

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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FRIDAY
MAY 2, 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
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KIMBERLY RASK, MD, PhD, Alliant Health
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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
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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:

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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

A-G-E-N-D-A

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

2 9:06 a.m.

3 CO-CHAIR FLAMM: All right. Good
4 morning, everybody. If we could all come
5 back to our seats we'd like to go ahead and
6 get started today.

7 I want to welcome everybody back to
8 day 2. And reflecting on yesterday thank
9 everybody for the tremendous amount of work,
10 good ideas and energy that we brought to the
11 table.

12 I heard several of you also sharing
13 that we were all a little exhausted last
14 night. So hopefully we had a good night of
15 sleep and we're ready to tackle the
16 challenges today.

17 I want to also thank the NQF team
18 who's done a great job yesterday and last
19 night and this morning in pulling together a
20 recap. It's forming as we speak and I think
21 it's going to be very helpful.

22 And I also thank Chris and Andy for

1 all of their leadership and work yesterday.

2 So, without further ado what we're
3 going to do this morning first is recap and
4 provide a little high-level summary which is
5 in and of itself a little bit of a challenge
6 of the great discussion that we had
7 yesterday.

8 And hope to -- since we made up some
9 time and did all of our breakout session
10 presentations yesterday we're going to have
11 a little bit of extra working time this
12 morning to make sure that we're getting
13 clarity and some details in places where we
14 might them as much as possible even though
15 there's a lot of big picture and new
16 thinking that we're doing.

17 And this is such new work that we're
18 doing that we're figuring it out as we go
19 along. And I think that's just an iterative
20 -- an understandable process that we're in.

21 Ashlie?

22 MR. AMIN: Actually, Ashlie stepped

1 out for a minute so I'll take the floor.

2 Realtime adjustments.

3 So yes, again, thank you all and
4 welcome to day 2 of this linking cost and
5 quality session.

6 So, the agenda for today is that we
7 will be going through, as Carole pointed out
8 we'll be going through just a review of the
9 goals and kind of the high-level summary at
10 the risk of potentially being a little bit
11 overly simplistic in terms of all the
12 conversations that we had yesterday. But
13 just summarize across the different
14 workgroups some of the information that
15 we've found.

16 And then have some discussions about
17 general points that we identified yesterday.
18 And then just go back to Chris and Andy to
19 see if there are any specific areas that we
20 might want to have some additional
21 conversation this morning.

22 We'll have a break at 10 o'clock and

1 then we'll go at 10:15 into a discussion
2 around implications for the NQF endorsement
3 process. And then some summaries of
4 recommendations and identifying the path
5 forward.

6 So, just to restate the goals of why
7 we're here. What we really wanted to do
8 over the two days is explore the current
9 approaches and applications for linking cost
10 and quality both at the measure level and at
11 the programmatic level.

12 And Chris and Andy's environmental
13 scan helped set the foundation for that work
14 in addition to our conversation yesterday
15 around the potential challenges of thinking
16 -- that more at the programmatic level and
17 at the measure level we had a discussion
18 yesterday around the challenges of thinking
19 about linking cost and quality in a single
20 composite measure.

21 Secondly, we wanted to identify key
22 methodological challenges to cost and

1 resource use measurement. And thirdly,
2 defining key principles and best practices
3 for linking cost and quality.

4 And the way that we did that
5 yesterday was to think about through the
6 lens of four different use cases and think
7 about considerations and potential
8 challenges for linking cost and quality in
9 four different use cases.

10 And the fourth which is what we'll
11 spend most of today thinking about is
12 thinking about providing operational
13 guidance to NQF related to the endorsement
14 process and the selection process and
15 recommendations for application for the
16 evaluation of efficiency measures going
17 forward.

18 And I know that we had a number of
19 conversations yesterday about potential
20 challenges of even getting down to the
21 measure-level programmatic-level guidance,
22 but we want to be able to explore that in a

1 little bit more detail today and understand
2 what really the path forward is for the
3 endorsement process and the selection
4 process.

5 And as a few of you noted yesterday
6 while there are some conceptual challenges
7 to being able to do this there is the
8 practical reality that NQF is being asked to
9 do this work currently and this in some ways
10 is already moving.

11 So we want to be able to make sure
12 that we're doing this in the most
13 scientifically sound fashion and that we're
14 advancing the goal of improving healthcare
15 value ultimately but at the same time not
16 sacrificing healthcare quality in the
17 pursuit of monitoring healthcare costs.

18 So ultimately that's the goal of
19 what we're trying to achieve today. We made
20 significant progress yesterday so I thank
21 you all for a pretty exhaustive day. It was
22 very good, deep conversations. And I hope

1 we can continue that progress today.

2 So, does anyone have any questions
3 about what we're trying to achieve today or
4 any general reflections about the discussion
5 or the conversation over yesterday? Okay.

6 So, we're going to go into just a
7 brief discussion of some general points that
8 we identified yesterday. I'd welcome, Erin,
9 for just a quick high-level summary of some
10 of the main topics and themes that arose
11 yesterday.

12 And then I'd welcome some comments
13 from Chris and Andy about any general
14 reflections of the high-level themes that we
15 discussed yesterday. And then would open
16 that up to the committee. And then we'll go
17 into more of a deep discussion around what
18 the breakout groups identified. And so,
19 Erin.

20 MS. O'ROURKE: Thanks, Taroon. So,
21 a few of the high-level themes that we
22 really heard yesterday was first that we

1 need to clarify the relationship between
2 quality, efficiency and value. And before
3 we can really move forward it's necessary to
4 know what exactly we mean by each of these
5 terms.

6 We discussed that composite measures
7 may be mathematically possible but are
8 probably not feasible or practical for real-
9 world applications.

10 We decided the selection of a model
11 may depend on the audience and the goals of
12 a program. Consumers and payers want
13 information to help them make informed
14 decisions and to really know where to take
15 their business if you will to get the most
16 bang for their buck.

17 But providers need granular
18 actionable data. A summary score that might
19 be useful to a consumer won't provide an
20 organization with the data they need to see
21 where they have inefficiencies or where they
22 can improve cost or quality to become more

1 efficient.

2 We outlined a few challenges to
3 implementing efficiency measurement. First,
4 a question about what level of scientific
5 rigor is necessary. Different audiences may
6 need a different level of detail.

7 There's also a question that we
8 started to raise yesterday about whether the
9 models should be reliable and valid within
10 themselves, or if it's necessary to show
11 that you would get a similar ranking if you
12 applied different models.

13 Finally, we started to discuss that
14 data may be a challenge to efficiency
15 measurement and the current limits to cost
16 accounting may impede cost measurement. And
17 may limit providers in what data they have
18 available to really drive down and improve
19 their costs.

20 MR. AMIN: Erin, Vy, do you mind
21 putting up the conceptual model for a
22 second?

1 There's one thing that I just wanted
2 to walk through again. We had a bit of this
3 discussion during the web meeting a few
4 months ago. But I wanted to just remind the
5 group.

6 I know we had a lot of conversations
7 yesterday about definitions and how we're
8 thinking about this group. And the question
9 of sort of objectivity versus subjectivity
10 and where that sort of comes up.

11 So the way that NQF thinks about
12 this work is based on the patient-centered
13 episode of care framework which was really
14 the foundational piece of work that
15 identified that we need to really move
16 toward a measurement framework that's
17 looking at cost and resource use in
18 conjunction with quality across time.

19 And ultimately there are a number of
20 different -- and where some of the
21 definitions first came from is really that
22 original framework.

1 And so the work around cost and
2 resource use is really -- the way that NQF
3 thinks about this is that they're really
4 counts of utilization that are generally
5 monetized but don't necessarily need to be.
6 So, counts of utilization monetized either
7 using actual prices paid or a standardized
8 pricing approach.

9 The unique feature of how we think
10 about cost and resource use is generally
11 there's not a clear indication of
12 directionality. We don't necessarily know
13 that up or down is actually better or worse.

14 And so to really understand health
15 system efficiency we really need to pair the
16 information about cost with quality to be
17 able to understand some sense ideally -- and
18 the way we've been thinking about it, and I
19 think that's open for some discussion, is
20 that there's an objective evaluation of
21 quality -- or efficiency that pairs quality
22 along with resource use.

1 And so this is sort of the orphan
2 that Chris described yesterday in some ways,
3 that there's this middle ground between
4 value which really thinks about stakeholder
5 preferences of the weighting of cost and
6 quality and sort of the pure resource use
7 measurement.

8 And so this is the area, this sort
9 of second-ring box here around measuring
10 efficiency is really what we're here to
11 discuss, whether there's some objective way
12 to look at cost and quality together without
13 the question of really getting toward value
14 which introduces the preference element.

15 DR. SCHUUR: Why is time there? I
16 understand early on there was a mention of
17 sort of time to see providers as a measure
18 that people have labeled as efficiency but
19 that's a timeliness measure. It's sort of
20 inappropriately labeled an efficiency
21 measure.

22 MS. WILBON: Yes. I mean, actually

1 I would probably -- I would say let's ignore
2 that box for now.

3 I think in our earlier stages this
4 model was kind of looking at time in terms
5 of some more of an activity-based costing
6 type thing. But I think I would recommend
7 for this discussion let's just kind of take
8 that off of the -- pretend we don't see that
9 box right now.

10 But for the purposes of this
11 discussion kind of looking at the cost and
12 resource use with the quality in terms of
13 thinking about efficiency.

14 DR. SILBER: A question about the
15 definition of the cost again. Because it
16 depends on the stakeholder, right. So, cost
17 for the individual patient, Lawrence was
18 saying true north, is really what they pay.
19 I don't think they care too much about
20 whether the hospital did it in the most
21 efficient way. They want to know what their
22 premiums are for their insurance policy when

1 they join whatever organization they're
2 going to join for their care.

3 So, then there's cost for the
4 hospital which is they're really interested
5 in what resources they need to buy to
6 provide the services to get the quality that
7 they deliver. So there is bean-counting.

8 Then there's payments to Medicare.
9 They're a little bit less interested in
10 bean-counting. They're more interested in
11 what they -- whether the payments that they
12 give out are providing the quality that they
13 would expect.

14 So I think we should at least in
15 part be clear to define what we mean by
16 costs in terms of resource utilization,
17 payments by patients, payments to providers
18 from Medicare. Because all of those are
19 going to be very different depending on the
20 stakeholder.

21 MR. AMIN: And I would just clarify
22 that the conceptual framework from which

1 this is based -- knowledge is that there's
2 various different sort of costs that are
3 borne by different parts of the healthcare
4 system.

5 And depending on the level of
6 analysis as you're describing, Jeff, you
7 would count different types of resources to
8 make sure that they're reliable and valid.

9 It's only to sort of orient us in
10 terms of the nature of where these terms
11 arise. I know many people think about
12 efficiency in a different way. This is sort
13 of the precursor work from which this
14 committee has been convened.

15 So I want to make sure there was a
16 sense of perspective. It doesn't mean that
17 you necessarily have to agree with. I just
18 wanted to provide that sense of perspective
19 of the panels that have come before us.

20 MR. BECKER: So, I know that you're
21 saying let's ignore time on that chart. So
22 let's imagine that it's not there for a

1 moment.

2 I would not break apart efficiency
3 and resource use the way you've got it. I
4 mean, resource use and quality are part of
5 efficiency. So, when you display it that
6 way it's almost as if those resource use and
7 efficiency are two entirely different
8 things.

9 MS. WILBON: It's more that the box
10 subsumes both of them. So if you think of
11 it like an inlaid diagram.

12 MR. BECKER: I think I know what
13 you're trying to get at.

14 MS. WILBON: Okay.

15 MR. BECKER: But the way this is
16 laid out it's sending a different message.

17 MR. AMIN: All right. So I just
18 wanted to provide that as sort of background
19 in terms of how these concepts relate to one
20 another in terms of the background for this
21 work. But I just wanted to maybe transition
22 from this conversation which is just to

1 provide a little bit of background.

2 Before we get to the summarization
3 of some of the breakout groups I just want
4 to turn it over to Chris and Andy if you had
5 any specific sort of overarching comments
6 from yesterday's discussion that might set
7 the tone for the next hour and 15 minutes.
8 Then we can go into some summary of breakout
9 groups from yesterday.

10 DR. TOMPKINS: Well, I hope I don't
11 necessarily set the tone.

12 (Laughter)

13 DR. TOMPKINS: What I'd like to do
14 is consolidate some gains, maybe, or at
15 least put out some refutable assertions
16 about what I think might be emerging.

17 Because one of our collective -- as
18 much as we might agree and disagree, and I
19 think we mostly agree, we're trying to come
20 up with a consensus statement among the
21 committee members and authors and NQF staff
22 so that you can move forward with something

1 that you have some confidence in that you
2 can say the committee actually stands behind
3 whatever this paper says and whatever NQF
4 turns into public statements about it.

5 So, just a chance while it's still
6 the beginning of the second day we can
7 revisit this and change it so that Andy and,
8 for example, don't go off the next several
9 weeks and write something that really
10 doesn't do that. So I welcome actually
11 participation in this particular process to
12 do this right now in this moment but also
13 for the rest of the day.

14 Yesterday for me was fun and
15 interesting, especially fun because I wasn't
16 necessarily bottled into one use case group.
17 Although people who were bottled in probably
18 had the most fun of all because it became
19 deep and engaging. And I bounced around not
20 to all of them but to some of them.

21 And for me it sort of represented a
22 microcosm of the world because in this room

1 yesterday was a reenactment of a microcosm
2 of the world. We have people in one corner
3 who are trying to focus on QI and they're
4 trying to grasp for target opportunities and
5 actionable information.

6 And they try to say we have to
7 understand that going forward we have a job
8 to do and we have to consider both of these
9 things simultaneously.

10 And then we have this group over
11 here scheming about network design. How are
12 we going to get rid of the bad apples.
13 Where are we going to draw hurdles. Who's
14 not going to get over it and so on.

15 And the p-for-p, how are we going to
16 get these rascals to change their mind. And
17 then public reporting, how are we going to
18 get consumers to stand up and pay attention
19 and use this information.

20 It's sort of an interesting
21 separation of perspectives which of course
22 was by design, but it was also fun and

1 interesting to observe as it was happening.

2 One of the things that I think cuts
3 across all of that. So here's sort of like
4 one statement that I think the group would
5 be ready to jump onto, but again, asserting
6 it to make sure that's the case is that
7 everybody needs to acknowledge that they're
8 working in this space.

9 Everybody needs to be here. The day
10 of quality is over here doing its thing,
11 quality measurement is over here doing its
12 thing and over here resource use is doing
13 its thing, it's -- we're in an era where the
14 quality improvement has to be cognizant of
15 resource requirements. And making judgments
16 about resource use and so forth has to be
17 cognizant of the different outputs that are.
18 So, everybody has to be in here.

19 Now, in here means just sort of
20 operationally for a minute one of these
21 models, the models that we've enjoyed
22 talking about so much for the last day.

1 None of them really fell out to say
2 that, you know, this model -- to play in
3 this space this model simply doesn't have a
4 role. There's a role for each of the
5 models. So therefore we can put forward to
6 say that to actually work and play and be
7 serious in this space can involve
8 participating in one of these models.

9 Now, you should do it with your eyes
10 open. You should understand you're choosing
11 a model that's different from the other
12 models and there are tradeoffs and so on.
13 But all the models in fact are legitimate
14 for some purposes at least.

15 One of the observations that I made
16 sort of yesterday but also during the
17 environmental scan is that there can be
18 hand-waving.

19 That is to say, I mean even written
20 in the environmental scan writeup there's,
21 you know, we've got this grid and the
22 columns and so forth.

1 And then you come to one row and it
2 says well, what is their measurement of
3 resource use. And it says, quote, "are they
4 working on their cost," something to that
5 effect. And it was like, well, they sort of
6 get it, they're working on the cost and
7 therefore they are. What does that mean?
8 Therefore they're efficient? Therefore
9 they're using resources wisely?

10 And then in the conversation
11 yesterday there was a similar allusion on
12 the other side that you might have a program
13 that's set up that's really around payment
14 reform.

15 And then along comes the fig leaf of
16 the quality measure. You know, well, we
17 have quality measured as a structural
18 measure and the structural measure is does
19 the hospital have a roof and four walls.
20 You know, they say okay, yes, quality met.
21 Game on, let's talk about resource use at
22 this point.

1 So I think that in addition to
2 saying that these models are perhaps
3 legitimate in their own right there has to
4 be some specification about what does
5 minimum participation mean.

6 And we can't just say -- I think in
7 other words we have to call out this notion
8 of hand-waving and to say something about --
9 even if it's side by side which for the
10 moment might be the simplest thinking model
11 because it doesn't have the concerted
12 attempt to put them together.

13 Even there to say that, yes, we're
14 participating because we're doing side by
15 side, there has to be some rigor, some
16 minimum floor in terms of what participation
17 really means.

18 Now, one of the things, again, sort
19 of a generalization from yesterday is that
20 everybody is involved in these decisions.
21 Sometimes they're implicit and sometimes
22 they're explicit. That's one dimension.

1 Another dimension is that sometimes
2 decisions are made just for -- by
3 individuals for themselves in which case we
4 think, I think, again, refutable, that in
5 circumstances where the information is
6 generated for the purpose of individuals to
7 make decisions for themselves we can allow
8 maximum discretion.

9 That is, for example, side by side
10 is maybe fine, maybe good, maybe minimum for
11 things like individuals who are trying to
12 make choices. Because this question about
13 how do you weight this and some of the
14 factors aren't there like travel distance
15 and so forth. We don't want to corner
16 people in with presumptions or baking in
17 assumptions in terms of what's better and
18 what's worse. And so therefore when the
19 individuals are really left to -- when
20 decisions about that, then maximal --
21 emphasize simplicity, transparency,
22 accessibility and then the flexibility of

1 being able to make decisions like that.

2 But, and it was interesting going
3 around the group how there was
4 acknowledgment, sometimes said, sometimes
5 implicit, that we're actually making
6 decisions that will affect lots of people
7 all at once.

8 And in one of the group I was
9 sitting in it rolled all the way up to
10 societal level. Hence the reference to
11 death panels and so forth. That there is
12 actually explicit tradeoffs going on here
13 that can affect whole classes of people.
14 Whether it's you're too old to have that
15 operation, or our budget can't afford that
16 at this time. So there's a lot of actually
17 hard tradeoffs that are being made.

18 And sometimes, well society up to
19 this point most of all have just sort of
20 floated along and let that be implicit. But
21 if the science is going to start marching
22 forward and thinking about how is it not

1 only for individuals making up their own
2 minds, and not even for health plans making
3 up some decisions that are systematic and
4 affect a lot of providers in their network
5 decisions, but even rolling up to higher
6 levels where everybody is affected at once.

7 In other words, the more that there
8 is a systematic effect where a decision
9 about this necessarily affects whole sets of
10 providers in terms of who's in, who's out,
11 who's in the network, who's not, or who wins
12 and who loses. And eventually who can get
13 care and who can't get care.

14 Those decisions actually should be
15 made in a way that is more rigorous, more
16 objective in the sense that the factors that
17 go into the decision-making process are
18 actually asserted and can be debated, and
19 the methods that use those objective factors
20 should in fact be rigorous.

21 So, the models -- even though the
22 first sort of plenary statement I made about

1 all the models are legitimate in their own
2 right, to use them not only requires minimum
3 but to the extent that you're involved in
4 the decision-making processes that are more
5 systematic you actually should move beyond
6 the minimum and move to models that are more
7 discoverable and replicable and eventually
8 objective, and methods that treat with sort
9 of rigor and respect the necessity of
10 including in those decisions that come out
11 of those models as much of the explicit
12 tradeoffs as there are involved.

13 DR. SILBER: Can you define
14 legitimate?

15 DR. TOMPKINS: When did I use
16 legitimate? I'm thinking extemporaneously
17 here. What was the sentence?

18 DR. SILBER: You were saying models
19 are legitimate. You used the word
20 "legitimate" a number of times and the
21 models being -- and I don't understand.

22 Because the NQF, up to now if you're

1 -- generally been certifying measures
2 relating to quality there isn't this kind of
3 debate. It's when you put these together
4 that this becomes very different.

5 So I want to understand what
6 "legitimate" means. It might be that the
7 NQF says it's not legitimate to form a
8 function that combines quality and cost. So
9 I just want to understand what "legitimate"
10 means.

11 DR. TOMPKINS: I guess -- I didn't
12 intentionally use that word. I guess what I
13 meant was that if we're going to make a
14 statement -- it was really drawn off my
15 first statement which is that NQF might be
16 in a position to put a stake in the ground
17 that says it is a requirement of the
18 measurement science world to be cognizant
19 and even act as if they were cognizant the
20 fact that the use of measures should be
21 multidimensional including the cost and the
22 resource uses at the same time.

1 And that maybe my first use of the
2 word "legitimate" was to say that the
3 discussion yesterday did not lead me to
4 think that any of the models that were
5 discovered in the environmental scan either
6 in play or in the literature were not at
7 least an acknowledged attempt to do that and
8 therefore are legitimate.

9 CO-CHAIR DUBOW: If I think about
10 that in the context of what NQF does to make
11 things legitimate there are explicit
12 criteria for scientific evidence, for
13 feasibility, a whole host of very specific
14 criteria that have been accepted by a
15 consensus body.

16 It seems to me that Chris is
17 suggesting that that kind of legitimacy
18 because it suggests acceptance by a
19 consensus body is the direction. If I
20 understand you correctly, Chris, that's how
21 I would interpret that with respect to its
22 applicability to NQF. That's what makes it

1 legitimate. It's broadly accepted. But the
2 reason it's accepted is because we have
3 very, very clear criteria to assess and to
4 make judgments about.

5 DR. TOMPKINS: I have a question
6 actually to Taroon in your introductory
7 remarks.

8 The title of this entire exercise is
9 "Linking Quality and Cost." And one of the
10 results of that can be characterized as an
11 efficiency measure. And then another result
12 of that can be a value measure.

13 Were you meaning to say that the
14 committee is saying that all of this
15 connecting or linking of quality and cost is
16 specifically and only for the purpose of
17 defining efficiency measures? Okay. And
18 not value measures?

19 Because I think clarifying the
20 difference is actually part of the role of
21 this.

22 MR. AMIN: It is and I --

1 absolutely. So I don't want to just give
2 you one-word answers but I would say yes.
3 And it is part of the scope.

4 Maybe, again, a sense of perspective
5 here would be helpful for us and for the
6 group.

7 You know, the main question and the
8 struggle that we have at NQF is that we
9 started down this journey on looking at
10 evaluating and measuring cost measures.

11 And we know that these measures are
12 being used potentially appropriately or
13 inappropriately in conjunction with quality
14 measures for programs.

15 Now, the question is that we don't -
16 - the science of how that is used in
17 programs is still new. And the most
18 important thing that we don't -- that we
19 want to make sure is not happening is that
20 you're just purely comparing on cost with
21 the underlying assumption that quality is
22 equal in the system. And we know that

1 that's not true.

2 So that's the history and the
3 foundation of what this organization is
4 intending to do. And so for the purposes of
5 ensuring that we're looking at cost which is
6 an important imperative in its own right we
7 don't want to undermine the quality
8 enterprise.

9 So ultimately putting these things
10 together, linking them if you will, can --
11 if this idea of efficiency as an objective
12 concept is not accepted, or it needs to be
13 explored I guess. Let's leave it at that.

14 DR. TOMPKINS: Right, because that's
15 one of the things that I think is purported
16 to be the difference between the efficiency
17 and value.

18 But I would say two statements. One
19 is that starting with this basic concept of
20 linking cost and quality measures the only
21 real reason for doing that is to go to
22 value.

1 And then the question is what's the
2 utility in the meantime of the way station
3 of efficiency. And where efficiency has
4 this specific definition that calls for the
5 evaluation of cost in the particular context
6 of the specified level of quality.

7 It's like what I said yesterday that
8 you're making determinations, quote unquote,
9 about efficiency first with regard to
10 understanding the specific level of quality
11 you're talking about. You just don't mix
12 all providers together regardless of the
13 quality level, come up with some common cost
14 benchmark that applies to everybody and then
15 saying, well, yes, you may be high-quality,
16 that may be justifying high cost, but we
17 don't look at it that way. We just think
18 that you're high-cost.

19 The efficiency measure is to say
20 before you jump to the preference weighting
21 do you first want to stop and make these
22 objective evaluations of relative resource

1 use in the context of specific or specified
2 levels of quality.

3 But even if you do that it's so that
4 when you combine the resource use and the
5 quality part of it what you're doing is you
6 have the more sophisticated measure of
7 efficiency which reflects the resource use
8 when used in combination with the quality
9 measures it becomes the preference weighted
10 value measure.

11 CO-CHAIR FLAMM: So I think this is
12 a very helpful and important clarifying
13 point.

14 We have three committee members who
15 would like to make some comments. I'll go
16 Cathy, then Jack, then Joseph.

17 DR. MACLEAN: Chris, your comments
18 just now and I was kind of reflecting also
19 over the evening last night. I think we
20 maybe want to explicitly call out where this
21 body of work ends and where comparative
22 effectiveness begins and the relationship.

1 Because, you know, the death panel
2 discussion which we were having which was
3 really if you were to think about the
4 outcome in terms of, say, a quality-adjusted
5 life year.

6 And the discussion came up around
7 cardiothoracic surgery and should you do a -
8 - what's the value of doing a valve in a 95-
9 year-old versus a 60-year-old. And that's
10 starting to get really into value judgments
11 and into comparative effectiveness.

12 And I just -- that's fine but I just
13 think we want to -- I think when most people
14 are thinking about the efficiency component
15 they're not thinking in those terms. I
16 think they're thinking about the same
17 outcome, you know, the outcome's equivalent
18 and then how does the cost differ for that
19 outcome.

20 DR. TOMPKINS: Yes, I mean it's a
21 little bit -- I don't want to subject people
22 again to this image but it's what I was

1 referring to yesterday when I referred to
2 the pinwheel. Which is that this body of
3 work is really concentrated on some set of
4 more basic and definitive issues.

5 But it actually -- you can see how
6 you can draw lines from it. To say that
7 this concept that maybe network designers
8 are grappling with or public reporting
9 actually has a societal level part to it.

10 And it's been usually the case that
11 the 95-year-old woman would get the valve
12 given the right insurance. And/or if you're
13 in a health system that has a big endowment
14 and sort of isn't pinching pennies and so
15 forth.

16 But then you put the same person in
17 a different context maybe without the
18 insurance, or maybe in a hospital that
19 doesn't have resources that they can
20 subsidize the treatment for and they don't
21 get it. The question is is that okay.

22 But that's one of the spinoff

1 things, to say that to the extent that this
2 linking quality and cost even raises to the
3 point of societal benefits versus resource
4 allocation to healthcare is -- what we're
5 talking about in the body of this
6 extrapolates to that level. And so
7 therefore we might want to think of an
8 orientation that ultimately rolls up to that
9 level as well. But without getting into the
10 death panels.

11 CO-CHAIR FLAMM: Go ahead, Andy.

12 DR. RYAN: I think that comparative
13 effectiveness idea isn't -- it's thought to
14 be generally applied to a population of
15 patients that this treatment, you know, is
16 effective, it's cost-effective, it's more
17 effective than something else. Typically
18 the statements aren't made with respect to
19 an individual provider. It's kind of like
20 this treatment is working on a population
21 level.

22 But you could think if -- in the

1 context of this work you could imagine that
2 certain procedures would be cost-effective
3 if done by certain providers that had a
4 certain cost and quality profile.

5 So I think that is a very kind of
6 interesting extension of this, that it would
7 -- conceptually at least you could get to a
8 more kind of fine-grained concept of
9 comparative effectiveness that wasn't just
10 at the kind of population level but was
11 brought to the provider level.

12 Now, we're not there at all, but
13 that's how I've kind of thought about that
14 kind of question. There's some things that
15 would never be comparative effective, some
16 things that would be cost-effective
17 regardless of who did it, and then some
18 things in the middle that, you know, it
19 would be cost-effective if some set of
20 providers did that procedure.

21 So, you know, I think mapping these
22 ideas on -- connecting those concepts is an

1 interesting extension of this work. But the
2 differences I see are those that I just
3 mentioned.

4 DR. MACLEAN: Cost-effectiveness
5 could also vary depending on who got it,
6 right?

7 CO-CHAIR FLAMM: So, Jack?

8 DR. NEEDLEMAN: Okay. At some point
9 this morning I would like us to have a
10 conversation about whether we really have
11 seven models, or three, or three and a half
12 models here. Because I think it will affect
13 the way we think about this stuff. But I
14 don't want to do that right now because that
15 will take us off in a completely different
16 direction.

17 I think this issue of efficiency
18 relates back to one of the summary points
19 that was made that Jeff has pushed quite
20 appropriately and very heavily about whether
21 we want a single measure.

22 We always go back to the car

1 analogy. Don't ask me why we always go back
2 to the car analogies but we always go back
3 to the car analogies.

4 You can be efficient in building a
5 Yugo. Right? But that's not the car we
6 want to drive.

7 So, we can have highly efficient
8 production of low-quality services. Lowest
9 possible cost to produce that service,
10 absolutely. And that an economist would say
11 is efficiency.

12 So, throughout our conversations
13 there's been this concept that there's this
14 minimum level of quality that we're prepared
15 to acknowledge, we're prepared to accept,
16 and there may be a quality level that we
17 aspire to, and that we want the system
18 pushing itself to.

19 And the measure should allow us to
20 measure where we are and also enable us to
21 understand where we need to go.

22 So if we look at -- so this was one

1 of the reasons why I think our committee and
2 some of the others have said we don't want a
3 single measure of efficiency because it
4 doesn't capture where you are on the quality
5 spectrum.

6 And we want to know where you are on
7 the quality spectrum and how much it costs
8 you to get there. And are you efficient in
9 getting there.

10 And when we look at the data from
11 the measures that have been presented from
12 the data that's in some of the papers that
13 we've seen there are two cases here and each
14 one needs to be analyzed separately.

15 One of them is that case where we
16 see high-quality low-cost providers. That
17 space is filled. There are a number of
18 examples in there. We know that's
19 aspirational. We can both improve quality
20 and get to lower cost.

21 And in those cases many of us would
22 argue we want payment systems that encourage

1 us to move everybody into that space. Raise
2 your quality if it's lower, lower your cost
3 if it's higher.

4 There are other cases when you do
5 that mapping of cost and quality we don't
6 see a lot of -- we don't see anybody, we
7 don't see a lot of folks in that space where
8 it's low-cost and high-quality.

9 There is this tradeoff. To get more
10 you need to spend more. And there the issue
11 for individual patients, for payers acting
12 as their agents is how much more quality is
13 worth spending that much more money on.

14 That's a different question than,
15 gee, we see examples of low-cost high-
16 quality places. Everybody looked like these
17 people.

18 So we've got these two very
19 different situations depending upon whether
20 we think low-cost high-quality care is
21 feasible. And the measures should allow us
22 to determine what that space looks like to

1 figure out what we're trying to do here.

2 The comparative effectiveness stuff
3 if we've got the clear tradeoffs between
4 cost and quality or cost and outcomes. And
5 the aspirational if we've got the case where
6 low-cost and high-quality are both feasible.

7 So we need measures that enable us
8 to understand what the space looks like, to
9 understand what's feasible, to understand
10 what decisions we have to make and what we
11 should be aspiring to.

12 And the question is do these methods
13 enable us to do that and talk about it in a
14 way that is thoughtful, intelligent,
15 supports the decisions of payers, supports
16 the decisions of patients -- that's where I
17 should have started. Supports the decisions
18 of patients, supports the decisions of
19 providers acting as the patients' agents,
20 supports the decisions of payers acting as
21 the patients' agents.

22 But efficiency by itself we don't

1 want to have efficiently-made Yugos in
2 healthcare. We want something better than
3 that. Even if it's efficient.

4 And I think that's the reason why
5 the argument is for at least two different
6 measures are keeping the quality measure
7 always there even if you're measuring how
8 efficiently the care is being delivered.

9 CO-CHAIR FLAMM: Joseph. Then I'll
10 go to Iyah.

11 MR. ROMM: So I find myself going
12 after Jack again which means I have very
13 little to say.

14 I guess the only comment that I
15 would make is, Taroon, in your frame I think
16 that part of what I keep getting stuck on is
17 you frame sort of the role of the NQF in
18 this as being in the space of we know
19 there's variability in quality and people
20 are looking only at cost.

21 And I guess I would suggest even
22 more so than -- and to Jack's point, even

1 more so than thinking about measure
2 frameworks that help us solve that problem
3 there are very different structures.

4 So in Massachusetts as we have
5 increasingly folks coming onto risk, we have
6 risk-bearing provider organizations that now
7 have to go through solvency assessments.
8 And we have mechanisms for patients who are
9 in risk, in various risk plans that have an
10 ability to complain about lack of services.

11 That to me is a very, very different
12 construct than what we're talking about
13 here. And really the only useful tool of
14 all of these conversations in the space of
15 assessing whether you are receiving care of
16 sufficient quality services is side-by-side
17 measurement. And I think we can move on if
18 that's the exercise.

19 I think as Jack has framed there is
20 another very interesting and exciting space
21 for this group to start to delve into in
22 thinking about for a variety of other

1 purposes where this measurement frontier
2 goes.

3 So I guess I would encourage that if
4 that is sort of the range of the construct
5 we can answer that quickly. But I think
6 we're trying to answer all questions with
7 one solution at this point and it's getting
8 us into trouble.

9 CO-CHAIR FLAMM: Peter.

10 DR. ALMENOFF: I think for the white
11 paper the area that I really haven't heard -
12 - I keep hearing the word "efficiency" and
13 "quality."

14 And quite honestly when you talk
15 with providers those don't go together.
16 Efficiency is purely about money and
17 efficiency. Quality has never looked into
18 that. In this group we seem to be putting
19 these words together and that's not what the
20 public perceives as efficiency.

21 So if we're going to talk about
22 quality and efficiency, or if we're going to

1 talk about efficiency with quality in it I
2 think it's a whole new re-definition and
3 education process because the average
4 provider, the average layperson will not put
5 that together. So I think that's one area.

6 The other thing is that efficiency
7 generally is a really dirty word in the
8 world. And I notice that when you try to
9 get a message across or try to push a metric
10 it's all about the message.

11 So, you might be saying -- you might
12 be talking about the same thing but you say
13 it a little differently. You know, when we
14 had a roundtable a couple of years ago with
15 Medicare we decided that the good word was
16 waste reduction, not efficiency.

17 Because nobody can argue about
18 waste, but everyone can argue about
19 efficiency. So I think waste should at
20 least be described somewhere in this paper.
21 Because it's a really easy -- you know, no
22 provider can push back and say we want more

1 waste. It's really hard to say that.

2 Whereas it's much easier to say
3 well, efficiency, you know, the Yugo concept
4 of we're going to have the Yugo healthcare
5 system and nobody wants that. So, but
6 nobody really can argue about the concept of
7 waste.

8 So just, the two points of if we're
9 talking about efficiency. In my mind when I
10 got here I don't look at that and quality
11 together. So to me they're two separate
12 items. Maybe everyone perceives that
13 differently than I do.

14 And then the second piece is we
15 really need to at least address the word
16 "waste" because I think that's a good term
17 that the public and the providers understand
18 pretty well. And they really have a hard
19 time pushing back on that.

20 CO-CHAIR FLAMM: Thank you. Okay,
21 Dennis.

22 DR. SCANLON: So, following up on

1 Peter's comment. I agree that waste is
2 something that maybe deserves a little bit
3 more attention.

4 But in terms of the public or
5 consumers understanding or not understanding
6 efficiency I'm not sure that I would agree
7 with that. I think that -- and my view
8 would be that efficiency is sort of holding
9 quality constant.

10 If we think about sort of other
11 areas of our lives, school district funding,
12 for example, I think efficiency is a concept
13 that consumers understand quite well. I
14 want a certain quality education in my
15 community, whatever that might be, but I
16 want it efficiently. I don't want the
17 school district wasting money.

18 In higher education this is all the
19 issue right now is tuition and a high degree
20 of tuition. How can we gain more efficiency
21 but still maintain that level of quality.
22 So I think a kind of understanding of

1 production and pricing that is competitive
2 in a fair deal relative to a level of
3 quality I think is something that consumers
4 can grab onto.

5 But I do think it points to sort of
6 this issue of, again, what is the purpose
7 and how do we expect realistically people
8 might, or organizations or entities might
9 use this information.

10 When it comes to consumers the only
11 rationale I can think as to why consumers
12 ought to care about efficiency under
13 traditional insurance arrangements is
14 because of what it does to kind of the
15 overall sort of cost of insurance generally.
16 And that's something that doesn't really
17 enter in any one individual decision.

18 When I'm choosing to go to this
19 provider or that provider because I'm only
20 paying a fraction of the care. So what
21 matters at that point in time to me is
22 price. And price is not cost nor is it

1 efficiency.

2 I can have a \$20 copay for very
3 efficiently priced care or very
4 inefficiently priced care, or produced care.
5 So at the point of service, and there's a
6 lot of move to kind of give consumers price
7 information.

8 But I think it's important to make
9 sure we understand that price, or out-of-
10 pocket price is not the same thing as cost
11 which is not the same thing as rendering a
12 judgment regarding efficiency.

13 And so for consumers it would seem
14 to me that packaging information in a way
15 that says, hey, just like your school
16 district is not an efficient producer of
17 education, your health plan is not an
18 efficient producer of education.

19 In your community there is variation
20 in terms of sort of those who are if you
21 want to use waste, wasting resources, or
22 those who are sort of using -- producing

1 healthcare more efficiently.

2 That becomes a different message and
3 a different level of presentation than I
4 think what a lot of people sort of push for
5 which is side-by-side information for each
6 provider.

7 CO-CHAIR FLAMM: Okay, Jeff and then
8 we'll go to Taroon.

9 DR. SILBER: Maybe -- I feel a
10 little bad because we're kind of saying we
11 don't want to do what Chris and Ryan want us
12 to do.

13 But actually I think what the
14 feeling of the group is is that you have to
15 break these apart before or during the
16 presentation of doing what you want to do
17 which is either say what's quality
18 conditional on cost, or what's cost
19 conditional on quality.

20 I have a sense that those are the
21 three different ways to do this, that maybe
22 what the consensus of the group is, and I

1 could be wrong, is that if we're going to do
2 this thing which you say is legitimate which
3 is give me cost conditional on quality, or
4 give me quality conditional on cost in some
5 fancy model like you referenced, the Timbie
6 model and others, right?

7 If we're going to do that what we're
8 saying is you have to also give us the side-
9 by-side. I think that might be what the
10 committee is feeling is that if you're going
11 to give legitimacy to the conditional models
12 you have to break it apart. Maybe that's
13 just one point.

14 And then in terms of the details of
15 the conditional models which -- the elegant
16 model that you reference a lot, Timbie and
17 Normand model which is used for a couple of
18 your different cases.

19 We haven't -- I don't know if we'll
20 get to it today but we haven't got into the
21 details of whether those models should or
22 shouldn't be used. Then you get into all

1 the issues that Jack had talked about before
2 in terms of shrinkage, et cetera.

3 So, maybe we haven't achieved
4 everything that you want from us in this
5 meeting but I think in part it's because
6 we're pushing back on the combination of
7 cost and quality.

8 But maybe what we're keeping up with
9 is this idea of if we're going to go that
10 route there are some prerequisites that are
11 needed in any presentation of the case.

12 CO-CHAIR FLAMM: We had wanted to
13 have this session end at 10 and you need to
14 present a slide, Taroon. Do you want to let
15 --

16 MR. AMIN: I would say keep going.

17 CO-CHAIR FLAMM: Okay, all right.
18 Andy, did you want to make a comment in
19 response to that? And then I'll come over
20 here.

21 DR. RYAN: Yes, I did. And you
22 know, Jeff, his comments were as if we'd be

1 disappointed by that comment. And I've had
2 numerous people express condolences for
3 yesterday's session.

4 (Laughter)

5 DR. RYAN: But you know, I thought
6 it was really -- this has been a great
7 conversation, it's been very enlightening
8 for us.

9 And I agree with what Jeff just said
10 and I think something that Jack said. And
11 I'll try to summarize it and maybe they can
12 disagree with me.

13 But when we're talking about this
14 linking cost and quality it seems like
15 there's no reason to not do side-by-side.
16 So, if we just take that, okay, let's start
17 with side-by-side.

18 Let's come up with an intelligent
19 way to combine the two domains not to
20 develop an efficiency measure per se but an
21 efficiency profile which is kind of the
22 output of these models we're talking about.

1 And then let's subject these profiles to the
2 kind of testing we're used to at NQF around
3 reliability and validity to say -- to see
4 which one holds up under which
5 circumstances, which one seems to make
6 sense.

7 And so given that it seems like
8 there's almost -- I feel like once you get
9 there there's almost no reason to develop an
10 efficiency measure. Because you're kind of
11 losing information.

12 If you keep quality and cost
13 separate you have a method to combine them
14 for a profile. And then we categorize
15 providers given the output of the model. I
16 don't know, it seems like that's -- there's
17 some -- I'm going to assert that there's
18 some consensus around that.

19 Now, there were a lot of other
20 general issues that were raised yesterday
21 about public reporting and how public
22 reporting can best be used to maybe engage

1 patients that I think are -- I think there's
2 particular use cases that we need to think
3 about the efficiency measures.

4 But some of the issues I think
5 raised yesterday, they're worth invoking in
6 the paper but don't -- and for commentary's
7 sake but we don't really need to -- we can't
8 really make a decision about those.

9 Price I would say, price
10 standardization kind of depends on the
11 circumstances as well. We should comment on
12 that, provide some context, but I'm not sure
13 about what we can do in terms of pushing
14 recommendations.

15 One thing that I feel like we didn't
16 get to yesterday that would be useful to
17 hear from the group and also maybe NQF is I
18 think there's kind of an idea -- so, and
19 we'll talk about endorsement later.

20 But, you know, the measures, the
21 input here, the inputs, I think there's an
22 idea that they should be NQF-endorsed on the

1 quality side or NQF-endorsed on the cost
2 side.

3 But what we've seen in the scan, the
4 composite measures are just people come up
5 with different ways to create composite
6 measures. And I don't think I've seen any
7 kind of NQF-endorsed composite measures on
8 the quality side that have gone into
9 efficiency.

10 So I don't know if we want to make a
11 statement about how the composite measures
12 should be constructed on the quality side,
13 if that's something that -- or we should
14 leave it up to the developer, or we should
15 have some guidance there.

16 Because I think that's an important
17 piece of this, of that kind of sausage-
18 making process is how you get to the kind of
19 quality metric which is crucial. And I
20 don't want this to kind of degenerate into
21 all the problems with composites or all
22 those issues, but I just wonder if we should

1 just remain agnostic about how that's done
2 or you know, have some guidance, suggest
3 some way forward with composites.

4 CO-CHAIR FLAMM: Okay, Steven?

5 DR. PANTILAT: I agree about the
6 concern about the ratio. It seems like
7 there are many ways to get to an efficient
8 ratio that don't maintain quality. That
9 seems like a real concern. And I think the
10 point that's being made about the cost of
11 achieving quality.

12 And then I think there's also the
13 sense of the cost of maintaining quality.
14 And so efficiency is an important way of
15 thinking about it.

16 I was thinking in my world of
17 palliative care there are teams for the same
18 staffing that might see 200 patients a year,
19 400 or 800 patients a year. And whether the
20 teams that see 800 a year for the same
21 staffing provide quality is actually a
22 really important question. And what it

1 takes to maintain a level of quality for a
2 certain amount of resource allocation.

3 And there's sort of another way of
4 looking at it which is what is the resource
5 that you'd need to maintain the quality.
6 And the measure that sort of tries to put
7 these together or at least sees them side by
8 side is actually incredibly important, I
9 think very helpful to the field.

10 And then just the other point. This
11 came up earlier just about in kind of a
12 moral or ethical dimension to this. But to
13 the sense that you can achieve the same
14 quality at lower cost there is kind of an
15 ethical imperative in that.

16 If you could achieve same quality at
17 lower cost it does allow you to put that
18 cost -- to either save the money and spend
19 it somewhere else either for healthcare or
20 something else. So there is a -- I think
21 that's something we haven't really talked
22 about but there is a dimension of that that

1 is important.

2 And so understanding efficiency that
3 way does have -- it's not just sort of a
4 business thing in a bad way but actually in
5 a very good way, that if you could be more
6 efficient it's actually better for society
7 really.

8 CO-CHAIR FLAMM: Thank you. Jack?

9 DR. NEEDLEMAN: I think Andy's
10 comments about composite measures is the
11 relevant place for me to raise the three and
12 a half or three measure thing.

13 When I look at the descriptions of
14 the methods and what's being done here there
15 are basically only three ways that cost and
16 quality are being measured or pulled
17 together. And they all -- the first one is
18 some variation of the side-by-side. So we
19 keep talking about that as a unique thing.

20 But in essence in the side-by-side
21 the conditional, the hurdle models, the
22 unconditional models, we measure cost

1 separately however we're going to do that.
2 And we measure quality or outcomes
3 separately, however we're going to do that.
4 And then the question is how we put them
5 together to display them.

6 So in the side-by-side we give you
7 your cost score, we give somebody the
8 quality score. This is a five-star plan on
9 quality, it's a three-star plan on cost.
10 Okay, so that's the side-by-side.

11 Or we can graph it up there. We've
12 got a cost dimension, we've got a quality
13 dimension. And then the different payers
14 begin saying where are we making cut points
15 to highlight specific folks here.

16 On the value payment where there's a
17 plus payment we highlight the high
18 performers. In the hurdle models we
19 highlight the low performers and we get them
20 out of our model.

21 But it's the same data. The cost
22 calculated in one way, the quality

1 calculated separately and then displayed
2 together and considered together. So, we've
3 got -- those are basically the same
4 measurement models. It's just the way
5 they're being used that are slightly
6 different.

7 The unconditional model is a hybrid.
8 That's why I said three and a half. Because
9 there we make some explicit weight between
10 cost and quality. We add them up and we get
11 a single score.

12 And if I heard one clear message
13 from yesterday it was don't do that. We
14 don't trust that. We don't trust that we
15 can get the weights right. We don't think
16 the information is there to help anybody
17 make informed decisions.

18 The two other methods that are here,
19 the regression model and -- actually there
20 are three methods here. The regression
21 model, the DEA which is based on an
22 operations research kind of model of drawing

1 the frontier, and the stochastic frontier
2 which is a regression-based model for
3 drawing the frontier. So we've got three
4 separate ways of doing the analysis.

5 Our efforts to graph the cost-
6 quality tradeoff differently and have a very
7 different metric. And when Timbie and
8 Normand looked at a regression model versus
9 side-by-side or some variation of it they
10 said we came to different rankings of folks.
11 So that ought to give us a little bit of
12 pause about just using the univariate models
13 in each dimension.

14 But that's been, you know, when I
15 look at the list of who's doing what -- with
16 the exception of our friends in the VA
17 virtually nobody is using anything other
18 than some variation of the side-by-side,
19 separately measuring cost, separately
20 measuring quality with all the weaknesses
21 and limitations of how each of those
22 measures are constructed. And we can

1 evaluate each of them separately.

2 But that looks like the state of the
3 art. We've got measure each one separately
4 and display them or consider them together
5 in various ways with different kinds of cut
6 points. Or do some more exotic method like
7 -- exotic. Sorry, that's a terrible
8 adjective.

9 Use some other method like
10 regression, or stochastic regression, or
11 frontier regression, or something else and
12 integrate the data differently.

13 And we've heard a lot of skepticism
14 here about the integration models. I would
15 characterize them mostly at this point in
16 terms of use in this space as not ready for
17 prime-time even though I like them a lot as
18 an analytic framework.

19 But I would encourage you to think
20 about simplifying the way you describe the
21 models in terms -- because you mention well,
22 this always starts out with the same two

1 steps in the unconditional model. That was
2 your reference point as opposed to the side-
3 by-side.

4 I think it's important to note those
5 two steps are both the measurement analytic
6 -- both of those are the measurement steps.
7 And everything else is just how do we
8 display it, and how do we think about it,
9 and where do we put the cut points.

10 And I'd encourage you to simplify
11 the presentation here to capture that in a
12 way of thinking about how many different
13 ways do we have to actually analyze and
14 integrate this data into some measure of
15 efficiency or resource use.

16 And what the efficiency measure is
17 measuring and what it doesn't capture in
18 terms of the quality levels that we want
19 because that's the other thing that's come
20 out of this conversation.

21 CO-CHAIR FLAMM: Thank you. Steven.

22 DR. ASCH: I would just like to make

1 the point that we seem to have come to a
2 consensus that side-by-side is the easiest
3 for people to understand but it's going to
4 be different I think for different
5 stakeholders.

6 There are some stakeholders that
7 want a more sophisticated ratio and can look
8 at all the quadrants, for instance, and
9 might want a stochastic frontier model. And
10 I think -- I wouldn't want to exclude those
11 kind of analyses.

12 And then with regard to the waste
13 issue I agree with my esteemed colleague Dr.
14 Almenoff that waste is an incredibly
15 politically popular way of describing
16 efficiency.

17 But the way I view it is it's kind
18 of the mirror image of the quality hurdle
19 approach. Right? You take the lowest
20 possible quality, meaning either it's
21 harmful or it has no benefit whatsoever, and
22 then you look at the variation in cost. And

1 any variation above the optimum is waste.

2 And so, I don't want us to -- even
3 though it sounds like I might be in the
4 minority, I don't want us to go too far and
5 say that the only thing that we can do is
6 side-by-side. I think there are plenty of
7 instances in which the ratio might be useful
8 to sophisticated audiences like policymakers
9 and purchasers.

10 CO-CHAIR FLAMM: I'm going to let
11 Larry go.

12 MR. BECKER: Thank you. So, it's
13 interesting because we know that costs
14 differ and we know that ways to achieve
15 costs differ. And I think the same is true
16 about quality. There are different ways to
17 achieve quality. And who's to say what's
18 good enough quality.

19 And all of that is to say that in
20 statistics you have upper and lower control
21 limits. And that we ought to create
22 corridors.

1 But I think what's really important
2 and right to the previous point it seems to
3 me that we should come out with a set of
4 stated principles and a stated set of
5 methodologies underlying how, for example,
6 you might combine these.

7 So if you're not going to do side-
8 by-side here's a series of either principles
9 or methodologies under which you should be
10 combining these so that when other people
11 look at it they can understand it and we
12 don't have a wild frontier out there.

13 CO-CHAIR DUBOW: So, that's exactly
14 where I'm going. I think that the issue --
15 I think Jeff actually has been saying this
16 all along. We need to be able to show what
17 we're doing. We don't want to obscure it.

18 And in the jargon, the contemporary
19 jargon, the buzzword in Washington these
20 days is transparency. I think that there is
21 absolutely an element of trust that is
22 lacking basically.

1 And I think differently about the
2 Medicare program, for example, and the
3 commercial sector. In Medicare I know that
4 they're going to weight HCAHPS, I think it's
5 30 percent because we advocated for 40
6 because we knew they wouldn't go there. So
7 -- well, that's the game you play. The
8 hospitals push back really hard and we knew
9 what we would get.

10 But it's public. And we know what
11 that weight is for those particular -- for
12 that particular patient experience
13 component.

14 In the commercial sector when an
15 insurer tiers consumers don't have a clue
16 about what goes into the composition or the
17 creation of that network. And they are --
18 they don't trust it. They think they're
19 being put in there because it's cheap.

20 The discussion around narrow
21 networks happened not because they know
22 they're bad but because they assumed they

1 were bad because they were done for very
2 specific reasons. Exactly what you're
3 talking about, Steven. Because we need to
4 be able to use our resources efficiently to
5 be able to make healthcare affordable.

6 So I think that the methods that we
7 choose have to be -- and the principles. We
8 have to go to the principles because NQF is
9 not yet engaged in implementation. NQF
10 doesn't tell anybody how to implement
11 something.

12 We can make a suggestion about
13 pairing particular measures. So sometimes a
14 side-by-side would happen because you say
15 pair this quality measure with this cost
16 measure. But NQF is not in the
17 implementation space. And it relies on
18 employers and insurers and whoever else is
19 publishing these data for the public.

20 I think one critical principle is
21 complete transparency about what goes into
22 the summation, to the summary score.

1 Because they're doing it now. We want to
2 know what's behind it. Just say so and then
3 people can make judgments. It's the drill-
4 down stuff. Most people probably won't even
5 look at it. But the fact that this stuff is
6 available will be reassuring or it will
7 direct decisions in particular ways.

8 CO-CHAIR FLAMM: Thank you. Cathy.

9 DR. MACLEAN: Just echoing some of
10 the other comments. I think that the very
11 useful output of this really is in defining
12 those principles and the framework.

13 And Andy, you said something about
14 if we were going to be linking quality
15 measures and cost measures. And that kind
16 of struck me a little bit because I guess I
17 wasn't really thinking about this in terms
18 of cost measures. I was thinking about it
19 in terms of cost. You know, you just
20 measure the cost rather than it necessarily
21 being an endorsed measure. But there are
22 cost measures.

1 But I think that in this framework
2 the existing cost measures have very limited
3 applicability and what we're talking about
4 is pretty broad. So I think that it would
5 be useful to define what -- how we ought to
6 go about measuring cost. What's the
7 episode. What should be -- that the
8 principle is that you need to define the
9 episode and you need to define what the
10 things are that are in it.

11 And the same thing on the quality
12 side, that the quality component of this --
13 we talked yesterday about outcomes. We also
14 talked about that in some instances maybe
15 outcomes aren't the best quality. There's
16 some debate in the room about whether you
17 think you could substitute process for
18 outcome.

19 But I think what we're looking for
20 is -- or what would be valuable is to lay
21 out that framework. So this is the stuff
22 that should be in for quality. This is the

1 stuff that we have to think about for cost.

2 CO-CHAIR FLAMM: Matt.

3 DR. ROUSCULP: To follow up on what
4 was said. You know, the one group, the U.S.
5 Preventive Services Task Force looked at
6 cost effectiveness. And they put together
7 the gold book and that was kind of the way
8 to move forward in really thinking about
9 bringing cost and outcomes or quality is
10 where they got to.

11 One area that I would hope that we
12 really kind of winnow down is we're really
13 looking at the precision of quality. NQF
14 has done a great job of really trying to
15 help to identify what are the appropriate
16 measures for quality.

17 We can also be very precise in
18 trying to estimate what our costs are, be it
19 episodes of care, be it -- however we want
20 to go and measure it.

21 I think it's important for us to be
22 quite precise on the relationship. So if we

1 have quality measures that someone is going
2 to come by and say this is what we want
3 measured we've got to make sure that those
4 relate to the appropriate cost. Because we
5 can very easily be very imprecise. We can
6 say this is what a quality of care for heart
7 transplant looks like.

8 But the cost element I'm bringing in
9 is everything within that hospital, be it
10 whether it's related to the heart transplant
11 or anything else. We've got to be very
12 careful in that because very easily we can
13 get to the point that any ratio that we
14 create can be gamed immensely. And we want
15 to make sure that we are precise and that's
16 the guidance that we give.

17 And maybe you had already thought of
18 this, but I just want to make sure that we
19 don't miss that because that's one of the
20 big lessons that we learned many years ago
21 when we tried to put together the task force
22 and they're in the process of redoing that

1 now. And I just think there's some lessons
2 and perhaps some benefits you want to look
3 at.

4 CO-CHAIR FLAMM: Christine.

5 DR. RYAN: I think this is an
6 important issue that I think it would be
7 good to get the feeling of the committee on.

8 Because just think about what's
9 happening on the hospital side, that -- so
10 quality is being measured for heart failure,
11 pneumonia, heart attack, infection. So it's
12 some subset of all the care that's provided.
13 The outcomes are for heart attack, heart
14 failure, pneumonia, right. And then some
15 complication things.

16 And then the cost is currently being
17 assessed for everyone. So, right now the
18 measurement system in Medicare for hospital
19 value-based purchasing would be inconsistent
20 with what Matthew just said we should do.

21 And I think a lot of what we've seen
22 in our scan, there isn't a clear -- this is

1 kind of what I tried to allude to yesterday,
2 that there aren't, you know, the conditions
3 on the cost side and those on the quality
4 side aren't necessarily the same. There's
5 not a whole lot of standardization.

6 And so I think the hard line would
7 be to say programs just shouldn't be
8 designed that way, that these are principles
9 of standardization in terms of the
10 conditions on both sides or the other
11 elements of standardization that Greg has
12 been alluding to. Or we could just say
13 these are things that developers should
14 consider.

15 So anyway, those are maybe two sides
16 of how the paper could kind of touch on
17 these. But I just wanted to get a flavor
18 for if what Matthew said is the kind of like
19 belief of the committee that the measures
20 shouldn't be inconsistent in that way.

21 CO-CHAIR FLAMM: Christine.

22 DR. GOESCHEL: Thank you. A couple

1 of things. Many things strike me.

2 The first is that I think it's
3 really going to be useful and critically
4 important to make sure that the high-level
5 framework for the paper is crisp and takes
6 us where we need to go.

7 And a couple of things that I heard
8 this morning made me feel better about what
9 happened yesterday. Because on my way home
10 I wasn't feeling so good about that.

11 The thing that struck me today is
12 the notion that everyone needs to be
13 involved in the space. The recognition that
14 the decisions that organizations or entities
15 make may have impacts on all society, that
16 notion of the pinwheel.

17 The phrase "rigor and respect"
18 struck me. I wrote it down. Because I
19 think wherever we come we have to
20 acknowledge that we are at the beginning of
21 a messy space. And the minute the white
22 paper is out we're going to know more about

1 either different methods or different
2 impacts. And what we don't want is people
3 to believe that this is an endpoint rather
4 than a beginning.

5 Jack, you have an amazing way of
6 simplifying for people like me that are not
7 in the space in terms of framing I'm going
8 to say where we are now, where we need to go
9 and potentially what might be involved in
10 getting us there.

11 As someone who lives primarily in
12 the quality space I think it is -- I do head
13 jerks because we're talking as though
14 measuring quality we know how to do. And I
15 would argue that we don't.

16 And so as we think about efficiency
17 and effectiveness and price and cost and how
18 to link all this to quality we're linking to
19 another messy space.

20 I guess the other thing that -- and
21 it ties into what you said, Joyce, and what
22 I hear, in terms of communicating whatever

1 we do in a place that engenders trust.

2 I think I mentioned yesterday that I
3 live in Maryland and we have a new waiver.
4 And when I got home last night I had emails
5 from people in my organization saying you're
6 our new person for quality. We have all
7 these effing ratios that came to us from
8 Maryland. We can't make any sense out of
9 this.

10 And this is finance calling the
11 quality person. And when we talk to the
12 rate-setting commission they say we use
13 really sophisticated regression models that
14 you wouldn't understand, but trust us.

15 (Laughter)

16 DR. GOESCHEL: Because we apply them
17 across the whole state.

18 I mean, and I think the reality is
19 that organizations and entities are living
20 this every day.

21 So the notion, and I look at the
22 brilliance in this room, I feel it. And we

1 get so much into the granular and the
2 potential. I think it's critically
3 important not to stick with just the side-
4 by-side or the variations, to really point
5 where we need to go to have better
6 understanding of what we're doing. But to
7 encapsulate it in a way that doesn't end up
8 sounding like we've -- and I'm not
9 suggesting that side-by-side is dumbed down,
10 but that we don't settle for something and
11 that we don't leave the impression of trust
12 us. Because I think that would be a really
13 horrific and false choice.

14 CO-CHAIR FLAMM: Kimberly.

15 DR. RASK: I'd really like to just
16 echo several of these remarks in thinking
17 about the framework.

18 As I listen to what Jack said one of
19 the thoughts for framework is really to kind
20 of think of this as we have our cost
21 measures, we have our quality measures and
22 we have the question of whether or not you

1 combine them. And one piece of the white
2 paper is talking about the side-by-sides not
3 mathematically combined cost-quality
4 measures.

5 We can -- based upon work that NQF
6 has already done about what principles are
7 for quality measures we can speak to that.
8 Any measure that's proposed, be it side-by-
9 side, hurdle, whatever that information,
10 what are the issues with the quality
11 measure, what are the principles of the
12 quality measures, what are the principles
13 with the cost measures, and what are the
14 principles, what would be new, what are the
15 principles with using a hurdle model versus
16 a side-by-side that we would want to
17 address.

18 Second, there are efficiency
19 measures that are going to try and
20 mathematically combine quality and cost, and
21 that's a new field. There's some
22 information out there. There's not a lot.

1 What are the principles that a
2 developer would have to be able to
3 demonstrate to have an organization like NQF
4 be ready to endorse something? Or perhaps
5 in looking at the field and what's there to
6 say this is a really promising future area
7 but it's not where we are yet and therefore
8 NQF at this point is not going to be
9 endorsing those measures but encourages the
10 development and study and evaluation of
11 innovative ways to do this. And welcomes
12 work by others who are in this area to help
13 move that forward. Doesn't mean we don't
14 want to go there, but it is kind of a little
15 bit different evaluation strategy depending
16 on what kind of measure it is and it gives
17 us the opportunity to provide some more
18 grounded principles around the one model
19 versus where we may hope to be in the
20 future.

21 CO-CHAIR DUBOW: I meant to say this
22 before but Andy's remark triggered this.

1 Because this is already being done,
2 your example of Medicare, I think the
3 principals have to have some kind of a
4 statement about having to express the
5 limitations of the approach so that people
6 understand how you can and cannot interpret
7 the data.

8 It's happening anyway. So there
9 needs to be some acknowledgment that
10 Medicare is using cost data that may not
11 correspond to the time we measured the
12 quality, for example. Or you know,
13 whatever. But people need help in
14 understanding.

15 Again, it's not to say that every
16 consumer is going to look at this. But
17 there ought to be full disclosure of how
18 that number can be interpreted.

19 I think though that what the paper
20 needs to help us understand is how far each
21 of these methodologies can go without really
22 going too far, without really doing damage

1 in terms of the ability to represent a
2 performance of efficiency. To really
3 distort what we're talking about.

4 I think we have to be able to say if
5 you do X it's -- you can't. Don't do that.
6 So again, full disclosure of the
7 limitations. How far can we go and get away
8 with it and then where are the barriers.

9 And I say that strictly from a
10 pragmatic perspective. This is happening
11 and we're not going to stop insurance
12 companies from tiering. In fact, we're
13 encouraging them to create these high-
14 performance networks.

15 So I think we just need to be
16 realistic about the fact that it's -- we
17 need to give guidance that's very, very
18 practical.

19 DR. RYAN: And Joyce, can you give
20 an example of going too far?

21 CO-CHAIR DUBOW: No, I need you to
22 tell me that. Because I don't know. I

1 don't know enough about the methodology to
2 know how far. But you guys, you guys all
3 do, how far -- where you really distort, or
4 where you don't really say anything that's
5 meaningful or fair. Maybe you can help me,
6 Jeff, I don't know.

7 DR. SILBER: I think we've given one
8 example that people seem to agree on that
9 the populations should be similar when
10 looking at the cost side and the quality
11 side.

12 And if you're going to be looking at
13 a combined measure we've also said that you
14 have to -- one guideline would be that an
15 efficiency measure should not be used in
16 isolation to the disaggregated cost and
17 quality measure. In other words, one of the
18 NQF -- a guideline could be you can't
19 present one without the other.

20 And then we said in terms of when
21 you go too far is when the data for cost
22 isn't related to the data for quality.

1 So those are just some examples.
2 But we could think of others, other
3 principles.

4 CO-CHAIR FLAMM: I just want to make
5 one brief comment on this notion of matching
6 the clinical design, the population scope of
7 the cost and the quality side.

8 To the extent that some of the
9 programs today do look at certain specialty
10 episodes of care and match the episode cost
11 to the quality side, that kind of works.

12 But as we start looking at measures,
13 and understanding that performance on cost
14 may vary by this specialty, may look very
15 efficient but overall perhaps they're not
16 efficient.

17 We have this measure of total cost
18 of care that is emerging. We don't have a
19 total quality of care measure. And we're
20 always going to have some degree of
21 imperfect kind of alignment. So getting
22 good enough with good intentions but not

1 necessarily perfection is something I just
2 wanted to throw in there.

3 Gary.

4 DR. YOUNG: Just to echo the points
5 about outlining a set of principles. I
6 don't know if I would frame it so much about
7 it going too far, but I certainly think that
8 an important outcome from the paper would be
9 to outline how these approaches match up
10 against certain scientific principles.

11 Some of that I think would require
12 empirical work. So yesterday in our own
13 group we talked about the importance of
14 robustness and that we'd all be pretty
15 squeamish if we saw providers being ranked
16 very differently depending on which approach
17 you're applying.

18 And some of these approaches may
19 lead to more consistent results than others.
20 Some of these approaches may produce similar
21 rankings. Other approaches may produce very
22 different rankings. And so I think those

1 are some of the principles we'd like to see
2 outlined in the paper.

3 And some of that may require some
4 empirical work where we can apply some data
5 and see how rankings match up across the
6 different approaches, look at reliability,
7 look at validity, the kinds of central
8 scientific principles that we all live by.
9 I think that's going to be an important
10 consideration in the paper.

11 CO-CHAIR FLAMM: Jeff.

12 DR. SILBER: Twenty-five years ago
13 when cost-effectiveness was relatively new
14 and people were bringing that into clinical
15 trials there was a lot of concern about,
16 again, taking data that wasn't from the
17 trial to extrapolate and make a cost
18 effectiveness statement.

19 So rules were set down. There were
20 task forces that came out from the
21 government -- people probably remember this
22 -- which said, for example, you have to use

1 the cost and the outcomes from the trial.
2 At least, there might be other things you
3 do, but one of your analyses that you have
4 to report is that they go together. So, it
5 wouldn't be the first time if we were
6 suggesting such things.

7 And going back to the rules that
8 were set up for clinical trials and cost
9 effectiveness might be one to look at.

10 CO-CHAIR FLAMM: Okay.

11 MS. WILBON: So, we are a little off
12 agenda but that's okay because we're making
13 adjustments.

14 I did want to -- I think this
15 discussion has been great, by the way. We
16 are I think really kind of getting at what
17 we were hoping to get out of this two days
18 and I think the group is on a roll. So we
19 don't want to stop if people still have
20 things to -- that they want to express.

21 But I did want to kind of bounce it
22 back to Andy and Chris to see if -- I know

1 Chris kind of jump-started the discussion
2 off with some of his thoughts and to see
3 whether or not the discussion after that
4 kind of addressed some of the concerns and
5 some of the concerns that Andy raised, or
6 whether or not there are any kind of major
7 topics that you feel like need more
8 discussion. And we can figure out how to
9 continue to facilitate that discussion. Or
10 just to kind of check the pulse on what you
11 guys are thinking.

12 DR. RYAN: The comments I want to
13 make I just made them after some comments in
14 the room were made. So I think my kind of
15 overview kind of direction comment, I don't
16 have anything further to say on that.

17 You know, I've raised a couple of
18 questions. One about composites on the
19 quality side, what kind of guidance we might
20 want to offer on that that I think is
21 unanswered.

22 I'm getting, you know, we're getting

1 some feedback on the notion of
2 standardization. And I think it seems like
3 the committee is leaning towards at least
4 stating a preference for measuring cost and
5 quality for the same populations.

6 But -- so that's good. But I don't
7 know if you, Chris, want to move the
8 conversation in any particular way right
9 now?

10 DR. TOMPKINS: No, I think that
11 we're good with this session and onto the
12 next.

13 MS. WILBON: Okay, so let's go ahead
14 and take about a 13-minute break until
15 quarter of 11. And then we'll come back and
16 move onto the next agenda item. Thanks,
17 everyone.

18 (Whereupon, the foregoing matter
19 went off the record at 10:31 a.m. and went
20 back on the record at 10:48 a.m.)

21 MR. AMIN: Okay, is everybody ready
22 for the next section of the discussion?

1 Please find your way back to your seats.
2 Want to make sure we get everybody out on
3 time.

4 So, the next portion of the
5 discussion is really to think about the
6 question of what NQF should be endorsing.
7 This sort of cuts to the very operational
8 guidance that we're looking for from this
9 committee.

10 So for those of you that are maybe a
11 little less aware, NQF has a formal
12 consensus development process which we call
13 the CDP to review and endorse performance
14 measures. We have a long history of
15 endorsing quality measures. We've been over
16 the last three years looking at cost of care
17 measures and many of you around the table
18 have been involved with those efforts. And
19 many of you from the beginning.

20 The proposed cost of care and
21 resource use measures are evaluated across
22 four overall criteria. The first criteria

1 looks at the importance to measure and
2 report. The second looks at the scientific
3 acceptability of the measure properties
4 which is really an evaluation of the
5 reliability and validity testing of the
6 measure to ensure that the costs of care
7 that are represented in the measure score
8 represent valid assessments of resource
9 utilization.

10 We also look at the feasibility of
11 the measure and then the use and usability
12 of the measure to ensure that the results
13 can be used for both accountability and
14 performance improvement objectives.

15 We've gone through -- so that's the
16 overall criteria that's looked at for cost
17 of care measures. I would just note one of
18 the major questions that's to be answered
19 that we'd like the group to discuss is that
20 currently there's no requirement for cost of
21 care measures that are -- cost or resource
22 use measures that are submitted to NQF to

1 have any sort of pairing or quality signal
2 that's associated with that, either at the -
3 - well, I'll just say at the measure level
4 for the purposes of this discussion.

5 So there's still I think some room
6 for discussion around the composite question
7 that Andy raised during our last session.
8 So I'll just point out that NQF's current gc
9 related to composites, I'll just recap a
10 little bit of what we discussed yesterday
11 for the sake of having all the information
12 for the discussion is that the composite
13 measures that are submitted to NQF, and we
14 have a number of them that are endorsed,
15 none of them which include -- I can say this
16 with full confidence -- that none of them
17 include both the cost and quality signal in
18 a single measure score itself.

19 So the guidance that we have for
20 composite measures is essentially the
21 quality construct itself should be
22 considered essentially. The individual

1 components of the composite measure should
2 demonstrate a gap in performance. And there
3 should be a conceptual and analytic
4 justification for including the components
5 in the overall composite measure.

6 And each of the components of the
7 composites should provide added value to the
8 overall composite, either empirically or
9 conceptually. And that reliability and
10 validity of the overall constructed
11 composite measure should be demonstrated.
12 So that's a little bit of just the general
13 framing of how the current guidance related
14 to composite measures again which currently
15 the only composites we have include
16 components that are of quality measures
17 only. So there's still I think a little bit
18 of discussion to be had around what
19 potential guidance we would expect if you
20 were to include multiple different types of
21 measures.

22 So the overall questions that we

1 have for the committee are what should NQF
2 be endorsing in terms of quote unquote
3 efficiency measures. Should it be the
4 programmatic methodology of the approach, a
5 combination of measures, or both?

6 How might the current endorsement
7 process for cost and resource use measures
8 integrate linking quality measures?
9 Specifically, should resource use measures
10 be evaluated in the context of identified
11 quality measures that would be linked or
12 evaluate them together, noting that that
13 would be a significant departure from where
14 we are today.

15 If NQF were to evaluate efficiency
16 models -- and I think we've moved away from
17 that potentially, but that's also an area
18 for discussion -- for endorsement which
19 criteria or principles should be considered
20 in terms of testing thresholds, feasibility,
21 or any of the guidance that exists in the
22 current NQF composite guidance.

1 And I think the last one is probably
2 a little bit out of scope considering the
3 discussions that we've had over the last day
4 but I'll just for the sake of completion
5 just ask it. What are the implications for
6 endorsement of efficiency measure/models
7 that include rating systems, i.e., the Star
8 rating system.

9 MS. WILBON: I would probably
10 slightly re-frame that question maybe in the
11 context of some of the discussions that have
12 come up potentially around the side-by-side.

13 And I think a place that NQF has not
14 gone that Joyce mentioned before is kind of
15 in the implementation space. To date we
16 don't really evaluate the way that the
17 measures are technically displayed. So we
18 look at kind of the construction of the
19 measure, the actual testing and so forth
20 that goes into the development and
21 construction of the measure, but not
22 necessarily how it's displayed.

1 So I think this whole notion of the
2 side-by-side display of potentially the
3 efficiency measure profile if you will, that
4 that would be somewhat of an added piece to
5 kind of our current process in terms of just
6 looking at measures individually.

7 So, just based on the discussion I
8 think it would be really good to hear some
9 feedback on whether or not that -- we need
10 to be looking at how people might be
11 proposing to -- or entities or organizations
12 might be proposing to display that
13 information, whether that should be part of
14 the endorsement process as well. So.

15 MR. AMIN: So, yes, I would just
16 summarize this discussion that we're hoping
17 to have before lunch to say that currently
18 NQF looks at endorsement of cost measures
19 and endorsement of quality measures. And
20 that's the extent of what we're doing.

21 What should be in addition to that,
22 if anything? I think that's inherently the

1 question being asked. And we can -- there
2 are various different levels of what can be
3 done from there. But at a very simple level
4 that's the question that's being asked.
5 Joyce?

6 CO-CHAIR DUBOW: Taroon, if you can
7 just remind me as a policy matter hasn't NQF
8 taken a position -- I just seem to have
9 participated in so many conversations where
10 we advocate for providing information --
11 when you provide information on cost that
12 you should also provide some information on
13 quality. Have we no policy position at NQF
14 that says that?

15 MR. AMIN: So it's operational
16 guidance. I would say the way that we sort
17 of, you know, that it's not clearly in the
18 criteria. There's no requirement in the
19 criteria but it's guidance as -- yes.

20 And as we've gone through the
21 governance structures of NQF, the standing
22 committees, the Consensus Standards Approval

1 Committee and the board in particular, all
2 those levels have reaffirmed that these
3 measures should be used in the context of
4 quality. I mean, there's more layers to
5 that but effectively that's the -- where it
6 stopped.

7 I mean, there's no specific
8 requirements as measures are submitted for
9 endorsement that they're linked with quality
10 measures or definitely not anything at the
11 programmatic level at this point.

12 So I would ask -- I mean the series
13 of questions is basically should there be
14 something more than that and then maybe a
15 further clarification around how would --
16 what would the pathway be to get there? So
17 any clarification?

18 Use your microphone. Thank you.

19 DR. YOUNG: I just want to clarify
20 this because I think I heard yesterday that
21 there's been a change in policy at NQF that
22 composites now don't require endorsement for

1 all of the individual measures that comprise
2 the composite. I know that was the policy
3 in the past but now it's the composite
4 itself that is endorsed and the individual
5 measures that comprise it don't each
6 individually have to be endorsed by NQF.

7 MR. AMIN: That is correct.

8 DR. YOUNG: Okay.

9 MR. AMIN: That is correct.

10 CO-CHAIR DUBOW: So are we looking
11 for discussion on these questions? Okay.
12 So, you all can see the questions in terms
13 of what NQF should be endorsing in terms of
14 efficiency measures. Do we all understand
15 what we mean by that? Tim, you want to take
16 a leap?

17 DR. LOWE: Well, I don't know about
18 that. I was thinking though in terms of --
19 I understand it's kind of new ground in
20 terms of providing guidance.

21 But I do think that how these are --
22 the end product does obviously influence the

1 selection. So, if we're going to select a
2 methodology that has implications for
3 display then obviously that has to be
4 specified.

5 Now, it may just be guidance. Maybe
6 you can't endorse a particular look. I do
7 think that the field comes up with some very
8 creative ways sometimes of explaining
9 things.

10 I know I give it to colleagues and
11 I'm somewhat color-blind so they always do a
12 better job than I am. And some of the stuff
13 is just gorgeous, what they create. So
14 there's creativity out there.

15 But if they know what the basic
16 structure needs to be, you know, because I
17 think people get lost in this. But also I
18 think without that end goal I don't know how
19 you would design the process to get there.

20 So I don't think I can answer all
21 these questions for you at the moment.

22 CO-CHAIR DUBOW: But we did have

1 that conversation yesterday about what the
2 purpose of the measurement was. And you
3 know, it seems to me that this is a very,
4 very broad question, but that we need to be
5 a little bit more granular in giving some
6 guidance. Because I think it all depends
7 what you're using it for. So. Greg.

8 DR. WOZNIAK: I guess I'm not sure
9 if you're kind of taking these dot point by
10 dot point, but at least a couple of
11 comments. One on the first one.

12 And I think you just said it. There
13 needs to be the flexibility to allow for the
14 developer and the user to have the kinds of
15 methods or use the kind of methods with the
16 kind of data that they have available.

17 And one of the things that's
18 apparent in the discussion, a lot of these
19 techniques, these models, they're driven by
20 what data is available, what you can do,
21 what you can't do. So it needs to have that
22 flexibility.

1 But jumping down to the last point.
2 I guess I'm unclear, are you talking about
3 how the data is visualized, or are you
4 actually talking about things like
5 thresholds? Because there was a lot of
6 discussion yesterday about we should not be
7 considering anybody, or we should not be
8 giving pay-for-performance bonuses or
9 whatever to anybody that's in that low-
10 quality tier.

11 I mean are we talking about
12 thresholds of values for some value of cost
13 and quality, or are we just talking about
14 we're using Stars, or we're using the
15 Consumer Report little circles. I always
16 forget the names of those. Like STS uses
17 those. Harvey balls, okay.

18 CO-CHAIR DUBOW: Is it Hardy or
19 Harvey?

20 DR. MACLEAN: Harvey. Half reds and
21 whatever they are.

22 DR. SILBER: We call them blobs.

1 DR. WOZNIAK: Whatever, right. But
2 I mean, are we talking about pure
3 visualization, or are we talking -- which
4 then has sort of the -- what's the
5 information.

6 CO-CHAIR DUBOW: Yes, I think that
7 needs some clarification.

8 DR. WOZNIAK: Or is it thresholds
9 we're talking about? I would avoid
10 suggesting thresholds because NQF doesn't
11 say performance measures, you need to meet a
12 threshold of 60 percent or 70 percent. But
13 which are we talking about?

14 MS. WILBON: I think we were talking
15 more in the -- my re-framing of that last
16 bullet was more in the display, more in the
17 visualization and whether or not that should
18 be integrated as part of the evaluation
19 given the kind of --

20 DR. WOZNIAK: I'd probably say no
21 there too.

22 CO-CHAIR DUBOW: Actually, I don't

1 understand what that means. I mean,
2 visualization reflects something that is
3 underneath. So the Five Stars and the
4 Medicare Advantage program, for example,
5 reflects a methodology.

6 It speaks to who's qualified to earn
7 bonuses because the requirements are very
8 particular. The cut points are established
9 so there are methods that are behind it.
10 You know, simply saying -- we're talking
11 about the display, are you saying use Stars
12 as opposed to Harvey balls? Not, I don't
13 think.

14 MS. WILBON: No. I think I'm just
15 trying to get at the fact that there's been
16 the discussion around the importance of
17 having a side-by-side model to show what the
18 efficiency profile is.

19 And so showing the efficiency
20 profile in a side-by-side model is key to
21 showing information that kind of
22 visualization of the cost and quality next

1 to each other is not typically part of the
2 way we ask for the information from them.
3 They may add it but it's not a part of the
4 evaluation process per se. So I guess
5 that's what I'm trying to tease out if that
6 makes sense.

7 CO-CHAIR DUBOW: So with that I
8 would ask Jeff this question because he's
9 the side-by-side man.

10 (Laughter)

11 DR. SILBER: I'm not the only one
12 here. But I think -- I would have thought a
13 scatter plot would have been -- a scatter
14 plot or its equivalent in terms of some
15 information that conveys the same
16 information in the scatter plot and leave
17 it.

18 If people want to use the different
19 letters -- but I mean -- the point is
20 there's got to be an X and a Y. I think
21 that's the key point.

22 CO-CHAIR DUBOW: I think the

1 question I have for you, though, scatter
2 plots will never fly on Medicare Compare.

3 DR. SILBER: So what I'm saying is
4 there's got to be an X and a Y. I think
5 that's the point. We want to disaggregate
6 cost from quality. That's the thing that
7 would need to be conveyed besides the
8 efficiency measure.

9 CO-CHAIR DUBOW: When we talk about
10 display in that last bullet, because I
11 really think we should focus on the other
12 questions, but the question is whether this
13 side-by-side has to be right there next to
14 the Stars, or whether you can click down and
15 see, okay, here's what went into the Stars.

16 Here's what -- there is no
17 efficiency measure in the Star rating for
18 Medicare Advantage right now. It's strictly
19 -- it's some administrative stuff which I
20 think is problematic but there's no
21 efficiency assessment. It's HEDIS measures,
22 it's CAHPS and it's some -- it's how fast

1 you answer your telephone for Part D.

2 DR. SILBER: I guess the point is --
3 we wouldn't want it to be that what we
4 require is for an efficiency measure that
5 somehow the details of that measure are in
6 terms of its functional form. People won't
7 understand that.

8 But they will understand that the
9 parts of the measure in terms of cost and
10 the parts of the measure in terms of quality
11 laid out in some side-by-side fashion, that
12 will understand that tradeoff that we're
13 talking about.

14 So it's -- when I heard earlier
15 today, we're talking about what needs to be
16 described and transparency, I agree you do
17 want to be transparent about whatever
18 efficiency measure you make.

19 But one important element of the
20 transparency is to give the two dimensions.
21 So if it's done by a scatter plot, or it's
22 done by a blob for quality and a blob for

1 cost and they're put next to each other, or
2 a number for quality and a number for cost
3 and they're put next to each other and you
4 have an element of the distribution across
5 the different choices that you can make in
6 terms of other hospitals that you would go
7 to or providers and this is where they
8 stand.

9 I think it's the disaggregation of
10 the two axes that are needed.

11 DR. PANTILAT: I just find myself in
12 this discussion wondering if it might be
13 helpful to think about a specific example
14 rather than a general example. And if there
15 was a way to look at a particular quality
16 measure and then think about what the -- how
17 you might think about a cost measure that
18 goes with it and then try to answer these
19 questions including how we might display it.

20 Just thinking about it in theory is
21 a little bit more -- for me at least is
22 being a little more challenging than

1 thinking about some of the measures that
2 were presented yesterday, some of those
3 composite measures and others.

4 If you chose those as measures of
5 quality how might those be combined with
6 cost to be an efficiency measure?

7 CO-CHAIR DUBOW: I think we
8 shouldn't focus on the display itself, but
9 rather what's behind the display. Because I
10 don't think this group is going to be the
11 one to be the dispositive voice on display.
12 That's a whole different science.

13 DR. PANTILAT: And I don't even mean
14 to focus on that, but just how might you
15 combine it with cost in a way that --
16 because the quality is very specific to a
17 population, to a measure. And then how
18 might cost be equally specific that way to
19 combine it into any kind of efficiency
20 measure.

21 CO-CHAIR DUBOW: -- an example from
22 the hospital side. I think you really are

1 conversant in what's happening in that space
2 right now.

3 DR. RYAN: So, with hospital value-
4 based purchasing it's kind of unique. And
5 Chris is more the expert because he was one
6 of the architects of this.

7 But it's -- each of the individual
8 measures kind of get filtered through this
9 attainment and improvement like paradigm
10 where attainment is basically based on these
11 standard benchmarks. You get these points
12 for attainment and then the year over year
13 changes, you get points for improvement.
14 And then each measure gets a performance
15 score.

16 And then these scores then kind of
17 go up to the domain level. And then at the
18 domain level they get weighted and put
19 together as a total performance score.

20 And so with hospital value-based
21 purchasing there's this efficiency domain
22 that's I guess online. Is it next year? I

1 think it's next year.

2 DR. RASK: It's now. The Medicare
3 spending per beneficiary? It's out.

4 DR. RYAN: And so that gets
5 weighted, I don't know, 30 percent,
6 something.

7 And so the domains get weighted, you
8 get a total performance score and then
9 there's a payment adjustment based on that.

10 But, so -- and this is kind of the
11 unconditional model is based on our
12 definitions.

13 Now, what some private payers would
14 do for cost is they -- some did a
15 statistical model where they said, okay,
16 like these people are -- let's take episode
17 cost. These people are significantly
18 different from mean cost so we're going to
19 put them in kind of high- and low-cost kind
20 of categories and then everybody else is in
21 the middle.

22 Other payers were just kind of

1 classified based on the distributions like
2 quartiles or something based on cost. And
3 then you'd have like, you know, maybe four
4 categories.

5 And then what was common for the
6 tiers is to say, you know, if you're, you
7 know, if you're just some combination of
8 that distribution. Like if you're just
9 bottom quartile for cost, high quartile for
10 quality, we'll say you qualify for
11 distinction.

12 And so that would be a way that the
13 measures would be operationally combined is
14 typically there's some kind of
15 categorization classification of the cost
16 input into some box. And then similar on
17 the quality side and that's how they're put
18 together.

19 CO-CHAIR DUBOW: Does that help you
20 think about the question a little bit
21 better?

22 MS. WILBON: So we're just

1 displaying an example if this helps from a
2 measure that we've received in the resource
3 use measure evaluation process on how
4 they're proposing to display the cost
5 measure in the context of the quality
6 measure. Thank you, Jack, for sending this
7 to us.

8 But I'll just add, and I feel like I
9 probably derailed the conversation or
10 confused it by re-framing that question.
11 But we didn't endorse their approach to
12 doing this. We just endorsed the cost
13 measure. So, the question for the group is
14 really more about --

15 CO-CHAIR DUBOW: What was the
16 measure?

17 MS. WILBON: So the measure is the
18 cost measure around, I don't remember what
19 this one was. Is this the total cost? I
20 don't know the measure number.

21 (Laughter)

22 MS. WILBON: But again, this was how

1 they were trying to show the committee how
2 they're using the measure in the context of
3 quality. So this was their -- okay, thank
4 you. So I'm just showing this as an example
5 of someone was saying that they would like
6 to kind of see an example of --

7 CO-CHAIR DUBOW: What's the unit of
8 analysis?

9 DR. NEEDLEMAN: This is the per-
10 member per-month -- fee-for-service
11 participants in Medicare per member per
12 month attributed to the physician group
13 measure. The practice measure.

14 MR. BECKER: What's the quality?

15 DR. NEEDLEMAN: Oh, we weren't asked
16 about that one. So I don't even remember
17 what they were displaying here. I can find
18 it out. I've got all the documentation
19 here. Give me a moment.

20 MS. WILBON: But this again was not
21 intended for you guys to go into detail.
22 It's just to show you an example of what we

1 have been presented with but we haven't
2 really gone into an evaluation on the
3 details of the questions that you're asking.
4 We didn't go there because that's not
5 currently part of the process.

6 So again, I feel like I'm taking us
7 down a rabbit hole going further. But
8 again, it was just purely for illustration
9 purposes to kind of demonstrate where we are
10 right now in terms of our evaluation
11 process.

12 We were given a cost measure and
13 said to evaluate under a separate -- under
14 current criteria and said -- and they told
15 us we are going to be using this in the
16 context of quality and this is how we're
17 going to use it.

18 But we didn't go down this rabbit
19 hole of, well, what are the quality metrics.
20 How are they going to be combined. How are
21 you determining, you know, what the scatter
22 plot numbers are. We didn't go there

1 because we don't have the guidance to do
2 that.

3 CO-CHAIR DUBOW: So was this
4 intended for public display? Was it
5 intended for regulation to look at outliers?
6 What was it intended for?

7 MS. WILBON: This is a CMS measure.
8 So it would have been provided to the
9 physician groups.

10 CO-CHAIR DUBOW: It looks like a CMS
11 measure.

12 MS. WILBON: It would have been
13 provided to the physician groups to tell
14 them where they are in the feedback report.

15 DR. PANTILAT: This is to evaluate a
16 specific cost measure? A way of assessing
17 cost?

18 MS. WILBON: Cost and quality.

19 DR. PANTILAT: And quality. No, I
20 understand that. But there's a specific
21 cost methodology here and a specific quality
22 measure that's here.

1 MS. WILBON: Right. But we didn't
2 evaluate the quality measures, or what
3 quality measures they were using. It was
4 only the cost measures.

5 DR. MACLEAN: We're kind of having
6 this little side conversation related
7 looking at the specs for the CMS physician
8 value-based modifier program which does
9 this.

10 And I just kind of wonder if it
11 would be instructive for the committee to
12 kind of go through this. I don't know how
13 many people are familiar with it.

14 But I think the thing that strikes
15 me about this program is it's very nicely
16 laid out. And they've got tiers and so on.

17 But when you look at the quality
18 measures which are basically the PQRS
19 measures it's kind of a whole bunch of
20 different measures. But then the cost
21 measures are pretty, you know, limited to a
22 couple of conditions.

1 And I think that's something we
2 ought to have some discussion around and
3 maybe make some recommendations on whether
4 there should be some sort of relationship.
5 If NQF is going to be looking at cost
6 measures if there should also be some sort
7 of a quality measure that goes along with
8 it.

9 You know, there are different --
10 like the -- I was also kind of pulling up
11 the -- Joyce, you probably were involved in
12 this. The patient disclosure program. The
13 consumer purchaser disclosure thing a few
14 years ago which basically a bunch of people
15 signed onto it and plans agreed that yes, if
16 we were going to report out anything about
17 cost on docs we also have to report it out
18 on quality. But it didn't get so specific
19 to say that it had to be on the same cost
20 and quality. Anyway.

21 CO-CHAIR DUBOW: But this does raise
22 the question that Greg talked about before

1 in terms of the flexibility that he's
2 looking for in terms of data sources and
3 availability of data. Remember, Congress
4 mandated the value-based modifier and CMS
5 had to hustle and come up with something.

6 And I wonder whether there are
7 challenges with respect to data. Certainly
8 there are limitations in terms of what
9 measures are around to do it within the time
10 frame. Which is a whole other story that
11 needs to be recognized.

12 We live in -- but I think the
13 question of data availability is an issue.
14 And how much flexibility NQF wants to be
15 able to exercise in terms of looking at some
16 of this stuff.

17 I mean, do we take into account some
18 of that stuff? Are we agnostic about what
19 the challenges are in developing these
20 things?

21 DR. BURSTIN: Just a few thoughts.
22 I think these are all good questions.

1 I think there's always a tradeoff
2 between specificity and comparability. You
3 just have to put it on the table. You can
4 give flexibility and then you're left with
5 measures that are not comparable.

6 So I think particularly on the cost
7 side these are primarily claims data.
8 Availability isn't really much of an issue.
9 It's more of an issue I think, my sense of
10 it, being the quality person more on the
11 quality side of very different data sources
12 producing very different results. Here it's
13 not quite that way.

14 I do think these are, you know, we
15 got a lot of heat to be honest when we
16 endorsed cost measures. A huge amount of
17 heat. I mean, endless comments, a couple of
18 people were on that committee saying how
19 could you. You said as part of a prior
20 framework report that NQF did not believe in
21 looking at cost measures in isolation. It
22 should always be done with quality. And

1 here you are endorsing cost and resource use
2 measures.

3 And that was the slide that Taroon
4 showed earlier. That building block slide
5 was exactly produced in response to that to
6 say yes, but to get to efficiency we have to
7 have reliable valid measures of cost and
8 resource use to combine with quality to get
9 to efficiency.

10 So I think we're still at the same
11 place now. We've now got some measures we
12 feel pretty comfortable are cost and
13 resource use measures. I agree with the
14 comments earlier that we've got a long way
15 to go on quality too in terms of which
16 quality measures you would actually put with
17 these cost measures.

18 Some of the PQRS process measures
19 don't seem like the kinds of things you
20 would throw in a box with a total cost of
21 care measure, for example.

22 But I think, you know, the question

1 I think really for all of you is should NQF
2 take a different approach. If in fact, and
3 we talked about this early on the cost
4 measure comes forward should we ask the
5 developer identify what is the related
6 quality measure. Whether it's side-by-side,
7 combined, whatever the case may be, but it
8 should be related to.

9 And you see that in the value-based
10 purchasing program from CMS where they've at
11 least got here's the cost measure, here's
12 the outcome measures. But those are exactly
13 the kind of questions we'd like to hear from
14 you.

15 And again, you know, the endorsement
16 criteria are intentionally fluid. We update
17 them every year. If there is again needed
18 updates to this around implementation and
19 how to look at these and perhaps put more
20 teeth around what has just been guidance we
21 are really looking to all of you to provide
22 that information to us.

1 MR. BECKER: So, as everybody knows
2 consensus is getting harder and harder as we
3 get deeper into the cost issues, the
4 reimbursement issues and all of that.

5 And it seems to me that I think
6 everybody in the room would agree that as
7 we've gone through this subject there
8 doesn't appear at least to be a right
9 answer. And there might be a consensus
10 around how we want to go, but we don't know
11 all the intended and unintended consequences
12 of whatever it is that we ultimately
13 recommend.

14 So as I think about processes like
15 these in a Black Belt process you would run
16 a pilot. I wonder if one of the things we
17 should recommend is some rapid cycle
18 learning events around let's figure out or
19 let's recommend that CMS, for example, run
20 some of these recommendations in small
21 pilots with how you display this kind of
22 data this way, or this kind of data. And

1 let's learn. Let's do some rapid cycle
2 learning. Because I don't know that if we
3 put 100 more learned people in this room
4 we'd come to an answer. So I think there's
5 a lot that needs to be understood about
6 this.

7 And I think if we write this paper
8 and we recommend that we run some processes.
9 And then thinking about when we're trying to
10 get to consensus and we're trying to
11 actually get to adopt a series of criteria
12 lots of good thoughts but I think we're
13 going to need some hard evidence that we've
14 really looked at this and here's what
15 happens when.

16 CO-CHAIR DUBOW: Let's just start
17 down there with Gary and come up the line,
18 please.

19 DR. YOUNG: I guess as I think about
20 this it seems to be there's sort of a truth
21 in advertising feature to this. Because
22 payers, purchasers want your endorsement

1 because it gives their measures or their
2 approach a legitimacy with respect to
3 providers.

4 Clearly you can endorse a cost
5 measure or some other measure, several
6 measures, and then they can put it together
7 in ways that in fact don't necessarily meet
8 the criteria in which the individual
9 measures were initially endorsed for.

10 And so what are they saying to their
11 provider community? Are they saying, you
12 know, are they saying the individual
13 measures were endorsed? That a provider may
14 come back and say yes, but you're holding me
15 accountable to something that's different.
16 You're holding me accountable to this
17 matrix, or this complex set of measures, or
18 this composite. Has that been endorsed?
19 Well, I think the response to that would
20 have to be no.

21 If they want endorsement for that
22 then yes, it has to go through NQF. So I

1 think there's sort of a truth in advertising
2 feature to this.

3 Payers, purchasers want your
4 endorsement because that provides a sense of
5 legitimacy that they can then communicate to
6 their providers. This has been endorsed.

7 But if you're combining different
8 measures that have each individually been
9 endorsed. So the example you gave us
10 before, the cost measure was endorsed. You
11 didn't ask questions about how they were
12 going to use it. Well, I think that's fine.

13 But if they're going to use it in
14 some sort of a process that didn't get
15 endorsed then they can't communicate that to
16 their providers as being endorsed. If they
17 want that endorsed then they have to go
18 through the NQF process.

19 CO-CHAIR DUBOW: Steven?

20 DR. ASCH: That's what I was going
21 to say.

22 DR. YOUNG: Well, we discussed it,

1 so it's all right.

2 CO-CHAIR DUBOW: Jack.

3 DR. NEEDLEMAN: The conversation has
4 moved on. Anybody who wants to know what
5 was on the quality side there I've got it
6 up. Come see me at lunch.

7 I'm coming back to the questions
8 here. And I've sort of migrated down to the
9 bottom of this list of four items rather
10 than the top.

11 I think use matters here even though
12 NQF does not endorse for use. And the
13 reality here is people are being on these
14 measures. People are being tiered on these
15 measures. People are being excluded from
16 these networks on these measures. So there
17 are sharp cut points in how the measures are
18 being used.

19 Most of the measures are like that
20 scatter plot we saw, two different measures.
21 So, each of the measures needs to meet all
22 the standards for endorsement. If we're

1 talking about composites each of those
2 dimensions, the X and the Y as Jeff has said
3 I think to me need to be endorsed.

4 The issue that's come up here which
5 is not as the criteria were explained when
6 we were on the Cost and Resource Use
7 Committee, that is not fully there in I
8 think the current standards that should be
9 is the concept of robustness.

10 We've got the split sample of things
11 to show validity. If we do the same thing
12 but we do it to two slightly different data
13 sets or two subsets of the data we get the
14 same answer.

15 But what we don't have answered
16 here, given the uncertainties about the data
17 is whether if we use slightly different
18 weighting systems, a slightly different risk
19 adjustment system, if we include the drug
20 data or don't include the drug data because
21 we only have it half the time do we wind up
22 with the same rankings.

1 And I would encourage that as we
2 think about this given the high -- given the
3 nature of the way in which these are being
4 used that the robustness of the measures
5 needs to have more consideration. And that
6 needs to be incorporated into the
7 conversation as well. So that to me would
8 be one of the things when I look at 3 and 4.

9 NQF, and indeed when we were looking
10 at the cost measures for CMS we were not
11 asked about where the cut point should be.

12 But if you're looking at a Star
13 system the cut points very much matter and
14 they're very much part of the measurement
15 system. So we don't have criteria for cut
16 points. We don't have criteria for when are
17 differences material and when aren't they.
18 We've got these sharp lines being drawn.

19 But if everybody is about the same
20 quality drawing a line that distinguishes
21 the top 10 percent from everybody else isn't
22 really capturing anything material. So the

1 distributions matter and that also has not
2 been considered when we've been looking at
3 these things. So how much variance there
4 actually is matters.

5 NCQA says they take that into
6 account when they're saying do we want to go
7 down this path from creating a measure in
8 this area. Are we ready to retire this
9 measure because everybody is basically at
10 the same level.

11 So NCQA some of whose measures we've
12 considered and endorsed takes that into
13 account. The question is whether the NQF
14 process should be taking the degree of
15 variance into account as well related to
16 this issue of cut points.

17 So, those are some of the things
18 that strike me as I think about the ability
19 to endorse here. Each dimension needing to
20 be endorsed, the robustness, thinking about
21 cut points and use and the implications of
22 that for how much variance and what the

1 variance is telling us.

2 CO-CHAIR DUBOW: You mentioned two
3 things. The issue of robustness I think is
4 an arguable question about whether that is
5 included in the criteria. I would suggest
6 that it is implicitly included in the
7 evidence requirement, isn't it? And it's a
8 judgment. Isn't that -- you don't think so?

9 MR. AMIN: I think the issue that
10 Jack is bringing up is around the current
11 criteria related to validity. We only --
12 the NQF criteria allows a systematic
13 evaluation of face validity which doesn't
14 get to the whole issue about the stability
15 of rankings that I think Jack was pointing
16 out.

17 CO-CHAIR DUBOW: So that brings me
18 to the second point. And I wonder whether
19 having a clear statement of principles where
20 we can articulate the areas where we need to
21 be robust and how we could be robust as well
22 as to address the second point that you made

1 would advance this conversation about cut
2 points and things of that sort.

3 Can we come up with a set of
4 principles that address some of these
5 concerns in a way that -- I mean one of them
6 you talked about is, you say, use matters.
7 And we have had that theme throughout these
8 two days. We agree that use matters.

9 So, is it helpful to think -- one of
10 the bullets here does ask us to think about
11 principles, to be able to identify some
12 principles that would incorporate some of
13 these ideas.

14 MR. AMIN: Can I also tag onto that,
15 Joyce? I think the point that you're making
16 is a really important one.

17 I think there's two points that have
18 been raised here by Jack and the second one
19 I think Andy has raised earlier.

20 I think the big question that, Jack,
21 you're raising is purely tied to the whole
22 question of use. You know, how these cut

1 points are, how the stability of the
2 rankings, depending on what the purpose of
3 the -- the way that the measure is used
4 drives how much the requirements need to be
5 in terms of some of the validity testing.

6 And again, I just would point out I
7 welcome discussion on this topic as well. I
8 mean, NQF has had its position right now and
9 I think we're certainly rethinking it, at
10 least more explicitly, about whether or not
11 the criteria need to be maybe not different,
12 but at least the way that the criteria are
13 applied need to be clearly -- clearly need
14 to be potentially different depending on the
15 use case.

16 And when we say use case that means,
17 you know, we broadly define accountability
18 applications as public reporting and pay-
19 for-performance applications. And you could
20 imagine there's a gradient there even.

21 So currently we don't think about
22 those as necessarily measure properties.

1 Those are things that happen after the
2 measure is endorsed. And you know, it's a
3 reliable, valid measure. It's good enough
4 to be used for payment. It's good enough to
5 be used for public reporting. And there's
6 really no distinction currently. I think
7 that's open for discussion.

8 And some of these questions around
9 cut points and the robustness I think really
10 relate to once you're starting to use it for
11 payment or limited networks the requirements
12 may be potentially greater. And I would
13 submit that for discussion.

14 I think the second question that,
15 Jack, you just raised and Andy just raised
16 before is the whole question of the profile.
17 When you actually look at this graph, you
18 know, Andy, you raised I think earlier today
19 or yesterday the question that you might
20 actually need to do reliability and validity
21 testing of some sort of this actual profile.

22 That's not something that we've ever

1 done in the past and I'm not -- I mean, I
2 analytically -- I'd be curious to understand
3 how analytically that would be done. And if
4 we could provide some additional guidance on
5 whether that's something we should be
6 requiring and how it should be, you know,
7 what we would expect in terms of a
8 submission from developers, that type of
9 clarity would be welcome as well.

10 So, I think the two that have been
11 brought up here that I would welcome some
12 additional conversation around is this
13 question about the profile and what exactly
14 we would require in terms of the profile.

15 And then secondly, this question
16 around use case and how much that should be
17 driving some of the criteria here.

18 DR. SILBER: I agree. I was
19 thinking about what Jack said. Usually
20 we're not in the context of having two
21 variables, it's one variable. So I don't
22 want to make a joke about double robustness

1 which is not anything to do with this.

2 But we're doubly concerned. And so
3 I think Jack's point is a really important
4 one.

5 Again, going back to the cost-
6 effectiveness literature and the cost-
7 benefit literature people didn't get too
8 hung up or haven't generally been about
9 needing to be robust for the cost and robust
10 for the benefit. But they have worked out
11 proper confidence intervals that are those
12 ellipses that deal with the cost and the
13 benefit. So, I mean, some -- and of course
14 some of the papers that were referenced
15 dealt with this.

16 But a statement from -- in this
17 document saying that when you're doing this
18 even with the side-by-side it probably isn't
19 a bad idea to have some confidence interval
20 around those points. But that's a separate
21 issue than the robustness.

22 But I guess I'm saying I totally

1 agree with what Jack said. It's double
2 important because of the new problem that
3 we're looking at. And there is some
4 literature from the past that could be drawn
5 on in terms of cost-effectiveness.

6 DR. SCHUUR: So I would echo the
7 point about use being very important here.
8 I think the value-based payment modifier
9 metric is a good example to look at which is
10 a continuous cost -- continuous adjusted
11 cost versus a performance on quality.

12 But really it's a tertile of quality
13 versus a tertile of cost. And so when
14 evaluating it I would suggest that the NQF
15 criteria should really look at that.

16 Is there evidence to support the cut
17 points for quality. Is there evidence to
18 support the cut points for cost. Is there
19 validity of those cut points.

20 And then the reliability test should
21 be testing those cut points as opposed to
22 testing whether or not the model on costs is

1 reliable in a linear or a logarithmic
2 framework for a continuous cost variable.
3 Because the important thing is going to be
4 how providers get ranked for those.

5 DR. MACLEAN: Just one comment on
6 that. So I think that there are times where
7 maybe there wouldn't be a statistically
8 significant difference between the different
9 tertiles or however you break it up.

10 But I would just caution that it's
11 still important to know the cost and the
12 quality and the efficiency. Because maybe
13 there are some areas where we as a society
14 or as a country don't do so well. And I
15 wouldn't want to lose the opportunity to
16 understand those point estimates to try to
17 improve it.

18 DR. SCHUUR: Let me just clarify. I
19 agree with that. And I think the case for
20 cost can be made. You know, cost is
21 important and so variation in cost is
22 important.

1 But rather than saying -- if your
2 model is looking at is there reliability on
3 the measure on average cost and you compare
4 using traditional reliability metrics you're
5 comparing the dollar costs.

6 What's really important is are
7 providers, groups, hospitals going into fall
8 into the high, low, or medium groups. And
9 what proportion of them are going to be
10 reclassified differently under the different
11 model. Because that's how the measure is --
12 that's the effect of the measure.

13 And you may get a very -- the actual
14 -- that's really the characteristic of the
15 measure is in tertiles. It's not being used
16 as a continuous cost model.

17 CO-CHAIR DUBOW: Back to use again.
18 Jack?

19 DR. NEEDLEMAN: As I've been sitting
20 here listening to the conversation I had two
21 additional thoughts. Again, partly driven
22 by use, partly thinking about principles and

1 criteria here.

2 One of the things that's come up
3 over and over again in the last couple of
4 days is this concept of you can be -- you
5 can efficiently produce low-quality care.
6 And I have not heard anybody say that's
7 acceptable.

8 So, the efficiency measures, however
9 you measure them, even if you're measuring
10 something different from cost, really do
11 need to be coupled explicitly. And even if
12 you're computing them with DEA or regression
13 or anything else, they do need to be coupled
14 with some sense of what the quality is. So
15 that to me is one of the principles I would
16 want to see in terms of endorsing a pure
17 efficiency measure.

18 The other thing is I do think the
19 conversation is different when there's
20 evidence -- evidence that there are many
21 low-cost high-efficiency high-quality
22 providers, that that is an attainable state

1 given the current technology and the current
2 way we organize and deliver care.

3 Because to me the issue of payment,
4 the issue of tiering, all are much easier if
5 I know there's no tradeoff between cost and
6 quality. So I think it's important for
7 those who are trying to think about using
8 these measures, think about whether that
9 space is filled, or whether that space is
10 empty. Because if that space is empty there
11 really is a tradeoff between cost and
12 quality.

13 And the conversation about what
14 we're trying to do in healthcare, where we
15 make the decision about what the minimum
16 acceptable quality is, whether we think
17 there's a maximum acceptable quality because
18 achieving anything more than that is too
19 expensive is part of the conversation. But
20 that's a different conversation than we can
21 have our cake and eat it. We can have high-
22 quality care at low cost.

1 So, looking at what the nature of
2 the relationship is between cost and
3 quality, whether efficient providers,
4 whether low-cost providers produce high-
5 quality care is -- or the tradeoff is to me
6 part of the discussion of use and part of
7 how we think about the issues -- the
8 decisions we have to make using these
9 measures. And those two conversations
10 differ depending upon whether that low-cost
11 high-quality quadrant is fillable.

12 DR. SCANLON: Jack, just -- I mean,
13 are you holding price constant in that, or
14 no? What's your view on that?

15 DR. NEEDLEMAN: No. Well, what I'm
16 saying is if we map, you know, go back to
17 that thing. If we map cost against quality,
18 however we measure cost, however we measure
19 quality, and that whatever -- that sweet
20 spot box of high-quality low-cost has folks.
21 So that's feasible.

22 If I can get CLABSI rate down to

1 zero without spending any more money then
2 I'm going to insist everybody go to zero.

3 But if the only way that I can get
4 to that highest quality is by spending more,
5 that's a different conversation, Dennis.
6 That's do we want to pay the amount to bring
7 everybody up to that level because it's
8 going to cost. Is there a lower level of
9 quality that we think is the sweet spot and
10 we're not going to pay to move everybody up
11 to that higher level.

12 That's a different conversation
13 about the -- the efficiency level to achieve
14 high quality is not a low-cost level.
15 That's a different conversation about the
16 cost-quality tradeoff than if we don't.

17 And I think in terms of moving the
18 quality and the efficiency agenda forward we
19 have to know which decision space we're in.

20 The frontier can be very squared in
21 which case we don't have the tradeoffs
22 because the sweet spot is there. But if the

1 frontier is not squared then we've got the
2 tradeoff and we need to be able to talk
3 about that in ways that don't get us into
4 death panels.

5 (Laughter)

6 CO-CHAIR DUBOW: Okay, Jeff.

7 DR. SILBER: It seems to me that I'm
8 concerned about an insurer that would want
9 to save money by using tertiles rather than
10 quintiles. So that they can group the
11 quality of the very best along with the
12 little bit better than average in the top
13 tertile.

14 And therefore -- and if they're not
15 going to provide the continuous measure then
16 the use of the tertile can be used in a way
17 that's devious.

18 I don't want that to happen. So
19 maybe what should happen is we might not
20 have to make a statement about whether you
21 have to use tertiles or quintiles or
22 quartiles or whatever. But we could say

1 whatever you give you also have to give the
2 continuous measure. Therefore, we could
3 ensure against the elimination of the
4 understanding of really good quality which
5 is beyond the upper -- it's not just that
6 you're in the upper tertile, right?

7 So I guess -- I don't want the game
8 the system by playing with tertiles or
9 quintiles. But I want the continuous number
10 as well. And I think that will be another
11 aspect of what we put into the report.

12 CO-CHAIR DUBOW: Greg?

13 DR. WOZNIAK: I think yesterday I
14 said my condolences to Chris and Andy.
15 Today you have my sincere condolences.

16 (Laughter)

17 DR. WOZNIAK: I think we got back to
18 a lot of the discussion has been around one
19 of my comments about are we talking about
20 thresholds or are we talking about
21 visualizations. And it seems like a lot of
22 this discussion has been around thresholds

1 and whether or not we should be talking
2 about the thresholds or the properties of
3 the thresholds. And whether or not we
4 should be trying to improve care and improve
5 quality. I think we all agree to that. I'm
6 not sure how that goes into this report or
7 how this feeds into the report.

8 The details around this get really,
9 really messy as we've heard. I mean, there
10 was the RAND report that did the reliability
11 study on ETGs and they showed the
12 reliability depended on the specialty that
13 you were looking at. And obviously sample
14 sizes. So now are we going to start saying
15 about you could use this, or this is
16 reliable and robust for this set of
17 specialties but not that set of specialties?

18 So I'm a little bit concerned about
19 how far we go and how much detail there is,
20 and that it be consistent with some of the
21 other NQF frameworks in terms of what are
22 the sort of high-level criteria that you've

1 applied to other types of measures.

2 So again, I don't think -- I go back
3 to my comment. None of those endorsements
4 and none of those criteria say things like
5 performance on a measure ought to be 70
6 percent. So I'm not clear that we can say
7 something about the threshold for minimum
8 quality needs to be X. And how you actually
9 then have the measure developers use that?

10 Because what's going to happen is
11 they're going to stop going to NQF to get
12 endorsement because there's all kinds of
13 measures that are being applied outside of
14 CMS, for example, and even within CMS that
15 don't have NQF endorsement.

16 There's all kinds of private payers
17 that use measures that haven't seen the
18 light of day of NQF. They're all home
19 baked, they're all homegrown.

20 So you've got to be concerned about
21 not only -- my sympathy to the authors here
22 in terms of what they include and don't

1 include, but what you put out and how far
2 you want to go in terms of your criteria and
3 what you want to actually consider or not
4 when these measures come to NQF.

5 CO-CHAIR DUBOW: But what about the
6 principle around robustness? Can't you
7 apply to different scenarios the principle
8 of robustness?

9 DR. WOZNIAK: Well, again, I think
10 you can. It depends on how far you want to
11 go and how far reliability, robustness,
12 validity all tie together. Because those
13 things all do tie together and there's
14 different metrics of those. And then it's a
15 question of what metrics would be acceptable
16 as a robustness criteria or a reliability
17 criteria.

18 DR. BURSTIN: Taroon hinted at this
19 earlier, that we've had a lot of discussions
20 about whether the idea of a binary yes/no
21 endorsement has outlived its usefulness, and
22 whether it's time to move to endorsement

1 that is perhaps more fit for the intended
2 purpose.

3 So you might, for example, just
4 playing this out. We don't have internal
5 consistency I think on staff this is a great
6 idea, but we know we need to do something
7 other than the yes/no.

8 But might you, for example,
9 incorporate that robustness when you know
10 the intended use is for high-stakes
11 financial payment as opposed to something
12 where it's perhaps a lesser --

13 MR. BECKER: As opposed to high-
14 stakes lives.

15 DR. BURSTIN: No, no, no, I was not
16 going to say that, Larry. I'm saying high-
17 stakes financial as an example. I didn't
18 say high-stakes lives. I'm just saying as
19 an example as opposed to something that
20 might be used for benchmarking or QI.

21 DR. MACLEAN: So I think our
22 discussion today is really kind of

1 highlighting some of the many challenges in
2 this. And I think that Andy and Chris, if
3 the paper could lay out what we hope to gain
4 out of this sort of a system and what we
5 want to avoid. And I think then kind of
6 work into what the way you do it would be
7 helpful.

8 In some of the discussion this
9 morning, particularly with the concern about
10 if you have a low efficiency you're going to
11 have high efficiency, low-quality care. So
12 I think that argues for having a threshold.

13 But yesterday we -- there were
14 concerns expressed about if you have a
15 threshold then maybe that would tamp down
16 trying to raise up scores even higher. And
17 Jeff has now raised a concern about
18 tertiles, or quartiles, or however you put
19 them together, that it's going to be less
20 transparent.

21 My concern about laying out the
22 point estimate is that you probably can't

1 validly discriminate against -- the
2 confidence intervals are going to be so wide
3 at the point estimate that I think that
4 there is methodological value to putting
5 people into groupings, or entities into
6 groupings that you can discriminate against.
7 So, that's another consideration.

8 But I think we want to just lay out
9 all the concerns and then maybe back into
10 what the model ought to be.

11 DR. ASCH: This is the problem with
12 putting your tent up and then having seven
13 people ahead of you. However, so I'm just
14 going to agree with two different things
15 that people have already said.

16 And that is if there are going to be
17 threshold measures then the continuous
18 measures should be made I believe
19 transparent or even published or attached,
20 despite the problem of confidence intervals.

21 I think the threshold measures will
22 have the effect that they're going to have

1 whether the continuous measures are attached
2 to them or not. And for all the reasons
3 that people have already said so I won't go
4 into them again.

5 Then, Helen, I had thought for a
6 long time that NQF should stop the yes/no
7 thing and start talking about how the
8 measures are going to be used and what the
9 optimum use case for a measurement is.

10 And that there should be a few
11 paragraphs associated with every measure
12 saying this is what we at NQF think the
13 ideal use of this measure is. And if people
14 choose to use it differently as they
15 probably will then they do. But at least
16 NQF has put its flag in the ground.

17 And other agencies have done things
18 like that as I'm sure you know at least to
19 some extent.

20 Because really measures aren't just
21 measures. Measures are how they're used.
22 And that's why we keep coming back to the

1 use case. And rather than be silent on it,
2 why don't we at least say what we mean.

3 CO-CHAIR DUBOW: Okay. Staff?
4 Where are we on this?

5 MR. AMIN: It appears that we've
6 exhausted the discussion. Is there more?
7 Joe, it seems like you have -- no?

8 Yes, I mean there are a number of
9 committee members who have been part of this
10 discussion from the standing committee's
11 perspective. And so we'd welcome the
12 committee members' discussion or thoughts on
13 this topic.

14 CO-CHAIR DUBOW: I think that's a
15 really good question, how helpful this would
16 be to you all on the standing committee.

17 DR. NEEDLEMAN: Well, not just me
18 but also Andy who's actually writing the
19 paper and a few other folks around the room.
20 Okay. So I think this is extremely helpful.

21 DR. WOZNIAK: I'm sorry, Jack?
22 Sorry. Could you maybe explain to the rest

1 of us what the standing committee is? I
2 guess we're not exactly clear.

3 MR. AMIN: So, across all of the
4 various different consensus standards --
5 across the various different clinical areas
6 and topical areas that are looking at
7 measures we have standing committees that
8 are tasked with two to three years of being
9 a sitting committee with the purpose of
10 owning a portfolio in a particular topical
11 area.

12 So, we've seated a Cost and Resource
13 Use Standing Committee. Many of those
14 members are part of this panel as well.
15 Jack, Joe, Herb, Andy, there are others.
16 Larry, obviously. So a number of folks that
17 are around the table. And so this input is
18 really to be given back to the standing
19 committee in terms of how they should be
20 evaluating cost of care measures going
21 forward.

22 And this group was particularly

1 tasked with the question -- this group
2 meaning the linking cost and quality group
3 was tasked with the question of whether we
4 should be expanding anything related to our
5 criteria for cost of care measures. And
6 that's been a topic of debate with the
7 standing committee for quite some time now,
8 probably last year.

9 So again, I'd welcome thoughts or
10 reflections from the standing committee
11 members on the topic that's been the
12 discussion for the last hour.

13 CO-CHAIR DUBOW: These used to be
14 called steering committees. They have
15 changed their name. They're a little bit
16 different now.

17 But the reason they're important at
18 NQF is that they make recommendations. And
19 those recommendations go out for public
20 comment.

21 And NQF receives the public comment.
22 The committee reconsiders or considers the

1 comments, reconsiders its recommendations
2 and then the recommendation goes forward.
3 And then it goes to the CSAC which stands
4 for the Consensus Standards Approval --

5 (Laughter)

6 CO-CHAIR DUBOW: So it goes to a
7 committee that again consider it but looks
8 at it from a policy recommendation.

9 The bottom line here is that the
10 recommendations of the standing committee
11 are very important. And the purpose of
12 having principles and guidance is to inform
13 the thinking of the people who sit on these
14 various committees, to help them figure out
15 how to apply some good -- some principles to
16 their deliberation so that they reflect NQF
17 policy. So it's very important work.

18 So, okay. And I apologize for
19 putting you on the spot, Jack. I forgot
20 that there were others here.

21 But it would be useful to know
22 whether we are heading in a right direction

1 and whether there's more that you need and
2 what you think. Because I think we're
3 probably heading for lunch soon, but we need
4 to be sure that both Chris and Andy have
5 what they need again, that we're getting
6 closer to having a set of useful principles
7 so that we can draw this conversation to a
8 close with respect to how NQF is going to
9 actually use this stuff.

10 MR. STEPHANSKY: I have been very
11 encouraged, particularly today because
12 yesterday I think we were still kind of
13 wandering around in the dark.

14 And I have a feeling that there are
15 things that we have not really articulated
16 here that are going to be in the paper that
17 will be even more useful.

18 I think the issue of the yes/no is
19 also going to be important. And I hope we
20 can continue to work on that one.

21 While I have not had much to say to
22 the group we've certainly been having all

1 sorts of conversations in the background
2 that had -- just are starting to really
3 become rich. So I'm very encouraged.

4 DR. NEEDLEMAN: When I think about
5 the committee deliberations that we've had,
6 and we've had from what I've heard from
7 staff some of the most contentious, lowest
8 consensus votes on the measures.

9 And I think it reflects the state of
10 the criteria and the sense of use as much as
11 the nature of the measures that have been
12 brought forward.

13 The issues that have sort of emerged
14 out of those discussions are very much in
15 the quality of the measure. So things like
16 the completeness of the data. The exclusion
17 of often drug costs sometimes, behavioral
18 health costs because of carve-outs have
19 driven some of us absolutely crazy in terms
20 of judging whether we've got complete enough
21 resource use measures.

22 The fact that we're working with

1 billing data has all kinds of other issues
2 related to what are we really measuring here
3 and what resources are visible and what
4 resources that are used in care are
5 invisible.

6 The standardization of pricing. All
7 these very technical issues.

8 The issue of Bayesian shrinkage has
9 not emerged very much in our discussions but
10 probably ought to come back into those.

11 But a lot of technical issues about
12 what data is counted, what's counted, what's
13 not have been issues.

14 We haven't discussed that very much
15 over the last couple of days but I think
16 those will continue to be issues.

17 Some of the issues about robustness
18 and the relative rankings we have discussed
19 in ways that we sort of snuck it into the
20 usability conversation. And snuck it into
21 an extension of the reliability
22 conversations beyond the traditional ways of

1 measuring reliability of measures.

2 And we have -- some people on the
3 committee have been more aggressive in doing
4 that and others have been more reticent to
5 do that.

6 I think the conversation we've had
7 today sort of reinforces that and in that
8 sense has been very helpful.

9 We've been treating them as cost
10 measures in some ways, relative resource use
11 measures. And the conversations we've had
12 in the last two days around efficiency
13 versus cost and value versus cost that
14 should be fully reflected in the paper I
15 think are going to be helpful in reshaping
16 some of the conversations and clarifying
17 what's being measured and what's not being
18 measured. What's being excluded here.

19 And as people try to do more
20 efficiency measurement, composite
21 measurement around efficiency I think those
22 -- the conversations we've had are going to

1 be -- and the paper are going to be
2 extremely helpful in informing the committee
3 and helping the committee reflect on what
4 we're trying to do, what the limits are,
5 what we're being asked to look at. So those
6 are some quick reflections. I'll probably
7 have a few more as we continue the
8 conversation.

9 DR. WONG: So, I won't belabor the
10 point, but I share the same view that Joe
11 and Jack have just mentioned.

12 I think the high-level remark that I
13 have is that I think that over the last two
14 days the conversation where we're blending
15 in the cost component and the quality
16 component together has helped put a better
17 framework, I guess that's the way we say it,
18 put a better framework in terms of how these
19 different components are functioning. So I
20 think that it is incredibly valuable.

21 DR. RYAN: What I would say from the
22 perspective of the Cost and Resource Use

1 Committee is that these have been really
2 complicated discussions. There's been a lot
3 of issues, maybe kind of alluded discussions
4 in some sense. But I think good issues that
5 people need to work through.

6 I think if we added a dimension to
7 that that was also simultaneously evaluating
8 quality measure and then the linking in that
9 same structure it seems like it would just
10 be overkill. It would be information
11 overload and be very difficult to come to
12 consensus.

13 And I think if that committee knew
14 that there was a process in place to kind of
15 link cost and quality and we could feel kind
16 of good about that, that NQF is saying,
17 okay, this is how you should do it. Then I
18 think that would make, you know, that would
19 make the job of that committee a lot easier
20 to kind of just focus on the issue at hand
21 or on the cost measures. That's the issue.

22 And knowing that there's a guidance

1 or there's a process or there's, you know,
2 I'm not sure how NQF wants to go with this,
3 but potentially kind of an approval process
4 that we buy into to combine these so we can
5 just kind of focus on the matter at hand.

6 CO-CHAIR DUBOW: A lot of pressure
7 on this paper.

8 MR. AMIN: Okay. So I think we have
9 one more comment from Matthew.

10 DR. ROUSCULP: No, no, that's okay.
11 Just for clarification. And I know it feels
12 like we've been going around this a little
13 bit which is about what NQF is seeking out
14 of this.

15 I mean does NQF want to be able to
16 say look, we want to have a way to assess
17 efficiency measure or measures to make sure
18 it goes forward, or is it more of saying,
19 look, we're creating these cost measures, we
20 have quality measures that we are approving,
21 and if you're going to look at efficiency,
22 you're going to use these, these are things

1 to consider and to think about going forward
2 and allow that to just be your stopping
3 point.

4 Because with both of those that kind
5 of dictates where your paper would go or
6 what your ongoing work will want to think
7 about. Because I think it's a big leap
8 forward for you if you want to get to that
9 point of being -- giving recommendations.

10 MR. AMIN: I think you certainly
11 identified the question.

12 I mean, in a lot of ways NQF doesn't
13 have an objective in its own right. The
14 purpose of what we're here to do is to
15 reflect the consensus of the community on
16 what's needed.

17 So, the basic place that we've been
18 is that there was a need for quality
19 measures, there was an increasing need for
20 cost measures. We heard feedback that if
21 you're going to be using these you should be
22 using them in the context of quality.

1 The question really is how far
2 should that go. Should the evaluation just
3 lie on the fact that of, okay, as we're
4 going through cost measurement, you know,
5 there's an acknowledgment that it should be
6 used in the context of quality. And that
7 could be where we stop.

8 Or is the fact that the measures are
9 being used together in these types of
10 potential applications, that for particular
11 applications that it would need to be -- the
12 evaluation would need to be more robust to
13 the point of evaluating the methodology of
14 how these are brought together, the actual
15 profiles are evaluated more systematically.

16 Whatever application that you could
17 imagine. There's obviously the four that we
18 looked at today. They might have a
19 different threshold for what, you know, how
20 we look at these two things together.

21 And ultimately the question that
22 we're trying to answer here is how far

1 should that go. Should it be more than what
2 we have now which is just sort of an
3 acknowledgment that they need to be looked
4 at together? Or does it need to be more
5 robust than that.

6 And I think what I've heard is that
7 depending on the use case it may need to be
8 more robust. We need to consider some of
9 these other -- you know, we can't overwhelm
10 the system in terms of requiring specific
11 cutoffs and things like that.

12 But also resting on the fact of if
13 you're going to be putting these two signals
14 together the methodology needs to be much
15 more transparent than it is now. So that's
16 at least some of what I'm hearing here. But
17 again, if there's other thoughts around that
18 topic.

19 DR. ROUSCULP: Because if you're
20 still at the point where you're saying look,
21 you're hoping that the white paper will help
22 you think through this a little bit more I'm

1 wondering if at the very end if you almost
2 have to say look, if NQF wants to get into
3 this point of being able to assess, kind of
4 say yes, this is an appropriate efficiency
5 measures, that's going to require a whole
6 lot of additional work that goes in one
7 direction.

8 And is that -- at the very end it
9 says look, here's the options for NQF at the
10 very end and here's all the work that would
11 be associated with each of those options.

12 MR. AMIN: I'm not hearing a
13 specific consensus around one. So I would
14 imagine we're going to be on the latter
15 which is going to be here are a few options
16 and here's what's going to be required to
17 get there. I think that's generally what
18 I'm hearing. But again, I'm not -- Chris,
19 I'd welcome --

20 DR. TOMPKINS: Well, yes, I think
21 that's probably where you are going to end
22 up.

1 What I've been struggling with is
2 that sometimes these -- some of these models
3 lend themselves to being more in your turf.
4 Because if somebody says you know what? I'm
5 going to produce an efficiency measure and
6 therefore in the submission requirements
7 they have to do all the diligence of saying.

8 For example, just drawing from the
9 literature that's been mentioned so much.
10 The cost for AMI. Cost for AMI discharge,
11 you know, mortality rates is the quality
12 measure and the cost and so forth, like
13 that.

14 If you're going to say, all right,
15 I'm going to model this. I'm going to model
16 this. I'm going to squeeze all the juice I
17 can out of this with a cost-effectiveness
18 measure and something like that. Then that
19 brings it into your measurement framework a
20 rubric already.

21 And so -- but going back to a lot of
22 this conversation started at least in my

1 mind back when Gary said about the
2 difference between someone claiming that
3 they're using NQF-endorsed measures and then
4 using them in a particular way that he
5 described as a matric which I think
6 corresponds to other people's use with a
7 scatter plot. And the using it in the
8 particular way is where the real action is.

9 And if NQF was to say, okay, all
10 these models are good, for people wanting
11 endorsement of the efficiency measure they
12 bring it all to you. But if they're trying
13 to do the efficiency they can still play off
14 tradeoff of your endorsement by using the
15 scatter plot side-by-side method but just
16 doing it in any way they really wish to
17 configure.

18 So the gray area question for you is
19 how much, and the ensuing conversation
20 around that discussed that a bit, how much
21 can you reach out or push your commentary on
22 how these ought to be used. Just a slightly

1 different -- I think we're about to break.

2 Steve actually stopped me in my
3 tracks a long time ago. He didn't mean to.
4 With your question, the way you framed it
5 which I thought was good which is we ought
6 to think if you have a given quality measure
7 in mind what should be the linkage, right?
8 What should be the logical linkage of the
9 methods.

10 It reminded me when I was sitting in
11 that corner with the QI group for awhile
12 yesterday when people were saying things
13 like just because you're efficient in this
14 doesn't mean you're efficient in that. We
15 might be the best in town for this and we
16 might be the worst in town for that.

17 So really what's running all this is
18 that it's the cost of what, quality for
19 what, and then linking them together. And
20 the number of instances in which that plays
21 out.

22 Some people know that one of my

1 current activities is building a grouper for
2 CMS. So at this time next year we may be
3 unleashing on NQF and everybody else 1,000
4 resource use measures.

5 Because, you know, you ask the
6 question is somebody efficient in managing
7 osteoarthritis patients. That's one
8 question. Which is -- and the efficiency
9 might be the rate at which they use medical
10 supervision and other things to avoid
11 surgery and conservative practice and so
12 forth. You might be very efficient at doing
13 that.

14 Separately is the question what
15 about the osteoarthritis patients who
16 actually have to have major surgery. Given
17 that that's true or that happens how
18 efficient is that?

19 So the way you, you know, you're
20 going to end up talking about hundreds of
21 conditions and embedded in those conditions
22 are many different treatment options. And

1 these are all opportunities to put
2 microscopes or spotlights or flood lamps on
3 different concepts of what efficiency is.

4 So that's why you stopped me.
5 Because if I'm about to roll out 1,000 --
6 your logical question is what is the linkage
7 process to make it appropriate to frame each
8 one of those as an efficiency measure,
9 whether it's any of these models, as opposed
10 to just the standalone cost measure.

11 And just as an advertising plug, in
12 the context of the episode grouper I've
13 argued for the logic and the necessity of a
14 grouper because it has some of the qualities
15 that I've stressed over the last two days
16 which is it makes the determination of how
17 you're assigning cost to particular
18 activities explicit and discoverable rather
19 than implicit.

20 I don't know how people build
21 resource use measures that are just saying
22 well, let's assemble some of these cost

1 items and call it that when the fact is that
2 when dollars are spent there are sort of
3 plausible reasons why they could be
4 categorized different ways. And I think
5 having a logical system that does all that
6 creates a discoverable largely objective and
7 debatable process for how that happens.

8 But now we've got the other
9 dimension on top of it which is how do you
10 make those logical linkages over to the
11 quality so that each of those resource use
12 measures becomes explicitly an attempt at
13 value or efficiency.

14 And that's the NQF goal here. If we
15 did it all in one measure it comes right to
16 you. But if it's all done after the fact in
17 the bushes, you know, sort of out of sight
18 then the real action -- going back to Gary's
19 point -- the real action is maybe happening
20 outside the context of the community
21 standards or consensus process.

22 CO-CHAIR DUBOW: Steven, you have

1 the last word before lunch. And public
2 comment.

3 DR. PANTILAT: I'll make it a quick
4 word then. But just on that point. You
5 know, again, the example I know best is
6 palliative care.

7 But if you just ask the question
8 what are the costs of patients seen by a
9 palliative care service it looks like
10 palliative care makes everybody more costly
11 because we see the most costly patients.

12 And so the way you assess cost has
13 to be very specific to the question that
14 you're asking. And it's the costs that
15 accrue after you see a palliative care
16 patient.

17 And a lot of people look at this and
18 say oh, palliative care makes everything
19 more costly but that's actually not the
20 case.

21 And so the way you assess the cost
22 and which costs are considered and when in

1 the course of care they're considered for
2 the service that's provided is incredibly
3 important to tell whether -- what kind of
4 impact you're having. If you took a global
5 measure it would be -- it would make it look
6 the opposite of what it is.

7 CO-CHAIR DUBOW: Could we ask the
8 operator for public comment? Operator, is
9 there anybody on the line who wants to make
10 a comment?

11 OPERATOR: Any committee members who
12 want to ask a question please press *1 on
13 your telephone keypad.

14 CO-CHAIR DUBOW: Nobody?

15 OPERATOR: There are no questions.

16 CO-CHAIR DUBOW: Thank you. Is
17 there anybody in the -- here today? Do you
18 want to make a comment? Okay.

19 MR. HAIDER: Hi again. Thank you so
20 much for taking public comment.

21 So sitting from the back of the room
22 here I feel the highly knowledgeable group

1 has quickly -- you've dived into very
2 complex details.

3 And I guess I would urge the group
4 to kind of divide -- you know, this is a big
5 problem. So in an engineering world if
6 there's a big problem I'll divide it into
7 small portions and then address kind of low-
8 hanging fruit first, and then say okay,
9 we're going to address the rest later. So
10 it's kind of like address the forest before
11 you start diving into the trees.

12 So maybe the report has a simple
13 problem, defines a simpler problem, and then
14 offers a multi-stage process, baby steps
15 before you run. So that's one general
16 comment.

17 The second thing gets into a little
18 bit of the details and that is I pulled up
19 the financials of some hospital groups. All
20 the hospitals publish their financials.

21 And so specifically Johns Hopkins
22 Hospital made \$1.8 billion in patient

1 revenue with an operating income of \$70
2 billion in 2013.

3 And so the business world would use
4 this as how profitable are they. But what
5 they do, and I look at a couple of other
6 hospital reports, is they only talk about
7 patient revenue, some other revenues in the
8 income, interest, et cetera, and then they
9 talk about how much they spent in salaries
10 and how much they spent in supplies.

11 Well, in the financial world when I
12 look at a company I'm evaluating I'm
13 looking, well, how much did you spend on
14 marketing. How much did you spend on R&D.
15 How much did you spend on salaries.

16 So I think maybe some metrics that
17 just come to mind that maybe would be
18 relevant to an efficiency white paper would
19 be, for example, doctor salaries per
20 revenue, bad debt per revenue, total
21 salaries which includes all the hospital
22 staff per revenue, supplies per revenue.

1 And then have some benchmarks to
2 say, look, if you're spending this much on
3 doctor for this much revenue that's a
4 benchmark. And how they exactly -- how the
5 percentages fall out would be probably
6 interesting. And then comparing that with
7 the quality metrics that you're discussing.
8 So those are my comments.

9 CO-CHAIR DUBOW: Okay, we're going
10 to reconvene in a half hour at 12:45. Thank
11 you very much. Very interesting
12 conversation this morning.

13 (Whereupon, the foregoing matter
14 went off the record at 12:13 p.m. and went
15 back on the record at 12:51 p.m.)

16 CO-CHAIR FLAMM: Okay, if everybody
17 can start moving towards their seats we'll
18 go ahead and be getting started in just a
19 minute.

20 Okay, so this next section that we
21 are going to have is really to start to
22 summarize where we are, be summarizing our

1 recommendations and the path forward for
2 where we're taking the work after these two
3 days of discussion.

4 We have about 45 minutes or a little
5 close to an hour for this discussion. And
6 in your discussion guides there are several
7 questions that we want to come back and
8 reflect on.

9 I think we have started to get a
10 better idea of what this is going to look
11 like after today's discussion. But if you
12 could forward to the discussion question
13 slides.

14 So these are the four questions that
15 were in the original discussion guide as
16 we've been reflecting on them. The first is
17 we can the evaluation of efficiency models
18 be use-agnostic.

19 Probably -- a lot of discussion has
20 been that use is very important. So, rather
21 than spending a lot of time on that
22 discussion we'll probably focus more on the

1 lower questions.

2 Reading those through what are some
3 of the benefits and unintended consequences
4 that might result from the endorsement of
5 efficiency models or efficiency measure
6 composites. And we have talked a good bit
7 about that.

8 And then particularly the final two
9 bullets. What challenges might present for
10 current and future measure development
11 efforts to align with the recommendations
12 that are coming out of this work and what
13 challenges might present for current and
14 future programs to apply the principles and
15 recommendations coming out of this. So it's
16 from the development and from the user
17 program perspectives. So I'll kind of let
18 those questions sink in a little bit.

19 While you're thinking I guess one of
20 the things that did come up earlier in the
21 day that I'll mention from a program
22 perspective as you're applying these things,

1 and we did talk about this earlier, is the
2 issue around data availability. And some of
3 these models, particularly ones involving
4 modeling, regression modeling or frontiers
5 imply that you have all the primary data at
6 the patient granular level.

7 And given that the quality measure
8 data kind of lives somewhere and rolls up to
9 summary statistics that are reported and
10 then we want to use that. And given all the
11 work that's happening in other venues around
12 alignment of measurement, alignment of
13 reporting and not wanting to create
14 redundancy in that space I think we have to
15 be cognizant that there's this imperfect
16 availability of the kind of data that are
17 needed for some of these combination models
18 depending on your program -- where you stand
19 and what you have access to. And there's
20 not universal accessibility of patient-level
21 data. Which is an understatement.

22 Comments?

1 DR. ROUSCULP: I'll jump in.

2 CO-CHAIR FLAMM: Go ahead, Matt.

3 DR. ROUSCULP: So I'll tell you
4 everything that's absolutely wrong so
5 everyone else can tell you why, what the
6 actual right answer is.

7 I will say that for the evaluation
8 of efficient models to be use-agnostic,
9 we'll start there. I think it will go back
10 again to where you're going to go.

11 If you feel as if NQF should be in
12 the arena of saying yes, we're going to have
13 an NQF-approved efficiency type score or
14 direction I think if you ever go to that you
15 will have to go where you can't have use-
16 agnostic.

17 You're going to have to go drill
18 down to say in provider-type measure of
19 efficiency, or in care provision. You're
20 going to have to kind of drill down and you
21 cannot be use-agnostic.

22 If on the other hand you're going to

1 step back to say, all right, we are not
2 going to make recommendations on efficiency
3 model but we know others are going to jump
4 in and start using cost and quality in some
5 sort of comparison then I think you can say
6 look, here are some general rules or
7 directions or I think it was -- I forget
8 what Jeff had said, principles. And I think
9 at that moment you might be able to go into
10 something that's more agnostic for whatever
11 its use might be intended.

12 CO-CHAIR FLAMM: Dennis?

13 DR. SCANLON: I'm not sure if I'll
14 articulate this well and it very well may be
15 wrong also. But what strikes me is we're in
16 an incredible period of incentives for
17 innovation, entrepreneurship and ultimately
18 efficiency.

19 And there's a lot of this happening
20 sort of between parties in ACO
21 relationships, deciding who to partner with,
22 you know, sort of who's going to be your

1 best partner and everything else.

2 And I think from a societal
3 perspective that's a good thing.

4 I guess I wonder -- and to some
5 degree private data which would be outside
6 of the scope of what we're talking about
7 here. I think there's probably strong
8 interest to make sure that private
9 organizations that are developing those
10 relationships have good information on who's
11 efficient and who provides high quality in
12 part because this has to be marketed to
13 patients around narrow networks or sort of
14 you need consumers to kind of come to your
15 plan.

16 So I guess I wonder whether there
17 may be, you know, I don't know if it's false
18 positives or false negatives, what the
19 publicly reported data that's endorsed says.
20 And then privately what organizations are
21 doing as they sort of partner for the dance
22 so to speak.

1 And I'm not sure if that's a
2 problem. I guess it could be if, you know,
3 sort of what's out there publicly maybe
4 somehow lags what the private sort of
5 organizations have and they're trying to
6 kind of sell products.

7 So they're selling products and
8 trying to justify their narrow networks,
9 saying hey, this is high-quality, this is
10 efficient care, maybe to employers, maybe to
11 others. But if that information somehow is
12 disconnected to sort of what's publicly
13 reported for whatever reason in my mind I
14 just wonder sort of how that may all play
15 out. So I don't know if that makes sense
16 but I find myself sort of trying to
17 reconcile how fast-paced and moving the
18 incentives shared savings models and other
19 things are for entrepreneurship, innovation,
20 efficiency which is a good thing with kind
21 of the public reporting.

22 CO-CHAIR FLAMM: Iyah.

1 MR. ROMM: So, I guess I would say,
2 building on that, and this comes a little
3 bit back to the I think yes/no question.

4 I think that there is -- there needs
5 to be a world in which we I think build
6 evaluation of these models in a way that is
7 both use-agnostic and use-case specific.

8 That is, I think in some ways there
9 is an opportunity for that side-by-side to
10 have some consensus standard as to what sort
11 of the true north to Larry's perspective on
12 efficiency measures or linking of cost and
13 quality measures is.

14 But then in the actual
15 implementation and/or endorsement of
16 measures I don't see a world in which we can
17 be use case-agnostic.

18 I think that one other comment sort
19 of building on this earlier principle of
20 benefits and unintended consequences is I
21 think that the rich conversation that we had
22 this morning around what efficiency is and

1 how it fits into this broader construct of -
2 - the linkage of cost and quality as its own
3 premise and linking towards value is that as
4 endorsement process is undergone that
5 precision is going to be absolutely
6 critical.

7 And ensuring that the endorsement
8 mechanism is sensitive to the fact that
9 there are many different perspectives on
10 efficiency and the NQF's may not be the only
11 one. And therefore building out this idea
12 of efficiency towards the end of that
13 linkage is critical.

14 DR. YOUNG: I'm not entirely sure
15 NQF has to make that decision about whether
16 or not efficiency measures have to be
17 evaluated based on use.

18 I think again, going back to some of
19 the points that were made earlier, maybe
20 also the point that Chris was making before
21 the break.

22 I think NQF has to send a very

1 strong message to its stakeholder community
2 that it cannot leverage the endorsement of
3 an individual measure into a larger
4 evaluation process that then claims it's
5 been endorsed by NQF.

6 You know, if the FDA approves a
7 particular two different types of medicines
8 or two different molecules manufacturers
9 can't combine them together and say this has
10 been FDA-approved. The combination may be
11 toxic.

12 Well, the same thing here.
13 Combining multiple measures in some way that
14 may on its own may be reliable and valid,
15 but combining them in some way may in fact
16 be toxic. So that can't be -- the purchaser
17 can't claim that that's been endorsed.

18 So I think that's what you want to
19 communicate to your stakeholder community,
20 that, you know, they can only claim
21 endorsement for what in fact NQF has
22 endorsed and can't extend it beyond the

1 boundaries of the endorsement.

2 CO-CHAIR FLAMM: Jeremiah?

3 DR. SCHUUR: So, a somewhat similar
4 comment I think. Thinking about challenges
5 and the path forward there's probably
6 agreement amongst everyone that we want to
7 improve efficiency and there's a lot of room
8 to improve efficiency in United States
9 healthcare.

10 The market's clearly creating
11 measures that they're labeling as efficiency
12 measures. And I think the challenge for NQF
13 is as an organization that's focused on
14 standards evaluation and trying to do that
15 in a reliable somewhat scientific way to
16 make sure that the response to be -- there's
17 a pressure to be in this space to be
18 relevant, to be responsive is not to
19 necessarily endorse everything or feel a
20 pressure to endorse measures in the space
21 that may not meet standards of efficiency.

22 And so I do think that the use case

1 is important as has been said before because
2 you want the NQF endorsement to mean
3 something.

4 And I think it's okay for measures
5 that are being used out in the marketplace
6 to be used. And some of them may have NQF
7 endorsement, some may not. But there may be
8 no measures of a certain type that get NQF-
9 endorsed and that doesn't mean they can't
10 get be used. But just -- if they don't meet
11 the standards.

12 CO-CHAIR FLAMM: Cathy.

13 DR. MACLEAN: So, echoing comments.
14 But first of all, the first question, can
15 evaluation of efficiency models be use-
16 agnostic.

17 We've had a lot of discussion about
18 linking cost and value and then efficient
19 measures kind of separately. And I think
20 that they're different. So I think that I'd
21 like to broaden this up a little bit to be
22 linking cost and quality. I think I said

1 cost and value. I meant cost and quality.

2 And efficiency is one. When you
3 actually kind of put it together then you're
4 going to have an efficiency measure.

5 And with regard to whether they can
6 be use-agnostic I think that there are
7 principles that could be use-agnostic but
8 I'm not sure that there's an individual
9 measure that's necessarily use-agnostic.
10 And I think that we should lay that out.

11 CO-CHAIR FLAMM: Jack.

12 DR. NEEDLEMAN: I'm thinking back to
13 the first cost and resource use committee
14 meeting I was at which is relevant because
15 it sort of got us to this committee meeting
16 where people were unhappy just looking at
17 cost measures or resource use measures.

18 Not just because of all the issues
19 about whether you could do it accurately
20 enough which remain but because as Helen
21 said and I think, Carol, you and Joyce, you
22 said, originally NQF said we don't do cost.

1 It's all about quality.

2 And that initial committee was
3 uncomfortable. The efficiency word came up.
4 Efficient, effective use, production of
5 high-quality care was the vision of what we
6 really wanted to be able to say something
7 about. And there was a recognition that the
8 cost and use measures were intermediate to
9 get us there.

10 And I think to think about how to
11 get us there was what helped create this
12 committee.

13 And I think the conversations of the
14 last two days plus the conversations on the
15 phone sort of reinforce the importance of
16 doing that.

17 These measures are being linked in
18 the world. And the need to not just look at
19 cost but to relate it to the performance of
20 the system I think has all been reinforced
21 by the conversations that we've had today.

22 And in that regard I think one of

1 the most important things that we've done in
2 terms of the conceptual stuff over the last
3 two days is we've taken the efficiency word
4 and we've really said we're talking about
5 measuring the efficient delivery of high-
6 quality care.

7 That you can't talk about efficiency
8 alone, you have to talk about the quality of
9 care that's being delivered efficiently or
10 inefficiently at the same time.

11 And that linkage, that tight linkage
12 to the continued concern that the care be
13 high-quality I think is one of the most
14 useful framing devices for thinking about
15 how these measures get used, what the
16 implications are, how an individual cost
17 measure gets interpreted.

18 So that I think has been extremely
19 important and really a major -- we've been
20 talking a lot at the conceptual level, one
21 of the major conceptual strengths of the
22 conversation the last couple of days.

1 Related to that is the concept of
2 use. And what we've been asked to endorse
3 at least on the cost and resource use side
4 has been the measure. How do we score
5 people.

6 Use is all about the cut points.
7 You know, who's high, who's low, what do we
8 do with that information.

9 And in addition to getting the
10 measure right, getting the cut points right
11 is an important element of use. And so, can
12 the evaluation be use-agnostic? We can ask
13 whether we can get the scale right,
14 accurate, robust, all the other words we've
15 used.

16 The question I think is whether NQF
17 committees should be engaged in thinking
18 about what -- looking at the measure,
19 looking at the distribution, looking at the
20 imprecision, precision, what we say about
21 the cut points. And I don't think we've
22 fully resolved that today. But that's one

1 of the ongoing challenges and questions that
2 relate to being use-agnostic versus use-
3 specific.

4 I think we've got to -- one other
5 thing that struck me about the conversation,
6 and we've had it in a couple of different
7 ways, is that in some sense the, you know,
8 to the extent we're talking about efficiency
9 as our shorthand for talking about this the
10 cost agenda and the quality agenda are a
11 single agenda.

12 The goal is to produce high-quality
13 care as efficiently as we can. If we only
14 focus on the cost, or we only focus on the
15 quality we lose where the system has to go.
16 And that becomes part of the rationale for
17 thinking about the linking.

18 But we're not trying to produce
19 cost-effective -- sorry, we're not trying to
20 produce efficient, low-quality care. It's
21 improving quality, improving -- reducing
22 cost, improving the efficiency of delivering

1 high-quality care as the rationale for why
2 we're measuring this stuff and how we want
3 it used.

4 CO-CHAIR FLAMM: Those are helpful,
5 thank you. All right, I have Cathy.

6 DR. MACLEAN: Jack, following on
7 that, something you just said, you said the
8 cost per unit of high-quality care.

9 Well that means you have to define a
10 cut point, right? You have to define what
11 threshold means high-quality care. And I do
12 think that that's important to define that
13 absolute threshold.

14 I just want to call out though that
15 that's not the way CMS is going with some of
16 its programs.

17 So, the Medicare Advantage Stars
18 program right now, the current way it's set
19 up is that for many of the measures to get a
20 four-star rating there is an absolute
21 threshold. But that's going to go away and
22 it's all going to be relative scoring.

1 The specs that just came out for the
2 exchange is all percentile-based. So it's
3 all relative scoring.

4 And I don't think that's a good idea
5 because I think that -- while on the one
6 hand it promotes improvement I think that
7 there does need to be a -- we need to define
8 what is good enough.

9 And then, you know, above that,
10 absolutely, let's report who's better than
11 good enough, right?

12 But this is a big issue. And if --
13 I think it would be instructive to kind of
14 explore that in this paper. This issue of
15 absolute versus relative.

16 CO-CHAIR FLAMM: Steven, thank you.

17 DR. PANTILAT: So, in thinking about
18 this issue of benefits and unintended
19 consequences, I mean it seems like it's
20 great to find high-quality low-cost
21 providers. And if you can do that, that's
22 great. But that's not always going to be

1 the case.

2 And it seems like the other benefits
3 of linking this is to understand how does,
4 for example, cost reduction impact quality.
5 So if you're looking at how do I reduce cost
6 at what point does that impact quality. And
7 a measure that looks at those two things
8 could look at that. Or how do you reduce
9 cost without changing quality.

10 And then I think the other piece is
11 that very often better quality is going to
12 cost more. And it gives you a way of
13 understanding that as well. Those seem all
14 very important to understand.

15 I think the unintended consequences,
16 just getting back to something Jack said
17 which is, you know, you could have an
18 efficiency measure that would say that low-
19 quality care looked great. And that to me
20 is an important unintended consequence that
21 could come out, that you could look great by
22 providing really lousy care but doing it

1 really, really cheaply and efficiently. And
2 that would be very wrong.

3 I think the other unintended
4 consequence is that somehow cost and quality
5 would not really be linked. And so you
6 would be sort of looking at a cost measure
7 and a quality measure that really aren't
8 linked.

9 And so that the costs that you're
10 looking at aren't really closely related to
11 the quality that's being provided. And so
12 that changes in one wouldn't necessarily
13 lead to changes in the other.

14 Again, just in my own world a lot of
15 people think palliative care should reduce
16 length of stay in the hospital. That may or
17 may not be true. It's almost impossible to
18 prove.

19 And so if that was the outcome where
20 you said palliative care and length of stay
21 were going to be linked somehow there isn't
22 a lot that you can -- that may be true, it's

1 just very hard to demonstrate. And so you
2 would not want to link those two as an
3 efficiency measure because it's not going to
4 be possible to demonstrate that.

5 And you may find that people want to
6 link those in a way that really doesn't make
7 sense.

8 CO-CHAIR FLAMM: Timothy.

9 DR. LOWE: I have a little bit of a
10 concern about the cutoffs. I do develop
11 measures and I have to tell you, my focus in
12 measure development is always to -- this is
13 how I was trained -- make sure the science
14 is done as best they can.

15 So I want to make sure that when
16 we're constructing a measure that it is
17 valid and it is reliable and it has a strong
18 evidence base.

19 That's one reason why we do publish
20 our measures, why we go through peer review,
21 to make sure that it's the best it can be.

22 I personally feel that the cutoffs

1 really are the responsibility of regulatory
2 bodies. And the reason why I believe that
3 is because you can game anything. If I know
4 what the end result is going to be I can
5 design the measure to create that. So to me
6 the two things have to be separate.

7 Now, I realize that if we are adding
8 quality and cost in an equation that we have
9 to have some way and we have to understand
10 that. But there may be a way of
11 bifurcating, whatever, how we decide to
12 divide it in such a way that we've done it
13 statistically that it's kind of -- that's
14 where the agnostic part of this is.

15 It has to be outside of the
16 political part of this which always gets
17 involved and also out of the desire to game
18 it. We have to find some way around it.
19 And so that's how I've approached it is to
20 focus on how can I best make the measure and
21 then leave it up to the market or the
22 regulatory body to see how they're going to

1 apply it.

2 CO-CHAIR FLAMM: Iyah.

3 MR. ROMM: So, just back to Cathy's
4 comment. I agree with her on the idea of
5 needing to apply both thresholds and this
6 idea of relativity.

7 But I would posit that it's
8 definitely going to vary across use cases.
9 And so thinking about that in the absolute
10 in and of itself is probably too narrow.

11 And so I think that we likely will
12 find ourselves in which relativity is
13 appropriate for certain use cases and not
14 for others.

15 CO-CHAIR FLAMM: Joseph? Oh, sorry.

16 MR. STEPHANSKY: Pardon?

17 CO-CHAIR FLAMM: Go ahead.

18 MR. STEPHANSKY: I want to throw
19 something in here that I actually disagree
20 with Jack on one thing. And it's the only
21 thing I disagree with him on. And this is
22 also going to drive Joyce a little bit

1 crazy.

2 Let's consider hospitals for a
3 moment. That if volumes are really going to
4 go down which is part of what we'd like to
5 see, less utilization of hospitals, the
6 hospitals that are out there, they're going
7 to have to make some choices about their
8 strategies for the future.

9 Many of them simply have figured
10 out, okay, the only way I'm going to make it
11 is I've got to eat that other hospital's
12 lunch. I've got to get their volume to make
13 up for my reduced volume.

14 And that's just part of how -- a lot
15 of different hospitals are going to have to
16 think about what their strategies are going
17 to be. Some of the small ones who don't
18 have a lot of physician practices and post-
19 acute care components may really have to
20 think about relatively small niches and kind
21 of stay with fee-for-service contracts.

22 And one of the -- out of all the

1 different kinds of strategies that hospitals
2 can adopt we have kind of an interesting
3 one. I won't name the hospital system in
4 Michigan but --

5 (Laughter)

6 MR. STEPHANSKY: -- they're going
7 for the low-cost good-quality label. Not
8 the high-quality label, the good-quality
9 label. Because there are employers who want
10 to look for that. It is a market niche.

11 And I'm just offering that when we
12 keep thinking about thresholds that we have
13 to realize that there are situations where
14 some people -- they might not want to buy a
15 Yugo, but they might want to buy a Chevy
16 Malibu and that's good enough.

17 So when we start thinking about this
18 we've got to understand that hospitals are
19 adopting strategies that may not match what
20 we think they should be, but they're real
21 strategies.

22 CO-CHAIR FLAMM: Jeff.

1 DR. SILBER: Malibu's a nice car.

2 (Laughter)

3 DR. SILBER: It's a really, really
4 good car.

5 Related to that and it's very
6 similar, and it's relating to what Cathy had
7 said who's now gone.

8 So my worry is if you have a
9 threshold and you meet the threshold, and
10 I'm just saying this again, but I just want
11 to reiterate it.

12 And I worry that you then might
13 diminish the importance of improving quality
14 to its higher levels. So I really worry
15 that I don't want the introduction of a
16 threshold to eliminate the importance of
17 knowing what the quality is all along the
18 continuum above that minimum threshold.

19 And I guess that's my biggest
20 concern. The way Cathy had stated it, and I
21 put my card up to react to Cathy, is if,
22 well once you get to that threshold, then

1 you can look at cost. I might be
2 misinterpreting what she was saying, but --
3 and then we can all look at efficiency in
4 one analysis.

5 But I think it's really important to
6 not do that. And that we can't fall into
7 the trap of saying that if you're above the
8 threshold quality is in a sense the same.

9 Because I think plenty of consumers
10 and insurers really also would like to know
11 about those highest -- the highest quality
12 hospitals. And they certainly might cost
13 more but provide the very best quality. So
14 I wouldn't want to group everyone above the
15 threshold in the same category.

16 CO-CHAIR FLAMM: Matt?

17 DR. ROUSCULP: To add to that. So
18 once you do set that threshold it's a cost
19 minimization exercise. That's what
20 efficiency is, it's a production function of
21 cost minimization. And I think that's where
22 the big gap is.

1 I guess the question that comes back
2 is we have talked about the efficiency kind
3 of being that no man's land that sat between
4 cost and value. And so the question comes
5 by is that the value -- however you get to
6 that value and that value exercise, I think
7 it's going to be very important.

8 Because efficiency alone as a
9 measure can very quickly get to the issue
10 that Jeff had brought up, unless you have
11 that value element to it.

12 CO-CHAIR FLAMM: Larry.

13 MR. BECKER: So I wanted to react to
14 what Joe said about thresholds.

15 And while I understand the
16 implications of a threshold and while
17 thresholds might be important they're not --
18 in practice application from my perspective
19 as a designer of a plan that serves 250,000
20 lives is somewhat impractical.

21 And the reason is because I've got
22 people in Xerox who perhaps are literally,

1 maybe not literally in every zip code in the
2 United States.

3 And so when I go into a market I
4 need -- let's take primary care docs. I
5 need so many primary care docs in my network
6 to be able to cover those people. And in
7 some geography, you know, if you think about
8 these cost and quality metrics somebody
9 might not meet the threshold but I still
10 have to have them because people still have
11 to get care.

12 And so there's the practical side of
13 setting thresholds that when you try to
14 implement something you might need to go
15 below that threshold. Then what? What does
16 that mean? So anyway, I put that out there
17 as just food for thought.

18 CO-CHAIR DUBOW: Well, I don't
19 actually understand the concept of a
20 threshold for quality. What does it mean?
21 Does it mean you meet basic competency
22 requirements? Does it mean you're licensed?

1 Does it mean you -- that you're board
2 certified? Does it mean you have MOC?
3 What's good enough? You know, it's laden
4 with values. Which I think is what you're
5 saying, isn't it.

6 You know, I think it's very hard for
7 the public to understand that somebody is
8 making me settle for something that I don't
9 quite know what I might be deprived of.

10 And I think that's a real -- so you
11 know, even though we don't love the relative
12 scales, at least we know that that's kind of
13 where everybody is right now as opposed to
14 what I could really be missing out on if I'm
15 -- I mean, you could really get screwed that
16 way. I don't think people understand it.

17 So, I'm a little uneasy about these
18 thresholds. Who sets them? I mean, it's
19 just -- in addition to -- Carole and I were
20 talking about that earlier, Larry, exactly
21 the point you make about the very practical
22 operationalizing challenges of doing it

1 which are not easy ones. Those are societal
2 questions about when do you decide to get
3 rid of a really bad hospital.

4 You know. I mean I don't know how
5 you design these minimum standards to take
6 care of public health and all of the rest of
7 that stuff.

8 MR. BECKER: But I think that's what
9 transparency is about.

10 CO-CHAIR DUBOW: Well, I don't know
11 if transparency is good enough because we do
12 want to have a certain modicum of protection
13 which is the regulatory function. And we do
14 that through licensure.

15 And that's kind of what that's
16 supposed to be, isn't it? It's the bare --
17 it's the necessary minimum to get into the
18 game.

19 CO-CHAIR FLAMM: So, I'm going to go
20 to Peter.

21 DR. ALMENOFF: So I've been
22 listening quietly for awhile and I keep

1 hearing this concept of high-quality. If
2 you really want to be very honest I'm not
3 even sure. You're not sure about cut
4 points. I'm not sure about our quality.

5 We have 10 different evaluation
6 systems for U.S. hospitals. You know, the
7 public ones, U.S. News & World Report and
8 all of them.

9 And a lot of people are embedded in
10 thinking that's real. And so when you drive
11 by a hospital you see we're the best this,
12 we're the best that and everyone buys into
13 it, and they advertise, et cetera.

14 But when you look at a world-class
15 university hospital in U.S. News & World
16 Report which will do very well. Then you go
17 into another model and they do awful.
18 Because it's really a matter of how you're
19 deciding you're going to measure quality.

20 So, you know, I think we need to be
21 a little careful about that whole notion of
22 we want high quality. That's apple pie and

1 I don't think anyone disagrees.

2 The other thing I've heard was high
3 cost, high quality go together. And in
4 fact, we find the opposite. I don't
5 remember who said it but spending more money
6 doesn't mean you're going to get better
7 quality.

8 And generally you get worse quality
9 because you do things you shouldn't be
10 doing, procedures that maybe aren't even
11 necessary. And the outcomes aren't very
12 good.

13 And I think the U.S. healthcare
14 system is a perfect example of that in that
15 we -- compared to the rest of the world
16 we're sort of like a third world nation when
17 it comes to our outcomes. And we spend
18 enormous amounts of money. So clearly
19 there's a problem with what we're doing.

20 As I mentioned yesterday we
21 probably, you know, I think the best thing
22 to do is develop a framework. You know, I

1 think all these techniques, some are good,
2 some are bad. Whether it's side-by-side.
3 You know, I think we had a lot of
4 conversation for two days on that.

5 But I think it's probably the most
6 valuable for at least the public to see or
7 the providers all the different ways that
8 these things could be done, how to do them.

9 As a user, whether you're a
10 healthcare organization or a provider. I
11 think that would offer a lot more value than
12 trying to say this group is going to be the
13 one who decides what's considered an NQF-
14 validated metric.

15 Because quite honestly, you know, as
16 many people said earlier today if I'm in a
17 healthcare agency and I'm doing it a certain
18 way and you don't want to validate my metric
19 I'm still going to do it. So I think we
20 need to be very careful and take baby steps
21 and create a basic framework that people can
22 use.

1 And there are clearly areas where we
2 shouldn't be using certain techniques for
3 certain areas. And I think we probably can
4 agree on a lot of those. But I think it's
5 best to just give them sort of a framework
6 to work in and then maybe in time as these
7 things become a little more mature be able
8 to sort of develop a little more stringent
9 criteria as we move along.

10 But to sort of say at the very
11 beginning we're going to sort of create this
12 very narrow framework. And we're talking
13 about cut points. To me we can't honestly
14 even talk about quality because I can -- we
15 do that game all the time. I can give you
16 hospital A is the best or it's the worst
17 depending on what kind of methodology I use
18 and what I'm looking at as my criteria.

19 So, I'm just -- sort of a sign of
20 caution that we clearly have a problem in
21 the United States. We clearly are spending
22 an enormous amount of money for questionable

1 return.

2 We probably need to do something.
 3 But at least there's not even a break
 4 framework on how to go about doing this. So
 5 by doing that you're at least I think
 6 pushing the agenda and sort of at least
 7 getting the system to maybe look in the
 8 right direction and kind of at least maybe
 9 go forward in the right areas.

10 CO-CHAIR FLAMM: Jack.

11 DR. SILBER: Thanks.

12 CO-CHAIR FLAMM: I apologize. I
 13 have you on the list but I did say Jack.

14 DR. NEEDLEMAN: Okay. We're not
 15 going to resolve these issues today.

16 (Laughter)

17 DR. NEEDLEMAN: I think it's
 18 important to understand where some of the
 19 heterogeneity of the vision comes from.
 20 Because we're -- to some extent some of this
 21 conversation is we're talking past one
 22 another when I think we're trying to talk to

1 one another. Or we think we are.

2 So there's tremendous heterogeneity
3 in the system. Lots of different services
4 out there. And I think for many of them
5 quality in fact doesn't cost more. Quality
6 saves money. I think that's absolutely
7 right. But it's not clear that that's the
8 case for all services.

9 I'm going to go back to the P word,
10 the patient word. So what do patients
11 expect of the system?

12 And for an awful lot of the care
13 that we're talking about patients expect the
14 care if they go into a hospital, they go
15 into a physician, care is going to be safe,
16 the care is going to be delivered reliably,
17 it's going to be to the standard of care
18 that's out there.

19 And for many of the conditions that
20 are there the result is going to be fairly
21 predictable and only dependent upon the
22 patient's unique physiology and social

1 circumstances, and not the system that they
2 encounter.

3 And that's the case for an awful lot
4 of the care we're talking about. I've been
5 studying, Jeff's been studying, Chris has
6 been studying nursing systems for over a
7 decade.

8 And I think we can talk about J.D.
9 Power's rankings of the hospitals or
10 Consumer Report's rankings of the hospitals
11 on nursing care but the patients don't want
12 that.

13 I don't think any patient wants to
14 look and say where is the hospital where I'm
15 going to get the best nursing care. They
16 want to simply assume that the care that the
17 nurses deliver is going to be safe,
18 reliable, efficiently delivered, that I
19 don't have to worry about that when I go in.

20 And for an awful lot of our quality
21 measures it's I don't want to have to worry
22 about that. And in that regard we need to

1 ask whether everybody can achieve that level
2 at a reasonable cost. And if so we ought to
3 tell everybody, go achieve that level at a
4 reasonable cost. And that's part of what
5 these efficiency measures are about.

6 For other services there may be real
7 choices that patients and their physicians
8 and their providers face. And Joe's
9 hospital system of good enough may in fact
10 closely match what some patients think.

11 So if there are hips or knees that
12 we can guarantee you this 90 percent of the
13 time is going to last 15 years but it's
14 going to cost \$50,000 to put in, or we can
15 put one in -- and the rheumatologist has
16 left so I can completely make this stuff up
17 -- but there's another device we can put in,
18 it lasts for 10 years in 80 percent of the
19 folks and 15 years in 50 but it only costs
20 \$5,000. And you're going to confront a
21 difference of five or ten thousand dollars
22 in your cost-sharing to do this. Do you

1 want to go the less expensive route and play
2 the odds? Or the more expensive route? And
3 that's a choice.

4 And that's exactly the kind of
5 choice where Larry's be transparent, be
6 visible, make it clear what the tradeoffs
7 are work. And where we potentially do have
8 this steep gradient of you only get better
9 quality by paying more for it. And people
10 have a right to choose where they are on
11 that grade.

12 But we need to think about which of
13 those cases we're in measure by measure,
14 care by care.

15 And we've got ambiguous cases. I
16 don't know whether every patient with
17 rheumatoid arthritis who is a candidate for
18 biologicals ought to be on a biological. Or
19 whether there's such a high cost difference
20 between that and the way we could treat
21 without biologicals that the patient ought
22 to bear some of that cost and bear some of

1 the decision-making and cost-related
2 decision-making in that.

3 Right? That's one of these
4 ambiguous cases. Is it the good enough
5 model, or is it the this is the standard of
6 care and everybody is entitled to expect to
7 get it model.

8 But we need to differentiate as
9 we're thinking about quality, cost,
10 efficiency and the tradeoffs between cost
11 and quality whether we have that, whether
12 we've got examples in that upper left,
13 whether everybody can seek to be in the
14 high-quality/low-cost quadrant where there
15 are real tradeoffs and who should be bearing
16 those tradeoffs, whether they should be
17 socialized in the insurance system or
18 internalized to the patient and the
19 patient's individual decision-making.

20 CO-CHAIR FLAMM: Okay. Jeff, you've
21 been so patient.

22 DR. SILBER: Well, allow me to react

1 to two comments, one from Joyce and one from
2 Peter. I guess I'll start with Peter.

3 I guess when we -- the whole
4 endeavor that we're in is in some way making
5 an assumption that it's worthwhile to look
6 at these things such that it's -- that we
7 have a decent measure of quality and a
8 decent measure of cost.

9 I think it's a little bit cynical to
10 say oh, we don't have a good thing and
11 therefore we can just put them in a big
12 group and not worry about it.

13 I think, first of all, there are
14 plenty of measures of quality that are well
15 validated and do measure what we think they
16 measure.

17 And so I guess I think it's a bit
18 confusing or distracting for our charge to
19 say we don't have a good quality measure and
20 therefore my -- the thickness that I draw
21 the tiers or whatever is some way affected
22 by that.

1 I can name plenty of good quality
2 measures that work and that should be
3 analyzed and I wouldn't be too worried
4 about.

5 And in terms of the idea of cost and
6 quality there's plenty of studies that show
7 -- mine being one of them from a few years
8 ago on aggressive medical care that
9 aggressive medical care improves your
10 outcomes. And so it costs more but you do
11 better. So we can debate that.

12 But the bottom line I want to say is
13 about your comment was that I think it's --
14 we are doing this under the assumption that
15 what goes into the cost and what goes into
16 the quality are reasonable measures. That
17 being said, we have to decide what we're
18 going to do.

19 My second point is on what Joyce
20 stated. And I think there's some confusion.
21 I just want to -- at least in my mind it's
22 confused when we talk about thresholds.

1 I thought the purpose of thresholds
2 in the context of the efficiency argument.
3 And correct me if I'm wrong, but the purpose
4 of thresholds is to say if I'm going to --
5 I'm worried about efficiency because I'm
6 worried about that case where you get
7 someone who's really efficient but giving
8 terrible quality.

9 So I want to build a threshold to
10 say I'm not ever going to -- I'm not going
11 to give an efficiency measure to someone
12 who's got clearly too low quality.

13 Now, I don't agree with the
14 threshold. And like I said many times, we
15 should just give all the data and not have a
16 threshold. Because I'm worried about, well,
17 once you make it past threshold what
18 happens.

19 But the purpose of the threshold is
20 really just to ensure that the efficiency
21 measure isn't misused. But my worry is that
22 it's not good enough, that the threshold

1 isn't a good enough tool to keep us from
2 misusing a pure efficiency measure.

3 So I think that's where the
4 thresholds came in. Maybe I'm wrong, but.

5 CO-CHAIR DUBOW: I think you still
6 have to decide where it is. You know --

7 DR. SILBER: Or not use it because
8 you're going to give all the data and leave
9 it at that.

10 CO-CHAIR DUBOW: That's right. And
11 then let the value of the user make a
12 determination about what's good enough.

13 DR. ALMENOFF: Yes. I think I was
14 trying to be a little more provocative than
15 serious. But we just in the last couple of
16 hours just keep circulating around this
17 same.

18 If we're going to focus on a quality
19 and efficiency measure we seem to need to
20 move forward on it. Instead of everyone is
21 coming up with every excuse not to.

22 So, I'm not saying I'm actually an

1 advocate of doing that, it's just everyone
2 keeps coming up with side points and we're
3 not kind of focusing on what we really need
4 to get to.

5 So I think maybe that's maybe a
6 little misunderstanding of what I was trying
7 to get to.

8 But it was really to be a little
9 more provocative to get people to start
10 deciding how we really need to move forward
11 as a framework. Because right now I'm very
12 confused about where we are. Maybe many of
13 you aren't but I'm still confused.

14 CO-CHAIR FLAMM: So, here we are.
15 One of the things that we are going to do.
16 We're going to take a few minutes and ask
17 for public comments.

18 But we are going to transition into
19 next steps and wrapping up what's going to
20 follow after this meeting. And we have
21 given some thought to another way to get
22 another round of clarity as we sort of see

1 another pass at this in writing. So I won't
2 give your whole punch line away, Erin.

3 But let me stop and ask the
4 operator, please, if there are any public
5 comments on the phone.

6 OPERATOR: Committee members, if you
7 have any comments please press *1 on your
8 telephone keypad. There are no comments at
9 this time.

10 CO-CHAIR FLAMM: Thank you. Are
11 there any public comments in the room?
12 Okay. Then let me turn it over to you,
13 Erin, to walk us through. Is that the plan?

14 MS. O'ROURKE: Sure. So I think we
15 realized that there's a need for the
16 committee to see this draft paper one more
17 time before it goes out for public comment
18 to make sure we're in agreement on what
19 we're releasing out into the world.

20 So we're going to aim to get you a
21 draft of the -- a revised draft of the white
22 paper on June 2. We've asked for a quick

1 turnaround to get your feedback by June 9 so
2 that Chris and Andy can quickly incorporate
3 that to release it for a June 16 public
4 comment.

5 That will be open for one month.
6 Then we'll be looking to reconvene with you
7 via web meeting the week of August 4 to
8 review those public comments and decide how
9 we want to act on them.

10 We'll then aim to take the draft
11 guidance to the CSAC at their September 9
12 meeting to meet an October 1 deadline for
13 this final paper.

14 CO-CHAIR FLAMM: The question was
15 when will we get the draft paper. She said
16 June 2. So about a month from now.

17 MS. O'ROURKE: We will be following
18 up with you to get the August call
19 scheduled. I think for the June feedback
20 we'll do it via email. Unless, do we want
21 to aim for a call?

22 MS. WILBON: We can try for a call

1 and just leave it open. If people can come,
2 they can come. If not, they can always send
3 their feedback via -- we'll take written or
4 those who can participate on the call. So
5 we'll look to see when we can do that. And
6 don't, you know, stress if you can't attend
7 the call. We'll welcome your feedback
8 written as well.

9 So we'll see what we can pull
10 together. But I think a discussion would be
11 useful but I think written comments are
12 always very helpful as well. People tend to
13 be a little more concise in their statements
14 and that's always really useful as well.

15 CO-CHAIR DUBOW: And if you could
16 share comments if you send them by email so
17 we can all see them.

18 MS. WILBON: Yes, we'll make sure
19 that there's -- actually there's a place on
20 SharePoint I believe that that can be
21 shared, or we can start a distribution list.

22 MS. O'ROURKE: Yes, we do have the

1 SharePoint discussion board up so people are
2 welcome to share thoughts there. Or if you
3 are would prefer an email distribution list
4 we could start that and everyone can reply
5 to each other if that's more efficient for
6 you.

7 MR. AMIN: Chris or Andy, do you
8 have any other sort of closing thoughts?
9 And then we can obviously turn it over to
10 the chairs. And then we might have some
11 here from NQF staff.

12 DR. RYAN: I wonder if the committee
13 could agree to pretend that this never
14 happened.

15 (Laughter)

16 DR. RYAN: No, I think, you know,
17 I'm not going to bother trying to summarize
18 everything, but I think something that we
19 heard repeatedly was this concept of
20 principles. And I think my feeling is that
21 it's going to be a good way to revise this.
22 If there's more agreement or potential

1 consensus around principles rather than
2 specific, more precise guidance. And so
3 that's going to be -- I haven't talked about
4 it with Chris, but kind of an approach
5 towards systematically revising this in
6 accordance with the comments that we've
7 gotten here.

8 Again, thanks for everything. We
9 appreciate it.

10 DR. TOMPKINS: I'd just add my
11 thanks to all. It's a lot to think about
12 and we hope that we can reflect a lot of
13 this in the next draft so it will be a
14 useful step forward. Appreciate the
15 meeting. It's been great.

16 CO-CHAIR FLAMM: Yes, just to add
17 appreciation. I think everybody has been
18 extremely dedicated, brought a lot of energy
19 and passion to the discussion. Great,
20 really great feedback and information. So
21 you've given us all a lot to work with.
22 We'll keep working through the summer to

1 take this to the finish line.

2 I don't know if, Joyce, you'd like
3 to add something?

4 CO-CHAIR DUBOW: I just want to
5 thank you all. It's been terrific meeting
6 you.

7 I want to thank my co-chair. It's
8 been a pleasure to work with you, Carole.
9 And the staff and the authors. You have
10 been enormously flexible and receptive and
11 respectful. We don't know what you're
12 thinking, but --

13 (Laughter)

14 CO-CHAIR DUBOW: But just -- but you
15 know, your insights have been, everybody's
16 insights have been so helpful. And I just
17 want to say thank you very much for your
18 participation.

19 MS. WILBON: I think from the staff
20 perspective again I think we just want to
21 echo the chair's sentiments and thank
22 everyone for coming with open minds and

1 really being fully engaged and
2 participating.

3 And I think from our perspective
4 Taroon mentioned when we first started
5 yesterday how we've been working with the
6 Resource Use Steering Committee and have
7 this idea about doing work on trying to
8 figure out how to link cost and quality
9 measures.

10 And I can say that starting this
11 work out. And I think we've definitely made
12 progress. And I think seeing how the
13 conversation went and kind of looking at how
14 the discussion kind of evolved organically
15 and took us in directions that we hadn't
16 really been considering. And I think that's
17 a really good place to be for us.

18 I'm glad that we were able to kind
19 of be flexible throughout the two days to
20 kind of accommodate the direction that the
21 panel was going. And I think that's going
22 to help us come up with a better product at

1 the end of the day, or at the end of this
2 process. And so I just want to thank
3 everyone again for being engaged.

4 And I think we're in general really
5 happy with the way things have ended up. So
6 again, just thank you and we'll definitely
7 be engaging you, continuing to engage you
8 for the rest of this process to make sure we
9 put out something that everyone is
10 comfortable with. So, thanks.

11 CO-CHAIR FLAMM: Thank you.

12 MS. WILBON: And thank you to the
13 chairs if I didn't say that for your
14 leadership and getting us through. Thank
15 you.

16 (Whereupon, the foregoing matter
17 went off the record at 1:44 p.m.)
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In the matter of: Linking Costs and Quality Measures

Before: NQF

Date: 05-02-14

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