

NATIONAL QUALITY FORUM

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LINKING COST AND QUALITY MEASURES

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EXPERT PANEL IN-PERSON MEETING

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THURSDAY  
MAY 1, 2014

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The Care Coordination Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street NW, Washington, D.C., at 9:00 a.m., Joyce DuBow and Carole Redding Flamm, Co-Chairs, presiding.

PRESENT:

PETER ALMENOFF, MD, FCCP, Veterans Health Administration

STEVEN ASCH, MD, MPH, VA Palo Alto Health Care System and Stanford University School of Medicine

LAWRENCE BECKER, Xerox Corporation

DAVID COHEN, MD, MSc, Saint Luke's Health System

MARY CRAMER, MBA, CPHQ, Partners HealthCare System, Inc., Massachusetts General Hospital

JOYCE DUBOW, AARP

CHRISTINE GOESCHEL, ScD, MPA, MPS, RN, FAAN, MedStar Health

DONALD LIKOSKY, PhD, University of Michigan

TIMOTHY LOWE, PhD, MSW, Premier Healthcare Solutions

CATHERINE MACLEAN, MD, PhD, WellPoint, Inc.  
JACK NEEDLEMAN, PhD, University of  
California, Los Angeles  
STEVEN PANTILAT, MD, FAAHPM, University of  
California at San Francisco  
KIMBERLY RASK, MD, PhD, Alliant Health  
Solutions  
CAROLE REDDING FLAMM, MD, MPH, Blue Cross  
Blue Shield Association  
IYAH ROMM, Health Policy Commission  
MATTHEW ROUSCULP, PhD, MPH, GlaxoSmithKline  
ANDREW RYAN, PhD, MA, Weill Cornell Medical  
College  
DENNIS SCANLON, PhD, The Pennsylvania State  
University  
JEREMIAH SCHUUR, MD, MHS, FACEP, Partners  
HealthCare System, Inc., Brigham and  
Women's Hospital  
JEFFREY SILBER, MD, PhD, The Children's  
Hospital of Philadelphia  
ALAN SPEIR, MD, Society of Thoracic Surgeons  
JOSEPH STEPHANSKY, Michigan Health &  
Hospital Association  
CHRISTOPHER TOMPKINS, PhD, Brandeis  
University  
HERBERT WONG, PhD, Agency for Healthcare  
Research and Quality  
GREGORY WOZNIAK, PhD, American Medical  
Association  
GARY YOUNG, JD, PhD, Northeastern University

NQF STAFF:

TAROON AMIN, MA, MPH, Senior Director  
HELEN BURSTIN, MD, MPH, Senior Vice  
President for Performance Measures  
ANN HAMMERSMITH, JD, General Counsel  
VY LUONG, Project Analyst  
ERIN O'ROURKE, Project Manager, Strategic  
Partnerships  
KAREN PACE, PhD, Senior Director of  
Performance Measurement  
ROBERT SAUNDERS, Senior Director, Strategic  
Partnerships  
ASHLIE WILBON, RN, MPH, Managing Director,  
Performance Measurement

ALSO PRESENT:

AMER HAIDER, Doctella.com  
REBECCA HANCOCK, American Academy of  
Ophthalmology  
DIEDTRA HENDERSON, The Institute of Medicine  
JACQUELINE KREINIK, Centers for Medicare &  
Medicaid

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

2 (9:03 a.m.)

3 MR. AMIN: So, I would just like  
4 to first welcome everyone for their very  
5 thoughtful contributions up to this point. We  
6 are very excited for this meeting to get  
7 started. This has been a very important topic  
8 at NQF broadly and we have, obviously, had a  
9 lot of discussions across the spectrum about  
10 how to actually advance linking cost and  
11 quality.

12 I am just going to turn it over to  
13 Erin for a second here to walk us through some  
14 of the logistics for the day on the next slide  
15 and then we will go through some introductions  
16 of project staff and then walk through the  
17 agenda for the meeting.

18 Erin?

19 MS. O'ROURKE: Thanks, Taroon.  
20 Just a few housekeeping items. Restrooms are  
21 outside the main conference area, past the  
22 elevators on the right. We will have two 15-

1 minute breaks, one at 10:30, one at 1:45. We  
2 would ask that you try to refrain from  
3 stepping out until those times but we  
4 definitely understand if people need to take  
5 calls or do other business.

6 The information for the wireless  
7 is there, if you need to log on. Please mute  
8 your cell phones.

9 During the meeting, we will be  
10 doing our standard raise your tent card, if  
11 you would like the co-chairs to call on you.  
12 And Taroon, anything else you want me to  
13 cover?

14 MR. AMIN: No, that's it for now.

15 CO-CHAIR DUBOW: If you could also  
16 just make your tent cards, please, so that we  
17 can see them because that would be great. We  
18 can't still necessarily see them, but it is a  
19 little bit better.

20 MR. AMIN: Thanks, Joyce. And  
21 just maybe we can spend a minute just to talk  
22 administratively about how this meeting is

1     going to be run. I know that this is the  
2     first NQF meeting for some of you in the room.  
3     So, I just wanted to remind you that we  
4     welcome a broad discussion about the topics  
5     during today's meetings. So please, we would  
6     encourage you all to provide your thoughts,  
7     particularly since we have a very broad  
8     spectrum of stakeholders in various interests  
9     at the table. So, we welcome all comments.

10                 Secondly, as tradition at NQF, the  
11     way the chairs will be leading the meeting  
12     with staff helping to facilitate to ensure  
13     that the goals of the meeting are completed,  
14     we would welcome you to just raise your  
15     placard, sort of on the side like this, in  
16     order to cue the chairs that you have a  
17     comment to make. And then we will help to  
18     make sure that the queue is sort of addressed  
19     in order.

20                 And this is a little bit different  
21     than our typical consensus development  
22     projects in the sense that we are not



1 reviewing measures but we are providing, we  
2 are setting forward strategic guidance, not  
3 only to the field but also specifically to  
4 NQF, in order to set future policy related to  
5 measurement.

6 And so in that sense, we won't be  
7 going through a voting process but we will be  
8 going through a systematic evaluation of the  
9 draft report that Andrew, Ryan, and Chris  
10 Tompkins helped to begin for us and will  
11 further refine after the input from this  
12 committee deliberation.

13 And so that will be the purpose,  
14 essentially, of how we get through the  
15 structure of the meeting over the next two  
16 days.

17 I would welcome any questions that  
18 anyone has related to the structure but we  
19 will, obviously, go through a little bit more  
20 description of the agenda in a moment.

21 So, just a quick introduction to  
22 the NQF staff that you have probably

1 encountered through the course of the work  
2 here. I am joined by Erin O'Rourke on the far  
3 side of the table here, Vy Luong here on the  
4 corner next to Chris, Ashlie Wilbon -- I'm not  
5 sure how I missed the order already but there  
6 is Ashlie Wilbon to my right, and my name is  
7 Taroon Amin. We have been helping to support  
8 sort of this work from developing the initial  
9 proposal to the Robert Wood Johnson  
10 Foundation, which we thank for their support  
11 for this committee work and the work of the  
12 authors.

13 So, we will go quickly through the  
14 agenda for the day. And then before we get to  
15 the scope and objectives, maybe we go through  
16 the expert introductions. Before we get to  
17 that, I would welcome any introductory  
18 welcoming statements by Joyce or Carole, if  
19 you have any, and Helen Burstin.

20 CO-CHAIR DUBOW: I was just going  
21 to say, add Helen Burstin and Ann Hammersmith  
22 to the mix because they are two important

1 members of the NQF staff.

2 I welcome you. Taroon says we  
3 welcome your comments. I encourage you and  
4 Carole and I both encourage you to  
5 participate. It is really important that we  
6 hear all of your views. So, don't be shy  
7 because this paper will only improve with your  
8 views addressed. So, I hope this will be a  
9 lively and engaged conversation.

10 Thank you so much for coming. We  
11 wiped away the rain that we had yesterday so  
12 that you could arrive in dry weather and I  
13 look forward to the two days and to working  
14 with Carole.

15 DR. BURSTIN: I just want to add  
16 my welcome. I gave my seat to Ann for the  
17 very important next step of doing your  
18 introductions and disclosures, which she will  
19 lead for us.

20 I am Helen Burstin. I oversee our  
21 Performance Measurement work here at the NQF.  
22 I just want to add my welcome.

1                   This has been a project long in  
2                   coming. I think our affordability staff and  
3                   cost and resource staff have been talking  
4                   about it for about two years, tried to seek  
5                   funding for it about two years ago, maybe even  
6                   three. I think we are a little ahead of the  
7                   curve and people thought we were strange by  
8                   asking to look at this question of how to do  
9                   this.

10                   I think the world has come a  
11                   little bit further along and we are really  
12                   glad RWJF agreed that the time was now right  
13                   to think about this issue. And we really do,  
14                   I think, important work to do thinking this  
15                   through. People talk a lot about how we are  
16                   going to combine cost and quality and don't  
17                   actually have a sense of how to operationalize  
18                   it.

19                   So, thanks to Chris and Andy for a  
20                   great start on having a great foundation for  
21                   this work. And again, I will be popping in  
22                   and out but thanks so much for this really

1 important work.

2 MS. WILBON: Did you want to --  
3 okay.

4 CO-CHAIR FLAMM: I will just add  
5 my welcome. I am very excited to be part of  
6 this project. I think we have a very diverse  
7 and rich set of perspectives here. And I  
8 think in our discussion, as Joyce was  
9 alluding, it will be so important today to get  
10 all of our thoughts out there but also to  
11 clarify what kind of guidance we are giving to  
12 this project. I think there are a lot of  
13 issues and nuances to sort of try and really  
14 hone in on what are the salient points we need  
15 to think of when we think about these  
16 different models.

17 MS. HAMMERSMITH: Hi, everyone. I  
18 am Ann Hammersmith. I am not Helen Burstin.  
19 I am NQF's general counsel. And, as Taroon  
20 explained, we will combine the introductions  
21 and the disclosures because it is a little bit  
22 quicker that way.

1           As Taroon pointed out, this isn't  
2           the typical consensus committee. So, for  
3           disclosures, it is highly unlikely you are  
4           going to have a conflict, frankly. But, we go  
5           through the process anyway, to be sure. And  
6           also to encourage you to think about what you  
7           have been up to in the last 12 months that may  
8           be relevant to the work of the committee  
9           today. So, you filled out a form a while ago  
10          where we asked you lots of questions about  
11          your professional activities.

12                 So what we would be looking for  
13          you to do today is to disclose anything that  
14          you think is relevant to the work that the  
15          committee will do today. Just because you  
16          disclose something doesn't mean you have a  
17          conflict. Part of what we are trying to do  
18          here is to be transparent and understand where  
19          everyone is coming from.

20                 So, please do disclose things that  
21          are relevant to the work of the committee  
22          today.

1                   So, let's go around the table,  
2                   introduce yourself, tell us who you are with  
3                   and we will get rolling.

4                   MR. BECKER: So, good morning. I  
5                   am Larry Becker. I work for Xerox  
6                   Corporation. I am a plan administrator for  
7                   Xerox. And then I am a Board member here at  
8                   NQF. I am also a Board member of PCORI. And  
9                   I am working on a TAP at Yale on one of the  
10                  measures. And I am relying on Helen to tell  
11                  me when that is a conflict with something that  
12                  we are doing.

13                  DR. BURSTIN: It's not.

14                  MR. BECKER: Okay. And so that is  
15                  me.

16                  MR. ROMM: My name is Iyah Romm.  
17                  I am one of the policy directors at the Health  
18                  Policy Commission, which is Massachusetts' new  
19                  independent state agency responsible for  
20                  implementation of our cost control  
21                  legislation. In that seat there, I oversee a  
22                  variety of activities, including a large

1 investment program for community hospitals, as  
2 well as our quality and system performance  
3 monitoring work.

4 I also have been, for a number of  
5 years, although I am no longer the lead staff  
6 on Massachusetts' development of a standard  
7 quality measure set through our process in the  
8 Commonwealth to seek to standardize much of  
9 the work that you are all doing here. So, I  
10 am pleased to be here and I don't think that  
11 I have anything else to disclose.

12 DR. LOWE: I'm Timothy Lowe. I  
13 work for Premier Healthcare Solutions. I am  
14 a principle research scientist. Most of my  
15 work is on infections and measure development,  
16 kind of metric measures, which I know it says  
17 in the paper we are not focusing on. But most  
18 of work tends to be looking at waste in  
19 healthcare.

20 And I do hold two patents and I  
21 have published but I have no financial stake  
22 in this.



1 DR. MAC LEAN: Good morning,  
2 everyone. I am Cathy MacLean. I lead the  
3 quality efforts at WellPoint.

4 With regard to conflicts, just  
5 potential things relevant to this, I guess I  
6 recently rotated off the Board of Directors of  
7 the American Joint Replacement Registry and I  
8 serve on the American College of Physicians  
9 Performance Measure Committee as well, and  
10 various other NQF things.

11 DR. LIKOSKY: Hi, I'm Donny  
12 Likosky. I am a cardiovascular epidemiologist  
13 at the University of Michigan. I work in the  
14 area of cardiovascular services, focusing on  
15 measurement of quality and cost.

16 DR. WOZNIAK: Good morning,  
17 everyone. I am Greg Wozniak. I am Director  
18 of Outcomes Analytics at the American Medical  
19 Association in the improving health outcomes  
20 area. I used to be in the PCPI area in terms  
21 of our roles around testing the measures and  
22 measure development. So, some of the

1 background is around the quality measurement  
2 and methodologies. I am also part of the  
3 project team working with Chris Tompkins on  
4 the Episode Grouper for Medicare.

5 DR. ALMENOFF: I'm Peter Almenoff.  
6 By background, I am a pulmonary ICU doctor.  
7 I am the Senior Advisor for the Office of the  
8 Secretary in Department of Veterans Affairs  
9 regarding healthcare value. And I also do the  
10 Director of Analytics, Operational Analytics  
11 and Reporting, which does a lot of the quality  
12 and financial analytic reporting for the  
13 Department of Veteran Affairs.

14 DR. SCHUUR: Jay Schuur. I am an  
15 emergency physician by training. I practice  
16 at Brigham and Women's Hospital in Boston,  
17 where I am the Vice Chair for Quality and  
18 Safety. I also serve as the Chair of the  
19 American College of Emergency Physicians,  
20 Quality and Performance committee. And I do  
21 health services research.

22 DR. SCANLON: Hi, I'm Dennis

1 Scanlon from Penn State University. I am a  
2 faculty member there and do research, health  
3 services research and study areas of quality  
4 performance measurement. So, I do work  
5 looking at what others are doing in this area  
6 and trying to make sense of it. Nothing else  
7 to disclose.

8 DR. COHEN: Good morning, I'm  
9 David Cohen. I am a cardiologist from Saint  
10 Luke's Mid-America Heart Institute in Kansas  
11 City and a health services researcher. I  
12 direct a research group there that spends a  
13 lot of time looking at issues of efficiencies  
14 and value in cardiovascular technologies in  
15 particular.

16 Nothing to disclose.

17 MS. CRAMER: My name is Mary  
18 Cramer. I am from Mass General Hospital in  
19 Boston. And the work I do really endeavors to  
20 improve efficiency throughout the operations  
21 from stem to stern at Mass General and its  
22 physician's organization.

1 DR. YOUNG: I'm Gary Young. I  
2 direct the Center for Health Policy and  
3 Healthcare Research at Northeastern University  
4 in Boston. Also a professor at the School of  
5 Business and College of Health Sciences at  
6 Northeastern University. I'm also affiliated  
7 with the VA's Health Services Research and  
8 Development Service at the Boston VA Medical  
9 Center.

10 DR. ASCH: Hi, I'm Steve Asch.  
11 I'm a professor at Stanford. I also work for  
12 the Palo Alto VA, where I am the Chief of  
13 Health Services Research and I direct a center  
14 called the Center for Innovation to  
15 Implementation Ci2i. Its focus is value  
16 measurement. I have nothing to disclose.

17 DR. ROUSCULP: Good morning. My  
18 name is Matt Rousculp. I am the Senior  
19 Director for Comparative Effectiveness  
20 Research and Health Policy Research at  
21 GlaxoSmithKline. I am an employee of  
22 GlaxoSmithKline and hold stock. I have

1 nothing else to disclose.

2 DR. NEEDLEMAN: I'm Jack  
3 Needleman. I am a professor at the UCLA  
4 Fielding School of Public Health and Associate  
5 Director of the UCLA Patient Safety Institute.  
6 I am also a member of the NQF Standing  
7 Committee on Resource Use Measures. And  
8 nothing else to disclose.

9 MR. STEPHANSKY: I'm Joe  
10 Stephansky. I am with the Michigan Health and  
11 Hospital Association. I fell into healthcare  
12 by accident. My Ph.D. is in agricultural  
13 economics, of all things but that gives me  
14 some background in some of the same kinds of  
15 techniques we are going to be looking at here.

16 As far as disclosures, I guess it  
17 is that I am simply becoming a grumpy old man  
18 very quickly and I think that is okay here.

19 DR. WONG: I'm Herb Wong. I am a  
20 Senior Economist with the Agency for  
21 Healthcare Research and Quality. Most of my  
22 work focused on the development of the HCUP

1 databases, the Health Care Cost and  
2 Utilization Project databases, developing  
3 them, getting them out, and conducting  
4 research with those databases and leading  
5 projects there. Other than that, I have  
6 nothing else to disclose.

7 DR. SILBER: I'm Jeff Silber. I  
8 am a Professor of Pediatrics and  
9 Anesthesiology and Healthcare Management at  
10 Children's Hospital of Philadelphia in Penn in  
11 Wharton.

12 I have been doing health services  
13 research for about 25 years. I am most  
14 interested, presently, in using matching  
15 techniques to evaluate quality.

16 In terms of disclosures, I have  
17 nothing to disclose. I am thinking about  
18 developing a few patents but haven't had any  
19 meetings with lawyers to see if it is a  
20 reality or not.

21 DR. RASK: Kimberly Rask. I am a  
22 general internist by training and associate

1 professor in the School of Public Health at  
2 Emory University in Atlanta and Medical  
3 Director for the Medicare QIO for the State of  
4 Georgia.

5 And I was going to disclose that  
6 Jeff and I were in the Ph.D. programs together  
7 but when he disclosed how long ago that was,  
8 I am going to deny it.

9 (Laughter.)

10 DR. RYAN: Hi, I'm Andy Ryan. I  
11 am an associate professor in the Department of  
12 Healthcare Policy and Research at Weill  
13 Cornell Medical College. I am on the NQF  
14 Standing Committee for Resource Use. And it  
15 has been a pleasure working with you so far  
16 and hearing everyone's comments. I am really  
17 looking forward to a great process over the  
18 next few days. And I have nothing, no  
19 financial conflicts to disclose.

20 DR. TOMPKINS: Hi, I'm Chris  
21 Tompkins from Brandeis University. I am a  
22 health services researcher on the faculty. I

1 look forward to today and tomorrow.

2 CO-CHAIR DUBOW: I'm Joyce DuBow.  
3 I am a member of the NQF Board as well. I  
4 represent consumers on a variety of NQF  
5 activities and at NCQA and other areas. There  
6 is always the need for consumers these days.

7 CO-CHAIR FLAMM: And I'm Carole  
8 Flamm. I am Executive Medical Director at the  
9 Blue Cross Blue Shield Association and lead  
10 the Center for Clinical Value, which involves  
11 our measurement activities around quality and  
12 cost of care. And I will disclose that I lead  
13 the Blue Distinction Center's Program, which  
14 is one of the programs listed in our table.

15 So, should we turn it back over to  
16 you, Taroon?

17 MS. HAMMERSMITH: I have one more  
18 thing to say and then I will go away.

19 Thank you for those disclosures.  
20 Is there anyone on the phone who needs to  
21 disclose? I don't think there is. Okay,  
22 nobody on the phone.



1           The last words I want to leave you  
2   with are with any conflict of interest  
3   process, we look to the committee members to  
4   make it work. So, as I said, it is highly  
5   unlikely that any of you are going to have an  
6   actual conflict, given what you are talking  
7   about today, but if you think you might or if  
8   you think that someone is behaving in a biased  
9   manner or if you think you might have a  
10   conflict, please do speak up. We don't want  
11   you sitting there quietly wondering if you  
12   have a conflict or thinking someone else is  
13   very biased and not saying anything about it.  
14   You are always welcome to bring it up openly  
15   in a meeting. You can go to your co-chairs,  
16   who will then go to NQF staff, or you can go  
17   directly to NQF staff.

18           So, any questions so far this  
19   morning about disclosures or anything anyone  
20   has disclosed?

21           Okay, thank you.

22           MS. WILBON: Thank you, everyone.

1 I don't think Andy and Chris actually  
2 introduced themselves as such, but they are  
3 the authors of the paper that is going to be  
4 the foundation for our discussion today. So,  
5 thank you guys for coming as well.

6 I did want to take some time to  
7 just over the agenda a little bit for the next  
8 two days so we have an idea of kind of what  
9 our thoughts are for how to get through this  
10 discussion.

11 So, this morning we will start out  
12 with kind of a brief overview of kind of why  
13 we are here, the scope of this discussion and  
14 the paper going forward and our goals. That  
15 will go into our first discussion at about  
16 9:30, which will just be we wanted to give you  
17 guys an open forum, if you will, to kind of  
18 give some general feedback on the paper, give  
19 us some feedback on whether or not there is  
20 anything based on what we already outlined on  
21 the discussion guide, if there is other things  
22 we need to be thinking about, so that can kind

1 of add them and address them as we go on  
2 throughout the next two days. I think the way  
3 we have decided to structure that discussion  
4 is kind of go section-by-section in the paper  
5 so it is not too much of a free-for-all but we  
6 did want to give you guys an opportunity to  
7 kind of get out some initial thoughts and get  
8 the juices flowing before we kind of get into  
9 some of the more nuance discussions.

10 We will take a break and then come  
11 back to back to talk about some of the  
12 efficiency measurement approach discussions.  
13 That part of the discussion will kind of, we  
14 will have some discussion questions around  
15 composite measurement approaches and whether  
16 or not that is feasible based on what we know  
17 so far. We will have one of our senior  
18 directors, Karen Pace, come talk to us about  
19 some of the work that we have done there as a  
20 foundation as well.

21 We will follow that by a  
22 discussion around -- we will talk a little bit

1     about the goals. There is kind of a two-  
2     pronged approach in terms of some of the  
3     operational guidance that we are looking to  
4     get. The first is kind of around implications  
5     for efficiency measurement in public and  
6     private programs. So, the staff will start  
7     out by giving kind of a broad overview of the  
8     purpose of the discussion around different  
9     programs and applications and then we will go  
10    into a discussion with the panel about that.

11                   We will break for lunch about  
12    12:30 and then after lunch come back to really  
13    dive into some of the different models that  
14    were outlined in the paper and have Chris and  
15    Andy kind of walk us through somewhat of the  
16    results of their environmental scan and then  
17    have some discussion whether or not there is  
18    other things we should be considering in terms  
19    of models and approaches.

20                   And then we will break out into  
21    various groups, four groups will be in this  
22    room. We are going to spread the groups out

1       into the four corners of the room. Our co-  
2       chairs and authors will kind of be travelers,  
3       if they will. They will be hopping from group  
4       to group. We have got everyone divided up  
5       already and we will share that with everyone  
6       probably before lunch or just before, so you  
7       have an idea of what group you are in. But we  
8       have divided folks into four groups, based on  
9       four different kind of applications, if you  
10      will.

11                   And that will be followed by a  
12      report out of the breakout groups. So, we  
13      will designate someone in each group to be a  
14      speaker for the group, if you will. We will  
15      have flip charts so we can kind of take notes  
16      and get everyone's ideas during the breakout  
17      groups and we will come back and have a  
18      discussion around where each group landed.  
19      So, we will be asking someone from each of  
20      those groups to kind of be the speaker for the  
21      group.

22                   We will follow that by a recap of

1 the day. And we will open it up for public  
2 and member comment. Oftentimes there are  
3 people on the phone or in the room who would  
4 like to provide input or have considerations  
5 for the committees. We will give them an  
6 opportunity to do that.

7 We will be looking to adjourn  
8 around five and then afterwards we have, for  
9 those that are interested, we have arranged  
10 for happy hour at a restaurant a couple blocks  
11 away called Mio. You are welcome to come and  
12 have a few drinks and relax and debrief for  
13 the day, if you like, and staff will be there  
14 to greet you.

15 I won't go too much into Day 2.  
16 That seems so far ahead right now. But does  
17 anyone have questions about how the day is  
18 going to go? A lot of our discussion will be  
19 guided by what we have laid out in the  
20 discussion guide. We put that together to  
21 make sure we have kind of a direction and some  
22 boundaries for our discussion today. But,

1 obviously, we are open to any suggestions, as  
2 I mentioned earlier, if you have things that  
3 you think we also need to be considering as we  
4 go through the discussion for the next day or  
5 two.

6 MR. AMIN: I would just note for  
7 those that are sort of new to the NQF process,  
8 this meeting is recorded and it will also be  
9 transcribed. And all of the committee's  
10 deliberations will be open to the public.  
11 Hence, the reason for the public and member  
12 comment, not only for those in the room, but  
13 the meeting is currently and will be, for the  
14 next two days, webcasted. Obviously, the time  
15 period that we go into breakout groups won't  
16 be. But just keep that in mind in terms of  
17 your comments. I'm sure everything would be  
18 fine but I'm just for full disclosure.

19 And in terms also of full  
20 disclosure, I just want to note for the social  
21 hour that we are going to have in the evening  
22 today, that we don't -- NQF doesn't have

1 funding to support that. So, we have the  
2 space located for you to join us but we are  
3 not -- you are on your own in terms of  
4 drinking.

5 Yes, do you have a question?

6 Sure.

7 DR. ASCH: Will the happy hour be  
8 recorded?

9 (Laughter.)

10 MR. AMIN: It may not be recorded  
11 but it might be transcribed.

12 CO-CHAIR DUBOW: Only if you own  
13 an NBA team.

14 MR. AMIN: So, that's good for the  
15 agenda. Before we go into the project scope  
16 and objectives, I know we are at the 9:30 time  
17 period but I just wanted to point out a few  
18 things as we get started here on just some  
19 foundational vision of why we are here. And  
20 I welcome Ashlie's comments and Helen, I  
21 think, alluded to a number of this in the  
22 introduction.



1                   But there is a two-fold effort  
2                   that we are really trying to achieve here.  
3                   For those of you who are familiar or maybe  
4                   less familiar with NQF's work, one of the  
5                   primary core functions of NQF is to endorse  
6                   multi-stakeholder performance measures,  
7                   consensus-based performance measures. And NQF  
8                   started down the pathway of looking at cost of  
9                   care measures in the last three to four years.  
10                  And a number of you, and I would welcome  
11                  comments from you as well, have been part of  
12                  that journey with us over the last three to  
13                  four years. And one of the things that has  
14                  been challenging and has been an area of  
15                  opportunity for us, in terms of endorsing cost  
16                  of care measures, is that there is clearly a  
17                  need in the country to try to look at the  
18                  question of the growth of healthcare cost.  
19                  And in particular, try to think about how we  
20                  can think about per capita measures and  
21                  episode of care measures that could be used  
22                  for accountability applications.

1                   However, one of the clear things  
2                   that we have learned through the evaluation  
3                   and endorsement of these measures through the  
4                   multi-stakeholder process is that there is a  
5                   concern that just looking at cost of care has  
6                   the potential to undermine the quality  
7                   enterprise that we have built over the last  
8                   number of, at least the last decade and  
9                   probably longer than that, which obviously is  
10                  the foundation for the National Quality Forum,  
11                  which is to advance healthcare quality for the  
12                  country.

13                  So one of the ways that we have  
14                  thought about moving this forward, and again,  
15                  the committee that is part of this work, many  
16                  of you are here with us, again, I welcome  
17                  comments on this, is that first we need some  
18                  consensus-based, scientifically acceptable  
19                  cost of care measures because measuring cost  
20                  in itself is important to the community, but  
21                  we really need a strategic approach on how to  
22                  actually link the question of cost and quality

1 together. And the practical operationalizing  
2 of that is, obviously a challenge. And that  
3 is the path that we want to start with this  
4 committee, that we have certainly started with  
5 this committee. And we want to actually be  
6 able to provide very clear guidance for our  
7 measure endorsement process on how we start to  
8 endorse cost of care measures and what that  
9 process looks like, vis-a-vis quality  
10 measures. And so that is one very clear need  
11 of this work and it has a very clear  
12 application.

13 The second is that the Measures  
14 Application Partnership, which is convened by  
15 the National Quality Forum recommends measures  
16 for various programs. It has multiple  
17 objectives but one, in particular, is around  
18 making recommendations to HHS around selection  
19 of measures for various federal programs.

20 The other component of what we are  
21 trying to explore here is that the question of  
22 how to link cost and quality may be at the

1     measure level but might also be or might only  
2     be at the programmatic level, meaning that the  
3     way that you think about cost and quality  
4     linkages may be need to be done through  
5     programmatic recommendations.

6                     And so the measures application  
7     partnership is generally interested in the  
8     question of whether there should be additional  
9     recommendations about how programs should be  
10    structured, in order to ensure that quality is  
11    not reduced through the process of looking at  
12    cost.

13                    And so those are the two dual  
14    objectives of what we are trying to achieve  
15    with this work. We recognize that it has a  
16    very broad scope but we are trying to at least  
17    set a foundation for how we can think about  
18    this going forward.

19                    So, this is not purely an academic  
20    exercise in the purpose of developing a white  
21    paper but it has very clear implications for  
22    how NQF thinks about both the endorsement of

1 measures and also the selection of measures  
2 for various different programs.

3 And so Ashlie and I, along with  
4 various different committee members felt that  
5 this was an extremely important area that  
6 needed to be explored and, again, we  
7 appreciate the support and leadership of the  
8 Robert Wood Johnson Foundation that was  
9 helpful in supporting the work of the  
10 committee and the authors. And again, I  
11 welcome comments from Ashlie or from any of  
12 the committee members who have some of that  
13 experience that they can share with the  
14 committee in terms of the foundational work of  
15 why we are here today.

16 Yes, Jack?

17 DR. NEEDLEMAN: Just a reflection  
18 from the Cost and Resource Use Committee work  
19 and its relation to what we are doing here  
20 today. At the last two meetings, the last two  
21 sets of measures that committee dealt with, we  
22 essentially had what is called the conditional

1 measures presented from CMS, a value grid  
2 crossed with a resource use measure grid. We  
3 are not asked to endorse the grid. We were  
4 simply asked to endorse the resource use  
5 measure. But clearly, the context for the  
6 resource use measure was in the grid and for  
7 payment related to both perceived value and  
8 perceived efficiency.

9               So, the NQF is in the process of  
10 reviewing these measures, even if it is not  
11 explicitly being asked to review them. And I  
12 think it is critically important that we have  
13 some guidance and framework in thinking about  
14 that.

15              MS. WILBON: I'll just add that in  
16 the discussion guide we will actually be  
17 having a much more detailed discussion about  
18 each of those kind of operational purposes  
19 around some of the work around the Measure  
20 Applications Partnership as well as the  
21 endorsement work that we do. So, the overview  
22 that Taroon gave is really just to kind of

1     give you an idea and a foundation for where we  
2     are going in the next two days with a lot more  
3     discussion to come around those two processes.  
4     And I think that is it.

5                 MR. AMIN:  So, if there are no  
6     other comments, we can just review the project  
7     scope and objectives very specifically and  
8     then we can jump into the conversation about  
9     the draft report.  And I would welcome Ashlie  
10    and the authors to lead parts of that  
11    discussion on walking the committee through  
12    the various sections of the report.

13                So, the main deliverable for this  
14    committee is to look at a commission paper,  
15    which Andy and Chris have started us down to  
16    explore the current approaches to linking cost  
17    and quality measures, to measure efficiency --  
18    And the way we are defining efficiency, again,  
19    is defined in the paper but really looking at  
20    the cost and quality signals -- and identify  
21    methodological challenges to linking costs and  
22    quality; defining key principles and best

1 practices for how these two signals should be  
2 -- how these two measures should be aligned;  
3 and provide operational guidance and  
4 recommendations for future evaluation,  
5 submission and evaluation of efficiency  
6 measures for endorsement, and I would add, for  
7 selection.

8 So, that is the objective of what  
9 we are trying to achieve over the next two  
10 days. And so are there any questions related  
11 to the scope?

12 Larry.

13 MR. BECKER: So, have we clearly  
14 defined two things: who is the customer for  
15 this output; and who are the ultimate end  
16 users of this output, so that we know how to  
17 form this?

18 CO-CHAIR DUBOW: -- as well. I  
19 think Jack's point about this train already  
20 having left the station is quite pertinent to  
21 our work.

22 MS. WILBON: So, I'll start. And



1     actually I meant to answer that in Jack's  
2     first comment. I lost my train of thought.  
3     So, I ended my comments early.

4                     So, to Larry's question, the  
5     audience, I think is probably multi-fold, if  
6     you will. So, for the operational pieces,  
7     obviously around for MAP and for the CDP  
8     process, I think we would definitely like to  
9     take some of that, the output of that  
10    discussion directly to our standing committee  
11    and say look, this is where we would like to  
12    go in this direction. We actually have a  
13    meeting coming up with our standing committee  
14    at the end of June, which, in terms of timing,  
15    to Joyce's point, by the time this paper goes  
16    out for comment, around that time, we will be  
17    able to bring some of the work of this group  
18    back to our standing committee and say this is  
19    some of the guidance. How would we like to  
20    operate as a committee in terms of the  
21    endorsement work going forward. So, that is  
22    one audience, if you will.

1                   The other audience, in terms of  
2                   the measure applications partnership,  
3                   obviously, would be for staff and for those  
4                   committees to consider some of the guidance  
5                   and whether or not the selection criteria that  
6                   they have might need to incorporate some of  
7                   the considerations that this panel has put  
8                   forth.

9                   And I think the other audience,  
10                  potentially, would be measure developers. So,  
11                  those that are out there kind of doing this  
12                  measure development work and are looking to  
13                  explore and expand the space around efficiency  
14                  measurement, what should they be doing, like  
15                  these key methodological challenges, what  
16                  should they be considering as they are  
17                  developing these measures and trying to put  
18                  measures out and also bring measures in for  
19                  endorsement.

20                  And so, I don't know if there is  
21                  probably other audiences.

22                  DR. BURSTIN: I would probably add

1     one more. I think some of the early work the  
2     train has left the station. There is a whole  
3     lot more work to do. So, I think end users  
4     who are really looking to think about how they  
5     are going to combine these two and put them  
6     forward to clinicians and others, I think,  
7     will really potentially find this very useful.

8                 I think there is going to be a lot  
9     of mid-course corrections, such as we have  
10    already seen in quality over the years. So,  
11    why would we not expect to see something very  
12    similar around cost and then the linkage of  
13    cost and quality?

14                MR. BECKER: I was thinking about  
15    so at the end of this, when we have great  
16    measures, who is going to use those measures?  
17    There are a whole bunch of stakeholders. And  
18    if we have that in view of how they are going  
19    to actually be able to use these and the way  
20    in which we develop them and the way in which  
21    we communicate them when we develop them.

22                CO-CHAIR DUBOW: You know, I think

1       that that need has been taken into account, in  
2       terms of how the agenda has been structured  
3       and in terms of how the breakout groups will  
4       take into account the work of Andy and Chris,  
5       because that is really what we are going to be  
6       focusing on. We are going to be thinking  
7       about use cases. So, stay tuned.

8               MR. AMIN: Okay. So, let's get  
9       started with really just starting with the  
10      deep dive in terms of the general feedback on  
11      the draft paper.

12             The basic question here is based  
13      on the stated scope of the paper, which we  
14      just talked about. I guess one of the first  
15      questions we want to start with is are there  
16      any other issues or topics that should be  
17      considered in addition to those that are  
18      indicated in the guide?

19             MS. O'ROURKE: Oh, Taroon, could I  
20      interrupt you before we get started?

21             MR. AMIN: Please.

22             MS. O'ROURKE: I wanted to give

1 Christine a chance to introduce herself and if  
2 she has any disclosures of interest.

3 DR. GOESCHEL: Thank you so much.  
4 I apologize for being late. The first spring  
5 in an Arlington home and I met water this  
6 morning when I went downstairs. So, I  
7 apologize.

8 I'm Chris Goeschel. I am the  
9 Assistant Vice President for Quality at  
10 MedStar Health. I really have nothing to  
11 disclose, have served on one previous NQF  
12 panel. I am delighted to be here.

13 I will say part of my intrigue is  
14 that many of our hospitals are in the State of  
15 Maryland and most of you may know that the  
16 State of Maryland does something unique in  
17 terms of cost and quality in linking yet to be  
18 defined. It continues to emerge. So,  
19 delighted to be here. I'm happy to answer any  
20 questions or concerns that folks might have.

21 DR. MAC LEAN: All right. So, to  
22 kick it off, nice draft. I think, though, I

1 want to call out the definition of quality  
2 that is in the draft. And I think that if we  
3 are going to be moving forward and having a  
4 solid definition of efficiency in measures, we  
5 need to start at first principles and have a  
6 strong foundation.

7 I think sometimes people get a  
8 little tangled up with the six aims that the  
9 IOM laid out. And the six aims are not the  
10 definition of quality. Healthcare quality is  
11 what we do to improve health outcomes and  
12 functional status. And if you go back to the  
13 Chasm Report, those aims were kind of the  
14 second objective. And the first objective  
15 was, in fact, to improve the health and  
16 functioning of the U.S. population. And the  
17 aims were laid out as the things we need to do  
18 to get to that desired result of improving  
19 health and function.

20 So, you know, as you saw in the  
21 draft, using those aims as the definition of  
22 quality gets a little circular, since one of

1       those aims is to improve efficiency.

2                       So, I would like to kind of pull  
3       back for a second and think about how we  
4       define quality. And I would propose we get  
5       back to the original IOM definition. And even  
6       back in 1990, the IOM had a report prior to  
7       the Chasm and even getting back to Donabedian.

8                       Quality is what we do in the  
9       healthcare system to improve the health or the  
10      functioning of the population. And then that  
11      way, I think the efficiency definition gets a  
12      lot more easy. And then it is cost per unit  
13      outcome and you can define outcomes in a  
14      variety of ways. But I think we need to get  
15      that part right.

16                      CO-CHAIR FLAMM: Jeff.

17                      DR. SILBER: I absolutely agree.  
18      It was one of the points that I wanted to  
19      make, which gets at the question of process  
20      measures. Do they have any validity in trying  
21      to state that we are looking at quality  
22      measure? We really want to look at the health

1 of the public and the health of the patient  
2 and the functional outcomes. And so process  
3 wouldn't be part of that numerator.

4 So, I absolutely agree with what  
5 you are saying.

6 CO-CHAIR FLAMM: Jack.

7 DR. NEEDLEMAN: I've got to admit,  
8 I really wanted the paper to be much richer.  
9 And there were at least three different ways  
10 in which I thought the conversation in the  
11 paper really needed to go further to enable us  
12 to do the kind of work we want to do.

13 One of them has to do with the  
14 definition of efficiency or value and whether  
15 we are measuring value strictly by the  
16 relative cost of producing services in  
17 different settings or whether, as Timbie and  
18 Normand do in one of the papers that is widely  
19 cited in this paper, a cost effectiveness  
20 study, which puts a value on the outcomes gets  
21 imposed on top of simply looking at the  
22 relative cost of the different providers.



1                   So, that wasn't sort of addressed.  
2       When we talk about efficiency or value here,  
3       how broadly should we be looking at it?  
4       Should we be limiting it to the relative cost  
5       of services -- relative cost of production in  
6       the settings?

7                   We have got other issues in the  
8       way we measure the relative cost of production  
9       but I will save that for later.

10                  The second area where I thought  
11       the paper didn't go and really address  
12       critical issues is in the lack of consistency  
13       in ranking or classification across different  
14       approaches. When we see an efficiency  
15       measure, we have seen lots of repetition  
16       within a given approach and say do we get a  
17       consistent ranking there. But this whole set  
18       of papers, and again, some of the papers cited  
19       I am heavily influenced by the reading of the  
20       Timbie and Normand paper, really underscore  
21       the fact that you don't get consistency in  
22       rankings across different methods.

1                   So, if that this the case, what  
2                   are the implications for an organization like  
3                   NQF who is reviewing measures in terms of the  
4                   reliability and the need to assess whether the  
5                   specific method of ranking you have picked on  
6                   the value dimension influences the results.  
7                   And I think we need more discussion in the  
8                   paper about that implication and how to think  
9                   about that.

10                   And likewise, not enough  
11                   discussion about the choice of outcomes. If  
12                   they are all highly correlated, 0.98, who  
13                   cares which one we choose to rank? We may  
14                   care about how we do the ranking. But who  
15                   cares? We are going to get the same answer.  
16                   But they are not highly correlated.

17                   And if we have got a specific  
18                   efficiency measure that is built around  
19                   deaths, or around infection rates, or around  
20                   13 different items, each of which has a very  
21                   different ranking in itself, how we put those  
22                   together and how we think about what we count,

1     what we don't count, how we weight them,  
2     critically important. It is mentioned in  
3     there but we need a lot more analysis about  
4     how to think about that in terms of a measure  
5     development process.

6                   CO-CHAIR FLAMM: Steven.

7                   MS. WILBON: Can you use your  
8     microphone, please? Thanks.

9                   DR. ASCH: I agree completely with  
10    the sentiment of the previous speakers in  
11    footnote that there is a circularity in using  
12    the six aims as the definition of quality.

13                   I guess I don't agree that we  
14    should exclude process measures. This comes  
15    both speaking as a practicing clinician and,  
16    of course, as a health services researcher,  
17    because process measures are what we have  
18    under our control. And as long as we imbue  
19    those process measures with a strong link to  
20    outcomes, perhaps by including definitions of  
21    appropriateness associated with them, I think  
22    that having them in-linked quality cost

1 measures actually will guide the system in the  
2 right way.

3 So, I urge us to think broadly in  
4 that regard.

5 CO-CHAIR FLAMM: Gary.

6 DR. YOUNG: Well, my point  
7 actually speaks to this already sort of a  
8 growing debate about whether to use process  
9 measures or not.

10 I thought the paper did a really  
11 nice job outlining some of the different  
12 approaches. And the fact is right, payers,  
13 purchasers are already developing approaches  
14 to combining cost and quality measures.

15 I think another step that may need  
16 to be taken is to develop a framework in  
17 helping purchasers select them on different  
18 approaches and that would take into account  
19 some of the points that Jack just made. I  
20 think also we need to think about how well  
21 these different measures can discriminate  
22 among providers relative to the goal of

1 promoting health, improving populations'  
2 health. Thinking about the clarity of the  
3 information that would be communicated to  
4 providers through these different approaches,  
5 potential behavioral responses. I think we  
6 need to think about the potential motivational  
7 qualities that could emerge from each of these  
8 different approaches.

9 So, I think we sort of need a  
10 framework as a starting point to help  
11 purchasers select among the different  
12 approaches.

13 CO-CHAIR FLAMM: Greg.

14 DR. WOZNIAK: I would echo Steve's  
15 comment around the support to have process  
16 measures, as well as more population health  
17 level measures. Both are important but again,  
18 process measures are more controlled.

19 My point was more generally around  
20 how actionable are some of these measures that  
21 are combinations. It is like some of the  
22 challenges with working with composites.

1 Composites have value in terms of high-level  
2 population levels but they are not very  
3 actionable. You have to get to the actual  
4 pieces of the measures or the potential. The  
5 components are the measures that you have  
6 control over.

7           So, I think actionability of some  
8 of these approaches that are laid out in the  
9 paper might be an area that could be expanded  
10 upon. Again, it addresses the usefulness and  
11 the usability, which is one of NQF's sort of  
12 standard criteria for their measures.

13           CO-CHAIR DUBOW: I just want to  
14 observe that it depends on the end user. When  
15 we think about composites and the end user is  
16 a consumer, for example, the fact that  
17 something is rolled up makes it -- it  
18 simplifies the decision. So, all the more  
19 reason that the aggregation and the composite  
20 is a valid assessment of performance but it  
21 depends who is using it.

22           CO-CHAIR FLAMM: So, Cathy, do you

1 have another comment?

2 DR. MAC LEAN: Just to wrap up the  
3 quality discussion, I agree that process ought  
4 to be included. I would kind of expand that  
5 to even include structure in some cases, the  
6 issue being, as long as the processes and the  
7 structures are clearly linked to the outcome.  
8 That said, I think that it would be valuable  
9 for this group to make recommendations with  
10 regard to the valuation, not in monetary  
11 terms, of the quality metric. And so, I would  
12 just call out that in some areas we have lots  
13 of process measures, appropriately so. It is  
14 very difficult to measure outcome measures and  
15 lots of things may impact those outcomes; for  
16 example, within chronic diseases. But the set  
17 of measures that we may have available for a  
18 given condition, you know, they may be kind of  
19 weak, actually, on a process level and really  
20 don't mean the same thing as the outcome that  
21 is more difficult to measure.

22 So, I think we need to be

1     cognizant of the fact that if we are getting  
2     into a quantitative measure of efficiency, to  
3     understand that that quality metric has  
4     different meanings. And so as long as you  
5     comparing apples to apples, you are fine but  
6     we need to be cognizant of that.

7                   CO-CHAIR FLAMM: Dennis?

8                   DR. SCANLON: So, I have some  
9     similar comments. Maybe I will frame them in  
10    a different way. I think what I heard Gary  
11    say is this may be kind of crying out for a  
12    little bit of a framework that addresses the  
13    complexity of a number of issues that I  
14    thought was sort of missing from the  
15    introduction of the paper. And I am sort of  
16    torn because I wonder how much the charge of  
17    this effort is sort of directing the paper in  
18    a certain area. Specifically, around the goal  
19    is to link measures of quality and cost for  
20    the purpose of measuring efficiency. So,  
21    there is some implication that we need to take  
22    what we have, the existing measures and link



1       them to come up with efficiency. As opposed  
2       to, and I think I made these comments back in  
3       February, to think about sort of what we want  
4       to measure and sort of what we need to sort of  
5       get to the goal line, if you will. If we want  
6       to really start with efficiency, what would  
7       do, rather than necessarily start with what we  
8       have. And I understand that is kind of a  
9       dicey situation because we have what we have  
10      and we want to use them.

11               But in terms of some things I  
12      think that would be important to address in a  
13      framework, some of which have been mentioned,  
14      is this issue of are we taking what we have or  
15      are we sort of thinking about, the paper  
16      mentions briefly sort of the economic concept  
17      of efficiency but it kind of washes it aside  
18      and says we are not really going to address  
19      that.

20               But that sort of gets to the  
21      second point, which is, ultimately, what is  
22      our goal? And there are a variety of goals

1     here.  If our goal is to sort of create a  
2     healthcare system that provides value and  
3     operates efficiently, then I think the concept  
4     of economic efficiency is probably an  
5     important one.  And what we might be trying to  
6     sort of do through measurement is for  
7     innovation spur folks who are thinking about  
8     different ways of delivering care that helps  
9     patients.

10                 You know somebody mentioned end  
11     users.  There is a variety of sort of end  
12     users of this.  I mean consumers for making  
13     choices about where to get care, particularly  
14     in a world that seems to be coming more high  
15     deductible, kind of health plan oriented.  
16     There are payers for thinking about centers of  
17     excellence like either Home Depot or Lowe's  
18     did in terms of Center of Excellence with the  
19     Cleveland Clinic and thinking about making a  
20     choice like that.

21                 There is certainly plans, thinking  
22     about tiered networks.

1                   So, I think outlining sort of  
2                   those goals and sort of thinking about this  
3                   measurement might or might not help or where  
4                   some of the nuances are important.

5                   I also thought that when you look  
6                   at sort of existing consumer products, take  
7                   cars or take electronics, for example, and  
8                   some might disagree with this but it is not  
9                   clear to me that the measures are necessarily  
10                  linked. They are presented side-by-side. You  
11                  have got the price and then you have got a  
12                  whole bunch of information on attributes. But  
13                  often, it is a third party that makes a  
14                  judgment about value.

15                  So, if you get to CNET.com or you  
16                  go to Kelley's Blue Book, or whatever, you get  
17                  the facts. The quality measures and the  
18                  attributes and you get the price. And then  
19                  usually, it is some other pundit or sort of  
20                  organization that sort of makes a judgment  
21                  about what the best value is in the sedan  
22                  range, mid-price or something like that. So,

1 I think that begs a question as well is do  
2 they really need to be combined or do we just  
3 need to sort of do each other well and present  
4 them. I guess that would sort of relate to  
5 the side-by-side approach that is referenced  
6 in the paper. But that is, I think, a central  
7 focus because the task here seems to suggest  
8 that we need to combine them, as opposed to  
9 just provide the information.

10 And the last thing I will say is I  
11 think that the role of context, particularly  
12 in the context of healthcare markets in  
13 pricing, as it relates to cost, I think it is  
14 a critical one here as well. I go back to  
15 that Jamie Robinson paper in Health Affairs,  
16 where they look at the impact of reference  
17 pricing in California, and prices converge  
18 pretty quickly on hip and knee replacements in  
19 California. You know I guess a question is  
20 would we call the providers, who lowered their  
21 prices because of market competition  
22 inefficient to start with and now efficient

1       once their price went down or were they just  
2       as efficient from a production perspective.  
3       It just happened that market forces reduced  
4       prices. And I think that whole issue is an  
5       important one to grapple with as well.

6                   CO-CHAIR FLAMM: Thank you.  
7       Before we continue with the discussion, we had  
8       two committee members join. If they could go  
9       ahead and introduce yourself and disclose any  
10      conflicts that you might have.

11                   DR. PANTILAT: Good morning.  
12      Steve Pantilat. I am a professor of medicine  
13      at U.C. San Francisco where I direct a  
14      palliative care program. I don't know if  
15      there is more introduction or if that is  
16      sufficient. Great. Nothing to disclose.

17                   DR. SPEIR: Good morning, I am  
18      sorry I was late.

19                   CO-CHAIR FLAMM: Microphone,  
20      please.

21                   DR. SPEIR: I've been sitting on  
22      the Beltway since about 8:00 a.m. So, I am

1       very glad to be here. I am Alan Speir. I am  
2       a practicing cardiac surgeon in Northern  
3       Virginia, representing the Society of Thoracic  
4       Surgery and I have no disclosures.

5               CO-CHAIR FLAMM: Thank you.  
6       Please put your cards forward. Thanks.

7               MR. AMIN: One other quick  
8       observation. You need to turn off your  
9       microphone after you are done. We can only  
10      have two at a time. So, that might be the  
11      reason why people are having a difficult time.

12              CO-CHAIR FLAMM: Go ahead,  
13      Christine.

14              DR. GOESCHEL: Great, thank you.  
15      I just want to say I think we are clearly on  
16      the right path with the richness of the  
17      discussion. I would just like to add a note  
18      of caution, and I think we have said it in a  
19      number of ways, the need to be really crisp  
20      and explicit in our audience, in our  
21      definitions, in our intentions.

22              I think it is also important, if

1 possible, to declare what this is not.  
2 Because what will happen when this is  
3 available is that people that we didn't intend  
4 to use it will take and use it for purposes  
5 that were not intended. And as much as  
6 possible, I think it is important going  
7 forward to keep that in mind so that the case  
8 that is articulated is kind of working with  
9 both of those models.

10 CO-CHAIR FLAMM: Thank you. We  
11 have Matthew next.

12 DR. ROUSCULP: Sorry, I was still  
13 thinking through a lot of this as comments, a  
14 lot of great insight. So, I appreciate that.

15 I guess for me, in reading this,  
16 instead of echoing what everyone else had  
17 already said, which I am in agreement, I  
18 applaud the authors' willingness to kind of  
19 write this and now come in front of  
20 individuals and kind of hear about our baby.  
21 It is nothing, I think, personal. I think  
22 this is a direction that hopefully we hope all

1       this just continues to get better. I thought  
2       this was a very good start.

3                   I guess for me just from a process  
4       element, I notice that as far as the  
5       literature that we are going to review was  
6       primarily in the PubMed area. And with Joseph  
7       sitting to my left, I am really kind of  
8       sparked to say there are the valuation of the  
9       public goods that other areas have kind of  
10      focused on and thought about and the linking.  
11      Because, again, I don't know if it is as much.

12                  Because earlier in this discussion  
13      with NQF, you have groups that are thinking  
14      about the cost and you have individuals  
15      thinking about the quality areas but it is  
16      more about that linkage and how do you kind of  
17      compare the two. And there is a lot of work  
18      done. And I would even echo going to the  
19      Federal Register and reading Ken Arrow's  
20      discussions that he had related to the Valdez  
21      Exxon.

22                  I would also say then a second



1 area, I promised I wouldn't echo but it is  
2 really this hierarchical issues. The idea  
3 that a lot of the discussion we had was more  
4 about the organizational perspective and we  
5 kind of gloss over it and we say well, that is  
6 the same thing with individuals. And I want  
7 to make sure that, as far as the linking, that  
8 when we start talking about signal to noise  
9 type issues, that that is really going to play  
10 a lot of difference.

11 And we can just use an example  
12 which is, at the very front, you talk about  
13 costs and costs for patients. That is out-of-  
14 pocket costs is growing as far as an issue for  
15 procedures being done in the hospitals but for  
16 outpatient or for drugs or other things,  
17 outpatient is just a lot higher percentage or  
18 proportion and not capturing that is really is  
19 going to cause some issues.

20 So, I just want to make sure as  
21 far as our linking that we don't just kind of  
22 wave over and just say everything is the same,

1 no matter what level of the organization or  
2 how hierarchical these issues are.

3 CO-CHAIR FLAMM: Thank you.

4 Coming back to Iyah.

5 MR. ROMM: I would echo Matthew's  
6 comments, both about the authors. I think  
7 that on one hand it is very easy to sit and  
8 provide all sorts of constructive feedback but  
9 it is extremely helpful for me to see the  
10 various models in play, which are few. And I  
11 think I am struck, in part, by the abject  
12 limitation nationwide of data to draw upon as  
13 we start this work.

14 I am mostly struck, coming back to  
15 some of the comments earlier, that we seem to  
16 make a leap almost immediately from linking  
17 cost and quality to efficiency. And I think  
18 we just pass over value entirely. And I think  
19 that that is a real opportunity for this group  
20 to start to think about that. Because I don't  
21 think that value and efficiency are the same  
22 thing for every audience. I think in some

1 settings they may well be. But especially  
2 from a consumer perspective, I think that they  
3 are considered and thought of very  
4 differently.

5 And I agree with the comment that  
6 as we think about linkage, not only do we need  
7 to think about different models of linkage but  
8 even with the same self-measures, the way that  
9 they are linked and presented is probably  
10 different for different audiences. I think  
11 there is a whole space there that we haven't  
12 begun to tease out.

13 I think that the other thing that  
14 I would just note is that I am almost struck  
15 by the fact that though we are having  
16 important and complex conversations about  
17 certain segments of care, we are just  
18 scratching the surface. And as we continue  
19 through this process, I think it is important  
20 when I look at the examples out there and I am  
21 most familiar with the self plan and the AQC  
22 in Massachusetts and others. It is entirely

1 hospital and a little bit of physician-based.  
2 We are not talking behavioral health. We are  
3 not talking long-term care. There is sort of  
4 a world of consumer-oriented area of focus  
5 that I think that we need to be thinking  
6 about.

7 So, I would encourage us to push a  
8 little bit further into that frontier as well,  
9 even if there is not much work done yet.

10 CO-CHAIR FLAMM: Larry.

11 MR. BECKER: Thank you. So, I  
12 also think that we need to build into this the  
13 thought about the fact that patients have  
14 preferences about the outcomes they want and  
15 how they can actually obtain those outcomes  
16 differ based on their circumstances. You know  
17 whether it is their education level, their  
18 socioeconomic status, and also they are going  
19 to make more and more choices as they are  
20 paying for more and more of the care that they  
21 received.

22 So, when we start to think about

1 linking these in value, to whom is the value,  
2 where is that perception? Who is perceiving  
3 the value? And I think we need to talk about  
4 that and how this all gets formed.

5 CO-CHAIR FLAMM: Jeff.

6 DR. SILBER: I can see that most  
7 don't agree with my statement about process.  
8 I would say that I haven't changed my mind and  
9 I won't. But if we do go down that road, I  
10 think, at least, and I heard some people say,  
11 that it is very important to define the  
12 guidelines for using process such that we  
13 don't create the tautology that I am worried  
14 about between process and cost. And secondly,  
15 that we don't confuse the users, which I  
16 always think of as the patient because they  
17 won't necessarily understand why a decrement  
18 in process is worth the money that they are  
19 spending.

20 So, I am just adding a warning.  
21 Clearly, people want to put process in but I  
22 would like there to be some strong guidelines

1     about how it could be -- about not to misuse  
2     those particular aspects of the process.

3                   CO-CHAIR FLAMM:   Herbert.

4                   DR. WONG:   So, let me begin by  
5     thanking the authors of the draft.  Get the  
6     straw man out there.  There is a lot of  
7     concepts are floating out here really designed  
8     to help shape and to improve it.

9                   Many of the comments that have  
10    already been stated I share a common view but  
11    there is a few that I think is worthy to  
12    emphasize, to make sure that we kind of get  
13    this draft right.

14                  One of the things that I think  
15    strikes everyone is that this is an incredibly  
16    complex area and that things that have been  
17    stated out there in terms of different  
18    perspective, different audiences and things of  
19    that nature, I think needs to be somewhat  
20    highlighted in the draft.  There is just this  
21    pure recognition and that we need to probably  
22    hone in on certain aspects of it.

1                   So, one of the things that  
2                   constantly comes to mind is the RAM report  
3                   that looked at the topology of efficiency that  
4                   was funded by the Agency. That document  
5                   probably should be highlighted to at least lay  
6                   out the concept of efficiency. So, from the  
7                   economic world, clearly, there are economic  
8                   terms that sits behind that efficiency  
9                   definition that economists and folks that work  
10                  there are very familiar with.

11                 As the concept of efficiency  
12                 emerge, at least in the healthcare  
13                 environment, it is well accepted, the term  
14                 health or economic efficiency but it is not  
15                 really accepted in the field.

16                 So, my caution is to recognize the  
17                 complexity of that. Many people interpret it  
18                 in a certain way and that that should be well-  
19                 documented.

20                 The other component I think that  
21                 needs some highlighting is that oftentimes  
22                 when we talk about efficiency and value, they

1     are somewhat intermingled. And in the end, if  
2     one were to step back and to use the analogy  
3     that Dennis presented, value almost by itself  
4     is subjective.

5                 So, if you use the car analogy,  
6     you can have a great metric of safe quality.  
7     You have a great metric of cost. And supposed  
8     you are buying a Cadillac versus a Smart car.  
9     The measure for the Smart car could be  
10    actually higher. It is a 2.0 or whatever  
11    versus the Cadillac but they are fundamentally  
12    very different. And someone could look at  
13    this and say from a value perspective, the  
14    Smart car gives me that better value. But  
15    really, I don't want to be driving a Smart  
16    car. I really want that Cadillac.

17                So, again, it goes back to one of  
18    the concepts that we have all played with is  
19    that perspective matters. So, whether it is  
20    the consumer's perspective or the payer's  
21    perspective and things like that.

22                And sometimes a single measure



1 will give us a signal. And it might be in  
2 totality of other metrics that help us make  
3 whatever decisions that we need to make.

4 CO-CHAIR FLAMM: Okay, next I have  
5 Tim.

6 DR. LOWE: Those of you who are  
7 clinicians will have to forgive the engineer  
8 scientist coming at this from a very different  
9 perspective.

10 I think one of the problems with  
11 the modeling that I see is that we assume that  
12 cost and quality are somehow separate and that  
13 we can -- when I look at the models, I tend to  
14 see cost put as a dependent variable and that  
15 in independent variables, we add measures of  
16 quality, whether that is mortality or length  
17 of stay and we simply try to understand how it  
18 works.

19 I don't think that they are  
20 separate. I think cost and quality go  
21 together. You can say there is a nexus  
22 between the two. And the relationship between

1       them is not linear. As one goes up or one  
2       goes down, sometimes they go up or down, I  
3       think it is much more complex than that.

4               Going back to the electronics  
5       example, since I am an electrical engineer, I  
6       can build a circuit board for \$2, especially  
7       if I have it built not in the United States.  
8       But I can built it for \$2 and the focus then  
9       could be maximizing profit. Or, I could build  
10      that board much more robustly and say instead  
11      of having planned obsolescence with your  
12      refrigerator or dishwasher, I can make it last  
13      much longer.

14             The thing is that so there is a  
15      production cost involved in this. How much I  
16      spend on that board has to do with its quality  
17      or its longevity. The interesting thing from  
18      a production's viewpoint is that the  
19      difference between the \$2 circuit board, which  
20      can burn out in a few years, and the \$4  
21      circuit board, which might last 20 years is a  
22      very small cost, in terms of production.

1                   But the pricing, and I think we  
2                   got at that, is a very different thing. So,  
3                   when we talk about cost, we are not just  
4                   talking about the production cost, and this is  
5                   where I agree with you, Jeff, because the  
6                   process measures that we have can be valued  
7                   for each something that a doctor does, he or  
8                   she, there is a charge for that. And that has  
9                   a direct relationship to a patient's outcome.  
10                  But there is a production cost and there is  
11                  how we price that. And the pricing seems to  
12                  be driven more by the market, which I think I  
13                  have heard, too. How that is competition or  
14                  how we decide to price it, which from a  
15                  manufacturing view is whatever the market can  
16                  stand or how I want to relate to my consumers.

17                  And I think that is different in  
18                  terms of value. Is somebody willing to pay  
19                  more for a better product or is pricing more  
20                  an issue and so, I will choose the lesser  
21                  product because maybe that is what I can  
22                  afford.

1 CO-CHAIR FLAMM: Cathy.

2 DR. MAC LEAN: Two comments. One,  
3 this is really complicated. So, I think we  
4 would be well-advised, perhaps, that the  
5 outcome of this effort is to lay out a  
6 meaningful framework. At the outset, I don't  
7 think that there is a single measure that is  
8 going to be valuable across all the different  
9 settings that we are going to be able to  
10 define. So, maybe we ought to be thinking  
11 about what is the framework for the context.

12 And then two other kind of related  
13 comments. This process outcome question, that  
14 is kind of the Holy Grail in quality. You  
15 shouldn't have a process measure, unless it is  
16 related to an outcome. And mathematically,  
17 you could do the math. You would have to  
18 build in a lot of assumptions to say well, I  
19 am a rheumatologist so I will go with  
20 something that I am really familiar with. So,  
21 one of the process measures is people who have  
22 rheumatoid arthritis should be on a certain

1 class of drugs call DMARDs. And the reason  
2 for that is because we know from a large body  
3 of literature that people who are in DMARDs  
4 have much better outcomes defined by standard  
5 outcomes for health and function and so on.

6 So, you could, mathematically kind  
7 of model it out to say okay, so if someone is  
8 on a DMARD, this is how that would translate  
9 into an outcome. If you wanted to go to that  
10 effort, I think there would be a lot of  
11 assumptions. And depending on the particular  
12 process measure, condition, it could be more  
13 or less assumptions. So, that is why I was  
14 saying before, not all quality measures are  
15 equal.

16 So, with regard to that process,  
17 outcome piece, that is something we can think  
18 about.

19 The other piece I just want to  
20 really emphasize is that the context is so  
21 very important, particularly when we are  
22 getting to this efficiency piece. And if you

1     take an example -- let's take knee  
2     replacements. So, someone references the  
3     CalPERS reference-based pricing experiment in  
4     California. Take a total knee replacement, if  
5     you are the hospital or hospital system, you  
6     have got a bunch of different surgical teams  
7     doing the procedure, you can look and see,  
8     okay, for this outcome, and we can measure  
9     function and functional outcome with that  
10    procedure, this is how much it costs for this  
11    group of surgeons to produce it, for this  
12    group of surgeons to produce it, or for this  
13    center to produce it. And so, as the hospital  
14    administrator, you can define which is the  
15    most efficient.

16               As the payer, you can look across  
17    and say well, how much does it cost me to  
18    purchase this as a health insurance payer.  
19    And then in that example, CalPERS, which is  
20    self-funded, said this is crazy. There is a  
21    five-fold variation in the cost of knee  
22    replacement surgery in the state. And so that

1 is clearly having to do with negotiations.  
2 Some hospitals are way better at negotiating  
3 a rate.

4 And you get to the member's side  
5 of it, if you have got a \$20 copay versus a  
6 \$30 copay, if your usual out of pocket is  
7 \$6,500, the consumer's value proposition of  
8 the efficiency is very different to that  
9 person, until you put in place reference-based  
10 pricing and kind of upturns the apple cart.

11 So anyway, the context, I think,  
12 is critically important to layout in this  
13 framework that we are going to be talking  
14 about.

15 CO-CHAIR FLAMM: Okay. I have  
16 Donald, then we are going to Joseph, back to  
17 Jeremiah, and back to Iyah. Donald.

18 DR. LIKOSKY: Thank you. I guess  
19 the only thing I am going to highlight goes  
20 back to the comment about perspective. And I  
21 am a little bit confused about whose  
22 perspective we are focusing on.

1                   For instance, I guess in the  
2                   introduction piece, the purpose we speak  
3                   specifically borne by the payer. But then in  
4                   the definition of terms, cost speaks to payer  
5                   or consumer.

6                   So, I am trying to understand  
7                   exactly when we are talking about cost whose  
8                   perspective because it appears to, at least on  
9                   the surface, to be unclear.

10                  CO-CHAIR DUBOW: You know I don't  
11                  know if the staff wants to address this.  
12                  Generally, NQF measures look are supposed to  
13                  be appropriate for quality improvement and  
14                  accountability, those two groups public  
15                  reporting. So that provides a range of  
16                  perspectives. The accountability includes  
17                  payment, public reporting, so it is a broad  
18                  swath, as well as quality improvement, which  
19                  means it has to be meaningful and relevant to  
20                  clinicians as well.

21                  So, that is typically. I don't  
22                  know if you want to add anything to that.



1                   MR. AMIN: Yes, Joyce. The only  
2 other thing that I would just add is that as  
3 we go through the later part of today, part of  
4 the use case really defines the audience as  
5 well. So, when we look at this question of  
6 how to link or looking at the question of how  
7 to measure efficiency, it will often partially  
8 depend on what the use case is, whether it is  
9 for quality improvement. The audience there  
10 would be providers. For pay for performance  
11 applications, that may be different, much more  
12 consumer-facing.

13                   So, it all depends on -- well, it  
14 doesn't all depend on but it is heavily  
15 influenced by the use case. And so when we go  
16 through each of the use cases this afternoon,  
17 part of that exercise is to understand it from  
18 various different perspectives, not simply  
19 one.

20                   DR. LIKOSKY: If I could just go  
21 back to that, though, it does say that we seek  
22 to evaluate the specific case in which cost

1 borne by the payer is the input of interest.

2 So, I guess I was --

3 CO-CHAIR DUBOW: Well, a payer is  
4 not only a purchaser. A consumer is a payer.  
5 You know out-of-pocket costs makes you a  
6 payer. So, I mean we shouldn't be narrowed to  
7 think only purchasers when we think about  
8 payers. Government is a payer. Health plan  
9 is a payer, reimbursing.

10 CO-CHAIR FLAMM: And it is very  
11 hard to tease apart the member component,  
12 given differences in benefit design. I think  
13 we have to think about it holistically,  
14 understanding that there is an inter-  
15 relationship between the two.

16 Okay, Joseph, do you still want to  
17 make a comment?

18 MR. STEPHANSKY: Well, I'm still  
19 concerned about whose costs are going to count  
20 here and whether we can talk about consumer  
21 costs. But those consumers have non-out-of-  
22 pocket, non-deductible, non-copay costs in

1     consuming healthcare. Are we going to count  
2     them or is that something, for the purposes  
3     here, we are going to leave out and just focus  
4     on the payer? We can get really wide here,  
5     really fast, if we are not careful.

6                 I am also concerned about we keep  
7     talking about outcome measures but about the  
8     only outcome measure that I see that is really  
9     solid is death, unfortunately. And when I  
10    look at things like readmissions, I am looking  
11    at intermediate output, rather than a final  
12    one.

13                So, I think we have a long way to  
14    go just on that quality side, which is, I  
15    think, what Catherine is talking about.

16                CO-CHAIR FLAMM: Jeremiah.

17                DR. SCHUUR: I'll try not to  
18    repeat too many comments. I would add that I  
19    think the perspective does need to be very  
20    explicitly articulated in this difference  
21    between whose costs is critically important  
22    and it should be articulated throughout the

1 paper.

2 And secondly, this was briefly  
3 mentioned, but I think it would be helpful for  
4 the paper to have a little discussion around  
5 externalities and unintended consequences  
6 because, in many areas of care, the price cost  
7 includes social goods. I think about my world  
8 and, for example, trauma center care where the  
9 care of all patients in trauma centers is more  
10 expensive but the existence of a trauma center  
11 does have clear evidence that it improves  
12 outcomes. And so, that should be addressed.

13 CO-CHAIR FLAMM: Iyah.

14 MR. ROMM: We can go to Larry  
15 first.

16 MR. BECKER: Okay, thank you. So,  
17 I wondered if, for this purpose, we could all  
18 agree that the patient is true north. So that  
19 was the comment.

20 MR. ROMM: Out of fear of  
21 repeating myself, I am going to come back just  
22 for a moment to the written definition of

1 value here because back to several comments  
2 that have been made, I think most precisely by  
3 Tim to my left, this idea of preference-  
4 weighted assessment is written into the  
5 definition of value from that patient  
6 perspective. And I think that what we are all  
7 tripping around a little bit is that that may  
8 not be something that this is the right group  
9 to wrestle with that preference-weighting.  
10 And I think that there may be a need for some  
11 acknowledgment that is for us to determine how  
12 we think about and present information. And  
13 the group that is around the table, largely,  
14 does not speak to that. But that there is a  
15 need for the preference-weighting to be sort  
16 of at the fore and for patients to be the true  
17 north.

18 I think the other thing that I  
19 continue to be struck by and it is referenced  
20 a little bit here in the conversation around  
21 normalized pricing and certainly to the  
22 CalPERS point, that context matters very much.

1 And we see in these segmented, Massachusetts  
2 most notably, that this idea of splicing apart  
3 price and utilization as we think about cost  
4 is critically important and we can't talk  
5 about them as being the same, when we have  
6 just vast price disparities in certain  
7 segments.

8 But also, where the entities that  
9 represent many of those price disparities are,  
10 sort of core functional units, Centers of  
11 Excellence for certain segments that are not  
12 available otherwise in markets. And so I  
13 think as we think about that context that Jay  
14 just referenced, it extends beyond just the  
15 question of certain segments of, for example,  
16 trauma care, and their social impact. But  
17 truly, the availability of specialized  
18 services in certain segments of the market.

19 CO-CHAIR FLAMM: Greg.

20 DR. WOZNIAK: Well, let me say I  
21 feel for Chris and Andy.

22 (Laughter.)

1 DR. WOZNIAK: I knew this was  
2 complicated coming in and that has been  
3 reaffirmed.

4 I guess one of the challenges,  
5 then, is to figure out what we can do and what  
6 we can put in a paper and recommendations to  
7 NQF that they can use, as opposed to what  
8 would be a wish list. And the comment just  
9 made around preference-weighted assessments,  
10 we don't have that. There is very little, if  
11 anything, on preference-weighted anything of  
12 any of these actors. We just don't have it.

13 So, if you are going to build in a  
14 framework where that is needed, that framework  
15 is not going to be very useful. You are not  
16 going to be able to operationalize that.

17 And it goes back to comments  
18 around efficiency from the economist's  
19 perspective, as an economist, and for the  
20 others in the room. It took us about 200  
21 years go get there. Right? So, for us to  
22 make a jump and a leap and, obviously, with

1     technology and things move a little more  
2     quickly these days, it is going to take us a  
3     while to get to that kind of a framework where  
4     there is a lot of assumptions around  
5     efficiency. There is a lot of givens around  
6     efficiency. It is a very standard framework  
7     that took, again, 200 years to develop. I  
8     won't go into Marshallian and all those kinds  
9     of concepts, in terms of economics. But we  
10    need to say what can we do here? What can we  
11    construct that we already have information and  
12    what is doable. And then maybe have something  
13    like we should have or, in addition, it would  
14    be nice to have and we should look to build  
15    some of these other tools, some of these other  
16    variables, into the framework and into some of  
17    these concepts.

18                 But to operationalize some of  
19    these things, are almost impossible. Go back  
20    to value is some cost over quality or quality  
21    over -- some cost quality metric, where you  
22    don't have a measure of either of those. So,



1     what does value really mean then, if you can't  
2     measure either the numerator or the  
3     denominator.

4             So, I think we need to have sort  
5     of a reality check. What can we do? What can  
6     we operationalize? What can NQF use? What  
7     can those recommendations say that somebody  
8     developing measures would be able to apply?

9             And also, the comment, I thought  
10    it was very useful, Dennis' comment, the title  
11    of this group "Linking". It assumes that you  
12    have got cost measure. You have got quality  
13    measure. You are going to somehow put them  
14    together. If you ever tried to do that, it is  
15    like building composites. There is all kinds  
16    of constraints that have to be met in terms of  
17    eligibility and the populations have to match  
18    and all kinds of things have to match up time-  
19    wise, population-wise, condition wise.

20            I don't know if anybody has -- has  
21    anybody gone out to start developing  
22    efficiency measures where they develop both

1 cost and quality at the same time? I don't  
2 know if anybody has done that. And maybe  
3 Chris and Andy, in your literature review,  
4 have looked to see that but I don't think  
5 anybody has done that. I think it has always  
6 been a linkage approach. And doing them  
7 simultaneously, or at the same time, however  
8 they are done, would be a useful maybe  
9 recommendation or something to look at as  
10 well.

11 CO-CHAIR FLAMM: Jeff.

12 DR. SILBER: There was an issue  
13 that I brought up at the phone conference a  
14 few months ago which didn't get into the  
15 report but I had, and I don't know if I made  
16 the point clear enough about direct and  
17 indirect standardization, but I just want to  
18 go back to it. It has to do with perspective.

19 But if I looked at some entity,  
20 say a hospital and I used indirect  
21 standardization to evaluate their quality and  
22 cost and, in the end, some kind of value

1     metric, I would be basing my metric on the  
2     patients that that hospital saw, which could  
3     be different and non-overlapping from other  
4     hospitals that see very different patients.

5             The indirect standardization  
6     approach, which is generally used, has that  
7     problem that you might have non-overlapping  
8     patients. So, for an individual patient, you  
9     might see excellent value at this hospital and  
10    poor value at that hospital. But in reality,  
11    the first hospital didn't really overlap with  
12    themselves.

13            So, another approach is to use  
14    direct standardization or do what we can to  
15    make the basket of goods that we are comparing  
16    similar, not just through the overall  
17    adjustments, there are different ways to do  
18    this. But we really need to make sure that,  
19    as a consumer, that number one, the basket of  
20    goods they are looking at is relative to them;  
21    and number two, that the basket of goods is  
22    similar across the entities that they are

1 comparing.

2 I don't think the report dealt  
3 with that, unless I missed it. But I think it  
4 is a crucial concept that needs to be  
5 incorporated into the report.

6 CO-CHAIR FLAMM: So, I just want  
7 to summarize who I have on the list. And we  
8 are coming up towards the end of our hours,  
9 just to capture -- Larry, did you have another  
10 comment?

11 MR. BECKER: No.

12 CO-CHAIR FLAMM: No, you put yours  
13 down. And then I have Alan and Steven. And  
14 then Iyah, do you have another comment?

15 MR. ROMM: No, I'm all set.  
16 Sorry. Thank you.

17 CO-CHAIR FLAMM: Okay. Thank you.  
18 And I have Jack and Matthew. Alan.

19 DR. SPEIR: Thank you. I would  
20 like to applaud the efforts of our authors to  
21 make some sense of this. You have given us at  
22 least a structure to shoot at and thank you

1       for that opportunity.

2                       I am attempting to resist the  
3       change to stay on task with linking quality to  
4       cost. And as I read through the document and  
5       then in listening to the comments, there is  
6       the seeming vacillating of using value that is  
7       thrown in in an ill-defined attempt because,  
8       as we have all said repeatedly, values being  
9       differentially defined by the payers, whether  
10      it is CMS or Medicaid, the private payers, and  
11      particularly the patient, it was pointed out  
12      before, patient satisfaction will ultimately,  
13      if we are led to believe and believe what we  
14      read up to 30 percent of reimbursement.

15                     So, there is a disconnect to me in  
16      that the more dissatisfied a patient is, that  
17      may actually save cost from the payers by  
18      lowering reimbursement. The more satisfied  
19      they are, there may be more payment given out  
20      to the providers.

21                     Be that as it may, there is also a  
22      disconnect, and I had hoped there would be

1 more focus given about the variability in  
2 pricing and reimbursement. Because, again,  
3 there may be, for one example, up to 75  
4 percent difference in how a ventricular assist  
5 device or transplant is reimbursed on the East  
6 Coast and in the Midwest. I think if we are  
7 moving from paying for value, rather than  
8 volume, this differential is unacceptable and  
9 we, I think, as a body, need to give some  
10 deference with that.

11 I would respectfully disagree with  
12 the previous comment that death is the only  
13 outcome. I think depending on the specialty  
14 with your practicing, there is very real  
15 definitions and focus given to the types of  
16 outcomes by which were measured and we are  
17 actually, as institutions and providers, given  
18 star rating systems. And again, there should  
19 be more motivation given, regardless of the  
20 specialty to helping to define what we can get  
21 our hands around as outcomes.

22 And lastly, the last section,

1       there were implications for the NQF  
2       endorsement. I found that somewhat  
3       disquieting, frankly, because we are hardly  
4       coming to grips with some of the grievances  
5       around these term definitions, much less  
6       allowing a formal body to then value what  
7       attempts are being made by well-meaning  
8       organizations or societies and should that  
9       validation be delayed until we are a little  
10      bit better in consensus as to what we are  
11      about.

12                     Thank you.

13                     CO-CHAIR FLAMM: Steven.

14                     DR. PANTILAT: So, from my world,  
15      as a palliative care physician, I have to  
16      agree that death is not the only important  
17      outcome, since that is a very common outcome.  
18      And we --

19                     (Laughter.)

20                     DR. PANTILAT: I know. And we  
21      think we provide a lot of quality in that  
22      setting. So, fair enough.

1                   But looking from that perspective,  
2                   our field has really been built on looking at  
3                   issues of cost and quality. And really in  
4                   thinking about the quality provided in  
5                   palliative care, you can't make a buck doing  
6                   it. And so the way that palliative care has  
7                   grown in this country is largely on cost  
8                   savings and so linking quality improvement and  
9                   cost savings has been essential to the growth  
10                  of this field and has been done for a long  
11                  time. It is not done at the micro level for  
12                  one patient but it is done really at the macro  
13                  level.

14                 And I think the comment about the  
15                 trauma center, I think really applies in  
16                 palliative care as well. There is actually  
17                 very good data to demonstrate that the  
18                 presence of palliative care services do  
19                 improve quality and reduce costs. And in some  
20                 ways that is a structural measure that says  
21                 you can link these two in a particular way  
22                 that deals with both issues. We tend to think



1 of it as value more than efficiency. But  
2 there may be efficiency there and there may be  
3 efficiencies within structures of palliative  
4 care services, for example, of how to make  
5 even greater efficiency, greater value.

6 And then the other point about the  
7 perspective, I think, is really important  
8 here, as far as the services. And I think the  
9 point about what services are included is very  
10 important. We have patients at the end of  
11 life for whom staying in the hospital cost a  
12 family nothing. That is not the quality that  
13 they want. The quality they want is actually  
14 to be home. But what they need is they need  
15 a caregiver to be there to take care of their  
16 family member, which could cost a fraction of  
17 a day in a hospital or a skilled nursing  
18 facility but there is no one who pays for it.

19 And so if you look at the  
20 perspective of efficiency, it really changes.  
21 But if you look globally at the issue of cost  
22 to the system, you would much rather have

1     someone at home. And for lack of a \$15 an  
2     hour caregiver, somebody spends \$1200 a day in  
3     a hospital. And so, it would be easy to  
4     manipulate sort of where the money is being  
5     spent. And I would encourage us to think more  
6     globally about it because then it allows us to  
7     really think about what kind of services are  
8     being provided. And if we take a global view,  
9     we might in fact say that there is greater  
10    efficiency by providing caregivers at home,  
11    than there would be in keeping people at the  
12    hospital.

13                   CO-CHAIR FLAMM: Jack, thank you.

14                   DR. NEEDLEMAN: It has been an  
15    interesting hour and a fascinating  
16    conversation. As I reflect on it against the  
17    committee's charge, I have got share Greg's  
18    reaction that I don't envy Andy and Tim.

19                   But I think it is useful to  
20    reflect on the three different levels at which  
21    comments have been made and the implications  
22    for where the committee's work has to do. And

1     Andy and Tim as the agents of the committee in  
2     structuring our report, one of them is we  
3     continue to go back to the broad conceptual,  
4     fundamental issues of what are we talking  
5     about. What do we mean by efficiency? What  
6     do we mean by value? What counts? What  
7     doesn't count? And it is clear from the  
8     conversation that we have had in the last  
9     hour, we have not resolve those, nor does the  
10    paper fully provide the framework for at least  
11    reflecting on the differences we have and how  
12    to think about that. And that is one of the  
13    directions we have to go in and it is going to  
14    keep shaping the day.

15                 But if we just stay at the broad  
16    philosophical issues, we have got two other  
17    issues that we are never going to get to that  
18    are equally important. One of them is there  
19    are a series of fundamentally alternative  
20    different approaches to linking cost and  
21    quality. Greg said has anybody tried to do  
22    this, besides the simple univariate grid. And

1 the answer is yes. And we have got some  
2 examples in the paper and we have got more  
3 examples of other potential ways to do this.

4 And in terms of those broad  
5 approaches, we really need to think about what  
6 their relative performance is. Because at  
7 some point, somebody is going to bring into  
8 NQF -- well people are already using some of  
9 these approaches to actually make payment  
10 decisions. At some point, somebody is going  
11 to bring it into NQF to say would you endorse  
12 this. And we need to understand the  
13 differences in the performance of the  
14 different approaches, that comparative across  
15 them. And we need to think about how to do  
16 that. And that is another area, where, as I  
17 said, initially, I don't think the paper has  
18 gone far enough.

19 And the third is a whole series of  
20 specific technical issues. Do we use  
21 shrinkage? How strong a shrinkage variable do  
22 we use? Standardized products and

1       standardized costing, Jeff has raised a whole  
2       bunch of technical issues.

3               A whole series of technical issues  
4       in terms of evaluating these measures as well  
5       that we at least need to get laid out, even if  
6       we don't fully resolve the best approach in  
7       the context of this paper.

8               But those three areas, the broad  
9       conceptual, the choice among alternative,  
10      fundamental models of how to do the linkage  
11      and the specific technical issues in  
12      implementing those models all need to be part  
13      of this paper, all need to be part of the  
14      committee's discussion.

15              CO-CHAIR FLAMM: Thank you. Matt,  
16      you are the last comment.

17              DR. ROUSCULP: Hard to kind of  
18      follow up on Jack.

19              (Laughter.)

20              DR. ROUSCULP: So just to build  
21      upon what Jack had just said, because I think  
22      he really hit it. When Alan was kind of

1     reminiscing or talking about the potential for  
2     gaming that we will see, any of us who have  
3     kids, pets, or distant relatives, we know  
4     gaming exists from a personal level.

5                     What I really thought of value of  
6     this paper was the actual grid you had put out  
7     to say look, this whole notion of linking of  
8     cost and quality is already occurring. It is  
9     not as if we are trying to create something  
10    new. It is not as if we are trying to kind of  
11    be at the front edge of this area, it is  
12    occurring already within the healthcare  
13    system.

14                    And there is, I am sure, an  
15    immense amount of learning to be able to go in  
16    there to be able to say look, what are these  
17    measures. What are the lessons learned?  
18    Where are the directions going? What is the  
19    good and the bad of it.

20                    And I think in large part there is  
21    a whole lot of information perhaps that you  
22    are aware of but just because of the direction

1 or the length of the paper you just didn't  
2 have the ability to kind of go into all that  
3 detail.

4 I think there is a whole lot of  
5 value there and I would hope that you would  
6 really take that portion of the paper and  
7 really expand upon it. Because at least to  
8 me, I found that to be the most important  
9 area.

10 CO-CHAIR FLAMM: Great. Ashlie,  
11 if you want to close this up.

12 MS. WILBON: Yes, I just want to  
13 thank everyone for their comments. I think we  
14 have been feverishly taking notes and kind of  
15 having side conversations. I think there is  
16 definitely some things that we can help  
17 clarify in terms of some of the discussions  
18 around scope and where we are going and focus.  
19 We will try to do that when we come back after  
20 a break. And I do also think there are some  
21 things that come up that we are going to try  
22 to make some adjustments or some additions to

1 the discussion guide to make sure that we  
2 integrate some of their comments into the  
3 discussion as the two days go on.

4 So again, thank you for a really  
5 rich discussion. And we will break for --

6 CO-CHAIR DUBOW: Before we break.

7 MS. WILBON: Yes, sure. Sorry.

8 CO-CHAIR DUBOW: Well, I just  
9 wonder whether Andy or Chris has any --

10 MS. WILBON: Yes, thank you.

11 CO-CHAIR DUBOW: -- quick reaction  
12 to the assault.

13 MR. RECHARDT: No comment.

14 (Laughter.)

15 DR. RYAN: I just wanted to -- you  
16 know these comments were really outstanding  
17 and it is really an esteemed committee and it  
18 is truly an honor to be working with you guys.

19 And I think you know we apologize  
20 for the existing shortcomings of the paper.  
21 Obviously, we are not inside all your minds  
22 and we can't put everything -- you know



1 everyone has their own perspective and we  
2 can't address everything. And this is a  
3 really good opportunity for us to really find  
4 out what are these key things that are out of  
5 here and should be in.

6 And some of the points that I  
7 think we will come back to over the course of  
8 the day, this idea of the context mattering  
9 and the use case is really critical and I  
10 think our discussions with NQF over the last  
11 week about how to organize this meeting will  
12 really get at that and the relative pros and  
13 cons of these different approaches for  
14 different uses is one.

15 I think another issue that has  
16 surfaced, actually, in a conversation that  
17 Chris and I had over the last few days and  
18 come up today is this, to me, this idea of --  
19 and Joyce and I were talking about this this  
20 morning is how much should an efficiency  
21 measure be specified? To what extent should  
22 it be specified before you are making a value

1 judgment? So, we don't want to just do a data  
2 dump of cost and quality. We want to make  
3 sense of it in some way. But what is the  
4 right -- how far should we go towards  
5 classifying efficiency in weighting measures  
6 before we are getting to this issue of value.

7 And we don't want to because,  
8 according to the NQF definitions, value really  
9 depends on the eye of the beholder. And we  
10 don't want say this is value. We want to have  
11 that next step be judged by the user. But at  
12 the same time, we want to have the measures be  
13 meaningful. So, I think that is an important  
14 intention that needs to get worked out.

15 Then one other point I would like  
16 to make and I would love to hear Chris'  
17 comments is we don't have -- there has really  
18 been basically no attempt to develop a single  
19 measure. You put cost and quality together  
20 and say this is efficiency and this is an  
21 efficiency score. I think it would be  
22 important to say why haven't we done that and

1 is this completely doomed? Because really it  
2 was striking to us that really no one did it.  
3 And so, I think just kind of coming up with a  
4 list of reasons maybe good or not so good as  
5 to why this hasn't happened would be, I think,  
6 a nice contribution of the group.

7 DR. TOMPKINS: Well, I'm going to  
8 be brief standing between us and the time-  
9 limited break.

10 At the very beginning when I  
11 introduced myself I said I was looking forward  
12 to the next couple of days. But the reason  
13 why we are having a two-day meeting and not a  
14 two-hour meeting is because we are trying to  
15 work together on all of this.

16 And the paper, as such as it is,  
17 seems to have been useful to stimulate the  
18 conversation, which is to say how far we have  
19 gotten and where else do we need to go. And  
20 so therefore this meeting provides for all of  
21 us a nice time for a mid-course correction,  
22 regrouping around what we are really trying to

1 intend to do and what is the most meaningful  
2 statement that we can make to the field. And  
3 as we have breakout sessions and further  
4 discussions in the next day or so, I hope that  
5 we can all come together and give us another  
6 direction.

7 One of the things -- now I am  
8 going to regret not just stopping there.

9 (Laughter.)

10 DR. TOMPKINS: You know I see this  
11 endeavor sort of in three categories. One is  
12 to have cost and quality measures just sort of  
13 out there. And then most obvious easiest  
14 thing to do is side-by-side. You say you want  
15 to know cost, it is over here. You want to  
16 know quality, it is over there. If you want  
17 to put them together and it makes sense, go  
18 ahead. That is sort of the costs as cost.

19 And then at the other end of the  
20 extreme is the attempt to actually come up  
21 with a value measure but that is actually  
22 implicit in the minds of the person who is

1     doing the side-by-side in the first place.  
2     So, when you bake it into and call it a value  
3     measure, what you are doing is baking in that  
4     subjectivity. Now, like it or not, that is  
5     exactly what everybody does. So, the question  
6     is, is there a scientific rigor around that or  
7     is it really just a subjective process which  
8     is unbounded and is up to the discretion of  
9     the user?

10                 So, part of what the workers are  
11     trying to do is to decide to what extent is  
12     there a scientific framework was a word that  
13     was thrown around a lot, technical way to do  
14     it is another way to think about it.

15                 Now, in the middle is the orphan,  
16     as far as I can tell, this efficiency measure.  
17     I'm not sure if there really is a demand for  
18     it, although everybody talks about it.  
19     Because one thing is this downside of it  
20     talking about efficiency is we bring in  
21     economists who have 200 years working on this  
22     and they say -- 200 years and counting -- and

1     it means a lot in the technical discipline of  
2     economics. And almost by bringing that word  
3     in, we are bringing in a field of discipline  
4     that talks about production efficiency,  
5     technical efficiency, allocated efficiency and  
6     so forth. And somebody mentioned the RAND  
7     framework and that word has a lot of technical  
8     deep-rooted meaning. And I am not sure if  
9     there is a demand in this room or in the field  
10    to bring all that in, aside from the  
11    production part of it.

12                 But as soon as you know -- and  
13    this is my last thing -- we tried to stayed  
14    tethered sometimes. Now one of the things  
15    that tethered us, for better or for worse, in  
16    the first draft was to say that we wanted to  
17    build this out on some already established  
18    beliefs or definitions, hence, the hand wave  
19    and say this isn't about the economics, the  
20    technical efficiency and production. And  
21    rather to say the field has announced, in  
22    part, including NQF, that they have some

1 definition already existing about efficiency  
2 and another, somewhat distinct definition  
3 already existing about value, and what we are  
4 going to do is borrow from that and build on  
5 it.

6 Now, I guess so as we go through  
7 the deliberations we say, okay, is that too  
8 much, being too tethered? Meaning that those  
9 definitions that are sort of widely understood  
10 and believed, are those still useful to build  
11 on? If that is the case, then that sets aside  
12 some of the production efficiency and so on  
13 that comes from the field of economics.

14 Now, almost a break.

15 CO-CHAIR FLAMM: Those were  
16 fabulous comments. Thank you.

17 In the interest of our break in  
18 our schedule, we are going to start at five  
19 minutes of. So, we will take an 11-minute  
20 break. Okay? Thank you.

21 (Whereupon, the foregoing meeting  
22 went off the record at 10:41 a.m.

1                   and went back on the record at  
2                   10:55 a.m.)

3                   CO-CHAIR FLAMM: All right, I  
4                   think our next agenda item, we should go ahead  
5                   and get started because we still have a lot to  
6                   accomplish before lunch. We will be, in the  
7                   next section, focusing on efficiency  
8                   measurement approach considerations. And we  
9                   will have Karen Pace from the NQF actually  
10                  walk us through the efficiency measurement  
11                  approaches. So, Karen, let me turn it over to  
12                  you.

13                  MS. WILBON: Karen, do you mind if  
14                  I just do a really quick intro? Karen Pace is  
15                  our lead methodologist here at NQF and she has  
16                  really been the leader in our work around many  
17                  of the challenging methodological issues that  
18                  come forth, one of them being composite  
19                  measures. And actually Andy's parting comment  
20                  in his remarks at the end of our last session  
21                  is a great transition into this session, which  
22                  we are really trying to get an idea from this



1 group on whether or not a composite measure or  
2 single measure of efficiency, in terms of  
3 combining cost and quality measures into one  
4 measure with a single score is actually  
5 feasible. Is it something we should be  
6 striving for, recommending?

7 And so, in order to do that we  
8 wanted to give you guys a little bit of  
9 background on some of the work we have already  
10 done in composites on the quality side. We  
11 have brought together, convened groups of  
12 methodologists in the past to really think  
13 through this in terms of what the  
14 methodological issues are and considerations  
15 and, in particular, how NQF evaluates them and  
16 defines them.

17 So, that is the purpose of this  
18 discussion. And so we are going to allow  
19 Karen Pace to --

20 MR. AMIN: Ashlie, can you also --  
21 one other thing that we wanted to point out as  
22 part of this discussion is to consider how the

1 models that have been proposed in this draft  
2 report, how they can be considered, whether  
3 they could be considered composite measure  
4 approaches or how they are different. How  
5 they are similar or different than a composite  
6 measure. So, that is another area in addition  
7 to what Ashlie described as one of the things  
8 that we really want to get cleared before we  
9 move forward.

10 MS. WILBON: And I would just add  
11 some of that -- after this session, we are  
12 going to have Andy and Ryan do much more, a  
13 deep dive on the review of each of the models  
14 that they propose and kind of talk in a lot  
15 more detail about the environmental scan. We  
16 will break out into groups and some of that  
17 discussion around whether or not these  
18 approaches could be considered composites may  
19 actually come out in some of that discussion  
20 as well.

21 So, we have only got about 30  
22 minutes for this discussion, so we will see

1       where we get but I just wanted to put that on  
2       your radar. So, there will be other  
3       opportunities to have this discussion around  
4       the models and other parts of the agenda for  
5       today.

6                       DR. PACE: Good morning, everyone  
7       and thank you. I am going to basically go  
8       through the conceptual thinking of our  
9       Composite Measure Committee and where we  
10      landed in terms of defining composite  
11      performance measures and how we are looking at  
12      them for purposes of NQF endorsement. So,  
13      let's go ahead. Next slide. All right, next  
14      slide.

15                     So, you have already seen this in  
16      terms of our definition of a composite  
17      performance measure is basically pretty simple  
18      is that it is a combination of two or more  
19      component measures, each of which individually  
20      reflects quality of care into a single  
21      performance measure with a single score. So,  
22      I guess one of the things you will have to

1 kind of think about in your mind, as I go  
2 through this, that efficiency is a domain of  
3 quality, at least for a lot of our thinking.  
4 So, quality here is a broad concept of quality  
5 but we have primarily seen this in the typical  
6 process in outcome type of measures.

7           So, one of the things to just keep  
8 in mind that we have done some work earlier in  
9 2008 around composite performance measures but  
10 we really explicitly keep talking about a  
11 composite performance measure because, as many  
12 of you know, the term composite can be used  
13 for describing an instrument this multi-item  
14 instrument and we do not -- NQF does not  
15 endorse those and we don't consider that a  
16 performance measure in itself. So, we can  
17 have more discussions about that if you have  
18 questions but I just wanted to make that note.

19           The other thing, like many of  
20 these areas, different disciplines may use  
21 different terminology. So, some people refer  
22 to composites as indexes. Some refer to them

1 as scales. And I think in my quick read of  
2 the paper, I guess composites would be most  
3 aligned with the unconditional model. But we  
4 will go through this in terms of our thinking  
5 and you can see where you think it falls.

6 Okay, next slide. So, just in  
7 terms of thinking through this, the committee  
8 really spent some time on really thinking  
9 about what is a composite performance measure  
10 and really focused a lot on what is the  
11 quality construct and rationale, that you  
12 really have to have a good idea of what it is,  
13 how you are defining quality in order to  
14 really construct a composite performance  
15 measure.

16 So you have to have that overall  
17 quality construct. What are the components  
18 that form the composite? How are the  
19 different components going to be aggregated  
20 and weighted? And then, ultimately, the  
21 composite performance score. You come up with  
22 one score. Next slide.

1                   So again, the committee looked at  
2                   common approaches for constructing composites.  
3                   And this is where you really get into  
4                   different languages in terms of reflective  
5                   approach, formative approach, patients  
6                   receiving all necessary care, individual  
7                   patients not experiencing, for example,  
8                   adverse events or complications.

9                   And I am going to go through some  
10                  examples of these but one of the things,  
11                  again, that the committee decided and finally  
12                  came out in their recommendations for our  
13                  criterion guidance is not to get hung up on  
14                  these terminology but to really very clearly  
15                  explain what the quality construct is and what  
16                  is included, versus trying to use terminology  
17                  like reflective and formative. Next slide.

18                 So, basically, if you get into the  
19                 literature about composite construction, a  
20                 reflective composite is where the quality  
21                 construct is seen as causing are reflected in  
22                 the component measures. Sometimes these are

1 referred to as psychometric composites,  
2 scales, homogenous scales, dimensional. So,  
3 you have an idea of what quality is and it is  
4 actually reflected in the individual component  
5 measures. Next slide.

6               Versus formative is where the  
7 quality construct is seen as being caused or  
8 defined by the component measure scores. And  
9 some of the literature refers to these as  
10 clinimetrics indexes, heterogeneous index,  
11 categorical. But again, this is why we didn't  
12 want to get too hung up on the terminology  
13 because this sometimes becomes difficult to  
14 think about. Next slide.

15               So, basically, again, in terms of  
16 the criteria we want people to have a good  
17 concept of what their construct is and how the  
18 components that are being suggested as being  
19 included relate to that overall construct.  
20 But we really have defined, and I know you  
21 have seen these, that a composite can, first  
22 of all, be a combination of two or more

1 individual performance measures. And I am  
2 going to go through a couple of examples of  
3 some of these just to make it more clear.

4 So, for example, we have a CABG  
5 Composite Score This is a measure from the  
6 STS. And it is a Comprehensive Assessment of  
7 Adult Cardiac Surgery Quality of Care. And it  
8 actually has four domains made up from 11  
9 individual NQF-endorsed cardiac surgery  
10 metrics.

11 So, I am not going to go through  
12 all of these but the four domains, there is  
13 operative care, then there is perioperative  
14 medical care. Next slide. It includes the  
15 risk-adjusted post-op mortality and risk-  
16 adjusted operative mortality for CABG and then  
17 risk-adjusted post-op morbidity. And then  
18 there is a complex aggregation and weighting  
19 methodology.

20 But the point here is that this  
21 composite you end up with one score and it  
22 includes the four domains or dimensions and



1 each of those domains or dimensions may have  
2 one or more individual performance measures.

3 Next slide. This is another one  
4 -- yes?

5 DR. SILBER: Go back to the other  
6 one.

7 MS. WILBON: Use your microphone,  
8 please.

9 DR. SILBER: Was there a rationale  
10 for why the composite score should be made up  
11 of those elements weighted by the standard  
12 deviations?

13 DR. PACE: Yes. In the measure  
14 submission, they do provide that justification  
15 and the rationale. I won't get into that  
16 right now. I am just trying to kind of  
17 describe what we would see as a composite.  
18 But that is exactly what needs to be reviewed  
19 when they come into NQF. In addition to our  
20 usual criteria is that we want to look at this  
21 idea of what is the quality construct and what  
22 is included in the rational for that. And

1       then, under scientific acceptability, there is  
2       criterion for composites where you actually do  
3       empirical analysis to justify what was  
4       included in the composite.

5                       Next slide.   Yes?

6                       DR. MAC LEAN:   Just, Jeff, I know  
7       you were going with this on this concept of  
8       can you link the process to the outcome?   And  
9       we have somebody from the STS here and I can't  
10      recall but was this composite linked to an  
11      outcome?

12                      DR. SPEIR:   Well, all of those are  
13      outcomes.   I'm sorry, I don't totally  
14      understand what you are getting at.   But it  
15      does link.   And I think what I was hearing,  
16      his question, is that it takes the total  
17      process of care from the preoperative  
18      treatment to the intraoperative care, the  
19      post-operative perioperative morbidity and  
20      then the discharge medications and the HCAHPS  
21      scores.

22                      DR. PACE:   It actually combines

1 process and outcome measures.

2 DR. SPEIR: Yes, so it is all the  
3 above.

4 DR. PACE: Right.

5 DR. SPEIR: But whether it is  
6 applicable to other specialties, it would be  
7 no.

8 CO-CHAIR FLAMM: So, I think we  
9 could have a long conversation as an aside.  
10 But let's bring us back to, if you don't mind  
11 --

12 DR. PACE: Right. So, these are  
13 just to give you an idea of different  
14 composites and what NQF is viewing as a  
15 composite performance measures. This is  
16 another one that combines two or more  
17 individual measures. And this is mortality  
18 for selected conditions. It is an AHRQ  
19 measure and it has several individual  
20 condition-specific mortality measures that  
21 they combine into getting one score from the  
22 combination of these individual performance

1       measures.

2                   Okay, next slide. So, the other  
3 kinds of composite measures that we tend to  
4 see are composites that most people refer to  
5 as all or none, meaning that they are  
6 conceptualized as all the necessary care or  
7 components of care for a particular topic.

8                   So, all the components must be  
9 achieved, meaning that you look at these  
10 patient-by-patient and if the patient is  
11 missing one thing that they should have  
12 received, then they are not accredited in  
13 terms of receiving all the necessary care.

14                   There are other scoring  
15 methodologies where you get partial credit.  
16 The more things that an individual patient  
17 receives, of course, the more credit. So,  
18 again, there are different ways of scoring  
19 these, even when you have the concept that the  
20 composite includes all of the items of  
21 necessary care.

22                   Next slide. So, an example of an

1 all-or-none composite is the optimal diabetes  
2 care from Minnesota Community Measurement.  
3 And this includes -- this is really described  
4 as the percentage of adult diabetes patients  
5 who have optimally managed modifiable risk  
6 factors.

7                   So, these are really, this is  
8 really a combination of outcomes but it is  
9 looked at the individual patient level first.  
10 So, you are not measuring each of these  
11 individually in the provider's patient case  
12 mix. You are looking at each patient to see  
13 was the A1c less than eight, was the LDL less  
14 than 100, blood pressure less than 140/90, are  
15 they a tobacco non-user, and are they taking  
16 daily aspirin. And again, it is looked at  
17 each patient. If you are looking at the  
18 scoring methodology, if the patient has met  
19 all of these, they get a one. If they  
20 anything is missing, it is scored as a zero.  
21 Next slide.

22                   Okay, and then kind of on the

1 reverse side of that, often referred to as  
2 any-or-none, these are composites that reflect  
3 non-experience.

4 So, usually this is about  
5 experiencing healthcare-acquired adverse  
6 events or complications. Or it could be a  
7 measure of unnecessary or inappropriate care.  
8 Typically we see these as composite  
9 complication measures. Next slide.

10 So, an example of an any-or-none  
11 composite is complications within 30 days  
12 following cataract surgery. And you can see  
13 here the components are listed here, retain  
14 nuclear fragments, infection, dislocated or  
15 wrong power, retinal detachment, wound  
16 dehiscence.

17 So, basically, again, this is  
18 looked at at a patient level. If the patient  
19 experienced none of these, that is the  
20 requirement to meet the measure. If they  
21 experience one of these, then it would trigger  
22 the scoring was different. So, it is either

1 any of them, any complication at all or none  
2 is basically the scoring for this type of  
3 measure. Next slide.

4 So, I think I will just talk about  
5 a few things in terms of the committee's  
6 thinking about these measures and how we would  
7 look at these in terms of evaluation. Again,  
8 this is in the context that NQF endorses  
9 performance measures that are intended for use  
10 both in performance improvement and  
11 accountability applications.

12 And the construction and  
13 evaluation of composite performance measures  
14 should be based on sound measurement science  
15 and not necessarily constrained to adhere to  
16 a specific method or categorization, such as  
17 psychometric and clinimetric approaches.

18 The primary concern for  
19 endorsement is whether the composite  
20 performance measure is based on sound science,  
21 produces a reliable signal, and is a valid  
22 reflection of quality. So, then that is

1 consistent with our criteria for any measure.

2 Next slide.

3 And again, coming back to a  
4 coherent quality construct and rationale, that  
5 constructing a composite really relies on  
6 that. The TEP really didn't subscribe to the  
7 notion of there is a bunch of measures out  
8 there and I am just going to throw them all in  
9 the mix and come up with a computed score.  
10 They really wanted them -- it could be a very  
11 broad quality construct but there had to be  
12 some thinking and rationale, not just because  
13 there is a measure we can throw it together  
14 and come up with a score.

15 Okay, next slide. I will just --  
16 and I think the other thing that you saw is  
17 that we did delineate what types of measures  
18 will be and will not be considered composite  
19 performance measures for the purpose of NQF  
20 submission evaluation and endorsement. We  
21 need to keep in mind that this is a pragmatic  
22 listing and we realize that there are



1 different categorizations and terminology out  
2 in the literature and in different disciplines  
3 but we needed to come up with a list because  
4 we have certain additional criteria that these  
5 are going to be judged by and people need to  
6 know in advance what to do, what to submit to  
7 us, so that the committee can evaluate them.  
8 And this is something we will need to continue  
9 to reassess.

10               Next slide. So basically, we said  
11 that these will be considered composites and  
12 these relate to the examples I just showed  
13 you. Any measure with two or more individual  
14 performance measure scores combined into one  
15 score and then these all-or-none, or any-or-  
16 none measures, that we have classified these  
17 as composites and we expect them to be  
18 submitted with the information to evaluate the  
19 additional criteria.

20               Next slide. And these will not be  
21 considered composite performance measures for  
22 purposes of NQF. I don't know that we need to

1 get into these but these are things that we do  
2 see performance measures that come in. A  
3 single performance measure, even if the data  
4 are patient scores from a composite  
5 instrument. So, this is where we have had  
6 some confusion in the past and this group  
7 really clarified it.

8           So, for example, CAHPS surveys.  
9 You may have a performance measure about  
10 physician communication and it is based on a  
11 multi-item instrument and the whole CAHPS  
12 instrument has lots of items, different  
13 domains. But the performance measures are  
14 really one kind of domain or concept and it is  
15 just an individual performance measure. It,  
16 by itself, is not a composite.

17           Now if CMS and AHRQ ever decided  
18 to put all those domains into a composite,  
19 then that would be a different story. But  
20 that was one of the things we wanted to try to  
21 clear up.

22           And also, we have some of our

1 outcome measures where the risk adjustment  
2 methodology has what some people have called  
3 reliability adjustment, Bayes shrinkage  
4 estimation, et cetera, where you are combining  
5 information from the provider with information  
6 from the average. Some people have termed  
7 those composites and the committee said no,  
8 for purposes of NQF, those are not going to be  
9 considered composite performance measures.

10 Obviously, we accept those  
11 measures and we have a whole lot of criteria  
12 to look at, those measures and the risk-  
13 adjustment methodology.

14 But anyway, I will stop there and  
15 we can see if you have any questions that I  
16 can help clarify.

17 CO-CHAIR FLAMM: So, we have about  
18 ten minutes for committee discussion. And, in  
19 particular, we would like to focus discussion  
20 around the question in the discussion guide,  
21 which is: Is a single score composite measure  
22 of efficiency feasible?

1                   Okay, so that is kind of one of  
2                   the things if you can touch on that. I have  
3                   Larry.

4                   MR. BECKER: Thank you. So, it  
5                   appeared to me that slides 27 and 30 were  
6                   similar. So, if you go to 27, I think it was,  
7                   there were two conditions and you had a series  
8                   of -- go to 30. No, it was the one with the  
9                   retina. No, the cataract and the -- right.

10                  DR. PACE: Keep going.

11                  MR. BECKER: Keep going.

12                  MR. BECKER: No, no, go forward.

13                  DR. PACE: No, you have go to  
14                  forward. Sorry.

15                  That was it.

16                  MR. BECKER: So, that is something  
17                  I know about because over the last 12 months,  
18                  I have had two detachments. I have had oil  
19                  placed in my eye. I have had a vitrectomy.  
20                  I have had a cataract surgery and a YAG.

21                  And what is really important to me  
22                  is can I see. And I don't see that there.

1 DR. PACE: You know, and again,  
2 these are very abbreviated information but I  
3 assume something about maybe the wrong power.  
4 I'm not sure. But you are --

5 DR. BURSTIN: It is a separate  
6 measure.

7 DR. PACE: It is. Right, that is  
8 a separate measure.

9 MR. BECKER: But you are talking  
10 about putting together a composite measure.

11 DR. PACE: Right, but this is a  
12 composite about complications.

13 MR. BECKER: Okay.

14 DR. PACE: And that gets, again,  
15 what is the quality construct that is being  
16 viewed for this composite? So, they started  
17 with the idea they wanted a composite of  
18 complications. And as Helen said, there is  
19 already a performance measure, which most  
20 people are most interested in the vision that  
21 they receive.

22 And I think that also points out

1 kind of one of the down sides of composites.  
 2 So, say you put that in here. The question  
 3 is, if that is what is most important to you,  
 4 wouldn't you like to see that separately,  
 5 rather than as part within a composite.

6 But again, these are the things  
 7 that are debatable and why you have to really  
 8 start out with a strong quality construct and  
 9 rationale of what you are trying to accomplish  
 10 with the composite and think those things  
 11 through. Good points.

12 CO-CHAIR FLAMM: Steven.

13 DR. ASCH: I have a question and a  
 14 comment, if that is okay. So, the question  
 15 is: Are any of the other composite measures  
 16 that you came across ratios rather than  
 17 essentially sums, which is what these are or  
 18 conditions?

19 DR. PACE: I don't think so.

20 DR. ASCH: Other than the  
 21 efficiency measures, which we are going to  
 22 consider today. Because I think the math

1 matters there.

2                   So, then my comment, which is  
3 unrelated, has to do with the thing you told  
4 us not to talk about, which is reflective  
5 informative measures. Because I really  
6 believe that it seems like a technical point  
7 but it is a really important point because it  
8 has enormous implications for the way people  
9 actually use the measures.

10                   Without going into my limited  
11 understanding of the distinction between the  
12 two, either you view them as you are measuring  
13 -- everything that is in the measure is in the  
14 composite or it is supposed to reflect  
15 something broader. It is an indicator of  
16 something beyond what it is actually  
17 measuring. And that indicator of something  
18 that is a broader concept is the way I believe  
19 most people interpret quality indicators. And  
20 if we don't take that into account in  
21 efficiency measures, then I think we are going  
22 to end up constructing measures that are

1       either too narrow or are pointing the system  
2       in the wrong direction.

3                   DR. PACE:   And I guess what ended  
4       up happening with the committee, because they  
5       kept talking about not worrying about the  
6       technical terms, but when it comes down to how  
7       you even do your analysis, it depends on how  
8       you view that, those components, whether they  
9       are reflective of or the reflective or  
10      formative model.   Because one is based a lot  
11      on correlation analyses, which may not  
12      necessarily translate to the other.

13                   So, again, you have to have a good  
14      idea of what that construct is and how those  
15      components relate to it.

16                   CO-CHAIR FLAMM:   Timothy.

17                   DR. LOWE:   I think what you are  
18      trying to do is great.   And I should have  
19      started out before saying you guys did a great  
20      job.   Thank you.   I'm sorry I didn't say that  
21      before.

22                   I see quality as a multi-national



1     construct. So, the question is can you create  
2     an index score, one number that will give you  
3     some meaning, in terms of we want to compare  
4     people. It raises some problems, though, and  
5     that is, if you want to have different  
6     subscales under that, each of these have their  
7     own demands unto themselves and each can be  
8     measured in a different way.

9             So, if we want to do this, I think  
10    it is feasible but you have to find a way that  
11    all of those demands can be measured on a  
12    similar scale. Now, I know people have used  
13    the -- I think you used the coefficient of  
14    variation. I saw the mean over the group  
15    standard deviation. So, I mean that is one  
16    way of solving that. But I do think people  
17    want to know because it is, going back to  
18    people's value, if I am having eye surgery, I  
19    am definitely going to want to know,  
20    especially if I am having cataract surgery,  
21    but if I am having my gall bladder, I am not  
22    particularly interested in -- I wouldn't see

1 an ophthalmologist anyway for that, hopefully  
2 not. Unless, I guess if it was really  
3 emergent, something on a highway maybe. But  
4 people's interest in this.

5 But I do think there have to be,  
6 if we are going to create one scale, maybe we  
7 can't do it. And I think you were saying  
8 probably not. I won't speak for you. But if  
9 we are going to have one number, then it is  
10 going to be very complex. Now, just coming at  
11 it from a statistical standpoint, it is very  
12 difficult to do this and I am not telling you  
13 anything you don't know. It is challenging  
14 but if you want to do that, which demands do  
15 we pick? And then how do we measure it in a  
16 way which we can combine? And if we can do  
17 that, then the answer to the question is yes.  
18 If we can't do that, then the answer is we  
19 have to find another way to display that  
20 information.

21 So, I am trying to answer your  
22 question the best I can but it is not

1 particularly an easy question to answer.

2 CO-CHAIR FLAMM: Okay, we have a  
3 number of people who want to speak. So, I am  
4 going to go to Peter.

5 DR. ALMENOFF: So, just from an  
6 operational perspective, we actually do build  
7 an efficiency model for 150 hospitals within  
8 our system and we actually have stars, which  
9 really make people extremely happy. I am  
10 saying that sarcastically. And it is a single  
11 score. But what we then do is we build sub-  
12 models. So, to just build a single score and  
13 have no action to it, is very problematic.  
14 The idea is if you are going to build a single  
15 composite, you really have to have sub-models.  
16 So, we have 14 sub-models to allow the  
17 different sites to strategically target what  
18 they are interested in focusing on.

19 So, if within our big efficiency  
20 model pharmacy, buying care outside, lots of  
21 different things that we look at, they can  
22 basically, through a menu, be able to select

1     what areas they want to focus on. And they  
2     are all risk-adjusted against everyone else.  
3     And the other critical thing is that you have  
4     got adjust across the country and that is  
5     something we do with our variables that we do  
6     make about 13 adjustments across the system to  
7     make everything sort of even.

8                 So, the answer is yes, you can  
9     have a single but you can't just have that  
10    alone. There has got to be something with it  
11    that is actionable or else it is meaningless.  
12    And you know, I have heard that from,  
13    unfortunately, 300,000 people when we built  
14    the original model, tried to explain we are  
15    going to build sub-models and first we had to  
16    build the macro. And so part of it is also  
17    translating some of that to the public. They  
18    don't always sort of understand what we are  
19    trying to do and they sort of fix on one issue  
20    and not the overall scheme.

21                CO-CHAIR FLAMM: Yes. Okay, I  
22    have about six or seven people that are

1 already with cards up and that is the group  
2 that we are going to go through.

3 Alan?

4 DR. SPEIR: Thank you. I would  
5 like to echo the previous comments. And I  
6 would submit that while the presentation you  
7 gave is intellectually feasible, it is,  
8 practically, unrealistic. To have an all-or-  
9 none type of methodology is profoundly  
10 limiting and I think that it would open up  
11 that composite score to really be worthless.

12 Thank you.

13 CO-CHAIR FLAMM: Joseph.

14 MR. STEPHANSKY: When we were  
15 looking at the composite models, the thing  
16 that stands out is the weights to me. And I  
17 will bring this up again later in the meeting,  
18 I am very willing to have the cardiac surgeons  
19 and the interventionalists work together  
20 coming up with a set of weights to apply to  
21 the cardiac measure.

22 And over here when we are talking

1     about a hospital system, we have people within  
2     the system, the administration, at least,  
3     assigning those weights.

4                     But once we move out of there, I  
5     think we are going to have some very difficult  
6     times trying to come up with any kind of  
7     objective way to come up with the weights.

8                     So, I am starting right out as a  
9     dismal scientist, being very pessimistic, and  
10    saying no, we probably come up with these  
11    measures. We shall see.

12                    CO-CHAIR FLAMM: Jack.

13                    DR. NEEDLEMAN: I'm going to go  
14    back to the fact that we see measures in use.  
15    And I want to relate what we are seeing in use  
16    to this issue of composites.

17                    So, we have seen in the CMS  
18    payment system, basically we divvy up the  
19    hospitals low, medium, high, in terms of cost,  
20    by some standardized measure of cost. We  
21    divvy up the hospitals low, medium, high, on  
22    some outcome like risk-adjusted mortality and

1 we sort of do a scatter plot. And when we  
2 have done these scatter plots, I have got some  
3 Ph.D. students who are busy working on  
4 surgical quality, so they are developing  
5 composite measures of complication rates among  
6 the surgeons and the hospital. The same sort  
7 of thing, low, medium, high; high, medium, low  
8 cost.

9                   When you do that, what we usually  
10 see is a pretty smooth distribution across  
11 that chart. All nine of those cells are  
12 filled. And when we see that, we go to the  
13 upper left cell, low cost/high performance and  
14 we say congratulations, these are the winners.  
15 And we can get more for less, which is roughly  
16 the way CMS is doing the value-based payment.

17                   Now, I can take those two scales  
18 and I can create some kind of weighting that  
19 basically tells me who is in that upper left  
20 cell. And in that case, I have just created  
21 a composite by combining the two scales. So,  
22 in some sense, I know I could do that. The

1 question is whether I get it.

2 So as I said that scatter plot is  
3 relatively smooth and I say there are clearly  
4 cases where I can get more for less. The knee  
5 in California. Right? We are fine.

6 What happens, one of the issues we  
7 have to deal with, the line items of that  
8 upper left cell is empty. The only way to get  
9 more is to pay more. We get more for more,  
10 less for less. And there, we need a different  
11 metric. And we have got examples of that in  
12 the cost manifest literature, which are  
13 ratios, answering Steve's question, where we  
14 got dollars for quality. And we can  
15 substitute quality for some other risk-  
16 adjusted scale for how much gain we are  
17 getting from the given service. And we could  
18 figure out how much more we have to pay to get  
19 those additional gains.

20 So again, yes, we can construct  
21 those measures in principle. We have done it.  
22 The question is, is this where we want to go



1 to help patients understand where their best  
2 choices are or to help payers think about how  
3 to pay to get value for the patients that they  
4 are paying for. And those, I think, are the  
5 open questions.

6 So, in theory, we can do this. Is  
7 it not clear that this is the right way to do  
8 it.

9 CO-CHAIR FLAMM: Because of the  
10 timing of this and our next discussion, I am  
11 going to -- Cathy, do you want to see? I was  
12 going to say Cathy and Dennis and did have --  
13 okay.

14 DR. MAC LEAN: It is basically it  
15 is mathematically possible, but is it  
16 something you want?

17 CO-CHAIR FLAMM: Okay. Any other  
18 significant comments that you want to go ahead  
19 and add, Jeremiah?

20 DR. SCHUUR: Just sort of briefly.  
21 A comment would be that a cost quality  
22 composite, to me, doesn't necessarily create

1     an efficiency measure. We can have cost  
2     quality composite but we shouldn't label those  
3     all efficiency measures. And I think that is  
4     one of the things that is being done because  
5     we don't want to discuss cost in this country.  
6     So, it is more politically acceptable to  
7     discuss efficiency. That doesn't mean that we  
8     shouldn't aim to improve efficiency but a cost  
9     quality composite does not necessarily equal  
10    efficiency.

11                   CO-CHAIR FLAMM: Herbert.

12                   DR. WONG: I'll just take a minute  
13     to just emphasize the point that most folks  
14     have kind of recognized during this  
15     discussion, and that is that from a technical  
16     point of view, it is in fact feasible to  
17     create the composite measure of some sort.  
18     And I think the real issue here is the end  
19     user and whether or not it is beneficial for  
20     them.

21                   So, let me give you an analogy  
22     because I just want through that, and it is my

1 daughter choosing a college and she made a  
2 decision last night. But you go through the  
3 normal process. You know the cost. It is  
4 tuition, room and board, et cetera. And then  
5 you have dimensions of quality. It is the  
6 prestige of the school. It is the acceptance  
7 rate. It is the return rate for the first  
8 year class and things of that nature. Many  
9 different dimensions. And she had a little  
10 spreadsheet that she looked at all of them.

11 Now, one could have came up with a  
12 composite measure of some metric quality  
13 divided by the known cost. But in the end, it  
14 was just this balancing act. Here is the  
15 trade-off. This has a good social environment  
16 but the academics is better here.

17 So, the question is really how  
18 useful is the composite measure to whoever the  
19 audience is.

20 CO-CHAIR FLAMM: Thank you.

21 Sorry, I -- okay.

22 DR. WOZNIAK: That goes back to

1 NQF's sort of criteria generally around  
2 measures. So, other than usefulness, there is  
3 always reliability and feasibility.

4 And in terms of the composite, if  
5 I recall the framework, each of the individual  
6 components needs to be reliable and show that  
7 they make those sort of requirements.

8 Correct?

9 DR. PACE: Actually, that is one  
10 of the things that changed in this latest  
11 guidance, where the focus is really on the  
12 reliability and validity of the composite  
13 score.

14 So, we don't require that the  
15 individual components individually meet the  
16 criteria or that they be individually  
17 endorsed. And I didn't want to get into all  
18 the specifics of the criteria, but ultimately  
19 what the last committee and the current  
20 guidance is, if you are creating this  
21 composite, it is going to be used as a  
22 composite. And that is where we need to see

1 the reliability and validity.

2 DR. WOZNIAK: I'm a little bit  
3 behind that NQF framework.

4 But the bottom line is the  
5 composite needs to be reliable and reliable to  
6 whom. So, it is really a combination of the  
7 use, the user, and the reliability.

8 CO-CHAIR FLAMM: Okay, so now we  
9 are going to shift gears and move into the  
10 next section on implications for efficiency  
11 measurement, as they translate into public and  
12 private programs, the MAP. So, Ashlie.

13 MS. WILBON: Thanks, everyone. I  
14 think one of the reasons we wanted to kind of  
15 keep the discussion going, I think we got a  
16 pretty good consensus from that last  
17 discussion on where that composite idea is  
18 going. So, but we wanted to make sure we had  
19 enough time to really talk about the next  
20 issue, which I think came up a lot in the  
21 first hour, kind of general discussion about  
22 the paper around audience and use cases.

1                   So, a lot of the models that were  
2                   found in the environmental scan were used for  
3                   various purposes, depending on who the entity  
4                   was that was identified in the table. We  
5                   really wanted to kind of have this discussion  
6                   with the group. We have identified kind of  
7                   four use cases, if you will: quality  
8                   improvement, public reporting, network design  
9                   and tiering and pay for performance. And  
10                  within those use cases, we wanted to have a  
11                  discussion around what might kind of broadly  
12                  -- again, we are going to have a more detailed  
13                  discussion in terms of the application of the  
14                  different models within the context of these  
15                  different use cases in the breakout groups but  
16                  before we got there, kind of wanted to have a  
17                  discussion with the panel about broadly, what  
18                  are considerations for measuring efficiency  
19                  within these different applications or  
20                  different use cases. And some of the examples  
21                  that we list in the discussion guide on page  
22                  four were some of the things that you guys

1 have already brought up, which is around  
2 audience, interpretability, and potentially  
3 the extent of scientific rigor.

4 So, I will leave it there and,  
5 hopefully -- I don't know if Taroon has  
6 anything to add. Okay, so we will open it for  
7 discussion and I will respond to any  
8 questions, if anyone has any.

9 MR. ROMM: So, and I think this is  
10 a perfect bridge of the last conversation to  
11 this. So, to Jack's comments and Jay's  
12 comments in the last conversation about the  
13 feasibility and then translating that to use  
14 cases.

15 We do this in Massachusetts and I  
16 currently create scatter plots of a variety of  
17 factors. So, a quote unquote composite of TME  
18 or of hospital operating efficiency. We wage  
19 index adjust it. We case mix adjust it. And  
20 we pivot it against things like readmissions,  
21 mortality, hospital process measures, a  
22 variety of other things.

1                   And we use it for three of these  
2                   four purposes. We use it for quality  
3                   improvement in an investment program that I  
4                   run. We use it for public reporting in our  
5                   cost trends work. And we use it for pay for  
6                   performance in that program as well.

7                   The dial is almost immoveable.  
8                   And so I think that one of the challenges that  
9                   we find from -- immoveable. It is really  
10                  challenging because the variation across  
11                  providers on quality is so slim and the  
12                  variation across providers on cost is almost  
13                  entirely driven by price differential. And  
14                  so, if you normalize prices, you don't see  
15                  that variation.

16                 And so I think that there is a  
17                 sensitivity question here around those uses  
18                 cases. While we have great interest but not  
19                 -- when you go down the path of normalizing,  
20                 any variation normalizes away and then  
21                 providers just don't believe it. And so use  
22                 for any of those three use cases, to date, has



1       been largely impractical, although we are  
2       trying.

3                   CO-CHAIR FLAMM: Gary.

4                   DR. YOUNG: Actually that was  
5       primary point, which is discrimination. And  
6       usually very often with measures, I find a lot  
7       of the quality measures that we have available  
8       probably do a pretty good job discriminating  
9       at the high end and low end. Then when you  
10      get into the middle, the information is not  
11      particularly helpful. And so, I think that is  
12      a very important consideration to what extent  
13      can these measures actually discriminate among  
14      providers. And again, not just on the high  
15      end or the low end but, as you get closer to  
16      the middle of the distribution.

17                  CO-CHAIR FLAMM: Jeff.

18                  DR. SILBER: I am kind of  
19      surprised to hear that after you did your  
20      adjustments you got no variation. We just --  
21      there is a paper that we have just published  
22      looking at general surgery and orthopedics

1 across the country. A huge variation in  
2 outcomes and huge variation in payments for  
3 Medicare and costs. So, I am just -- I mean  
4 so that there are hospitals in all of those  
5 quadrants and huge differences. I am just  
6 surprised that you didn't see anything.

7 So, I am wondering if you, in some  
8 sense, by standardizing the prices you took  
9 away from any differences. But then I am  
10 surprised that you didn't get any difference  
11 in outcomes either.

12 MR. ROMM: So, just to respond to  
13 that, I think the balance is that the  
14 challenge that we face is that unless you  
15 overfit. I agree. I think that is the  
16 challenge that we face. We are overfitting  
17 everything. But unless you overfit -- yes,  
18 over-adjusting everything. And unless we do  
19 that, though, providers don't feel that it is  
20 appropriately applicable. And so that is the  
21 tension that we face.

22 And so, comparing a 73 percent

1 Medicaid mix hospital to a 2 percent Medicaid  
2 mix hospital, unless I adjust that, it is just  
3 not meaningful. But when I adjust it, the  
4 variation generally goes away.

5 So, we see substantial variation  
6 in cost. But that cost, when you normalize  
7 out the prices to utilization goes away. And  
8 so again, back to the sort of price disparity  
9 issues that we face in our market, that is a  
10 big driver.

11 CO-CHAIR FLAMM: Yes, Steven.

12 DR. ASCH: So, I would like to  
13 point out as probably many of us are thinking,  
14 the interim section between our last  
15 conversation and --

16 MS. WILBON: Can you come a little  
17 closer to your mike?

18 DR. ASCH: Sorry. I was getting a  
19 little too relaxed there, leaning back.

20 I would like to point out the  
21 intersection between, as many of us are  
22 thinking, between the last conversation and

1     this one, which is how do you aggregate  
2     measures. What is a composite measure? And  
3     what do you use it for?

4                 So, one of the big knocks, as I  
5     think Peter was trying to point out on  
6     composite measures, is that as they get more  
7     and more composite, meaning more and more  
8     comprehensive in some sense, they get less and  
9     less actionable. People don't know what to do  
10    with them. But it depends on who those people  
11    are. And that is what these four use cases  
12    are pointing out.

13                So, it might be in quality  
14    improvement that the amount of composite  
15    measures that we have put into the numerator  
16    of an efficiency, well, the quality portion I  
17    should say of the efficiency measure would be  
18    smaller. Because in quality improvement, you  
19    want to narrow down and figure out what is it  
20    you are going to do fix cardiac surgery. What  
21    aspects of cardiac surgery are you going to  
22    fix?

1                   For public reporting, as I think  
2           Joyce implied earlier, maybe I misinterpreted  
3           her comment, what do patients want? They want  
4           to know is it a good health plan. Right? And  
5           so you want bigger composites. And the  
6           numerator and the denominator have to match.  
7           So you have to have costs of the health plan  
8           and then some overall aggregate quality for a  
9           health plan, something that we all have  
10          reservations about but that is what patients  
11          would want.

12                   And I can make the same arguments  
13          for the other two use cases at varying levels.  
14          So, I think it is important in this paper, as  
15          the paper already begins to do that, I  
16          believe, to make sure that if we are talking  
17          about composition, we are not just talking  
18          about the composition of cost and quality, so  
19          the ratio, but we are also talking about the  
20          scope of, meaning the composition of both the  
21          numerator and the denominator, making sure  
22          they match.

1 CO-CHAIR FLAMM: Andy, you wanted  
2 to comment?

3 DR. RYAN: Thanks, Carole. So, I  
4 had two comments; one about the issue of  
5 discrimination. And when we did the  
6 environmental scan, I think that, particularly  
7 on the private payers, there was the same  
8 concern, even if it wasn't stated explicitly,  
9 that Gary raised that on the margin, these  
10 measures might not really discriminate very  
11 well with providers but maybe it can say these  
12 are better. In other words, this is the group  
13 we want to note for distinction and say these  
14 are the best. These ones we think are not as  
15 good.

16 And so, I think that was kind of a  
17 concession in how kind of the tiering is done  
18 with a lot of these in practice and how  
19 distinction is kind of noted that maybe that  
20 broad groups can be identified but incremental  
21 differences in these measures probably don't  
22 mean that much. And I think that concern is,

1 in some ways, reflected in how the measures  
2 are actually being used in the private side.

3 I wanted to also comment on  
4 something that Herb said about his daughter  
5 making the decision for colleges. And you  
6 know it is a very interesting case study to  
7 me. So, she looked at these factors and said  
8 I come up with an answer I think this is best.  
9 But did she make the decision that is going to  
10 optimize her happiness? Because now we know  
11 from all like the behavioral economic stuff  
12 that people make decisions that are  
13 systematically wrong. And there is probably  
14 --

15 (Laughter.)

16 DR. RYAN: If she had just chosen,  
17 if her simple metric was distance to the  
18 closest beach that probably would have worked.

19 And so there is a similar analogy  
20 with how we are doing this in healthcare.  
21 Because you know patients could look at a  
22 series of measures and say I think this one is

1 the one that matters to me and matters for my  
2 outcomes. But that might not actually be  
3 right.

4 So again, it is a question of how  
5 we want to think about that kind of  
6 architecture of choice that might be, I think,  
7 a contribution that this group could make.

8 CO-CHAIR FLAMM: Good points.  
9 Timothy.

10 DR. LOWE: I think Iyah hit the  
11 nail on the head. And that is, a lot of what  
12 drives this is buy-in. The frustration that  
13 I have for developing measures is that I  
14 decide to do measures and my primary focus is  
15 what is most clinically meaningful. What  
16 areas can we say that a clinician can actually  
17 make a difference in? When I think apply that  
18 to data analysis, I find that it discriminates  
19 very poorly between them.

20 If I come at it from a data mining  
21 perspective, I can find things that  
22 discriminate very well between providers but



1     aren't particularly clinically meaningful.  
2     Even if I am able to come up with some of  
3     them, as soon as I send that out to our  
4     members, I get the have you risk-adjusted  
5     these.

6                 So, when you risk-adjust them,  
7     then sometimes the differences become very  
8     small. You find out the same thing. It  
9     depends on how you risk-adjust and whether we  
10    are over-fitting our models because some  
11    things we just don't know.

12                So, the question is, for me,  
13    always, what is going to motivate people to  
14    change their behavior. And that changes then  
15    how we approach the measurement process.  
16    These may be great measures but if these don't  
17    result in the changing of provider behavior to  
18    make it better for patients, then why are we  
19    measuring those things? Why do I spend my  
20    time doing this if I am going to get  
21    questioned or people are going to be  
22    suspicious that does this really work or is

1       this really fair? It has to be fair and it  
2       has to be workable.

3                   CO-CHAIR FLAMM: Okay, just to put  
4       a little context on this part of the  
5       discussion, we will take these comments for  
6       those who have cards up right now but then we  
7       are going to shift into another part of this  
8       discussion.

9                   So, I have Dennis next.

10                  DR. SCANLON: So, I think the way  
11       this is organized up here for these four  
12       different purposes but I actually would  
13       suggest that these are very much related and  
14       there might be some utility in thinking about  
15       how they are related from the perspective of  
16       those that might implement these types of  
17       things.

18                  So, take quality improvement, for  
19       example. I may provide high quality very  
20       efficiently. I may produce high quality very  
21       efficiently as a provider and may not need to  
22       sort of engage in efficiency-based quality

1 improvement if my market share is something I  
2 can maintain and if there are market forces  
3 that doesn't cause me to sort of address the  
4 efficiency issue. So, that sort of  
5 illustrates how sort of the reason why I might  
6 want to engage in efficiency-based quality  
7 improvement is largely due to some of these  
8 other things, like payment reform, which maybe  
9 we will call pay for performance, or public  
10 reporting, where someone has a stake in the  
11 game financially that sort of forces me to do  
12 so.

13 So, I think that it is useful for  
14 thinking about these as separate but I do  
15 believe that they are interrelated and nested.  
16 And again, conceptually, there might be some  
17 value in really thinking about how these  
18 things relate to each other.

19 And ultimately, I would suspect, I  
20 am not sure that I am correct here, that at  
21 end of the day, and this gets back to sort of  
22 the definitions that we have been talking

1     about, really what might be the kind of common  
2     element here is value. What this sort of  
3     converges to is a situation where society,  
4     individuals, employers, whoever, want to sort  
5     of get the appropriate level or the best level  
6     of quality for the minimum amount of  
7     expenditure.

8                     Now, providers might not have an  
9     interest in sort of making that happen, unless  
10    the market forces sort of encourage them to do  
11    so. And consumers may not have the tools to  
12    sort of help them make that happen.

13                    So, I think there is some utility  
14    in thinking about these separately but they  
15    are related. But I guess at the need of the  
16    day, in my mind, is value kind of this  
17    overarching thing that really is the reason  
18    for talking about efficiency.

19                    So, should the question be what  
20    are the considerations for measuring value and  
21    efficiency as kind of being a component of  
22    that? And sort of what folks might do with

1       this is all around sort of the framework of  
2       trying to get at value.

3                   CO-CHAIR FLAMM:   Okay, Larry.

4                   MR. BECKER:   Thank you.   So, I  
5       agree with Tim.   And I think these are signals  
6       for providers to make changes and for  
7       consumers or patients to make choices.   And I  
8       am really troubled by the notion that there is  
9       one right, that one of these measures embedded  
10      in it, if you have a single measure, is  
11      somebody else's point of view.

12                   And that what I think this is  
13      about is a series of choices across a series  
14      of dimensions that the biggest computer in the  
15      world couldn't solve for.   And so, each  
16      person, given their circumstance, their  
17      genetics, their family history, wherever they  
18      are in life, makes a series of choices.   And  
19      for us to try to get it into a single measure,  
20      I'm sorry, I think it is chasing a unicorn.

21                   CO-CHAIR FLAMM:   Iyah.

22                   MR. ROMM:   I guess I somewhat

1     agree and I also think though that, especially  
2     for those who are represented around the  
3     table, that part of where we really need to  
4     understand where we are going, especially with  
5     the third use case, because I think tiering,  
6     in some ways, is the greatest opportunity  
7     here, to figure out what the underlying use  
8     cases even of tiering are.

9             Because what we are finding in  
10    Massachusetts, specifically, is that largely  
11    quality is being pushed aside in tiering and  
12    tiering is happening almost entirely based  
13    upon TME. And in fact in many cases, folks  
14    have noted that that is a conscious choice.  
15    So, we are undergoing an interesting  
16    conversation right now, trying to decide if we  
17    are going to standardize quality measures  
18    across plans for tiering. And uniformly, the  
19    answer is no, both from the providers and from  
20    the plans, which is very interesting.

21             And so I think that back to this  
22    question of is chasing uniformity a unicorn,

1 I don't think it is. I think we all want some  
2 standardization. And frankly, I think that  
3 for a consumer to understand what that means  
4 is essential. We have to have uniformity.

5 But I think that the idea that we  
6 are going to boil that into a single measure  
7 or a single set of measures I tend to agree  
8 with Larry. I just don't think that is what  
9 the future holds.

10 DR. BURSTIN: Well, why don't they  
11 want it?

12 MR. ROMM: Because I don't think  
13 that most consumers, from my perspective, are  
14 looking at cost and quality as being the same  
15 thing. I think they are looking at as being  
16 pivots of a given experience. And so, rolling  
17 it up into one, I think it is an  
18 individualized variation. So, I think that  
19 part of the challenge is that if we look at  
20 this, this definition of sort of self-  
21 determination of what value means, you can't  
22 say for low SES versus high SES consumers it

1 is one thing. I think it is an individualized  
2 choice.

3 DR. BURSTIN: I think you said  
4 that the plans and the providers didn't want  
5 uniformity.

6 MR. ROMM: I'm sorry. They do not  
7 want uniformity because it is a market game.  
8 So, back to the comment earlier, everybody  
9 wants to be able to be able to build their  
10 incentives in their own way and they don't  
11 want to treat providers the same way. And so  
12 the interesting thing is that providers don't  
13 want uniformity either. The plans, I get it  
14 but the providers don't either.

15 PARTICIPANT: To avoid black box,  
16 you make choices.

17 MR. ROMM: Because it is still all  
18 a negotiation, right? I mean even underlying  
19 tiering, it is still a negotiation.

20 CO-CHAIR FLAMM: So, this  
21 conversation is clearly getting on a roll,  
22 which is a very good thing for the breakout



1 groups. So, largely, we are going to continue  
2 this discussion in the break out groups. I  
3 think, Alan, you had one last comment and then  
4 we are going to move into the section about  
5 the MAP discussion.

6 DR. SPEIR: I want to discuss  
7 examples of what we are talking about about  
8 behavioral change, about both physicians,  
9 patients, and insurers. In the original  
10 Medicare demonstration programs in the last of  
11 the '90s that were tasked with quality and  
12 reducing costs, only one of the hospitals  
13 actually was able to achieve that. That was  
14 Saint Joe's in Atlanta. And it was directly  
15 tied into incentives to the surgeons  
16 themselves.

17 So, unless the physicians were  
18 incentivized, then they weren't going to  
19 change their behavior. And this has the  
20 practical implication now because over 80  
21 percent of physicians are now employed by  
22 their healthcare system. And if you look in

1 Virginia at the 12 practices in 18 hospitals,  
2 their entire reimbursement is predicated on  
3 RVUs, volumes and they are not tied at all to  
4 achievement of any quality measures, which I  
5 think is a difficult subject.

6 Secondly, in terms of motivating  
7 patients, it has been my experience and those  
8 of my colleagues that patients view their  
9 hospitals in their locale as providing  
10 excellent care. And getting them to move from  
11 one locale to 12 miles away to a nationally-  
12 based hospital with excellent outcomes doesn't  
13 happen. You would think that it does but I  
14 think that is an opportunity for groups like  
15 this to really focus on efficiency and what  
16 outcomes really mean.

17 And that goes to the third point  
18 around insurers is that there was an  
19 extraordinary amount of effort in the last 12  
20 years around Centers of Excellence. But yet  
21 while those designations were made,  
22 particularly around cardiac surgery, the

1 patients were never challenged. They were  
2 never given the directive that they would pay  
3 lower deductibles to move from one center to  
4 another around outcomes. So, what difference  
5 did it make to make those designations?

6 But I think that the more focus we  
7 have here on efficiency, on outcomes, is a  
8 huge window for education for all of us.

9 CO-CHAIR FLAMM: Yes, and the  
10 trend towards increasing those incentives and  
11 benefit designs is something that has been  
12 picking at more recently but early on for  
13 certain.

14 Okay, do you have a question,  
15 Dennis?

16 DR. SCANLON: Yes, it is just a  
17 question. I guess I am wondering why  
18 regulation isn't up here. And is that sort of  
19 implicitly subsumed in one of these other  
20 categories? Because I think a lot of -- you  
21 know some of the discussion here is around  
22 these trade-offs and, presumably, regulators

1 in terms of establishing minimum quality  
2 thresholds, making sure that the cost  
3 dimension doesn't sort of go too far down the  
4 track for populations that are being covered.

5 So, I guess a question is whether  
6 uses for regulation is something that should  
7 be thought of separately or whether that is  
8 subsumed I any one of these categories.

9 CO-CHAIR FLAMM: Okay.

10 CO-CHAIR DUBOW: Well, pay for  
11 performance incorporates regulations. I think  
12 the pay for performance assumes that there is  
13 a regulatory process and we, certainly in the  
14 context of the MAP discussion with the MAP  
15 considerations, where MAP is making  
16 recommendations to the Secretary about the  
17 measures that should be used or over 28  
18 federal programs, there is a regulatory  
19 underlay, undergird what the Secretary is  
20 going to be using it for. And her authority  
21 is regulatory, usually, or based on statute.  
22 But it is reflected in regulation. So, I

1 think it is sort of implicit.

2 I think you probably could think  
3 about regulatory underlying some of the public  
4 reporting. It depends on who the payer is.  
5 If it is a public payer, there is probably a  
6 regulatory structure. And even in the private  
7 side there are regulations and statutes that  
8 govern some of the things that happen.

9 So, I think it is implicit.

10 CO-CHAIR FLAMM: Okay. So,  
11 shifting into the implications of MAP.

12 MR. AMIN: Yes, so I am going to  
13 actually ask Erin to take the lead on this  
14 section. But the basic question here is to  
15 think about the question of selection, of how  
16 the models and the particular questions of how  
17 measures are selected and how that interacts  
18 with the models is really the section, this  
19 next section. But anyhow, I will turn it  
20 over.

21 MS. O'ROURKE: Thanks, Taroon.  
22 So, I am one of the NQF staff supporting the

1 Measures Application Partnership and Joyce is  
2 a member of the Coordinating Committee  
3 overseeing this work. So, we wanted to bring  
4 this to you as a way that NQF will be  
5 advancing the work of this panel and making  
6 this not purely an academic exercise but using  
7 the guidance of this committee for real world  
8 applications.

9 To give you a little bit of  
10 background, MAP is a public-private  
11 partnership convened by NQF where we provide  
12 input to the Secretary of Health and Human  
13 Services on the selection of measures for  
14 public reporting, pay for performance,  
15 including a number of programs intended to  
16 measure efficiency.

17 MAP's goals are to identify the  
18 best available measures for use in specific  
19 programs, to provide input to HHS on measures  
20 for specific uses, -- as Joyce mentioned, we  
21 provide input on over 20 federal programs --  
22 and to encourage alignment of public and

1 private sector efforts.

2                   So, I have noted a number of these  
3 programs are intended to be focused on  
4 efficiency. The main way MAP provides input  
5 is through our annual pre-rulemaking process,  
6 where we receive a list of about 500 measures  
7 for these 20 programs and make specific  
8 recommendations on whether or not MAP supports  
9 HHS proposing these measures for use in their  
10 programs.

11                   So, we are really looking for  
12 guidance from this panel to help us refine our  
13 decision-making for these efficiency programs.  
14 I think I was struck in the paper noting that  
15 the importance of the measures you put into  
16 the model is really tied to whether or not you  
17 are actually measuring efficiency. Otherwise,  
18 are you just measuring unrelated cost and  
19 quality outputs?

20                   So, these are the current MAP  
21 measure selection criteria. I don't want to  
22 read them out to you in too much detail. I

1     should note that we consider these at the  
2     program set. These are not criteria meant to  
3     judge an individual model. But what we are  
4     looking for here are there additional measure  
5     selection criteria, if you will, that we  
6     should be thinking about for efficiency  
7     programs and what guidance would this panel  
8     have to the MAP as we make recommendations on  
9     use of measures in some of these programs,  
10    such as the value-based purchasing, the  
11    Medicare Shared Savings Program, or the  
12    physician value-based modifier.

13                 So, with that, I will turn it back  
14    to Ashlie and Taroon for discussion.

15                 MS. WILBON: Yes, I will just add  
16    a couple of things. One, in the break we had  
17    a discussion with Joyce and she pointed out  
18    that for the purposes of the work that NQF  
19    does, obviously, we were looking for  
20    operational guidance for the measure  
21    applications partnership but that broadly,  
22    that this type of criteria could be used by



1 other entities as well, who are looking to  
2 select measures and into programs for their  
3 own purposes.

4 So, we have framed it in the  
5 discussion guide and for the purposes of this  
6 panel based on kind of our own selfish needs  
7 for potentially additional guidance for the  
8 measure application partnership but also  
9 wanted to include the broader context of these  
10 type of guidance could be used for other  
11 entities as well. So, I just wanted to  
12 include that.

13 And I wanted to also mention that  
14 we are going to, I know we moved away from the  
15 measure selection criteria on this slide but  
16 in your discussion guide, it is also listed  
17 and we are going to have you guys, the next  
18 probably 25 minutes of our discussion will be  
19 focused around the questions in the box on the  
20 top of page five, which include should the  
21 selection of measures for a model or approach  
22 vary depending upon its use case and whether

1 or not the selection of measures depends on  
2 the purpose of the model or does it not matter  
3 which approach we are going to use to measure  
4 efficiency and that the selection of measures  
5 is kind of agnostic from the actual approach  
6 used by the model.

7 And whether or not there are other  
8 models that we should be considering that are  
9 not included in the paper that Andy and Chris  
10 found in their environmental scan that we  
11 should be considering as a part of our  
12 discussion for the next section.

13 Following this, we are going to  
14 have Andy and Chris really go into some more  
15 detailed description of what they found in  
16 their environmental scan in a more detailed  
17 description but wanted to get some overarching  
18 ideas about that as well.

19 So, with that, I will open it up  
20 to the group. Andy and Chris, do you have  
21 anything? Okay, you looked like you were  
22 getting ready to comment.

1 DR. TOMPKINS: Well, I was  
2 actually going to pose that question that you  
3 just posed. Meaning, since you posed it, I  
4 want to emphasize it. Before we get into  
5 breakout sessions, does somebody have to put  
6 forward now a model that doesn't fit in the  
7 taxonomy in the listing that is in the  
8 background paper? Because if the answer is  
9 yes, then as all the breakout sessions  
10 consider the models, they should be an  
11 inclusive list and not just the ones  
12 artificially in that case restricted to what  
13 was in the background draft.

14 If the answer is no, that's fine.  
15 But since you asked it, I thought, we don't  
16 want to have some undisclosed model.

17 CO-CHAIR FLAMM: Go ahead, Donald.

18 DR. LIKOSKY: I just have a quick  
19 question. Have we come to terms with how we  
20 evaluate the models, what systematic way we  
21 evaluate them?

22 I mean in part I am still trying

1 to address the questions posed on the top of  
2 page five and going back to how do we evaluate  
3 it. Have we come to terms about a framework  
4 or is that really the purpose of --

5 CO-CHAIR FLAMM: In the breakouts,  
6 I think we are going to talk about pros and  
7 cons and the different kinds of issues around  
8 applying them in the use cases that we are  
9 focusing on. So, I think that is going to be  
10 fleshed out in terms of evaluation aspects.

11 DR. LIKOSKY: Okay.

12 DR. TOMPKINS: Well, I don't want  
13 to necessarily increase the scope of the work  
14 but I will make a suggestion that the breakout  
15 sessions don't have to be strictly along the  
16 lines of okay, Model 1, Model 2, Model 3, as  
17 if that is necessarily the most productive way  
18 to do it. Although, contradict me if that is  
19 exactly what you want people to do.

20 Because it might more liberating  
21 and more useful to have people say oh, I'm  
22 sitting in the public reporting group. What

1 of all the issues swirling around in the room  
2 are the most important ones to remember in any  
3 step of this, whether it is one of the  
4 measures, process versus outcome, whether it  
5 is the reliability issues, things like that.

6 And then to the extent that that  
7 MAPs better to one model than another, then  
8 that could be an intermediate finding in the  
9 group. But otherwise, I think an enumeration  
10 of the use cases and taking that perspective  
11 and the interesting contrast would be if  
12 people come back with either a different  
13 mapping to the models or a different sense of  
14 the way in which the construction of the  
15 linking process would ensue should be noted.

16 CO-CHAIR FLAMM: Okay, all these  
17 cards appeared at once in my mind as I was  
18 looking. I am just going to go in order  
19 around here. Go ahead, Iyah.

20 MR. ROMM: Sure. I'm not going to  
21 be very helpful. I am going to introduce a  
22 question and not an answer, which is to say

1     one of the things I was struck by in reviewing  
2     these is the extent to which most of the  
3     models that are out there, and this has  
4     certainly been our experience, adhere to one  
5     of the models of your taxonomy, Chris and  
6     Andy, and I don't have a suggestion of another  
7     one that doesn't MAP there.

8                 But I am going to pose the  
9     question of should the model drive the  
10    measures or should the measures drive the  
11    model? That is, I think that all of this is  
12    sort of framed around the idea that within a  
13    given program we want to choose a model and  
14    then find measures that fit.

15                I am not sure, given the state of  
16    measurement of efficiency that that is the  
17    right approach.

18                MS. WILBON: That is, in fact, one  
19    of our questions for you.

20                CO-CHAIR FLAMM: Cathy.

21                DR. MAC LEAN: So, I 'm just going  
22    to echo that and I was going to ask the

1 question is the purpose of the discussion to  
2 discuss these different models and understand  
3 how things work or don't. Because I have to  
4 say as I went through these models, there are  
5 a couple of situations that I really couldn't  
6 quite figure out where they fit in. So,  
7 bundled payments and part of the issue with  
8 the bundled payment is you are negotiating a  
9 rate with the provider. Right? So, right  
10 there, it is all about the negotiation. And  
11 so, how does that fit in?

12 Or the reference-based pricing  
13 example that we have talked about a few times,  
14 how does that fit into these models?

15 So, my question to you is, as we  
16 go to do this, what is our task? Are we using  
17 these models to raise important discussion  
18 points or what is it that we are tasked to do?

19 MS. WILBON: Are you asking  
20 specifically about the breakout groups or  
21 about the -- I just want to make sure I can  
22 address your question appropriately.

1 DR. MAC LEAN: Both the breakout  
2 groups and what is it you want us to do with  
3 these models, either now or in the breakout  
4 groups. What is the purpose of these models?  
5 Is it to engender discussion or is the purpose  
6 of our work to try to fit things into these  
7 models?

8 MS. WILBON: So, part of the scope  
9 of the work and I will open it up to Taroon as  
10 well to discuss, was to do an environmental  
11 scan of what is currently out there. So,  
12 these models are a reflection of what Chris  
13 and Andy kind of found of what people are  
14 actually doing out there now. And that is  
15 reflected in the table and from the different  
16 entities that they have found.

17 So, it is not that we are trying  
18 to -- this is kind of what is out there. We  
19 are not necessarily trying to fit anything to  
20 the model. I think it was intended to be kind  
21 of an exhaustive, to the extent that they  
22 could find, an exhaustive list of kind of this



1 is what people are doing out there. And then  
2 for us, for this panel to provide some  
3 guidance on what is the best application of  
4 these models, is the way they are being used  
5 now most appropriate and is there some  
6 additional guidance we can provide, based on  
7 the context of those models, how measures  
8 should actually be -- cost and quality  
9 measures should actually be brought into those  
10 models in order to measures efficiency.

11 I don't know if that is helpful.  
12 Maybe Taroon can be more articulate than me.

13 MR. AMIN: I will try. I think  
14 you have characterized it pretty well. I  
15 think -- so, let me just describe the current  
16 state.

17 So, we have these cost and quality  
18 measures that exist sort of independently of  
19 one another and then we have programs that are  
20 sort of using them. And there are various  
21 different ways that these programs are using  
22 them and the purpose of the environmental scan

1       was to describe the models in which the  
2       programs are using them.

3               Now, the basic question that is  
4       being asked that we are interested in  
5       understanding is that, first of all, the way  
6       that the programs are designed, meaning the  
7       use of the program, whether it is for public  
8       reporting, for payment applications, we want  
9       to understand in more detail how the model  
10      selection and the use case are related or not.  
11      That is the first question, which is why maybe  
12      the use case is driving the model design or  
13      not. Just understanding and characterizing  
14      that relationship.

15             The second is to understand right  
16      now we are selecting measures for programs,  
17      based on its use case but there is also this  
18      intermediary where you have, there is various  
19      different models that which programs are sort  
20      of using in their program design.

21             And it may seem like just  
22      selecting the measures without really thinking

1     about the way that the model is constructed  
2     might not be the best approach. That you  
3     might actually need to think about the  
4     program, the model, and then selecting the  
5     measures for the model. And so that is the  
6     second dimension that we want to explore.

7             DR. RYAN: Catherine, so with  
8     respect to where does bundled payment fit in,  
9     if you look at a number of the programs we  
10    have identified use some kind of episode-based  
11    measure of cost. So, some kind of like  
12    looking over an extended based on some index  
13    event and assessing cost within some bundle of  
14    services over some specified period. And that  
15    is how cost is specified.

16            And then so, then that program  
17    might have some other way of looking at how  
18    quality is specified and then some model for  
19    combining the cost and quality measures  
20    together.

21            So, the bundled payment part is  
22    just kind of how cost is specified and the

1 model is how that specification of cost is  
2 then subsequently combined with quality to  
3 give some measure of efficiency. And also  
4 with reference pricing, the one real example  
5 I think is CalPERS. And there is no explicit  
6 integration of quality information right now  
7 with CalPERS.

8 Jamie talked to our group. It was  
9 like well, you know we think these are high or  
10 low quality. We think we got people who  
11 provide reasonably good quality kneed  
12 replacements or whatever who can do this for  
13 \$15,000. And so that is our price. We think  
14 we have some people who are doing that.

15 And so there wasn't like an  
16 explicit way to integrate that cost and  
17 quality signal in that program. So, that was  
18 left out of our table.

19 So, I don't know if that is  
20 helpful but that is kind of the rationale for  
21 how we organized this.

22 DR. MAC LEAN: Well, just for the

1 CalPERS, Anthem administered that. And there  
2 were quality criteria. Now, they were pretty  
3 minimal quality criteria like the hospital had  
4 to be accredited. There had to be some  
5 minimum volume of procedures. So, there were  
6 quality criteria. They were quite minimal, I  
7 will admit. But they were there.

8 So, and I guess maybe in the side-  
9 by-side model but I don't know that it even  
10 matters. I'm just not sure where we are going  
11 with these models. Are we trying to figure  
12 out how to fit these into the models or are we  
13 just using this as a framework to kind of move  
14 our discussion?

15 CO-CHAIR FLAMM: And I don't know  
16 if this helps but I think Chris' comments  
17 earlier about this idea of maybe using our  
18 breakout groups to talk about from this  
19 perspective of this use case, what are the  
20 requirements that I am trying to accomplish?

21 It might actually help filter  
22 through the models because each model had

1 different implications in what it produces.  
2 They don't produce all the same things. And  
3 maybe there is a different applicability or  
4 fit between each of the models and the use  
5 cases. We sort of popped that through.

6 Craig.

7 DR. WOZNIAK: I guess backing up  
8 there was a question about are there other  
9 models that we ought to consider or that are  
10 not listed. And I will go back to my point I  
11 made earlier and Jack said they are in there.  
12 But I am not sure if measures that are  
13 developed with the cost and the quality  
14 measure developed simultaneously are included  
15 in this table.

16 DR. NEEDLEMAN: Nobody is paying  
17 them. But that is the difference.

18 DR. WOZNIAK: Well, that is a  
19 different issue, right. Are there are other  
20 models that ought to be -- the question was  
21 are there other models that ought to be  
22 considered? And I am speaking more on the

1 physician side than on the hospital side but,  
2 take for example, on the physician side you  
3 have quality measures that have very well-  
4 defined specifications that maybe are pulled  
5 from EHRs, PCPIMA measures, for example.

6 The cost measures may be totally  
7 different in terms of the time frames, even  
8 the patient population so that you may have  
9 different populations that are being used to  
10 measure the quality than you are to measure  
11 the cost. You have an aggregate cost measure,  
12 for example.

13 Or again, you could have an  
14 episode of care with a certain time frame and  
15 a certain population of patients. That is not  
16 the same population of patients that goes into  
17 the quality measure. So, you have got sort of  
18 an odd mismatch of the denominators, the  
19 numerators, the levels of analyses and how you  
20 aggregate it up. So, that is what I meant in  
21 terms of having measures of cost and quality  
22 developed simultaneously. So, measurement

1 periods match, populations match, the unit of  
2 analysis match. The components that go in are  
3 consistent across the elements of these two.

4 And again, it is probably there is  
5 more of a void on the physician side,  
6 possibly. Maybe it is less applicable on the  
7 hospital side but I don't see those kinds of  
8 measures being listed in the table. I mean,  
9 clearly, side-by-side means there a measure of  
10 cost and there is a measure of quality and  
11 maybe some of the patients are the same.  
12 Maybe some of the docs, the sites are the  
13 same, but they are really not the same  
14 denominators.

15 CO-CHAIR FLAMM: Okay, Dennis.

16 DR. SCANLON: So, one of the  
17 things I thought about in looking at the table  
18 and the paper, which I agree was helpful to  
19 sort of put some of these programs or things  
20 that are happening around the country on  
21 paper, is that while we sort of identify which  
22 model among the category that the authors sort



1 of put in play, these programs are all for  
2 different purposes. And there may be some  
3 value in trying to sort of organize them by  
4 purpose or primary purpose and then see if  
5 there is some convergence around some of the  
6 model. So, just as an illustration, the  
7 Medicare Shared Savings and Pioneer Program,  
8 I sort of view that as the purpose is to  
9 incentivize innovation on the delivery side to  
10 take care of patient populations for a cost  
11 that is lower than traditionally we have paid  
12 and to sort of develop a financial incentive  
13 so there is shared savings around doing so.

14 So that really, the purpose there  
15 is really around delivery system innovation  
16 for purposes of accomplishing a broader  
17 societal goal, which is to reduce healthcare  
18 trend.

19 Contrast that with sort of number  
20 23, which is Castlight. And you know what I  
21 know about Castlight is that is really a tool  
22 for consumers to make decisions, largely in

1 kind of a high deductible plan context at a  
2 point of service or something, completely  
3 different from the Medicare shared savings  
4 program.

5 Health Partners, what I know about  
6 that program is a lot of the reason for Health  
7 Partners sort of developing their tools was to  
8 become more efficient internally in their  
9 delivery system and have a way in kind of an  
10 apples to apples fashion to kind of compare  
11 provider to provider within their own  
12 integrated delivery system, where they have a  
13 high degree of control over providers within  
14 that organization. So, there was a real  
15 internal purpose to that.

16 And then if you take a look at  
17 others like episode payment approaches, those  
18 may be for purposes of setting reference  
19 prices or developing tiered networks, which  
20 might be sort of objectives of health plans or  
21 payers.

22 So, one thing that I think might

1 be helpful is to really categorize these  
2 things and then look and see if you look at  
3 the sort of innovation efficiency of the  
4 delivery system ones, do certain models seem  
5 to fit where there are a subset of models that  
6 seem to apply. I think that would be sort of  
7 a good step.

8 But I also sort of want to say  
9 that in terms of alternatives, I am not sure  
10 this is an alternative model. If you really  
11 want to think outside the box, it goes back to  
12 our discussion at the very beginning of today  
13 of what is sort of the goal or purpose of this  
14 is. If the goal or the purpose is to sort of  
15 create a more efficient health care system  
16 without sacrificing quality or perhaps even  
17 improving quality, there could be other sort  
18 of approaches to this. I mean you might sort  
19 of take a measure which is not condition-  
20 specific like of them are or not episode-  
21 specific but you might look at investment of  
22 organizations and what they are doing to

1 address things like waste or to redesign their  
2 delivery system. It might be more of a  
3 structural measure in the sort of Donabedian  
4 traditional kind of approach of thinking about  
5 measurement.

6 But it is sort of more what is  
7 being done in the name of sort of reducing  
8 waste or redesigning the delivery system or  
9 creating innovation, which is entirely  
10 different than a lot of what we are seeing  
11 currently, which is clinical or disease-  
12 specific type measures.

13 So, that is a little bit outside  
14 of the box but I guess it gets back to why are  
15 we doing this to begin with.

16 CO-CHAIR FLAMM: So, we have run a  
17 little bit over our time. Let's take about  
18 five more minutes for this discussion, then we  
19 will move into the public comment. So, we  
20 have a lineup of folks that need to speak. I  
21 had Matthew next, and then Jack, and then I  
22 will circle around.

1 DR. ROUSCULP: Thanks. And again,  
2 I am following Dennis. He laid out a lot of  
3 very great points. So, I am not going to  
4 repeat all that.

5 I think the one area that I am  
6 hearing from you at NQF is you are saying we  
7 have to be pragmatic here. You are saying  
8 that you get a lot of quality measures and you  
9 are starting to get cost measures. And CMS is  
10 coming to you or whatever the organization and  
11 it is saying hey, we have legislation that is  
12 dictated. We have to talk about efficiency.  
13 It sounds to me, then, because of that, that  
14 you are asking that when cost measures are  
15 starting to come in is that you don't want to  
16 just have cost measures but you want to say  
17 how do those link back to the quality measures  
18 that already exist. I think that is what --  
19 at least that is what I have taken. I could  
20 be completely wrong. I have been wrong before  
21 many times.

22 So, from that, I guess what I am

1     trying to think about as far as the models  
2     themselves, it is not necessarily are these  
3     the penultimate models to move forward but it  
4     is saying within what you are being asked to  
5     take on at NQF, what are the ways that you can  
6     have guidance from us that you can look at  
7     whatever these cost measures come by that you  
8     can turn around and ask that before we accept  
9     your cost measures, you must show us how you  
10    are linking this to quality.

11                   And so to me, I want to make sure  
12    either A, that is correct and then B, it is  
13    not ever going to be one of these models is  
14    going to the penultimate. What is going to  
15    happen is these models are going to be again  
16    dictated by what Dennis was bringing up, which  
17    is saying whatever the end point is it about  
18    decreasing costs? Is it more about increasing  
19    performance? Is it more about increasing the  
20    quality of care or decreasing the safety  
21    signals that you are starting to see? I think  
22    that is where we are going to kind of winnow

1 down and we can kind of help with you on some  
2 of those elements and say which of these  
3 models can be helpful or where are the ones  
4 that aren't here.

5 CO-CHAIR FLAMM: Jack.

6 DR. NEEDLEMAN: I think there are  
7 four things and these all relate to issues we  
8 have talking about here.

9 First of all, we have got a lot of  
10 models. Some are in use and some aren't. And  
11 I will come back to the ones that are in use  
12 in a moment. But things like data  
13 envelopment, stochastic frontiers, the  
14 regressions models, not being used in any of  
15 the programs we see. They are very different  
16 in concept. They are out there in the  
17 economic literature. I played around with  
18 them. They are all feasible to do but nobody  
19 has gone that way.

20 So, some are in use, some are not.  
21 The ones that are in use are all a variation  
22 of the side-by-side. Fundamentally, you know,

1 side-by-side, hurdle, conditional,  
2 unconditional, they all basically say for the  
3 cost -- they are all some variation of the  
4 scatter plot, throw them up on the cost  
5 dimension, throw them up on the outcome  
6 dimension, and then take your eraser and  
7 decide where we are going to start erasing and  
8 saying these folks are in and these folks are  
9 out or these folks are getting paid well and  
10 these folks aren't.

11 So, they are all basically  
12 variations of the side-by-side and all the  
13 action in those are really around what  
14 determines where you get ranked or what you  
15 get scored on each of the individual  
16 dimensions. And those raise all the issues  
17 that Greg raised.

18 So, in reviewing any of those  
19 measures, you come back to where did they get  
20 the data from? Is it consistent? How are we  
21 weighting things? How much are we pulling  
22 things in a Bayesian way? And on, and on, and



1 on. Lots of very specific issues.

2 But those four measures, the ones  
3 that are in use are basically the same  
4 measure. And so, you have got that issue.

5 I think the question becomes a  
6 question of robustness and relative  
7 performance. When you begin changing these  
8 things, when you begin changing how Joe's  
9 daughter weights closeness to the beach versus  
10 academic rigor, do you come up with the same  
11 ranking or a different ranking? And we  
12 haven't talked about the robustness of these  
13 measures as a critical component of deciding  
14 how much confidence should I have in them.

15 And then we get to the  
16 interpretability and that may affect -- you  
17 know if they all come to the same answer, then  
18 the interpretability determines which one you  
19 pick. But if they come to different answers,  
20 we have got to spend a lot of time thinking  
21 about getting which answer we believe the  
22 most.

1 CO-CHAIR FLAMM: Gary and Jeff.

2 Steve, you want to make a quick comment?

3 DR. ASCH: It's just a point, a  
4 very quick point of clarification.

5 So, the VA actually is using  
6 stochastic frontier models for efficiency. It  
7 poses all sorts of application problems, which  
8 I would be happy to talk to you about.

9 CO-CHAIR FLAMM: Okay. Gary and  
10 then Jeff.

11 DR. YOUNG: Well, I guess we are  
12 all struggling with sort of the same issue,  
13 same concern about trying to think about how  
14 we might have a meaningful discussion about  
15 these models and trying to think about what  
16 again is the large goals. And again, going  
17 back to this morning's discussion, the earlier  
18 discussion about potentially the need for some  
19 sort of overarching framework because placing  
20 those models in context is going to be hard  
21 without doing that and having a meaningful  
22 discussion. I mean, many people, for example,

1 in their comments, have talked about the  
2 importance of the actionability of the models  
3 and the measures but from a consumer  
4 standpoint, they may not care about  
5 actionability. They just want to be able to  
6 make a choice. So, whether or not the  
7 provider improves or not is not terribly  
8 important.

9 Other comments have talked about  
10 whether having a single measure or a single  
11 score is feasible and useful. But, obviously,  
12 it doesn't have to be only a single score.  
13 There is also drill-down opportunities. So,  
14 is that something that needs to be considered  
15 as an important consideration. And then, of  
16 course, there is stakeholders. So, going back  
17 to the example of choosing a college and beach  
18 versus academic rigor, parents and kids tend  
19 to have very different preference weighted  
20 considerations around those kinds of  
21 dimensions.

22 So, I think that needs to all be

1       considered as part of a larger framework to  
2       have a meaningful discussion about these  
3       different models.

4                   CO-CHAIR FLAMM:   Jeff?

5                   DR. SILBER:   Yes, to answer  
6       Christopher's question, the list of models is  
7       not complete.  And I think, in part, you could  
8       have given more weight to the side-by-side in  
9       terms of there are variations on the side-by-  
10      side model that have been not explicitly made  
11      clear in the document.  And so that,  
12      basically, for the first models before you get  
13      the side-by-side, we are talking about  
14      efficiency in one way or another that is  
15      incorporated into the model.  And side-by-side  
16      splits those out but there are so many ways to  
17      do that, that I think you have underplayed  
18      that in the document.

19                   So, that would be the big problem  
20      that I see with the document and also in terms  
21      of answering your question, we have to also  
22      think about how to present side-by-side in

1 ways that are most useful to the consumer.

2 And I don't think efficiency is  
3 something that the consumer is necessarily  
4 interested in, the consumer being, facing  
5 north, the patient. They want to know price  
6 and they want to know quality. Maybe they  
7 don't want to know quality but we hope that at  
8 some point they will.

9 CO-CHAIR FLAMM: All right. Thank  
10 you, everybody. This was a really wonderful  
11 discussion. I think it sets us up well for  
12 the breakout sessions that we are going to  
13 have after lunch.

14 At this time, we would like to  
15 open it up for public comment. So, we will do  
16 two things. Operator, if you could let us  
17 know if there is anybody on the phone who  
18 would like to make a comment first.

19 OPERATOR: If you would like to  
20 make a public comment, please press \*, then  
21 the number 1.

22 At this time, there are no public

1       comments.

2                   CO-CHAIR FLAMM:  None?  Okay, we  
3       do have some guests in the room.  Public  
4       members, do you have anything you would like  
5       to add?

6                   MR. HAIDER:  Shall I speak from  
7       here?  Can everybody hear me?

8                   Thank you very much.  Thank you  
9       very much for providing an opportunity for the  
10      public to give comments in such an esteemed  
11      group.

12                  So, I am a technology  
13      entrepreneur.  I have left my tech world and  
14      moving to healthcare to start a company to  
15      help patients.  And I have a personal story  
16      behind that that is driving that.

17                  So, I have to analogies that I  
18      hope will help the group from a tech  
19      perspective.  So, the first analogy is the  
20      cell phone market.  And I have kind of  
21      mentioned to two people while I was talking  
22      about it.  So, the cell phone market is

1 continuously giving us higher quality with  
2 more features and reducing cost. Right? Now,  
3 if you look at your cell phone bill 30 years  
4 ago, how many of us had a cell phone bill?  
5 Zero. But you look at your cell phone bill  
6 today, I am quite astonished how much money I  
7 spend on it and I am happy to do it. So, even  
8 though I am spending more money, I am happy to  
9 do it because it is providing a value to me.

10 So, what I mean by that, where I  
11 am going is that tech markets are extremely  
12 efficient. If you look at the cell phone  
13 guys, they have just taken the cell phone that  
14 cost \$20,000 at one point and now driven it to  
15 \$200. It was only available to the elite.  
16 Now, it is available to everybody. And  
17 everybody is happy paying more. The market  
18 has grown.

19 And so, the reason why that tech  
20 market or many markets, as you go into the  
21 economics of it, is because of the ability for  
22 choice. And that is what I would urge the

1 group is to look at -- I urge the group to  
2 look at the efficiency in the context of the  
3 market. And as part of the white paper, add  
4 the fact that we are restricting patient  
5 choices is a problem.

6 That being said, I want to bring  
7 one more analogy for constraint. In the tech  
8 market, if I choose to buy Apple, I am  
9 constraining myself. I am going to get just  
10 a certain type of power adapter and monitor  
11 and stuff. I can choose to go with Samsung  
12 and I will get maybe a different type of  
13 Android-type ecosystem. But again, that was  
14 my choice. So, based upon my choice, I might  
15 enter into certain constraints.

16 So, in the healthcare market you  
17 can think I may enter into different plans.  
18 So, that is the first point.

19 The second point I would like to  
20 make is on feedback on quality measurement and  
21 models. So, open markets have quality  
22 measurements. They are determined by



1 prioritized by my, as a consumer, individual  
2 values.

3                   And the analogy of going to  
4 college, I want to choose. Do I want to go to  
5 a place where there is a beach or do I want to  
6 go where there is no beach and it is all  
7 studies, or do I want to try to get both? And  
8 the way that is done today is that those  
9 values are communicated to me through brands,  
10 Consumer Reports, J.D. Powers, Yelp, U.S.  
11 News. All of these provide different values.  
12 And I may read Consumer Reports but I don't  
13 look at Yelp. I may look at Yelp but not J.D.  
14 Powers because that is the way I like reading  
15 reviews.

16                   And I think the industry groups  
17 and government's role is very important, and  
18 especially this industry, to enforce  
19 transparency and meeting safety guidelines  
20 like CE Mark and so forth. So, I, as a  
21 consumer, can make safe choices. But still,  
22 I am allowed to make that choice.

1                   And then in this regard, I urge  
2                   the group to look at metrics that need to be  
3                   reported that will help people make choices  
4                   based on their wide ranges of values.

5                   And the analogy, one more analogy,  
6                   there is the food label. That hey, I want to  
7                   choose how much calories I am taking, how much  
8                   protein I am taking, and how much -- but I can  
9                   choose whatever I want as an individual.

10                  And in final, I have one point on  
11                  the culture. When I go to my doctor, I feel  
12                  like I am talking to my dad when I was ten-  
13                  years-old. And Dad says I am going to make  
14                  this choice for you. And here is my response  
15                  to my dad, I am going to say, Dad, please tell  
16                  me what you think is important. Give me your  
17                  experience but let me make my choice because  
18                  I have to live with it.

19                  So, those are my points.

20                  CO-CHAIR FLAMM: Thank you. Are  
21                  there any other comments? Okay, thank you.

22                  Well, with that, then we are going

1 to move to lunch. We would like to allow a  
2 half an hour for lunch. So, if we could start  
3 to gather back here right around one o'clock,  
4 we will get started shortly there with the  
5 session at one o'clock.

6 All right. Thank you, everyone.

7 (Whereupon, at 12:31 p.m., a lunch  
8 recess was taken.)  
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# A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:16 p.m.)

CO-CHAIR DUBOW: Can we reconvene, please? We have a busy afternoon. And we also have an important announcement, Erin, before you begin.

Could everybody please at least be  
silent so we can hear the important  
announcement that Herbert wants to make?

DR. WONG: So, many folks have been asking me what the conclusion of my daughter's decision was. So, I will say that she did create a spreadsheet. There were all sorts of quality dimensions put on this. None of them really had distance to the beach on it but you know, it is possible that she was keeping that aside, absolutely. So, she had other things such as school rank, size of the population, the percentage of first-year that comes back to the school as an indication, enrollment dollars or endowment dollars for the university. So, it was a little bit

1       sophisticated. I am fairly certain that the  
2       distance to the beach was not in her choice  
3       set because the school that she selected must  
4       be at least 200 miles away from a beach.

5               So, in the end, she selected  
6       Colgate University, Hamilton, New York, in  
7       Central New York, a very isolated place. And  
8       Mom and Dad are happy with her selection. So,  
9       there we go.

10              PARTICIPANT: There is skiing  
11       nearby.

12              DR. WONG: There is probably cross  
13       skiing nearby and things like that,  
14       absolutely.

15              CO-CHAIR DUBOW: Okay, Erin.

16              MS. O'ROURKE: So, we wanted to  
17       spend some time now to let Chris and Andy  
18       really tell us the details of the approach  
19       they took to the environmental scan and walk  
20       us through each of the models and what they  
21       entail, and then give the committee some time  
22       to weigh in on both the approach to the scan

1 and the models, generally.

2 DR. RYAN: Great. Thank you,  
3 Erin. So, I am going to start and take you  
4 through the methods and results and just some  
5 kind of high level summary thoughts about kind  
6 of what it boils down for the group. And then  
7 I will let Chris comment on this.

8 So, what we did was we did a  
9 couple -- had a couple approaches to the  
10 literature search. We did search the PubMed  
11 databases for English languages. Articles in  
12 the last 25 years that had -- you know we had  
13 a variety of search terms we used and quality  
14 measurement, cost efficiency. And then we  
15 tracked down articles that use these.

16 So, I want to say that as Herb  
17 mentioned before, AHRQ contracted -- did a big  
18 contract with RAND a couple of years ago to  
19 summarize the state of efficiency measurement.  
20 And so that was a nice kind of input to this  
21 process, but we didn't try to duplicate their  
22 systematic review.

1                   So, we did that. We pulled  
2                   articles that way. And actually you know we  
3                   emailed everyone on the committee. I apologize  
4                   if we missed any of you but I don't think we  
5                   did. And we got a lot of great feedback that  
6                   way. And a lot of really key materials that  
7                   kind of led us in different directions. So,  
8                   a number of people were very helpful for that.  
9                   And that helped us identify programs.

10                  So, this led us to identifying 30  
11                  plus programs. And then we kind of dug  
12                  through. We took information that community  
13                  members gave us but, where possible, you try  
14                  to find supporting information on the websites  
15                  and contacted people to follow up with  
16                  specific program information.

17                  So, we compiled this list of  
18                  programs that are using, that are linking  
19                  measures of cost and measures of quality. And  
20                  again, this is not -- the perspective we had  
21                  were the cost was not on the kind of provider  
22                  side or production costs. It was costs for

1 the payer, the purchaser, or the patients,  
2 since that was our perspective in identifying  
3 programs.

4 So we identified about 30  
5 programs. We filled in information on kind of  
6 the what kind of provider was being profiled,  
7 was it hospitals, was it physicians, was it  
8 healthcare systems. How was quality specified?  
9 How was cost specified? And then what we did  
10 was we went through and said what are all  
11 these different -- how can we come up with a  
12 taxonomy of ways for combining quality and  
13 cost measures. And after kind of reviewing  
14 all these programs and kind of iterating  
15 through, we came up with these seven mutually  
16 exclusive models that either programs have  
17 used or a couple of these have just been  
18 proposed by researchers but they met our other  
19 criteria that they were designed to profile  
20 individual providers on the basis of  
21 efficiency, based on cost and quality  
22 performance.



1                   So, and let me just I will go  
2                   through and kind of describe what these  
3                   models, the key features of these models and  
4                   then come back to how they were kind of  
5                   applied to the programs that we identified.

6                   So, the first on this list is the  
7                   so-called conditional model and this is our  
8                   name. It has been called different things by  
9                   Tim, Ormond, and then Chris, in their paper a  
10                  couple of years ago gave it a somewhat  
11                  different name. But basically the idea is  
12                  that you get -- there is a separate process  
13                  through which cost is assessed, through which  
14                  quality is assessed. And then there is this  
15                  kind of joint determination of what is the  
16                  cost for some given level of quality is  
17                  typically how it is specified.

18                 So, I think the key thinking about  
19                 this is it is -- these aren't like independent  
20                 signals but they are dependent signals and we  
21                 are looking at the thing about efficiency by  
22                 saying, by first kind of classifying quality

1 and then thinking about cost within that  
2 classification of quality.

3 So, I would say that is the  
4 essence of the conditional model. And this  
5 was used, I think for private insurers with  
6 tiering, how they created value tiers or  
7 whatever the distinction program that Blue  
8 Cross that Carole described and other payers  
9 are doing similar things. They typically use  
10 this approach.

11 So, an alternative approach that  
12 was, I think, more common, these kind of  
13 shared savings type models is, I mean it is  
14 related but they kind of idea is to set kind  
15 of a minimum threshold for either quality or  
16 cost, which is a so-called hurdle and then  
17 profile on the other dimension.

18 An example that came up before, I  
19 think Dennis mentioned, was the Medicare  
20 Shared Savings Program for ACOs and the kind  
21 of structures that there is a minimum quality  
22 standard and then there is this after, if an

1 ACO kind of doesn't hit that standard, then  
2 there is no shared savings, based on how they  
3 do on cost but if they do hit that hurdle,  
4 then there is the ability to share savings,  
5 based on how they do on cost.

6 So, these can be specified that  
7 kind of once you hit that hurdle, you are done  
8 and then quality kind of doesn't matter  
9 anymore. Or how savings is shared can be kind  
10 of weighted, based on how well you do on  
11 quality. That is kind of a variation on that.

12 And so we also saw kind of a cost  
13 hurdle model, where you start with some  
14 minimum threshold for how providers do on cost  
15 and then you start profiling quality above  
16 that. So, those are both variations that we  
17 saw.

18 So, another approach that was used  
19 fairly frequently was this unconditional  
20 model. And so the idea here is that you just  
21 have some quality signal, you have a cost  
22 signal and that they are weighted and

1 combined. But profiling isn't done kind of  
2 within specified levels of either of those  
3 dimensions. They are orthogonal and -- sorry,  
4 Joyce there.

5 CO-CHAIR DUBOW: I would like you  
6 to use plain English.

7 (Laughter.)

8 DR. RYAN: And so they are  
9 evaluated kind of independently and then  
10 combined through a waiting scheme. So, that  
11 is kind of what Hospital Value-based  
12 Purchasing uses now. And Alan invoked this  
13 before. But so in that program, so NQF  
14 actually endorsed the Medicare spending per  
15 beneficiary measure in that process. So, I  
16 forgetting the weighting but let's just say it  
17 is 30 percent of the hospital total  
18 performance score is based on how they do on  
19 cost. You know 30 percent is how they do on  
20 outcomes, 40 percent patient experience. That  
21 is not quite right but then those are combined  
22 to give a total score.

1                   But that how cost is assessed  
2           isn't kind of dependent on any level of  
3           quality.

4                   So the other model we have here is  
5           the regression model and I am not going to --  
6           this is one that was proposed by Tim and  
7           Ormond and what I thought was a really  
8           excellent thoughtful paper. And it is trying  
9           to think about these, I think Larry said this  
10          before or it could have been someone else,  
11          maybe it was Tim, that is kind of wrong to  
12          think about quality and cost as being  
13          unrelated, that they are part of kind of joint  
14          production process. And if we don't think  
15          about that, the correlation and quality and  
16          cost within providers that we are kind of  
17          missing part of the signal. So, that is kind  
18          of the thinking behind the regression model is  
19          to kind of incorporate the within provider  
20          correlation between the quality and cost  
21          dimension and for how efficiency is profiled.  
22          So, there is a lot of technical details and I

1     refer you to the paper to sort through that.  
2     But it is a model that I think has some  
3     conceptual appeal but isn't currently in use  
4     by any sponsors.

5                     And then let me -- yes, please,  
6     Jeff.

7                     MS. WILBON:   Microphone please.

8                     DR. SILBER:   Could you go into a  
9     little more detail on that?  When you are  
10    talking about these being related, do you mean  
11    that the error structure is related between  
12    cost and quality and that is why you want to  
13    put them into a single model?  Is that the  
14    reason?

15                    Because that is a very different  
16    reason that suggesting that you do then what  
17    they did, which was report a conditional  
18    quality, based on cost.  I mean there is two  
19    different concepts that are going on.  One is  
20    a worry about the kind of metrics and the  
21    measurement and the other is just -- well, my  
22    concern is just what you get out of it is so

1 controversial.

2               So, would a patient care about  
3 what you get out of it? They might be glad  
4 that you got the error structure right but  
5 what you are giving them is something they  
6 might not want or understand.

7               So, I guess I want to separate  
8 those two concepts, what you get out of it and  
9 why they are -- you say it is nice that they  
10 are doing it with regression. Fine, they have  
11 somehow handled some of the error questions  
12 but they haven't -- but they are doing  
13 something that is very controversial in terms  
14 of saying to the public, well, okay, you do  
15 great, given that you don't spend very much,  
16 which isn't exactly what I think consumers  
17 want.

18              Am I right or wrong? Maybe I am  
19 misunderstanding it but I think that is the  
20 issue. So, I am not sure. We are praising  
21 them for a technical issue that is pretty  
22 minor, compared to what they are trying to do

1 with the model, which I think is concern.

2 DR. RYAN: Well, I think that is a  
3 great point. I hope that in the breakout  
4 session that we will have some time to kind of  
5 hash through the kind of implications of the  
6 technical specifications with respect to the  
7 use cases that we do consider.

8 So, and let me just continue on  
9 just at a high level to discuss another model  
10 that that same group proposed, which was to  
11 try to, and I think this gets us a little bit  
12 more towards this issue of value and that may  
13 or may not be a place where the group wants to  
14 go, but the idea with this cost effectiveness  
15 model is to try to put some valuation on the  
16 health benefits when considering efficiency.

17 And I think they are kind of the  
18 intuition here is that there could be a  
19 hospital that has say a much higher cost and  
20 slightly higher quality and, through an  
21 unconditional framework, could be considered  
22 to be inefficient. But if we consider if the



1 valuation of the benefits of that  
2 incrementally higher quality is very high,  
3 then they may, in fact, be producing health  
4 quite efficiently.

5           So that is what I think is an  
6 important consideration around, particularly  
7 around the units and how we think about the  
8 quality dimension. And you know if we are  
9 talking about an outcome that is mortality  
10 that we value very highly, small improvements  
11 of that on that measure could have --  
12 societally could be very valuable. And I  
13 think this approach tries to get at this  
14 concept of the efficiency-producing health  
15 state, rather than of limiting it to the kind  
16 of more hard to interpret metric that we often  
17 kind of assign to say a generic composite  
18 quality of measure.

19           So, that is another approach that  
20 was taken in the literature. Again, it hasn't  
21 been put in use by any program sponsors.

22           So, let me just wrap up with the

1     final two.  There is the DEA or stochastic  
2     frontier analysis.  So, we heard from Peter,  
3     and then Steven as well, that this actually  
4     has been used in the VA to profile  
5     inefficiency.  But it has been one, as Gary  
6     mentioned before that has had more kind of  
7     interest in traction on the kind of academic  
8     side.

9                     And the basic idea here is that --  
10    and Joe also relayed a very interesting  
11    anecdote which I hope he will share later --  
12    we can define a frontier based on these inputs  
13    and outputs.  And so what often has been done,  
14    and this was in the RAND report that Herb  
15    mentioned before, a lot of the kind of  
16    literature around measuring efficiency has  
17    defined output as kind of hospital days or  
18    some kind of standard kind of our physician  
19    used something like that.  And then that would  
20    be the output.

21                    And then we have something like  
22    physician labor or nurse labor or different

1 types of labor or capital are the inputs. And  
2 then you see which, based on that loose  
3 combination of inputs and outputs, there is a  
4 frontier. Then providers are profiled based on  
5 their kind of proximity to that frontier.

6 And I think that is some -- what  
7 is kind of nice about it is that efficiency is  
8 defined kind of over the range of all these  
9 combinations that we are not relying on. Kind  
10 of cut points around and thresholds to say  
11 that this group, these are efficient providers  
12 and these aren't efficient providers. So, I  
13 think there is some appeal there.

14 But I think, again, getting back  
15 to this idea of discrimination and  
16 interpretability, potentially one of the  
17 reasons why this hasn't gained a lot of  
18 traction in the field is that maybe kind of  
19 distance from the frontier isn't the kind of  
20 measure that is going to hold a lot of sway  
21 for patients or other people who are looking  
22 at these models.

1                   And then let me just finish by  
2     talking about the side-by-side model. So,  
3     this is a model insofar as that there isn't a  
4     formal process of combining the quality and  
5     cost of dimensions to say this, to then kind  
6     of score providers in some way, based on the  
7     concept of efficiency.

8                   So, this could be numerous  
9     measures that are shown together, numerous  
10    quality measures and kind of an episode cost.  
11    It could be a star system, which is being used  
12    more frequently. As Jeff mentioned, we didn't  
13    explicate all the ways that side-by-side  
14    models could be used but they are numerous.

15                  But the kind of idea here is that  
16    there kind of isn't a judgment being made. It  
17    is just this is the information. This is  
18    cost. This is quality. And we are showing it  
19    together for assessment.

20                  Yes, Peter?

21                  DR. ALMENOFF: I guess for us,  
22    when we do the SFA or even DEA, quality isn't

1 part of that when we do it. After we have run  
2 the model, then we run quality against it to  
3 just make sure. High efficiency leads to bad  
4 quality would be, basically, a bad starter.  
5 So, the idea is to really show, either no  
6 relationship or a positive relationship.

7 But then once we have done that,  
8 then we actually will do side-to-side. So, we  
9 are doing, I guess, six and seven and it is  
10 also regression so far.

11 Because somebody already brought  
12 up this point. If I am a person wanting care  
13 and someone brought up I guess the Cadillac  
14 and what was the other?

15 DR. GOESCHEL: The Smart Car.

16 DR. ALMENOFF: It's not too smart.

17 So, a patient buying care might  
18 want a five-star for this and a five-star for  
19 that. But if you combine them altogether,  
20 there is no way of knowing what component they  
21 are interested in. One consumer might want a  
22 very good deal and doesn't really care about

1 the fact that it is not five, it is three.  
2 But to me, if you want to have a single score  
3 that is fine but you have to be able to break  
4 it out to know the differences because  
5 consumers want to know is the quality good and  
6 is the cost reasonable. And if we can't tell  
7 them that, then it is not really useful.  
8 Because as you know, you can have a 1-1 or a  
9 5-1 or 1-5, the opposite direction, giving the  
10 same score but yet one is horrible efficiency,  
11 one is horrible quality. And I think  
12 somebody, a consumer really want -- and they  
13 will have a middle of the range score. And so  
14 here I was saying this is an average place but  
15 it could be horrible in one and really great  
16 in the other and they don't know that. So, I  
17 think it is important for them to at least  
18 understand those distinctions.

19 DR. RYAN: Right. And one thing I  
20 should note is that, and you just hinted at  
21 that, you mentioned it directly, Peter, is  
22 that there is kind of combinations of some of

1       these features for some of the models.

2                       So, you could have a conditional  
3       model but you know the data are displayed,  
4       too. So, that is a good point. But some  
5       programs just kind of stop with that  
6       comparison.

7                       Tim?

8                       DR. LOWE: I don't see this so  
9       much as models as they are methods. So, I  
10      mean if we go back to our basic research  
11      class, I mean the research question and data  
12      drive the selection and the method.

13                      So, what dependent variable are we  
14      using? Are we looking at cost? To me, I  
15      think we should be looking at variation as to  
16      the dependent variable, variation between  
17      providers, taking into consideration cost and  
18      quality. So, all things being equal are  
19      physicians, hospitals, whatever, providing the  
20      same care and kind of the unexplained  
21      variation. So we have explained variation and  
22      unexplained.

1                   But my thing about the regression,  
2           I was going to ask you both which model would  
3           you or method are you arguing for or are you  
4           just kind of leaving it open?

5                   And what is nice about the  
6           regression and I think, Jack, you probably  
7           would be pro the envelope. It is the most  
8           sophisticated, right? But the nice thing  
9           about regression is that there is a -- that  
10          you can do multi-level with it. So, we can  
11          look at a patient level and a provider level.  
12          Because there is a quality at the patient and  
13          there is a quality at the provider level.

14                  And you had raised the idea, Jeff,  
15          about these error terms. And that is one way  
16          of parsing out the error because there is a  
17          mixing of those two, the organizational as  
18          opposed to the patient level. Because,  
19          obviously, there is an interaction effect.  
20          And that is one way of parsing that out, that  
21          error that you had referred to is by  
22          separating these into two level models. It is



1 much more sophisticated and I suppose it is  
2 probably, I think for the envelope analysis,  
3 as much as I like it, it is very difficult to  
4 explain it to people. Economists we can but  
5 to the average person, they are going to go,  
6 what.

7 But now that you have reviewed all  
8 these things, which are you recommending or  
9 where do you see, both of you see this going,  
10 in terms of actually doing the research? I am  
11 going to put you on the spot here.

12 DR. RYAN: Well, you know that is  
13 not -- I can just punt and say that is not our  
14 charge.

15 (Laughter.)

16 DR. TOMPKINS: I was just  
17 following orders.

18 DR. RYAN: So, you know we want to  
19 identify the universe and say what is there  
20 and, through this process, hopefully, get  
21 towards a consensus.

22 But I think that -- well, actually

1 I do want to stop there. Sorry, Tim.

2 DR. TOMPKINS: No, we are a team  
3 and I don't want to run over my teammate here.  
4 But just to say something that probably  
5 everybody knows and you started to allude to  
6 it and you did, actually, earlier, too.

7 To the extent that you are really  
8 going to focus on the technical properties of  
9 the modeling or derivation process, there are  
10 some elegances to be had, including DEA for  
11 its own sake, regression for its own sake,  
12 because of the error structures or the  
13 attempts to systematize the comparisons and so  
14 forth.

15 And so I have one of my colleagues  
16 at Brandeis is one of the world's foremost DEA  
17 advocates and proponents and I hear from him  
18 often enough to be convinced that that is an  
19 interesting way to look at it. Most of the  
20 world uses regression techniques or central  
21 tendency and, therefore, it is usually more  
22 tractable.

1                   So from the point of view of  
2           measure development specification separating  
3           the errors and the variances into their  
4           levels, as you say and to be careful about not  
5           making inferences, for example, without  
6           respect to confidence intervals and likelihood  
7           et cetera is the territory of mistake and,  
8           therefore, more advanced statistical  
9           techniques can help guard against those kinds  
10          of things. So, we have to admire that there  
11          is a place for that.

12                   Now, whether the place for that is  
13          in developing the original quality measure  
14          itself and the original resource use measure  
15          or cost measure itself, that could be the  
16          case, in which case we are still left with  
17          this conceptual problem of how do you bring  
18          the cost and the quality measures into some  
19          sort of nexus where simultaneously  
20          determinations are being made, inferences made  
21          across multi-dimensions. And I think that the  
22          focus of this meeting and the charge, as Andy

1 put it, is to contemplate the various ways in  
2 which, reaching back to Greg's pragmatism, the  
3 various ways in which measures, as they have  
4 been developed so far, anyway, can be  
5 legitimately or perhaps not so legitimately  
6 combined in a way that expresses validly what  
7 somebody is trying to say, namely, purporting  
8 to measure efficiency or value.

9 DR. SILBER: I agree with what you  
10 said and what Greg had said earlier. I just  
11 think that in the report, you could have, for  
12 the side-by-side model, you could have  
13 described methods of side-by-side that are  
14 meticulous in using the same patients that  
15 made the estimate for the cost as the quality.  
16 Or you could have looked at other side-by-  
17 sides that do things in aggregate and then  
18 hope that the model adjusts for it adequately.  
19 And you could do it by matching, which is  
20 another method that wasn't listed.

21 So, I just think that you have  
22 given us a lot of detail on one through six

1     and I think seven should be broken out into  
2     various approaches.

3                   DR. PANTILAT:  Yes, it's really  
4     great to see all these methods laid out here.  
5     From the conversation, just understanding that  
6     there are benefits to different ways of  
7     approaching this.  But I worry a little bit  
8     that we might be confusing a little bit the  
9     method with sort of how it is ultimately  
10    presented to the end-user, whether that is the  
11    individual patient or purchaser or anyone  
12    else.  And it seems to me it is possible to  
13    separate those two, that there might be a more  
14    sophisticated approach to analyzing quality  
15    and cost and even combining them in some way,  
16    and yet a very simple way to explain it.

17                   At first I was thinking side-by-  
18    side makes a lot of sense to me to kind of  
19    keep things separate.  But then as I was  
20    listening more, I thought I think there is a  
21    way in which we should use sort of the best  
22    method that produces the most accurate

1     assessment, and then think about how do we  
2     present it in a way that actually simplifies  
3     it so that someone can make use of it.

4                   CO-CHAIR DUBOW:   Dennis, did I see  
5     your card?

6                   DR. SCANLON:   So, just a couple of  
7     questions.  One was about the time dimension  
8     and whether you thought about that or so much  
9     in the different approaches.  So, you might  
10    think, for example, especially when you are  
11    concerned about both cost and quality, it is  
12    the cost trend that might matter.  It is sort  
13    of how does a provider do kind of year to year  
14    and sort of what is the trend then in how --  
15    or sort of how important is anyone, period, if  
16    you are measuring just at a single cross-  
17    section.  So you can say the same thing in  
18    terms of quality measures as well.

19                   If you think about use in  
20    decision-making, and this often comes up in  
21    the context of consumer choice, I get a report  
22    card based on a provider for HEDIS data that

1     was collected two years' ago or a year and a  
2     half ago. And so if I literally take that  
3     seriously and I make a choice, given variation  
4     in a provider, what is the likelihood that the  
5     decision that I make, which ultimately comes  
6     into play two to three years after the data  
7     that the choice was based on.

8                 So, I was wondering if you might  
9     sort of talk about whether there was any  
10    consideration of time dimension in the things  
11    that you found or whether you think that there  
12    should be.

13                And related to that, one other --  
14    well, not related to that. But one other  
15    question I guess related to the quality hurdle  
16    model. It seems to me that a number of public  
17    reporting models also take the distribution  
18    and create cut points. You know, top third,  
19    middle third, bottom third, or deciles or  
20    whatever the case may be. And often times,  
21    just make cut points to the extent I mean when  
22    we have collectively looked at the

1 readmissions rates, what we have found is that  
2 the cut points, actually, you could do that,  
3 but the difference between one decile and  
4 another actually is very small because they  
5 cluster. The distribution isn't as large as  
6 it is. It sort of clusters together.

7 So, I don't know. Would that type  
8 of thing come under the hurdle model? I think  
9 of the way this was presented in the paper,  
10 the hurdle was kind of a low-level threshold  
11 and then sort of above that, you start to  
12 sort, based on other things but I was  
13 wondering about that as well. So, really the  
14 time dimension and then this distribution cut  
15 point.

16 DR. RYAN: So, with respect to  
17 time I think there is two issues that occur to  
18 me. One is the one that Greg has been  
19 mentioning about synchronizing measure costs  
20 and quality measurement over the same interval  
21 and having a kind of joint measure. Probably  
22 the episode is the best way to think about it.



1     Where you have a defined episode, you have  
2     costs in there and you have quality in there  
3     and there is something very clean and neat  
4     about that.

5                 We agree with that but we don't  
6     see that really happening in this space. I  
7     think one of the main reasons is that the  
8     quality measures that are out there, and this  
9     is a point that Carole made in one of our  
10    calls, there has been a lot of work specifying  
11    these and what is the right time period to  
12    look at all these things? When do you need  
13    this care? When do you need that care? And  
14    all those windows vary.

15                So, coming up with cost measures  
16    that kind of map on to all those, that fit  
17    those quality specifications is pretty -- that  
18    is a tough challenge. And I think so far the  
19    program sponsors have just said we are not  
20    going to be overly concerned. We think we are  
21    going to think about these signals as roughly  
22    reflective of what is happening in this

1 patient population. It doesn't need to map  
2 out exactly.

3 But with respect to like the time  
4 lags, you know wouldn't you say -- the two  
5 issues there are there is sometimes just a lag  
6 from program sponsors kind of getting,  
7 processing data, and getting it out there.  
8 And that is just detrimental to the whole  
9 process of profiling and public reporting.

10 But then the second issue is just  
11 for reliable signals, particularly for  
12 outcomes, you often need a longer time window  
13 for more cases to come in to be able to say  
14 with a degree of confidence that this is the  
15 point estimate. We feel confident that this  
16 is the level of quality from an end  
17 perspective.

18 So you know I think the issue,  
19 what we are talking about, is all those same  
20 issues that are out there in profiling costs  
21 and quality. They are still out there. These  
22 are, I want to say, kind of generic issues

1 with public reporting. And I don't think we  
2 are any, frankly, closer, to addressing them  
3 but I do agree from the perspective,  
4 particularly from consumer choice that these  
5 kind of lags in information being used for  
6 profiling inhibits informed choice from  
7 patients.

8 CO-CHAIR DUBOW: I just want to  
9 call attention to the time. So, I think that  
10 the tents that are up, we can talk about what  
11 we need to get to the breakout groups.

12 So, I have -- did you answer both  
13 of Dennis' questions by the way? Dennis, did  
14 we? We talked about time and there was the  
15 cut points.

16 DR. SCANLON: Yes, I think it was  
17 good enough.

18 CO-CHAIR DUBOW: Okay, Matthew.

19 DR. ROUSCULP: So, I guess going  
20 back a couple of elements. So, first of all,  
21 from a pragmatic perspective, it sounds as if  
22 we want to be able to capture variables that

1 are relatively easy. If we look at NQF  
2 measures, these are things that are kind of  
3 straightforward and direct and it is usually  
4 at the organization level of provider level.

5 But the question is when you start  
6 going into the regression model and some of  
7 these elements, especially when you are  
8 talking about quality and patient level  
9 quality but there is some of those patient-  
10 level variables that are going to be very  
11 important. That is kind of like ultimately  
12 where we would want to go but we have to be  
13 pragmatists here.

14 So, from your perspective, I was  
15 just wondering understanding some of the  
16 limitations as good as any of these models or  
17 the analyses that are going to go into these  
18 models, whether there are some of these things  
19 that we can say look, it is a good approach  
20 but it is not good enough. Therefore, the  
21 results are going to be shown is more about  
22 sensitivity analyses. And it is even with the

1 conditional model of others. We are going to  
2 have to present the data with a very wide  
3 range that is occurring. We need to be  
4 considerate of that, especially if we start  
5 talking about ratios. So, now I won't have  
6 the cost but I will have quality. We kind of  
7 mesh it. That kind of gets us really into  
8 some ugly problems as far as what are our  
9 results.

10 And that then gets back to, do we  
11 need to be considering some of those things to  
12 be able to say look, when we start doing these  
13 analyses, there isn't a certain number. There  
14 isn't going to be something clean that comes  
15 out of it and is that okay with us.

16 And the second, I guess, is around  
17 a lot of the discussions and more about a  
18 static approach. Right? It says what is the  
19 value as of whatever is being measured. Is  
20 there a dynamic nature, to expand upon what  
21 Dennis was talking about, whereas, timing. Is  
22 there change over time that we are actually

1 seeking and is that of value? So, you may not  
2 be one of the top performers but by moving  
3 upwards and becoming a mid-level performer in  
4 quality or being the high cost and going down  
5 to not such a high cost, does that actually  
6 have value in that because you are moving in  
7 the correct direction?

8 DR. RYAN: I'll take this. Okay,  
9 those are both excellent points.

10 So, the first one about how should  
11 we manage uncertainty in the estimates, you  
12 know I think this really is the way that  
13 measurement has been going is that a lot of  
14 measures are trying to do this at the measure  
15 level. So you see how the kind of measures  
16 that CMS has -- that have been endorsed here  
17 for mortality and readmissions. What they are  
18 trying to do is trying to take the noise out  
19 to the extent possible through this shrinkage  
20 approach, which Jeff and others are thrilled  
21 about.

22 (Laughter.)

1 DR. RYAN: And so at that measure  
2 level, they are trying to manage the  
3 uncertainty. And so but that is done to a  
4 varying extent across different quality  
5 measures and typically process measures. I  
6 have never seen any kind of shrinkage applied  
7 there. There is often just kind of cut  
8 points.

9 But the issue as to how do we say  
10 whether the output of kind of the quality and  
11 cost combination is sufficiently reliable, I  
12 think that gets into how NQF is going to -- it  
13 gets into the kind of guidance that we are  
14 going to be giving them for how should we --  
15 what should the kind of recommendations be  
16 with respect to how should reliability of an  
17 efficiency measures -- should we apply those  
18 same kind of criteria that we apply to  
19 individual measures with how those two things  
20 are combined in the output of that model.

21 And I, personally, think yes, we  
22 should. And a lot of that same testing that

1 we could do with reliability and validity is  
2 come up, I think, Jack and the other people  
3 have mentioned that the different models could  
4 give you different rankings and a way to show  
5 a model could be kind of a validity check  
6 could be if different models are giving you  
7 kind of a similar rankings of providers.

8 So anyway, I think there is kind  
9 of standard methods that we could use to apply  
10 to the combination of these measures that  
11 would kind of speak to the issue of  
12 reliability.

13 On that second point about  
14 improvement, so I know Hospital Value-based  
15 Purchasing, I know the program well. So, that  
16 is one where there is incentives for both  
17 attainment and improvement. It kind of gets  
18 rolled up into a total performance score for  
19 on the measure level, the maximum points for  
20 improvement or attainment are assigned and  
21 then hospitals get that. So, I recall there  
22 being one other program that incentivized



1 improvement but from most of what we have  
2 seen, it is really we are talking about levels  
3 that are being kind of profiled incentivized.  
4 So, it is kind of like how we first thought  
5 about pay for performance just profiles based  
6 on levels and leave it at that.

7 So, I think, again, I am not -- I  
8 can't speak to the entire universe of burdens  
9 but I think the emphasis has really not been  
10 on improvement to date. It has really been on  
11 levels of performance.

12 CO-CHAIR DUBOW: Although, I think  
13 in some cases that improvement, attainment  
14 business is statutory. Congress has looked to  
15 that as a mechanism for I think appeasing some  
16 constituents to give credit for improvement,  
17 as opposed to having to hit a mark.

18 So, I urge you, please, let's be  
19 concise so that we don't go too far over. And  
20 we still haven't heard from Chris, which I  
21 want to do after we run through our round.

22 Jack?

1                   DR. NEEDLEMAN: The point that I  
2     don't think has been made is that there is an  
3     analytic relationship among all these methods,  
4     including the regression-based methods. And  
5     the way to think about that is, to me, the way  
6     I think about it, is I think about the scatter  
7     plot of however I have measured quality and  
8     however I have measured cost. And each of  
9     those have an uncertainty about them because  
10    of the uncertainty in my data and a lot of the  
11    arguments we have over the measures and a lot  
12    of Jeff's concerns about shrinkage or how we  
13    position those points, given those  
14    uncertainties in the data.

15                  So, we have got the issue of have  
16    we got the scatter plot right or are the  
17    points moving around when we measure things  
18    differently. And that is one set of issues  
19    that is across all of these measures. But if  
20    you think about that scatter plot, what we are  
21    seeing with the conditional, the side-by-side,  
22    basically we are drawing lines in that scatter

1 plot and saying this quadrant is good and this  
2 quadrant is bad. And we are potentially  
3 paying people who are doing that. And that  
4 works.

5 And an awful lot of our analysis  
6 is driven by the fact that whenever we do  
7 these scatter plots, the space is reasonably  
8 full of points. So, what conditional model,  
9 what the side-by-side do, is they basically  
10 divide things up nonparametrically and say  
11 where on this graph of scatter points is your  
12 place. And is that a good place to be or a  
13 bad place to be?

14 What the regression line does is  
15 it puts a line through the middle of that data  
16 cloud and basically says who are positive  
17 deviants. And what the stochastic frontier  
18 analysis as the data envelopment people do is  
19 they put a line around the outside of that  
20 cloud and they say how close are you to that  
21 line of possibility and, preferably, how close  
22 are you to that line of possibility at low

1 cost.

2 Now, with the clouds completely  
3 filled, that DEA or frontier line is going to  
4 swing over the whole top of the thing. And we  
5 have got low cost providers that are  
6 delivering high quality and high-cost  
7 providers that are delivering high quality.  
8 And that is what the DEA will tell us. That  
9 is what the conditional model will tell us.  
10 That is what the scatter plot will tell us.  
11 And an awful lot of our decision-making around  
12 this, built around the assumption we are going  
13 to have a pretty scatter plot where we have  
14 more troubles and more difficulties is when  
15 that upper left quadrant, low cost high  
16 quality is basically empty. And the only way  
17 you get higher quality is to pay more.

18 And it is in those models that the  
19 regression models, the data envelopment, the  
20 stochastic frontier tell us something useful  
21 about the nature of those trade-offs in ways  
22 that simply drawing the lines and say I am

1     going to circle this group doesn't. So, we  
2     need to think about the models. We also need  
3     to think about what the distribution of  
4     quality and cost are and how uniformly  
5     distributed along both dimensions places are,  
6     because that affects the way we use it. It  
7     affects the way we interpret it.

8                     It is like if you are doing your  
9     -- it open enrollment and all the five-star  
10    health plans are \$400 a month more than all  
11    the four-star health plans. It is a different  
12    decision than if you have got a cheap five-  
13    star and an expensive five-star. And that is  
14    what we are dealing with. And each of those  
15    scatter on those two dimensions differently.  
16    That is what we are dealing with here but  
17    there is a relationship among all of these  
18    approaches, in terms of they are looking at  
19    the same data and they are trying to give us  
20    different metrics for interpreting.

21                    MR. ROMM: So, I agree very much  
22    with all of those points and that is the

1 pathway that I was actually heading down. So,  
2 I will not say any of that, other than to say  
3 absolutely.

4 I think that on top of that, there  
5 is another interesting consideration as we  
6 start to think about use cases, especially.  
7 Larry and I were talking about this a bit at  
8 the break. All of these models, except for  
9 maybe the side-by-side were developed for the  
10 purpose in healthcare effectively of payment.  
11 They are not being used for anything else at  
12 this point, really. There is a little bit of  
13 public reporting in small pockets but not  
14 much.

15 And so I think that then when you  
16 recognize that on top of that, fundamentally,  
17 all of that payment is in negotiation in  
18 almost every setting, except for Medicare.  
19 Then, it become somewhat of a useless  
20 exercise, I have to say. And so now, when we  
21 are talking about a commercial market, I think  
22 that we have to start to set some expectations

1     about where we want efficiency to go, which  
2     means making some very hard decisions about  
3     directionality here. Because otherwise, it is  
4     a fairly useless exercise and it becomes a  
5     negotiated base, negotiated performance  
6     targets and there is not much there.

7                   CO-CHAIR FLAMM: Just one quick  
8     response, though. I think, especially for the  
9     designation programs and those that are listed  
10    in there, they are not actually for payment.  
11    They are for informing benefit designs and  
12    member choice. So, I think that is a little  
13    bit of a different lever, than payment per se.

14                   CO-CHAIR DUBOW: But it is payment  
15    because you have set a value to it.

16                   MR. ROMM: Exactly.

17                   CO-CHAIR DUBOW: It has an effect  
18    of payment.

19                   MR. ROMM: Agreed.

20                   CO-CHAIR FLAMM: Okay, sorry.

21                   CO-CHAIR DUBOW: Okay, Peter and  
22    Alan, and then Chris.

1                   Jeff, is it really pertinent? All  
2 right, quickly.

3                   (Laughter.)

4                   CO-CHAIR DUBOW: Is it apropos to  
5 this point, Jeff? Are you commenting on this  
6 observation?

7                   DR. SILBER: I was going to be  
8 brief. But I was just going to say I think we  
9 are missing the forest from the trees. And  
10 that if you go to a simple example, like look  
11 at observed over expected, when you look at  
12 that metric in Health Services 101, you don't  
13 put hospital characteristics into the expected  
14 part of that ratio. If you put, say nurse to  
15 bed ratio in that expected part, you would say  
16 oh, this hospital is great, given that they  
17 have a terrible nurse to bed ratio but the  
18 death rate is terrible.

19                   I think we have to keep  
20 remembering that that is the problem. And as  
21 we talk about efficiency in method one through  
22 six, we have that problem. And I just feel



1     like the conversation is missing the point and  
2     that we are going to get into trouble if we  
3     use one through six and give that to the  
4     public. It is like saying, they were a great  
5     hospital, given they had terrible nursing.

6                   CO-CHAIR DUBOW: Peter.

7                   DR. ALMENOFF: One quick comment  
8     and then a question.

9                   Somebody had asked which model is  
10    probably the best model to use. And actually  
11    reading the study, the white paper you wrote,  
12    I think that something that would be extremely  
13    beneficial to everybody is actually just list  
14    all the possible models that exist, what their  
15    pros and cons are, what their use and  
16    strengths are. That would, actually, be a lot  
17    more beneficial than us trying to figure out  
18    which model is the right model. Because I  
19    don't think any of them -- I think all of them  
20    work in the right situation and in the right  
21    hands.

22                   So, just the fact that we know

1     some of these models clearly are not going to  
2     work in certain scenarios, some of them were  
3     built for the payers. Some of them were built  
4     for the providers. Some of them were built  
5     for big health systems that deliver money to  
6     hospitals. So, they all have pros and cons.  
7     But I think if we could just outline that,  
8     that would be much more useful to the public  
9     or anybody trying to build these measures that  
10    they don't try to give us an SFA model and an  
11    individual provider reimbursement system  
12    because it is probably not smart to do it that  
13    way.

14                 So, I think that would be  
15    beneficial because I have not actually seen it  
16    -- I know about most of these models but I  
17    have never seen them altogether and it was  
18    actually a very nice summary for me.

19                 The question I had was one of the  
20    things we are struggling with and maybe you  
21    know from some of the other issues is it is  
22    very hard for us to look at this over time

1     because we sort of have risk adjustments. We  
2     adjust across the country. As I mentioned, we  
3     look at things like snowfall. People complain  
4     we have more snow than other places in the  
5     country so we are less efficient. By the way,  
6     that is not true. We check it. We look at  
7     the snowfall in every place in the U.S. and  
8     there is no relationship.

9                 But when we do that, every year  
10    the models does change a little. And the  
11    purist in our group say we can't really say  
12    that if a place was eight percent efficient  
13    last year and is six percent efficient this  
14    year, I can't actually say they are better or  
15    worse.

16                So, I think a lot of these models  
17    are going to have those similar issues. And  
18    so if we are looking at a fixed period in time  
19    and we are deciding a lot, then a provider or  
20    health plan gets better, I'm not sure how to  
21    reconcile all of that.

22                DR. RYAN: Right. If all of the

1 comparisons are relative, then how do you say  
2 every year that there is a real change?

3 DR. ALMENOFF: So did you come  
4 across anybody who was able to address any of  
5 that? Because we haven't been able to figure  
6 it out.

7 DR. RYAN: The example you just  
8 gave, I mean it sounds like if there was just  
9 a frontier that was joined over both periods,  
10 then you wouldn't have a shifting frontier in  
11 both cases. I think you could assess whether  
12 there was a kind of difference in that  
13 distance in the two periods. But no, I can't  
14 think of -- nothing comes to mind that  
15 explicitly addresses that.

16 DR. ALMENOFF: Then the last  
17 comment was, people mention a lag of quality.  
18 What we have is a lag of the financials. So,  
19 we have a harder time getting accurate up-to-  
20 date financials. And we only can build this  
21 thing once a year because the data, the  
22 financial systems are not stable. And I don't

1 know if that is the same in the private sector  
2 but I have a feeling that they are the same.

3 So, we are having the opposite  
4 issue of we have very accurate quality data,  
5 pretty current, but we lag the efficiency  
6 side.

7 CO-CHAIR DUBOW: Okay, Alan, very  
8 quickly, I hope.

9 DR. SPEIR: As we move into our  
10 breakout sessions and we are going to be  
11 discussing these different models and the  
12 components of them, there is a fundamental  
13 question I still have that it has been touched  
14 on particularly by Jack and Jeff but I still  
15 don't get it. And that is, we can understand  
16 outcomes. We can understand and agree upon  
17 how those transcend variation.

18 How do you normalize cost? So,  
19 how am I to understand that a model that works  
20 in one locale and if I build, in your words,  
21 an efficient frontier that would be  
22 established and then the provider efficiency

1 will be based upon the variation from that  
2 frontier. But as I mentioned earlier this  
3 morning, given the variation in cost and how  
4 that is defined by the different payers in the  
5 different sectors, how does that relate and  
6 how can we get a model that will then be able  
7 to be understood globally, absent the  
8 normalization of these costs and how that  
9 relates to these models because I don't get  
10 it.

11 DR. RYAN: It is, I think,  
12 something that we just alluded to here. But  
13 we have heard a number of comments today about  
14 normalization. And we heard from the  
15 Massachusetts experience, it is an interesting  
16 question how much do you want to normalize,  
17 how much do you want to standardize? I mean,  
18 do you want to strip away price differences  
19 that are done on the basis of negotiating  
20 leverage? Probably not. Do you want to  
21 adjust for regional wage differences? You  
22 probably do.

1                   So, I think --

2                   DR. MAC LEAN: But why -- I'm  
3                   sorry. So, let's talk about say I am an  
4                   employer and I have got this group of  
5                   employees and I have to pay for their  
6                   services. And if it is cheaper for me to send  
7                   my employee to a hospital in Ohio than it is  
8                   for them all things included, airfare and  
9                   hotels and the like, if it is cheaper for them  
10                  to go there, then why not consider that, than  
11                  to have it done in Los Angeles?

12                  PARTICIPANT: Because I just  
13                  don't want to travel. Patients don't want to  
14                  travel.

15                  DR. MAC LEAN: Well, actually, we  
16                  have patients who do travel.

17                  CO-CHAIR DUBOW: We are not going  
18                  to resolve that one. That is a very  
19                  complicated question.

20                  (Laughter.)

21                  CO-CHAIR DUBOW: I just want to  
22                  give Chris the chance to add any commentary or

1     make any other observations before we hear  
2     from Ashlie with our directions for the  
3     breakouts.

4                   DR. TOMPKINS:   Sure.   Well, given  
5     the hour, what I will do is I will try to do  
6     a mini segue, successfully or not.   I don't  
7     know.

8                   One of the things I have been  
9     envisioning is the pinwheel, merely to make a  
10    point here, which is that there is a heart to  
11    the issue that we are having to address as a  
12    committee and as authors.   And distinguishing  
13    that heart from all of the strands that come  
14    off of it; i.e., the pinwheel.

15                   And I think that even from our  
16    earliest conference call and comments, we have  
17    all agreed that you can't have the heart alone  
18    without the pinwheel.   That is, even if it is  
19    just a reference for sophisticated readers, we  
20    have to say that there are other important  
21    issues that connect here, even though the  
22    purpose of this paper or the purpose of what



1 comes out from NQF isn't necessarily handling  
2 them with sufficient thoroughness and so forth  
3 to be topics in and of themselves. But they  
4 are reminders, signals to the reader that note  
5 that this is an important related concept.  
6 So, as you think about the heart of this, go  
7 elsewhere, too, and consider what else is out  
8 there that impinges on the heart of the  
9 pinwheel.

10 The second comment, which is quite  
11 different, maybe just tell a quick story. It  
12 begins with -- maybe some people remember this  
13 and maybe some people prefer to forget it.  
14 The word is RHQDAPU. Does that ring a bell?  
15 It probably does because if you have heard it  
16 once, you have probably heard it a thousand  
17 times. And if you haven't heard it at all, be  
18 glad. It is one of the government acronyms,  
19 Reporting Quality Data for Annual Payment  
20 Update. Is that rate? It was the hospital  
21 reporting requirement, which still exists to  
22 produce the aspirin on arrival measures, the

1     beta blocker measures and all the other skip  
2     measures and so forth that is now,  
3     fortunately, under IQR, instead of RHQDAPU.

4                     The Hospital Value-based  
5     Purchasing is one of the models here. And I  
6     actually kind of led the development of that.  
7     And I had some help from around the table.  
8     Andy was with me at the time and Gary Young,  
9     at the end of the table, he was part of my  
10    team. And we started that when there was  
11    RHQDAPU. That is, there was a public  
12    reporting program. But the charge was to come  
13    up with a Value-Based Purchasing Program. And  
14    the question is whether you pull it over from  
15    now what is called IQR versus what is  
16    different.

17                    All right, the reason I am saying  
18    this partly is segue is it would have been  
19    nice to have this paper. It would have been  
20    nice to have this committee's considerations  
21    and outputs back then. Because, for example,  
22    when you started out with just the public

1 reporting, you can have any number of stand-  
2 alone measures and that is what they did. You  
3 can go to the -- say here is one measure.  
4 Here is another one, for what it is worth.  
5 How do you like this one? Here's another one  
6 and here's another one. And it is the  
7 ultimate side-by-side, at least on the quality  
8 part because there was no attempt to comment  
9 on which is more important and which one is  
10 more reliable and which is more  
11 discriminating. It is just like pull up the  
12 hospitals in your area and you can see how  
13 well they deal in this sort of thing.

14 And for public reporting, it is  
15 actually okay, for example, if everybody does  
16 well in that measure. It might be reassuring.  
17 It might be informative. It might, in a  
18 sense, be useful. But, going from public  
19 reporting, which is just this full disclosure  
20 sort of transparency model to value-based  
21 purchasing, what you have to do is to say we  
22 are actually going to start to cause -- we

1     need some summaries here. We need to  
2     integrate these measures and we need to  
3     eventually come up with a singular measure,  
4     which we call the total quality measure Andy  
5     referred to with the attainment and the  
6     improvement, and the point system and so forth  
7     like that. It was an attempt to take  
8     disparate measures that otherwise did and  
9     could stand alone and turn them into a  
10    singular message.

11                   And without elaborating this sort  
12    of too much with the domains and so forth and  
13    so on, one of the things that we discovered  
14    was that, as I started to say, some quality  
15    measures, if everybody does well, is fine.  
16    But if you are trying to discriminate, you  
17    can't really use the -- you can't necessarily  
18    use the same set of measures because if some  
19    -- just because you can rank order providers  
20    on a measure, if it is a highly clustered  
21    distribution, the differences aren't  
22    meaningful. So, what you end up doing is

1     splitting hairs. Yes, somebody scored 93.0005  
2     versus 93.0004. So, therefore, one is better  
3     than the other? No, I don't think so.

4             So, the implications if you are  
5     trying to start to distill for payment  
6     purposes, or particularly a use case, you have  
7     to decide the quality of the measures and what  
8     they are really saying and how much it really  
9     brings and new useful information versus  
10    whether it is redundant or whether it is just  
11    bringing noise and it is confusing the story.

12            But then came along the ACA and it  
13    insists that the CMS develop efficiency  
14    measures. And now the Agency goes what is  
15    that. And that is where this paper could have  
16    been useful in part -- well the paper yet to  
17    be written of course -- where the paper that  
18    we are envisioning could have been useful  
19    because one of the implicit questions there  
20    was to say okay, you have got these domains  
21    already in quality. You have a process  
22    domain. You have an outcome domain. You have

1 a patient experience domain. And they are  
2 weighted, the preference weighting for value  
3 and so on.

4 Well, let's just make another one.  
5 Let's call it the efficiency domain. It  
6 doesn't matter what is in it. It is just that  
7 this is going to be where the resource use and  
8 the dollars are in. And so candidates started  
9 to be well, one measure that could go in there  
10 would be the emergency room throughput time  
11 and maybe blood units per surgery. In other  
12 words, resources that are actually used in the  
13 ingredients of production.

14 Okay, what turned out to be the  
15 case because ACA also required the hospital  
16 spending per beneficiary measure to be  
17 calculated, which is probably familiar to some  
18 of the heads that are nodding and others as  
19 well. And we started to work on that. We  
20 worked on the first version of that. But that  
21 became the candidate for what had become the  
22 sufficiency.

1                   But the question there in the  
2                   efficiency became, particularly as it related  
3                   to hospital spending per beneficiary was, this  
4                   is now the 30-day cost measure, it is the DRG  
5                   plus the 30-day post-acute. The question  
6                   became -- now this goes back to what I said in  
7                   the morning about being tethered or better or  
8                   for worse, so the previous definitions. If  
9                   the definition that NQF, AQA, and so forth  
10                  were saying what efficiency was, cost in  
11                  relation to a specified level of quality.

12                 Then the question is, if you just  
13                 had cost as its own separate domain, standing  
14                 alone in what is called here the unconditional  
15                 model, is that good enough? Or, to be  
16                 compliant with ACA's requirement for an  
17                 efficiency measure and to also be faithful to  
18                 what the industry is saying is what an  
19                 efficiency measure is, do you have to link the  
20                 two?

21                         In other words, so here is a  
22                         practical question. If you are going to

1     compare the resource use or the cost of a  
2     given set of hospitals, should it be on  
3     average across all hospitals or should the  
4     comparisons be limited to hospitals that are  
5     said to provide the same level of quality,  
6     which comports with the definition? And if  
7     you do that, then implicitly, the cost  
8     distributions could be different, if you said  
9     the highest quality hospitals will only be  
10    compared to highest quality hospitals.

11                 And if it turns out that it is  
12    cheaper to produce lower quality hospital  
13    products, that doesn't matter for this  
14    comparison because we want to know which  
15    hospitals among those that produce the highest  
16    quality are the most or the least efficient.

17                 And I think it is sort of in this  
18    realm of whether or not you need to consider,  
19    and that is the practical question, does the  
20    benchmark for cost, and the distribution, the  
21    implicit distribution for comparisons, be made  
22    in light of a specified level of quality or is



1     it okay to say it is a separate unconditional  
2     domain?

3                     And so, therefore, the segue part  
4     of my comment is that if we are going into the  
5     breakout sessions, it is a question about what  
6     are you trying to accomplish here. And then  
7     it is not so much do I like regression or do  
8     I like DEA. The point is from the perspective  
9     of this stakeholder, the person who reads this  
10    report or the person who is actually going to  
11    try to use these measures or make decisions  
12    along these lines, if you are trying to do it  
13    for public reporting, take that perspective  
14    and decide what is the question. What are the  
15    most important questions to tackle, the  
16    priorities, what is important, what is less  
17    important, if you are thinking about public  
18    reporting. And then another group might be  
19    thinking about network management and so  
20    forth.

21                    And I think that what we want to  
22    do is to have everybody bring their best ideas

1       into whatever group you are in, make sure you  
2       heard but use it within the constructs of that  
3       use case and see whether or not, at least to  
4       generalizable conclusions, they could spill  
5       over to other use cases or maybe you identify  
6       things that are really particular and special  
7       for use case. And so, therefore, that has  
8       implications about how we might, as it were,  
9       stratify our recommendations.

10               CO-CHAIR DUBOW: Thanks very much,  
11       Chris. Ashlie?

12               MS. WILBON: Yes, thanks. Chris  
13       actually hit on several things in his  
14       comments, hopefully that will actually be a  
15       very good segue into our breakout discussion.

16               So, you probably saw us huddling  
17       before lunch started. And we have really been  
18       kind of digesting everything that has been  
19       said today. There has been some really great  
20       discussion and we were trying to figure out  
21       the best way to integrate some of the comments  
22       that you have and also kind of give you the

1 best direction that we can, so that are you  
2 are able to continue to give the rich input  
3 that you have in the context of what we are  
4 trying to get out of here and make sure that  
5 you have clear direction as well.

6               So, what we landed with is we are  
7 going to continue to have you break out into  
8 groups based on use case, and we will share  
9 the assignments shortly, into four groups.  
10 But we have kind of tweaked the questions that  
11 were in the discussion guide a little bit. We  
12 are going to have -- one of the suggestions  
13 that we are going to go with and see how this  
14 works because a lot of this has been somewhat  
15 of an organic discussion and obviously, we  
16 came with a plan but sometimes things change  
17 and we want to be adaptable and flexible and  
18 go with that so that it works for the rest of  
19 the discussion.

20               So, rather than you have guys  
21 focus specifically on the models, per se, and  
22 how the models fit a particular use case. We

1     are going to have a little bit broader  
2     discussion around the use case and what types  
3     of considerations you would have for measuring  
4     efficiency within that use case. And if  
5     through that discussion you come up with, as  
6     Chris described, for you to do this particular  
7     use case that you need to have measures or an  
8     approach that does A, B, C, and D, that  
9     perhaps you end up describing some parts or  
10    pieces or a full model that has already been  
11    identified in the environmental scans, we are  
12    trying to break you free of having to stick to  
13    specifically a model but have you think  
14    broadly about kind of what you would need to  
15    be thinking about for that particular use  
16    case.

17                 So, hopefully, that resonates with  
18    people and will help kind of facilitate the  
19    discussion a little bit more so you don't feel  
20    constrained. And there will be a staff  
21    facilitator in each of the groups. So, we  
22    will try to answer questions. We are going to

1 have Chris and Andy, as well as the co-chairs  
2 rotating between the groups. So, to the  
3 extent that you have questions, hopefully they  
4 will get to every one of the groups.

5 We are going to have the groups  
6 kind of move to different sides of the room so  
7 it is easy logistically for people to rotate,  
8 for our chairs and authors. And we may end up  
9 shifting a little bit. And it is not  
10 particularly ideal because, obviously, you are  
11 going to hear discussions of other groups but  
12 we will do our best to work with it. If it  
13 gets too noisy, we do have an alternative. We  
14 can move to a space somewhere else upstairs.  
15 But we are going to do our best with the space  
16 and, hopefully, we can work that out.

17 Again, we will identify a  
18 spokesperson to report out. And I think,  
19 given the time, we are going to -- I think the  
20 agenda had us only going to 3:15 for the  
21 breakout sessions but I really feel like we  
22 are going to need more than 45 minutes at this

1 point to discuss the different use cases.

2 So, why don't we go to -- would  
3 people be okay with going to let's see, 3:30  
4 at least 3:30 or 3:45? We will do a pulse  
5 check around 3:30 to see how groups are going  
6 and if you guys need a break if you can go  
7 another 15 minutes, we will keep going and we  
8 will kind of go from there. Let's say 3:30  
9 for now and we will pulse check.

10 I do just want to go through the  
11 question that we are posing for each of the  
12 groups. Again, we are trying not to constrain  
13 you too much but we want you to have some  
14 structure. You have got to have an idea of  
15 what we are looking to discuss. Many of these  
16 things are some of the kind of topics that  
17 Chris touched on in his last comment.

18 So, for each use case, we are  
19 looking for you to talk about the  
20 considerations for measuring efficiency for  
21 the use cases, which includes the audience,  
22 interpretability, extent of the scientific

1 rigor that may be required and then the four  
2 use cases that we discussed earlier, quality  
3 improvement, public reporting, network design,  
4 or tiering and then pay for performance.

5           And then again, how might the  
6 intended perspective of the intended audience  
7 impact the selection of the model for a  
8 particular use or uses. And then Erin, could  
9 I have you go to the next case? There should  
10 be another. There we go.

11           And then what, again, principles  
12 should be considered when selecting individual  
13 measures for cost and quality into the use  
14 case. So, again, how are you deciding which  
15 measures get put into, for that particular use  
16 case, how are you deciding which measures you  
17 are picking to measure efficiency?

18           So, we have some examples here of  
19 some things you might want to consider. But  
20 again, we are encouraging discussion to the  
21 extent that you have ideas about this, measure  
22 type, whether or not there is a performance

1 gap. Is there room for improvement? What the  
2 focus of the efficiency measure is to be. And  
3 then stakeholder perspective, which we have a  
4 lot of discussion about already as well.

5 Then, I think, there is one more  
6 set of questions around kind of the need or  
7 lack of need for technical or conceptual  
8 alignment of the various measures that are in  
9 the actual efficiency approach. So, do they  
10 need to be aligned in terms of the developer  
11 having developed both a cost measure and the  
12 quality measures at the same time and sharing  
13 the same denominator, measure population, risk  
14 adjustment and so forth.

15 So, again, this is not an  
16 exhaustive list. This is just, again, to give  
17 you a framework of what to be thinking about.  
18 We encourage a rich discussion to the extent  
19 that you can, based on your use case that you  
20 have been assigned to.

21 Does anyone have questions about  
22 where we are going with this?



1 CO-CHAIR DUBOW: I think we're  
2 going to just try to get the question to each  
3 group.

4 MS. WILBON: Yes, we will print  
5 them out for you. And we changed a few of the  
6 questions but for the most part, they are in  
7 the discussion guide. So, if you have your  
8 discussion guide, it will give you a pretty  
9 good idea of what we are going to be talk  
10 about and your staff lead will help facilitate  
11 that as well. So, but we will also make sure  
12 that you have an updated list of those  
13 questions.

14 CO-CHAIR DUBOW: I just have a  
15 very quick question. Does anybody have an  
16 absolute hard stop at five o'clock?

17 Matt? Okay. Did I see somebody  
18 else? That's two. Okay, thank you.

19 MS. WILBON: Vy, can you share the  
20 breakout group assignments, please? Thanks.

21 So, Group A we will put in the  
22 corner behind us to the left. That

1 facilitator will actually be Lindsey -- not  
2 Lindsey. It says Lindsey but it will be Erin.  
3 Group A up here in the corner.

4 Why don't we put Group B up here  
5 in the right-hand corner with Rob, another  
6 staff person here? He's over here.

7 Group C, we will put in the back  
8 to the right. That is with Taroon. And then  
9 Group D is pay for performance, that is me,  
10 will be back by the food and the coffee.

11 (Laughter.)

12 MS. WILBON: So, we will give  
13 everybody a couple of minutes to get to their  
14 groups.

15 (Whereupon, the foregoing meeting  
16 went off the record at 2:29 p.m. and went back  
17 on the record at 4:02 p.m.)

18 MS. WILBON: If everyone could  
19 start making their way back to the table, we  
20 would like to go ahead and get started with  
21 the first report out, which was, I think we  
22 are going to go in order, starting with Group

1 A.

2 CO-CHAIR DUBOW: So, can we bring  
3 everybody back together so we can -- we don't  
4 have enough of a quorum, I don't think.

5 So, this part of the afternoon is  
6 devoted to the report outs from the first  
7 breakout sessions. Is that right, Ashlie?  
8 And do we have -- if we go in order, is the  
9 quality improvement group here and is your  
10 spokesperson here? Well, I actually know you  
11 are.

12 DR. WOZNIAK: Should I stand up?

13 CO-CHAIR DUBOW: You can do  
14 anything you like, just so long as we can hear  
15 you.

16 MS. WILBON: Hold on one second.  
17 Erin, did you guys have slides? We don't have  
18 slides for our group, by the way.

19 CO-CHAIR DUBOW: But you know we  
20 are going to need to hear you.

21 MS. WILBON: Hold on a second. We  
22 are going to give you a microphone so it's

1 recorded. Thank you.

2 DR. WOZNIAK: Well, I don't know  
3 if anyone read that New York Times article a  
4 couple of years ago about how in the Army they  
5 don't do anything without PowerPoint, the  
6 whole PowerPoint culture. So, hopefully, we  
7 can do something with that PowerPoint.

8 Our group had a really interesting  
9 discussion. The first thing we discussed was  
10 actually what is our question. Because we  
11 were not certain if the question was what  
12 measures are useful to determine the  
13 efficiency of quality improvement efforts or  
14 what measures will be useful for assessing  
15 performance improvement efforts to improve  
16 efficiency, efforts to improve efficiency.  
17 And we decided to focus on the latter. We  
18 thought what we were looking for was measures  
19 and models that would be used as the measures  
20 when providers, organizations, were doing  
21 projects to improve their efficiency.

22 So, the first observation, an

1 observation we had is that there is a  
2 difference between measures for our  
3 perspective and the three others. The three  
4 other perspectives are largely external,  
5 either patient or payer perspectives on  
6 healthcare delivery and total cost as price  
7 can work for those perspectives. But for the  
8 perspective that we were talking about, it  
9 really depended, you really wanted to get the  
10 economic efficiency of the cost of production  
11 of services by the provider and match that  
12 with the quality of those services.

13           There was a thought that the  
14 metrics are going to need to be actionable.  
15 And the perspective is very important. And  
16 this perspective would be the healthcare  
17 delivery system or provider. So, we should  
18 probably give some examples. But if the  
19 example was the cost to produce a cabbage --  
20 so stepping back, we thought the measurement  
21 perspective was largely for an organization or  
22 provider that was ranked in one of these other

1 systems as an efficient system, as an example,  
2 and wanted to improve their rating on the  
3 tiering scale.

4 MS. WILBON: I actually think your  
5 microphone went out. Try it again, maybe. We  
6 would like to get it on --

7 DR. WOZNIAK: So, the metrics need  
8 to be actionable. Many of the measures that  
9 have been developed are not going to be  
10 actionable at the provider or the institution  
11 level. So, the example of the -- some of  
12 these examples, a tiering program that tiers  
13 hospitals in three levels of quality, that is  
14 generally not going to give the hospital  
15 actionable information on how to improve their  
16 efficiency.

17 And so, measures in this domain  
18 are going to need to align cost and quality  
19 measures around episodes or conditions that  
20 are actionable. And data is a challenge in  
21 this space. Most American healthcare  
22 providers don't have accurate cost accounting

1 information and so that is another area that  
2 is a challenge.

3 We thought that outcomes measures  
4 would be best. So, the true production cost.  
5 And if you read about Intermountain Health and  
6 Brent James and all of the work they have  
7 done, they have a very accurate cost  
8 accounting system and so they can look at  
9 their true costs. But in many systems, we  
10 don't have that. And so process measures  
11 would be important, things like average length  
12 of stay for admissions, nursing ratios, and  
13 other process measures of cost, as long as  
14 those are not being done or improved at the  
15 expense of overall cost.

16 Because we had an example that was  
17 if you wanted to improve the internal  
18 efficiency of care for patients with pneumonia  
19 and you had long length of stay, you might  
20 hire a hospitalist service. But the cost of  
21 hiring a hospitalist service, unless you are  
22 accounting for that, you might be able to

1     improve the process of length of stay but you  
2     need to measure cost to get the whole part of  
3     that.

4                   Having compatible benchmarks was a  
5     key issue. And so, there are currently  
6     organizations, ActionOI, UHC Premier that do  
7     these sorts of measures for improvement on  
8     efficiency internally. And the hospitals in  
9     particular get their data because they want  
10    comparable benchmarks. But the challenge is  
11    that since our cost accounting systems aren't  
12    accurate, often even these metrics are not  
13    really comparable across institutions. So,  
14    the way in which nursing hours are accounted  
15    or in which other pieces that go into these  
16    are accounted may not be comparable across  
17    institutions.

18                   And so for the models selection, I  
19    think that was the next one, we thought the  
20    potential model that would work would be the  
21    side-by-side model, where an institution would  
22    look at -- and this I how many institutions do



1     this now. They have a dashboard of some type  
2     that has internal cost measures, either  
3     process or actual cost measures and also has  
4     quality measures. And the people who are  
5     doing the performance improvement look at both  
6     of them.

7                     And that the quality hurdle  
8     framework would probably be how most places  
9     would approach this. They wouldn't want to  
10    decrease quality in order to -- to decrease  
11    quality less than they are decreasing costs.  
12    So, they would want to hold quality constant  
13    and usually at some level that they had set as  
14    a goal.

15                    You could imagine using a method  
16    like DEA if you had a network of providers and  
17    could compare lots of different providers,  
18    different hospitals or entities to look at  
19    across the production frontier how they would  
20    compare. But as an individual institution, it  
21    would be hard to do that.

22                    So, I think that is the summary

1 from our group but I want to let other people  
2 from the group speak up because we had a  
3 diverse and interesting discussion.

4 I guess one last point, our last  
5 point of debate was is this the space that NQF  
6 should be. Should NQF be in the space of  
7 reviewing and endorsing measures which are  
8 essentially for internal improvement? And NQF  
9 used to do that a long time ago but now all  
10 measures have to be outward facing also. And  
11 we thought this probably is not actually an  
12 area for NQF to be active.

13 And so we thought it was important  
14 for the product of this workgroup, the paper  
15 to discuss the limitations of current  
16 efficiency measures in providing actionable  
17 information to improve the actual efficiency  
18 of care.

19 CO-CHAIR DUBOW: So, do any of the  
20 members of the breakout group have anything to  
21 add?

22 So, let's have a -- are there any

1 questions from the rest of the workgroup?

2 I think I would like to ask NQF  
3 staff about the very last point that was made  
4 with respect to what NQF's interest is in  
5 having your measures alone.

6 MS. WILBON: So, I'll start. So,  
7 we are actually going to have a more in-depth  
8 discussion around the endorsement process  
9 tomorrow, which I think is where that  
10 discussion probably goes. But he is correct.  
11 In generally, we have our policy is that we  
12 endorse measures for performance, improvement  
13 and accountability purposes, and not only  
14 internal QI. I mean, there are measures that  
15 can be used for accountability purposes and  
16 performance improvement that are also used for  
17 internal QI but not just approaches for  
18 internal QI.

19 I will say in the concepts of the  
20 paper, though, while endorsement may be off  
21 the table for those particular applications of  
22 efficiencies, approaches or models, that type

1 of thinking around that context may be useful  
2 to other entities that would pick this up and  
3 say maybe NQF is not going to endorse our  
4 efficiency approach but maybe the approach  
5 that we use at our institutions, we can take  
6 some of these principles and apply it.

7 So, I think, obviously, the work  
8 of the group is still very valuable. But in  
9 the context of NQF endorsement, perhaps --

10 CO-CHAIR DUBOW: Although there  
11 has been -- I am just blocking on the term we  
12 used but there has been some discussion at NQF  
13 about looking at a continuum of measure types  
14 and being very clear about purpose of the  
15 measure and slotting them. I can't remember  
16 what we call that.

17 So, there has been some discussion  
18 about that but I think the point is well taken  
19 and that we should think about that.

20 If there is no further discussion  
21 or questions about this, we can move onto the  
22 second group, which was public reporting. Who

1 is the spokesperson for that group?

2 DR. SCANLON: Okay, so I am.

3 CO-CHAIR DUBOW: Dennis.

4 DR. SCANLON: I was nominated and  
5 we sort of passed the baton a few times but I  
6 think that all of us had enough uncertainty to  
7 some extent that I am going to pause at a few  
8 occasions and let others on the group sort of  
9 chime in so I don't screw it up.

10 So, public reporting, obviously,  
11 is a very common use of measures reporting and  
12 we wanted to sort of take a look at this in  
13 the context of efficiency. We really sort of  
14 answered these questions. Why would we  
15 publicly report? We really found ourselves  
16 after the fact kind of coming back to that  
17 question and saying what is the value of doing  
18 this. I'm not sure that that was necessarily  
19 on the list. What do we hope to get out of  
20 it, how to involve stakeholders, what type of  
21 efficiency could be reported and what is  
22 needed for the future if NQF and others are

1       going to go in this direction.

2                       And so the question why would we  
3       publicly report efficiency, the credible  
4       threat of consumer use in many respects when  
5       it comes to provider quality or patient  
6       experience, I think there are some who sort of  
7       wonder whether consumers, patients look at  
8       this information, whether they use it, whether  
9       they make decisions based on it but there is  
10      the view that there still is value in the  
11      market place for purposes of improvement or  
12      for providers to kind of benchmark relative to  
13      others and consider where they stand and make  
14      changes as a result of it.

15                     You know, it is, in specific  
16      cases, things like labs, imaging, there might  
17      be opportunities where people would use this  
18      information. We spent some time talking about  
19      kind of the choice situation from a consumer  
20      perspective in considering specialist  
21      referrals or acute and emergent conditions,  
22      versus conditions where you have more time to

1       make a decision.

2                       There is a lot of factors that  
3       would potentially prevent consumer use of this  
4       information or patient use. But there are  
5       some circumstances where it might be more  
6       likely than others. There is certainly the  
7       provider reputation reason and the notion that  
8       when things are reported, they become public.  
9       They get disseminated through the media,  
10      through the social media and reputation can be  
11      affected or impacted by virtue of how one  
12      looks in these types of reports. And as a  
13      result, that may motivate providers as well.  
14      And there may also be some research value as  
15      well.

16                     So, anything else from our group's  
17      perspective on this question?

18                     DR. WONG: I think that is a fair  
19      characterization. I think our group really  
20      started from the point we had some doubts  
21      whether or not consumers would really look at  
22      efficiency measures. So, we came across the

1     notion or recognition that this is a train  
2     that is kind of moving forward. To the extent  
3     that we want to contribute to the  
4     conversation, what are some of the reasons why  
5     we believe folks might looking at that. And  
6     so the credible threat sort of aspect came up  
7     and the provider reputation sort of came up.  
8     And that is how our conversation progressed.

9                   CO-CHAIR DUBOW: Dennis, if I  
10    could just take my chair hat off for a minute.  
11    You know, again, if we think about linking  
12    cost and quality measures, as opposed to  
13    thinking about efficiency measures, then I  
14    think there is a clear consumer interest. So,  
15    I think again this becomes definitional or  
16    focus or however we characterize this. But I  
17    would not want to take consumer interest out  
18    of this public reporting space without some  
19    acknowledgment that cost and quality together  
20    represent a very important area for consumers.

21                   DR. SCANLON: Yes, I think that  
22    gets back to sort of definitional sort of what



1     it is being sold at and a whole variety of  
2     things that we have talked about today. I  
3     mean is it a composite with a name like  
4     efficiency. Is it side-by-side. But I guess  
5     maybe you are making a case for or possibly  
6     making a case for the side-by-side component  
7     where quality is very clear. And then there  
8     maybe this other piece, which may or may not  
9     be as actionable.

10                 CO-CHAIR DUBOW: And I think we  
11     can't lose sight either of the sheer value of  
12     putting sunlight on performance and the well-  
13     known responses from the clinical community to  
14     doing that. It has driven improvement, even  
15     if consumers don't use the data themselves.

16                 DR. GOESCHEL: I think, Dennis, if  
17     I could, just to speak to that, I think we get  
18     at some of that as we get closer to -- even as  
19     we went around the circle, I think we got some  
20     of that. So, I agree with you.

21                 DR. SCANLON: Right. So thinks  
22     like this, getting consumers to ask questions,

1     have greater awareness of variation, maybe, as  
2     we said, select efficient providers. So that  
3     is kind of the area I think that creates the  
4     most uncertainty in our mind.

5                     You know we even talked about  
6     things like from a public policy or sort of  
7     public goods perspective the notion that --  
8     just the fact that there is variation or there  
9     may be variation in efficiency in expenditures  
10    due to that from a publicly funded healthcare  
11    program perspective as a series of tax payers,  
12    consumers might be interested because their  
13    money is potentially being spent on less than  
14    optimal or less than efficient providers.  
15    That might require a packaging of information  
16    that is a little different. In that case, it  
17    is the message. There is variation and there  
18    is inefficiency and somebody is paying for it,  
19    as opposed to sort of information in a  
20    traditional kind of report where you might be  
21    using it to make a choice.

22                     And then certainly to have prices

1 converge to rational pricing is a vehicle to  
2 sort of have things converge. We talked  
3 earlier about the example in reference pricing  
4 in California.

5 For patients, the information  
6 would be better if it was easily  
7 understandable, had face validity, was  
8 meaningful, displayed in a visually  
9 understandable way, so less technically  
10 complex, perhaps, or at least displayed in a  
11 way that the technical complexity of the  
12 computation would not overwhelm the  
13 presentation and from a trusted source.

14 So, other comments in our group?  
15 Anything that we --

16 Okay, in terms of involving  
17 clinicians, hospitals, providers, getting  
18 their buy-in, again, the validity issue, face  
19 validity, scientific validity is very  
20 important here as well. You know there was  
21 discussion about the measures needing to be  
22 related to something within their control and

1       that they could improve. So, from the  
2       provider stakeholder perspective, this was  
3       what we discussed.

4               Again, earlier on this morning, we  
5       talked about the role of regulation or from a  
6       regulatory perspective. So, again, there  
7       could be value in and of itself of documenting  
8       variation in efficiency. You know you might  
9       say that this is regulation on the part of a  
10      payer, particular a public payer, but there  
11      may be regulatory decisions that could be made  
12      based on this information and it could be  
13      useful for incorporation for that purpose.

14             Payers, obviously, used for  
15      negotiation to avoid unintended consequences.  
16      And somebody may want to speak to that because  
17      I am blanking on sort of the point here,  
18      making sure that we are measuring what we  
19      think we are measuring and good communication  
20      message to explain these concepts.

21             Does somebody want to address the  
22      unintended consequence issue?

1 DR. RASK: The unintended  
2 consequence issue is just being sure what  
3 metric you are using for cost and that you  
4 don't do it in such a way that there is an  
5 unintended consequence of a provider looking  
6 good on that measure by denying access, by  
7 denying appropriate care.

8 DR. SCANLON: Okay. In terms of  
9 organizations, the ability, so how would  
10 organizations sort of internalize or use this,  
11 the ability to use and apply to their users,  
12 their audience, making sure the information is  
13 consistent and maintain integrity as it is  
14 disseminated. And this may lead to complex  
15 methods being lost or adulterated as they are  
16 passed on. And so that is certainly something  
17 that one would need to look out for.

18 In terms of what type of  
19 efficiency could be reported, we had, I think  
20 a fairly significant discussion on this is  
21 that discrete quality measures that actually  
22 represent efficiency, for example, things like

1 readmissions, and there was some discussion  
2 that in and of itself, preventable or  
3 avoidable readmissions are, by nature,  
4 potentially inefficient.

5 Discrete episodes that could be  
6 selected or improved or broader report card  
7 categories or stars for overall efficiency for  
8 clinicians or hospitals. And I think I will  
9 ask Iyah, do you want to say a few things on  
10 this? We had some discussion on this point.

11 MR. ROMM: So, I think the  
12 challenge that we wrestled with is that we  
13 felt that were in some ways treating all  
14 efficiency as the same and recognizing that  
15 there probably are many flavors of efficiency.

16 There is the vector of cost and  
17 quality which we spent a lot of time talking  
18 about this morning and/or the linkage of them  
19 side-by-side, even if they do not combine into  
20 some vector.

21 There is the efficiency that, as  
22 Dennis said, is sort of the quality measures

1 in and of themselves that may or may not be  
2 truly what we mean by efficiency but I think  
3 ease of meaning. And when we think about  
4 things like choosing wisely and the wasted  
5 space there, I think there potentially is  
6 import in bringing that back to bear as well  
7 and really highlighting that area in a  
8 consumer-oriented way around those things that  
9 both are inefficient and potentially harmful.

10 And then we have done a lot of  
11 work in recent years on things like segmenting  
12 certain episodes, deliveries, hip and knee  
13 replacements, other things that patients can  
14 make choice around.

15 I think one of the challenges, and  
16 back to your other comment around consumers  
17 want this information, I agree with you in  
18 every conversation that I have with consumers  
19 is in that direction. Part of the challenge  
20 that we face is in Massachusetts we had a cost  
21 and quality website for a number of years that  
22 had dollars signs and stars and nobody used

1     it. And it had every provider. It had  
2     physician groups. It had hospitals. It had  
3     all sorts of procedures. It had the same  
4     quality measures we are talking about here,  
5     side-by-side and it was never in use.

6                     And so I think we have to face  
7     sort of a fundamental challenge. And we  
8     stopped doing it, Massachusetts as a  
9     commonwealth stopped doing it. So, there is  
10    a challenge that we were also wrestling with  
11    in this conversation around we all believe  
12    that this is the case but there is sort of an  
13    information and use gap that we have to figure  
14    out how to address in that public reporting  
15    space, specifically around consumers.

16                    CO-CHAIR DUBOW: And my two-second  
17    answer: I think there is value to publishing,  
18    even if they are not using it.

19                    MR. ROMM: Agree completely. I am  
20    not a proponent of not doing it. But I think  
21    that specifically for the consumer segment, I  
22    think that we all agree that there is value



1 simply to transparency and that the sunshine  
2 that comes along with that and the behaviors  
3 that potentially change, but specifically on  
4 a consumer use perspective and driving choice,  
5 one of the things that we spent a bit of time  
6 talking about is that we can talk a lot about  
7 quality but actually measuring cost and  
8 pivoting cost against quality is incredibly  
9 hard. We had some conversations about things  
10 like facility fees.

11 And within a given organization,  
12 the fact that different sites of care have  
13 various rate bases integrated, academic,  
14 affiliated, there is huge variation here. So,  
15 what cost means in this sort of a setting, I  
16 think is very complex.

17 DR. SCANLON: And so yes, I don't  
18 think message should be that we, as a group  
19 suggested that this shouldn't be valuable or  
20 there shouldn't be a use for consumers but  
21 there is a lot of unknowns and I think a lot  
22 more study and research needs to sort of go in

1 to sort of help how to understand where there  
2 is value for a consumer and how to present it.

3 So, I won't necessarily, in the  
4 interest of time read through this list, but  
5 you can see that the first two certainly do  
6 address that issue related to consumers. What  
7 do they want. What is efficiency from their  
8 perspective. Are the measure developers'  
9 notion of efficiency consistent with sort of  
10 how consumers or consumer audience might  
11 interpret that information?

12 Other important issues, such as  
13 should we normalize quality and look at price?  
14 What is quality worth? There is a whole host  
15 of statistical issues and things related to  
16 timing, decisions about do we standardize  
17 input prices or do we sort of allow for market  
18 variation in pricing and account for that in  
19 terms of our measures of efficiency. What is  
20 the right choice to make and does it depend on  
21 the particular situation for which we might be  
22 publicly reporting?

1                   And I think that is it.

2                   Let me pause, as well, and see if  
3                   there is anything else from our group's  
4                   perspective. Okay.

5                   MR. BECKER: I just wanted to say  
6                   that I am right where Joyce is. Put the  
7                   information out. People will figure out what  
8                   to do with it and how to use it. If Chester  
9                   Carlson and Joe Wilson had listened to the  
10                  first person that told them that the copier  
11                  was going nowhere, where would we be? Or  
12                  Steve Case, when they told him, this IM thing,  
13                  that will never work. And they told Lonny  
14                  Reisman the care considerations, he was a  
15                  blithering idiot.

16                  So, put the information out and  
17                  let's see how people will use it and manage it  
18                  and I think people will make use of it in good  
19                  ways for consumers and others.

20                  DR. SCANLON: And just related to  
21                  that point, I think we talked a little bit  
22                  about that and sort of said we have a recent

1     experience of that and one that is not  
2     necessarily too distant from this topic, which  
3     was the release of the information last week  
4     by CMS. But I think that some would argue  
5     that what you just described is perhaps what  
6     just happened. And of course if you have been  
7     paying attention to the news, there is a whole  
8     variety of opinions about that.

9                     MR. BECKER: It is way too early.  
10    It is two weeks.

11                    CO-CHAIR DUBOW: But it is  
12    premature to evaluate consumer use of  
13    information. I always talk about premature  
14    evaluation. You know the data are getting  
15    better. The efforts to produce the  
16    information and to present the information are  
17    increasing. But many people don't have access  
18    to it or know where it is.

19                    This is new. And I think that we  
20    should not be hasty in evaluating it and in  
21    understanding who is using it. I just think  
22    that we should not jump to conclusions about

1       whether people will find this interesting or  
2       not.

3                   MR. BECKER:   In five years, just  
4       try to take an EMR away from a physician.  
5       Just wait five years.

6                   DR. SILBER:   Can I ask Iyah why do  
7       you think the consumers in Massachusetts  
8       didn't use the quality report?  Could it be  
9       that they didn't believe the quality report or  
10      were there issues about the quality report?  
11      Was this the Shahinian model for surgery  
12      outcomes that was in that report?

13                  MR. ROMM:    So, could I take the  
14      liberty of the microphone and ask a question  
15      that we were asked sort of softly around our  
16      group?  A show of hands.  How many people in  
17      this room use quality data before you choose  
18      where to go to get your quality data.

19                  Exactly.  And so I think that --

20                  CO-CHAIR DUBOW:  Ask how many  
21      people have access to some information.

22                  MR. ROMM:    How many people feel

1       that you have access to some information?

2                   DR. NEEDLEMAN:  Well, there is  
3       some.

4                   MR. ROMM:  So, I think my point is  
5       I am absolutely with you.  I think that the  
6       challenge that we faced in Massachusetts is  
7       that the information that we have in hand has  
8       proven not to be good, useful information or  
9       has proven to not be perceived as good useful  
10      information.

11                   And I think that it also was not  
12      -- you know no marketing, no communications,  
13      no sort of outreach to consumers.  But also  
14      know evaluation of how consumers are  
15      interested in using the data.  And I think  
16      that that is a real lesson to be learned.  And  
17      we are trying to go at it again.  
18      Massachusetts is working to build a new  
19      consumer website oriented in a different way.  
20      But interestingly, not oriented at data,  
21      oriented at how consumers make decisions in  
22      general.

1                   So, I think that there is an  
2                   interesting conversation to be built upon. I  
3                   am a huge advocate of this sort of data  
4                   transparency. I was a regulator for a while.  
5                   But I think that our early lesson, and we had  
6                   it for four years, it is still up, the data  
7                   are just very old and are not updated anymore  
8                   is that people the hits tracked in the  
9                   hundreds on annualized basis and it was almost  
10                  all researchers.

11                 CO-CHAIR DUBOW: I don't mean --  
12                 we don't need to shoot the messenger. We  
13                 appreciate your efforts.

14                 DR. NEEDLEMAN: This issue of  
15                 trying to understand how consumers make  
16                 decisions and where information falls into it  
17                 I think is central to this. If you are going  
18                 to try to put this stuff out, it is not just  
19                 how it is packaged.

20                 I mean, look at Bill Clinton.  
21                 Right? Bill Clinton goes to his doctor. He  
22                 is told he needs by-pass surgery. New York

1 State has been publishing for a decade  
2 information about both hospitals and  
3 individual surgeons. He is clearly going to  
4 a good doctor because he has got access to a  
5 good doctor. New York Presbyterian Hospital,  
6 two different campuses, the Presbyterian  
7 campus, the New York Hospital campus. The New  
8 York Hospital campus scores right on the  
9 cardiothoracic surgery data and the  
10 Presbyterian campus scores poorly on it. And  
11 he winds up at the Presbyterian Hospital and  
12 ultimately winds up with a complication that  
13 is due to the poor surgery he got the first --  
14 he got.

15 If he and the doctors serving him  
16 can't get it right, with all the data that is  
17 out there, what is going on? And until we  
18 figure out what is going on and how to change  
19 the decision-making, this data is going to go  
20 out there. It is mostly going to be an  
21 embarrassment to the providers and that is  
22 what is going to generate the change, not



1 consumer behavior.

2 DR. ASCH: Two things. One, just  
3 a response to this ongoing conversation.  
4 Everybody makes decisions that are socially  
5 constructed. I heard behavioral economics  
6 mentioned earlier. It is not like we just all  
7 look at numbers and come to some rational  
8 decision about it. I imagine Bill Clinton is  
9 no exception. When he was the President, I  
10 remember him making some pretty terrible  
11 personal decisions.

12 (Laughter.)

13 MR. ROMM: He didn't think so.

14 DR. ASCH: In the end, I bet he  
15 did think so.

16 And so I guess what I think is  
17 likely to happen for consumer choice on  
18 efficiency is that people will end up with  
19 narrative descriptions on the web like Yelp or  
20 Doctor Choice, there is a zillion of them out  
21 there. But the numbers that groups like this  
22 would probably be more comfortable with will

1     inform those narrative descriptions.  Let's  
2     hope that is the way it will be.  But that  
3     wasn't what I was going to say.  That was just  
4     a reaction to what you just said.

5                   What I was going to say is I am  
6     surprised that we have not mentioned  
7     measurement burden as one of the ways in which  
8     we should choose between measures of  
9     efficiency.  We could actually adversely  
10    affect efficiency directly by requiring a lot  
11    of extra measurement.  And if it was going to  
12    come up in one group, I thought it would come  
13    up in this one.  Did it not?

14                  MR. ROMM:  I think sort of  
15    tangentially.  But I think that most of the  
16    frame of the conversation was really around  
17    use of existing data to report on efficiency.  
18    There really wasn't conversation around  
19    generating new data.  And I think that may be  
20    just sort of individualized perspectives.

21                  From my state, I can't think of  
22    anything on the state basis that I would need

1 to generate to do any of the things that we  
2 talked about. It is a question of whether we  
3 are comfortable with the calculation.

4 You know things like cost  
5 accounting came up tangentially as sort of  
6 broader structural challenges around capturing  
7 efficiency as come up in the first group but  
8 we didn't really go down that pathway.

9 DR. ASCH: The only reason I bring  
10 it up again is that if we are really going to  
11 try and synchronize cost and quality measures  
12 for true measures of efficiency, as you  
13 brought up a few times and I agreed with, it  
14 may actually require changes in the way data  
15 are collected and that could impose a cost on  
16 the providers and health plans.

17 CO-CHAIR DUBOW: You know I meant  
18 to ask Andy and Chris earlier today about  
19 feasibility with respect to data collection  
20 and things of that sort among the approaches  
21 that they proposed, in terms of whether these  
22 are equally feasible, whether one requires a

1 whole lot more effort, whether the skills.

2                   Somebody talked about -- Cathy it  
3 was you who talked about big insurers, small  
4 insurers, and whether there is the capacity to  
5 do this. And I think that is something that  
6 has to be taken into account.

7                   DR. MAC LEAN: I agree, Steve. We  
8 do have to consider measurement burden.

9                   I think, though, we need to get  
10 back to first principles. And I would hope  
11 that the charge of this group is to actually  
12 define what is needed to produce valid,  
13 meaningful, not just reliable, the difference  
14 between reliability and validity measures.  
15 And I think that part of the measurement  
16 burden that we currently have, quite honestly,  
17 is because we are trying to retrofit data that  
18 were never intended to be used for quality,  
19 for example, into this quality construct. And  
20 it is problematic.

21                   So, I think that we ought to  
22 define what is needed and define what is

1       needed to get there. And hopefully, we can  
2       then move to that place.

3                       MR. ROMM: I guess just a last  
4       thought that we spent a few minutes talking  
5       about that I think is worth us carrying  
6       forward. We spun back at the end of our  
7       conversation to the fact that I think our  
8       perception was the task of this group is  
9       really thinking then about how do we take all  
10      of these concepts about how we should be using  
11      efficiency measures and translate it to  
12      selecting measures themselves and found that  
13      much of our conversation really came back to  
14      either measures that exist in the form of not  
15      linking cost and quality but rather those  
16      measures of efficiency, case mix adjusted,  
17      average length of stay came up, readmissions,  
18      those sort of things that we can start to  
19      promote a little bit more, choosing wisely and  
20      the sort. But also then simply the side-by-  
21      side pairing.

22                      And we talked about things like

1       ways that consumers themselves or other users  
2       of data could stratify up or down the various  
3       weighting, if you will, and whether there were  
4       ways that we could think about simplifying  
5       approaches to do such in a public space.

6                       I think, though, that the idea of  
7       sort of then how do you select measures  
8       appropriately was something for public  
9       reporting specifically that we really couldn't  
10      make any headway on. And so I think that is  
11      sort of a broader challenge of we really don't  
12      know what is and is not appropriate in the  
13      space to put out publicly and that is  
14      something that needs a lot more explanation.  
15      My two cents, personally, is that we should  
16      put everything out.

17                   CO-CHAIR DUBOW: I think we should  
18      move on because there is so many ways to  
19      respond to that, because I am looking at the  
20      clock now.

21                   Group three is the network design  
22      tiering group. I don't know who the

1       spokesperson is.

2                   MR. AMIN:  I think actually I am  
3       going to take that for the group.

4                   CO-CHAIR DUBOW:  Really?  We are  
5       not doing everything?

6                   MR. AMIN:  No, we are.  I will  
7       take group three.

8                   CO-CHAIR DUBOW:  Oh.

9                   MR. AMIN:  I was the facilitator  
10      but I didn't assign somebody to report.

11                  CO-CHAIR DUBOW:  Okay.

12                  MR. AMIN:  We were going for quite  
13      some time.

14                  CO-CHAIR DUBOW:  And no slides.

15                  MR. AMIN:  No, there are no  
16      slides.  We went all the way to the end.  Is  
17      there a microphone still or no?  Okay, thanks.

18                  Okay, is this working?  Okay,  
19      great.

20                  So, again, I would welcome the  
21      input from the committee members -- from our  
22      group members on this.

1                   So, ours was around network design  
2                   and tiering. And the basic function of  
3                   network design and tiering that we discussed  
4                   was basically which providers are in the  
5                   network. And there are three elements that  
6                   were at play for this particular use case, the  
7                   first being network adequacy, the second being  
8                   the cost, those two being the major drivers,  
9                   and then quality.

10                  So, we discussed multiple  
11                  different audiences for this use case, the  
12                  employers one of the main and cost being a  
13                  major factor for them. And then additionally,  
14                  consumers, and then providers and then a  
15                  regulatory.

16                  So, when we were thinking about  
17                  the question of looking at the link between  
18                  cost and quality, we noted some general  
19                  considerations that there really isn't full  
20                  information about cost and quality,  
21                  particularly around the indirect cost that  
22                  consumers would likely face in consuming



1 healthcare. And particularly, we didn't want  
2 cost to be used as a proxy for quality. And  
3 then additionally, the concern around access,  
4 that we don't want to limit the number of  
5 providers, potentially, in particular markets.

6 And so when we looked at the  
7 question of complexity for the different  
8 audiences, in particular consumers and  
9 employers, for consumers we generally felt  
10 that there should be more of a straightforward  
11 approach and generally simple to understand,  
12 which generally lent itself to the side-by-  
13 side model that allows for ease of  
14 interpretability.

15 For employers, we discussed that  
16 there was probably a tolerance for something  
17 greater than that, although with the shift to  
18 exchanges, that would be a topic that I would  
19 welcome discussion from the committee, the  
20 small group, that we discuss that a little bit  
21 more.

22 So, from the health plan

1 perspective, what we basically discussed was  
2 that really there is more of -- the current  
3 state is sort of the cost hurdle and then a  
4 look at quality later, the cost being the  
5 negotiated price being the major driver and  
6 then quality standards are often part of the  
7 discussion but are sort of secondary to the  
8 first cost hurdle.

9           And then it is also complex, given  
10 that quality may vary across service lines for  
11 different accountable entities, in particular,  
12 for different hospitals or different service  
13 lines within hospitals. But generally the  
14 transparency may help to drive improvement.

15           And then finally, our major  
16 discussion that we sort of ended with was  
17 around scoring the difference between relative  
18 and absolute scoring, that in this particular  
19 use case, we may be better off creating  
20 thresholds slash hurdles because there may not  
21 be sufficient discrimination among providers.  
22 Although, there was a concern that this type

1 of approach might not incentivize improvement.

2 And I think that was the basic --  
3 we also drew a distinction here between when  
4 we are looking at the various models, which  
5 considerations we would make for the  
6 methodology and then which considerations we  
7 would have for the display.

8 And for the methodology, really  
9 today it is a cost hurdle, as I described  
10 before for inclusion in the network and then  
11 quality comparisons. But the methodology  
12 should be fair and scientifically acceptable.  
13 And for the display, really that it should be  
14 understandable and actionable.

15 So, I welcome reflections from the  
16 committee about the discussions about any of  
17 those topics or any that I missed.

18 DR. RYAN: Taroon, I have a  
19 question about this absolute versus relative  
20 scoring.

21 It seems like the whole point of  
22 tiering is some relative distinction.

1 Providers are on different tiers. So, it  
2 seems like if everyone is on the same tier,  
3 everyone is good, then it seems like the tiers  
4 aren't doing anything, unless the tiers  
5 distinguish providers somehow and has a  
6 relative comparison to kind of not functioning  
7 in terms of how I see them.

8 So, I just wonder if there any  
9 comments from the group that could address  
10 that issue.

11 MR. AMIN: Yes, I would welcome  
12 comments on that topic from the workgroup.

13 DR. MAC LEAN: But there is two  
14 dimensions, right? There is both cost and  
15 quality. And that discussion that we had was  
16 about the absolute was really relative to the  
17 quality component. And we kind of expand --  
18 so you could have equivalent quality and have  
19 different costs. Right? So, there could be  
20 differences there.

21 So, I think that should answer  
22 your question.

1 DR. SPEIR: I'll just mention on  
2 thing. I think there was also a consensus  
3 that perhaps that scoring system may also have  
4 to do with both the robust data with some  
5 providers and the paucity of data with others.

6 And so the necessity to score in a  
7 consistent way may be as much altered by what  
8 we are seeing to build across the board with  
9 what is currently present with some that have  
10 kept such data, like in my specialty, for a  
11 long period of time.

12 Secondly, is what is good enough.  
13 And as we are moving forth in this particular  
14 setting, particular thresholds, is it three  
15 tiers where you have got the very good, the  
16 good, and the not so good, and so is it good  
17 enough to be in the good category.

18 Or if you have got others that are  
19 over 90 percent in the scoring system, is  
20 there really any value in looking at whether  
21 somebody is at 91 percent and 93 percent? Is  
22 there the ability to differentiate in that

1       regard?

2                       So, as you are building such  
3       scoring systems, particularly in provider  
4       networks, what types of categories would you  
5       build, five categories or three or one, or  
6       those that aren't any good at all?

7                       And that led us then to the  
8       discussion about access, which is a real issue  
9       both around manpower, as well as when we start  
10      scoring, particularly paying for outcomes, our  
11      value. Are you going to be limiting a whole  
12      group of providers that aren't going to be  
13      acceptable really for providing care? Where  
14      does that take us?

15                      So, those were some of the general  
16      ideas that we had some trouble getting clarity  
17      for. And it was very helpful to have both a  
18      cross-section of payers, as well as providers.

19                      CO-CHAIR DUBOW: Steve, you had a  
20      -- yes?

21                      DR. ASCH: Actually, you said  
22      mostly much of what I wanted to say. Great

1 job on doing the report out for a very  
2 talkative group. It's okay that you didn't  
3 tell one of us to be the reporter. I think  
4 you probably did a better job than any of us  
5 would have.

6 But the only thing I would add to  
7 what you just said, is to emphasize something  
8 you went over very quickly, which is there is  
9 a problem with all threshold measures, which  
10 is the incentive for improvement is limited to  
11 just getting over the threshold. Say you have  
12 a measure of quality and you have to get above  
13 a certain measure of quality and after that,  
14 only cost matters. Well, after that, only  
15 cost matters.

16 So, if you set it too low, then  
17 the incentive to do better on quality is  
18 limited, which is why I was very glad to hear  
19 you talk about the number of levels that might  
20 be needed for a system of measuring value or  
21 efficiency.

22 CO-CHAIR DUBOW: Steve, why can't

1       you keep raising the threshold?

2                   DR. ASCH:   You could keep raising  
3       the threshold but you are only incentivizing  
4       innovation at the bottom then.  You are not  
5       incentivizing people to continuously improve.  
6       And the quality improvement literature, at  
7       least to me, and there are a lot of people  
8       around this table that know it as well as I do  
9       would lead you to believe that that is not the  
10      best way forward.

11                  CO-CHAIR DUBOW:  What about  
12      changing the -- swapping out the measures once  
13      the desired -- when they are topped out?

14                  DR. ASCH:  I'm all for that but I  
15      think the same criticism applies to all  
16      threshold measures.

17                  CO-CHAIR DUBOW:  Okay.  I think  
18      Jeff is on the group.  So, just -- oh, no, you  
19      are on the other one.  Never mind.  So, Greg  
20      first.  You are in the same group.

21                  DR. WOZNIAK:  Yes, maybe this is  
22      more of just a clarifying question.  People



1     probably can't see it but on the bottom sheet  
2     there is creating a link between cost and  
3     quality. And then there is full information  
4     and then there is indirect cost. What were  
5     those indirect costs? And are those indirect  
6     costs to the plans, the consumers? Another  
7     cost concept that just came up.

8                   MR. AMIN: If you can speak to it,  
9     I would welcome the small group. But I think  
10    the way that it was referenced was in  
11    particularly related to interactive -- you  
12    know the example that we used was if you  
13    created a network where it might be cheaper to  
14    send your patients to Cleveland but there is  
15    additional costs related to time away from  
16    work to be able to do that, your family has to  
17    fly across the country, those costs that are  
18    potentially borne by the patient that might  
19    look efficient from a cost perspective. But  
20    their costs are borne by the patient and may  
21    not be really captured in the system. But  
22    again, I would open it to the work group.

1 DR. SILBER: I wanted to explore  
2 the idea of the hurdle again, for what you  
3 were talking about.

4 So, if you reach a certain hurdle,  
5 a certain level, then you can use the  
6 efficiency metric. I think that is what you  
7 are saying. But below the hurdle or that you  
8 can't, because you wouldn't say if you want  
9 quality you would be too low.

10 But so what is really happening is  
11 unless you use your metric along with a side-  
12 by-side, you are saying after we get to a  
13 certain level of quality, we can ignore the  
14 data on cost and quality and just use the  
15 efficiency metric. Am I right in suggesting  
16 that is what you are suggesting? Because to  
17 me, that would be a mistake. The concept of  
18 a hurdle is a mistake and it should be you  
19 should see the cost, you should see the  
20 quality. And the hurdle is confusing things  
21 because you are depending on the efficiency  
22 metric after the hurdle when it is still

1 relevant to know what the X and Y is, what is  
2 the cost and what is the quality.

3 Maybe I am wrong on how the hurdle  
4 is being used. So, I just wanted to  
5 understand that.

6 DR. LOWE: It wasn't the -- it was  
7 when you reached a certain threshold of  
8 quality, then they compete on price. Because  
9 once you -- this is an acceptable threshold.  
10 All things being equal, if physician A,  
11 physician B, physician C all produced the same  
12 basic outcomes, then what differentiates those  
13 three positions is pricing, not quality.

14 DR. SILBER: So it is a huge  
15 assumption to say that they are the same  
16 outcomes. Once you are beyond a very bad  
17 level -- above the minimum and then you are  
18 all the same is a bit odd. Even dividing it  
19 up into five groups, Cochrane would say five  
20 is generally a good number but that is because  
21 he said you could do statistical adjustments  
22 after the five groups. That is the famous

1       Cochrane paper, right? We are not doing that.  
2       So, even five isn't right.

3               So again, if we are going to get  
4       into this point where we are going to say  
5       well, we can use efficiency after we get to a  
6       certain point of quality, then I think it is  
7       very dangerous and I would say that we really  
8       should think hard about advising that that  
9       could be an acceptable metric.

10              DR. LOWE: I wouldn't call it  
11       efficiency. It is cost.

12              DR. SILBER: Well, okay, it is  
13       even worse.

14              DR. LOWE: The assumption would be  
15       as cost went up, efficiency would go down.

16              DR. SILBER: So you are really,  
17       really in dangerous territory when you are  
18       then assuming that say two-thirds of the  
19       quality is all the same and we are just going  
20       to go for the lowest cost. That is really  
21       dangerous. That is exactly what we wouldn't  
22       want. I wouldn't want for the NQF to endorse.

1 CO-CHAIR DUBOW: There are a lot  
2 of signs up and I don't know if -- Cathy, do  
3 you have anything? And Steve are you and Andy  
4 and --

5 DR. MAC LEAN: Just commenting  
6 further on I will answer that and then make  
7 the comment.

8 I think that the whole discussion  
9 around efficiency or value, I think the first  
10 thing we called out in our group was that it  
11 is difficult to kind of in this sort of a  
12 network sort of design to come up with a  
13 single metric. And in all cases we, I think,  
14 advised a side-by-side model.

15 So that you might have some  
16 threshold to get into it but that in all cases  
17 you would be reporting out kind of side-by-  
18 side what the cost is and what the quality is.  
19 Because the whole thing is confounded by so  
20 many factors with regard to getting into the  
21 network and negotiating the price with the  
22 providers. It is all about the negotiation

1 and it can get quite complicated, those  
2 negotiations. It is not just no, I want more  
3 money. And kind of highlighting my point, it  
4 can even get to the point where well, okay, I  
5 will give you this for this procedure. We  
6 will give you this price for this procedure  
7 but you have got to make it up on this one.  
8 Or, okay, I will negotiate that with you but  
9 only if you let me -- say, we are talking  
10 about a commercial contract -- I will do that  
11 for your PPO or HMO business but you need to  
12 put me into your contract for the exchange  
13 business.

14 So, the price piece is very  
15 complicated with regard to what you are  
16 actually paying. So, that is in response to  
17 your comment.

18 The other thing I wanted to raise,  
19 was we were getting into a very interesting  
20 discussion when we had to come back here and  
21 why we didn't have slides. And Steve was  
22 really kind of leading this discussion. I had

1     this raised this on one of our prior calls.  
2     Is the concept of how do you value -- what is  
3     the value of a procedure in different  
4     populations or what is the value of different  
5     procedures across different populations? So,  
6     the example that was given in our group was  
7     doing a valve replacement in a 95-year-old  
8     versus a valve replacement in a younger  
9     patient. What is the value to that and how  
10    can we concur that? And Steve brought up the  
11    concept of quality adjusted life years. And  
12    I think that that is important, not only in  
13    comparing the value of doing the procedure  
14    within -- as single procedure across different  
15    populations but also comparing the value of  
16    different procedures. So, a total knee  
17    replacement in a 65-year-old, versus the third  
18    stage of chemotherapy in someone who has got  
19    metastatic pancreatic cancer.

20                 So, I think that -- I don't know  
21    if we should explore that more but I think  
22    that this quality adjusted life year concept

1 or some other sort of concept of outcomes we  
2 can measure across patients and populations is  
3 worthy.

4 DR. ASCH: Can I respond to that  
5 directly or is there somebody else in line?

6 CO-CHAIR DUBOW: Yes, do it but --  
7 yes, please.

8 DR. ASCH: Last comment. First of  
9 all, thanks for tagging me with the death  
10 panel thing. No problem.

11 (Laughter.)

12 DR. ASCH: In all seriousness,  
13 what this means to me is that we have to have  
14 ways of comparing across different procedures  
15 and across different clinical situations. And  
16 I don't know, I was mentioning to somebody at  
17 the break, the article that I really enjoyed  
18 by Steve Schroeder, putting the value back in  
19 the relative value unit. Did anybody get a  
20 chance to see it? It was in the New England  
21 Journal a while back.

22 So, the idea is that if you pay



1     for something that is by volume, like we do  
2     now, we get what we have now, which is a  
3     dysfunctional system. But on other hand,  
4     there is a modest tweak, at least, that we  
5     could do. And I think health plans could lead  
6     the way here, along with the government. And  
7     that is pay for appropriate volume, pay for  
8     volume that is likely to lead to a benefit,  
9     even if we don't do formal cost effectiveness  
10    analyses and actually value people's future  
11    years in dollars. I think we could get part  
12    of the way in so doing.

13                   CO-CHAIR DUBOW: And then we are  
14    going to go to the last group.

15                   MR. ROMM: I guess just a quick  
16    comment back to the points that Cathy was  
17    making around this issue.

18                   I think that one of the really big  
19    challenges here is that I would posit that  
20    this actually is not a question about  
21    efficiency measures at all but about what the  
22    role of the NQF in this process is in thinking

1 about sort of the principles of how these  
2 measures come together in limited and tiered  
3 products. Because at the end of the day, the  
4 challenge here is that not only is there a  
5 price negotiation the way that you are talking  
6 about but people are negotiating what quality  
7 measures are in.

8           So, I know of limited networks  
9 where the only quality measures that are  
10 captured are five HEDIS measures where  
11 everybody looks the same and a bunch of  
12 Hospital Compare measures where everybody  
13 looks the same. And so that is not to say  
14 across all quality measures everybody looks  
15 the same, but rather to say that where it is  
16 not only a negotiation of base price but a  
17 negotiation of what measures and people can  
18 therefore game that element, too.

19           There is actually a really  
20 interesting space for a policy conversation.  
21 I don't know if this is the right setting for  
22 that, though and I feel like we could veer

1 down that path very far.

2 CO-CHAIR DUBOW: Well but the  
3 issue of -- I mean I don't know why the policy  
4 question is not relevant to the NQF process of  
5 providing meaningful and useful information to  
6 people who may be directed to one tier, one  
7 network or another, depending on how it is  
8 constructed. And so, giving guidance as to  
9 what is methodologically fair, for example, to  
10 the range of users, providers, consumers, may  
11 be quite relevant to the NQF process.

12 MR. ROMM: So, I can't speak to  
13 that. I would love to see it. I would love  
14 to see somebody who is really taking that ball  
15 and running with it. I think it is a huge  
16 opportunity and a huge gap in the way that we  
17 are thinking about these products popping up  
18 all over the place. I think that the biggest  
19 threat to them is this negotiation question.  
20 And market leverage comes into bear everywhere  
21 but it is really starting to intrude into a  
22 product that was designed expressly for the

1     purpose of overcoming that market force. So,  
2     I would love to see that. I just am not sure  
3     what the right setting is.

4                   CO-CHAIR DUBOW: I am simply  
5     suggesting that, as a minimum, we need some  
6     outward bounds. It may be one of our  
7     audience's regulators. Maybe this needs to be  
8     regulated because it has that kind of impact  
9     on individuals. So, just a thought.

10                  We have one more group. We are  
11     going to just bleed a little bit past five  
12     o'clock, since you are all coming back  
13     tomorrow anyway. So, we figured we would take  
14     advantage of that.

15                  And the last group is the P for P,  
16     the pay for performance.

17                  MS. WILBON: So, Gary is going to  
18     be our spokesperson. Thanks, Gary.

19                  DR. YOUNG: Okay, so I will go  
20     quickly. I will speak quickly and I will also  
21     outline what I thought was a fairly wide-  
22     reaching, far-reaching discussion. And I will

1     also invite my group members to sort of  
2     amplify what I am saying here, as well as  
3     correct any misstatements that I may make.

4                 So, this was for pay for  
5     performance. We saw our audiences, including  
6     purchasers' plans and also consumers, because  
7     they ultimately get affected by the design and  
8     implementation of pay for performance  
9     programs.

10                We saw as an important principle  
11     that pay for performance programs should not  
12     just entail a single efficiency score that  
13     would be used for payment purposes and for  
14     communicating information to providers but  
15     that it should also include side-by-side  
16     information that providers should be given  
17     side-by-side information for cost and quality  
18     and let them have that information as part of  
19     a pay for performance program.

20                Also that payers certainly should  
21     reward providers who are at the highest levels  
22     of quality and the lowest levels and at the

1 lowest levels of cost. So it is sort of in  
2 that top quadrant there. And at the same  
3 time, the providers should be rewarded who are  
4 at the high end of quality but where there is  
5 still opportunity to reduce costs.

6 More debate over whether providers  
7 should reward, whether payers should reward  
8 providers for improvement for those, for  
9 example, at the frontiers of highest  
10 efficiency but low quality, whether there  
11 should be rewards that are made available to  
12 those who sort of improve when they are  
13 already at the frontier for high efficiency  
14 but also low quality.

15 In terms of scientific rigor,  
16 there was agreement that whatever methods,  
17 models, approaches that are used, we want to  
18 see the rankings, the relative position of  
19 providers, that that be robust to different  
20 models, approaches, and that there is  
21 robustness there and that a provider's ranking  
22 or standing isn't sensitive to one particular

1 model or approach, that it is robust across  
2 models and approaches.

3 In addition, there was discussion  
4 and consideration about including outcomes in  
5 pay for performance approaches in that if you  
6 are including outcomes, there should be some  
7 concern about possibly using indirect  
8 adjustment approaches. When you have  
9 differences in population characteristics  
10 among providers and that the more different  
11 those population characteristics are, the less  
12 they overlap, indirect standardization becomes  
13 increasingly problematic. And so then you  
14 need to be thinking about direct  
15 standardization, again, if those population  
16 characteristics really don't overlap in a  
17 substantial way.

18 Additionally, another  
19 consideration around scientific rigor is the  
20 use of standardized prices and a recognition  
21 that standardized prices become very  
22 problematic because of cost shifting and that

1 we have got different providers with different  
2 percentages of their patient population that  
3 are uninsured, Medicaid, Medicare, and private  
4 sector, standardized prices can become very  
5 problematic because you have got providers  
6 sort of shifting those costs onto the private  
7 sector side.

8 And so from a resource  
9 perspective, they are looking more expensive  
10 than they may actually be relative to those  
11 that have patient populations that are largely  
12 private pay.

13 So, I will turn it over to my  
14 group members to add anything.

15 CO-CHAIR DUBOW: Anybody in that  
16 group have something to add? Alan, you have  
17 a question or comment?

18 DR. SPEIR: I just have one  
19 comment. We have a nine-year history of a pay  
20 for performance model in Virginia with Anthem  
21 for the cardiac surgery population, where it  
22 was both process as well as clinical outcomes



1       that was normalized with observed or expected  
2       complications and mortality. And there was  
3       not an absolute dollar amount, rather a  
4       percentage over what was normally reimbursed  
5       to the physicians.

6                   CO-CHAIR DUBOW: Any other  
7       comments or observations? Everybody is very  
8       tired now. We are winding down.

9                   You know, Andy and Chris, I don't  
10      know whether you want to give us your  
11      reactions now or wait until the morning, until  
12      you have a chance to think about this.

13                  DR. RYAN: I have a 45-minute  
14      prepared statement.

15                  (Laughter.)

16                  DR. RYAN: No, I have nothing more  
17      to add right now, Joyce.

18                  DR. PANTILAT: You can turn that  
19      into a PowerPoint.

20                  DR. TOMPKINS: I also have to  
21      defer my 45-minute comments. I have a call  
22      that starts at 5:15 and I don't get coverage

1 in this building, so I have to go down the  
2 elevator.

3 MS. WILBON: On that note, I know  
4 everyone is tired and this will be perfect  
5 timing to go two blocks away called Mio and  
6 help you unwind.

7 So, we will wrap up now. I think  
8 we have decided that we are going to do the  
9 actual Day 1 recap tomorrow. It will give us  
10 all some time to absorb and I am sure we will  
11 all come back with some more ideas tomorrow on  
12 kind of where we landed today on our  
13 discussion.

14 So, for tomorrow, we start at the  
15 same time. Breakfast starts at 9:30. We will  
16 begin the meeting at 9:00 a.m. We will shift  
17 some things around a little bit, since we  
18 actually finished the report outs of the break  
19 out groups early. So, we will probably shift  
20 everything up and I don't think we will have  
21 a problem filling the time tomorrow.

22 So, tomorrow morning when we get

1       started, we will kind of give an overview of  
2       the agenda and where we landed with things.

3               Unless there is any other kind of  
4       parting -- oh, thank you!   Public comment.  
5       Thank you.

6               Is there anyone in the room or on  
7       the phone, Operator, who would like to provide  
8       a comment to the panel?

9               OPERATOR:   At this time, if you  
10       would like to make a comment, please press \*  
11       then the number 1.

12              There are no comments at this  
13       time.

14              MS. WILBON:   Okay, sound like  
15       we're -- everyone is just worn down.   So we  
16       are going to let you go.

17              We will recap the agenda for  
18       tomorrow and thanks again everyone for a great  
19       day of really great discussions.

20              (Whereupon, at 5:07, the meeting  
21       was adjourned to reconvene at 9:00 a.m. on  
22       Friday, May 2, 2014.)

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In the matter of: Linking Costs and Quality Measures

Before: NQF

Date: 05-01-14

Place: Washington, DC

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