

NATIONAL QUALITY FORUM  
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NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR  
ENDORISING PERFORMANCE MEASURES FOR RESOURCE  
USE: PHASE II STEERING COMMITTEE

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THURSDAY  
JUNE 30, 2011

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The Steering Committee met in the  
Capital Room of the Venable LLP Conference  
Center, 575 7th Street, N.W., Washington,  
D.C., at 8:30 a.m., Tom Rosenthal and Bruce  
Steinwald, Co-Chairs, presiding.

PRESENT:

TOM ROSENTHAL, MD, Co-Chair  
BRUCE STEINWALD, MBA, Co-Chair  
PAUL BARNETT, PhD, VA Palo Alto Health Care

System

JACK BOWHAN, Wisconsin Collaborative  
JEPHTHA CURTIS, MD, FACC, Yale University  
School

of Medicine

LISA GRABERT, MPH, American Hospital  
Association

ETHAN HALM, MD, MPH, University of Texas  
Southwestern Medical Center (via phone)  
ANN HENDRICH, RN, MSN, FAAN, Ascension Health  
JACK NEEDLEMAN, PhD, FAAN, University of  
California, Los Angeles School of Public  
Health  
MARY KAY O'NEILL, MD, MBA, CIGNA HealthCare

DAVID PENSON, MD, MPH, Vanderbilt University  
Medical Center

DORIS PETER, PhD, Consumers Union

STEVE PHILLIPS, MPA, Ortho-McNeill-Janssen  
Pharmaceutical, Inc.

DAVID REDFEARN, PhD, WellPoint

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

WILLIAM RICH, MD, Northern Virginia  
Ophthalmology Associates

BARBARA RUDOLPH, PhD, MSSW, The Leapfrog Group

JOSEPH STEPHANSKY, PhD, Michigan Health and  
Hospital Association

DOLORES YANAGIHARA, MPH, Integrated Healthcare  
Association

NQF STAFF:

TAROON AMIN

HELEN BURSTIN, MD, MPH

LAURALEI DORIAN

SARAH FANTA

CAMILLE PRESBURY

SALLY TURBYVILLE, MA, MS

ASHLIE WILBON, MPH, BSN

ALSO PRESENT:

DAN DUNN, Ingenix (via phone)

BEN HAMLIN, NCQA

CHAD HEIM, HealthPartners

SUE KNUDSON, HealthPartners

TODD LEE, ABMS (via phone)

TOM LYNN, Ingenix (via phone)

JEN PEARSE, Ingenix (via phone)

JAIME ROSENZWEIG (via phone)

ARJUN VENKATESH, Brigham and Women's Hospital

KEVIN WEISS, ABMS (via phone)

CHERI ZIELINSKI, Ingenix (via phone)

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

8:32 A.M.

CO-CHAIR STEINWALD: Now it says we're supposed to recap yesterday and we'll do that in the briefest way possible.

One thing that Tom and I would like to do and if anyone protests this, please speak up. We think it would be beneficial to finish the discussion of the HealthPartners measure. We got through scientific acceptability at the end of the day yesterday and we still have usability and feasibility.

We believe that the issues related to those two criteria have been discussed at some length already. And we're hopeful that we could finish up those two criteria fairly quickly and then get to the diabetes measures.

The chair of the Diabetes TAP will be joining us by telephone and we understand that he's available only through the morning and so we want to make sure we are able to get to the diabetes measures as quickly as we can.

1                   And then once we're through the  
2 diabetes measures we have the wrap-up of the  
3 Ingenix measure to complete our agenda before  
4 we're able to adjourn.

5                   Sally, are there any  
6 administrative or other issues, or Ashlie,  
7 that we need to talk about?

8                   MS. TURBYVILLE: Just thank you  
9 for showing up for Day 2, rather than delay.  
10 So I understand this morning there's been  
11 confusion, somehow miscommunication on NQF's  
12 side about the hotel. So please be sure to  
13 clearly expense your hotel bill, if the hotel  
14 didn't already have it already covered back to  
15 NQF. If you have any questions, you can  
16 contact Ashlie or Sarah or anyone at NQF and  
17 we'd be glad to help you.

18                  DR. BURSTIN: Brief item. When we  
19 get to the measures that have associated costs  
20 with them, we'll take a brief pause and I'll  
21 go over some issues of how we're going to  
22 handle some of that information.

1 CO-CHAIR STEINWALD: The  
2 associated costs that enter into our  
3 feasibility discussion?

4 DR. BURSTIN: Exactly. So for  
5 proprietary measures for which there's an  
6 associated fee, that becomes a subcriteria  
7 under feasibility and as we get to some of the  
8 follow up, it will be somewhat relevant under  
9 the ACG's use and HealthPartners, but  
10 especially for Ingenix.

11 CO-CHAIR STEINWALD: Okay. All  
12 right --

13 DR. ROSENZWEIG: Hello?

14 CO-CHAIR STEINWALD: Yes, hello?

15 DR. ROSENZWEIG: This is Jaime  
16 Rosenzweig. I'm calling in.

17 CO-CHAIR STEINWALD: Thank you.  
18 Dr. Rosenzweig, this is Bruce Steinwald. We  
19 didn't quite complete a discussion of one of  
20 the non-condition-specific measures yesterday  
21 and we're hoping to complete that fairly  
22 quickly this morning and then very quickly

1 after that go on to the diabetes measure. So  
2 if you can bear with us for a few minutes,  
3 that's what we'll do. Is that okay?

4 DR. ROSENZWEIG: No problem.

5 CO-CHAIR STEINWALD: All right,  
6 thank you.

7 DR. ROSENZWEIG: Yes.

8 CO-CHAIR STEINWALD: So the  
9 measure is 1604. The HealthPartners measure.  
10 And we completed scientific acceptability.  
11 Once again, the Steering Committee is acting  
12 as its own TAP, which means that we have to  
13 evaluate the subcriteria individually.

14 And the first one is usability. I  
15 guess we need to have on the board -- the  
16 first one.

17 MS. TURBYVILLE: Usability 3a is  
18 the measure performance results are reported  
19 to the public in national community programs  
20 by the time of endorsement maintenance review  
21 -- and so this is initial endorsement. So as  
22 we give you the context is if there is an

1 ability for them to be reported for public  
2 reporting or accountability models.

3 CO-CHAIR STEINWALD: Questions or  
4 discussion? Hearing none can we proceed  
5 directly to scoring. ?

6 MS. WILBON: Does everyone have a  
7 remote from yesterday?

8 CO-CHAIR STEINWALD: All right,  
9 let's take time out and make sure everyone has  
10 their remote. All right.

11 MS. WILBON: Okay, thanks.

12 MS. TURBYVILLE: So again this is  
13 high, moderate, low or insufficient. So go  
14 ahead and vote.

15 CO-CHAIR STEINWALD: And Sarah,  
16 we're ready to go? Oh, you've already got a  
17 platform. Very good.

18 Tell us when you're ready. Go  
19 now? Okay.

20 Paul suggested that the metallics  
21 in the case might be interfering. Do what you  
22 did yesterday.



1 (Laughter.)

2 MS. TURBYVILLE: If you vote high  
3 on Usability 3a, please raise your hand.  
4 Eight.

5 Moderates, please raise your hand.  
6 Eight.

7 (Laughter.)

8 Clearly, since staff can't count  
9 in a consistent way, so it's not reliable, I  
10 think you're right.

11 (Laughter.)

12 CO-CHAIR STEINWALD: Okay, so  
13 we're starting over electronically. We're  
14 going to start over. One, two, three, go.

15 MS. TURBYVILLE: So we have nine  
16 high and seven moderate.

17 Moving on to 3b, the measure  
18 performance results are considered meaningful,  
19 understandable and are useful to the intended  
20 audience for both public reporting and  
21 informing performance improvement.

22 An important outcome may have not

1 an identified improvement strategy, still can  
2 be useful for informing quality improvement by  
3 identifying the need for simulating new  
4 approaches.

5 (Pause.)

6 Four high, eight moderate, and  
7 four low.

8 Moving on to 3c which is that the  
9 data and the result details are maintained in  
10 such a way that the resources measure  
11 including the clinical and construction logic  
12 for defining of measurement can be decomposed  
13 to facilitate transparency and understanding.

14 So if you're ready to vote, go  
15 ahead and start, sir.

16 (Pause.)

17 So here we have seven high, six  
18 moderate, and three low.

19 And then 3d is not applicable. We  
20 actually -- it's a harmonization question,  
21 given where we are, this being the first  
22 resource use effort, at this time we didn't

1 ask developers to harmonize. Later on, if  
2 similar measures are endorsed, we'll either --  
3 if there are opportunities for harmonization,  
4 we'll discuss it at that time, but right now  
5 we're not there.

6 And then for usability overall,  
7 this is not a yes/no. It is high, moderate,  
8 low overall and this is the Steering Committee  
9 vote. Please go ahead and start.

10 (Pause.)

11 I think one of you may have pushed  
12 your button before, sir. There we go. Two  
13 more, I think. There we go.

14 For the overall usability of this  
15 measure, we have six high, seven moderate, and  
16 three low.

17 CO-CHAIR STEINWALD: Any objection  
18 to moving right on to feasibility? Hearing  
19 none, so Helen, do you want to wait until we  
20 get to the subcriteria? Go ahead.

21 DR. BURSTIN: No, I'll just point  
22 out that I believe Ashlie said it's in your --

1 yes, part of -- NQF a couple of years ago  
2 allowed proprietary measures to come through  
3 the process, but part of that was to  
4 incorporate the associated fees with using the  
5 measure into the overall endorsement process,  
6 into that consideration.

7           So we requested, since the  
8 HealthPartners measure uses ACGs, that we  
9 actually provide for you the actual costs of  
10 using the ACGs. I know the submission  
11 indicated other potential tools are available.  
12 It had been tested with ACGs. So we thought  
13 it was important that you see this. It is one  
14 consideration as a subcriterion under  
15 feasibility. We at least wanted to have the  
16 chance to just point --

17           DR. CURTIS: I thought I saw on  
18 the application that the ACGs are now publicly  
19 available. Is that not correct? Okay.

20           MS. TURBYVILLE: And we would want  
21 to vote on it how it is now, even -- there  
22 might be some future efforts, but right now

1 this is -- just in case you're having a hard  
2 time reading it up on the screen, if you go to  
3 the thumb drive folder that you were provided  
4 by our team yesterday, there's a measure  
5 developer response sub-folder. If you click  
6 it open, you'll see each measure developer  
7 listed there.

8 There is the HealthPartners'  
9 folder, and if you open that, there is an  
10 Excel document which you can open up and will  
11 be this particular document right here.

12 CO-CHAIR STEINWALD: Let's move  
13 ahead.

14 MS. TURBYVILLE: Is everyone able  
15 to -- I just want to make sure people can read  
16 this. Yes, please.

17 MS. WILBON: As everyone came in,  
18 Sarah went around to everyone's computer and  
19 downloaded. We didn't get it until a couple  
20 days before the meeting, so we didn't send it  
21 out. It's called HP Price Table Proprietary  
22 Fees.

1 DR. BURSTIN: While everybody is  
2 looking for it, we'll just read it.

3 So -- it's simpler -- so the ACG's  
4 price that they provided to us were based on  
5 the client size, based on the number of  
6 covered lives. So under 50,000 covered lives  
7 on the commercial side it was \$33,000. They  
8 specifically indicated that for other  
9 noncommercial entities there was no -- right,  
10 Sally, no associated causes?

11 And then it rises from there. So  
12 greater than -- less than 500,000 lives is  
13 between 42,000 and 159,000, and over 500,000  
14 it raises from there to 2,000 to 299.

15 CO-CHAIR STEINWALD: We'll wait  
16 until we get to the right criterion. We have  
17 4a on the board.

18 MS. TURBYVILLE: Does everyone --  
19 when we get to the subcriteria we'll just make  
20 sure everyone has had a chance to review the  
21 fee. So 4a does not involve the fee  
22 structure; 4a for feasibility is about the

1 clinical measure for the measure. The  
2 required data elements are routinely  
3 generated, and used during care delivery.

4 So thinking about this being based  
5 on administrative claims data, we would then  
6 request you to rate this particular  
7 subcriteria. Is it high, moderate, low,  
8 insufficient.

9 CO-CHAIR ROSENTHAL: Can I ask for  
10 clarification?

11 MS. TURBYVILLE: Please.

12 CO-CHAIR ROSENTHAL: Do we consider  
13 -- this talks about data elements routinely  
14 generated during clinical care. We wouldn't  
15 consider claims data or claims in this.

16 MS. TURBYVILLE: Yes, we would.

17 CO-CHAIR ROSENTHAL: Okay, all  
18 right. Claims. Okay.

19 MS. TURBYVILLE: It's meant to be  
20 broad, okay?

21 DR. BARNETT: And the  
22 consideration of costs, which subcriteria will

1 that apply to?

2 MS. TURBYVILLE: Four-D, and we'll  
3 be sure to remind you that that's it.

4 CO-CHAIR STEINWALD: I do notice  
5 that Sarah is not there. Are you going to  
6 stand in? Okay. Are you ready?

7 Let's go.

8 MS. TURBYVILLE: So for 4a we have  
9 11 high and 7 moderate.

10 Moving on to 4b, the required data  
11 elements are available in electronic health  
12 record or other electronic sources. So are  
13 the required data elements available  
14 electronically is the question for 4b.

15 CO-CHAIR STEINWALD: Question.  
16 Turn your mic on and go ahead.

17 DR. NEEDLEMAN: I've been a royal  
18 pain in the ass asking about carve-outs.

19 (Laughter.)

20 But I think it is important if  
21 we're talking about capturing total resources,  
22 mental health services for a whole variety of



1 things that we're dealing with, including  
2 dealing with depression associated with  
3 chronic illnesses, and pharmacy costs are  
4 major components of our resources.

5 Historically, when they've been  
6 carved out, health plans have had a lot of  
7 trouble getting those back, and we're looking  
8 at a total cost of care measure here which  
9 means all I need is the total pharmacy costs.  
10 When we begin look at -- but when we also look  
11 at condition-specific costing algorithms that  
12 say we're going to get pharmacy costs from  
13 claims data, this will be an even bigger  
14 issue.

15 There are several ways this can be  
16 done. The worst is to take the per member/per  
17 month charges that are being paid to the  
18 pharmacy benefit managers and just bringing  
19 that back because that makes the charge or the  
20 costs associated with the HIV positive person  
21 and the kid who had an ear infection the same  
22 in pharmacy for a given year.

1           The most precise way would be to  
2           get all that claims data back and at least do  
3           a standardized pricing even if you didn't get  
4           the actual prices from the pharmacy benefit  
5           manager. I don't know, and I keep asking, is  
6           that what you're doing with these folks and  
7           sometimes they said no and sometimes they --  
8           there are other options in between those two  
9           including doing some kind of imputation based  
10          upon the health condition of the patient,  
11          historic costs, and the average amount you're  
12          paying to the pharmacy benefit manager.

13                 Every time you do an imputation  
14                 or -- there's an element that imprecision, if  
15                 not biased, introduced into these measures.  
16                 So in the long run, if we're really going to  
17                 have resource-based measures, the core plans  
18                 need to figure out how to get some usable data  
19                 back from the pharmacy benefit managers.

20                         In the interim, we need to be sure  
21                         there's a reasonable imputation method for  
22                         approximating the pharmacy costs associated

1 with each patient. And that's why I've been  
2 a pain in the ass about this.

3 I had a conversation with the  
4 HealthPartners people yesterday about how they  
5 do this. And I think I got it. Unless you  
6 want to amend what you said yesterday, which  
7 involves doing some weighting of the average  
8 cost they're paying to the pharmacy benefits  
9 managers when they have a carve out around  
10 case suggesting that, which is good enough --  
11 I'd say it's good enough for right now, but  
12 the long term future of resource-based  
13 measures has got to be to increase the  
14 precision of that and our report to the Board  
15 should reflect that concern.

16 MS. TURBYVILLE: Just a question  
17 for you, Jack, and the rest of the Steering  
18 Committee, because I do think this is an  
19 important point. I wonder if this is in 4c  
20 and 4d. My interpretation of 4b is that the  
21 data are available electronically, so I wonder  
22 if these sources aren't in electronic format,

1 but perhaps there are operational barriers, so  
2 they're not being collected. They're being  
3 carved out and it creates susceptibilities for  
4 error.

5 DR. NEEDLEMAN: It could be a 4d  
6 issue.

7 MS. TURBYVILLE: Just a question,  
8 okay, so it's not so much that they might not  
9 exist currently in electronic format, it's  
10 that they're, due to contractual arrangements  
11 in carving out, that they're not available for  
12 a total resource-used calculation.

13 DR. NEEDLEMAN: Right.

14 MS. TURBYVILLE: Okay.

15 CO-CHAIR STEINWALD: Are we  
16 content then to hold off this issue for 4d?  
17 Is that okay?

18 CO-CHAIR ROSENTHAL: I don't know.  
19 It looks to me like it's relevant. Available.  
20 They're not available.

21 MS. TURBYVILLE: Well, the longer  
22 read is that there are existing electronic

1 sources. I mean I'm not trying to split  
2 hairs. I just want to make sure it's captured  
3 -- I want to capture the conversation.

4 DR. NEEDLEMAN: Yes, so my  
5 understanding is the pharmacy benefits  
6 manager, the behavioral health managers, when  
7 you've got a carve out, are being paid a flat  
8 premium or payment per member/per month and  
9 the risk is shifted from the health plan that  
10 is the initial health plan for the beneficiary  
11 to the subcontractor.

12 And the subcontractors clearly  
13 have this because they're getting claims data,  
14 but historically the health plans have not  
15 been able to get detailed data back from them  
16 and have not gotten it back. So somebody has  
17 it, but if you're asking whether the --  
18 whether Mary Kay has it, then the answer is no  
19 at the moment under most of those contracts.

20 So if somebody has it in  
21 electronic form, the prime insurer or health  
22 group does not have it if they've carved out,

1 is that a b or a d issue? I don't know.

2 DR. O'NEILL: I mean, I would --  
3 just from an industry perspective, this is  
4 obviously an issue in evolution and so I think  
5 historically when there is carve outs for PBMs  
6 that they ran their business and like you say  
7 it was a financial arrangement. However, the  
8 whole world knows that this access to data is  
9 increasingly important for everybody's  
10 business in having a comprehensive view of  
11 what utilization looks like is increasingly  
12 important.

13 So basically from our industry's  
14 perspective, we in our contractual dealings  
15 with these organizations or through our self-  
16 insured employers who are choosing to opt out  
17 of our own benefit plan, increasingly those  
18 contracts have data-sharing language in them.  
19 It's usually the two legal teams that are  
20 getting in the way.

21 And sometimes the IT guys who  
22 don't have their databases talking, but I

1 think that this is the horizon for this  
2 becoming less and less of an issue is fairly  
3 close to us.

4 CO-CHAIR ROSENTHAL: I think the  
5 only question is really not whether it's a  
6 valid question, because I think Jack has made  
7 a compelling case. The only question is do we  
8 vote that issue in this one or in 4d. What  
9 does 4d say, if you give us guidance, then I  
10 think we can go ahead and vote.

11 MS. TURBYVILLE: So 4c, I'll talk  
12 about both, is susceptibility to inaccuracies  
13 or errors and then 4d is the data collection  
14 and measurement strategy can be implemented as  
15 demonstrated by operational use.

16 It's in here. So 4b really is  
17 that they exist electronically. And then we  
18 talk about barriers to getting these data that  
19 might hurt feasibility. Okay?

20 CO-CHAIR STEINWALD: So on the  
21 table is the notion that we'll address this  
22 issue in 4d and go ahead and vote on 4b.

1 We're back to 4b.

2 (Pause.)

3 MS. TURBYVILLE: Can we have the  
4 results? So the result is 11 high, 6 moderate  
5 and 1 low. Interesting. Okay.

6 Moving on to 4c which is  
7 susceptibility to inaccuracies, errors, or  
8 intended consequences related to measurement  
9 are judged to be inconsequential. So high  
10 would be that it's inconsequential. Or can be  
11 minimized through proper action or monitored  
12 and detected.

13 CO-CHAIR STEINWALD: Yes, Paul.

14 DR. BARNETT: So I would just  
15 remind that the two ideas, as a possible  
16 subject to unintended consequences, one is  
17 just by excluding anybody that doesn't have  
18 any visits or not setting some higher  
19 threshold for more than one visit to include  
20 people. There is this unintended consequence  
21 that the provider or plan that's being  
22 evaluated would want to get everybody in for



1 at least one visit a year so that they're in  
2 the denominator.

3 The other issue is because of the  
4 attribution rule that the visit with the  
5 primary care provider doesn't have to happen  
6 before the care is provided for that to be  
7 attributed to that primary care provider.  
8 There's going to be a disincentive for primary  
9 care providers to take on people who have had  
10 high healthcare costs who haven't had a  
11 primary care provider, and maybe even those  
12 that have.

13 And then the third is the fact  
14 that people are -- that only people in primary  
15 care specialties are counted as providers in  
16 this, that some specialties that act as  
17 primary care providers, and we gave the  
18 examples of cardiologists or people with  
19 serious cardiac problems or the infectious  
20 disease specialists who's caring for patients  
21 with HIV, the care that they provide will be,  
22 could be attributed to a primary care

1 provider.

2 An example might be someone that's  
3 receiving antiretrovirals and being managed in  
4 an infectious disease clinic, goes to a  
5 primary care clinician for some Zyban to stop  
6 smoking and all those costs then get  
7 attributed to that primary care provider and  
8 the infectious disease specialist is not  
9 considered as a provider.

10 So that's going to provide some  
11 sort of disincentive for providers to get  
12 involved with these patients who are generally  
13 being managed in special clinics.

14 CO-CHAIR STEINWALD: Thanks for  
15 that. Yes, Mary Kay?

16 DR. O'NEILL: I know we discussed  
17 all of those yesterday and I mean the second  
18 part of what Sally read was can these  
19 otherwise be detected and managed. And so I  
20 guess even though we had a robust discussion  
21 amongst ourselves, I am not sure if there's  
22 any information from you about how those

1 issues have historically been handled within  
2 your organization?

3 I know that there are different  
4 percentages of primary care sort of driving  
5 the ship in different markets, but these  
6 issues can't possibly be new.

7 CO-CHAIR STEINWALD: Do you want  
8 to respond, HealthPartners?

9 MS. KNUDSON: Sure. I'll make a  
10 couple of comments and ask Chad to comment as  
11 well. I think on the non-user component, at  
12 the plan level, if that's the unit of  
13 measurement, that non-users could be brought  
14 into play at the plan level, if that's the  
15 unit of analysis. I think for the issue of  
16 assignment with the clinic visit being done  
17 after a hospitalization, a key element to  
18 recall is that risk adjustment for the acuity  
19 of that hospitalization will also come  
20 through. So in terms of mitigating and making  
21 that comparable, that's the whole design  
22 there.

1                   And in terms of attributing just  
2                   to the primary care for now, you know, so the  
3                   premise that we operate on is that primary  
4                   care is viewed as an opportunity to really  
5                   enhance care coordination, partner with  
6                   specialists to smooth transitions of care and  
7                   improve, really, Triple Aim outcomes for the  
8                   patients and members. And so we see a role in  
9                   that for primary care.

10                   We understand that in other areas  
11                   of the country, perhaps that is not as strong  
12                   right now, but again, reflecting on the  
13                   discussions from yesterday as to whether or  
14                   not there's opportunity for use of this  
15                   measure in ACO development as it relates to  
16                   understanding those models and how the care  
17                   designs adapt in different areas of the  
18                   country is a potential opportunity. So that's  
19                   kind of where we've organized it.

20                   I'll just see if Chad has  
21                   comments.

22                   MR. HEIM: The only other thing

1 I'd probably add is in our experience actually  
2 working closely with the providers, regarding  
3 the inheriting a case, I guess I'll call it,  
4 and actually what this measure does is kind of  
5 promote that coordination outreach, working  
6 with the specialists knowing that there's  
7 handouts and also intakes. They know who the  
8 referral partners are and so they want to  
9 reach out to them before so there's a smooth  
10 handoff from a specialist to a primary care  
11 and then vice versa.

12 And then also in terms of if  
13 there's, I guess, I'll call it opportunity to  
14 maybe to game, if you're going to go out and  
15 try to get everyone in to just get in for a  
16 wellness visit or a preventive service might  
17 come in and actually you find out they're  
18 diabetic and you've just inherited someone  
19 that you have to do some more care for them.  
20 So you get the ACG with that.

21 CO-CHAIR STEINWALD: Okay, thank  
22 you. Yes?

1 DR. J. RICH: So speaking of the  
2 flip side of this unintended consequence would  
3 be primary care provider who is now an  
4 exaggerated gatekeeper because he does not  
5 want to send his patient who needs a  
6 hospitalization for something to the hospital  
7 because those costs will fall to him.

8 Have you seen a reduction in  
9 services to any of the patient population  
10 that's not justified?

11 MS. KNUDSON: Actually, when we  
12 measure Triple Aim results for our care  
13 systems, in a lot of cases, and just use our  
14 own care system as an example, we see improved  
15 health outcomes in both process as well as  
16 clinical outcome measures, improved patient  
17 experience, and an improved total cost of care  
18 performance and we've tracked that over time  
19 for several years.

20 CO-CHAIR STEINWALD: Bill.

21 DR. W. RICH: One other issue I  
22 think you didn't get a chance to address

1 yesterday, I think this is a great measure for  
2 the region of Minnesota. You have lots of  
3 groups and you have a large patient population  
4 that you can assign to those groups, primary  
5 care groups. But again, this is a national  
6 metric.

7           How do you address the discussion  
8 we had yesterday about the difference in  
9 composition and the difference in patient  
10 population of Minneapolis versus Memphis. I  
11 hate to go back to that. One is about 60  
12 percent African American with huge disparities  
13 in diseases compared to Minneapolis. How do  
14 you compare -- the measure doesn't say this is  
15 just regional. It's national.

16           So how do you address that?  
17 Because that fits right into the feasibility  
18 here, but perhaps unintended consequences, a  
19 change in a two-man primary care group that is  
20 taking care of 80 percent African Americans in  
21 Memphis versus a very large group in  
22 Minneapolis.

1 MS. KNUDSON: Right, and you know,  
2 actually that may be the traditional  
3 understanding of Minnesota and Minneapolis,  
4 but we have a very growing diverse population.  
5 We have one of the largest Hmong populations  
6 in the country as well as several other  
7 diverse populations.

8 Several of our clinics serve a  
9 large proportion of patients of color and we  
10 track those measure results, as I had  
11 discussed yesterday, on a quality and a  
12 patient experience realm and stratify those  
13 measurements in order to close disparities  
14 gaps.

15 We covered yesterday that this --  
16 that we're not segmenting this measure in that  
17 regard, but so just to somewhat update the  
18 understanding of really the cultures in  
19 Minnesota and how growingly diverse it is. So  
20 that's one component.

21 And then I guess the other piece  
22 that I would add is reflecting on that



1 discussion from yesterday and some of the  
2 other discussions as well. Many of the  
3 measures that are endorsed by the National  
4 Quality Forum need community adaptation. So  
5 there's several of the clinical measures, for  
6 example from the Forum, that we can't  
7 implement in Minnesota because they're not  
8 endorsed locally by practice either by the  
9 Institute for Clinical Systems Integration,  
10 ICSI, and Minnesota Community Measurement,  
11 which is similar to the Wisconsin  
12 Collaborative for Community Measurement, uses  
13 a slightly different definition.

14 So I just raise as an example of  
15 community adaptation to making the measure  
16 work. So it's not always a one size fits all,  
17 but you know we work in sort of an imperfect  
18 world, but really with the goal of improving  
19 all those outcomes for patients and members.

20 CO-CHAIR STEINWALD: Thank you for  
21 that. An interesting discussion. I think  
22 some of it overlaps with yesterday's. My

1 preference would be to -- I appreciate that,  
2 but I think we should -- no, you're not  
3 prepared to do that, move to the vote?

4 DR. O'NEILL: I just think that  
5 some of the discussion here is based on a  
6 premise that if we endorse this measure  
7 somehow it will be nationally rolled out by  
8 some national entity whereby people are in  
9 every corner of the country are going to be  
10 compared with each other on the same measure.  
11 And I guess that's not my understanding of how  
12 these measures are utilized.

13 And so what I'm afraid of, sitting  
14 where I sit and based on the discussion  
15 yesterday, is that we have a very powerful  
16 measure here that measures something that the  
17 other things that we have considered so far do  
18 not measure which is what this stuff costs  
19 people and what it costs businesses and what  
20 it costs individuals out of pocket. And that  
21 somehow this discussion on this measure which  
22 is the same as the other measure we discussed,

1 but had standard pricing, suddenly all of  
2 these concerns which are really the nature of  
3 the measure in both points is a bigger deal.  
4 But it seems to me it's a bigger deal because  
5 there is not standardized pricing. That seems  
6 to be the biggest thing.

7           So I think that this measure is  
8 very powerful, very actionable and something  
9 that people in a local community and setting  
10 can get their heads around. And from a  
11 feasibility standpoint, if they're in Memphis  
12 and have primary care delivered by an  
13 endocrinologist and cardiologist that there's  
14 nothing in this data that would make that  
15 difficult to understand, and that this has the  
16 kind of power that the other measures don't.  
17 And just because it has real pricing and not  
18 standardized pricing, I'm just very worried  
19 that this whole measure is going to be  
20 jettisoned.

21           So I think if you take this  
22 measure and put it on a system or on a

1 community, there's a value in it. And even if  
2 the community looks different than the Twin  
3 Cities, you know, it still will have value  
4 locally. I actually, I'm not sure I haven't  
5 heard anything in the measure design that  
6 would tell me that -- say if my community has  
7 a particular medical community structure with  
8 heavily weighted to specialists, I don't see  
9 any reason why they couldn't be considered  
10 primary care. Maybe not.

11 I just don't want to abandon this  
12 opportunity. Thank you.

13 CO-CHAIR STEINWALD: We hear you.  
14 My sense of the chair is that we've covered  
15 the issue as well as we should feel that we  
16 have not left anything out. Can we move to  
17 the vote, please, on this sub-criterion.

18 MS. TURBYVILLE: Let's wait for  
19 Mary Kay to get back to the table.

20 CO-CHAIR STEINWALD: She has a  
21 whole minute.

22 (Laughter.)

1 MS. TURBYVILLE: So there are  
2 susceptibilities to inaccuracies or errors,  
3 high, moderate, or low, please vote.

4 (Pause.)

5 So we have four high, six  
6 moderate, and eight low.

7 Moving on to 4d, we have the data  
8 collection and measurement strategy can be  
9 implemented as demonstrated by operational  
10 use. And external reporting programs or  
11 testing did not identify barriers for  
12 operational use; barriers related to data  
13 availability, for example, timing, frequency,  
14 etcetera.

15 And 4d includes the consideration  
16 of the proprietary fees which Ashlie has  
17 kindly put back up on the screen so you'll  
18 want to take that into account as to whether  
19 or not that would constitute a barrier for  
20 feasibility for implementation.

21 So again, it's a high, moderate,  
22 low. And I'll leave it to you to decide.

1 CO-CHAIR STEINWALD: We also  
2 decided that this was where we would consider  
3 the carve out issue that Jack raised. Any  
4 discussion? Yes.

5 MS. YANAGIHARA: This relates to  
6 the carve outs and the availability of data.  
7 I think ultimately we're all trying to move  
8 toward having all types of data available, but  
9 we're not there yet. And so I'm just  
10 wondering in the interim if there's a way that  
11 when -- that there's an option to say either  
12 mental health is in or out, you know, pharmacy  
13 is in or out. And as long as it's clearly  
14 stated what is in or out and it's used  
15 consistently within -- wherever it's being  
16 measured, it can -- you can use it then  
17 without it.

18 For example, our total cost of  
19 care measure, we don't get mental health data.  
20 So it's out. But it's out across the board  
21 for all the groups in California that we're  
22 measuring. And so as long as it's clearly

1 stated, it might be a way in the interim to  
2 kind of allow us to keep moving forward  
3 without letting this always be a barrier to  
4 moving forward and a barrier for people using  
5 the measure, but it's clearly stated what's in  
6 and what's out, especially for those data sets  
7 that are known to be problematic.

8 CO-CHAIR STEINWALD: Further  
9 discussion? Okay, let's move to vote.

10 (Pause.)

11 MS. TURBYVILLE: So for 4d, we  
12 have 13 moderate and 5 low. So we will now  
13 vote for feasibility overall.

14 (Pause.)

15 So in thinking about those  
16 subcriteria and how you would weight them in  
17 an overall score, I don't know if there's any  
18 discussion needed, but we can go ahead and  
19 start the vote.

20 (Pause.)

21 (Vote: 3 high, 8 moderate, 7 low.)

22 CO-CHAIR STEINWALD: What the

1 discussion up front here is do we need an  
2 overall vote on the measure.

3 DR. BURSTIN: And I'm saying there  
4 was enough discussion that I think it deserves  
5 a final vote and especially because I think  
6 how partners would likely want to respond  
7 following this to some of those concerns  
8 raised about scientific acceptability.

9 The other thing is it is very  
10 common in these days, especially with  
11 controversial measures, that sometimes that  
12 NQF puts out a measure indicating there was  
13 lack of consensus and gets comments. So I  
14 don't want to lose the chance. This is so  
15 important. I think it deserves to go out for  
16 comment, so I would move forward.

17 CO-CHAIR STEINWALD: The only  
18 consensus I see is that there's lack of  
19 consensus.

20 DR. BURSTIN: There you go.  
21 That's my point.

22 (Laughter.)



1 CO-CHAIR STEINWALD: So we have --

2 MS. TURBYVILLE: So this is a vote  
3 for a recommendation of endorsement and as  
4 already noted, it's a yes/no and abstain.

5 (Pause.)

6 One more out there. Maybe  
7 somebody voted before -- there we go.

8 (Laughter.)

9 So as was stated prior to the  
10 vote, we have kind of a lack of consensus  
11 here. Nine, yes; eight, no; and one is  
12 abstaining.

13 DR. BURSTIN: Yes, all measures go  
14 out for comment. We actually invite comments  
15 on any measures that are not recommended, but  
16 there will be a specific section in the  
17 report, the draft report that will indicate  
18 this one did not reach consensus, very close  
19 votes. But in the interim though, you'll  
20 still have a chance to have the measure  
21 developers respond, so again that may sway you  
22 ultimately, but I think this does happen

1 fairly commonly.

2 CO-CHAIR STEINWALD:

3 HealthPartners, thank you very much for  
4 enduring this discussion over a two-day period  
5 and we look forward for our issuance and your  
6 response to some of the concerns that have  
7 been raised. Thank you.

8 MS. KNUDSON: Yes, thank you to  
9 the NQF staff as well as the Steering  
10 Committee.

11 CO-CHAIR ROSENTHAL: So I think  
12 we're going to move to item 1557, relative  
13 resource use for people with diabetes and this  
14 measure is from NCQA. Welcome back.

15 DR. ROSENZWEIG: Hello, hello?  
16 Can you hear me?

17 MS. TURBYVILLE: Jaime, this is  
18 Sally and we should have thought of this  
19 earlier as you weren't here yesterday. So the  
20 order that we have found that works  
21 successfully is we'll ask the measure  
22 developer to provide an introduction to the

1       measure.  Then we'll hand it over to you as  
2       the co-chair of the top four diabetes measures  
3       and ask you to provide input as we go through  
4       the criteria on what the top discussions were,  
5       as well as offer your expert opinion, but try  
6       and help us understand when it's TAP and when  
7       it's your input.

8                       And then open it up to the  
9       Steering Committee starting with the Steering  
10      Committee folks who were assigned to leave  
11      particular components.  So I will be sure to  
12      signal you and make sure we're opening up the  
13      phone here and there throughout the discussion  
14      for you to provide input.

15                     DR. ROSENZWEIG:  Okay, very good.

16                     MS. TURBYVILLE:  Jaime, also, I'm  
17      not sure -- we just logged into the webinar.  
18      I'm not sure if you were able to do that, if  
19      you're at your computer, but we'll be  
20      displaying slides of distribution of the task  
21      ratings if that helps you kind of summarize  
22      your feedback as well.

1 DR. ROSENZWEIG: Okay, I'm now on.

2 CO-CHAIR ROSENTHAL: So I think we  
3 have the order of the morning here now set on  
4 the three diabetes measures and the first one  
5 will be from NCQA so if you give us a little  
6 quick summary and then we'll have at it.

7 MR. HAMLIN: Thank you very much.  
8 So our relative resource use measure for  
9 diabetes is a very similar methodology to the  
10 RCA measure you reviewed yesterday. So all of  
11 our resource use measures are a standardized  
12 price, use standardized prices to assign  
13 effectively standardized utilization across a  
14 number of service categories with a predefined  
15 eligible population for people with diabetes,  
16 using a multi-year denominator that's very  
17 similar to our HEDIS quality measures.

18 Really, the only difference in  
19 this from the approach the other day is that  
20 the population is different in a sense. The  
21 service categories are identical. There are  
22 also service frequency categories that were

1 reported alongside of these for in-patient  
2 procedures, as service frequencies for this  
3 same population. So I'll just leave it at  
4 that. We went through the other measure in  
5 detail, yesterday, and again it's the same  
6 methodology applied for this population as was  
7 for the cardiovascular population.

8 CO-CHAIR ROSENTHAL: Jaime, would  
9 you give the TAP review and again, one other  
10 piece, we'll do this -- we'll vote on  
11 importance, then scientific acceptability,  
12 usability and feasibility in that order and  
13 we'll take the same -- this is for Jaime's  
14 benefit, that the importance -- we can't to  
15 vote on importance, but I've got a feeling  
16 that this one is going to pass the importance  
17 hurdle without a lot of discussion.

18 So Jaime, if you just give us kind  
19 of the first piece of the TAP which is the  
20 importance part, and then we'll get into the  
21 meat of the thing with the scientific part.

22 DR. ROSENZWEIG: Sure, this

1 particular measure was developed by NCQA and  
2 basically, their rationale for the importance  
3 of the measure was very well done, talking  
4 about the increase and prevalence of diabetes  
5 in the general population and the economic  
6 burden of diabetes which is very substantial  
7 in the general population as well. And they  
8 gave a number of good citations for the  
9 importance of high impact. Is that how you  
10 want me to do this?

11 CO-CHAIR ROSENTHAL: Yes, that's  
12 perfect.

13 DR. ROSENZWEIG: So in the voting  
14 in the Steering Committee nine voted, or all  
15 nine people voted to support the high impact  
16 part of this.

17 CO-CHAIR ROSENTHAL: Super, then  
18 let's take a moment and vote at the Steering  
19 Committee for the importance of the measure,  
20 given that the TAP recommendation is strongly  
21 positive and in this, one is yes, two is no.

22 (Pause.)

1                   One vote is not getting tabulated  
2                   every time. Oh, even better. Okay, passes  
3                   the importance hurdle.

4                   MS. TURBYVILLE: Seventeen high.

5                   CO-CHAIR ROSENTHAL: Seventeen to  
6                   nothing. So Jaime, now I think is the time to  
7                   get into the discussion of the scientific  
8                   merits. And so if you would give us the TAP  
9                   view of that and then we'll open it up for  
10                  discussion.

11                  DR. ROSENZWEIG: So we have  
12                  already covered 1b as well.

13                  MS. TURBYVILLE: So for the  
14                  Steering Committee, they rate on the overall,  
15                  so they're not rerating the subcriteria that  
16                  the TAP did, Jaime.

17                  DR. ROSENZWEIG: Okay, so we're  
18                  already moving on to Section 2.

19                  MS. TURBYVILLE: Exactly, exactly.

20                  DR. ROSENZWEIG: Okay, I  
21                  understand. All right. So basically, the  
22                  measure specifications really utilize the same

1 measure set that is being collected by the  
2 HEDIS effectiveness of care measures from  
3 NCQA. So it's been fairly consistent and they  
4 rely on -- they report on the total use of the  
5 diseases by service category and standardized  
6 prices related to service units for each  
7 measure.

8 And it has the advantage of being  
9 able to look at their quality measures in  
10 combination, their existing quality measures  
11 in combination with the cost-of-care data that  
12 they're collecting at the same time.

13 CO-CHAIR ROSENTHAL: Yes, and to  
14 whom -- if I could summarize and see if I've  
15 got it right, this is a total cost of care  
16 measure for people with diabetes using a  
17 standardized pricing methodology and a roll up  
18 of total costs and then indexed. But I missed  
19 to whom is the cost attributed? I missed  
20 that.

21 DR. ROSENZWEIG: It's attributed  
22 on various levels as far as I can understand,



1 but primarily on the per capita -- primarily  
2 the per capita, but it's population based for  
3 the most part.

4 DR. CURTIS: It's the same as  
5 yesterday, it's still specified by the payor  
6 at the health plan --

7 CO-CHAIR ROSENTHAL: At the health  
8 plan level, right. Thank you. And higher,  
9 yes. So it's the health plan.

10 DR. ROSENZWEIG: For the most  
11 part, HEDIS measures are not reported per  
12 physician.

13 CO-CHAIR ROSENTHAL: Right.

14 DR. ROSENZWEIG: They're reported  
15 per plan for the most part.

16 MR. HAMLIN: So the same criteria  
17 apply having multiple years of communities in  
18 enrollment, minimum sample size at 400 members  
19 in your population. Again, it's all the same.  
20 We attribute the health plans for our health  
21 plan support.

22 CO-CHAIR ROSENTHAL: I was just

1       trying to clarify so there was -- we had a  
2       common starting point on the discussion.  So  
3       we've heard from the TAP.  Now our technical  
4       scientific reviewer, Sally, help me, who?  Who  
5       on the committee did scientific?

6                   MS. TURBYVILLE:  Carlos is not  
7       here.

8                   CO-CHAIR ROSENTHAL:  Not here.  
9       Well, I'm going to open it for a discussion  
10      then.  I think we have a pretty good idea from  
11      yesterday's conversation what, if any, of the  
12      scientific issues are.  So I'll open this for  
13      discussion.

14                   Jack?

15                   DR. NEEDLEMAN:  I had a question  
16      because I'm not sure -- to the developer  
17      because I'm not sure I understood the answer  
18      from yesterday.  But before I ask the  
19      question, with all these claims-based  
20      measures, I don't think this is a deal  
21      breaker.  It is just inherent limitation of  
22      moving forward on measuring resource use right

1 now. But it's important for us always to  
2 remember and keep in mind that we're only  
3 counting resources that are billed, that  
4 health plans or groups which have unbilled  
5 services they make available to their  
6 patients, care coordination, nurse educators,  
7 diabetes nutritionists that are not billed  
8 services, those resources are real resources.  
9 We think they make a difference in the  
10 effectiveness of the care.

11 We have no way of measuring  
12 whether -- how -- we may not have ways of  
13 measuring what's there and how that's done.  
14 To the extent that groups have negotiated  
15 differential prices to pay for that because  
16 they said look at the additional things we're  
17 doing, we need a higher physician fee or  
18 whatever, standardized pricing wipes out those  
19 differences.

20 CO-CHAIR ROSENTHAL: Comment on  
21 that?

22 MR. HAMLIN: Right, so our

1 approach is we're measuring utilization and we  
2 feel that because we're attributing these to  
3 the health plan, the health plan, through  
4 their various programs, their DM programs,  
5 their wellness programs, other incentives for  
6 participation, if you will, all affect  
7 utilization. And so by looking at the high  
8 level utilization across specific service  
9 categories, we're basically giving them a  
10 snapshot of their utilization for a specific  
11 period of time. And they can go back and look  
12 and see how these specific programs may affect  
13 the utilization results, if you will.

14           So all these programs, we feel,  
15 affect the utilization of the plan members  
16 when you're looking at it in the aggregate.  
17 We do not have ways of measuring specific care  
18 coordination components at this time, so  
19 therefore, we're measuring what we can measure  
20 at this current time and giving that back to  
21 the plan as here's how your utilization  
22 compares to other plans when you risk adjust

1 it and when you standardize it.

2 CO-CHAIR ROSENTHAL: I think Dr.  
3 Needleman would probably agree. You're  
4 agreeing.

5 DR. NEEDLEMAN: Yes.

6 CO-CHAIR ROSENTHAL: His point  
7 that was still valid in the sense that costs  
8 are being expended for certain things to get  
9 that utilization and consequently if your  
10 total cost of care will underestimate because  
11 it's claims based will underestimate the  
12 actual cost that was necessary to deliver  
13 those volumes of services and it's just a  
14 weakness of the extant methodology.

15 Somehow we have to figure out --

16 MR. HAMLIN: The plan is not able  
17 to capture that because they will be able to  
18 plug in their actual prices for each  
19 individual service categories based on this  
20 methodology. They can also -- I'm assuming,  
21 will be able to roll up as some sophisticated  
22 plans like how partners can do, show their

1 total costs, be it total actual costs for all  
2 services for these categories and they will be  
3 able to then make those arguments to each of  
4 their stakeholders, if you will, about the  
5 differences between these and why they look  
6 this way. But at NCQA's level, we only get  
7 the utilization level data. So we can't, as  
8 a measurement organization, measure that, but  
9 I think there are ways to measure it using the  
10 same template, if you will. It just requires  
11 an additional drill down into the data by the  
12 plan themselves.

13 DR. NEEDLEMAN: Just again, I  
14 don't think it's a deal breaker on moving  
15 forward with measures, claims-based measures  
16 of resource use. We just need to understand  
17 there are certain kinds of services and  
18 certain kinds of clinicians that are simply  
19 invisible in these measures and we just --  
20 that's a general issue that we ought to just  
21 keep in mind and any reports that come out of  
22 the Committee ought to acknowledge that.

1                   The question I had and I'm still -  
2                   - I'm confused. We heard -- I asked about how  
3                   in-patient pricing was done in terms of the  
4                   standardized pricing, and I thought I  
5                   understood your answer yesterday. And then  
6                   one of the other measure developers said they  
7                   were using your standardized in-patient  
8                   pricing method and it was different from the  
9                   way you described it.

10                   So can you, once again just try to  
11                   help me understand how in-patient pricing is  
12                   done and therefore how and what kinds of  
13                   variances of in-patient use beyond admissions  
14                   we're actually capturing in our measures of  
15                   relative resources.

16                   MR. HAMLIN: So we use a number of  
17                   different resources to generate standardized  
18                   pricing tables which are again, the Medicare  
19                   fee schedule, we have a large research  
20                   commercial database that Ingenix has  
21                   maintained for us over the years that that  
22                   feeds into this. Our pharmacy data comes from

1 First Bank. Primarily, we're capturing about  
2 33,000 of the prescriptions that are written  
3 frequently enough so that we can actually feel  
4 like we can standardize, price these things.

5 We then annually publish the  
6 standardized pricing table which is down to  
7 the code level. So CPT, there's a  
8 standardized price assigned. We make this  
9 freely available on our web site. Anyone can  
10 use it any way they wish to. We use it  
11 specifically in the section that's detailed.  
12 I believe it's 9.7 in your materials for our  
13 measures of measuring health plans against  
14 each other.

15 ABMS, I know, uses our  
16 standardized pricing tables and they use them  
17 in different ways, but again, but to use the  
18 standardized prices as sort of a leveling  
19 ground for removing the proprietary fee  
20 schedules and contract specifics out of the  
21 equation and we're fine with that. That's why  
22 we published these. We make these freely



1 available because we have spent considerable  
2 resources to generate these tables every year  
3 and we feel like we want to get more out of it  
4 than just five measures worth.

5           So we know that they do that.  
6 That's why they make them freely available.  
7 They're again, just a standardized,  
8 effectively national price index for these  
9 services that we can identify and we feel that  
10 we can price effectively because there's  
11 adequate utilization or there's adequate  
12 information that allows us to assign a  
13 standardized price to each of these individual  
14 components. But again, different measures.  
15 Stewards for different measures may use these  
16 prices in a different manner.

17           CO-CHAIR ROSENTHAL: Are there  
18 other questions either for the developer or  
19 for our own TAP chair?

20           Yes, Paul?

21           DR. BARNETT: Yes, I just noticed  
22 that looking at the TAP's scores that there

1 were a few concerns on the 2b and also 2b3  
2 exclusions. I guess the exclusions had to do  
3 with the exclusion of people over 75. That  
4 was the concern. That was expressed by the  
5 TAP and maybe our TAP chair can explain why  
6 those votes happened.

7 CO-CHAIR ROSENTHAL: Jaime, did  
8 you hear the question?

9 DR. ROSENZWEIG: If you're talking  
10 about the voting for the 2b1, 2b2, and 2b3?

11 CO-CHAIR ROSENTHAL: Yes.

12 DR. ROSENZWEIG: They're still  
13 basically mostly high with only some of the  
14 people giving a medium rating. I'm not sure -  
15 - it doesn't mean they were against the --

16 CO-CHAIR ROSENTHAL: Jaime, no  
17 doubt. He is just asking what was the basis  
18 even for some people having only rated those  
19 three moderately.

20 MR. HAMLIN: I actually do  
21 remember the specific conversation because it  
22 applied to our mandatory exclusions for ESRD

1       transplantation primarily because in this  
2       population, the TAP felt that those two  
3       actually were things that could really  
4       contribute to the cost of care. And so what  
5       we have done is then take that back now and  
6       we're reinvestigating that now as a measure  
7       update.

8                       So maybe our four mandatory  
9       exclusions for active cancer, transplantation,  
10      ESRD, and HIV may not be applicable across all  
11      five measures because they are particularly  
12      relevant to the diabetes population.

13                      CO-CHAIR ROSENTHAL: Thank you.

14                      DR. ROSENZWEIG: Who is this  
15      speaking?

16                      MR. HAMLIN: This is Ben.

17                      DR. ROSENZWEIG: Oh, Hi.

18                      MR. HAMLIN: Dr. Rosenzweig, how  
19      are you?

20                      DR. ROSENZWEIG: Yes, he just  
21      described that pretty accurately. I think the  
22      main issue was the ESRD and the fact that a

1 lot of those people were excluded from this  
2 population because they go to Medicare.

3 CO-CHAIR ROSENTHAL: And it's  
4 clearly just a modest concern because none of  
5 these were ranked low in the event.

6 Other questions? Yes, ma'am.

7 MS. HENDRICH: I have a comment.  
8 I just wanted to build upon the point that's  
9 already been made for just a moment. I think  
10 one of the most difficult questions we have to  
11 answer in the future is the issue of care  
12 management, disease burden, and readmissions  
13 back into acute care and from being on the  
14 acute care side, as long as we continue to  
15 bundle these care models within these large  
16 process measures where there are intermediate  
17 level providers, especially in the area.

18 And I was going to bring this up  
19 around the congestive heart failure measure  
20 where we have really some of the strongest  
21 evidence around the cost effectiveness of  
22 that. I think we're not going to be able to

1 answer the question. I think it's a yes and  
2 I'm hearing that the developer is saying that  
3 through the different groups, we're going to  
4 be able to unbundle that and perhaps answer  
5 it.

6 So my philosophical comment to  
7 this group and challenge is at what point  
8 though do we start to challenge developers and  
9 say we have to be able to code in such a way  
10 that we can start to identify the actual care  
11 model that lies beneath the cost structures  
12 we're looking at.

13 MR. HAMLIN: And our new measure  
14 development in the EMR realm that actually  
15 have and include measures of care coordination  
16 because that data is available, I think will  
17 strengthen our utilization approach because  
18 we're reporting the quality of care with the  
19 utilization by strengthening our quality side.  
20 By understanding how these specific components  
21 of care coordination and patient satisfaction  
22 will affect the quality results, we can then

1 link those more directly to the utilization.

2 But in the absence of quality  
3 measures around care coordination and  
4 management of patients and patient  
5 satisfaction, and the ability to access care,  
6 I don't think we as NCQA don't want to dive  
7 too deeply on the utilization side because we  
8 don't have supporting evidence that those  
9 indeed do make a difference. And again, we  
10 have very high threshold for tolerance in that  
11 arena as far as what we will use to report and  
12 rank plans for our results.

13 CO-CHAIR ROSENTHAL: I'm not sure  
14 either hers or Jack's comments really were  
15 directed at this measure as they are kind of  
16 the general feel. I think there would be  
17 widespread agreement and in fact we had a  
18 measure yesterday that excluded everybody that  
19 was sent to a SNF. You know, when you think  
20 about that, it's insane. And yet the SNF  
21 costs are very hard to capture.

22 And we're on this crusade now to

1 dump people at a "Uwe Reinhardt" of dumping  
2 people out of acute care hospitals as if  
3 that's the salvation of the healthcare cost  
4 system without any notion that where they're  
5 being dumped to is going to really and truly  
6 and unequivocally be a lower cost proposition.  
7 I think that's frankly still an untested  
8 hypothesis. But anyway, I don't think any of  
9 these comments are really directed at this  
10 measure as much as they are kind of a general  
11 --

12 MR. HAMLIN: That was an FYI.

13 (Laughter.)

14 DR. BURSTIN: I do think it's an  
15 important thing to consider into the final  
16 report. That's again, the exact kind of thing  
17 we want to make sure the Committee emphasizes  
18 the fact that the broad scope of cost codes  
19 are going to be really important to consider  
20 across the board to really get a full handle  
21 on who is doing what, what works, what doesn't  
22 work as it relates to quality and cost.

1 MS. HENDRICH: At the risk of  
2 being redundant, since we know that comment is  
3 going to be inserted, I would also stretch our  
4 thinking beyond just intermediate level care  
5 providers because this really goes into the  
6 issue of home health care aides, right? Which  
7 I think that need will probably outstrip  
8 everything we've looked at thus far based on  
9 what we're seeing in doing the deep dive into  
10 readmissions around chronic disease. So  
11 thanks for considering that.

12 CO-CHAIR ROSENTHAL: Mary Kay.

13 DR. O'NEILL: This is a comment  
14 from the carrier industry. When you're --  
15 this measure is designed to compare our  
16 industry, not really compare practices and  
17 delivery systems. And so there's a lot of  
18 variability. And in fact, one of the things  
19 I think we compete on is our ability to  
20 support our members to various different care  
21 episodes. So we have huge infrastructure on  
22 disease management, case management, health



1 advisor, integrated behavioral health data,  
2 predictive modeling, preference-sensitive  
3 care.

4 I mean the amount of money that  
5 our company spends on this aspect of  
6 management of our specific population is what  
7 we sort of put our stake in the ground around  
8 and why we are active in NCQA and have been  
9 for a number of years. So this isn't really  
10 even getting at the codes that will allow  
11 practices to bill for care coordination.

12 There's other entities within the  
13 larger healthcare world that are providing  
14 this level of service. And so when you look  
15 at some folks that are coming in from Medicare  
16 or Medicaid, the robustness of their carrier  
17 in these areas is not comparable.

18 So anyway, I mean the cost and the  
19 benefit of this kind of activity resides  
20 different places and we're not going to ever  
21 get -- we don't have any claims data. That's  
22 our business investment.

1 CO-CHAIR ROSENTHAL: That needs to  
2 be done. Let me bring us back to this measure  
3 and the scientific -- I have one last question  
4 and then I think it's looking like we'll be  
5 able to bring this to a vote, which is you do  
6 have a truncation, as I recall and would you  
7 share with us the logic behind the truncation  
8 scheme?

9 MR. HAMLIN: Again, because in the  
10 population we want to avoid a small proportion  
11 of members driving the standardized costs up  
12 beyond a comparable level so when members  
13 reach that cap and there's a table of caps for  
14 specific costs, they're basically just  
15 truncated at a cap and they're not excluded  
16 from the population, but it prevents small  
17 spikes from skewing the results in one  
18 direction.

19 CO-CHAIR ROSENTHAL: And the  
20 number was 100,000 or something like that?

21 MR. HAMLIN: I don't remember the  
22 actual current number. We adjust it slightly

1 every year.

2 CO-CHAIR ROSENTHAL: It's not  
3 important.

4 MR. HAMLIN: Yes.

5 CO-CHAIR ROSENTHAL: It's not so  
6 important. Any other questions, comments, or  
7 discussion on the scientific merits? If not,  
8 then I think we're prepared to vote on the  
9 scientific portion of this and if I recall,  
10 this is yes or no. One is yes, two is no.

11 (Pause.)

12 MS. TURBYVILLE: So after a lot of  
13 sending signal we have 18 yes, Jaime, so we'll  
14 move on now to usability.

15 CO-CHAIR ROSENTHAL: So Jaime, if  
16 you would, give us the TAP view of this,  
17 please.

18 DR. ROSENZWEIG: Right. Can you  
19 hear me well?

20 CO-CHAIR ROSENTHAL: Yes.

21 DR. ROSENZWEIG: Basically, the  
22 usability part of this was generally -- the

1 analysis was pretty well received by the TAP.  
2 I'm looking to the section here. Because of  
3 the fact that they're collecting all of their  
4 data through HEDIS that this could be -- that  
5 they could be able to understand it fairly  
6 clearly and be able to use it for decision  
7 making because it was coordinated well with  
8 measures that -- of quality of care. So it  
9 can be use for quality improvement and public  
10 reporting and quality improvement with  
11 external benchmarks.

12 So for those reasons I think we  
13 gave them high scores with the exception of  
14 the issue of the harmonization part.

15 CO-CHAIR ROSENTHAL: But that's  
16 not applicable. Right.

17 Doris, I think you were our  
18 internal reviewer.

19 DR. PETER: Yes, I don't think  
20 there's too much to add. It's publicly  
21 reported. The plan obviously uses -- the  
22 aggregate results were reported for the public

1 and annual reports that they put out and I  
2 think we discussed it with the other measures.

3 CO-CHAIR ROSENTHAL: All right.  
4 Is there any discussion of usability? Boy,  
5 are we getting good.

6 I think then that this is ready  
7 for vote.

8 MS. TURBYVILLE: And this one is a  
9 high, moderate, low, insufficient.

10 CO-CHAIR ROSENTHAL: So one, two,  
11 three, and four.

12 (Pause.)

13 CO-CHAIR ROSENTHAL: Okay.

14 MS. TURBYVILLE: So 12 high and 6  
15 moderate.

16 CO-CHAIR ROSENTHAL: All right,  
17 and then finally, feasibility. So Jaime, if  
18 you'll give us the TAP version of this.

19 DR. ROSENZWEIG: Yeah, here again,  
20 the TAP felt that this was quite feasible to  
21 be able to collect the data. There was a  
22 really -- it was uniformly agreed that NCQA

1 was able to be able to collect the data that  
2 they wanted to and be able to correlate it  
3 well with the measures. The only issue where  
4 there was disagreement was in the area of  
5 susceptibility to inaccuracies and unintended  
6 consequences. I guess there was some concern  
7 that there might be some issues related to the  
8 data audit process that might make it  
9 occasionally a little more difficult to be  
10 able to collect accurate data.

11 CO-CHAIR ROSENTHAL: Ben, do you  
12 recall what that was in specifics or an answer  
13 for that?

14 MR. HAMLIN: No, I mean, we do --  
15 all of it is submitted to NCQA. I'm sorry,  
16 closer. All of the data submitted to NCQA has  
17 to go through a certified auditor before it's  
18 allowed to be reported. So we do reduce the  
19 amount of errors in the data through this, and  
20 each auditor must be certified through a very  
21 extensive process and recertified every year,  
22 like a licensing agreement kind of thing.

1                   Again, there's a lot of data  
2 points. We're working to improve that process  
3 and automate much of it, so there will be  
4 automatic validations, so next year there will  
5 be a number of additional automatic  
6 validations that will again reduce any kind of  
7 misrepresentation of the data, but it's 50,000  
8 data points. There's possibility for some  
9 error somewhere along the line.

10                   CO-CHAIR ROSENTHAL: Okay, and  
11 Paul, you were our Committee reviewer, I  
12 think?

13                   DR. BARNETT: Yes, I don't have  
14 anything to add.

15                   (Laughter.)

16                   CO-CHAIR ROSENTHAL: Okay. This  
17 is now open for discussion. Questions?  
18 Hearing none, I think we are ready to vote on  
19 this and -- I'm sorry, Jack.

20                   DR. NEEDLEMAN: I'm going to vote  
21 somewhere between high and moderate, but I  
22 think NCQA is a well-established measure

1 developer and measure producer. A couple of  
2 times during the conversation, we've basically  
3 heard reliance upon the auditing function of  
4 the individual health plans. I think there's  
5 an issue of transparency there in terms of  
6 exactly what's being done and so forth.

7           So I just want to note that,  
8 without initially saying it indicts the  
9 measure, I think it's very feasible, but we  
10 ought to think about transparency here for  
11 understanding exactly what data is coming  
12 forward from the plans.

13           MR. HAMLIN: The audit is an  
14 independent audit. It's not a health plan  
15 audit. The auditors are certified as  
16 independent auditors of the data, and the  
17 health plan will contract with them to comply  
18 with the audit. But they're not health plan  
19 employees or have any other relationship other  
20 than their --

21           CO-CHAIR ROSENTHAL: Okay. Any  
22 other -- Delores?



1 MS. YANAGIHARA: I just wanted to  
2 comment that I think the data elements are  
3 available. It can be collected. But once the  
4 data are collected, there's still a lot of  
5 analysis that needs to happen before the  
6 measure can really be meaningful and you get  
7 a result back.

8 So what the health plans actually  
9 do is submit a whole bunch of data to NCQA.  
10 NCQA has to crunch the numbers and come up  
11 with all of the benchmarks and the results for  
12 each plan. So it's not something that an  
13 individual plan or individual organization  
14 could do on their own. It's all about the  
15 data are submitted and the data together  
16 needed to be calculated. So it kind of lays  
17 into feasibility here. It's a great measure,  
18 but it does rely on that very sophisticated  
19 analytic analysis after the fact, after the  
20 data collection. It's not just like here's  
21 the numerator. Here's the denominator.  
22 Here's the rate, you're done. It's quite

1 complicated.

2 CO-CHAIR ROSENTHAL: I see, so your  
3 point was different than Jack was making.

4 MS. YANAGIHARA: Different from  
5 Jack's, yes.

6 CO-CHAIR ROSENTHAL: And it  
7 relates to the fact that without NCQA --

8 MS. YANAGIHARA: You need some  
9 kind of data aggregate or body to collect the  
10 data and do all the analysis and spit out the  
11 results. It's not just an individual  
12 organization that can do that because it's all  
13 about how you compare it to others.

14 CO-CHAIR ROSENTHAL: That was a  
15 good question, but the algorithms are in the  
16 public domain.

17 MR. HAMLIN: We post them on our  
18 website.

19 CO-CHAIR ROSENTHAL: Pardon me?

20 MR. HAMLIN: We post all our  
21 methodology on our website. If another data  
22 aggregator wanted to do this, they would be

1 able to do so.

2 CO-CHAIR ROSENTHAL: I think  
3 that's a really -- it's not a black box, but  
4 it's not trivial. I couldn't do it.

5 MS. YANAGIHARA: I think the other  
6 comment related to the audit, the audit also  
7 is not black box. The audit manual is posted  
8 on the web. That's all transparent as well  
9 and exactly what's done in the audit, and  
10 their prophecies and what they're looking for  
11 is all on the website as well.

12 CO-CHAIR ROSENTHAL: Other  
13 comments or questions? Was there another hand  
14 up over here?

15 All right, then I think we are  
16 prepared to vote on feasibility. I'm breaking  
17 my back checking to see how much time. This  
18 is one, two, three, and four. So high,  
19 moderate, low, and insufficient. Okay?

20 (Pause.)

21 MS. TURBYVILLE: Eleven high and  
22 seven moderate. So I think we're ready to

1 vote on the measure overall.

2 CO-CHAIR ROSENTHAL: That's next.

3 So now it's time to vote on the measure  
4 overall and this is yes/no and abstain, unless  
5 there's any further discussion about the  
6 measure in toto. Hearing none, let us vote.

7 (Pause.)

8 MS. TURBYVILLE: So we have 17 yes  
9 and 1 abstain.

10 CO-CHAIR ROSENTHAL: All right,  
11 that concludes the discussion on 1557.

12 MR. HAMLIN: Thank you very much  
13 and thank you, Dr. Rosenthal.

14 CO-CHAIR ROSENTHAL: Thank you.

15 DR. ROSENZWEIG: That was -- I  
16 hope all the others go half as smoothly.

17 CO-CHAIR ROSENTHAL: Well, when  
18 they go smoothly, they go smoothly. I think  
19 that's about all we can say.

20 DR. ROSENZWEIG: Yes, I shouldn't  
21 editorialize. Okay. I'm sorry.

22 CO-CHAIR ROSENTHAL: We all share

1 that hope that the rest of them are as smooth  
2 as that.

3 So next is 1576, which is episodes  
4 of care for patients with diabetes over a one-  
5 year period. This is an ABMS measure. And is  
6 Kevin on the phone?

7 DR. WEISS: Yes.

8 CO-CHAIR ROSENTHAL: Kevin, good  
9 morning. Did I hear a yes?

10 DR. LEE: I'm not sure if Kevin is  
11 on, but Todd Lee is here I can --

12 DR. WEISS: Kevin is on as well.

13 CO-CHAIR ROSENTHAL: Good morning,  
14 gentlemen. If you would not mind giving us a  
15 brief summary of the diabetes measure.

16 DR. WEISS: This is Kevin. I'll  
17 give a short intro and then I'll ask Todd if  
18 he'd like to add to it. But essentially, as  
19 we have proceeded with the work group on this  
20 measure, the question was what would be a look  
21 at a person who has need for management of a  
22 diabetes that was stable in the time period of

1 what's recognized as a long disease process,  
2 recognizing that it's at different times in  
3 the disease process, particularly towards the  
4 advanced stages, that it has a very different  
5 set of complexity and thereby a whole set of  
6 different expectations than it does for much  
7 of the time of the person who has diabetes.

8 It shows a one time period to  
9 measure this and we're very reflective on the  
10 fact of how it would eventually match up to  
11 quality measures since there are quality  
12 measures in this area, so we're so well  
13 advanced, recognizing that in the one-year  
14 period what resources really could be  
15 attributed to the provider, recognizing in  
16 that context that there are a number of  
17 activities that may be associated with  
18 resources that may alleviate the long-term  
19 supply, then really what could be looked at in  
20 one year.

21 So rather than look at total  
22 costs, we look for anything adverse to that in

1 the context of this, but rather looking at  
2 diabetes-specific costs as it relate to the  
3 type of activities one would expect in a one-  
4 year aspect of care.

5 We had the work group ask the  
6 question as to what primarily would one want  
7 to look towards attribution, and they thought  
8 that this could be attributed to an individual  
9 provider or based upon a provider group that  
10 you had.

11 Those are the basic elements of  
12 this diabetes measure.

13 Todd, would you like to add  
14 anything to that?

15 DR. LEE: I'll just add how this  
16 is similar or different than the other  
17 measures that you all have reviewed from us.  
18 Unlike -- this is probably more similar to the  
19 CAD measure in that individuals are identified  
20 during a 12-month period. And then we look at  
21 the resource use in the following 12-month  
22 period, so we have an identification and a

1 measurement year, unlike our AMI measures  
2 which are triggered by an index event. So  
3 we're taking an approach from a chronic  
4 disease standpoint and looking at resource use  
5 over the 12-month measurement period of  
6 individuals who had identified in a previous  
7 year.

8 CO-CHAIR ROSENTHAL: All right.  
9 Great. Thank you very much.

10 Jaime, will you discuss the TAP  
11 discussion?

12 DR. ROSENZWEIG: Sure. This was  
13 the 1576 on the ABMS measure and -- hold on a  
14 second. Let me just get my notes. Yes, as  
15 was just discussed, this measure discussed  
16 resource use and costs associated with  
17 management of diabetes over a one-year period.  
18 It identified patients in a management phase  
19 of diabetes by including people in the year  
20 prior to the measurement year and resources  
21 use and cost during the measurement year and  
22 patients with new diagnosis of diabetes and



1 those with end-stage disease, which was not  
2 exactly clearly defined, were excluded from  
3 the measure and resource use was attributed at  
4 the level of the individual provider as  
5 opposed to the last measure set.

6 So the measure type was per  
7 episode, but really it is over a year period  
8 and the level analysis was at the clinician or  
9 individual level. So with respect to 1a,  
10 everyone clearly agreed that the measure had  
11 a very high impact and high importance. Eight  
12 thought that it was high and one thought that  
13 it was medium.

14 However, there was a sense that  
15 there might be some resource use or cost  
16 problems. The TAP discussed that the  
17 submission provided evidence of gender and  
18 only racial disparities and did not address  
19 the other areas of disparities, including  
20 socio-economic issues, and the TAP discussed  
21 that this may be due to a lack of literature  
22 in the area. But I think there is some

1 literature in the area, and there was some  
2 suggestion that if in the future that the  
3 Steering Committee would have to give guidance  
4 with respect to how this resource measure  
5 should be used.

6 And then with respect to the  
7 purpose clearly described there again, there  
8 were six highs and three mediums, and the  
9 concern among some of the people was that they  
10 needed more detail about whether the measure  
11 is paired to other quality measures. It's  
12 discussed later on in the section, and then  
13 there was also some concern about the resource  
14 use service and categories being consistent  
15 and representative. And here again, there was  
16 disagreement over this issue.

17 CO-CHAIR ROSENTHAL: All right.  
18 Thank you very much. I think it sounds as if  
19 the TAP on this one looked at this importance  
20 question in the dimensions like we talked  
21 about yesterday. Does the importance apply  
22 specifically to the measure? Just to clarify,

1 we've been considering the importance question  
2 more broadly, and so I would suggest that we  
3 go ahead and vote on that and then we can get  
4 to the scientific questions on this thing.  
5 And this is one, yes; two, no.

6 (Pause.)

7 MS. TURBYVILLE: So we have 18 yes  
8 on importance, so we can move on to scientific  
9 acceptability.

10 CO-CHAIR ROSENTHAL: So Jaime, if  
11 you all would discuss the -- if you discuss  
12 the TAP discussions --

13 DR. ROSENZWEIG: Okay, going to  
14 2a1, which is whether or not the measures are  
15 well defined and the specifications were  
16 precise, there was actually a sense that this  
17 was not fulfilled. And some of the issues  
18 that came up included as to -- it was unclear  
19 as to why renal failure codes 585.3 and 585.2  
20 and 585.4 were excluded from the measure. The  
21 codes apparently that they listed were not  
22 updated.

1                   Bariatric surgery was not  
2 included. The TAP required rationalization  
3 for the specific drug selections, in  
4 particular, why the uses of only oral  
5 hypoglycemic or injectable medications are in  
6 the inclusion criteria and others should be  
7 considered.

8                   They requested a clarification for  
9 the lower age band of 30 years for Type 2  
10 diabetes that was being specified. The  
11 developer responded that the measure was  
12 supposed to be focused on Type 2 diabetes.  
13 However, Type 2 diabetes is being seen at  
14 earlier and earlier ages, as most of you  
15 probably are aware.

16                   And there was some issues, if  
17 that's the case, then the TAP said that the  
18 title and measure description in 10 should  
19 clearly state the focus on Type 2 diabetes  
20 rather than just on diabetes as a whole.

21                   I don't know if that's been  
22 changed since we reviewed it or if the actual

1 text has been changed. And then the TAP  
2 required clarification on Type 1 exclusion and  
3 how you would exclude it, considering it's  
4 very difficult based upon data from the chart  
5 or data from administrative data. The  
6 distinctions between Type 1 and Type 2 are  
7 listed in coding, but they're often not used  
8 correctly by physicians.

9 And there was also a sense that  
10 the inclusion and exclusion criteria needed to  
11 be tightened up, at least as written in this  
12 protocol to be sure to exclude patients with  
13 Type 1.

14 And also, there was a question as  
15 to how new diabetes would be excluded. New  
16 diabetes diagnosis would be excluded since  
17 there's a fairly high proportion of patients  
18 who are diagnosed, who are under-diagnosed and  
19 may be diagnosed in one place and they're not  
20 listed elsewhere. So those are a lot of the  
21 issues related to definition, which caused a  
22 lot of debate.

1                   With respect to reliability  
2           testing, people felt that that was, indeed,  
3           very sound and has been tested in large  
4           database by ABMS.

5                   With respect to the issue of  
6           specifications consistent with resource use  
7           and the cost problem, and here again, there  
8           was a lot of people who had concerns about  
9           this particular part of the protocol because  
10          the specifications were not always clear.  
11          Issues related to the time of entry into the  
12          target population, how that would be  
13          determined, and how that would be counted with  
14          respect to resource use. There was some  
15          concerns that they were not listed precisely  
16          enough and that they should also -- the  
17          costing method -- it was felt that the costing  
18          method should require more clear  
19          clarification.

20                   And there were also concerns about  
21          the issue of exclusion and exclusion criteria,  
22          which it was felt at least within the respect

1 of this particular protocol that they required  
2 more clarity and specific rationale. And in  
3 addition, the target population  
4 identification, as listed earlier, needed to  
5 be more precise.

6 In general, there was also some  
7 issues that were raised about the validity  
8 testing. The general sense was there was  
9 insufficient information provided on the  
10 validity testing, testing analytic methods,  
11 and results.

12 With respect to exclusions, also,  
13 there again, almost all the people voted  
14 medium, with one low and here this was --  
15 largely the rationale for this was that they  
16 were -- we didn't know whether they were going  
17 to be consistent inclusion and exclusion  
18 criteria across the measures that were  
19 relevant. And the measure as was written  
20 didn't provide clear rationale for measure  
21 exclusions.

22 Also, there was some disagreement

1 as to the score for the risk adjustment. The  
2 TAP wanted confirmation upon which risk  
3 adjustment approach would be selected and the  
4 methodology that they listed there appeared to  
5 be based upon the widely-used CMS HCC  
6 approach, which TAP liked, but the TAP  
7 couldn't assess risk adjustment because some  
8 things were missing, including fit testing and  
9 the RSQ value and the rationale and list of  
10 selected covariates.

11 So we felt that they needed to be  
12 more clear on how to instruct the users how to  
13 apply risk adjustment to this measure. And  
14 then it was felt, however, that in general  
15 that most people felt that the identification  
16 of statistically significant and meaningful  
17 differences could be done with this measure  
18 set. The minimum sample size for reporting  
19 implementation was not provided, and that's  
20 important because this measure is being  
21 selected on the -- is actually looking on the  
22 physician level, and many physicians don't



1 take care of that many patients with diabetes  
2 in their population, and there may be a large  
3 percentage of them that would have a small  
4 number of patients that could not be  
5 sufficiently compared with other physicians.

6 CO-CHAIR ROSENTHAL: All right,  
7 thank you very much.

8 DR. ROSENZWEIG: Am I missing  
9 anything? Yes, the multiple data sources  
10 thing was not applicable, and stratification  
11 for disparities, there was no real  
12 stratification listed there.

13 DR. CURTIS: The only other thing  
14 I thought was the issues of attribution that  
15 we discussed, the difficulties of assigning  
16 particular physician. I think you raised the  
17 concern about --

18 DR. ROSENZWEIG: Oh, yes. I'm  
19 glad  
20 -- who is that, is that Jephtha?

21 DR. CURTIS: Yes, that's me.

22 DR. ROSENZWEIG: Yes, yes. That

1 was an important issue was that typically the  
2 care of these patients is very shared, okay,  
3 among various providers and how you would  
4 attribute the overall care to which provider  
5 with respect to the costs, how the costs would  
6 be, would be sort of clarified, becomes very  
7 complicated in the diabetes population.

8 DR. HELM: This is Ethan. You  
9 know, the attribution part, the complexity was  
10 one of the things that caught my eye in  
11 reviewing this as well. There's sort of a  
12 tiered algorithm of costs of attributed to  
13 sort of the primary diabetes provider, based  
14 on three criteria. One is that that provider  
15 did 70 percent of those visits in a year. If  
16 that's not met, then it's the person who did  
17 30 percent of the visits, and then there's a  
18 third tier which is kind of like we don't know  
19 who attribute it to, and one of the things  
20 empirically which was kind of striking but  
21 probably not surprising was that 55 percent of  
22 the patients that they identified, they could

1 not attribute to a provider, so it's slightly  
2 over half could not be attributed to a  
3 provider. So it brings up some  
4 generalizability concerns.

5 CO-CHAIR ROSENTHAL: All right,  
6 thank you very much. A lot of work went into  
7 doing that analysis, and this Committee much  
8 appreciates the effort that you guys put into  
9 thinking that through and doing such a careful  
10 and thorough evaluation.

11 Our internal primary reviewer for  
12 scientific acceptability is not with us. I  
13 wonder if, out of order, but Steve, feel free  
14 to say no, but you did look at the usability.  
15 And I imagine that perhaps you might have read  
16 this a little more closely than some of us  
17 based on having to look at it from a usability  
18 point of view. Do you want to make any  
19 comments with regard to the science?

20 MR. PHILLIPS: Well, just a couple  
21 and they were actually touched on in the TAP  
22 review. Looking -- coming at it from the

1 usability review, I guess the biggest question  
2 is just as was touched on linking this with  
3 some sort of quality measures because just  
4 with the resource use, I'm not sure what I  
5 would make of it, given the outputs, this  
6 higher resource expenditures, good or bad.  
7 But you know, we've already talked about the  
8 need, eventually, that these will have to be  
9 meshed with quality measures.

10 I guess the biggest issue that I  
11 saw, again, was just touched on as far as  
12 attribution. I can think of situations where,  
13 basically, you're not able to attribute a  
14 patient because they're really not being very  
15 well managed and so then they end up getting  
16 spread across or attributed to someone else or  
17 multiple providers. To me, that's a  
18 significant problem because that's exactly  
19 what I think we're trying to get at here is  
20 identifying -- you may not have much resource  
21 use because you're not really managing the  
22 patient very well, and then you lead to these

1 downstream expenses in the overall health  
2 system. I think those were my main comments.

3 CO-CHAIR ROSENTHAL: Okay, open  
4 for discussion. I thought I saw a hand up  
5 over here earlier, maybe out of sequence.  
6 Jack?

7 DR. NEEDLEMAN: Yes, a question  
8 for the TAP. When you looked at the services  
9 and procedure codes that were being included  
10 in this measure because it's diabetes-specific  
11 care rather than a total cost of care for  
12 patients with diabetes, were there any  
13 important exclusions with things you felt  
14 should have been on the list that weren't?

15 DR. ROSENZWEIG: Well, there were  
16 a number of things that were excluded that we  
17 felt shouldn't have been. I mentioned that  
18 earlier. The renal failure codes which are  
19 closely related to diabetes, bariatric  
20 surgery, things of that sort.

21 I cannot recall whether there were  
22 very many specific codes that were missing --

1 that were just missing by accident. They  
2 looked like they were including most of the  
3 diabetes-related codes that -- that was my  
4 recollection. I don't have the actual list up  
5 in front of me right at the moment, but I  
6 don't think that there were many problems that  
7 were raised related to that.

8 DR. ROSENZWEIG: I can imagine  
9 with patients with a chronic disease like  
10 diabetes, some codes that are not specific to  
11 diabetes -- you would expect to be part of the  
12 diabetes management would be included in  
13 something else. So that's the kind of things  
14 that aren't are on the list that I'd be a  
15 little bit concerned about.

16 DR. NEEDLEMAN: Yes, there are a  
17 lot of things that are hard to sort out.  
18 Patients get admitted for an acute infection,  
19 but it's also maybe associated with  
20 uncontrolled diabetes, and sometimes -- that  
21 would probably be listed as something that's  
22 not diabetes-related in most settings, but in

1 fact, it is diabetes-related.

2 I think we had some discussion  
3 about the issue about how in many cases length  
4 of stay, hospital length of stay may be  
5 increased fairly significantly in some of  
6 these situations, but they're not really  
7 dealing with most of those issues. They're  
8 dealing with in this particular measure set  
9 with the diabetes-related admissions, which  
10 mostly includes either a hyperglycemia or a  
11 hypoglycemia, those kinds of things.

12 CO-CHAIR ROSENTHAL: This is a  
13 question out of ignorance, but they exclude  
14 polycystic ovary disease explicitly. Why  
15 that? I'm sure there must be some reason, but  
16 it's not specifically apparent to me.

17 DR. ROSENZWEIG: Well --

18 CO-CHAIR ROSENTHAL: Kevin, could  
19 you answer that?

20 DR. WEISS: I think it's because  
21 in order to define the patients with -- in  
22 this data set with diabetes, they use

1 medications that are normally associated with  
2 treatment of diabetes. And what's happening  
3 nowadays is that some of these medications are  
4 being used in situations other than diabetes.  
5 So metformin is being used quite commonly to  
6 treat polycystic ovarian disease.

7           So if you're using some of these  
8 medications to identify patients with diabetes  
9 by the use of medications, then you have to  
10 exclude -- I mean, some patients with  
11 polycystic ovarian disease have -- a  
12 significant number of them have concurrent  
13 diabetes, but the issue is that you can't --  
14 if they're being identified by the use of  
15 metformin or thiazolidinedione, which are  
16 drugs which are usually used to identify  
17 patients with diabetes, some of them are being  
18 used to treat PCOS.

19           CO-CHAIR ROSENTHAL: I think we  
20 got it. Thank you. I didn't get that.  
21 That's an interesting confounder.

22           DR. WEISS: It's going to occur



1 more and more in the future because some of  
2 these drugs may be used actually to prevent  
3 diabetes. There are varying studies that have  
4 shown that some of these drugs actually can  
5 decrease the risk of getting diabetes by a  
6 certain amount. Whether or not they're cost  
7 effective is a great concern and there's  
8 certainly no uniformity in terms of clinical  
9 guideline.

10 CO-CHAIR ROSENTHAL: But the  
11 trigger in almost every one of the diabetes  
12 measures that's extant is the pharmacy  
13 identification of drugs being prescribed,  
14 right?

15 DR. WEISS: It's a combination of  
16 that and then the diabetes-related codes.

17 CO-CHAIR ROSENTHAL: Right, right.  
18 Okay, are there questions? Mary Kay.

19 DR. O'NEILL: I just would like to  
20 say I think it's great that DME is in here on  
21 this and that I actually didn't notice if it  
22 was missing on the other ones, but it's

1 significant for chronic management.

2 CO-CHAIR ROSENTHAL: I had one  
3 question. In the culling out of eligible  
4 cases, one of the slides has the Market Scan  
5 enrollees started off with about 1.4 enrollees  
6 with a diabetic indication. By the time the  
7 various exclusions are applied, the cohort is  
8 down to 212,000. Does that cause the TAP any  
9 concern or am I missing something about that?

10 DR. WEISS: I can't answer this  
11 question. I missed it. This is in the actual  
12 protocol?

13 CO-CHAIR ROSENTHAL: No, it's in  
14 the slide set that accompanied the measure,  
15 Slide 4.

16 MS. WILBON: Jaime, we'll try to  
17 pull it up on the webinar for you.

18 CO-CHAIR ROSENTHAL: Half of them  
19 were because of coverage issues, and I think  
20 this came up yesterday in some of the  
21 discussions about we're missing a whole chunk  
22 of people because of the rule set. And again,

1 this is not a critique of the developers.  
2 You've got to have some rule set and that's  
3 not a ridiculous one. But the net effect is  
4 if you apparently start with 1.4 million  
5 potentials and you get it down to 200,000.

6 So Kevin, the question I would ask  
7 is, and it's the question we asked several  
8 times yesterday, which is if you've got 200,  
9 approximately 212,000 episodes, how many  
10 episodes per physician then did this end up  
11 being attributed? Do you know that number for  
12 the diabetes one?

13 DR. WEISS: I'll ask Todd that,  
14 but I just also remind the Committee that this  
15 is to some degree a feature of this data set  
16 as well. We need to be mindful that in a data  
17 set that may have more information or more  
18 pharmacy coverage, those numbers will  
19 dramatically change and so I want to be  
20 careful that we're not looking at data sets  
21 specific concerns or that we have random or  
22 nonspecific biases introduced by trying to

1 look at this now.

2 Now Todd, I don't know, do you  
3 have the average numbers close at hand?

4 DR. LEE: I don't. The  
5 attributable issue is exactly the same as we  
6 have for other measures where about half of  
7 our final episodes indicates that it's  
8 actually a little under half, end up being  
9 attributed at the physician level because of  
10 the missingness with provider ID that you all  
11 heard about yesterday and talked about.

12 DR. ROSENZWEIG: Now, looking at  
13 this slide, I remember when we reviewed this.  
14 I don't have any real big problems with them  
15 picking a well-defined cohort and eliminating  
16 patients that they may have problems with,  
17 even though it is a relatively small  
18 percentage of the initial -- but they're  
19 talking about people with any diabetes  
20 indication in 2006, and they're eliminating  
21 people with discontinuous coverage and with --  
22 and a variety of other issues, patients who

1 hadn't had any visits during the previous  
2 year. So I guess this was not of great  
3 concern, at least it didn't come up as an  
4 issue of great concern as far as I could tell  
5 during our discussion, as far as I can recall.

6 CO-CHAIR ROSENTHAL: All right,  
7 thank you. Doris?

8 DR. PETER: I just had a question  
9 about why is it just the first half of 2006.  
10 It excludes a huge number of people between  
11 the eligible enrollees and the cohort one.  
12 Why not the whole year?

13 DR. WEISS: Is that for us, the  
14 developer?

15 CO-CHAIR ROSENTHAL: Yes. Thanks,  
16 Kevin.

17 DR. WEISS: Because we are trying  
18 to focus on a group of people that are not  
19 newly diagnosed. If they had a diagnosis in  
20 December of the identification year, we didn't  
21 want to bring in a cohort of patients that had  
22 a new diagnosis. So the definition, was let's

1 make them have a diagnosis in the first six  
2 months of the identification year to ensure  
3 that the resource is not going to be a  
4 function of trying to manage a patient with a  
5 new diagnosis.

6 CO-CHAIR ROSENTHAL: So you were  
7 trying to make it established diabetes, as  
8 opposed to new diagnosis diabetes in the index  
9 year.

10 DR. WEISS: That's exactly right.

11 DR. PETER: Could you look at the  
12 prior visit though? Maybe -- you still can't  
13 tell because it's the second half. The first  
14 half -- to me, it doesn't make sense. You'd  
15 have to look at the prior visits still and see  
16 if you can see diabetes even before.

17 DR. WEISS: Well, there could be a  
18 new diagnosis in this first half, but then  
19 they're going to have six plus months of  
20 experience of management of their initial  
21 diabetes care that won't be counted as part of  
22 the episode because we don't set the clock

1       until at least six months later or start  
2       counting resources until at least six months  
3       later. And they have to have a diabetes visit  
4       in the follow-up year, so we know that they're  
5       continuing to be managed for their diabetes.

6                   CO-CHAIR ROSENTHAL: Thank you for  
7       that explanation. Just to clarify though, of  
8       the cohort that was very precisely defined,  
9       you're not sure, though, then how many per  
10      physician that ends up being. Again, I think  
11      for the group that's a somewhat relevant  
12      concept because if this ends up being five  
13      cases per physician attributed, it's hard for  
14      me then to know how would that be validly  
15      distinguishing one from another, but you don't  
16      have that number.

17                   DR. WEISS: I don't have that  
18      answer for you.

19                   CO-CHAIR ROSENTHAL: Okay, thank  
20      you. Jack?

21                   DR. NEEDLEMAN: Yes, Kevin, quick  
22      question on these no prescription drug

1 coverage, which is the way you've  
2 characterized it in the slide set. Is that  
3 people with no coverage or people with PBM  
4 coverage that was not -- where the claims  
5 were not submitted to Thomson Reuters by the  
6 primary insurer. Do you know what proportion  
7 falls into that category?

8 DR. WEISS: We don't know what  
9 proportion falls into those two buckets, but  
10 it's likely that the larger of the two is the  
11 latter, where the PBM is not part of what's  
12 submitted to Thomson Reuters and contained in  
13 the MarketScan data.

14 CO-CHAIR ROSENTHAL: Thank you.  
15 Just again, this illustrates this issue of  
16 carve-outs and its impact to identify disease  
17 specific and general.

18 CO-CHAIR STEINWALD: An issue  
19 that's come up several times is the issue of  
20 exclusions of certain procedures and diagnoses  
21 from the assessment of resource use.

22 Recall yesterday, there was one



1 measure where they adopted a very inclusive  
2 strategy. Once they identified the  
3 population, they basically let everything in,  
4 knowing that there would be a lot of noise  
5 coming in with certain events that occurred  
6 that were unrelated to the underlying  
7 condition.

8           But I'm personally more  
9 comfortable with that. I'm thinking back to  
10 a previous conversation I had with a clinician  
11 who said, told me, that if you exclude  
12 fractures, for example, you may, because they  
13 don't look like they're relevant to the  
14 underlying chronic condition, you may actually  
15 be missing some important information about  
16 the management of the chronic illness because  
17 the likelihood of a fall and a fracture may be  
18 related to how well that chronic disease is  
19 managed.

20           So I guess when I hear this  
21 discussion of why did you exclude this certain  
22 diagnosis, it makes me think of this issue all

1 over again, and my preference would be  
2 personally to be much more inclusive than  
3 exclusive.

4 CO-CHAIR ROSENTHAL: Kevin, would  
5 you guys want to comment on that in  
6 relationship to diabetes of sort of lumping,  
7 rolling in, basically, all things that happen  
8 to the diabetics and how you guys thought  
9 about the question that Bruce just posed?

10 DR. WEISS: It's a great question  
11 and it's one of those that can get easily  
12 debated. There's no right answer. I think  
13 the issues parse off into the signal to noise.  
14 We threw in all these other things, including  
15 bumps and lumps and skin tags and twisted  
16 ankles and stuff. You just threw in a lot of  
17 information that may or may not be relevant,  
18 and that creates noise which makes it very  
19 hard to detect signal. That's just a  
20 technical concern explained very non-  
21 technically.

22 The other is what is a reasonable

1 expectation for in one year's care of a person  
2 with diabetes and in that section of care  
3 where they don't have advanced sequelae and  
4 they're not newly diagnosed, what can you  
5 really attribute to a physician to say what  
6 you should be spending money on. And for  
7 that, you know, and what should the patient's  
8 adverse complications where money is being  
9 spent be attributed to that one year of care?

10           And we heard in the work group a  
11 clear recognition. These are great diabetes  
12 experts and they were clearly cognizant of all  
13 of the relationships that exist over time, and  
14 if this was a five or seven year cost-of-care  
15 measure, they would probably have looked at it  
16 very differently, adding cardiovascular and  
17 adding in a huge amount of issues related to  
18 end-stage -- end-organ damage that starts to  
19 develop. And it's even the five-year cost-of-  
20 care measure that would have been difficult  
21 for them, but they would have been more  
22 comfortable. But over one year, both on the

1 issue of the technical signal to noise and the  
2 second issue related what really in terms of  
3 cost can you hold a provider accountable for.  
4 It didn't make sense to that work group to go  
5 for total cost at this degree of granularity  
6 of measurement.

7 I hope that's helpful in terms of  
8 a response.

9 CO-CHAIR ROSENTHAL: No, I think  
10 that was a perfect response. And I think the  
11 discussion demonstrates how difficult this  
12 whole field is when you capture all of the  
13 complexity and trying to get it right in all  
14 of the dimensions that we're asking these  
15 measures to perform against.

16 Yes, Jeffrey.

17 DR. J. RICH: A point of  
18 clarification. This slide says cohort 1.  
19 There's a cohort 2 on the next slide which  
20 even has a much lower number, 4 percent at the  
21 final. I think -- I went back to look at the  
22 inclusion, and cohort 2, I think, are the

1 people who are on insulin and not on oral  
2 hypoglycemics. So it begs the question, I  
3 thought this was a measure for Type 2 diabetes  
4 in the introductory remarks. So why is there  
5 a cohort that involves insulin only?

6 DR. ROSENZWEIG: Just to answer  
7 that, this is Jaime Rosenzweig. Just a very  
8 large percentage of patients with Type 2  
9 diabetes are on insulin. It's 20 or 30  
10 percent.

11 DR. J. RICH: Without being on  
12 oral hypoglycemics?

13 DR. ROSENZWEIG: No, some of them  
14 are on oral hypoglycemics.

15 DR. J. RICH: Well, if you go to  
16 the inclusion criteria in this document, the  
17 including criteria says no oral hypoglycemics,  
18 but insulin, way back, on some earlier page.

19 DR. ROSENZWEIG: Yes, but some of  
20 them are on insulin alone, so there are a  
21 group of patients within that population that  
22 are on insulin.

1 DR. J. RICH: Okay, thanks. And  
2 then the second question --

3 DR. ROSENZWEIG: One thing that  
4 did come up is there was a question as to why  
5 people who have Type 2 diabetes and are on no  
6 -- either oral or insulin medications, why  
7 they were not included in this population.

8 DR. J. RICH: So that comment  
9 comes from page 11, top of page 11.

10 The second question I had related  
11 to the risk adjustment model. And this looks  
12 very complicated and robust and I don't think  
13 I heard anybody from the TAP discuss it. I  
14 was wondering if there was some discussion  
15 from the TAP or reflection on it. It seems  
16 very complicated.

17 CO-CHAIR ROSENTHAL: Jaime, I  
18 think you did mention that briefly in your  
19 presentation, but would you mind --

20 DR. ROSENZWEIG: Yes, I think we  
21 did think it was complicated. I thought I had  
22 mentioned that.

1 CO-CHAIR ROSENTHAL: Just  
2 reiterate just briefly again, if you would.

3 DR. ROSENZWEIG: Yes, the  
4 enrollment criteria was kind of confusing and  
5 they used in one case, as I said, some who  
6 were on insulin and some were on oral  
7 medications. And there are people exactly as  
8 you're mentioning who are on both and there  
9 are also people who have neither. And then in  
10 addition, there are patients who are on  
11 medications that are neither insulin nor oral  
12 hypoglycemic medication.

13 CO-CHAIR ROSENTHAL: Thank you.

14 DR. ROSENZWEIG: Like the GLP-1  
15 agonists, which are injectable, non-insulin  
16 medication. It becomes kind of complicated,  
17 and the definitions were not very well  
18 clarified.

19 CO-CHAIR ROSENTHAL: Thank you.  
20 Lisa, are you following the rules from the  
21 last time where we said if you wanted to speak  
22 you turn your thing up? That's amazing. From

1 one year, she remembered and she's the only  
2 person who did that.

3 (Laughter.)

4 MS. GRABERT: It's just easier  
5 than holding your hand up.

6 CO-CHAIR ROSENTHAL: I'm trying to  
7 be respectful of that. So you're next, and  
8 then Bill, and then David.

9 MS. GRABERT: Are we supposed to  
10 comment on price standardization and  
11 scientific acceptability? Is that the right  
12 category for that?

13 CO-CHAIR ROSENTHAL: It is. It  
14 has not come up yet in the discussion, but if  
15 you'd like to.

16 MS. GRABERT: I just have a  
17 question for the developer, since this is  
18 specified for both commercial and Medicare  
19 data. How did you price standardize,  
20 specifically, the Medicare data?

21 DR. WEISS: We didn't. We only  
22 tested this specific measure in a commercial



1 population and created a standardized price  
2 file from that commercial population.

3 CO-CHAIR ROSENTHAL: Does it say  
4 Medicare in there somewhere?

5 Well, the clarification is, it's  
6 not Medicare, so Bill is next, and then David.

7 DR. W. RICH: I'd like to go back  
8 to Jeff's point. I had this same concern and  
9 actually I queried the staff to see if the TAP  
10 had Carlos' scientific acceptability and had  
11 some comments that I'll read. And  
12 specifically the risk adjustment methodology,  
13 is it described completely inaccurately? No.  
14 Six models were tested and the most  
15 parsimonious chosen.

16 Carlos is the technical  
17 statistician's evaluation of the -- was it  
18 adequately described? The answer is no. In  
19 general, the only descriptive process is the  
20 threshold of a P value of less than .1 was  
21 used for variable selection. And general  
22 selection process based only on significant

1 testing is not reliable, blah, blah, blah. So  
2 there were some significant comments, and I  
3 had the same concerns that Jeff did about the  
4 lack of clarify of the risk-adjustment model.

5 CO-CHAIR ROSENTHAL: David?

6 DR. PENSON: So I wanted to add to  
7 that and ask the instrument developer a  
8 question, and then I wanted to ask the TAP  
9 chair a question.

10 With regard to the risk  
11 adjustment, I mean, this is the same thing  
12 we've seen with all the ABMS foundation  
13 measures, and in the end, the same basic  
14 methodology is used, but we run into problems  
15 with how extensively it's tested. So I wanted  
16 to ask the instrument developer if it's been -  
17 - if this has been tested the same as the  
18 other ones, if not at all, if it was just the  
19 Delphi process and preliminary testing because  
20 you know, Bill Rich's comment reading the  
21 statistician's comment is important. It seems  
22 like there's a problem with the risk

1 adjustment. So that's the first thing.

2 The other thing I wanted to ask  
3 the TAP was about the accountability piece and  
4 I think we've sort of touched on it a little  
5 bit, but I'm just -- when I looked at the  
6 accountability piece, ascribing it to a  
7 provider who had more than 70 percent of the  
8 E&Ms associated with diabetes, it just made me  
9 a little nervous because you could have a  
10 patient that has an acute event one year vis-  
11 a-vis has a below-knee amputation or some sort  
12 of heart event which is coded with the  
13 diabetes.

14 And suddenly, the cardiac surgeon  
15 or the vascular surgeon is now held  
16 accountable for the E&M care of the diabetes  
17 which he or she had nothing to do with. So  
18 it's a two-parter. Sorry, Tom.

19 CO-CHAIR ROSENTHAL: I would elect  
20 to do them separately. Okay, so the first one  
21 was?

22 DR. PENSON: The first one was the

1 instrument developer with regard to risk  
2 adjustment. Is this basically the same as the  
3 other measures we've seen? The same very  
4 basic testing but still a lot of questions  
5 left to be answered?

6 CO-CHAIR ROSENTHAL: Kevin, that  
7 one is for you.

8 DR. WEISS: If I could -- Todd  
9 will take that partly, but I just wanted to  
10 note, we did submit a substantial additional  
11 information with regards to testing after the  
12 TAP meeting. I don't know if you had the  
13 chance to receive that and review it. It  
14 sounds like that may not have happened.

15 But with that in mind, I just want  
16 to ask Todd if he wanted to say anything  
17 additionally?

18 DR. LEE: Yes, sure. We went  
19 through a process, as is described in the  
20 submission forms and maybe not extensively  
21 enough, a process of asking our work groups  
22 what conditions from the HCC list they felt

1 were important in terms of adjusting diabetes-  
2 related costs. We then compared those models  
3 to models that were derived via standardized  
4 statistical fit, you know, looking at T  
5 values.

6 And I understand the  
7 statistician's comments. It's an issue.  
8 However, when we compare the performance of  
9 those two models, we're stuck in a spot where  
10 if we pick the model that's derived wholly  
11 from the Delphi process where our clinical  
12 work groups selected it, we're going to say  
13 your model doesn't fit very well because it  
14 doesn't predict the tail.

15 So we tried to predict or select a  
16 model that fit our distribution, wrote the  
17 best, and was the most parsimonious. That was  
18 our strategy. And as Kevin noted, we've  
19 submitted additional documentation about the  
20 performance of our models for I think all,  
21 maybe not all of the conditions, but the  
22 majority of the conditions that you've

1 reviewed in the last two days.

2 CO-CHAIR ROSENTHAL: So Ashlie,  
3 let's clarify, was the additional information  
4 factored in to Carlos' review when he wrote  
5 it?

6 MS. WILBON: Yes, he did -- the  
7 information that ABMS sent we did package and  
8 send out to the TAP and to the Steering  
9 Committee. We also sent it back to Carlos for  
10 him to update his original analysis, and I  
11 believe, I have to double check. We sent a  
12 couple of versions of the analysis out, but  
13 I'm 99 percent sure.

14 CO-CHAIR ROSENTHAL: Can we be  
15 sure that the thing that Bill Rich quoted is -  
16 -

17 MS. WILBON: I can't right now  
18 because I'd have to check emails and stuff.

19 CO-CHAIR ROSENTHAL: Okay, I would  
20 say for the purposes of discussion, let's --  
21 I don't know quite what the right idea is, but  
22 let's put -- the reading of Carlos' report

1 into

2 -- on hold because I don't think we can be  
3 sure that it factored in all of the elements.

4 DR. LEE: Again, we have Carlos  
5 writing that it was inadequate. They respond,  
6 here's why it's really okay. Unless Carlos  
7 looked at it and said it's okay or not okay,  
8 I'm not sure what to do with his analysis.  
9 That's all I'm saying.

10 DR. BARNETT: It says 616 in the  
11 file name.

12 CO-CHAIR ROSENTHAL: Okay, so it  
13 appears that it was all factored in. Okay,  
14 all right. After, after, after. Okay, thank  
15 you. Unfortunately, Carlos not being here, we  
16 can't easily clarify.

17 Now David, your other part and  
18 then we have a couple of questions.

19 DR. PENSON: So my question was to  
20 the TAP members because again, it's hard for  
21 me, not doing research in this particular  
22 condition, whether or not the accountability

1 technique described is appropriate and,  
2 frankly, the word I would use is fair.

3 CO-CHAIR ROSENTHAL: You're  
4 thinking about attribution.

5 DR. PENSON: Attribution.

6 DR. ROSENZWEIG: I would say that  
7 your concerns -- these were concerns that were  
8 raised during the TAP, that there was a sense  
9 that maybe this method of attribution might be  
10 somewhat arbitrary and then might also  
11 actually interact with a question related to  
12 risk adjustment because typically in a  
13 particular year, you might find a patient  
14 would let's say develop a retinal hemorrhage  
15 or a vitreous hemorrhage or something like  
16 that. And during that particular year, over  
17 70 percent of their visits might be  
18 attributable to the ophthalmologist who would  
19 see the patient. It would be a high-cost year  
20 and a lot of issues related to that.

21 On another year, in addition,  
22 patients who are more severely affected with



1 diabetes might be on insulin would more likely  
2 be seen by an endocrinologist, as opposed to  
3 a primary care doc, and therefore might be  
4 seen at more frequent intervals and therefore  
5 could very well be higher, much higher  
6 resource use and also would require a lot more  
7 diabetes education.

8 CO-CHAIR ROSENTHAL: This is why  
9 we need multi-specialty group practices  
10 because then you could attribute this to the  
11 multi-specialty group and who cares which one  
12 of them didn't do their job. They all need to  
13 do their jobs. But unfortunately, that's not  
14 the world we live in.

15 DR. ROSENZWEIG: And the other  
16 issue was that certainly the endocrinologist  
17 might be seeing a larger proportion of their  
18 patients having diabetes, so they would have  
19 much larger ns than a lot of the individual  
20 primary care docs who might only see 20 or 30  
21 or 40, maybe 50 patients with diabetes that  
22 would be part of this particular group. So

1       there were a lot of concerns that were raised  
2       about this particular system.

3               The other issue was that the  
4       identification -- they used their  
5       stratification model, the hierarchical -- the  
6       HCC model, hierarchical condition categories  
7       model and we -- there was a lot of concern  
8       about that, the way they were using it with  
9       respect to individual physicians that might  
10      not be as successful. And if it was used in  
11      much larger groups like the plans which was  
12      used in the case of NCQA.

13              CO-CHAIR ROSENTHAL: Okay, I think  
14      we have a few more people who want to pose  
15      questions or make comments and maybe we want  
16      to start trying to make sure that it's on,  
17      perhaps, a new topic because I think we've  
18      been round and round on several of these, so  
19      hopefully, we won't need to go back. But Paul  
20      and then Jack and then Bill.

21              DR. BARNETT: So I'm also thinking  
22      that we have three other measures to get to

1 before we finish. And if you look, I think  
2 there are nine criteria for scientific  
3 acceptability and for five of them, this  
4 measure didn't get a single high rating. So  
5 I think in reality, this is not going to fly  
6 and I think we ought to vote on the scientific  
7 acceptability. I think that the measure  
8 developers have a lot of skill. They've got  
9 some great ideas here. It's just not far  
10 enough along yet. So you and I were beginning  
11 to think alike on this, that we probably heard  
12 most of the issues. So if there's something  
13 new or --

14 DR. NEEDLEMAN: In the spirit, I  
15 agree with Paul. In the spirit of thinking  
16 about next directions, I'm a little concerned  
17 about the risk-adjustment model, but not  
18 because of it being regression-based.

19 I'm concerned about your concern  
20 about parsimony in your model. That you've  
21 got tens of thousands of cases that you're  
22 using to project your -- to try to project the

1 expected costs of care from. You've got lots  
2 of degrees of freedom here. I would much  
3 prefer to see you do a standardized, get all  
4 of the HCC categories into your regression  
5 model so we're not picking and choosing which  
6 ones we're doing. And the only reason for  
7 dropping one would be you have such a small  
8 cell in your data that you're going to have  
9 trouble fitting that one or there's a clear  
10 risk of overfitting.

11 But treat as your default not  
12 going for parsimony, but going for inclusion  
13 of these measures as a way of standardizing  
14 what you're doing across all your measures and  
15 doing it in a way that minimizes the work.  
16 Parsimony is not a high value here in terms of  
17 getting your risk adjustment right.

18 CO-CHAIR ROSENTHAL: A free  
19 consultation.

20 DR. WEISS: Can I respond to that?  
21 Because that's exactly what we did. I mean  
22 that was the second set of six models that we

1 fit. I mean, we fit the first several based  
2 on input from our work groups. The others  
3 were data driven. It was all the HCCs. And  
4 where we had very, very small sample sizes, we  
5 dropped those. So we then selected the model.  
6 If they fit similarly, we opted for one that  
7 was more parsimonious. If they didn't, that's  
8 why you see in our diabetes submission this  
9 long list of coexisting conditions that are  
10 used in our risk adjustment. It was not the  
11 list that the work group told us. It was the  
12 methodology that was just described.

13 CO-CHAIR ROSENTHAL: Okay, well,  
14 thank you for that clarification.

15 Bill, maybe the last comment and  
16 then we'll --

17 DR. W. RICH: Last thing. One of  
18 the intents of this type of measure is to  
19 identify outliers, and again, as a result of  
20 the risk adjustment and the exclusions and the  
21 data where you have that tremendous  
22 compression issue, it overestimates the

1 observed by 100 percent at the low end. And  
2 underestimates the observed by 60 percent, so  
3 the implication of this is that you're not  
4 going to be able to differentiate anybody who  
5 is not right in the middle, so it doesn't  
6 work.

7 CO-CHAIR ROSENTHAL: Okay, well, I  
8 think we've pretty thoroughly covered the  
9 various issues. Let's look at the TAP  
10 scoring. So again, for me to remember how we  
11 did this. We separately will vote -- we're  
12 going to vote scientific acceptability, but  
13 along the dimensions of the grid of  
14 reliability and validity and as the drivers of  
15 scientific acceptability, and if you recall  
16 the grid, if either one in your mind is ranked  
17 low, then it fails. If validity is ranked  
18 low, it fails automatically. If reliability -  
19 - you've got the grid.

20 (Laughter.)

21 I'm sorry. I thought I could do  
22 that --

1 MS. TURBYVILLE: These are high or  
2 moderate --

3 CO-CHAIR ROSENTHAL: I thought I  
4 could do that out of my head. I really  
5 thought I had that in my head.

6 You can have moderate to high on  
7 reliability and still get it passed. The grid  
8 is the same one we used yesterday. But  
9 fundamentally, if either one is ranked low,  
10 then it doesn't pass scientific acceptability,  
11 but here is the top vote on reliability, which  
12 was nine, high; seven, medium; and two, low.

13 Wait --

14 MS. TURBYVILLE: These are the  
15 number of ratings because there are numerous  
16 subcriteria. So when you look at the  
17 subcriteria, there were nine high ratings on  
18 subcriteria for reliability; seven moderate on  
19 the subcriteria ratings.

20 CO-CHAIR ROSENTHAL: Oh, summed up.

21 MS. TURBYVILLE: Summed up.

22 CO-CHAIR ROSENTHAL: I couldn't

1 make it work. On the validity --

2 MS. TURBYVILLE: I know.

3 DR. BURSTIN: It's supposed to  
4 give you a visual detection of how they all  
5 fit together. You can see the size of the  
6 bars of high to moderate versus low.

7 CO-CHAIR ROSENTHAL: I do think  
8 though for the sake, and maybe this is worth  
9 spending one minute on, because this  
10 discussion was, I would say, just trying to  
11 broadly weigh it, was, I would say,  
12 substantially more negative than the TAP vote.

13 So maybe Jaime, you've listened to  
14 this whole discussion, hopefully, and  
15 hopefully have been able to follow it. I know  
16 it's difficult at times when you're on the  
17 phone. But do you want to make a comment  
18 about the discussion you heard here versus  
19 your TAP discussion and make, maybe, a final  
20 comment or recommendation to the group?

21 DR. ROSENZWEIG: Are we still on  
22 scientific acceptability or have we moved on?



1 CO-CHAIR ROSENTHAL: Pardon me?

2 DR. ROSENZWEIG: Are we still on  
3 the scientific acceptability section?

4 CO-CHAIR ROSENTHAL: Yes, yes,  
5 yes.

6 DR. ROSENZWEIG: Our votes weren't  
7 all that high. Reliability testing was high,  
8 but most of the others were not so good.  
9 There were a lot of lows in the specifications  
10 consistent with resource use section.  
11 Validity testing was all in the medium range.  
12 So I don't know.

13 And then in addition, there was --  
14 the measure set didn't really -- wasn't able  
15 to stratify for disparities.

16 CO-CHAIR ROSENTHAL: I don't think  
17 this has to do with inter-related  
18 reliabilities.

19 DR. ROSENZWEIG: I think there's a  
20 big disagreement between what I'm hearing here  
21 and what we were discussing.

22 DR. CURTIS: Jaime, I think it has

1 more to do with how the group discussion in  
2 the TAP got rolled up. I don't think the  
3 rolling up necessarily is effective for this  
4 because our concerns about this individual  
5 measure were mainly expressed in 2b1, which is  
6 the specification consistent with research use  
7 and cost. I mean that was, I think, kind of  
8 where we got into a lot of the issues that  
9 have been raised.

10 And so when you roll all those up  
11 into one mega vote, I think you lose that.  
12 But I don't think anything that's been said  
13 here was substantively different than the  
14 tenor of the TAP's recommendation.

15 DR. ROSENZWEIG: Yes, I agree.

16 DR. W. RICH: The other thing was  
17 that Carlos was there verbally. They did not  
18 have the advantage of looking at his final  
19 statistical analysis that we sought today. So  
20 that's why I think some of the other ones --  
21 I was struck also by the --

22 CO-CHAIR ROSENTHAL: When you look

1 at that roll out and there is a kind of  
2 interrelated reliability question in the sense  
3 of what was a medium score in the TAP on this  
4 one versus a medium or low score on the other  
5 one. So I think it's just --

6 DR. BURSTIN: Just one comment,  
7 again, for initial endorsement, we are only  
8 requiring that they demonstrate pilot testing  
9 on the data source they have. So it's a  
10 little difficult to compare a measure that's  
11 been out in use for four and five years and  
12 extensive testing to this. I think you have  
13 to keep that in context.

14 The overall ratings of the testing  
15 they had done were still moderate or high. I  
16 just want to point that out.

17 CO-CHAIR ROSENTHAL: All right, so  
18 I think we've heard plenty on this. Again, I  
19 think the time was well spent in really trying  
20 to understand this thoroughly, and it's very  
21 complex and it would have been a mistake to  
22 sort of just gloss over the details because

1 the details matter. But I think with that and  
2 we have the TAP and we've had this very  
3 thorough discussion, I think it's time to  
4 vote, and on this one, this will be yes and no  
5 on scientific acceptability. Right, Ashlie?

6 (Pause.)

7 DR. ROSENZWEIG: Hello?

8 CO-CHAIR ROSENTHAL: We're just  
9 tabulating the vote.

10 DR. ROSENZWEIG: Okay.

11 CO-CHAIR ROSENTHAL: Five, yes;  
12 13, no. Can we take her word for it that  
13 that's what it was?

14 (Laughter.)

15 Or is it only valid if it's  
16 projected on the wall? Now we all feel  
17 comfortable. It is 5, yes; 13 no.

18 So I think that concludes the  
19 discussion on this issue. We won't consider  
20 usability, feasibility.

21 Yes, Paul?

22 DR. BARNETT: Doesn't this mean

1 that we no longer consider item 3 or 4 either,  
2 right?

3 CO-CHAIR ROSENTHAL: That's what -  
4 - this concludes the discussion on this.  
5 Again, I would say a huge vote of thanks to  
6 ABMS on their careful consideration of this  
7 issue. And hopefully, some of the  
8 conversation will provide some ability to make  
9 some adjustments to this because again,  
10 there's no doubt that trying to be able to  
11 figure out how to attribute diabetes at the  
12 physician level and the cost issues is an  
13 enormously important task and this was an  
14 unbelievably good first run at it. And so I  
15 wouldn't let the rather intense criticism be  
16 a barrier for going forward.

17 Sally, did you have something you  
18 wanted to add on that? Okay, so we have an  
19 operational announcement, and then I think  
20 it's -- we're going to have a break and then  
21 we'll do the Ingenix measure or are we moving  
22 forward? We have the diabetes and Ingenix.

1 Are we scheduled for a break?

2 (Laughter.)

3 I'm ready to keep going? How many  
4 people want to keep going? No, that's not  
5 open for discussion.

6 Sally, you've got a housekeeping  
7 tooling and then we'll take a break.

8 MS. TURBYVILLE: So for those of  
9 you who were charged for the room at the  
10 hotel, our meetings folks have contacted the  
11 hotel and is requesting that they refund your  
12 credit cards, so your statement should show  
13 the credit back for the rooms and that the  
14 bill should come directly to NQF. So let us  
15 know if that does not happen. The hotel  
16 should be crediting to whichever credit card  
17 you gave them today. Thanks.

18 CO-CHAIR ROSENTHAL: All right, so  
19 a 15-minute break. Thank you.

20 (Whereupon the meeting recessed  
21 from 10:51 a.m. to 11:07 a.m.)

22 CO-CHAIR ROSENTHAL: All right.

1 We are ready to deal with Number 5795, ETG-  
2 based diabetes resource use measure from  
3 Ingenix. And do we have somebody from Ingenix  
4 on the phone?

5 DR. LYNN: Yes. Tom Lynn is here,  
6 as well as Jen Pearse and Cheri Zielinski.

7 CO-CHAIR ROSENTHAL: All right.  
8 Thank you very much.

9 And, Jaime, you're still on the  
10 phone for the TAP?

11 DR. ROSENZWEIG: Yes, I am.

12 CO-CHAIR ROSENTHAL: All right.  
13 Well, terrific. Then, we will go ahead and do  
14 this, and we will start with a brief overview  
15 from Ingenix, and then we will vote on  
16 importance, and then we will get to scientific  
17 acceptability in that sequence.

18 So Ingenix?

19 DR. LYNN: Thank you. My name is  
20 Tom Lynn. I'm a Medical Director working with  
21 Ingenix. This rule is based on our ETG  
22 methodology. That's their treatment group's

1 methodology. And it starts with creating an  
2 episode of diabetes that's a year long by  
3 examining administrative claims and putting  
4 claims in diabetes episodes back -- that sit  
5 in the episodes.

6 And then, once the episodes are  
7 created, identifying severity of the diabetes  
8 using clinical diagnostic-based markers and  
9 then evaluating expected costs and observed  
10 costs for diabetes based on those -- the  
11 different severity level and looking at the  
12 observed cost of a physician or a physician  
13 group or a health plan compared to the  
14 expected cost based on the severity level.

15 We were asked to respond to a  
16 number of issues from the TAP. I'm just going  
17 to hit the highlights. One of the concerns  
18 was that some of our labels were confusing in  
19 that they used "other" but didn't really  
20 explain what was underneath that. And we  
21 tried to update those labels to make it clear  
22 what was included in those categories.



1                   We also included data from our  
2                   large data set, benchmark data set, that  
3                   examined the grouping of diabetes and the  
4                   severity assigned to diabetes in a case where  
5                   we dropped the fourth diagnosis code off of  
6                   the claim, so we compared grouping using all  
7                   of the four diagnosis codes that we had versus  
8                   grouping only using the first three diagnosis  
9                   codes.

10                   We've done smaller sets of that in  
11                   the past and noted relatively small  
12                   differences, because there was a question  
13                   about whether the grouper should set some  
14                   diagnosis codes or not. And that was  
15                   concluded in the -- in the work since the TAP  
16                   met.

17                   In addition, there is a more  
18                   detailed description of how we take into  
19                   account members that don't have a pharmacy  
20                   benefit during a diabetes episode, and  
21                   basically we stratify those cases, those  
22                   without pharmacy benefit and those with

1 pharmacy benefit.

2 And, finally, we were asked to  
3 look at some statistics around how well our  
4 severity level works inside of diabetes. We  
5 did show some data for total costs as well as  
6 the different categories of metrics showing  
7 progression across the different severity  
8 levels and calculating R squareds for the  
9 different measurements, the total cost R  
10 squared being 0.22.

11 That's all I have.

12 CO-CHAIR ROSENTHAL: All right.  
13 Jaime, a quick summary on importance from the  
14 TAP.

15 DR. ROSENZWEIG: Sure. I'd just  
16 like to say that, you know, we looked at this  
17 measure very carefully, and we recognized the  
18 great effort and extent to which the measure  
19 developers put into this -- into this effort.

20 With respect to the importance,  
21 obviously, here again, they were able to make  
22 a very good case for sufficient support for

1 the high impact of diabetes in the population  
2 and the importance of looking at resource use  
3 in this population. So everyone agreed on  
4 that.

5           There was -- the question was  
6 whether or not there were some issues related  
7 to resource use and problems with cost, and  
8 there was a very large discussion, at least in  
9 the text that I have.

10           I don't know if it has been  
11 changed by the time that you have had a chance  
12 to look at it, but there was a lot of  
13 discussion about how in their database there  
14 was a lot of variation in resource use and  
15 cost between various geographical regions, but  
16 there wasn't much discussion of other types of  
17 variation, such as socioeconomic differences  
18 or the severity of illness and those kinds of  
19 things, in this particular group.

20           And there was -- it was also felt  
21 that the -- that the -- that they could have  
22 tried to more clearly describe the purpose of

1 the use of the measures than they did in this  
2 particular summary.

3 They did think -- they did have a  
4 very large and extensive resource use list,  
5 and that was the -- looked like it was very  
6 adequate.

7 CO-CHAIR ROSENTHAL: All right.  
8 Any discussion on importance from the  
9 Committee?

10 (No response.)

11 Hearing none, I think we should  
12 vote. And we have the TAP scores on the  
13 screen, and this is one yes, two no.

14 DR. ROSENZWEIG: I'm not sure I  
15 understand that.

16 CO-CHAIR ROSENTHAL: It's okay.

17 (Laughter.)

18 The vote is 18 to -- 18 yes, that  
19 this is important, zero no.

20 So with that, we will move to the  
21 scientific acceptability portion of the  
22 discussion, and, Jaime, if you would share

1 with us the TAP review of scientific  
2 acceptability.

3 DR. ROSENZWEIG: Yes. There was  
4 -- with respect to the specifications and the  
5 precise specifications of the measured  
6 properties, there was some disagreement about  
7 this.

8 Five thought they were highly  
9 specified, and the rest were either medium or  
10 low, and it was basically felt that the  
11 specifications of the various comorbidities  
12 were not totally clear, and it was especially  
13 unclear if the severity of ratings were  
14 weighted based upon services of comparable  
15 cost. And only costs that are mapped back to  
16 the diabetes code were accounted in the  
17 episode, so they weren't considering a lot of  
18 the other kinds of costs that occur with  
19 patients with diabetes.

20 And then, with respect to  
21 reliability testing, it was felt that there  
22 was internal consistency and reliability in

1 this patient population.

2 With respect to whether or not  
3 those specifications were consistent with  
4 resource use, and if there was a problem  
5 related to the cost, it was unclear in the  
6 text as to whether or not diabetes education  
7 was included as part of the specifications and  
8 whether or not any of the education codes were  
9 included, and that obviously would add a  
10 certain amount of resource use that is very  
11 important.

12 DR. LYNN: Just to interrupt -- I  
13 apologize -- this is Ingenix. There is one  
14 thing that they asked us to address that I  
15 didn't mention. Between the TAP and the  
16 steering committee alert, there is a list of  
17 diabetic education procedure codes, and they  
18 are eligible to group the diabetes.

19 DR. ROSENZWEIG: Okay. I just  
20 should mention to the Steering Committee that  
21 I am looking -- I am basically looking at the  
22 document that we were looking at when we had

1 the TAP meeting. I don't think I have the  
2 updated version, as far as I can tell.

3 So, and validity testing -- it  
4 appeared to be that there was some -- a little  
5 bit of disagreement on this, but in most cases  
6 people felt that validity testing was adequate  
7 with the information that was provided. And  
8 it was unclear as to -- at least to us in the  
9 TAP as to how the exclusions were identified,  
10 at least in this protocol.

11 And then, one of the big issues  
12 that did come up was the issue of risk  
13 adjustment. And I believe they use -- Ingenix  
14 uses a proprietary model of risk adjustment,  
15 and it was, at least it was felt by some, that  
16 it was kind of a black box, that it may be  
17 valid, it has certainly been used by -- in a  
18 large patient population already.

19 But to the individual providers  
20 who might be graded on how well -- how, you  
21 know, effective, you know, they are in  
22 controlling costs, the black box aspect of it

1 was of concern to a number of people, so that  
2 there were a lot of lower scores with respect  
3 to the whole issue of risk adjustment, largely  
4 because it was not transparent.

5 And then, identification of  
6 statistically meaningful or significant  
7 differences. Here again, there was  
8 insufficient evidence, at least that was  
9 presented to us, that the sample size  
10 threshold and analysis at the physician level  
11 was meaningful.

12 They were talking about a 30-  
13 sample size as being important to distinguish  
14 between different physicians, 30 patients I  
15 assume, and it was unclear how they came up  
16 with that number or how that would necessarily  
17 be adequate to compare individual physicians.

18 And then, they didn't use multiple  
19 data sources. They were using their own data  
20 source, so it was felt -- that issue was felt  
21 to be non-applicable, and there was also not  
22 evidence about whether or not they actually



1 stratified for disparities.

2 So I think that pretty much  
3 summarizes what we discussed with relationship  
4 to this particular section.

5 CO-CHAIR ROSENTHAL: All right.  
6 Thank you very much.

7 David, your comments on scientific  
8 acceptability.

9 DR. REDFEARN: Yes. The first  
10 thing I will say is this definition of  
11 diabetes is the standard episode treatment  
12 group definition of diabetes that has been in  
13 the ETG model out there for years, used pretty  
14 widely. So it has a lot of experience in use  
15 and practical experience with whether it makes  
16 any sense and holds together.

17 The definition of the episode, I'm  
18 not a clinician, and I can't comment on that,  
19 but you have to look at it and there is reason  
20 -- people vary in terms of what goes into an  
21 episode, and particularly what should be a  
22 comorbidity complication and add it into that

1 episode, or what might be something different.

2 I know the CMS, when they looked  
3 at ETGs -- the Medstat MEG Program a while ago  
4 -- they differed in terms of what the two  
5 methods captured into diabetes. So you have  
6 to look at that clinically, I think, and make  
7 some sense about whether you think it does  
8 make sense. It is a definition.

9 The only other comment I'll make  
10 is about the risk adjustment methodology.  
11 This is a little different from what all of  
12 the other measures have been doing. This is  
13 a risk adjustment specific to that episode of  
14 diabetes. It is not a global patient risk  
15 characteristic.

16 So they build it -- if you look at  
17 the methodology, they build it -- they build  
18 levels -- four levels inside the diabetes  
19 episode based on the specifics of the risk  
20 associated with that definition of diabetes,  
21 which is a little different. And you can  
22 argue that you might want to use global

1       because that captures global risk, but this  
2       has some -- this is designed specifically to  
3       be used in that measure, in that way.

4                 DR. ROSENZWEIG: One aspect of the  
5       issue of the diabetes-related episode of care  
6       was that, at least the way it was explained to  
7       us at the time of the TAP meeting was that  
8       this diabetes is a chronic disease and really  
9       reflects overall care during the course of  
10      this particular period.

11                It is hard often to define  
12      specific episodes of care within a 12-month  
13      period, so that for the vast majority of these  
14      patients the actual episode is the full 12  
15      months.

16                Perhaps a measure developer would  
17      want to comment on that, but it appeared to --  
18      at least it appeared to -- that was the way it  
19      was explained to us, that it was a -- even  
20      though it -- these costs are concentrated  
21      around what is called an episode of care, it  
22      just seems like it was reflecting a full 12-

1 month period.

2           And I think some questions were  
3 raised as to what happens if the patient, you  
4 know, enters the plan in the middle of the 12-  
5 month period or if -- you know, if it hasn't  
6 been seen for a while and then starts being  
7 seen later. Am I explaining this correctly?

8           CO-CHAIR ROSENTHAL: Yes, I think  
9 so.

10           DR. LYNN: If I can comment on  
11 that, we do divide -- diabetes is chronic. We  
12 do divide it up into year-long episodes.  
13 However, if the member is not eligible during  
14 that entire year, then the episode is marked  
15 as incomplete, and the method that we used is  
16 not the method everybody uses.

17           But the method that we presented  
18 excludes those episodes where the member  
19 wasn't eligible for the entire year. There  
20 are some methods where you make an adjustment  
21 for the partial year, but that's not the  
22 method we presented.

1           In addition, I wanted to make one  
2           comment about the minimum 30. We do set a  
3           minimum of 30, but we try to make the point,  
4           especially in response to the TAP that was  
5           provided since the TAP meeting, that what  
6           really matters is that you only -- that you  
7           only show the statistically significant  
8           differences and that you measure that.

9           And the method we presented does  
10          measure that, which is a requirement of  
11          PHQ 2008 when you are measuring for resource  
12          use. The minimum number was once used as a  
13          proxy for statistical significance, and in  
14          that case it is really important that you get  
15          that right, and it may be sort of impossible  
16          to get it right.

17          But in the case where you are  
18          actually measuring statistical significance,  
19          that minimum number is not as critical. Our  
20          opinion.

21                   CO-CHAIR ROSENTHAL: Bill.

22                   DR. WILLIAM RICH: A couple of

1 questions for the developer. Is this risk-  
2 adjusted methodology that you outline  
3 different than the one that was up on your  
4 website about two years ago?

5 And, secondly, what was the total  
6 -- to get to 30 per provider, what we have  
7 seen in others -- other groupers that have  
8 come before us is that problems with the  
9 physician ID dramatically decreased the  
10 eligible number of assignments to a physician.  
11 What was the total -- what percentage -- if  
12 you take 30 by your number of total  
13 physicians, what percentage of that is the  
14 total number of claims and physicians that you  
15 evaluated? Does that make sense? Probably  
16 didn't verbalize --

17 CO-CHAIR ROSENTHAL: Tom, I think  
18 that was addressed to you guys.

19 DR. LYNN: I'm sorry. I was on  
20 mute. I think it makes sense. I'm not sure  
21 I know. Were you -- are you asking if we  
22 looked at diabetes and measured a physician

1 and found that that physician had more than 30  
2 cases, what percentage of the dollars for that  
3 physician would we have captured on average?

4 DR. WILLIAM RICH: What percentage  
5 of the claims were you able to identify at the  
6 physician level?

7 DR. LYNN: Well, okay, so the  
8 question is --

9 DR. WILLIAM RICH: And the first  
10 part -- I'm sorry you were on mute was -- is  
11 this risk adjustment methodology different  
12 than the risk adjusted methodology that you  
13 had up on the -- on your web page about 18, 24  
14 months ago?

15 DR. LYNN: No, it's the same. The  
16 second question is: are we -- since the data  
17 that we use -- maybe I'm being dense, I'm  
18 sorry, but the data that we're using, are we  
19 able to successfully identify which physician  
20 was -- which physician was responsible for the  
21 claim?

22 DR. WILLIAM RICH: Yes. And the

1       third part is, where did you get the number  
2       30? I mean, 30 is a statistically significant  
3       sample for surveys and things like that, and  
4       then people that have published in this area,  
5       like Dr. Thomas, Bill Thomas, says 100. How  
6       did you get to the number of 30 and decide  
7       that that was statistically significant?

8                   DR. LYNN: The first question, you  
9       know, we -- we certainly have challenges with  
10      matching physicians, but, you know, we are --  
11      we only sort of bring in -- use data where  
12      those challenges have been sufficiently  
13      resolved amongst identifying physicians  
14      across.

15                   Our data doesn't, in fact, include  
16      data for multiple health plans, but we do the  
17      best we can to make sure that we have valid  
18      physician IDs that work across the health  
19      plans. If we don't, then we don't include  
20      that in the data that we use. That's -- I  
21      think that answers the first question.

22                   The second question is about the



1 number of cases, and, you know, honestly, the  
2 number of cases -- 30 -- comes from one of the  
3 original NCQA documents about doing resource  
4 utilization required a minimum of 30 cases.

5 But, again, you know, I think the  
6 important thing is that you -- when you're  
7 doing measurement that you identify  
8 statistically significant differences from an  
9 expected benchmark, which is usually the  
10 average across the peer group, and only report  
11 statistically significant differences. And if  
12 the differences are not statistically  
13 significant, basically, say that you can't  
14 tell a difference.

15 And we think that it's more  
16 important to use a valid statistical method,  
17 which is a method that's -- we use a method  
18 that has been published and used by RAND in  
19 some of the work they do. And then, the  
20 number of cases is not as important, because  
21 if the number of cases is too small, then you  
22 won't have cases that are statistically

1 significant.

2 CO-CHAIR ROSENTHAL: So to that  
3 point, Tom, with the attribution model and the  
4 30 cases, what percentage were either higher  
5 than expected or lower than expected?

6 DR. LYNN: Oh, that's a good  
7 question. I don't have that off the top of my  
8 head. I would -- we would have to go back  
9 into the data and look at that.

10 MS. TURBYVILLE: This is Sally.

11 DR. LYNN: If you looked at the  
12 number of doctors that had some range of  
13 cases, what percentage of them would be  
14 statistically significant or different? I --  
15 we would have to go back and do that work.

16 MS. TURBYVILLE: Just for point of  
17 clarification -- it may or may not change the  
18 request for that information -- similar to  
19 what the HealthPartners measure, remember that  
20 for sample size, because we knew this might  
21 vary, we allowed it be a guideline.

22 And in their submission, they do

1 state that a valid statistical test is  
2 preferable, and then -- and we can -- we  
3 pulled it up for you -- and then they talk  
4 about 30, but that actually, as Tom said,  
5 what's more important is that you can  
6 demonstrate to statistical differences.

7 CO-CHAIR ROSENTHAL: Right. I  
8 think I'm saying the same thing.

9 MS. TURBYVILLE: Okay.

10 CO-CHAIR ROSENTHAL: And,  
11 therefore, it would be really interesting to  
12 know in this cohort what is statistically  
13 significant and what fell out above or below  
14 based on the 30. So, okay, but they don't --  
15 they don't have --

16 DR. LYNN: Again, we could say  
17 that we'd provide that to you. We just -- I  
18 don't have it. I'd have to go back and  
19 calculate it.

20 CO-CHAIR ROSENTHAL: Okay.

21 DR. REDFEARN: I can comment about  
22 -- we use the same methodology, using episode

1 data, across all types of episodes when we do  
2 provider profiling. And we do confidence  
3 intervals around the observed-to-expected  
4 ratio, and you get about 50 percent of the  
5 docs that fall into the middle "don't know"  
6 category. That is, there is no statistically  
7 significant difference, but about somewhere  
8 around 25 percent efficient, 25 percent  
9 inefficient. That's rough, and it varies  
10 across a lot of episodes.

11 But if you do confidence  
12 intervals, you get a huge "don't know"  
13 category. You get a lot of cases in which you  
14 can't make a determination that the doctor is  
15 efficient or inefficient, costs are higher  
16 than expected or lower than expected.

17 And that -- to reinforce what Tom  
18 was saying about sample size, you see that for  
19 doctors in which we have assigned 300 episodes  
20 to the doctor. Even in that case, there is so  
21 much variability, we say we can't say it, but  
22 we do assign efficiency to doctors that have

1 had 10 or 15 episodes, way below the 30,  
2 because they are absolutely rock consistent in  
3 terms of how they perform, either high cost or  
4 low cost.

5 So you always have that big  
6 category, but you can make this determination  
7 with this data.

8 CO-CHAIR ROSENTHAL: But it  
9 clearly does -- sample size matters, and there  
10 is no doubt that with a small number, if  
11 somebody has a gigantic Six Sigma outlier,  
12 that it will be statistically significant.  
13 But generally, the smaller number of  
14 attributable cases, virtually everybody falls  
15 into an indistinguishable one. That's  
16 certainly true of the transplant data, where  
17 we have that for years.

18 The one that --

19 DR. LYNN: Yes, I think that's  
20 absolutely right. I think, you know, what  
21 Dave just said, that the percentage -- the  
22 detail depends upon what you said is your

1 minimum number of cases.

2 But what -- to me, the important  
3 thing is making sure that you are doing some  
4 sort of test to make sure even someone with  
5 100 cases, the difference is statistically  
6 significant, or even, as Dave pointed out,  
7 300.

8 CO-CHAIR ROSENTHAL: Absolutely.  
9 No doubt.

10 The one other area that I don't  
11 think we have touched on at all is the  
12 attribution model here went on for a page and  
13 a half and was rather complex. Perhaps could  
14 we -- could you discuss your thinking about  
15 that? And, well, let's just leave it that  
16 open ended for the moment. Tom, could you  
17 guys sort of talk about your attribution  
18 methodology?

19 DR. LYNN: Yes. I think in the  
20 case of diabetes, the attribution methodology  
21 -- and if I said something wrong, it may have  
22 been because I believe we presented

1 alternatives that the attribution methodology  
2 is to identify counts of contacts between  
3 physicians and members for diabetes that were  
4 grouped in this diabetes episode.

5 And then we assigned that episode  
6 to the physician that has the most number of  
7 contacts -- the highest number of contacts as  
8 long as the number of contacts is greater than  
9 30 percent of the total number of contacts.

10 So even if you have a provider who  
11 has -- let's say if you had a member with 10  
12 contacts for the episode of diabetes, and they  
13 were all assigned to different doctors except  
14 for two of them, then that doctor would not be  
15 assigned the diabetes. Nobody would be  
16 assigned to diabetes because no doctor met the  
17 30 percent threshold for attribution.

18 Then, I think a lot of the  
19 complexity may come from, you know, what  
20 happens when you -- when there is a tie. When  
21 there is a tie, then you use the cost as a  
22 tiebreaker. And there may be a third

1 tiebreaker, but I'm not -- I don't have it  
2 right in front of me. I could pull it up  
3 here, if someone would remind me what section  
4 it was in. Is it in S8?

5 CO-CHAIR ROSENTHAL: It's in  
6 Section 11. And just to clarify, though, you  
7 are proposing options for attribution. Did I  
8 get that correct? So an entity that would  
9 want to use this measure could pick one of the  
10 attribution methodologies and apply it?

11 DR. LYNN: Right. But the one I  
12 describe is the one that was used in this  
13 analysis.

14 DR. REDFEARN: Yes. The -- my  
15 notes indicate that they sort of leave it up  
16 to the user. There is a lot of different ways  
17 you can do this. They have a suggested one,  
18 but there's lots of different ways of doing  
19 it.

20 CO-CHAIR ROSENTHAL: Well,  
21 assuming a different -- I mean, we have  
22 struggled with the attribution on these



1 specific measures, you know, diagnosis-  
2 specific measures. And we have been critical  
3 of the people who sort of narrowly picked one.

4 It might be internally  
5 inconsistent to be, then, critical of somebody  
6 who says, "Pick whatever one you want," but to  
7 pick one -- "whatever one you want" appears to  
8 have been the alternative strategy here to the  
9 really challenging difficulties in,  
10 particularly, diabetes that we talked about in  
11 the last one of -- does the primary care doc  
12 get it? Does the endocrinologist get it?  
13 Does the surgeon get it who happens to do the  
14 amputation, or the ophthalmologist who ends up  
15 with the eyes?

16 And, I don't know, does anybody  
17 have a comment on sort of the fact that they  
18 have taken the opposite approach to this and  
19 whether that's a better way to do it, or not  
20 a better way to do it?

21 DR. STEPHANSKY: I much prefer the  
22 flexibility. In practice in Michigan, we have

1       been dealing with a lot of different health  
2       payers and a lot of different attribution  
3       models, and I guess the best way to describe  
4       it is in the meetings it gets very  
5       contentious. And while there has never been  
6       an actual murder in one of the meetings --

7                       (Laughter.)

8                       -- the homicidal ideation is so  
9       high that the --

10                      (Laughter.)

11                     -- so I think we are much better  
12       off being as flexible as we can with  
13       reasonable attribution models, leaving it up  
14       to how it's going to get used for a local  
15       community or a region.

16                     DR. LYNN: There is an attribution  
17       method. That varies depending on what you're  
18       using it for.

19                     DR. STEPHANSKY: Right.

20                     DR. LYNN: Absolutely.

21                     DR. NEEDLEMAN: Got a question  
22       because one of the bases for attribution

1       you've got are, you know, who is the assigned  
2       PCP under the plan? You know, who somebody  
3       picked. And I'm just wondering, when you look  
4       at that, have you seen -- have you looked how  
5       consistent the PCP that is formally assigned  
6       is -- how close -- how often that matches who  
7       you wind up attributing the diabetes care to?  
8       So have you done any cross-checking of what  
9       the different attribution models --

10               DR. LYNN: No, that -- that  
11       particular attribution method, you know, would  
12       be used in a case where that primary care  
13       provider was acting as a gatekeeper, unless  
14       I'm not sure it would be the best one.

15               DR. NEEDLEMAN: But your data  
16       should be able -- would answer the question  
17       posed.

18               DR. LYNN: Yes, we could go back  
19       and say, "Of the physicians that were  
20       identified as primary care, and the members  
21       that had diabetes for those physicians, what  
22       percentage of the time did the primary care

1 physician get attributed to a diabetes  
2 episode?" We could answer that question.

3 CO-CHAIR ROSENTHAL: All right.  
4 But you didn't --

5 DR. LYNN: I don't have the answer  
6 to that question, but we --

7 CO-CHAIR ROSENTHAL: -- you didn't  
8 -- don't have it, okay. So the answer is  
9 don't know.

10 DR. LYNN: Right.

11 CO-CHAIR ROSENTHAL: Paul?

12 DR. BARNETT: I have a question  
13 about a different part of it. Is that all  
14 right -- okay?

15 CO-CHAIR ROSENTHAL: Absolutely.

16 DR. BARNETT: So trying to think  
17 about how this differs from the NCQA diabetes  
18 measure, which takes all costs, so the costs  
19 here, as I understand it, are attributable to  
20 the episode which, in the case of a chronic  
21 disease, is the entire year. But it's things  
22 pertaining to diabetes visits.

1                   And so what I was wondering about  
2           is, so if somebody has diabetes and they get,  
3           you know, ischemic heart disease and they  
4           become a CHF patient, or they become -- you  
5           know, they get eye problems and become an  
6           ophthalmology -- that's an ophthalmology  
7           episode, and then that cost is not  
8           attributable to diabetes anymore, or is it --  
9           it's end stage renal disease, and that cost is  
10          no longer attributable to diabetes anymore, is  
11          that right?

12                   DR. LYNN: Yes, that's a good  
13          question, and that's a good description. You  
14          know, this episode is part of, obviously, an  
15          application that groups claims to all sorts of  
16          diseases, not just diabetes, and this  
17          particular thing that we hold out looks at the  
18          cost of the direct treatment of diabetes and  
19          not the cost of the sequelae of diabetes.

20                   We know that's important, but  
21          inside of our applications it's easier to pull  
22          things -- it's easier to put things together

1 than it is to pull things apart.

2 I mean, another approach, which we  
3 did not present here, would be to say let's  
4 look at -- especially when you're measuring,  
5 say, a system for a primary care doctor that  
6 maybe has the responsibility, let's look at  
7 the entire -- let's look at all of the  
8 episodes for diabetes and its sequelae  
9 together.

10 We call that an ETG family. And  
11 we have a method for doing that and an opinion  
12 about what -- if these should be grouped  
13 together to do that sort of thing. But if  
14 you're measuring the ophthalmologist who is  
15 taking care of the diabetic retinopathy, most  
16 of our customers would want that to be pulled  
17 out separate.

18 So the application pulls them out  
19 separately, and, you know, basically the  
20 philosophy there is it's easier to put things  
21 together than to take them apart.

22 DR. BARNETT: So the retinopathy

1 screening, would that be a different episode,  
2 or is that part of diabetes care?

3 DR. LYNN: The retinopathy  
4 screening would be part of -- it would be part  
5 of diabetes care if the diagnosis was  
6 diabetes. If they had some diabetic  
7 retinopathy, then it would go into a diabetic  
8 retinopathy episode.

9 DR. BARNETT: That makes sense,  
10 and so then the -- I guess the big concern is  
11 is that the -- how do you tease out diabetes  
12 from, say, coronary artery disease? Because  
13 those are really, you know, linked together.  
14 It's kind of a chicken and egg thing, I think,  
15 isn't it? So I'm just --

16 DR. LYNN: I think the diabetes  
17 probably comes first, but that doesn't really  
18 matter. Yes, I mean, it is challenging to  
19 tease it out, and, you know, we try to -- we  
20 look at the diagnosis code, we look at the  
21 procedure code and how -- and the clinical  
22 information contained in the procedure code to

1 help us make the determination, and we have  
2 extensive tiebreaker logic, which, you know,  
3 honestly is a little bit hard to read to try  
4 to figure out what is the best place for a  
5 claim to go that could be eligible for  
6 different episodes. But I -- you know, I  
7 think we do as good a job as you can do given  
8 the limitations of the claims data.

9           You know, the point being made,  
10 which I think is a valid one, is that, you  
11 know, in some situations don't even try --  
12 just look at how much it costs to take care of  
13 the patient or limit some of that choice of  
14 which episode it goes to by using a more  
15 expensive ETG family. And, you know, we  
16 certainly agree that there are times when that  
17 may be the better approach.

18           CO-CHAIR ROSENTHAL: Let me ask  
19 one last quick question about the risk  
20 adjusting. I hate to go back to that, but it  
21 wasn't completely clear to me. If somebody  
22 has a four-vessel CABG and diabetes in that



1 year, do they get risk adjusted differently  
2 than a normal person who only has a little bit  
3 of hyperglycemia? Is that accounted for in  
4 the risk adjustment?

5 DR. LYNN: Right. So there's two  
6 things -- there's two parts to that answer.  
7 The first part is the coronary bypass graft  
8 surgery and the coronary artery disease that  
9 was directly responsible for that surgery,  
10 would be captured in a separate episode. It  
11 would not be part of this episode.

12 After that occurs, then the fact  
13 that the person did have coronary artery  
14 disease at the same time as diabetes is taken  
15 into account in building the severity model  
16 for diabetes, recognizing -- and the models do  
17 recognize because it's mathematics, that the  
18 cost that is increasing cost for diabetes is  
19 indirect. It's a direct cost of coronary  
20 artery disease, and the CABG is captured by a  
21 separate episode.

22 CO-CHAIR ROSENTHAL: Okay. I've

1 got it now.

2 DR. LYNN: It did not --

3 CO-CHAIR ROSENTHAL: I've got it.

4 DR. LYNN: It did not look at  
5 whether there was a CABG or not.

6 CO-CHAIR ROSENTHAL: Okay. I got  
7 it, I got it. I got it. The answer was yes.  
8 The answer was yes.

9 DR. LYNN: All right. I'll try to  
10 limit my answers. Sorry about that.

11 (Laughter.)

12 CO-CHAIR ROSENTHAL: No, I  
13 appreciate it. You have the unfortunate thing  
14 of not being able to read the body language,  
15 and so -- Jephtha.

16 DR. CURTIS: I understand that  
17 approach, and it makes sense on one hand. I  
18 just want to raise the issue that down the  
19 road, if we're trying to match these resource  
20 use measures with quality measures to get to  
21 value, this is leading to a potential paradox  
22 where you will have quality measures that are

1 specifically set up that you risk adjust on  
2 things that are present before the estimation  
3 of quality, and you have resource use measures  
4 that are adjusting for things that could  
5 potentially be complications or consequences  
6 of care.

7 And so I'm not sure how we should  
8 involve that at this stage, but I can  
9 definitely see that becoming a major issue  
10 down the road.

11 CO-CHAIR ROSENTHAL: Okay. Thank  
12 you. Jack, I think you had your hand up.

13 DR. NEEDLEMAN: Yes.

14 CO-CHAIR ROSENTHAL: And then,  
15 we'll perhaps try to sort of maybe bring the  
16 scientific part of this to a vote.

17 DR. NEEDLEMAN: I've got two  
18 questions for the developer. One is, you  
19 know, you talked about a family of diabetes  
20 ETGs, and I'm just wondering, can you explain  
21 what you see as the scope of what this ETG is  
22 trying to measure and where it fits into the

1 family of other diabetes-related ETGs that you  
2 also have that we're not looking at as  
3 specific measures? So that's question one.

4 DR. LYNN: This is -- this episode  
5 captures the direct cost of diabetes. If  
6 there is a complication of diabetes, that --  
7 you know, that is basically a disease in and  
8 of itself, it is captured in a separate  
9 episode.

10 Our concept of the diabetes family  
11 is not a separate episode, but a way to  
12 combine multiple episodes to come up with one  
13 cost -- you know, the cost of -- the cost of  
14 the diabetes, coronary artery disease, the  
15 congestive heart failure, the renal failure,  
16 are some examples of what we included in the  
17 diabetes family.

18 So it would be calculated by  
19 basically summing up costs in the separate  
20 episodes for diabetes as well as complications  
21 of diabetes.

22 CO-CHAIR ROSENTHAL: And your

1 other question, Jack?

2 DR. NEEDLEMAN: And my second  
3 question -- you talked about dealing with the  
4 pharmacy carve-outs that exist in much of your  
5 data by basically stratifying your cost  
6 analysis for patients where you have that data  
7 and where you don't.

8 There are also carve-outs in  
9 behavioral health. And if you were looking at  
10 the direct cost of diabetes, obviously,  
11 depression as a diabetes-related comorbidity  
12 is not in the cost -- the cost of this. But  
13 I'm wondering if it's part of your risk  
14 adjuster and -- because somewhere you talk  
15 about psychosis as part of your risk adjuster.

16 And how are you dealing with  
17 behavioral health carve-outs for your risk  
18 adjusters, to the extent that they include  
19 mental health services or mental health  
20 conditions?

21 DR. LYNN: Yes, we do have --  
22 you're right, we do have severity markers that

1 are comorbid that are based on mental health  
2 issues. And we do not stratify based on  
3 mental health -- whether mental health is a  
4 carve-out. So we don't deal with that  
5 probably the way you want it, you know, dealt  
6 with.

7 You know, hopefully that is  
8 mitigated by the possibility that some of  
9 these diagnoses may be included in medical  
10 claims, because they are relevant to the  
11 treatment.

12 CO-CHAIR ROSENTHAL: All right.

13 DR. LYNN: So that's the answer to  
14 the question.

15 CO-CHAIR ROSENTHAL: Okay. Thank  
16 you. I think we have pretty well run the  
17 gamut of the issues around this. Jaime, maybe  
18 I'd like to give you, on behalf of the TAP,  
19 kind of the last word.

20 And in turn, for having  
21 participated in this conversation -- and we've  
22 got your -- the TAP scores up in terms of

1 reliability and validity -- and apropos of  
2 sort of the last observation -- the last  
3 review of this where -- give us your summary  
4 of what you think these numbers mean on the  
5 screen. Can you see them?

6 DR. ROSENZWEIG: Well, you know, I  
7 think there was -- there is certainly internal  
8 consistency that was demonstrated, but the  
9 other validity measures were highly debated,  
10 and there was a lot of variability in the  
11 scores between the various members of the TAP.

12 In general, I think the -- one of  
13 the bigger issues was this proprietary nature  
14 of their risk adjustment score, and I think  
15 there was sort of a difference between the  
16 clinicians on our Committee and the people who  
17 were more in tuned with health plans with  
18 respect to their ability to trust the data  
19 with respect to that particular aspect, and  
20 that's why there was kind of a mixed review.

21 CO-CHAIR ROSENTHAL: All right.  
22 Thank you. I was --

1 DR. CURTIS: Can I follow up on  
2 that?

3 CO-CHAIR ROSENTHAL: Please.

4 DR. CURTIS: These ratings broken  
5 down into the individual elements show that  
6 the lows in this case are different than for  
7 the last measure, which was more on  
8 specifications. This is more about the risk  
9 adjustment than the identification, and that,  
10 as I recall, was directly our concern, that  
11 you were adjusting for things that were  
12 happening during the measurement year, as well  
13 as the difficulty of attributions.

14 DR. ROSENZWEIG: Correct.

15 CO-CHAIR ROSENTHAL: I think with  
16 that clarification, does the group feel  
17 prepared to make a judgment on scientific  
18 acceptability? It appears so. This is one  
19 yes, two no.

20 MS. TURBYVILLE: We have 10 yes  
21 and eight no.

22 CO-CHAIR ROSENTHAL: All right.



1 So we will move now into -- that at least  
2 gives us the opportunity to discuss usability  
3 and feasibility, and so, Jaime, would you give  
4 us a TAP rendition of usability?

5 DR. ROSENZWEIG: Yes. With  
6 respect to the usability issue, the measured  
7 performance results are already publicly  
8 reported, but the usability information that  
9 was submitted was the same -- was really not  
10 specific to diabetes, but really for all of  
11 the Ingenix measures.

12 And there was some concern in the  
13 TAP that -- about the -- with the availability  
14 of this data to the public and requested --  
15 and we requested clarification from NQF as to  
16 what would be required for public reporting.

17 So I think this is an issue that  
18 came up, and, as a result, with respect to 3A,  
19 most of the people felt that the data was  
20 insufficient.

21 And there was also some -- here  
22 again, on 3B, the usability information

1 submitted was not specific to diabetes and for  
2 Ingenix measures. It was for all Ingenix  
3 measures.

4 The usability -- and it was felt  
5 that diabetes presented specific problems that  
6 had to be addressed. So we had some concerns  
7 about this here, and that applied to 3C as  
8 well.

9 There was also some -- felt that  
10 there was -- that it was difficult to assess  
11 the extent to which this particular -- the  
12 individual measures could be evaluated. And  
13 then, I think basically the major issue was  
14 that the whole section here that was put in  
15 place with respect to usability was fairly  
16 generic and could apply to a whole variety of  
17 different measures other than diabetes. I'm  
18 repeating myself.

19 CO-CHAIR ROSENTHAL: All right.  
20 Thank you. That's very thorough. Jack,  
21 you're our rep on this.

22 MR. BOWHAN: Yes. I mean, it's in

1 the notes and the description, and I wouldn't  
2 have anything to add. But these are all  
3 complex measures, and I don't know that --  
4 with any of the groups that it's any easier to  
5 figure these out than this one. But it is  
6 complex.

7 CO-CHAIR ROSENTHAL: Do you want  
8 to comment on the 3C?

9 MR. BOWHAN: Other than knowing  
10 that -- you know, trying to decipher down to  
11 the level of figuring out where you fit in and  
12 how you got to your rating, you know, it's  
13 complex.

14 CO-CHAIR ROSENTHAL: But I think  
15 the issue -- what I'm hearing from the TAP is  
16 more than complex. Is this -- or maybe I'm  
17 misunderstanding it, but is this not the place  
18 where the fact that the methodology is not at  
19 all transparent is the issue? This is the  
20 black box issue. I mean, or am I missing it?  
21 I'm hearing some yeses so, but if somebody  
22 wants to --

1 DR. BARNETT: Yes. So one  
2 important -- another important way that this  
3 differs from the NCQA diabetes measures, I  
4 looked at the NCQA thing, and I was thinking  
5 as -- I could have one of the programmers in  
6 my center do this. I could read it, and I  
7 could have them do it.

8 And so it's partly the complexity  
9 issue, yes, that it's simpler. But, you know,  
10 we don't -- so I was just looking at the  
11 submission. I don't see any further  
12 documentation that I can go to, unless I have  
13 overlooked something in there, that explains,  
14 you know, all the codes.

15 So I think that their -- what they  
16 have done is great. The issue is, if we are  
17 going to start judging plans and providers on  
18 it, we really have to understand exactly how  
19 it is constructed. And it's a dilemma because  
20 they can't give this -- build it and then have  
21 something so complicated, and then give it  
22 away. So I'm -- it is a dilemma.

1 MS. ZIELINSKI: This is Cheri  
2 Zielinski. I have a couple of salient points  
3 I think would help this discussion.

4 Number one, due to the fact that  
5 the diabetes measures for usability are cited  
6 for all of the other measures that we have --  
7 due to the fact that, you know, the way we  
8 package our software -- ETG -- those measures  
9 are grouped together, you know, and can be  
10 recorded publicly. You know, so several  
11 chronic conditions can be reported on publicly  
12 -- and are reported on publicly by our clients  
13 and users.

14 And so we envision that to be  
15 widespread usability using all of our  
16 measures, which we feel is an advantage.

17 And then, secondly, in terms of  
18 the black box technology, we do have a website  
19 -- it's [ingenix.com/transparency](http://ingenix.com/transparency) -- that  
20 people who -- people who have questions about  
21 how the episodes are constructed who want to  
22 know how the coding -- how the coding maps

1 and, you know, what codes are included in  
2 diabetes, ETGs, and so on.

3 Anybody that is open to the public  
4 do not need proprietary measures. You don't  
5 have to have a license in order to see our --  
6 how our codes are constructed and how our  
7 episodes are constructed, so that's something  
8 that can be accessible to the public as well.

9 CO-CHAIR ROSENTHAL: Okay. Other  
10 discussion, then, on the usability criteria?

11 (No response.)

12 Hearing none, I am assuming that  
13 that means the group is ready to vote.

14 MR. PHILLIPS: Just to -- I mean,  
15 I guess a follow up --

16 CO-CHAIR ROSENTHAL: I thought so.

17 MR. PHILLIPS: -- a follow up on  
18 the point about the transparency website. And  
19 so, I mean, is the point, then, that a  
20 provider could work back using this  
21 information to decipher its score?

22 MS. ZIELINSKI: That was exactly

1 why we constructed that website, because  
2 people who are being measured with these tools  
3 need to understand the measurement being used.  
4 And so it's primarily -- well, it's for  
5 anybody who is interested in the construct of  
6 the episodes, but, yes, it's especially for  
7 providers who are being measured.

8 CO-CHAIR ROSENTHAL: Bill?

9 DR. WILLIAM RICH: Yes. In  
10 reality, a physician first has to get their  
11 report from the -- whoever put the report  
12 together using the Ingenix. They have to get  
13 the data. Then, they can go to the website.  
14 To look at one measure, if you will, takes  
15 about six to eight hours, but it is there, and  
16 you can go through and see how, as an  
17 ophthalmologist, I was assigned urograms and  
18 things like that, but you can go through  
19 everything and actually map it out.

20 CO-CHAIR ROSENTHAL: Is it an  
21 issue of usability that, in point of fact, the  
22 only people who could use this would be ones

1 who would hire Ingenix? Is that a usability  
2 issue? You don't think so?

3 DR. WILLIAM RICH: More  
4 feasibility.

5 CO-CHAIR ROSENTHAL: Well, no, I'm  
6 not talking about the money, that it is not  
7 feasible. I mean, the only people that are  
8 going to have -- be able to use this tool are  
9 going to be health plans that would engage  
10 them. Is that an issue about usability? If  
11 --

12 DR. RUDOLPH: Well, it could be  
13 others in the health plans, right? I mean,  
14 I'm thinking, you know, say a large employer  
15 with all of their own claims or it could be,  
16 you know, some other group -- a state, many of  
17 the states --

18 CO-CHAIR ROSENTHAL: Could also  
19 engage them on --

20 DR. RUDOLPH: -- who have health  
21 data, which is --

22 CO-CHAIR ROSENTHAL: Okay. All



1 right.

2 DR. RUDOLPH: -- just like all  
3 payer claims data, states could use this  
4 measure. So --

5 MS. YANAGIHARA: Big medical  
6 groups in California license the product.

7 MS. ZIELINSKI: Well, we have  
8 several provider organizations, NCOs, large  
9 employer groups, state Medicaid programs, all  
10 using it.

11 CO-CHAIR ROSENTHAL: Mary Kay?

12 DR. O'NEILL: Without playing an  
13 economist for a second, though, if it does  
14 take as many hours as Bill described to figure  
15 this out, that is actually a cost.

16 CO-CHAIR ROSENTHAL: If there is  
17 no other point -- Jack, last point.

18 DR. NEEDLEMAN: A number of the  
19 folks that we have been -- were using some  
20 variation of the HCC weighting system, that's  
21 documented, and the sources of it are  
22 documented. You've got your own comorbidities

1 that you are including, your own other  
2 weighting factors that you are including, and  
3 your weights.

4 Can you just briefly tell us a  
5 little bit about how those were developed, and  
6 what kinds of analysis went into them? I'm  
7 sure it's documented on your website, but I'd  
8 just like the slightly -- a long elevator ride  
9 explanation of where that is and how it  
10 contrasts to the HCC kind of development,  
11 which looks very similar in terms of the  
12 weighting up of each individual.

13 DR. LYNN: Yes, I think -- I'll  
14 try to keep it to the long elevator ride  
15 explanation. I think there are two components  
16 to it. One is the -- what is going on outside  
17 the episode that has an indirect cost that we  
18 capture, and that is similar to the HCC model,  
19 you know, which tells you what comorbidities  
20 the member has.

21 We felt like it was important, and  
22 I think some of our colleagues that have

1 presented felt like it was important, that you  
2 see what the specific comorbidity rate was for  
3 diabetes as opposed to taking some overall  
4 disease burden quote from an HCC system, using  
5 the individual markers. I think our  
6 colleagues have used the individual markers.

7 We use markers that are similar,  
8 and I think the HCC models that are used, and  
9 our models that are used, are similar. But  
10 that's looking at what's outside. We also  
11 looked at what is inside the episode for --  
12 you know, that might explain costs, the  
13 clinical diagnosis, as opposed to procedures  
14 and use those markers as well.

15 So I think we felt like it was  
16 important to have a specific diabetes model  
17 that the comorbidity had specific effect on  
18 the severity of diabetes that you don't use on  
19 some sort of measure of overall disease  
20 burden, because maybe migraine doesn't has  
21 much of an effect on diabetes, and they -- you  
22 know, COPD, for example. But they might have

1 similar increases in the disease burden.

2 So I think it was the specificity  
3 built in a specific model for diabetes and  
4 looking outside for the indirect effects of  
5 cost and inside for the more direct effect of  
6 cost, and making sure it was all diagnosed.

7 The way they were developed -- you  
8 know, a lot of our comorbidities jive with our  
9 definitions of other diseases that we looked  
10 at. That worked well with what is happening  
11 outside of the episode.

12 And then, we modeled it. We used  
13 that large database that we have been working  
14 with, although it's a version a couple years  
15 old -- older, but -- and we modeled those  
16 markers, looked at sort of a -- cast a wide  
17 net clinically about what would be a marker  
18 and what wouldn't be a marker, looked at what  
19 effect those markers had, ran the model,  
20 looked at what is statistically significant,  
21 what wasn't, you know, and adjusted the model  
22 until we felt like we had the best marker for

1 diabetes.

2 And, of course, all of this is,  
3 you know, done as much mathematically as it is  
4 clinically. We tried to use the two together.

5 And that's sort of the long  
6 elevator ride explanation about how the models  
7 were developed.

8 DR. NEEDLEMAN: Thank you.

9 DR. LYNN: Diabetes models.

10 DR. NEEDLEMAN: We got to the  
11 100th floor.

12 (Laughter.)

13 DR. LYNN: Yes. I'll stop.

14 DR. NEEDLEMAN: Thank you.

15 CO-CHAIR ROSENTHAL: All right.

16 Okay. I've lost all train of thought now  
17 about usability. Hold on. Now, focus, focus.

18 I think we are ready. I think we  
19 have dealt with the various issues around  
20 usability, and I get the sense the group is  
21 ready to weigh in on this.

22 And if we recall, let's -- can we

1 look at the TAP scores on this? And then,  
2 this one will be high, moderate, low, and  
3 insufficient. All right. So we've got 3A, B,  
4 and C. Here D is N/A.

5 And, Jaime, do you want to just  
6 very quickly review -- just get the last word  
7 in on this?

8 DR. ROSENZWEIG: Yes. Here again,  
9 I think with respect to usability, the issue  
10 was that it wasn't specific to diabetes, that  
11 the data that was presented -- it might be  
12 usable for overall costs and other disease  
13 states, but there wasn't any data of their  
14 diabetes -- people of their subgroup within --  
15 that they have already looked at with respect  
16 to diabetes.

17 CO-CHAIR ROSENTHAL: In terms of  
18 what has been publicly reported.

19 DR. ROSENZWEIG: And we are --  
20 with respect to what has been publicly  
21 reported, yes.

22 CO-CHAIR ROSENTHAL: Yes.

1 DR. ROSENZWEIG: And there was a  
2 certain amount of concern about the fact that  
3 it was because of the lack of attribution --  
4 if you go back to where we discussed the  
5 attribution, there were so many different  
6 options for attribution that physicians who  
7 would be judged by this might be judged  
8 compared to other physicians with respect to  
9 their resource use, whereas the -- with  
10 respect to the overall picture they may be  
11 saving money, keeping people out of a  
12 hospital, even though they were using more  
13 resources.

14 CO-CHAIR ROSENTHAL: Okay. And  
15 then --

16 DR. ROSENZWEIG: Does that make  
17 that sense?

18 CO-CHAIR ROSENTHAL: Yes,  
19 absolutely. And then --

20 DR. ROSENZWEIG: It's a big issue  
21 in diabetes, you know, obviously, because the  
22 proportion of actual resources that are

1 actually related to outpatient provider use is  
2 actually relatively small compared to the  
3 entire resource use picture.

4 CO-CHAIR ROSENTHAL: And then, 3C  
5 is the decomposition, the ability to decompose  
6 the data had some negative votes.

7 DR. ROSENZWEIG: Yes, yes. The  
8 TAP thought it was difficult to assess the  
9 extent to which the measure could be  
10 decomposed --

11 CO-CHAIR ROSENTHAL: Okay.

12 DR. ROSENZWEIG: -- as currently  
13 specified.

14 CO-CHAIR ROSENTHAL: I think this  
15 is very helpful, and the discussion on this  
16 point has been good. And I think we are ready  
17 to vote. It's 1 through 4, then, on this one  
18 with high, moderate, low, and insufficient.

19 MS. TURBYVILLE: So we have nine  
20 moderate, six low, and three insufficient.

21 CO-CHAIR ROSENTHAL: All right.  
22 So we will move on to feasibility. So, Jaime,



1 the TAP. Oh, yes, I'm sorry. Helen goes  
2 first on this one.

3 DR. BURSTIN: Yes. So I just want  
4 to have a couple of minutes to talk to the  
5 Steering Committee about this particular issue  
6 for feasibility. So as you saw earlier, when  
7 we considered the HealthPartners measure, we  
8 -- you have the ability to look at the fee  
9 schedule for the ACGs as part of that data.

10 To date, we still have incomplete  
11 information from Ingenix. We have not yet  
12 received the fee schedule. So at this point,  
13 you actually can't assess feasibility, so I  
14 think at this point we're going to -- we are  
15 having some continued ongoing discussions with  
16 Ingenix, but I think at this point we are  
17 going to table feasibility. You also can't  
18 make an overall assessment of the measure,  
19 because you won't have feasibility, won't have  
20 the benefit of looking at that.

21 It is important to note this is  
22 clearly, as part of the policy the Board

1 approved a couple of years ago of proprietary  
2 measures, the fact that they thought it was  
3 important that the Committee and the end users  
4 have a chance to see the fees involved and  
5 have that incorporated into feasibility.

6           Clearly, we can't -- you know, the  
7 measures may score well, as they have sort of  
8 done moderately on many of these other  
9 criteria, but if they are not feasible they  
10 can't move forward.

11           So at this point, we really just  
12 need to -- we will work with Ingenix to  
13 continue to get that information to share with  
14 you, and then we will continue at a later date  
15 on feasibility.

16           CO-CHAIR ROSENTHAL: Do we have  
17 some way of capturing the key points of this,  
18 so that we don't have to repeat the entire  
19 exercise when we are finally able to have  
20 feasibility, and then have the overall vote?  
21 Because otherwise we will have wasted an hour.

22           MS. TURBYVILLE: We're taking

1 meeting notes right now and summarizing the  
2 discussions and key points. And you voted on  
3 the first three, so hopefully that will be  
4 sufficient for all of you. You know --

5 DR. WILLIAM RICH: I would venture  
6 to say, Tom, we can't, because there's other  
7 issues in feasibility about adverse  
8 consequences of the reporting that we haven't  
9 addressed. So we are going to table this.

10 I would be unable to vote until  
11 we -

12 CO-CHAIR ROSENTHAL: I was not  
13 suggesting a vote today. I was suggesting a  
14 methodology by which we could have some of the  
15 discussion crisply summarized, so that we  
16 don't have to repeat it all --

17 DR. WILLIAM RICH: I'm sorry.

18 CO-CHAIR ROSENTHAL: -- when we do  
19 that thing. I --

20 DR. WILLIAM RICH: I thought you  
21 were talking of calling for a consensus.

22 CO-CHAIR ROSENTHAL: No, no, no,

1 no, no, no. I understand the absolute  
2 constraint on our freedom on this one.

3 MS. WILBON: Tom, when we are  
4 ready to bring it back to the Committee, we  
5 will provide you guys with a summary of what  
6 your votes were, what the key points were for  
7 the previous three prior criteria, so that you  
8 have an idea of where the discussion was --

9 CO-CHAIR ROSENTHAL: Okay.

10 MS. WILBON: -- before that.

11 CO-CHAIR ROSENTHAL: And then, as  
12 a point of order, the same will apply then to  
13 the other Ingenix thing, which we were  
14 supposed to do usability and feasibility wrap  
15 up, and which in fact we are going to have to  
16 rediscuss a little bit of the scientific  
17 thing, because we didn't really complete all  
18 the votes on that, and so we'll need a short  
19 conversation. But it's clear we will not  
20 reach a final decision on it either.

21 I assume people are beginning,  
22 though, to direct themselves in their heads.

1 And to the extent that you can do that so that  
2 you remember how you were at least leading up  
3 to this, so I'm just trying to, again, create  
4 some efficiencies for our group, so that we  
5 just don't -- because this is complex stuff,  
6 and the details are important.

7 And if we come back two weeks  
8 later or three weeks later on a phone call,  
9 and we have to reiterate every single point,  
10 that will be unpleasant for all involved, I  
11 think.

12 DR. WILLIAM RICH: Do we need a  
13 motion to table?

14 CO-CHAIR ROSENTHAL: Yes.

15 DR. WILLIAM RICH: So moved.

16 CO-CHAIR ROSENTHAL: Okay.

17 Second?

18 DR. STEPHANSKY: Second.

19 CO-CHAIR ROSENTHAL: Any  
20 discussion? Not discussable. Motion to table  
21 as not discussable. Thank you, Robert's Rules  
22 of Order.

1 (Laughter.)

2 No, you can't speak. It's not  
3 discussable. Oh, you can eat. Oh, you said  
4 we can eat.

5 Okay. All in favor?

6 (Chorus of ayes.)

7 Okay. All opposed?

8 (No response.)

9 Motion carries.

10 We will take --

11 CO-CHAIR STEINWALD: We need to  
12 take some lunch, yes?

13 CO-CHAIR ROSENTHAL: Right. So  
14 half an hour for lunch?

15 DR. LYNN: Can I ask you a  
16 question?

17 CO-CHAIR ROSENTHAL: Yes,  
18 absolutely.

19 DR. LYNN: Will 1599 be discussed  
20 at 2:30, or will that be tabled as well?

21 CO-CHAIR ROSENTHAL: Oh, 1599 will  
22 be discussed in about a half an hour. Sorry,

1 we should have clarified that.

2 DR. LYNN: Okay. So we are going  
3 to do that right after lunch.

4 CO-CHAIR ROSENTHAL: Yes, right  
5 after lunch.

6 DR. LYNN: Okay.

7 CO-CHAIR ROSENTHAL: So about a  
8 half an hour break, and then we will go right  
9 into 1599.

10 MS. ZIELINSKI: Was that agenda  
11 item -- this is the first I've heard of it.  
12 I'm not sure if our resource is going to be  
13 available. I have him coming at 2:30. I was  
14 not aware of this agenda change.

15 MS. WILBON: Cheri, I think I sent  
16 you an e-mail yesterday afternoon about 1572  
17 getting moved and 1591 getting removed.

18 MS. ZIELINSKI: And then we  
19 started today, but then those -- there were no  
20 changes to it.

21 CO-CHAIR STEINWALD: Well, the  
22 question is, do you think that you could get

1 the person that we need to have involved at  
2 12:45?

3 MS. ZIELINSKI: Not in a half  
4 hour. I apologize. I have him coming at  
5 2:30, which was what the agenda had said.

6 DR. ROSENZWEIG: I'm going to sign  
7 off here. Thank you very much. Bye-bye.

8 CO-CHAIR ROSENTHAL: We'll confer  
9 with staff here, and we'll get back to you on  
10 this.

11 CO-CHAIR STEINWALD: But as it  
12 stands, we're going to start the discussion at  
13 12:45.

14 MS. ZIELINSKI: Ashlie, can I talk  
15 to you offline?

16 MS. WILBON: Sure.

17 MS. ZIELINSKI: I'm not going to  
18 be able to have a resource there for that  
19 discussion. I -

20 MS. WILBON: Okay. Give us some  
21 time to confer to see what we can do.

22 MS. ZIELINSKI: Okay. So you'll



1 send me an e-mail, then?

2 MS. WILBON: Yes, I will.

3 MS. ZIELINSKI: Thank you.

4 CO-CHAIR ROSENTHAL: We are going  
5 to adjourn now. We will confer and we will  
6 have an offline conversation with you about  
7 how we are going to manage this.

8 MS. ZIELINSKI: Okay. Thank you.

9 (Whereupon, at 12:16 p.m., the  
10 proceedings in the foregoing  
11 matter recessed for lunch.)

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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (12:53 p.m.)

3 CO-CHAIR STEINWALD: It's the  
4 sprint to the finish line, and the sooner we  
5 start the sooner we can go home.

6 If my co-chair would come and take  
7 the -- take his seat. All right.

8 Well, in the course of a number of  
9 challenging discussions, we have an extra  
10 challenge. The agenda says we are going to  
11 have the usability and feasibility wrap up of  
12 the ETG-based non-condition-specific resource  
13 use measure by Ingenix.

14 We have, in fact, had a conference  
15 call that many of you were present at, and we  
16 discussed the importance and the scientific  
17 acceptability criteria.

18 However, we did not have any  
19 official vote, even though some people  
20 attempted to access the monkey -- the monkey  
21 bars --

22 (Laughter.)

1                   -- service, okay. All right.  
2           That either didn't get recorded or it's  
3           unofficial, and so we do have to go back and  
4           -- again, since we're acting as our own TAP,  
5           we have to vote on the individual subcriteria  
6           of the measures that we have already  
7           discussed.

8                   We hope we are going to be able to  
9           leverage the discussion that we already had.  
10          Sally and staff will use their notes and  
11          remind us of main points that were made or  
12          conclusions that were drawn during our  
13          discussion of importance and scientific  
14          acceptability.

15                   And the measure developer was  
16          present and did make a presentation of the  
17          overall characteristics of the measure. I  
18          guess there is some question about whether the  
19          appropriate person from Ingenix will be able  
20          to join us or not in this conversation, but we  
21          will forge ahead in any case.

22                   Ingenix, are you on the line?

1 DR. DUNN: Yes. Hi. This is Dan  
2 Dunn from Ingenix.

3 CO-CHAIR STEINWALD: Good. Thank  
4 you. So you are available to respond to  
5 questions and points made.

6 DR. DUNN: Yes, sure. Happy to.

7 CO-CHAIR STEINWALD: Okay. But  
8 why don't we go directly -- all right.  
9 Ingenix, please say your name again, please?

10 DR. DUNN: Hi. This Dan Dunn,  
11 Ingenix.

12 CO-CHAIR STEINWALD: Okay. Would  
13 you give us an overview of your measure,  
14 please, for the members of the Committee who  
15 weren't present on the conference call?

16 DR. DUNN: Sure. Just to confirm,  
17 we are talking about the population-based  
18 measure for total cost, right?

19 CO-CHAIR STEINWALD: That's  
20 correct, the non-condition-specific measure.

21 DR. DUNN: Okay. Thank you. This  
22 is a measure, you know, based on a title which

1 is designed to be not condition-specific, but  
2 to be a measure of groups of individuals at a  
3 population or member level, if you will, so  
4 it's not looking at their resource use related  
5 to congestive heart failure or diabetes. It's  
6 looking at their resource use for all the  
7 services and all the conditions that they  
8 present with.

9 The measure includes total  
10 resources or total cost as one of the  
11 numerators of measures. It includes resources  
12 by type of service, the cost as well, and also  
13 includes some utilization measures, such as  
14 in-patient admits, days, and so on.

15 The risk adjustment approach is --  
16 I'm sorry, just sort of step back, so there is  
17 -- you know, including all members in the  
18 measure, with risk adjustment based on their  
19 underlying risk as measured by episode risk  
20 groups. Each individual information is  
21 processed to identify all those numerator  
22 measures to all of the cost in use.

1                   Also, the information for a 12-  
2                   month period is processed through episode risk  
3                   groups, which is a risk adjustment methodology  
4                   that uses episode treatment groups and  
5                   episodes of care as its foundation.

6                   And ERGs is essentially looking at  
7                   an individual mix of episodes of care and  
8                   translating that into an overall risk core,  
9                   and that risk core is then used to risk adjust  
10                  the measures themselves.

11                  CO-CHAIR STEINWALD: Remind us,  
12                  was there a standardized pricing or costing  
13                  technique used as well?

14                  DR. DUNN: No, this has actually  
15                  been applied using either approach. It will  
16                  work either way, and we left that up to the  
17                  user to decide which way they wanted to go.

18                  CO-CHAIR STEINWALD: Steering  
19                  Committee members, any questions for Dan  
20                  before we proceed?

21                  (No response.)

22                  All right. Then, let's bring

1 importance up. Individual criteria.

2 MR. PHILLIPS: I have -- do we  
3 have a TAP?

4 CO-CHAIR STEINWALD: No. We're  
5 the TAP.

6 (Laughter.)

7 MS. TURBYVILLE: Right. So in  
8 this measure, like the other non-condition-  
9 specific measure submitted by HealthPartners,  
10 the Steering Committee is serving both as the  
11 Technical Advisory Panel, so you will be  
12 rating each of the subcriteria, and then, of  
13 course, as the Steering Committee.

14 We have a few notes about what we  
15 heard on the call, realizing that we would  
16 follow up. And we did feel confident that the  
17 Committee, acting as the TAP during the  
18 June 22nd call, wrapped up importance.

19 The notes that we walked away --  
20 was that, in our sense, though this is without  
21 a final rating, so it's those who shared their  
22 sentiments that the measurement area is of

1 high impact.

2           There is a resource use and cost  
3 problem that the description of the purpose of  
4 the measurement was described well enough in  
5 the submission, and that they were in -- they  
6 were able to meet the criterion about the  
7 service categories that they are proposing as  
8 they are quite numerous and comprehensive.  
9 That's what we heard. Those were our  
10 walkaways.

11           CO-CHAIR STEINWALD: So are we  
12 prepared to vote on the subcriterion 1A? And  
13 it's -- this is one where we vote high,  
14 moderate, low, or insufficient. Are we ready?  
15 Okay.

16           MS. TURBYVILLE: Great. So there  
17 are 16 Steering Committee members here in the  
18 room, and there were 15 high and one moderate.

19           So moving on to subcriterion 1B,  
20 demonstration of resource use or cost problems  
21 and opportunity for improvement includes  
22 showing data demonstrating variation, et



1 cetera.

2 CO-CHAIR STEINWALD: Can we take  
3 the vote? All right.

4 MS. TURBYVILLE: Thirteen high,  
5 three moderate.

6 Moving on to subcriterion 1C,  
7 which is that the purpose and objective of the  
8 resource use measure is clearly described.  
9 Twelve high, four moderate.

10 Moving on to 1D, which is that the  
11 resource use service categories that are  
12 included are consistent with and  
13 representative of the conceptual construct  
14 represented by the measure. Eight high and  
15 eight moderate.

16 For our -- because this split is a  
17 little bit different, I would be interested if  
18 anyone who voted on moderate, if you could  
19 give us a little input on that, so we can  
20 capture that in our notes.

21 It's the 1D which is that the  
22 resource use service categories are consistent

1 with the conceptual construct of the measure.

2 DR. NEEDLEMAN: Yes, I voted  
3 moderate here, just because the pharmacy data  
4 is not required, the mental health carve-outs  
5 are not clear. Those are important cost  
6 categories and resource use categories, and  
7 I'm concerned that they're not always  
8 consistently present.

9 MS. TURBYVILLE: Anyone else who  
10 thinks it might be new information for us to  
11 consider?

12 (No response.)

13 All right. Well, then, let's just  
14 move on to scientific acceptability.

15 CO-CHAIR STEINWALD: No, we have  
16 the --

17 MS. TURBYVILLE: Oh, I'm sorry.

18 CO-CHAIR STEINWALD: This should  
19 be --

20 MS. TURBYVILLE: Clearly, I'm  
21 going faster than I'm supposed to.

22 CO-CHAIR STEINWALD: This is a yes

1 or no. Are you ready? Go.

2 MS. TURBYVILLE: Okay. For  
3 overall importance, the final tally is 16 yes.  
4 So now we can move on to scientific  
5 acceptability. Fantastic. Do you want me to  
6 recap some of the --

7 CO-CHAIR STEINWALD: Yes. I'm not  
8 sure if it's good to recap it all at once or  
9 parse it out? I leave it up to you. It  
10 depends, really, on how much recapping there  
11 needs to be.

12 MS. TURBYVILLE: These are very  
13 draft notes, because we hadn't yet tried to  
14 synthesize them for appropriate distribution  
15 at this time. We heard questions about making  
16 sure the -- which is the minimum threshold on  
17 face validity was explained, and I believe  
18 that Ingenix provided more clarity on that.

19 We did hear a lot of questions  
20 around the risk adjustment method and wanting  
21 more explanation of how it worked and what  
22 that meant for the ERG measure, and how the

1 weights were assigned to the ETG. And then,  
2 we did hear a request for a verbal description  
3 of the individual R squareds.

4 I do want to say that there have  
5 been a couple of questions to Ingenix about  
6 the ERG measures, primarily about -- and let  
7 me pull it up, because we documented it and  
8 they did respond verbally, and it gets the  
9 scientific acceptability. Just give me -- I  
10 think I remember, but because my brain is in  
11 crash mode, I do not want to inadvertently  
12 provide you -- you have notes, too?

13 While I pull up their response,  
14 Ashlie, do you want to -- just on scientific  
15 acceptability, in general.

16 MS. WILBON: So I'm looking  
17 through my notebook here. So for reliability,  
18 I remember that Carlos was on the call, and he  
19 was -- you guys had asked him for his input on  
20 reliability and validity, and he had thought  
21 that they had done a good job of their  
22 reliability testing, and that there was I

1 think a 99 percent match in the way they had  
2 compared their results and their reliability  
3 testing, that they -- he didn't find any  
4 results for face validity in the submission  
5 that was given.

6           There was some discussion about  
7 the risk adjustment and how the risk  
8 adjustment assigned severity scores, taking  
9 into account comorbids, and some explanation  
10 of how -- the ERG grouping of ETGs and how  
11 they assign weights using the ETG risk score.

12           CO-CHAIR STEINWALD: These are  
13 questions that were raised that Ingenix  
14 responded to?

15           MS. WILBON: Yes, it was more of  
16 -- I think I was writing down more where the  
17 discussion --

18           CO-CHAIR STEINWALD: Okay.

19           MS. WILBON: -- was going, and I  
20 think there was definitely some -- I remember  
21 Dan -- it might have been Dan that was on the  
22 phone, and he can clarify if he also remembers

1 from that phone call. But I know there was  
2 some questions from the Steering Committee  
3 about -- for him to kind of explain how the  
4 risk models work and how the ETGs feed into  
5 the ERG in determining the risk adjustment.

6 DR. WILLIAM RICH: All of a sudden  
7 my brain is clearing. I do remember the  
8 construct was that -- you heard it addressed,  
9 how they do it for a measure. But how you do  
10 it to a population-based thing didn't make a  
11 lot of sense to us at face value, so that's  
12 why we asked them to.

13 MS. TURBYVILLE: And then, Ingenix  
14 had provided some written input to us, a  
15 couple of things specifically, and I think  
16 Taroon also may have something to add. But  
17 there was a question about what happens to  
18 records or claims that do not match to the  
19 ETGs and what is the implications for the then  
20 total cost of care that the ERG measure is  
21 putting forth.

22 Ingenix did respond that, as far

1 as identifying the members who are in ERG --  
2 and, Dan, please correct me if I'm not  
3 representing your written response back  
4 accurately -- that they might not be included  
5 in the measure, but all costs are.

6 So even if a claim is not being  
7 grouped by the ETG when they are estimating  
8 the total cost, they go back and make sure the  
9 claims -- whether or not they made it into the  
10 ETG that is helping support the risk  
11 adjustment. They are still including those in  
12 their total cost, and they provided some  
13 statistics on those implications, but I think  
14 that gets to the heart of the question on that  
15 one.

16 So they, while not included in the  
17 ETG and risk adjustment, they are included in  
18 total cost.

19 And then, they did respond to us  
20 formally about more adequately describing how  
21 the face validity, at minimum, was vetted  
22 through their process.

1                   Did you have something to add to  
2                   what you have or --

3                   CO-CHAIR STEINWALD:   Then, why  
4                   don't we go to the subcriteria, and then if  
5                   there's more discussion --

6                   MS. TURBYVILLE:   Walk through?

7                   CO-CHAIR STEINWALD:   Yes.

8                   MS. TURBYVILLE:   Okay.   So 2A(1),  
9                   if you recall, having just gone through this  
10                  earlier today, is about the precision of the  
11                  specifications that are provided, such that it  
12                  could be implemented consistently.   So it  
13                  includes, as you can see, many components.   So  
14                  how well defined and precise are the  
15                  specifications?

16                  CO-CHAIR STEINWALD:   Questions?

17                  (No response.)

18                  Okay.   Then, let's call the vote.

19                  MS. TURBYVILLE:   We have 10 high,  
20                  five moderate, and one low.

21                  And so moving on to 2B(2), which  
22                  focuses on the reliability testing



1 demonstrating that the results are repeatable  
2 was the -- is 2A(2).

3 CO-CHAIR STEINWALD: Call the  
4 vote.

5 MS. TURBYVILLE: Nine high, seven  
6 moderate. Okay.

7 Overall reliability of the measure  
8 as submitted. Eight high, seven moderate, one  
9 low.

10 I'm tempted to --

11 DR. BARNETT: Well, I voted low.

12 (Laughter.)

13 So, you know, I don't -- I don't  
14 see -- so one thing that the -- some of the  
15 measures that we've done actually have some  
16 measure -- have some indication of how well  
17 the case mix measures perform, and also how  
18 well they repeat in different years for the  
19 same providers. And so I don't see that sort  
20 of reliability testing in this submission.

21 DR. REDFEARN: Well, Paul, the  
22 ERGs was in the Society of Actuaries paper,

1 along with all of the other ones and tested in  
2 all those same ways, and it performs about the  
3 same as the others.

4 DR. DUNN: This is Dan. We did  
5 submit some R squared measures as well.  
6 Actually, we did reference the SOA study in  
7 our internal testing. We did -- you're right,  
8 we did not cover the year over year for the  
9 same provider issue. We did not comment on  
10 that.

11 DR. BARNETT: So I'll just  
12 observe, you know, the Adams paper which was  
13 -- you know, you distributed to us before we  
14 started our meeting last year -- that was sort  
15 of their -- the key issue was is that -- for  
16 them was is that you would want a provider to  
17 be judged the same way or similar ways.

18 You would want them to flip-flop  
19 around from year to year. You would expect  
20 that they would be doing things reasonably the  
21 same. Or another way of thinking about it was  
22 with different cohorts of patients that their

1 practice would -- style would end up showing  
2 the same result.

3 If you split the sample, say, and  
4 half their patients, and then compared that to  
5 another half of patients, you would expect  
6 them to get rated about the same. So that's  
7 the kind of measures of reliability that I  
8 hope we would be looking at in these measures.

9 DR. DUNN: And then, we did see  
10 that clarification, the Adams paper and  
11 others, in The New England Journal. That was  
12 relating to episode-based measures, and this  
13 was a population-based measure.

14 But the point is still valid --  
15 you would want the quality of the -- one of  
16 the qualities of the measure is that, you  
17 know, time over time consistency -- and just  
18 as a note, you know, I think the conclusion of  
19 that was you need a reasonable sample size to  
20 support, you know, that type of reliability.

21 And we did provide some guidance  
22 in our response around both that issue as well

1 as tests of statistical significance, which  
2 should take into account, you know,  
3 appropriate sample size as well as the general  
4 precision of the measure.

5 CO-CHAIR STEINWALD: Okay. Let's,  
6 if we can, move on to validity, and keep in  
7 mind that there are six separate subcriteria  
8 for validity.

9 MS. TURBYVILLE: Okay. So two --  
10 thanks, Dan. So 2B(1) is about the measure  
11 specifications being consistent with the  
12 evidence presented to support the focus of the  
13 measurement under criterion 1B. So is it  
14 consistent with what was presented under  
15 importance for its purpose, as specified?

16 CO-CHAIR STEINWALD: Just a  
17 footnote here. My recollection of the  
18 conference call is that there was much more  
19 discussion and some disagreement or different  
20 kinds of concerns raised in the validity area.  
21 So this is an area where we may want to raise  
22 some of those concerns again for the benefit

1 of the entire group.

2 Should I call the vote? All  
3 right. Go ahead.

4 MS. TURBYVILLE: For 2B(1) we have  
5 seven high, eight moderate, and one low.

6 So moving on to 2B(2), which is  
7 about the validity testing itself,  
8 demonstrating that the measure data elements  
9 are correct, or the measure score correctly  
10 reflects the costs of care or resources  
11 provided and adequately distinguish higher and  
12 lower.

13 DR. O'NEILL: And it looks like  
14 Carlos had a lot of comments on this  
15 particular one.

16 CO-CHAIR STEINWALD: Comments or  
17 questions?

18 (No response.)

19 Okay. Let's call the vote. Oh,  
20 Carlos's comments.

21 (Laughter.)

22 DR. BARNETT: I was trying to find

1 -- I tried to find Carlos's comments in the --

2 CO-CHAIR STEINWALD: Okay.

3 DR. BARNETT: -- it's in the other  
4 file.

5 CO-CHAIR STEINWALD: We'll pause,  
6 then. My recollection was that he said that  
7 there wasn't much in the way of validity  
8 testing. That was what their summary --

9 DR. O'NEILL: They said they were  
10 going to follow up, and they did, right,  
11 follow up?

12 MS. TURBYVILLE: Right. They  
13 followed up and provided a little information  
14 to demonstrate face validity.

15 Dan, did I get that correct?

16 DR. DUNN: That's right, Sally.

17 MS. TURBYVILLE: So, and then just  
18 as a reminder, as we discussed yesterday from  
19 the NQF testing task force report that face  
20 validity would be the minimum threshold to  
21 demonstrate validity, that it is something  
22 that we allow to come through to demonstrate

1 validity, but it is kind of the minimum.

2 CO-CHAIR ROSENTHAL: I'm trying to  
3 play by the rules now. What would a statement  
4 of face validity be against this measure?  
5 What would be an articulation of that? I'm  
6 not asking that as a challenge. I'm asking it  
7 because I'm unclear in my own mind of what a  
8 statement of face validity would be against  
9 this.

10 I get the definition, but I'm  
11 trying to -- I'm posing the question for  
12 myself of, what would that mean in  
13 relationship to this measure? Open to anybody  
14 to help me with.

15 MS. GRABERT: I don't have a  
16 response to your question. I have a question  
17 for the developer. As I read this definition  
18 it says, "Validity testing demonstrates that  
19 data elements are correct, or that the  
20 measures score correctly reflects the cost of  
21 the care."

22 So if you accumulate all of the

1 episodes into one per capita measure, how do  
2 you account for the fact that an individual --  
3 whoever this is attributed to, some of the  
4 episodes may be high cost and some of the  
5 episodes may be low cost, when you look at the  
6 total resource utilization.

7 DR. DUNN: Yes. So maybe this is  
8 a clarification, so -- and I apologize if this  
9 wasn't clear in our submission. So think of  
10 it as a numerator and denominator type of  
11 concept.

12 In the numerator, we are capturing  
13 all of the costs for an individual, you know,  
14 whether or not they grouped episodes, no  
15 matter what episode they grouped to -- you  
16 know, it's very similar to some of the other  
17 population-based measures. You see like the  
18 NCQA or you measure, for example, all the  
19 costs for the individual identified.

20 And then, where the episode, then  
21 episode risk groups, come in is categorizing  
22 individuals based on their relative risk. So



1 it is going to capture all of the costs, you  
2 know, from high, low cost episodes. Even  
3 things that didn't group to episodes are part  
4 of the measure.

5 But getting back to I think the  
6 point you're getting at is, what do we do with  
7 outlier patients? And part of our  
8 specification was a guideline that you would,  
9 you know, develop an approach for outliers on  
10 the higher side, and we had proposed as the  
11 guideline there that you would Windsorize or  
12 truncate the costs for high or, you know,  
13 really outlier patients at some level.

14 So, you know, for example, say  
15 that was \$50,000. We would count the first  
16 \$50,000 towards the measure and ignore those  
17 other dollars above that threshold for the  
18 patient.

19 MS. GRABERT: Do you Windsorize  
20 for outlier episodes as opposed to outlier  
21 patients?

22 DR. DUNN: It's outlier patients.

1 I'm sorry. Did I say episodes? It's a  
2 patient-based measure. The only real episodes  
3 at play here is in trying to estimate that --  
4 an overall level of risk for the patient.

5 CO-CHAIR ROSENTHAL: Is the answer  
6 to my question that, in fact, it is ipso facto  
7 valid because it sums up total cost, and the  
8 total cost is the total cost? So it, by  
9 definition, is -- has face validity? I'm  
10 trying to figure out what the criteria is for  
11 answering this question, so I can figure out  
12 how I should vote.

13 CO-CHAIR STEINWALD: Okay. Total  
14 costs are generated through claims. Claims  
15 have their own adjudication process, so that's  
16 an element of it as well. But then, it is  
17 subject to all the other kinds of problems of  
18 the kind that Jack and others have raised.  
19 Jack?

20 DR. NEEDLEMAN: Yes. Well, I'm  
21 going to raise it again.

22 (Laughter.)

1                   Again, we have got -- you've dealt  
2 with the pharmacy carve-outs by acknowledging  
3 some of your folks don't have pharmacy data.  
4 And pharmacy isn't a problem in terms of  
5 identifying ETG groups, because pharmacy claim  
6 cannot be the trigger event for an ETG. So it  
7 doesn't affect your risk adjustment.

8                   But you have also got carve-outs  
9 in some of your populations for behavioral  
10 health or mental health benefits. And you've  
11 got ETGs, which will be affecting your risk  
12 adjustment that are mental health based, and  
13 there are clearly costs associated with  
14 treating various kinds of behavioral health  
15 issues.

16                   So you've got some groups with  
17 carve-outs and some groups without. Can you  
18 tell us what kind of bias is being introduced  
19 into the measure to not have -- to have carve-  
20 outs and whether -- what kinds of steps you  
21 take to adjust for that in your analysis.

22                   DR. DUNN: Again, that's a good

1 point, and this did come up in the earlier  
2 meeting. And maybe even take a step back, you  
3 know, if -- our specification was assuming we  
4 at least had complete medical services, and  
5 then there was the option that we could risk  
6 adjust, you know, for the difference, or they  
7 would measure adjustment for the difference if  
8 someone had pharmacy data available or not.

9 So missing mental health or  
10 behavioral health claims or lab claims or  
11 anything else, that bets against our, you  
12 know, guideline and specification for the  
13 measure.

14 I'm not sure that helped, but, you  
15 know, obviously, if you want me to answer the  
16 question if someone didn't have information,  
17 I certainly wouldn't compare, say, one  
18 organization against another where one had  
19 that information, one didn't.

20 You potentially could argue the  
21 measure could still work if you were able to  
22 equalize, you know, the fact that you didn't

1 have behavioral health services on either  
2 side. But that wouldn't be my recommendation.  
3 It would be, you know, that you would have,  
4 you know, complete and consistent medical  
5 service claims as a minimum, and we -- and if  
6 you have pharmacy data, we were able to --  
7 measure data to use on it, and it adjusts  
8 appropriately for people with and without.

9 CO-CHAIR STEINWALD: Tom?

10 CO-CHAIR ROSENTHAL: Jack, I think  
11 this is an issue of, to some extent, possibly  
12 of how these measures have been used in  
13 practice, which is, as it was described either  
14 at a health plan level or a state level or  
15 whatever, where the differences in -- and then  
16 applied it to physician groups.

17 So if it's Blue Cross of Ohio, the  
18 carve-outs are going to be basically the same.  
19 And so when they're saying physician group A,  
20 physician group B, physician group C are  
21 different, they have accounted for, in  
22 general, the pharmacy benefit or lack thereof,

1 but that could be different for, you know, the  
2 State of Wisconsin, if they chose to do it.

3 So there's internal consistency  
4 when it's used by one set of people. But it  
5 raises the question, which I think will come  
6 up in 2B(2), of, as we talked about yesterday,  
7 how comparable are these results across  
8 entities that might be using this, and then  
9 the challenge of some having pharmacy in and  
10 some having pharmacy out, some having mental  
11 health in, some having mental health out, is  
12 going to render those comparisons to be --

13 DR. NEEDLEMAN: Yes. And if  
14 you've got physicians with -- you know, who  
15 are serving patients in multiple health plans,  
16 some of which have carved out mental health  
17 benefits, and some of which haven't, and  
18 you're getting data from all of them and you  
19 want to pool it, so you get a richer vision of  
20 what the experience of this -- of physician A  
21 is, you've got real problems if --

22 CO-CHAIR ROSENTHAL: Then you've

1 got real validity problems.

2 DR. NEEDLEMAN: You've got both  
3 risk adjustment problems, and then you've got  
4 cost problems.

5 CO-CHAIR ROSENTHAL: I think  
6 that's -- I mean, I've been thinking what I'd  
7 vote on this one, and I think it's 2B(2). And  
8 the same issues will come up about cost  
9 adjusters across geographies, which I don't  
10 think are here, because, again, they are not  
11 using standardized pricing on this.

12 DR. DUNN: This is Dan. Maybe I  
13 can -- in my mind, I don't think this relates  
14 to the validity of the measure, because the  
15 measure itself, you know, includes the  
16 behavioral health services or any carve-out as  
17 part of the specification. It maybe relates  
18 more to applicability and challenges in  
19 measurement using this measure.

20 CO-CHAIR STEINWALD: Okay. Any  
21 further -- this is still 2B(2) -- on validity  
22 testing? Can we call the vote?

1 DR. BARNETT: I just wanted to --  
2 we have mentioned Carlos's work.

3 CO-CHAIR STEINWALD: Right.

4 DR. BARNETT: And then, but we  
5 never -- we never actually said, "What does it  
6 say?" And so he says, "Has measured score  
7 validity been shown?" and his response is,  
8 "No."

9 "Description of the approach used  
10 to test validity lacks detail and clarity."  
11 I'm just reading from this, right? "It is  
12 mentioned that the process described above to  
13 test validity included a review by clinical  
14 analysts to assess face validity, but no  
15 details are provided."

16 And then in the fourth paragraph,  
17 "Finally, there is an attachment in the  
18 submission labeled 'Reliability Validity  
19 Testing' consisting of several tables  
20 describing resource use and its components for  
21 different peer groups stratifying by the  
22 presence of pharmacy benefits. Unfortunately,



1       there is no description accompanying the  
2       tables that explain how they relate to  
3       validity -- to reliability and validity." So  
4       that's Carlos's --

5                   MS. TURBYVILLE: Right. And so  
6       then there was -- thank you, Paul. That's  
7       absolutely right. And then, there was follow  
8       up by Ingenix. The table that was attached  
9       wasn't intentionally supposed to be a part of  
10      their reliability testing.

11                   What I understand and what was  
12      submitted was face validity was established  
13      for this measure. So as far as the table  
14      having empirical results and validity, it was  
15      really focused on the face validity, which  
16      they did provide a more detailed review of how  
17      they vetted it.

18                   CO-CHAIR STEINWALD: Anything  
19      further?

20                   (No response.)

21                   Okay. Then, we'll call the vote.

22                   MS. TURBYVILLE: For 2B(1), we

1 have eight moderate and six low.

2 Moving on to 2B(3), which is  
3 exclusions are supported by the clinical  
4 evidence, they are supported -- yes, 2B(3).

5 CO-CHAIR STEINWALD: All right.  
6 This is the one that addresses exclusions.  
7 Jack has already weighed in. Anyone else like  
8 to raise a question or make a comment?

9 (No response.)

10 Well, there are no exclusions of  
11 resource use. That I think was explained  
12 pretty clearly. And, yes, I don't have -- I  
13 mean, there is certainly the carve-outs issue,  
14 but I don't have anything else to raise  
15 myself. Anyone?

16 MS. TURBYVILLE: Dan, do you want  
17 to briefly describe what exclusions the ERG  
18 measure specifies?

19 DR. DUNN: Is the question patient  
20 exclusions or service exclusion?

21 MS. TURBYVILLE: Patient  
22 exclusions.

1 DR. DUNN: There are no patient  
2 exclusions other than -- which I guess there  
3 are patient exclusions -- the handling of  
4 patients with extremely high cost due to  
5 outlier methodology, but there are no patient  
6 exclusions.

7 CO-CHAIR STEINWALD: Anything  
8 further?

9 DR. O'NEILL: What Carlos refers  
10 to as low outliers, that is not excluded.

11 CO-CHAIR STEINWALD: That's for  
12 you, Dan.

13 DR. DUNN: Yes. No, there would  
14 be no outliers, because there is not a lot of  
15 -- different from an episode, a lot of people  
16 have no services, no costs in any given year.  
17 But a low outlier doesn't apply to this type  
18 of measure.

19 CO-CHAIR STEINWALD: Okay. Any  
20 further?

21 (No response.)

22 Okay. Let's call the vote.

1 MS. TURBYVILLE: Nine high, four  
2 moderate, and two low.

3 CO-CHAIR STEINWALD: Okay. Then,  
4 on to 2B(4), which is where risk adjustment is  
5 addressed. I have -- I am going to, with some  
6 trepidation, raise the same question that I  
7 raised before on the conference call. I don't  
8 understand, once you accomplish risk  
9 adjustment through ERGs, why the patients then  
10 subsequently need to be grouped into ETGs as  
11 well.

12 DR. DUNN: Yes, they do not -- I  
13 apologize again if this wasn't clear in the  
14 submission. Think of the ERG risk adjustment  
15 having two steps. One step is to categorize  
16 the patient's ETG, so what episodes were  
17 observed. If they have congestive heart  
18 failure episodes, diabetes, episodes, and even  
19 within diabetes episodes, what level of  
20 severity are they? That's step one, and that  
21 is where ETGs play a role.

22 Second step is taking those

1 episode results of the presence or absence of  
2 episode -- of certain ETGs for an individual  
3 and translating that into an overall risks  
4 core. So think of ETGs as giving is the risk  
5 markers, if you will, similar to the way, you  
6 know, the CMS HCC model has diagnosis-based  
7 markers of risk.

8 ERGs also has diagnosis-based  
9 markers of risk, but that sort of diagnostic  
10 categorization is based on the episode of care  
11 framework. And once you have a member's  
12 episode of care, you know what ETGs mix they  
13 had, and where computing an overall ERG risk  
14 score.

15 But once you have an ERG risk  
16 score, you don't need to use ETGs at any point  
17 in either the measure numerator or  
18 denominator.

19 CO-CHAIR STEINWALD: Thank you.  
20 That helps. Any questions or comments?

21 DR. O'NEILL: My question has to  
22 do with whether or not a situation, you know,

1 with the Dartmouth Atlas that shows that there  
2 is different levels of utilization in  
3 different populations.

4 If you had a high level of  
5 utilization of a given set of procedures,  
6 would that set off more ETG identification of  
7 patients that would drive a higher risk score  
8 through the ERG, or would that look like  
9 overutilization? I'm just wanting to make  
10 sure that the frequency of a treatment that  
11 would trigger an identification of a patient  
12 is looked at independently of the utilization  
13 that is evident in the database. You know,  
14 I'm trying to make sure this isn't circular.

15 CO-CHAIR STEINWALD: You don't  
16 want to -- Dan, that's for you. Go ahead.

17 DR. DUNN: Okay. Good question.  
18 You know, ETGs are diagnosis based. So, you  
19 know, even though ETGs won't capture the fact  
20 that someone had a -- you know, with a CAD  
21 episode had a CABG surgery or catheterization,  
22 you know, that doesn't effect what ETGs are in

1 that, just kind of what is observed within the  
2 episode. And so then, following from that,  
3 given ETGs is driving ERGs, that wouldn't  
4 affect the risk scoring that should be  
5 observed as over -- a relative over or under  
6 utilization.

7 CO-CHAIR STEINWALD: Satisfied?  
8 Yes. So the -- even the frequency of  
9 episodes, then, would not generate a higher  
10 ERG score.

11 DR. DUNN: No, that could be -- so  
12 if they're diagnosis based, so if, you know,  
13 certain patients in an area had, you know,  
14 more -- had a higher prevalence of CAD or  
15 hypertension or congestive heart failure  
16 episodes, that does drive risk score for the  
17 area.

18 So whatever is, you know,  
19 triggering those -- similar to any of these  
20 models, risk models, things that are  
21 triggering more observable and usable  
22 diagnoses are going to -- you know, going to

1 generate a higher number of episodes or  
2 diagnoses and higher levels of risk.

3 DR. O'NEILL: Can I use as an  
4 example lumbar fusion where in some  
5 neighborhoods that looks like an automatic  
6 surgical case, and then other places it does  
7 not. And the fact that a higher percentage of  
8 people would get the surgery would not  
9 necessarily indicate that there is a higher  
10 level of more severe back pain.

11 CO-CHAIR STEINWALD: But it would  
12 generate a higher risk score.

13 DR. O'NEILL: That's right.

14 DR. DUNN: No, it would not,  
15 because what drives the risk score is the  
16 diagnosis of back pain, not whether there was  
17 lumbar fusion or not.

18 CO-CHAIR STEINWALD: You know, I  
19 think part of the -- and accepting what you  
20 say, the very fact that you call them ETGs,  
21 where the T stands for "treatment," is a  
22 source of some confusion. Paul?



1 DR. BARNETT: I was going to say,  
2 my understanding is that ETG is sort of a way  
3 of grouping the records, and then the ERG is  
4 based on the codes in there. And they don't  
5 allow the medical treatments to define the  
6 risk group, except they said one category,  
7 which was malignant neoplasm.

8 So I think that we're going to  
9 find that every time we rely on claims data,  
10 administrative data, to characterize the  
11 health of a population, that we are going to  
12 be in this -- in this -- have this same  
13 problem. And that actually it seems to me  
14 that this is as best we can parse it out from  
15 what's available to us, that this is a pretty  
16 elegant solution, that they are only looking  
17 at the diagnosis and not the procedures that  
18 were done, not the treatment.

19 But where all the risk models  
20 break down is for the people who don't get  
21 very much care. If they're outside the health  
22 care system, we don't really know what their

1 health state is, and so, really, at the low  
2 end risk models perform poorly. But, you  
3 know, there is not so many resources being  
4 used in that case, so maybe we are less  
5 worried about it.

6 So it seems like a very elegant  
7 and detailed method, and it makes me wonder  
8 how well this performs compared to some of the  
9 simpler models that are more transparent and  
10 free, like the HCCs, so this is presumably a  
11 pretty expensive product to go this route for  
12 a case mix.

13 And so what are we gaining? You  
14 know, what's the marginal benefit from this  
15 more extensive case mix measure compared to  
16 something that is free like HCC or maybe just  
17 a different product?

18 And we have that Society of  
19 Actuaries study that I have not read or seen,  
20 which seems to say they all perform equally  
21 well. So we have to think, well, do we need  
22 to spend millions of dollars, because, after

1 all, we are really using all of the  
2 complicated ETG/ERG stuff for is to get a case  
3 mix measure. The rest of it is just total  
4 costs in that year pretty much.

5 CO-CHAIR STEINWALD: Further  
6 comments, questions?

7 DR. BARNETT: Well, I'd actually  
8 like to know if the measure developer has an  
9 idea of what is the marginal benefit of their  
10 case mix measure in terms of variance  
11 explained compared to some of the others.

12 CO-CHAIR STEINWALD: Dan, you're  
13 up.

14 DR. O'NEILL: Sure. And maybe  
15 I'll note the free -- the free HCC model is  
16 the one that I'm -- at least my understanding  
17 is the one, you know, modified by CMS to  
18 support Medicare Advantage payments, built for  
19 an elderly population, and actually somewhat  
20 different than a model that you would likely  
21 use for measurement purposes.

22 You know, on purpose, the CMS

1 excluded some diagnoses and/or some HCCs in  
2 that model, so it-- I'm not sure I would use  
3 the free model here.

4 But, you know, in terms of the  
5 other approaches -- and there are -- you know,  
6 there are, you know, other, you know,  
7 methodologies to do this, like ACGs, the  
8 commercial HCC model which is licensed in the  
9 same way ERGs is, you know, we have always  
10 found we have done as well or better than the  
11 competitor.

12 So it -- the characterization that  
13 it is -- they are all in the same ballpark is  
14 probably valid, and, you know, I think there  
15 is reasons, though, people would use one of  
16 the commercial models, whether ACGs, you know,  
17 DXCG, HCCs, or ERGs, you know, versus what is  
18 free, you know, through the CMS HCC model, for  
19 example.

20 CO-CHAIR STEINWALD: Further  
21 comments or questions?

22 (No response.)

1                   This is 2B(4). Can I call the  
2                   vote?

3                   MS. TURBYVILLE: Six high, eight  
4                   moderate, and one low.

5                   So moving on to 2B(6), which is --

6                   CO-CHAIR STEINWALD: Five.

7                   MS. TURBYVILLE: Oh, sorry. Thank  
8                   you. 2B(5), which is that the data analyses  
9                   demonstrate methods for scoring and analysis  
10                  of the specified measure allowed for  
11                  identification of statistically significant  
12                  and practically or clinically meaningful  
13                  differences in performance, or there is  
14                  evidence of overall less-than-optimal  
15                  performance.

16                  CO-CHAIR STEINWALD: Tom, do you  
17                  have something?

18                  CO-CHAIR ROSENTHAL: A question I  
19                  want to clarify, if I could, is, have there  
20                  been instances where this measure has compared  
21                  across geographies? So I think this is  
22                  addressed to the developers.

1 DR. DUNN: Well, for this and  
2 measurement applications, I don't know of any  
3 application that goes beyond, you know, what  
4 geographic area, like a state or market. It  
5 could be used for that purpose, but I am not  
6 aware of any.

7 CO-CHAIR ROSENTHAL: Just to stay  
8 somewhat internally consistent, to my  
9 knowledge, it has not been used across  
10 geographies. And, again, I would submit that  
11 the -- a) it hasn't, and part of the reason it  
12 hasn't is that isn't the way it has been used,  
13 and that we get into the same set of issues  
14 that we talked about yesterday, which is this  
15 is a total -- this is about a dollar  
16 denominated number, not a resource use that  
17 has standardized pricing.

18 And so the aptness and accuracy of  
19 a comparison of applying this in one geography  
20 won't be -- for some provider group that you  
21 say this primary care doctor has 1.8X of the  
22 norm of utilization using the ETG grouper

1       won't be a meaningful comparison of comparing  
2       individual doctor internists in another part  
3       of the country, or a group of internists who  
4       might have .8. It's quite possible that those  
5       numbers will be -- would be incorrect.

6                   CO-CHAIR STEINWALD: Bill?

7                   DR. WILLIAM RICH: You also state,  
8       again, that this can be used -- this is a  
9       total resource use measure. But you also say  
10      it can be used for comparing physicians. We  
11      have the same issue. You avoid the issue of  
12      attribution if you just look at total costs,  
13      total resource use.

14                   You also address that -- stated  
15      that you will eliminate some for low number.  
16      What -- is there a specific low number that is  
17      specified, or is that based on statistical  
18      significance of that individual provider? But  
19      you specifically say there is a low number.  
20      What does that mean?

21                   DR. DUNN: So this is related to  
22      low number of patients, for example, for a

1 measurement entity, like a physician. That's  
2 the question?

3 Yes, we actually didn't specify  
4 when we specified a statistical significance  
5 test using confidence intervals or something  
6 similar. And we also I believe had submitted  
7 -- you can almost get two thresholds here.  
8 One may be more judgmental is -- what is the  
9 number of patients that it's even worth  
10 reporting a number, you know, even with a  
11 confidence interval?

12 And we had just suggested that  
13 number, you know, was 30, and -- but, you  
14 know, beyond that is, you know, some  
15 application of a statistical test that adjusts  
16 a sample size, and that that was our preferred  
17 approach.

18 CO-CHAIR ROSENTHAL: We're a  
19 little bit recapitulating the same thing we  
20 talked about in the diabetes measure, but I --  
21 it feels to me even more troubling here of  
22 this balance between an attribution model that



1 is quite specific, but the specificity creates  
2 issues.

3 But it's not certain to me that  
4 you solve the specificity problems by making  
5 it totally more or less open-ended, that the  
6 individual user in an individual site can sort  
7 of decide how they want to attribute it.

8 I think, then, the comparisons  
9 from one place to the other, possibly now even  
10 within a state, could be quite challenging.  
11 And I'm personally trying to be internally  
12 consistent with our discussions in fairness,  
13 and our Health Partners friends are sitting  
14 here. So in respect to that, I am trying to  
15 be internally consistent.

16 But I also don't want to  
17 necessarily recapitulate the whole set of  
18 arguments from yesterday, but I do think they  
19 --

20 DR. WILLIAM RICH: My point is  
21 just to point out we have the same issue.

22 CO-CHAIR ROSENTHAL: The same

1 issue I believe resides here.

2 CO-CHAIR STEINWALD: It's the same  
3 issue. But I am going to call on Mary Kay,  
4 who is going to tell us why there are times  
5 when we want to -- we don't want to adjust.

6 DR. O'NEILL: Well, it does state  
7 in here you can use standardized pricing.  
8 It's not only the real dollar thing.

9 DR. DUNN: And maybe to comment --  
10 that's correct, you can use standard pricing.  
11 And, you know, the State of Wisconsin, for  
12 example, uses this measure, and they use  
13 standard pricing to do comparisons across the  
14 state.

15 And maybe to point to attribution  
16 is -- you know, I think we provided the  
17 guideline there on what are reasonable ways to  
18 do that. I think the challenge is, you know,  
19 depending where you're using this, whether  
20 it's, you know, for an ACO or for an  
21 individual physician or places where -- I  
22 mean, there is still some gatekeeper type

1 arrangements.

2           You know, attribution is -- the  
3 right attribution approach often, you know,  
4 makes sense for where the application is  
5 applied. That's why we had provided it as a  
6 guideline with options rather than out of the  
7 specification itself.

8           CO-CHAIR STEINWALD: Yes, Mary  
9 Kay.

10           DR. O'NEILL: So to talk about  
11 this for a moment, I mean, if you -- if we are  
12 going to do our famous Memphis-Minneapolis  
13 comparison --

14           (Laughter.)

15           So if we ran standardized pricing  
16 in those two markets, which is a surrogate for  
17 utilization -- and I'm taking standardized  
18 pricing as a function of essentially weighting  
19 the different types of services, which is why  
20 use it and not just utilization numbers. So  
21 like you're a little off on your labs, but  
22 nobody is going in the hospital, it's less of

1 a big deal.

2 What I would really love to be  
3 able to see is to do the standardized pricing  
4 check and see where people are comparatively  
5 on their utilization, then run the real  
6 dollars and see where we're spending our most  
7 money. And the combination of those two  
8 analyses would be the most powerful thing that  
9 we could do.

10 CO-CHAIR ROSENTHAL: If in fact  
11 standardized pricing were specified, I would  
12 probably be in favor of the whole thing.  
13 Well, I get it, but, I mean, it's not clear to  
14 me -- first of all, when we asked them on the  
15 phone, that was the first question the Chair  
16 posed to the developers, "Was there  
17 standardized pricing?" and the answer was no.  
18 So --

19 MS. YANAGIHARA: They don't  
20 specify a particular standardized pricing  
21 methodology, but it can be -- this methodology  
22 can be used with standardized pricing. So you

1 can use the NCQA one posted on their website  
2 for -- I mean, there --

3 CO-CHAIR ROSENTHAL: Yes, but  
4 somebody has got to do it. This is the  
5 measurement. I mean --

6 MS. YANAGIHARA: Right.

7 CO-CHAIR ROSENTHAL: -- I don't  
8 know what the rule set is around, again,  
9 something being a guideline versus being  
10 specified, but it seems to me, again, this  
11 needs to be specified and not just kind of,  
12 "Oh, it's out there," and then they can sell  
13 it. I mean, they are a commercial entity.

14 If they can sell it to people who  
15 want to use it any old way, we are supposed to  
16 be adjudicating this for the country. So I  
17 think it has to be specified and not just kind  
18 of people can use it any old way they want.  
19 And that is a problem, because we've been told  
20 over and over, once we approve it, people can  
21 use it any way they want consistent with the  
22 actual written measurements.

1 MS. TURBYVILLE: So whether or not  
2 you think it's complete enough, they do  
3 explicitly state in their specification that  
4 the measure should use complete and valid  
5 financial amounts, or a standard price-to-  
6 resource cost amount. Is that -- that's as  
7 submitted by the spec, but so --

8 CO-CHAIR ROSENTHAL: I don't think  
9 those are equivalent. The first one of those  
10 is in fact -- if in fact you have total claim  
11 data from a particular plan, you've got --  
12 you've met Category 1. And that does not  
13 invoke standardized pricing. In fact, they  
14 use standardized pricing in that articulation  
15 of it sort of in lieu of maybe we've got  
16 inadequate claims data, so we'll use some kind  
17 of standardized pricing to do it. Well,  
18 that's the way I heard it.

19 MS. TURBYVILLE: I don't want to  
20 unfairly represent what they wrote.

21 DR. BARNETT: So this kind of  
22 relates to which peer are you being compared

1 to, and in terms of the performance results  
2 reported, which is I think what we're -- the  
3 topic we're on right now. So there is in the  
4 submission packet a sample report for the year  
5 ending 12/31/2007 -- or two years ending  
6 December 2007, and it shows a cost and also  
7 utilization for this provider compared to the  
8 peers. And there it is magically on the  
9 screen in front of us. Very good, Ashlie.

10 And, boy, it took me a lot longer  
11 than that to chase this down. And so the  
12 question -- it says page 4 on the paper, but  
13 --

14 MS. WILBON: If you open the PDF  
15 packet, it's bookmarked. Item S12, Attachment  
16 Sample Score Report. If your bookmark doesn't  
17 open when you open the file, just click on the  
18 bookmark icon and you can --

19 DR. BARNETT: So is it up to the  
20 consumer to identify the peer, or is that  
21 something that comes with the product? And  
22 then, how do I know if I'm the primary care

1 physician and my pharmacy costs here are 32.78  
2 versus the peers' -- let's see, I guess we're  
3 on a slightly different page. Next page  
4 maybe. So how -- my costs are actually  
5 different from the -- my peers' cost. Whether  
6 that's a really significant difference or --  
7 it's a little bit further than -- is it?

8 CO-CHAIR ROSENTHAL: Is the one  
9 she's looking at close enough?

10 DR. BARNETT: No, this is the one  
11 I was thinking of, see? So here we have my  
12 actual and then my peers. And so I'm  
13 wondering, well, who is my peer? Is the user  
14 of this responsible for finding the peer to be  
15 compared to, and defining that peer, and how  
16 do I know that the -- my costs are  
17 significantly better or worse than the peers?  
18 I mean, is there some sort of confidence  
19 interval or statistical significance that  
20 comes with this?

21 DR. PETER: Yes, it says it  
22 actually at the first page of the report. It



1 has -- I think maybe the results of the sample  
2 were not -- on the first page of the report,  
3 which is page 80 of the PDF, there it says --  
4 you see the little sort of footnote it says,  
5 "Statistical significance," I think if it were  
6 it would have an asterisk, but I don't think  
7 it is, so it's not -- it doesn't say "not  
8 statistically significant."

9 CO-CHAIR STEINWALD: Dan, can you  
10 tell us, for purposes of this analysis, how  
11 peer groups were defined?

12 DR. DUNN: Sure. That isn't part  
13 of the specification. You know, to be honest,  
14 it is usually something that the user defines  
15 given a guideline as -- usually, you know,  
16 same specialty within a homogeneous geographic  
17 area.

18 But you do get -- I'm not sure how  
19 you would ever specify that, to be honest,  
20 but, you know, I guess you could say only use  
21 for providers, physicians where their  
22 specialty is X or Y, but then the geographic

1 definition I think would be pretty  
2 challenging, and even you could go beyond that  
3 to be honest.

4           So in terms of peers -- and the  
5 related followup question was related to  
6 confidence intervals between many of the  
7 measures, and that is -- although not shown on  
8 that report, that was part of our, you know,  
9 recommendation was to use confidence intervals  
10 to assess differences between a provider and  
11 their peers.

12           And most -- I think as a -- all of  
13 -- and just as a note, that is just a  
14 representation of how this measure may be  
15 reported. You know, there are some users, in  
16 my experience, of this measure who decide to  
17 report by using a different format and  
18 template. So that is not necessarily tied to  
19 the measure itself.

20           CO-CHAIR STEINWALD: Thank you.

21 Any further --

22           DR. BARNETT: I guess the question

1 is -- is have -- has this been done, or is  
2 this something that is hypothetical, that  
3 could be done?

4 DR. DUNN: Sorry. Your question  
5 -- has this measure been used? And the answer  
6 is yes.

7 CO-CHAIR STEINWALD: And I thought  
8 I heard you say that the kind of analysis that  
9 we are looking at here is likely to be  
10 confined to within geographic area, as I  
11 understood.

12 DR. DUNN: Right. That's not part  
13 of the specification, but my experience is it  
14 is always linked to a geographic area, and it  
15 is -- you know, this type of measure, when  
16 used for physicians, always linked to either  
17 a general adult permanent care concept,  
18 internal medicine/family practice combined, or  
19 those separately, and then pediatrics is a  
20 separate entity.

21 And, you know, increasingly now  
22 you will see organizations looking to use this

1 type of measure for ACOs or medical homes as  
2 well, but there may be more groupings of  
3 providers and individual providers.

4 DR. O'NEILL: So to Tom's point  
5 and concern historically that we have  
6 difficulty -- we get into difficulties in  
7 trying to compare delivery in different  
8 markets with different market structure and  
9 habits and all of those kinds -- and, you  
10 know, contracted rates, that that has not  
11 actually to date been an application. But  
12 some of your concerns are to make this measure  
13 able to be used in that fashion. Is that --

14 CO-CHAIR ROSENTHAL: That has been  
15 my concern.

16 DR. O'NEILL: Yes.

17 CO-CHAIR ROSENTHAL: And we did  
18 see one that had a very specified standardized  
19 pricing. I can't remember which one it is  
20 now. They are all running together. But we  
21 had one that had it very well specified -- a  
22 standard -- oh, yes, that's right, it was the

1 Health Partners resource use one, the initial  
2 one that we approved.

3 And they exist -- this is not, you  
4 know, impossible. It just -- so I -- you  
5 know, I think this is the same set of issues  
6 that we talked about yesterday.

7 CO-CHAIR STEINWALD: Bill?

8 DR. WILLIAM RICH: I think we're  
9 seeing a real issue with a commercial product  
10 that can be sold and adapted for many  
11 different ways. I don't know how we are going  
12 to ever address this issue.

13 At least they're honest enough to  
14 say that it -- that this -- if there is any  
15 attribution, they say what it is and people  
16 are free to use it any way they want. I don't  
17 know how we can control that except to express  
18 some concerns as we have as we go along. And  
19 we don't have any primary care docs here  
20 anymore, but -- oh, I -- I'm sorry. I have a  
21 right homonymous hemianopsia, but --

22 (Laughter.)

1 I actually got that out after  
2 lunch. But I don't think we are ever going to  
3 be able to control the -- they are very honest  
4 enough to say, if you look at their  
5 applicability, they list a whole bunch of  
6 different things.

7 And so we're trying to hit a  
8 moving target. Whether it's, you know, how  
9 the things are aggregated to the doc, whether  
10 it's standard pricing or not, I don't think we  
11 are going to be able to address that except to  
12 express some concern that if you are going to  
13 compare across areas, geographic areas, that  
14 there be standardized pricing.

15 CO-CHAIR STEINWALD: Any further

16 --

17 (No response.)

18 Hearing none, this is 2B(5), let's  
19 call the vote.

20 High five, moderate seven, low  
21 three.

22 And now we go on to 2B(6), which

1 is possibly non-applicable.

2 MS. YANAGIHARA: Just a quick --  
3 it's kind of related to the standardized  
4 pricing, because I think it's going to keep  
5 coming up over and over. But I wonder -- I  
6 think with attribution that is tied more  
7 closely to the business case than business use  
8 of it.

9 But with standardized pricing I am  
10 wondering if there might be an opportunity to  
11 select a standardized pricing methodology that  
12 would then should be -- I mean, as the  
13 endorsed standardized pricing methodology. It  
14 doesn't seem like there is much -- as much tie  
15 to the business use in that case. It's just  
16 really how do you cost a particular item.

17 So I'm just thinking -- I'm not  
18 saying we should adjust that today, but just  
19 for future thinking and NQF work, it may be  
20 worth it, because that would help standardize  
21 things and not just, well, pick whatever  
22 method out there, but here is the endorsed

1 method.

2 CO-CHAIR STEINWALD: This is for  
3 Helen's bucket list.

4 (Laughter.)

5 All right. So 2B(6) is non-  
6 applicable. And that means that we have an  
7 overall vote on --

8 PARTICIPANT: Did we do 2C?

9 CO-CHAIR STEINWALD: No, we have  
10 to do an overall on 2B? First --

11 DR. BARNETT: Can I just follow up  
12 something -- on what was just said about the  
13 standardized pricing?

14 CO-CHAIR STEINWALD: Yes.

15 DR. BARNETT: Which is this is not  
16 trivial. Every year there is dozens, if not  
17 hundreds, of new CTP codes and HCPCS codes to  
18 add. Two years ago they entirely revised the  
19 DRG system.

20 As head of a center that does this  
21 routinely, it costs a lot of money, and it's  
22 non-trivial.



1 CO-CHAIR STEINWALD: Duly noted.

2 Somebody raised a question about 2B(6)?

3 MS. WILBON: Right. It talks  
4 about multiple data sources.

5 CO-CHAIR STEINWALD: Right.

6 MS. WILBON: We can open it up for  
7 discussion. But generally, since they are  
8 only using admin data, then it's not really  
9 right. Okay.

10 CO-CHAIR STEINWALD: It's non-  
11 applicable, which means, then, we move to an  
12 overall vote on validity and taken as a whole.  
13 Call the vote?

14 MS. TURBYVILLE: Two high, 10  
15 moderate, and three low for overall validity.

16 CO-CHAIR STEINWALD: Okay.

17 MS. TURBYVILLE: Okay. So now to  
18 2C, which is the last subcriterion for  
19 scientific acceptability, and it is concerning  
20 disparities in care, if they have been  
21 identified, that the measure specification  
22 scoring and analysis allow for identification

1 of disparities through stratification of  
2 results -- again, getting to that one exposed  
3 these differences. The examples are race,  
4 ethnicity, et cetera.

5 MS. WILBON: So I just wanted to  
6 interject quickly. I do have some notes from  
7 a call on your discussion on this, and it was  
8 talked about that, to the degree that low SES  
9 and different racial groups use more or less  
10 resources, that it is relevant.

11 But it's often not captured in the  
12 admin data, and that it can't be captured  
13 systematically right now, and that the  
14 Committee would recommend that this would be  
15 captured in the future in this measure to the  
16 degree that it's possible.

17 CO-CHAIR STEINWALD: Further  
18 discussion or questions?

19 (No response.)

20 Let's call the vote, keeping in  
21 mind that there are four choices.

22 (Laughter.)

1 MS. TURBYVILLE: So four moderate,  
2 two low, and nine insufficient.

3 CO-CHAIR STEINWALD: And now --  
4 well, yes, we have an overall on scientific  
5 acceptability. This should be --

6 MS. WILBON: I can read it aloud.  
7 So keeping in mind that grid that we've been  
8 referring to for the overall scientific  
9 acceptability votes, your rating for the  
10 overall reliability was eight high, seven  
11 moderate, and one low. And your overall  
12 rating for validity that you just completed  
13 was two high, 10 moderate, and three low.

14 CO-CHAIR STEINWALD: So can we  
15 call the overall for scientific acceptability?

16 MS. TURBYVILLE: So for overall  
17 scientific acceptability for this measure, we  
18 have nine yes and six no.

19 CO-CHAIR STEINWALD: So now that  
20 we've finished our recapitulation of our  
21 conference call --

22 MS. TURBYVILLE: It was much

1 shorter this time.

2 CO-CHAIR STEINWALD: -- then we  
3 move on to usability, and we have had a number  
4 of discussions of usability. But we do have  
5 four subcriteria that we have to separately  
6 vote on. Would anyone object if we moved  
7 right to the first one?

8 (No response.)

9 Okay.

10 MS. TURBYVILLE: So 3A asks about  
11 the measure performance results are reported  
12 to the public in national or community  
13 reporting programs by the time of endorsement  
14 maintenance review. This is actually the time  
15 of initial review and is not being currently  
16 reported for public and accountability models,  
17 whether there is demonstration that it will or  
18 does benefit those models in which it is  
19 reported.

20 CO-CHAIR STEINWALD: A question  
21 for Dan. Has this measure been used in any  
22 published peer reviewed articles?

1 DR. DUNN: No, it has not.

2 DR. WILLIAM RICH: Is it currently  
3 being used to profile physicians on an  
4 individual level, group level?

5 DR. DUNN: Yes.

6 CO-CHAIR ROSENTHAL: Do we know,  
7 though, a public reporting of any of those  
8 individual analyses?

9 DR. DUNN: No. They are used for,  
10 you know, information-sharing with physicians  
11 where the users will present and discuss  
12 results with, you know, those folks who are  
13 deemed to be outliers, either that or used in  
14 some cases to -- you know, if there is some  
15 pay for performance type strategy, so both  
16 that information-sharing and there may be some  
17 financial compensation related to performance  
18 based on the measure. But taking those  
19 results and reporting them to the public, I am  
20 not aware of that happening.

21 CO-CHAIR STEINWALD: Further  
22 comments or questions? Doris?

1 DR. PETER: Sorry. I have a  
2 question about the document you submitted in  
3 the -- under public reporting. It says that  
4 the information was used to support public  
5 reporting initiatives. It looks like it is  
6 health plan related, but -- so was that not to  
7 the public? On page 32 of your submission,  
8 U1.1.

9 DR. DUNN: And so does that -- has  
10 that been put on our website, for example, and  
11 has Dr. -- whatever -- Jones, Dr. Smith, and  
12 so on, that was my interpretation of public  
13 reporting, and that was what I was responding  
14 to.

15 DR. PETER: Well, just in the  
16 phrase above it says public reporting  
17 disclosure to performance -- of performance  
18 results to the public at large. So in some  
19 form -- I guess it wouldn't have to be -- I  
20 don't know, it just -- this is your  
21 submission. It says current use for public  
22 reporting. Am I missing something?

1 DR. O'NEILL: It looks like it  
2 might be on a health plan --

3 DR. PETER: Health plan level,  
4 right, right. So to the beneficiaries of that  
5 provider, is that where they're reported? But  
6 it's to the public, I mean, to the people who  
7 are covered, the patients covered by the plan.

8 DR. O'NEILL: Right.

9 DR. PETER: Not the providers.

10 DR. O'NEILL: And it wouldn't be a  
11 publicly available -- you couldn't go on --

12 DR. PETER: No, but if I were a  
13 covered provider.

14 DR. O'NEILL: Right, right.

15 DR. PETER: Okay. That's what I  
16 wanted to clarify.

17 CO-CHAIR STEINWALD: Bill? Oh, go  
18 ahead, Dan. I'm sorry.

19 DR. DUNN: Again, I wouldn't  
20 change my response. I'm -- an inconsistency  
21 of my response in the -- what we've put -- to  
22 my knowledge, that has not been done, and I

1 think I'm being accurate. Not that it  
2 couldn't be done, but I do not know of that  
3 happening.

4 CO-CHAIR STEINWALD: Bill?

5 DR. WILLIAM RICH: Is the -- since  
6 you said it is used for payment between the  
7 payers and the individuals, is the tiering  
8 that results from the use of this tool, is  
9 that publicly available?

10 DR. DUNN: Well, I'll have to get  
11 back to you on that. I can't completely  
12 answer that. I do not know of that, but I  
13 couldn't be sure.

14 CO-CHAIR STEINWALD: Anything  
15 further?

16 (No response.)

17 Okay. Let's call the vote.

18 MS. TURBYVILLE: So for three --  
19 yes, 3A, four moderate, six low, and four  
20 insufficient.

21 CO-CHAIR STEINWALD: Okay.

22 MS. TURBYVILLE: So moving on to



1 3B, which is about measured performance  
2 results are considered meaningful,  
3 understandable, and useful to the intended  
4 audience for both public reporting and  
5 informing quality improvement.

6 CO-CHAIR STEINWALD: Questions or  
7 comments?

8 DR. WILLIAM RICH: This is going  
9 to make this itself.

10 (Laughter.)

11 If you a four-person internal  
12 medicine group on the east side, which is  
13 fairly affluent compared to a four-doc east --  
14 internal medicine group on the west side,  
15 which is probably 80 percent African-American.

16 These are not actionable reports,  
17 because of the different patient populations  
18 and the aggregate costs. So how is an  
19 internist going to find these reports  
20 actionable? That's a question there.

21 DR. DUNN: Well, the assumption is  
22 that you are making -- you cannot compare --

1 that it is not being appropriately adjusted  
2 for. Is that the point, that there are  
3 differences in those patients that has been  
4 captured by the measure, therefore --

5 DR. WILLIAM RICH: Right. And  
6 actually they are not actionable. Some of  
7 them are, some of the costs are actionable.

8 DR. DUNN: Maybe take -- if I  
9 could take it separately and at a general  
10 level, then comment -- I think there's two  
11 questions in that question. One is, you know,  
12 what is the composition of the peer group?  
13 And if it's heterogeneous in some way, does  
14 that compromise the ability to interpret  
15 results? And put that one aside for the  
16 moment. And the second -- and are these  
17 measures actionable?

18 You know, you have the total cost  
19 measure, which is a challenge in terms of  
20 actionability, which is why we also specified  
21 the major components of total costs, so  
22 they're broken into imaging of different

1 types, breaking out advanced imaging, you  
2 know, breaking out, you know, labs from, you  
3 know, sort of specialty and consultative and  
4 hospital, and so on.

5 You know, and I guess I would  
6 argue those measures have some level of  
7 actionability. If total cost is measured on  
8 its own, I think it's more of a challenge.

9 CO-CHAIR STEINWALD: Further  
10 comments or -- comments, questions?

11 (No response.)

12 Can we call the vote on 3B?

13 DR. WILLIAM RICH: We haven't  
14 answered the last part of the question about  
15 heterogeneity, if they --

16 CO-CHAIR STEINWALD: Okay. Hold  
17 off for a second. Go ahead.

18 DR. DUNN: Oh, I'm -- yes, I'm not  
19 sure how to answer that one. I think that  
20 must be more to the point of, have you  
21 constructed the right peer grouping? It also  
22 gets back to that question on, how do you

1       measure disparities and have them unveiled by  
2       this type of measure?

3                   And, you know, if you measure just  
4       those differences in SES and other factors,  
5       then you are not going to observe them.  If  
6       you decide that those were appropriate things  
7       to adjust for in a measure, then you would  
8       stratify the population when you create your  
9       peer groupings, you know, to support that type  
10      of difference.

11                   I'm not sure I answered your  
12      question, but I -- it's -- you know, it  
13      relates to the objective of the measurement,  
14      and to what extent you'd want to be  
15      homogeneous in terms of the peers you are  
16      comparing a physician against or the  
17      organization.

18                   CO-CHAIR STEINWALD:  Paul?

19                   DR. BARNETT:  I was just going to  
20      say, those problems are going to exist for  
21      every measure we are going to look at for the  
22      whole course of this.  And I think we are

1       unfairly putting them on the spot for those  
2       issues.

3                   CO-CHAIR STEINWALD:   Barbara?

4                   DR. RUDOLPH:   I agree, and in the  
5       old days when you did risk adjustment you  
6       included those data elements in your risk  
7       adjustment.  You include race and ethnicity,  
8       and SES if you had it, so -- but then we  
9       wisely -- NQF took those out, so that we could  
10      stratify.  But in -- and I agree with Paul  
11      that we are just not capable of doing that  
12      yet.

13                   CO-CHAIR STEINWALD:   Any further?

14                   (No response.)

15                   Okay.  We will recall the vote.

16                   MS. TURBYVILLE:   Okay.  So we have  
17      three high, six moderate, three low, and three  
18      insufficient.

19                   CO-CHAIR STEINWALD:   That's very  
20      symmetrical.

21                   (Laughter.)

22                   MS. TURBYVILLE:   Okay.

1 CO-CHAIR STEINWALD: All right.

2 Moving on? On to 3C.

3 MS. TURBYVILLE: All right. So on  
4 to 3C, the data and the results detail are  
5 maintained such that the resource use measure  
6 can be decomposed to facilitate transparency  
7 and understanding.

8 CO-CHAIR STEINWALD: Comments,  
9 questions? Tom?

10 CO-CHAIR ROSENTHAL: If we were  
11 going to be internally consistent, we would  
12 review our diabetes vote.

13 MS. WILBON: I can do that for you  
14 real quick. So this -- I don't have that  
15 vote. Did you guys write that down? I don't  
16 have it. Just bear with me for a second.

17 CO-CHAIR STEINWALD: Sorry.  
18 Anything further? I'm not hearing anything  
19 further except for people cranking up. Vote,  
20 let's call the vote.

21 MS. TURBYVILLE: Okay. So we have  
22 one high, eight moderate, five low, and one

1 insufficient. Getting a little bit more to  
2 the normal distribution there.

3 CO-CHAIR STEINWALD: Yes. Is 3D a  
4 non-A?

5 MS. TURBYVILLE: Yes. 3D on the  
6 harmonization of the measures we explicitly  
7 told the measure developers at this point not  
8 to try and harmonize it. As the project  
9 progressed, if that came up as an issue, we  
10 would work with them and you through that. So  
11 it's non-applicable at this time.

12 So that means that we would be  
13 ready to ask you all to rate usability overall  
14 for this measure.

15 MS. WILBON: And just a quick  
16 clarification -- the reason why we couldn't  
17 find the score, the usability score for 3C, is  
18 because the TAP scored that. That was a  
19 diabetes measure, and the TAP scored the  
20 subcriteria.

21 So that's why we couldn't find it  
22 in what the Steering Committee had done

1 because it was in the TAP notes. You guys  
2 just scored the overall criteria for that one.

3 CO-CHAIR STEINWALD: Right.

4 MS. WILBON: Okay.

5 CO-CHAIR STEINWALD: Let's call  
6 the vote, overall usability.

7 MS. TURBYVILLE: One more? There  
8 we go. So for overall reliability we have 10  
9 moderate --

10 DR. DUNN: Usability.

11 MS. TURBYVILLE: It ends with a T-  
12 Y, okay?

13 (Laughter.)

14 I even got the L right. For  
15 overall usability -- sorry, Dan -- the score  
16 is 10 moderate and five low. And at this  
17 time, based on where we are, feasibility will  
18 not be assessed by the Steering Committee on  
19 the Ingenix measures.

20 CO-CHAIR STEINWALD: And the  
21 reason for that is the same as the prior  
22 measure. We don't have the information on



1 pricing. Is that correct?

2 DR. BURSTIN: Right. So once  
3 Ingenix shares with the Steering Committee the  
4 fee schedule for the measure, which we will  
5 then share with you, we will return to  
6 feasibility on both of the Ingenix measures so  
7 you can assess feasibility and your overall  
8 recommendation for the measure.

9 MS. TURBYVILLE: So I think, Dan,  
10 that's all the questions for you. We really  
11 appreciate you adjusting your schedule and  
12 providing responses and input to the Steering  
13 Committee today.

14 DR. DUNN: Okay. Thank you. Take  
15 care.

16 MS. WILBON: Operator, can you  
17 open the line to see if there is anyone who  
18 would like to provide a comment, a public  
19 comment to the Steering Committee, before we  
20 wrap up?

21 OPERATOR: Yes, thank you very  
22 much, and I will open it up.

1 MS. WILBON: Okay. Is there  
2 anyone on the line who would like to ask a  
3 question for the Steering Committee?

4 (No response.)

5 Anyone in the audience who would  
6 like to ask a question or make a comment to  
7 the Steering Committee based on the  
8 discussion?

9 (No response.)

10 Okay.

11 MS. TURBYVILLE: Clearly, we want  
12 to say thank you, and thank you for hanging in  
13 there for two days, in addition to all of the  
14 pre-work and conference calls that we have had  
15 all through this year.

16 I think we have a few next steps.  
17 I will ask Ashlie to speak to those, but I  
18 want to make sure I give the Co-Chairs an  
19 opportunity to provide any final thoughts on  
20 the past two days. Or is everybody done?  
21 Which is fine. We can just wrap it up.

22 (Laughter.)

1 CO-CHAIR STEINWALD: All right.

2 Tom, you're up.

3 (Laughter.)

4 CO-CHAIR ROSENTHAL: I checked out  
5 about 30 seconds ago.

6 MS. TURBYVILLE: Anybody else?

7 DR. BARNETT: So the voting  
8 process and the being able to collectively see  
9 where we were at in polling was very helpful  
10 I think for the process. And if, when we're  
11 participating in conference calls, we had some  
12 way to do through the meeting, so I know that  
13 we -- Web Meeting and Microsoft Live Meeting,  
14 they all have poll functions, right? So we  
15 can use the poll function in the future. That  
16 would be great.

17 The other thing is, just as a  
18 consumer of all the materials, it was hard for  
19 me to keep them straight, and it would be  
20 great if we had some consistent way of naming,  
21 you know, like the consultant's document and  
22 the -- the submissions all pretty much began

1 with the submission number, and that was very  
2 helpful.

3 And if the attachments also began  
4 with the submission number, I think that would  
5 help us, you know, keep things straight. So,  
6 you know, that -- that was a struggle for me  
7 to -- you know, and I'm --

8 MS. TURBYVILLE: Yes, it's a lot.

9 DR. BARNETT: It's a lot of stuff,  
10 so to the extent that you can kind of help us  
11 by organizing it, that would be great.

12 DR. NEEDLEMAN: Likewise, you  
13 know, Carlos's submission were extraordinarily  
14 helpful, but some got labeled with numbers,  
15 multiple numbers, because multiple things --  
16 one in a document. I'd rather have more  
17 documents that are easy to find.

18 MS. WILBON: Okay. That's  
19 helpful. We try to sometimes do things in a  
20 PDF and bookmark, because we don't want to  
21 send you like 50 files and then it gets hard  
22 to send them through e-mail. So, you know, we

1 try to think about when it's best to try to  
2 package things in one -- one PDF versus  
3 sending separate files.

4 So, you know, we do weigh that,  
5 but it's hard sometimes when we have so many  
6 things to send you, and we don't want to have  
7 to send you 10 e-mails to get so many  
8 documents to you.

9 DR. BARNETT: So the website is  
10 great. I don't know whether -- you know, are  
11 some of the things -- some of the things --  
12 what do I want to say? Confidential, you  
13 can't put them on the website, but --

14 MS. WILBON: We --

15 DR. BARNETT: But all the  
16 submissions could be gotten from the website,  
17 and that was very helpful.

18 MS. WILBON: Yes.

19 DR. BARNETT: And all the meeting  
20 minutes and those sorts of things.

21 MS. WILBON: It's timing.  
22 Sometimes it takes us -- we don't have the

1 ability to personally post things to the  
2 website, so, you know, we may have something  
3 ready for you, but we have to wait two or  
4 three days for it to get posted to the  
5 website.

6 So rather than waiting for there  
7 to be like a hyperlink, we sometimes will just  
8 go ahead and send it to you, so --

9 DR. BARNETT: Well, there's Google  
10 Groups, there's SharePoint.

11 DR. BURSTIN: And SharePoint has  
12 just been put into place, so my guess is  
13 within the next --

14 MS. WILBON: We're working on it.  
15 We're -- but that's helpful.

16 CO-CHAIR ROSENTHAL: Doris?

17 DR. PETER: Yes, I was going to  
18 bring up the SharePoint site, because I know  
19 we had talked about that before. But I also  
20 wanted to say thank you for all your help. I  
21 know it's a lot of documents for you, too, so  
22 thank you.

1 MS. WILBON: Thank you.

2 DR. WILLIAM RICH: Ditto. I'd  
3 like to thank the staff, because I don't even  
4 know how to work a watch, so I really  
5 appreciate their help.

6 MS. TURBYVILLE: Is someone on the  
7 phone?

8 DR. JEFFREY RICH: Yes, it's Jeff  
9 Rich.

10 MS. TURBYVILLE: Jeff, hey,  
11 welcome.

12 DR. JEFFREY RICH: Thanks. I  
13 wanted to make a comment about the  
14 documentation, if I may. Sometimes the  
15 applications are so complex, and having them  
16 on your laptop trying to find bullet points,  
17 you know, while we're talking is a little bit  
18 difficult.

19 I might suggest that having an  
20 executive summary of the application would be  
21 very helpful, just, you know, basic things  
22 like where is the level of attribution, you

1 know, what time period are we talking about,  
2 it's easy -- I mean, because as you go through  
3 it and talk and have discussions, I am always  
4 flipping back and forth through a very long  
5 document trying to redefine that for myself.

6 And I don't know if I'm the only  
7 dysfunctional one in the group, but it would  
8 help me a lot, you know, with that. I don't  
9 know if anyone else feels the same.

10 CO-CHAIR ROSENTHAL: I had the  
11 same feeling. And, obviously, the  
12 applications have to be thorough and detailed  
13 and all the rest of that. But as we are  
14 beginning to figure out where the honing-in  
15 points are -- I mean, for example, I now know  
16 that the attribution thing is in Section 11.

17 But if it could either be  
18 highlighted or pulled out, those very key  
19 things, what the risk adjusting methodology is  
20 in a couple of bullet points, but I -- I  
21 hesitated to make the suggestion, because I  
22 think the staff has already got a ton of work.



1 But if it could be done without making it a  
2 ton-plus of work, that really -- it would be  
3 helpful.

4 And also, trying to keep the thing  
5 straight, because to now go back and compare  
6 one to another is really a big challenge. And  
7 yet there are really only a half a dozen  
8 elements that are kind of the key ones that we  
9 are going -- seeming to come back to over and  
10 over now.

11 DR. BARNETT: And maybe we could  
12 just skip importance.

13 (Laughter.)

14 I mean, the reason that these --  
15 that we even have these measures is because  
16 NQF has already decided that they're  
17 important. So I'm not sure we gain much by  
18 all of that.

19 MS. TURBYVILLE: I think the only  
20 time potentially it could come in is if it's  
21 really not a resource use measurement area,  
22 but I think that's right, so --

1 DR. O'NEILL: Could I just -- I  
2 mean, this has been a great exercise, and it  
3 is -- I think there is a couple of overarching  
4 things. I guess I'm a convert from Jack here.  
5 There are a few overarching things that have  
6 come up over and over again.

7 And as a Steering Committee in  
8 this area, I don't know if there is any  
9 opportunity to do something like advocate for  
10 things like pharmacy data to be included. I  
11 mean, there is ways of making this happen in  
12 the commercial world by having the data  
13 sharing be a standard part of contracting with  
14 the PBM and things like that.

15 But in terms of having the  
16 resources at our fingertips to analyze how  
17 well things are going, there are some  
18 overarching things that I think we have kind  
19 of learned here. I just hope we can capture  
20 them as a kind of policy or, you know,  
21 standard that we would like to see on a go-  
22 forward basis. And it's outside of each

1 individual measure, so --

2 CO-CHAIR STEINWALD: Jack?

3 DR. NEEDLEMAN: Yes, two things.

4 First, in terms of process, I thought that  
5 Sally occasionally asking people who were at  
6 the extreme to explain their votes in a non-  
7 judgmental way --

8 (Laughter.)

9 -- was extremely helpful. And I  
10 actually think there may be opportunities to  
11 think about straw polls before the formal poll  
12 is taken -- vote is taken. Just have us do it  
13 once and see where we are, because there is at  
14 least one vote. If I had known it would have  
15 been as close as it was, I would have switched  
16 from one category to another, from a yes to a  
17 no.

18 So I just want to encourage Bruce  
19 and Tom to think about straw polls as a way of  
20 checking how much consensus there is, how much  
21 we need to discuss things, so that might be  
22 helpful to use the technology.

1                   The other thing -- I want to thank  
2                   the staff. The materials were great.  
3                   Everything you did in real time as we were  
4                   working was great. Helen, you are a very  
5                   lucky person.

6                   (Laughter.)

7                   CO-CHAIR STEINWALD: Anything  
8                   further?

9                   MS. WILBON: I just wanted to  
10                  thank the Co-Chairs for your efforts  
11                  throughout the last couple of days. It really  
12                  helps when you have two good Co-Chairs to lead  
13                  you through a meeting as arduous as this, and  
14                  we recognize that the materials are quite  
15                  challenging, and we appreciate everyone  
16                  sticking through.

17                  And I also want to thank Jeptha  
18                  and Jaime, because they have already had a TAP  
19                  meeting and then they kind of had to rehash  
20                  the whole thing again and be prepared to that  
21                  level again. So I don't know if Jeptha is on  
22                  the line, but I wanted to thank him for that,

1 and Jaime, who is off the phone, so --

2 CO-CHAIR STEINWALD: Okay.

3 MS. WILBON: -- thanks.

4 DR. BURSTIN: Please leave your  
5 voting devices.

6 MS. WILBON: Yes, don't take them  
7 with you.

8 DR. BURSTIN: They don't work on  
9 anything else.

10 DR. NEEDLEMAN: Did we just get  
11 finished an hour early?

12 DR. BURSTIN: Yes,  
13 congratulations.

14 CO-CHAIR STEINWALD: If we can --  
15 if I can adjourn the meeting.

16 It's adjourned.

17 (Whereupon, at 2:32 p.m., the proceedings in  
18 the foregoing matter were adjourned.)

19

20

21

22

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Before: NQF

Date: 06-30-11

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