person getting measured,
21 in decomposing, is higher because -- and
22 that's not a challenge, I just want to make

1 sure or not, or -- so, is it the specification
2 is not having enough of it, to allow for that?
3 Is it the complexity? Is it the relationship
4 to the other ETG's? I just want to make sure
5 I -- or was it all of those things?

6 CO-CHAIR CURTIS: You're looking
7 at me, but I voted moderate--

8 MS. TURBYVILLE: No, I'm looking
9 at everybody else. I'm sorry, Jeptha, just
10 was looking so intently and thoughtfully.

11 So, just to -- so, anyway --

12 DR. LYNN: Because, I mean, it's
13 rudimentary, but this measure does provide
14 some forays into what drives costs, ER counts,
15 hospitalization, things like that.

16 MS. TURBYVILLE: Okay, okay. So,
17 any thoughts on this?

18 CO-CHAIR CURTIS: I think it might
19 be just sort of varying, like, depending on
20 what time of day, how we think about what
21 decomposition means --

22 MS. TURBYVILLE: No, that's fair.

1 CO-CHAIR CURTIS: -- and so, I
2 think it probably, I would feed it back,
3 rather than re-vote, I would say that maybe we
4 need additional guidance from the Steering
5 Committee --

6 MS. TURBYVILLE: Yes.

7 CO-CHAIR CURTIS: -- et cetera, as
8 to really, what this particular element means.

9 MS. TURBYVILLE: And what I'm kind
10 of fishing for here is, it may be more input,
11 also, from the measure developer, as we
12 prepare for--

13 CO-CHAIR ROSENZWEIG: I think it's
14 possible, yes, I think it's possible that it
15 could be decomposed --

16 MS. TURBYVILLE: Okay.

17 CO-CHAIR ROSENZWEIG: -- for more
18 transparency and understanding, that -- at
19 least at the level that we've been evaluating
20 at the present. It's difficult for us to
21 assess the extent of that.

22 CO-CHAIR CURTIS: And I think

1 that's true for all of the -- well, the two
2 measures that we've gone through, to this
3 stage.

4 MS. TURBYVILLE: Right, okay.

5 CO-CHAIR CURTIS: So, Jamie, do
6 you want to go through feasibility?

7 CO-CHAIR ROSENZWEIG: Did we do
8 3d?

9 CO-CHAIR CURTIS: I think we're
10 skipping, we're punting.

11 CO-CHAIR ROSENZWEIG: Okay, 3d,
12 okay, so, basically, feasibility, the 4a, this
13 is -- this measure is -- the data elements are
14 generated as a byproduct of care processes.
15 Certainly, that is the case and it is
16 generated and used by healthcare personnel,
17 including a whole variety of specific
18 information.

19 I didn't know that blood pressure
20 was specifically being measured as a part of
21 this. Lab values and medical conditions --

22 CO-CHAIR CURTIS: I think that is

1 a drop-down box from NQF, maybe, or -- because
2 I think that has been on the other ones.

3 MS. TURBYVILLE: Yes.

4 DR. WEINTRAUB: That is a very
5 important point, blood pressure is not going
6 to be found in--

7 CO-CHAIR ROSENZWEIG: I don't
8 think you're going to find that in claims
9 data.

10 DR. HWONG: That is just generic
11 language.

12 CO-CHAIR ROSENZWEIG: Right,
13 unless you're using CPT categories, category
14 two codes. Oh, so, this is generic?

15 CO-CHAIR CURTIS: Well, I think
16 it's -- the blood pressure --

17 MS. BOSSLEY: Generic, EG, the
18 whole statement is a generic check box that
19 they check.

20 CO-CHAIR CURTIS: Right.

21 DR. HWONG: Right, the language
22 is, yes.

1 CO-CHAIR CURTIS: So, the one that
2 is relevant here is medical conditions, as
3 assessed by administrative data.

4 MS. TURBYVILLE: Exactly.

5 CO-CHAIR ROSENZWEIG: Well, I
6 would say certainly, that is the case, yes,
7 and electronic sources, yes, all data elements
8 that are not from electronic sources -- are
9 you using anything other than electronic
10 sources? Okay.

11 DR. LYNN: No.

12 CO-CHAIR ROSENZWEIG: That is what
13 I thought. So, 4b, and then susceptibility to
14 inaccuracies, errors, and unintended
15 consequences, wow, I mean, they mention small
16 sample size here. Is that also something
17 that's generated -- is that something that was
18 --

19 MS. TURBYVILLE: Can you scroll
20 down to that?

21 CO-CHAIR ROSENZWEIG: Okay, so,
22 here again, now, I guess this is -- you know,

1 I think the issue is largely the inaccuracies,
2 errors and unintended consequences, my worry
3 would be in small sample size per physician,
4 generating a score that could be used for
5 tiering of physicians, that might not
6 necessarily be appropriate.

7 So, we have to worry about that
8 particular issue. I have less of a concern
9 about this being used to compare individual
10 plans or large provider groups, so to speak,
11 with respect to their costs, okay.

12 So, that would be the issue
13 related to that. So, you want a reasonably
14 sized peer group, which is what they mention
15 in here as being a factor, as well, to be able
16 to do that, and to a certain extent, the
17 company, Ingenix, understands this better than
18 -- how to evaluate this, better than anyone
19 else.

20 But it is an issue that does come
21 up. There is a tremendous amount of concern
22 and anger and frustration in the medical

1 community about physician tiering based upon
2 costs of care, which is being implemented, and
3 to physicians, it looks like a black box,
4 okay, and it affects whether or not
5 physician's co-pays are changed, at least in
6 Massachusetts, it affects whether or not
7 they're listed on lists as preferred
8 physicians for individual plans, and it's
9 usually based upon two criteria, quality of
10 care, which is much more transparent, and then
11 some sort of a score of their costs, compared
12 with the population as a whole.

13 And to a physician, this often
14 looks like a black box, so to speak, and their
15 lawsuit -- I know, was -- there is a big
16 lawsuit in this, in the State of New York, and
17 there was a -- in Massachusetts, this has gone
18 to the -- it's still being subject of -- I
19 think it's the Board of Medicine in
20 Massachusetts, with respect to this issue,
21 there a lawsuit involved with that, on behalf
22 of the Mass Medical Association.

1 So, these are complex issues for
2 obvious reasons, and so forth, and so -- am I
3 going on too long?

4 DR. HWONG: Jamie, only one thing,
5 I might want to comment on.

6 I agree with you, like there are
7 these complications, in terms of limit supply
8 in some of these settings.

9 But I get the sense that, you
10 know, it's not that Ingenix creates this for
11 that one expressed purpose, right. I mean, in
12 terms of how it's ultimately implemented, I
13 think there is sort of -- you can have sort of
14 different business rules, different, you know,
15 programs and how you want to use it.

16 So, I just sort of want to make
17 sure that we were evaluating this, that it's
18 less on, you know, sort of like downstream
19 specific, you know, some implementation, some
20 kind of program in a way, but much about, is
21 this able to kind of discern, for whatever you
22 do with it in the end, you know, I mean, it

1 has nothing to do with, you know, score -- you
2 know, how you want to do sort of tiered co-
3 pays or what not.

4 But, just, you know, does it have
5 the ability to kind of, you know, make, you
6 know, allow you to discern between sort of
7 costs that are generated from one physician to
8 another?

9 CO-CHAIR ROSENZWEIG: Well, I
10 think, you know, I agree with you. I'm not
11 suggesting that Ingenix would -- this is not
12 being used by Ingenix, for tiering. It's be
13 used by the plans, and the plans have -- and
14 in fact, there have been NQF specified
15 measures, quality measures, that have been
16 misused by plans, as well. Not NQF, but NCQA
17 HEDIS measures that have been used by plans in
18 wrong ways as well.

19 So, I think it's not the -- the
20 question is whether or not it's susceptible to
21 inaccuracies and errors or unintended
22 consequences. That's my concern here, and I

1 would think that there is this susceptibility.

2 CO-CHAIR CURTIS: I think that's
3 overall, a good issue that you raise and one
4 that we should -- we discussed at the level of
5 Steering Committee, it's how specific we need
6 to be and how these measures could be used in
7 isolation, as a resource use measure, as
8 opposed to one that's getting more at value.

9 So, you know, I think we can
10 discuss it further at that level.

11 CO-CHAIR ROSENZWEIG: I think it's
12 something that NQF as an organization probably
13 needs to think about, as it produces these
14 measures.

15 CO-CHAIR CURTIS: Also, it's a --

16 CO-CHAIR ROSENZWEIG: And be able
17 to specify how they might be used, or the
18 limitations.

19 CO-CHAIR CURTIS: Right, but it's
20 a very thin ice for them, from their other set
21 of consumers, which are the people that are
22 developing the measures and want to -- defer

1 them to use the measures.

2 So, it has to do with what is the
3 scope of the purview, and I know there is back
4 and forth at very high levels.

5 CO-CHAIR ROSENZWEIG: Yes, I
6 understand.

7 DR. PALESTRANT: But the crux of
8 the matter there is that it's relying -- I
9 endorse the interest endorsement, it's a big
10 deal for many of these - the providers of
11 these measures.

12 And so, if they can -- they can
13 then at least market their measures, for doing
14 this work, and so, what I could see, not just
15 with Ingenix, and it's not that -- it may
16 actually be unfair, I've got to get to that in
17 a second.

18 But basically, what's been applied
19 is, that in many of these metrics that we've
20 looked at, they've never actually been used in
21 the past, for the purpose for which they're
22 now being evaluated.

1 And it's kind of difficult then,
2 to endorse them, if there is no track record,
3 and you don't want to endorse something that
4 then is going to have widespread use.

5 CO-CHAIR CURTIS: I mean, I
6 disagree that there is no track record. There
7 is no track record, necessarily for public
8 reporting, but there is a track record for its
9 use in the estimation of cost.

10 DR. PALESTRANT: I would
11 absolutely disagree. I mean, for each of
12 these metrics, if you realize whether it be
13 diabetes, coronary artery disease, they're
14 applying these metrics, these methods for
15 analysis, to what's being asked, and very few
16 of them have been able to give us long
17 substantial track record of data, and you say
18 that Ingenix hasn't, and from what I've been
19 seeing of the other ones there isn't a lot of
20 track record.

21 DR. WEINTRAUB: I agree with
22 that, absolutely, completely, where, you know,

1 we're -- we're breaking new ground.

2 The question is, where are we with
3 that, and how do we move forward?

4 DR. PALESTRANT: Well, I think you
5 may be putting the cart before the horse, at
6 least it seems to me.

7 DR. WEINTRAUB: Maybe so.

8 CO-CHAIR CURTIS: Perhaps we
9 should go ahead and vote on feasibility. I
10 mean, don't want to curtail the conversation,
11 but I think it might be --

12 CO-CHAIR ROSENZWEIG: Sure.

13 CO-CHAIR CURTIS: It's not beyond
14 the -- it's a very broad question, and it's
15 beyond, I think, the scope of this individual
16 TAP, and I think the message can be sent
17 upstairs to the Steering Committee, but
18 probably even higher.

19 Again, that there is discomfort
20 within the TAP, as to, you know, are we
21 accountable, at the end of the day, for how
22 these measures are being applied to our peers,

1 for the clinicians and otherwise?

2 CO-CHAIR ROSENZWEIG: But just to
3 mention, 4d, I do think that they have had a
4 lot of experience in the use of, not this
5 measure, but other measures in a variety of
6 situations.

7 They have a lot of clients and
8 they've used them for that purpose. So, they
9 have a strategy for data collection.

10 DR. PALESTRANT: I understand
11 that, and I don't want to belabor this, but
12 and basically, we'll get to it. I reviewed
13 the stroke measure, and it's just quite clear,
14 that this is not being used, and you look at
15 some of the examples that they give, using the
16 databases, and there is some problems with the
17 examples that they give.

18 That gives me pause to think, "Can
19 this actually be extracted to all these
20 different metrics that we're asking them to
21 do?"

22 You know, from that point, are we

1 going to be able to do that when we review
2 that section?

3 CO-CHAIR ROSENZWEIG: Okay, let's
4 vote on the feasibility.

5 Okay, the first one is routinely
6 generated and used during care delivery.
7 They're not -- okay, all right.

8 CO-CHAIR CURTIS: I think we've
9 clarified this measure. It's administrative
10 and routinely generated.

11 CO-CHAIR ROSENZWEIG: Okay.

12 CO-CHAIR CURTIS: And then for
13 two, that it's available in electronic format.

14 CO-CHAIR ROSENZWEIG: Yes, yes.

15 CO-CHAIR CURTIS: I think there is
16 going to be sort of a pro-forma.

17 CO-CHAIR ROSENZWEIG: Available in
18 electronic format. The third one is
19 susceptibility to inaccuracies, errors, and
20 unintended consequences.

21 So, I assume a high score means
22 that it's not susceptible and a low score

1 means that it is susceptible.

2 DR. WEINTRAUB: Or it can be
3 minimized.

4 MS. TURBYVILLE: Right, there is
5 the 'or detected'.

6 CO-CHAIR ROSENZWEIG: Okay, or it
7 can be monitored, okay, all right.

8 MS. TURBYVILLE: In this case,
9 high means it is --

10 CO-CHAIR ROSENZWEIG: It is
11 susceptible to inaccuracies.

12 MS. TURBYVILLE: That it is not,
13 okay.

14 CO-CHAIR ROSENZWEIG: Yes.

15 CO-CHAIR CURTIS: I hope that is
16 how people have been voting all along. We
17 probably should have clarified that yesterday
18 morning.

19 CO-CHAIR ROSENZWEIG: Do we want
20 to do this again, so that -- everyone clear
21 that they voted the right way on this?

22 DR. WEINTRAUB: Yes.

1 CO-CHAIR ROSENZWEIG: Okay, good,
2 okay. Two high, two moderate and three low,
3 very evenly divided, okay.

4 Then susceptibility -- then the
5 last one is the data collection strategy
6 measure is in use.

7 Four high, two moderate and one
8 low, all right, thank you.

9 DR. LYNN: Thank you.

10 CO-CHAIR ROSENZWEIG: Thank you
11 for your help.

12 DR. WEINTRAUB: I'd like to bring
13 up a general issue that came up, it's sort of
14 been percolating in my mind. I don't think it
15 has to do with anyone, but --

16 In doing this kind of modeling,
17 what is an acceptable R-squared?

18 Now, what kind of R-square do you
19 expect? I'll tell you what the R-square is.
20 You know, the R-square, as we're talking about
21 the model high -- you're saying the model has
22 to be stuff you know in advance. What kind of

1 R-square can you expect, and I can tell you
2 what you can expect. You can just pick real
3 low R-squares here, on the order of, are you
4 ready? Point-two or lower, .1, .2, I'd be
5 surprised.

6 There, what you're talking about,
7 you're talking about age and gender and stuff
8 like that. You're not talking about the big
9 drivers and things that actually cost, which
10 is hospitalizations.

11 MS. CLARK: The HCC ones, I've
12 gotten some that have been the highest, around
13 .3, I think.

14 DR. WEINTRAUB: Yes, so, there you
15 go, the other one is .3. You're predicting
16 that 30 percent of the variability in costs.

17 Now, you know, Jephtha's heard me
18 go through this kind of stuff before, do you
19 believe a model like that, and one of the
20 responses that Ronald Crumhold got to this,
21 well, it's gives lots of -- well, that means
22 you have lots of room for variability of your

1 providers, and you can say, that doesn't
2 matter at all, you know, if you can't predict
3 costs, then just use average costs, and it
4 doesn't matter.

5 But if that's the case, then you
6 really -- then I don't believe that, at all,
7 I mean, what you'd like to see is that
8 providers help determine that, and I guess one
9 of the things you could do, in looking at
10 this, is looking -- if you add in providers to
11 the cost, does that add to variability in a
12 validation sample?

13 I mean, there are things you can
14 do to try and get at this, but I think this is
15 -- that the ability to truly risk adjust here
16 is going to be pretty minimal.

17 CO-CHAIR CURTIS: I think that's
18 why we didn't see the results in any of the
19 applications.

20 DR. WEINTRAUB: Maybe so. I don't
21 want to know. But should, not just in terms of
22 this kind of modeling, but also, when you're

1 using modeling where there are discriminations
2 with the C-index.

3 Should NQF be setting some kind of
4 standards? I realize that goes beyond this
5 panel, but carrying it forward is something to
6 think about.

7 MS. TURBYVILLE: I think right
8 now, the most recent guidance is in that
9 testing task force report, that came out at
10 the end of last year.

11 So, but you're right, that's
12 something for us to think about, and take
13 back, as we continue to build our guidance for
14 the expert panel.

15 So, I did want to make sure that
16 we open up for public comment, before most of
17 you dart out of the room, just in case it's
18 something they would like feedback from all of
19 you.

20 So, Operator, please, at this
21 time, could you open the lines for public
22 input or comment?

1 OPERATOR: Certainly, that is *1
2 for public input or comment.

3 We have no one in queue at this
4 time.

5 MS. TURBYVILLE: So, Jeptha, it's
6 three o'clock, now. So, we're suppose to end
7 at 3:30 p.m. today. Should we wrap up with
8 next steps?

9 CO-CHAIR CURTIS: Yes, so, I think
10 we should defer in the --

11 MS. TURBYVILLE: Or did you want
12 to go into --

13 CO-CHAIR CURTIS: -- process going
14 forward, we have seven more measures. We've
15 gotten through --

16 CO-CHAIR ROSENZWEIG: It's seven
17 more.

18 CO-CHAIR CURTIS: -- seven, in two
19 days, which is sobering, and probably, is
20 useful for you guys to reflect on further
21 ones.

22 But I don't know what the worst

1 case was, but that's pretty close to my worse
2 case.

3 MS. TURBYVILLE: Worst case
4 scenario in this situation was zero.

5 CO-CHAIR ROSENZWEIG: So, we did
6 seven, is that right?

7 MS. TURBYVILLE: That's right,
8 congratulations.

9 CO-CHAIR ROSENZWEIG: And there
10 were 14 on the list?

11 MS. TURBYVILLE: Right, and so,
12 we've hit every single vendor within this
13 group. So, hopefully, as we did with the ABMS
14 measures, we'll continue.

15 CO-CHAIR CURTIS: So, I think
16 there are two parts that I think we should
17 cover.

18 First, next steps, how we're going
19 to get through the additional measures, and
20 then secondarily, kind of just pause for a
21 reflection from the members here, the TAP
22 members, as to is there any way that we could

1 refine this process, as we do it?

2 I mean, we're kind of, I think,
3 stuck with what we're at, in terms of the
4 criteria, for assessment, but process-wise.

5 MS. WILBON: So, operationally,
6 we've got, as Jeptha said, we've got seven
7 measures left.

8 One is an NCQA measure, which is
9 for relative resource use of people with
10 cardiovascular conditions.

11 We've got one, two, three ABMS
12 measures left, two on CHF and one on -- I'm
13 sorry, two on CHF and one on CAD, and then
14 we've got another three Ingenix measures.

15 So, I guess it depends on -- we've
16 got a couple of ways to address it. We're
17 definitely going to need some follow up
18 conference calls, so, what we'll be doing, if
19 not by the end of this week, by early next
20 week, sending out an availability survey to
21 you guys, to probably schedule, I'm going to
22 start with three conference calls over the

1 next month, to try to get through as much as
2 possible, so, we can start filtering -- well,
3 we can probably start filtering some of this,
4 probably just right now, the NCQA measures.

5 The only one that we didn't really
6 ask for a lot of follow up -- we have to check
7 our notes, but to see what we can start
8 filtering to the Steering Committee, for them
9 to get through, and I could -- we can kind of
10 ask the Co-Chairs of the committee, how they
11 would like to kind of chunk those out.

12 Do you want to start with the NCQA
13 measure, or start with the ABMS measure, since
14 there seems to be a little bit of kind of
15 comfort with those now, and then save the
16 Ingenix measures for last, or how do you guys
17 want to try to address those?

18 CO-CHAIR ROSENZWEIG: Can I just
19 ask? What is the deadline, in terms of
20 presenting of this material to the Steering
21 Committee?

22 MS. WILBON: Right, so, the

1 Steering Committee meets at the end of June,
2 and that meeting at June 29th and 30th, that
3 meeting is a two day meeting and our goal for
4 that meeting was to have them review
5 everything from this meeting, from this group.

6 So, the focus of that meeting is
7 only this -- just this TAPs work.

8 CO-CHAIR ROSENZWEIG: Just this
9 task force?

10 MS. WILBON: Yes.

11 CO-CHAIR ROSENZWEIG: Well, that
12 is going to be difficult. I mean, if you
13 think about seven measures and if we do this
14 over, let's say, if we schedule conferences
15 calls to do them, I mean, you can't really
16 expect a conference call to last all day.

17 MS. WILBON: No, absolutely, but
18 we do two hour --

19 CO-CHAIR ROSENZWEIG: So, the
20 maximum for conference call would be two
21 hours.

22 MS. WILBON: Yes.

1 CO-CHAIR ROSENZWEIG: And that
2 might be two measures.

3 CO-CHAIR CURTIS: So, we have a
4 month? A month to do this, and two hours is
5 ambitious, although if we're going to do it,
6 we're going to do the ABMS measures as a group
7 --

8 MS. WILBON: First, okay.

9 CO-CHAIR CURTIS: -- and we're
10 going to do the Ingenix as a group, you know.

11 MS. WILBON: Okay.

12 CO-CHAIR ROSENZWEIG: Can we
13 suggest, that we at least finish CAD and ask
14 that the Steering Committee delay its
15 consideration of the other clinical
16 conditions, like stroke and CHF?

17 MS. WILBON: Well, what --

18 CO-CHAIR ROSENZWEIG: To a later
19 meeting?

20 MS. WILBON: What we would do, I
21 mean, ultimately --

22 CO-CHAIR ROSENZWEIG: I'm getting

1 a dirty look from her.

2 MS. WILBON: If we can't get
3 through, we can't get through. We would send
4 the Steering Committee as much as we could, by
5 the time -- that meeting is already scheduled.
6 It's in the works.

7 We can't really delay that work,
8 but we would give them as much as we can.
9 We're going to try to give them about a month
10 or so, at least three weeks, to review what
11 you guys have done, and I suspect that even
12 with -- even if we give them four or five
13 measures, that it may take them as long, if
14 not longer, to get through them.

15 So, even if we had, honestly, if
16 we gave them all 14 measures, I'm not sure
17 that they would get through them all in a two
18 day meeting.

19 So, we can talk. We'll probably
20 need to talk a little bit more internally with
21 the team, to figure out what is the strategy
22 for that.

1 But I think it is reasonable if we
2 could give them at least half of the measures
3 by -- to review at the June meeting.

4 CO-CHAIR CURTIS: Well, we've
5 already done that.

6 CO-CHAIR ROSENZWEIG: We've
7 already done that.

8 MS. WILBON: Right, but there is
9 still some follow up and you know, some
10 potentially re-voting. So, that takes time,
11 as well.

12 CO-CHAIR CURTIS: Do you think the
13 measure developer -- I mean, just based on
14 prior experience, have measure developers been
15 able to respond and have follow up TAPs within
16 a month?

17 MS. WILBON: Yes.

18 CO-CHAIR CURTIS: My recollection
19 is that it's usually a little bit -- I know
20 there are time --

21 MS. WILBON: It depends. I think
22 the type of -- a lot of the information we're

1 asking, should be relatively -- shouldn't take
2 them that long to respond with.

3 So, they should already have these
4 R-squares and they shouldn't -- the things
5 we're asking, not to re-test or, you know, it
6 should be clarification. Most of them are
7 clarifications, or things that shouldn't
8 require weeks to --

9 CO-CHAIR CURTIS: So, I think
10 people are just starting to realize that this
11 is a full-time, but unpaid job.

12 DR. WEINTRAUB: Most of us have
13 three or four of those already.

14 CO-CHAIR CURTIS: Yes.

15 CO-CHAIR ROSENZWEIG: Yes.

16 CO-CHAIR CURTIS: Well, I think
17 what we should do is sort of set, what is the
18 expectation for participation before June
19 10th, and I think it would be reasonable to,
20 you know, not reasonable, but the highest that
21 I would feel comfortable committing to is like
22 three, two hour conference calls, and I think

1 beyond that, you're really pushing the
2 boundaries of both good will.

3 MS. WILBON: I think that is
4 reasonable.

5 CO-CHAIR CURTIS: I don't know if
6 others --

7 DR. HWONG: I just want to point
8 out that there is Memorial Day weekend, kind
9 of at the end of May, just to be cognizant of
10 travel plans.

11 CO-CHAIR CURTIS: And also, like,
12 what is the quorum that's going to be like,
13 getting nine or ten people together, for two
14 hours, three times in the next three weeks?

15 DR. WEINTRAUB: It's not going to
16 happen.

17 CO-CHAIR CURTIS: It is going to
18 be difficult.

19 CO-CHAIR ROSENZWEIG: It's going
20 to be impossible, yes. I think we could
21 probably get one follow up conference call,
22 but three by the end of June?

1 CO-CHAIR CURTIS: I don't know.

2 MS. TURBYVILLE: Before the end of
3 June.

4 CO-CHAIR ROSENZWEIG: Before the
5 end of June?

6 DR. WEINTRAUB: It can't be done.

7 MS. BOSSLEY: I think we need to
8 just let us spend a little time thinking
9 through, because we have a better sense of
10 what we'll take and what you need, to run
11 through these measures.

12 So, give us a little time to
13 huddle and we'll come up with a plan for you.

14 MS. WILBON: A reasonable plan.

15 MS. BOSSLEY: Yes, sure.

16 CO-CHAIR ROSENZWEIG: So, could
17 you just run, mention the ones that are still
18 left to be done?

19 MS. WILBON: Yes, we have the
20 NCQA, RRU, for cardiovascular conditions,
21 relative resource use for people with
22 cardiovascular conditions.

1 CO-CHAIR ROSENZWEIG: Okay.

2 MS. WILBON: Fifteen-seventy-two,
3 which is the episode of care for management of

4 -- CO-CHAIR ROSENZWEIG: CAD?

5 MS. WILBON: -- coronary artery
6 disease, which is from ABMS, 1574, which is
7 episode of care for CHF over 12 month period,
8 from ABMS, 1575, episode of care for
9 management of post-hospitalization CHF over a
10 four month period, from ABMS, ETG based CHF,
11 from Ingenix, 1591, 1594 is ETG for CAD, from
12 Ingenix, and 1596, ETG stroke from Ingenix.

13 MS. PARKER: And my recollection
14 on the last one, the 1596 was that there was
15 going to be some discussion among the lead
16 discussant, as well as maybe the rest of the
17 group, that was to review that, based on its
18 applicability, to the same criteria as the
19 AMI.

20 CO-CHAIR CURTIS: Right, so, we'll
21 follow up --

22 MS. PARKER: Is that correct?

1 CO-CHAIR CURTIS: -- with the
2 measure developer and the NQF staff about
3 that.

4 MS. PARKER: Okay.

5 MS. WILBON: Okay.

6 MS. TURBYVILLE: You still need
7 someone on the TAP's input on it, so, yes --

8 MS. PARKER: That will be the
9 discussant, correct?

10 CO-CHAIR CURTIS: Right.

11 MS. TURBYVILLE: We'll see if we
12 can take it offline and see what is going on
13 with that.

14 DR. HWONG: And the only one thing
15 I'd mention, in terms of like, yes, time frame
16 and whatever, but you know, having -- I'm sort
17 of the lead reviewer on the CHF version of the
18 Ingenix, you know, Ingenix CHF ETG and because
19 it is that same kind of episode, excuse me,
20 the one year episode concept, a lot of it, at
21 least when I was looking at it, it looks
22 extremely similar.

1 So, I mean, you know, hopefully,
2 maybe if we can emphasize like, when we get on
3 these calls, just time saving like, really,
4 you know, just, even if we had like, sort of
5 the write-ups or something from like the
6 previous voting, just to kind of have the lead
7 person go through and say, "Yes, that is the
8 same, that is the same," you know, here is
9 where it might be a little interesting or
10 different, if at all, you know, and then --

11 CO-CHAIR CURTIS: I think Brenda
12 did a nice job with that approach for the --

13 CO-CHAIR ROSENZWEIG: Yes.

14 MS. PARKER: Thank you.

15 CO-CHAIR ROSENZWEIG: Yes, it's
16 really up to NQF to decide what order they
17 want us to do these, but I would suggest that
18 we try to get the CAD one completed, you know,
19 at least --

20 CO-CHAIR CURTIS: Do we have the
21 diabetes ones completed?

22 CO-CHAIR ROSENZWEIG: The

1 diabetes, yes, get the diabetes and CAD and MI
2 ones completed, and because once we get into
3 CHF and we get into stroke, we're dealing with
4 new disorders, so, probably a lot of
5 additional things.

6 So, I would --

7 MS. TURBYVILLE: However, that
8 might --

9 CO-CHAIR ROSENZWEIG: Just
10 consider that.

11 MS. TURBYVILLE: Yes, we'll
12 definitely consider that, but it could break
13 up with the vendor approach on the Steering --
14 on the conference call.

15 But we'll play around with it.
16 We'll bounce it off of you guys. We'll come
17 up with a strategy and in the very near
18 future, so that we can bounce if off of you
19 guys, as we prepare for these calls.

20 MS. BOSSLEY: Yes, it will depend
21 on whether the developers are available too,
22 and there is no point in having a call to

1 discuss the measures, if they're not there.

2 So, we have to factor all of that
3 in and --

4 CO-CHAIR CURTIS: It might be
5 fast.

6 MS. BOSSLEY: It may be fast, but
7 then you have a lot more comments to deal with
8 on the back end. So, one way or the other,
9 you're going to have to deal with it.

10 CO-CHAIR ROSENZWEIG: Do we come
11 from lots of different time zones? Are we all
12 from the east?

13 MS. BOSSLEY: David, you're in
14 California?

15 DR. PALESTRANT: Hello.

16 MS. BOSSLEY: L.A.?

17 CO-CHAIR ROSENZWEIG: Well, that
18 creates problems, then. I mean, that means an
19 evening call.

20 DR. PALESTRANT: There are certain
21 times that I can do it late morning, or at
22 least, I can work with you guys.

1 CO-CHAIR ROSENZWEIG: I've been on
2 many 7:00 to 9:00 p.m. calls.

3 CO-CHAIR CURTIS: Anyway, I just
4 want to thank the members of the TAP and the
5 NQF for doing a wonderful job of getting us as
6 far as we've come, and obviously, as I
7 predicted, it's been intense, and continuing,
8 ongoing.

9 MS. WILBON: Thanks to our Co-
10 Chairs, too, for helping us plow through and
11 get through as much as we did. I know Jephtha
12 was a little scared, unsure about how this was
13 going to go, but I think we actually did a
14 really good job.

15 This is brand new, as we said, so,
16 great job for plowing the way.

17 (Whereupon, the above-entitled
18 matter concluded at 3:06 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Technical Advisory Panel

Before: NQF

Date: 05-11-11

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