

NATIONAL QUALITY FORUM  
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PATIENT OUTCOMES ALL-CAUSE  
READMISSIONS STEERING COMMITTEE

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MONDAY  
DECEMBER 5, 2011

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The Steering Committee met, at the  
National Quality Forum, 9th Floor Conference  
Room, 1030 15th Street, N.W., Washington,  
D.C., at 10:00 a.m., Sherrie Kaplan and Eliot  
Lazar, Co-Chairs, presiding.

PRESENT:

SHERRIE KAPLAN, Co-Chair  
ELIOT LAZAR, Co-Chair  
TANYA ALTERAS  
BRENT ASPLIN  
RICHARD BANKOWITZ  
JO ANN BROOKS

PAULA FOLTZ  
FRANK GHINASSI  
LAURENT GLANCE  
JEFFREY GREENWALD  
BRUCE HALL  
LESLIE KELLY HALL  
ASHISH JHA

MICHAEL LANGBERG  
PATRICIA McDERMOTT\*  
DAVID POLAKOFF  
BRUCE POMERANZ  
MARK SCHUSTER  
CHRISTINE TRAVIS

NQF STAFF PRESENT:

TAROON AMIN

HEIDI BOSSLEY

HELEN BURSTIN

JANET CORRIGAN

ALEXIS FORMAN MORGAN

ANN HAMMERSMITH, General Counsel

KAREN JOHNSON

ADEELA KHAN

LAURA MILLER

KAREN PACE

ALSO PRESENT:

DAWN ALAYON, NCQA

ELIZABETH DRYE, Yale University

JENNIFER FAERBERG, AAMC

NANCY FOSTER, American Hospital Association

JEREMY GOTTLICH, NCQA

JEPH HERRIN, Yale University

LEORA HORWITZ, Yale University

RABIA KHAN, CMS

HARLAN KRUMHOLZ, Yale University

KAREN NAKANO, CMS

BOB REHM, NCQA\*

MARA RUBIN, UnitedHealthcare

ROBERT SAUNDERS, NCQA

GRAEME SCANDRETT, UnitedHealthcare

RON STETTLER, UnitedHealthcare

\*Participating via telephone

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

2 10:13 a.m.

3 MR. AMIN: Good morning,  
4 everybody.

5 Thank you all for joining us this  
6 Monday morning in Washington for, hopefully,  
7 a very interesting two days' discussion on  
8 readmission measures.

9 I would like to introduce Helen  
10 Burstin for some quick introductions.

11 DR. BURSTIN: Hi, everybody.

12 I am Helen Burstin, Senior Vice  
13 President of Performance Measures, here at  
14 NQF.

15 I recognize a lot of familiar  
16 faces. We did pull on many of you who have  
17 been through committees before, understand our  
18 process, since this is our first expedited  
19 review. We have never done a project quite  
20 this fast before or potentially, I was going  
21 to say, "or potentially as high-profile," but  
22 every time I say that, the next project that

1 comes along, we say that one is the most high-  
2 profile.

3 (Laughter.)

4 I think certainly at the moment  
5 cost and resource use is consuming much of  
6 that energy at NQF, but I think readmissions  
7 is going to follow right behind.

8 I am really thrilled to have you  
9 here. This is a bit unusual as well because  
10 we also don't usually have the luxury of a day  
11 and a half for three measures, but these are  
12 quite complex, and we recognize that. We are  
13 also very much invested these days in not  
14 putting out competitive or duplicative  
15 measures that just confuse the field.

16 So, we are trying very hard, and,  
17 hopefully, as a result of your efforts today  
18 and primarily tomorrow, to have you actually  
19 give us a sense of which measure is best in  
20 class and could be used for the broader set of  
21 applications. And so, that will be a good  
22 exercise tomorrow.

1                   You are in great hands. Taroon  
2                   has been fabulous, really understands this  
3                   work. Also, Karen Pace, our lead  
4                   methodologist, is here with us as well and  
5                   will offer insights on risk adjustment and  
6                   other issues.

7                   And with that, I will turn it back  
8                   over to Taroon.

9                   We actually are waiting for Eliot,  
10                  but I think we can go ahead and sort of get  
11                  the usual stuff taken care of while we are  
12                  waiting for him.

13                  MR. AMIN: Also, I would like to  
14                  introduce our Chairs, Dr. Sherrie Kaplan and,  
15                  also, Dr. Eliot Lazar, who is not here yet,  
16                  but I am sure he will be joining us soon, if  
17                  you want to have any welcome/introductions to  
18                  the Committee.

19                  CO-CHAIR KAPLAN: I would just  
20                  like to also add my welcome to everyone and  
21                  invite a rich discussion.

22                  Just to lead off, I am a

1 psychometrician by training, full disclosure.  
2 So, I am a measurement scientist. My mother  
3 has no idea what I do for a living, but,  
4 happily, Helen knows what I do.

5 (Laughter.)

6 But I am a measurement scientist,  
7 and I am a professor of medicine at UC-Irvine,  
8 Assistant Vice Chancellor for Healthcare  
9 Measurement and Evaluation at the UCI School  
10 of Medicine.

11 In order to sort of frame this  
12 quickly, a couple of housekeeping details. I  
13 have chaired a few of these discussions in the  
14 past. What would help us all move this thing  
15 forward, if everybody could keep their  
16 questions and comments concise and focused, we  
17 can get a lot richer discussion, and  
18 especially responses, if there are any  
19 responses from measure developers. If you can  
20 keep it focused and concise, we can pedal a  
21 lot faster.

22 So, thank you again and welcome.

1 MR. AMIN: So, I will turn it over  
2 to our Chief General Counsel here, Ann  
3 Hammersmith, to do the disclosure of interest.

4 MS. HAMMERSMITH: Thank you,  
5 Taroon. I like that "Chief General Counsel".

6 MR. AMIN: "Chief," yes. I just  
7 added that on.

8 (Laughter.)

9 MS. HAMMERSMITH: Good morning,  
10 everyone.

11 If you recall, when we invited  
12 nominees for the Committee, you were given a  
13 conflict-of-interest form, a disclosure form,  
14 to fill out. What we are going to do this  
15 morning, in the interest of openness and  
16 transparency, is go around the room and have  
17 you make any disclosures that you might have.

18 To give you some guidance about  
19 the kind of thing we would be looking for, it  
20 is any consulting work that you have done that  
21 is relevant to what is before the Committee,  
22 grants or research support that you have,



1 again, relevant to what is before the  
2 Committee, and also any speaking engagements  
3 that are relevant to the work that will be  
4 done here.

5 We don't expect you to recount  
6 your CV, and really we would prefer it if you  
7 do not because that will eat up a lot of your  
8 meeting.

9 I want to remind you of a few  
10 things before we start. You sit as an  
11 individual. Sometimes Committee members will  
12 say, "I'm here representing the American  
13 Association of...", fill in the blank. You  
14 actually are not here representing anyone but  
15 yourself. You are here because you are an  
16 expert. We want to know what you think, and  
17 you don't represent anyone, including your  
18 employer, anyone who may have nominated you to  
19 sit on this Committee.

20 The other thing that I just want  
21 to give you a quick reminder about is  
22 sometimes I hear people say, "I have no

1 financial conflict of interest." We are  
2 interested in a potential financial conflict  
3 of interest, but because of the nature of the  
4 work we do, there is a possibility that there  
5 could be a real or apparent conflict of  
6 interest, even where you haven't been  
7 compensated for what you are doing. For  
8 example, if you sit on a committee with a  
9 measure developer that is relevant to what is  
10 before the Committee, that is likely  
11 uncompensated, but that could be something  
12 relevant that we would want to know in  
13 connection with your service on this  
14 Committee.

15 So, I am going to start with Dr.  
16 Kaplan, and then we can just go around the  
17 table.

18 CO-CHAIR KAPLAN: In the spirit of  
19 full disclosure, my colleague and partner, Dr.  
20 Sheldon Greenfield, and I have developed a  
21 total illness burden index, patient-reported  
22 comorbidity, total comorbidity, for outpatient

1 use with multiple different funding sources in  
2 the past. However, we have never used it to  
3 date in readmissions for hospitals, and we  
4 don't have, I really don't have any experience  
5 with all-cause readmission.

6 In addition, I just want to  
7 clarify I have chaired many committees of this  
8 nature, but I have never chaired an NQF  
9 committee. So, apologies in advance if I make  
10 some rooky moves on sitting in this seat.

11 But that is the probable end of my  
12 conflict.

13 MEMBER KELLY HALL: Leslie Kelly  
14 Hall. I have no conflict.

15 MEMBER SCHUSTER: Mark Schuster.

16 MS. HAMMERSMITH: Oh, excuse me.  
17 I am just going to jump in for a minute.

18 I neglected to ask you to identify  
19 yourselves and who you are with.

20 MEMBER KELLY HALL: I am Leslie  
21 Kelly Hall with HealthWise.

22 MEMBER SCHUSTER: Mark Schuster

1 from Children's Hospital, Boston, Harvard  
2 Medical School.

3 I am heading up an AHRQ-funded  
4 Center of Excellence for pediatric quality  
5 measurement. We have two first assignments,  
6 one of which is to create a pediatric  
7 readmission measure, and the other, since  
8 readmissions keeps coming up in the  
9 discussions about it, I will also mention to  
10 develop a pediatric hospital CAPS measure,  
11 family experience-of-care measure.

12 MEMBER POLAKOFF: David Polakoff  
13 with MassHealth, the Massachusetts Medicaid  
14 Agency, and the University of Massachusetts  
15 Medical of School, Commonwealth Medicine  
16 Division.

17 I have no conflicts of interest,  
18 but I am doing some related work that I will  
19 mention. I co-chair the State's Expert Panel  
20 on Performance Measurement, where we are in  
21 the process of evaluating and, hopefully,  
22 selecting soon a readmission measure for

1 statewide transparency reporting.

2 And I am also a member of the  
3 Medicaid Medical Directors Learning Network,  
4 where all of the states' Medicaid agencies are  
5 working together on figuring out how to  
6 measure readmissions in the Medicaid  
7 population.

8 MEMBER ALTERAS: Tanya Alteras  
9 with the National Partnership for Women and  
10 Families and Associate Director of the  
11 Consumer-Purchaser Disclosure Project.

12 And I have nothing to disclose.

13 MEMBER TRAVIS: Christy Travis,  
14 Memphis Business Group on Health. I do serve  
15 on the NCQA Purchaser Advisory Council, but  
16 there is no conflict of interest relative to  
17 this particular measure. I also serve as Vice  
18 Chair of the Leapfrog group.

19 MEMBER GHINASSI: Frank Ghinassi,  
20 University of Pittsburgh Medical Center,  
21 Western Psychiatric. I am on a committee for  
22 NCQA on the behavioral health MAP Program.

1                   MEMBER JHA: Ashish Jha from the  
2 Harvard School of Public Health and the Boston  
3 VA.

4                   And I don't believe I have any  
5 direct conflicts, but I will just run through  
6 a few things. I have done consulting work for  
7 a few different companies, including UpToDate,  
8 which is a medical textbook, an electronic  
9 medical textbook company; MedCo, which is a  
10 pharmacy benefits management company, and I am  
11 on the Scientific Advisory Board of a company  
12 called Umedica, which does analytics. But  
13 none of them really relate to readmissions.

14                  I have written a lot about  
15 readmissions. I have gotten grants studying  
16 readmissions from Commonwealth-funded. I have  
17 a couple pending from the NIH. And as I  
18 already said, I am from the Department of  
19 Veterans Affairs, which obviously is very  
20 interested and involved in a lot of work  
21 around readmissions.

22                  Thank you.

1                   MEMBER LANGBERG: Hi. I'm Michael  
2 Langberg. I am from Cedars-Sinai in Los  
3 Angeles.

4                   I don't think I have any  
5 conflicts, but, again, full disclosure, I  
6 serve on an AAMW task force looking at  
7 variations in various outcomes, including  
8 readmissions. We haven't actually done  
9 anything yet. So, I am not sure that counts  
10 as a conflict.

11                   (Laughter.)

12                   And some people who are direct-  
13 reports to me are principal or co-principal  
14 investigators in an AHRQ-funded grant along  
15 with five other University of California  
16 hospitals, looking at outcomes in heart  
17 failure, including readmissions. But I don't  
18 have that directly.

19                   MEMBER GREENWALD: I'm Jeff  
20 Greenwald. I am from Mass General Hospital.  
21 I am a hospitalist in internal medicine there.

22                   I have nothing to report in terms

1 of conflicts. I work with Project BOOST as a  
2 clinical investigator, formerly with Project  
3 RED, and I am the physician lead for  
4 readmissions for Partners HealthCare.

5 MEMBER ASPLIN: Good morning.

6 I am Brent Asplin, President of  
7 Fairview Medical Group in Minnesota, part of  
8 the Fairview Health Services System. I also  
9 chair the Quality and Performance Committee  
10 for the American College of Emergency  
11 Physicians, but do not have any direct  
12 conflicts.

13 MEMBER BROOKS: My name is Jo Ann  
14 Brooks. I am the Vice President of System  
15 Quality for Indiana University Health in  
16 Indianapolis, Indiana.

17 I have no direct conflicts  
18 regarding readmissions. I am a speaker for  
19 Cadence Pharmaceuticals as well as a quality  
20 consultant, and I serve as Chairperson of the  
21 Quality Improvement Committee for the American  
22 College of Chest Physicians.



1                   MEMBER FOLTZ: I am Paula Minton  
2 Foltz. I am the Assistant Vice President for  
3 Education Quality and Patient Safety at  
4 Harborview Medical Center, which is part of  
5 the UW Health System in Seattle, Washington.

6                   I have no conflicts of interest.

7                   MEMBER POMERANZ: Good morning.

8                   I am Bruce Pomeranz. I am Medical  
9 Director at the Kessler Institute for  
10 Rehabilitation and Chief Quality Officer for  
11 Rehabilitation for Select Medical.

12                   And I have no conflicts to report.

13                   MEMBER GLANCE: Good morning.

14                   My name is Laurent Glance. I am  
15 from the University of Rochester. I am a  
16 professor of anesthesiology and community and  
17 preventative medicine, as well as Vice Chair  
18 for Research.

19                   I don't really have any direct  
20 conflict of interest. I do have funding from  
21 AHRQ looking at performance measurement in  
22 trauma and I sit on a number of committees,

1 including the Committee on Performance and  
2 Outcomes Measures for the American Society of  
3 Anesthesiologists, as well as serving on some  
4 advisory committees, one for trauma, and also  
5 the Anesthesia Quality Improvement Panel.

6 Thank you.

7 MEMBER BANKOWITZ: Good morning.

8 I am Richard Bankowitz. I am the  
9 Chief Medical Officer of Premier, which is an  
10 alliance of about 2500 hospitals.

11 I will note that Premier has its  
12 own proprietary risk-adjustment methodologies,  
13 including one for readmissions. And I don't  
14 believe that is a conflict of interest.

15 I will also note, since one of the  
16 measure stewards is CMS, that Premier has  
17 quite a few applications for contracts pending  
18 before CMS for the CMMI, but I don't believe  
19 that is a conflict of interest.

20 MS. PACE: I am Karen Pace on the  
21 NQF staff.

22 CO-CHAIR LAZAR: I must have found

1 the only slow cab driver between New York and  
2 D.C.

3 (Laughter.)

4 I am the Chief Medical Officer and  
5 Senior Vice President at New York Presbyterian  
6 in New York City.

7 And I don't think I have any  
8 conflicts of interest, either, but belong to  
9 a number of groups, sit on a variety of  
10 committees, probably like many of us in the  
11 room, in Greater New York, the American  
12 College of Physicians, and so on.

13 CO-CHAIR KAPLAN: Okay. Let me  
14 just add that I forgot something. I am on the  
15 same project that Dr. Langberg is on that has  
16 yet to produce anything. So, apologies for  
17 that.

18 MS. HAMMERSMITH: Okay. Thank  
19 you.

20 I understand there are some  
21 members of the Committee on the phone. Is  
22 Patricia McDermott on the phone?

1 MEMBER McDERMOTT: Hi. Yes, I am.

2 I work for Aetna. I work in  
3 cooperation with in metrics development. We  
4 have had an readmissions measure that we have  
5 used and developed over the last 18 years  
6 within Aetna. It is not anything that is  
7 using logic from any other vendor. We have  
8 also looked at other vendors' logic, but our  
9 logic is its own. And I don't think there is  
10 any conflict of interest.

11 MS. HAMMERSMITH: Okay. Thank  
12 you.

13 Is Mark Williams on the phone?

14 (No response.)

15 Okay. I guess he is not on the  
16 phone yet.

17 Is Jim Bellows on the phone?

18 (No response.)

19 Okay. Thank you for those  
20 disclosures. Do any of you have anything that  
21 you want to discuss with each other or any  
22 questions of me regarding the disclosures that

1 have been made?

2 (No response.)

3 Okay. Thank you. Have a good  
4 meeting.

5 MR. AMIN: Okay. Thank you.

6 I just want to quickly introduce  
7 our staff here. Adeela Khan will be taking  
8 over starting the project introductions.

9 Clearly, you guys have heard from  
10 Alexis Forman Morgan, who has been great in  
11 getting materials prepped for our meeting as  
12 well.

13 And I am Taroon Amin.

14 So, I will turn it over to Adeela.

15 MS. ADEELA KHAN: Good morning,  
16 everyone.

17 So, we want to know why we are  
18 here today. The Affordable Care Act, under  
19 Section 3011, directs the Secretary of HHS to  
20 develop a National Strategy for Quality  
21 Improvement, which is called the NQS. The NQS  
22 is used as a guide and includes a strategic

1 plan on how to increase access to quality  
2 affordable healthcare for all Americans.

3 So, the NQS identified reduction  
4 in preventable hospital readmissions as an  
5 opportunity for success and uses all-cause  
6 readmissions within 30 days of discharge as an  
7 illustrative measure for effective care  
8 coordination.

9 And some of the other goals that  
10 readmissions relate to with regard to the NQS  
11 were effective care coordination, prevention  
12 and treatment of leading causes of mortality,  
13 and safer care.

14 So, just a little bit about our  
15 project scope. Right now, we are seeking to  
16 identify and endorse a cross-cutting, non-  
17 condition-specific measure for accountability  
18 and quality improvement that specifically  
19 addresses all-cause readmissions to hospitals.

20 And we are also going to be  
21 reevaluating under the maintenance process any  
22 measures that were endorsed by NQF before June

1 2009.

2           So, our meeting objectives today  
3 are member introductions and disclosure of  
4 interest, which we just finished. We are  
5 going to be evaluating the measures to  
6 determine if they meet the measure evaluation  
7 criteria, make recommendations regarding  
8 endorsement as a voluntary consensus standard,  
9 vote on the rating for each of the four major  
10 criteria and overall on whether to recommend  
11 each measure for endorsement.

12           Discuss related and competing  
13 measures to facilitate measure harmonization  
14 of related measures. We are probably going to  
15 get to discussing related and competing  
16 measures tomorrow, I believe. And from among  
17 related and competing measures, we are going  
18 to select which measure is the best.

19           MS. FORMAN MORGAN: Okay, and as  
20 Adeela said, we will be evaluating the  
21 measures based on our NQF criteria. These are  
22 our major criteria.

1                   The first one is importance to  
2                   measure and report. And so, we need to make  
3                   sure that the measure focus is evidence-based,  
4                   there is opportunity for improvement in  
5                   quality, and it demonstrates a high impact  
6                   where there is variation or overall less-than-  
7                   optimal performance.

8                   In order for the measure to  
9                   continue through the review process, it must  
10                  pass all of its three subcriteria under  
11                  importance to measure and report in order for  
12                  it to be evaluated against the remaining  
13                  criteria.

14                  The second criteria is scientific  
15                  acceptability of measure properties. This is  
16                  looking at the measure. Is the measure  
17                  consistent and credible? Does it present  
18                  credible results when implemented? So,  
19                  looking at reliability and validity. And in  
20                  order for the measure to continue through the  
21                  evaluation and the criteria process, it must  
22                  pass the reliability and validity criteria.



1                   The third criteria is usability.

2                   Is this measure understandable to those who  
3                   will use it, to the intended audience? Can  
4                   they understand it? Can they understand the  
5                   results of the measure?

6                   Looking at the fourth criteria,  
7                   usability, this is looking at, is the data  
8                   available or can it be collected without undue  
9                   burdens.

10                  Again, as Adeela stated, our next  
11                  criteria is we do have competing measures, and  
12                  in order for us to evaluate competing  
13                  measures, the measures must pass all of the  
14                  above criteria. So, all of the above criteria  
15                  must be met in order for the measures to be  
16                  considered competing, if there are any, and in  
17                  this case all of the measures are considered  
18                  competing.

19                  So, today we will mainly focus on  
20                  the four criteria, making sure that the  
21                  measures meet all those criteria. And then,  
22                  tomorrow we will focus on the competing

1 discussion.

2           So, our process, it is an  
3 endorsement/maintenance process. What that  
4 means is we look at measures that are  
5 currently in our NQF portfolio and they have  
6 been endorsed for three years. And so, now  
7 they are going through their maintenance  
8 cycle. We evaluate those measures based on  
9 the same criteria that we evaluate newly-  
10 submitted measures.

11           As we are evaluating the  
12 maintenance measures, we do solicit for new  
13 measures in that topic area as well. So, that  
14 is what we mean by endorsement/maintenance.

15           As Helen stated earlier, this is  
16 our first expedited review process. And so,  
17 in order for a project to have an expedited  
18 review process, it must meet these three  
19 criteria. The three criteria are the measures  
20 must have been tested or currently in use.  
21 That looks at our usability criteria. The  
22 second, a measure or project must be narrow.

1 In this case, it is readmissions to the  
2 hospital, pretty narrow. And there must be a  
3 time-sensitive legislation mandate for the  
4 measures.

5 The role of the Steering  
6 Committee, we expect the Steering Committee to  
7 evaluate the measures, and we want to thank  
8 everyone for submitting their preliminary  
9 evaluations.

10 You will make recommendations to  
11 the NQF membership. You will work with the  
12 project staff to achieve the goals of the  
13 project, and you will respond to comments  
14 received during the public and member  
15 comments. We have that conference call  
16 scheduled.

17 The Co-Chairs will represent the  
18 Steering Committee on the project webinar  
19 which occurs at the beginning or during the  
20 first part of the member voting period -- and  
21 we will go into that in more detail -- as well  
22 as the CSAC meeting.

1                   This is just an illustration of  
2                   our endorsement process, and you can see what  
3                   is highlighted in yellow/green. This is where  
4                   we currently are in the process with the  
5                   Committee reviewing the measures.

6                   And this is our project timeline.  
7                   So, today we are here to discuss and recommend  
8                   measures. And then, following this meeting,  
9                   the project staff will compile all the  
10                  rationale and all the discussion points and  
11                  put it into a draft report. We in that draft  
12                  report will list the voting. We will list  
13                  everything, all the major discussion points  
14                  from this meeting, and we will send it to the  
15                  Committee to review before we post it for  
16                  member and public comment.

17                  Member and public comment is a 30-  
18                  calendar-day comment period. Anyone can  
19                  comment, NQF members, not NQF members. Anyone  
20                  can comment on the Committee's recommendations  
21                  and rationale behind the measures that were  
22                  recommended or not recommended.

1                   Following the close of that  
2                   period, the Committee will meet via conference  
3                   call on January 31st, and we will send this  
4                   information out so everyone can have it. You  
5                   will via a conference call, for a two-hour  
6                   conference call, discuss all of the comments  
7                   that came in regarding your recommendations.

8                   MR. AMIN: So, I will give a brief  
9                   overview of the discussion format for the  
10                  Committee deliberations over the next two  
11                  days.

12                  I will ask if we know where the  
13                  microphone is. Okay.

14                  After I go through the discussion  
15                  format, it would be great to have all the  
16                  measure developers and members of the audience  
17                  introduce themselves.

18                  So, we will go through each  
19                  measure individually. The first measure of  
20                  the day will be Measure No. 1789, the  
21                  hospital-wide all-cause unplanned readmission  
22                  measure.

1                   We will ask each of the measure  
2 developers, as we move through the measures,  
3 to give a brief, three-to-five-minute  
4 introduction to the measure, noting that each  
5 of the measure developers submitted  
6 supplementary materials post the initial  
7 submission of the measure. We will ask that  
8 the measure developers focus on the updates to  
9 focus the Committee.

10                   We will then move to Measure No.  
11 0329, the risk-adjusted 30-day all-cause  
12 readmission measure submitted by UHC, and then  
13 Measure 1768, the plan all-cause readmission  
14 measure.

15                   The first measure, staff will  
16 guide the Committee through the subcriteria  
17 and the measure submission form to familiarize  
18 the Committee members on the evaluation  
19 process.

20                   For the second two measures, the  
21 NQF staff will not guide the Committee  
22 members, the evaluation Committee. We expect

1 that by the time you will get through the  
2 measure, you will get the hang of it, and if  
3 there are more process-related questions, feel  
4 free to ask as we sort of move through this  
5 process.

6                   During the Committee  
7 deliberations, we will have the preliminary  
8 evaluations, which you should have received in  
9 your materials this morning, and also before  
10 attending today's session. This will help to  
11 guide the discussion on where there are major  
12 concerns for the measures that were submitted.  
13 Also, the comments that were submitted by  
14 Committee members prior to attending here are  
15 also listed in these materials.

16                   This is really provided to help  
17 focus the discussion. So that, if there are  
18 no major considerations for various  
19 subcriteria, we can help facilitate moving  
20 this day along.

21                   While we only do have three  
22 measures for discussion today, we expect each

1 of the measure discussions to be very robust,  
2 particularly around scientific acceptability,  
3 potentially even the risk-adjustment models.  
4 So, if there is not a major discussion around  
5 importance, because of the nature of this call  
6 for measures, we can move pretty briskly into  
7 the voting procedure.

8 And I will just say that we will  
9 also stop for various public and member  
10 comment periods at various points throughout  
11 the Committee deliberations, which is listed  
12 on the agenda. We have Nicole on the line,  
13 who the Chairs will ask to open the lines for  
14 public and member comment.

15 CO-CHAIR LAZAR: Taroon, Sherrie  
16 and I thought that it might be helpful for the  
17 group for you to give a little bit of a  
18 framework in terms of what is congressionally-  
19 mandated. In other words, what flexibility  
20 does the group have, you know, and so on?

21 MR. AMIN: Okay. Actually, Helen,  
22 if you can help me out with this as well?



1 DR. BURSTIN: Sure. Again, there  
2 are folks in the room, like Nancy Foster, who  
3 really know it even better than me, from the  
4 American Hospital Association.

5 There is an expectation that an  
6 all-cause readmission measure would be used as  
7 part of the hospital readmission program. It  
8 is an ACA. We have agreed to have a measure,  
9 hopefully, endorsed by April 1.

10 DR. BOSSLEY: But I think we  
11 should emphasize this process is agnostic of  
12 whatever is out there. So, if you all -- it  
13 hasn't happened yet, but it can happen -- if  
14 all of you determine that none of these  
15 measures meet the criteria, you can say that  
16 none are endorsed.

17 We do say we are agnostic of what  
18 is occurring. Ideally, we would be putting  
19 that forward, but it is very important to just  
20 remember you truly need to evaluate the  
21 measures against the criteria.

22 MR. AMIN: Can we have

1 introductions of --

2 DR. BOSSLEY: I am Heidi Bossley,  
3 Vice President of Performance Measures at NQF.

4 MR. AMIN: And could we have  
5 introductions for the members who are in the  
6 audience?

7 MS. RABIA KHAN: I am Rabia Khan  
8 from CMS.

9 MS. NAKANO: My name is Karen  
10 Nakano. I am one of the medical officers also  
11 from CMS.

12 MR. GOTTLICH: Jeremy Gottlich  
13 from the National Committee for Quality  
14 Assurance.

15 MR. SAUNDERS: Robert Saunders  
16 from the National Committee for Quality  
17 Assurance.

18 MS. ALAYON: Dawn Alayon from the  
19 National Committee for Quality Assurance.

20 MS. FOSTER: Nancy Foster from the  
21 American Hospital Association.

22 MS. FAERBERG: Jennifer Faerberg,

1 Association of American Medical Colleges.

2 MR. SCANDRETT: Graeme Scandrett,  
3 UnitedHealthcare.

4 MR. STETTLER: Ron Stettler,  
5 UnitedHealthcare.

6 MS. RUBIN: Mara Rubin,  
7 UnitedHealthcare.

8 MS. NEWELL: Alexa Newell, NQF.

9 MR. HERRIN: Jeph Herrin, Yale  
10 University.

11 MR. AMIN: So, with that, are  
12 there any other procedural questions as we  
13 begin? I know there is a lot of information  
14 presented. I think we will get to know the  
15 process as we sort of move along. But if  
16 there are any preliminary questions, we are  
17 happy to entertain them. If there are any  
18 questions, just please raise your placard, as  
19 such, and the Chairs will lead the discussion  
20 in that fashion.

21 I guess we will just start. Shall  
22 we give a brief introduction from the measure

1 developers on this measure and any updates  
2 that you have?

3 We will begin discussion of the  
4 measure, and as your colleague comes, I think  
5 we can have additional discussion at that  
6 point.

7 So, moving on to the first  
8 criteria, overall impact, opportunity, and  
9 evidence, the importance to measure and  
10 report. What this criteria is really aiming  
11 to evaluate is the extent to which the measure  
12 focus is evidence-based, important in making  
13 significant gains in healthcare quality, and  
14 improving the health outcomes for a specific  
15 high-impact area of healthcare.

16 This will be evaluated through  
17 three subcriteria, high impact, gap in  
18 performance, and evidence to support the  
19 measure focus.

20 Specific evaluation considerations  
21 for this project that should be kept in mind  
22 is that readmissions is considered an outcome

1 measure, a proxy for an outcome measure. So,  
2 evidence will not be required, measure  
3 developers will not be required to submit a  
4 body of evidence. However, they should submit  
5 a rationale that supports the relationship  
6 between this health outcome and at least one  
7 healthcare structure or process, intervention  
8 or service. Evidence, however, would make the  
9 submission stronger, but is not required. As  
10 I noted, readmission is considered a proxy for  
11 healthcare status.

12 And just one more slide, actually.

13 That one.

14 So, the importance to measure and  
15 report is, again, a must-pass criteria. The  
16 two subcriteria that we should consider here  
17 is the performance gap, the distribution of  
18 performance scores, the number and  
19 representativeness of the entities included in  
20 the measure performance data, data on  
21 disparities, the size of the population at  
22 risk, the effectiveness of interventions, and

1 the likely occurrence of the outcomes, and  
2 also the evidence, since the measure focuses  
3 on outcome.

4           Again, the rating of the quality,  
5 quantity, and consistency of the body of  
6 evidence is not required. However, a  
7 rationale that supports this relationship  
8 should be presented.

9           So, I will turn it over to the  
10 Chairs to facilitate discussion, if there is  
11 any, on this particular measure. And then, we  
12 will move to voting once you are ready for  
13 that.

14           CO-CHAIR KAPLAN: I think the  
15 first issue is whether or not people have  
16 burning issues about the importance of the  
17 measure and the performance gap and the  
18 evidence given, not the scientific  
19 acceptability, but sort of high-impact  
20 performance gap and evidence, given the  
21 congressional mandate.

22           So, if this is a burning issue, I

1 mean, we should have a discussion about this,  
2 if people feel strong about some of these  
3 issues. But this is clearly from, and the  
4 reason it is expedited is, there is this  
5 congressional mandate out that has a very  
6 tight timeline.

7 Has anybody got any issues around  
8 either -- well, let's start with performance  
9 gap.

10 (No response.)

11 Hearing none -- I think that is a  
12 safe window of silence -- what about evidence?  
13 If the measure is a health outcome, then the  
14 rating and the quality, this body of evidence  
15 is not required by NQF.

16 Comments? Yes, go ahead.

17 MEMBER LANGBERG: I have to say I  
18 am a little puzzled by the process. I  
19 certainly understand there is a congressional  
20 mandate for the purpose of Congress, and  
21 ultimately CMS, deciding what to do with a  
22 measure. So, I certainly understand that

1       there is a mandate there.

2                   But I am back to the comment that  
3       was made earlier that we are supposed to be  
4       agnostic and look at the measures themselves.  
5       And so, I am not sure what the direction is  
6       here for us.  Are we supposed to be kind of  
7       agnostic when we look at the measures  
8       themselves, looking at their capacity for  
9       accountability and performance improvement?  
10      Or are we supposed to acknowledge that there  
11      is a mandate, so we just --

12                   DR. BURSTIN:  I don't think there  
13      is any reason to say there is a mandate and  
14      acknowledge it and just move on.  I think,  
15      though, importance is threefold, the first of  
16      which is, how important overall is the issue  
17      of readmissions?  I think that may be the  
18      issue that may be a bit of a fete accompli in  
19      and of itself.

20                   The issue about whether the second  
21      -- two parts of importance I think are  
22      especially important for you to consider.  The



1 second is, do you believe that there is a  
2 significant gap in performance and variation  
3 among the entities being measured? That is  
4 the second part of it.

5 And the third is whether you  
6 believe there is evidence for the measure  
7 focus. This is a little bit more complicated  
8 because this is what many would consider an  
9 outcome measure. And so, we really want a  
10 rationale for the evidence, you know, evidence  
11 for the rationale for the evidence.

12 But having a congressional mandate  
13 in and of itself doesn't really answer our  
14 criteria. So, that is somewhat separate. I  
15 think it was just in the bill; obviously, it  
16 is an important general area, but it still  
17 doesn't change the fact that we need to fully  
18 evaluate and rate each of our criteria.

19 Brent?

20 MEMBER ASPLIN: Yes, I think what  
21 we are testing here is, can we move off this  
22 category relatively quickly? I think the

1 general answer is yes.

2 The only area where there was some  
3 discrepancy is within the evidence criterion  
4 and the subcriteria within that. Is this  
5 measure a health outcome? And it looked like  
6 most of the Committee said yes, and I said no.  
7 So, I don't if now is the time when I have a  
8 discussion about that. It is an outcome  
9 measure. It just didn't strike me as a health  
10 outcome.

11 DR. BURSTIN: Brent, do you want  
12 to --

13 MEMBER ASPLIN: If you don't want  
14 to have this dialog now, that's fine.

15 DR. BOSSLEY: I actually think it  
16 is a good one to have. Actually, Karen was  
17 going to give you our thoughts on how we would  
18 handle this today.

19 MS. PACE: Right. I think it is a  
20 good question, and it has come up in other  
21 projects where we have had readmission  
22 measures.

1 I think the reason we have kind of  
2 put it in the overall bucket with health  
3 outcomes is that it is really a proxy for  
4 deterioration in health status.

5 So, although it is not really  
6 considered -- you know, it could be considered  
7 a utilization measure, but we are really  
8 looking at it in terms of patients have a  
9 reason, you know, there is something that  
10 happens that brings them back to the hospital.  
11 And so, from that standpoint, it is viewed  
12 more in the vein of the health outcome because  
13 of the health status relationship.

14 MEMBER JHA: That sounds like a  
15 decision that has been made. I guess the  
16 question is, is that a decision we are  
17 interested in revisiting or have we decided  
18 readmissions are a health outcome? And if we  
19 have, then I don't need to sort of revisit  
20 that, but I just want to know if that is on  
21 the table for a discussion or not.

22 MS. PACE: I think that is how we

1 have viewed readmission measures up to this  
2 point. So, we certainly could entertain  
3 additional discussion about that. You know,  
4 it will have implications beyond this project.

5 So, if we want to be consistent  
6 with precedent, then we would consider it a  
7 health outcome, but that doesn't mean that we  
8 can't have new discussion and a new way of  
9 looking at things that would perhaps alter our  
10 approach to these.

11 CO-CHAIR KAPLAN: Does that  
12 require that, then, the measure developers go  
13 back and provide the evidence of quality,  
14 quantity, and consistency of somebody that had  
15 been suggesting that this is an outcome  
16 measure? Because it does have implications  
17 for what was submitted.

18 MS. PACE: So, I guess, you know,  
19 I don't want to just cut it off and say, no,  
20 we are not going to revisit that. I guess my  
21 question would be, what is it that you are --

22 MEMBER JHA: So, I am not

1 convinced it is a health outcome. At the same  
2 time, I am not trying to create trouble on it,  
3 meaning I know there has been a long process  
4 here. This is not like a burning platform  
5 that I want to revisit this issue. So, if  
6 there is broad consensus that this is a health  
7 outcome, I am comfortable with that; I can  
8 live with that, and we can move on.

9 So, I guess I am just trying to  
10 test the waters of how much room is there for  
11 discussion around that, knowing if you say  
12 there is not a lot of room, I am not going to  
13 feel like I've been shut down. I got my two  
14 cents in. But I personally am not convinced  
15 it is a health outcome.

16 CO-CHAIR LAZAR: Well, I guess I  
17 would ask the group, is there strong sentiment  
18 one way or the other? In other words, are  
19 others having a problem considering this a  
20 health outcomes measure? Or are we simply in  
21 the sort of shades-of-gray nuance region?

22 Perhaps this is one to speak up.

1 I am personally okay with it, although I  
2 understand that there could be two sides to  
3 it.

4 MS. PACE: And I think we should  
5 characterize it as a proxy for health outcome.  
6 Because I agree that people would look at this  
7 and say, why is that a health outcome? So, I  
8 think it is important that we kind of talk  
9 about it.

10 MEMBER GHINASSI: I am not sure if  
11 this is the right time, either, to discuss  
12 this. I am learning this process as well.  
13 But, as for whether it is a good proxy for  
14 health outcome, I think much of that is going  
15 to depend on the discussion about the level of  
16 adequacy of risk adjustment on these things,  
17 the level of adequacy for controlling in that  
18 risk adjustment for many of the variables,  
19 which some of these things have addressed in  
20 varying levels. Like other factors post-  
21 hospitalization, they are going to have a  
22 major impact on readmission, which may or may

1 not be connected to what we traditionally  
2 think of as health outcome.

3 SES chaos, a variety of different  
4 kinds of issues which post, you know, seven to  
5 fourteen days after admission impinge on an  
6 individual's health status, which may  
7 contribute to readmission, which is in no way  
8 directly connected to the outcome of a health  
9 intervention. I am not sure where that is  
10 being discussed.

11 MS. PACE: Well, the risk  
12 adjustment will be discussed under scientific  
13 acceptability and measure properties. In  
14 terms of a discussion about adjusting for  
15 things that happen after the hospitalization,  
16 the way NQF has viewed readmission measures is  
17 really an integrative measure and shared  
18 accountability measure.

19 And so, the readmissions measures  
20 are really unique, in that they have an  
21 element of utilization. They have an element  
22 of health status and what happened in the

1 hospital. And they also have an element  
2 related to transitions of care and care  
3 coordination and our health system.

4 That is one reason that they are  
5 considered really important measures. It is  
6 also a reason that they generate discussion  
7 and questions.

8 But our goal is to have measures  
9 that really do move us for better care, better  
10 care coordination, better care in the  
11 hospital, better transitions. And this is a  
12 very integrative measure in that respect.

13 So, when we talk about the  
14 scientific acceptability, risk adjustment, and  
15 what factors are included, and how that  
16 impacts the validity of the measure, I think  
17 that is where we would want to have those  
18 discussions.

19 MEMBER GHINASSI: So, that is  
20 going to happen in a different section?

21 MS. PACE: Yes.

22 MEMBER GHINASSI: Thank you very



1 much.

2 MEMBER ASPLIN: As one of the four  
3 rated as not a health outcome, I am perfectly  
4 fine moving on. Because I think we could  
5 spend two hours on the discussions; it is not  
6 going to change my conclusion about the  
7 overall importance to measure, which I think  
8 is the broader question. And so, I am very  
9 comfortable with it. Besides, I don't want to  
10 be labeled a troublemaker.

11 (Laughter.)

12 CO-CHAIR KAPLAN: We'll make sure  
13 that doesn't happen.

14 Also, in terms of all-cause,  
15 remember, the breadth of this is 30-day all-  
16 cause readmission. Just sort of remember  
17 that, and so as a proxy for everything wrong  
18 that could happen, and a suboptimal outcome  
19 attributable to a variety of different  
20 sources. The decision is made to view this as  
21 anything that puts you back in the hospital  
22 within 30 days. So, just to kind of keep that

1 in mind.

2 Yes?

3 MEMBER HALL: I would just like to  
4 say I agree very strongly with Frank and Brent  
5 that these are dilemmas, in the sense that all  
6 outcomes are either intermediate or  
7 incomplete. Even death is incomplete if your  
8 real concern is satisfaction or happiness or  
9 something else.

10 Then, I think we can agree this is  
11 at least an intermediate outcome. It is not  
12 a process in the sense that we are not asking  
13 whether this was applied for the benefit of  
14 the patient. So, we are not considering it a  
15 process measure in that sense. The process  
16 measure is where we incur this obligation to  
17 prove the evidence.

18 So, I would agree with what  
19 everyone said, that in that sense we have sort  
20 of met this mark. And I do think a lot of the  
21 difficult discussions here will be around the  
22 scientific acceptability.

1 CO-CHAIR KAPLAN: So noted.

2 MR. AMIN: Bruce, do you mind just  
3 introducing yourself and if you have any  
4 disclosures to the group?

5 MEMBER HALL: Yes. Sorry. I  
6 apologize for being a few minutes late.

7 I am Bruce Hall. I am at Wash U  
8 in St. Louis, and I also am a Director of the  
9 NSQIP for the American College of Surgeons in  
10 Chicago. At Wash U in St. Louis, I have a  
11 corporate position with BJC Healthcare.

12 So, my only disclosures would be  
13 that I have a corporate role for BJC  
14 Healthcare and that I am involved with the  
15 American College of Surgeons' National  
16 Surgical Quality Improvement Program.

17 MEMBER ALTERAS: Well, it sounds  
18 like this conversation is over now, but I just  
19 wanted to say, you know, from the patient and  
20 the consumer perspective, a readmission is a  
21 real health outcome. That is a real concern.  
22 It is obviously a proxy, but it is also a

1 matter of real-life issues that a patient and  
2 their family have to deal with. So, we do  
3 like to think of these as outcome measures.

4 CO-CHAIR KAPLAN: Thank you.

5 So, is there a consensus of  
6 opinion that at least in this instance it is  
7 acceptable to the group to declare this okay?  
8 And can we vote?

9 MR. AMIN: Yes, on that particular  
10 question, there is no need for a vote. But we  
11 can just move to vote on the importance to  
12 measure and report. Yes, so we can move to a  
13 vote on overall importance, if the Committee  
14 is ready for that.

15 CO-CHAIR KAPLAN: Okay. Is there  
16 a consensus that we are okay to vote?

17 MEMBER LANGBERG: Sorry for asking  
18 a procedural question again.

19 CO-CHAIR KAPLAN: That's okay.

20 MEMBER LANGBERG: This being the  
21 first time I have gone through this process  
22 and this being the first of three, so we are

1 going to cut our teeth on this.

2 If it turns out later on I think  
3 that a topic ought to be addressed elsewhere  
4 and it turns out it should be brought up here,  
5 is the process flexible enough that we visit  
6 that or, once we vote on this, it is done?  
7 Because I am not sure what is going to be on  
8 versus what should be talked about now. It is  
9 hard for me to really kind of parse it the way  
10 the experts in the room have.

11 DR. BURSTIN: I think, in general,  
12 we will walk through each of the criteria  
13 today. You have a lot of opportunity  
14 tomorrow, when you do the side-by-side  
15 comparisons, to rehash a lot of the  
16 discussion, I think.

17 CO-CHAIR KAPLAN: I think the  
18 question is, can he revote if he changes his  
19 mind somewhere along the line?

20 DR. BURSTIN: Not unless the  
21 Committee's desire is such that they believe  
22 new evidence is emerging and you agree, and

1 probably would have to take a vote to revote.  
2 If you decide to do that, that is certainly  
3 within your purview.

4 CO-CHAIR KAPLAN: I think that  
5 answer was probably not -- so, everyone is in  
6 agreement we should be voting on this part of  
7 the criteria right now?

8 Do you want to tell them how they  
9 vote?

10 MS. ADEELA KHAN: So, does  
11 everyone have a voting clicker? Everyone  
12 should have.

13 MEMBER HALL: I'm sorry, maybe I  
14 did miss this earlier, but so how are we going  
15 to work? Are we going to walk through all  
16 three measures before making final decisions?  
17 You mentioned, Helen, there is a side-by-side  
18 and all that. When will that happen, and will  
19 it be before or after a final decision is  
20 made?

21 DR. BURSTIN: The side-by-side is  
22 tomorrow. So, what you will be asked to do

1 today, if you will vote on each of the four  
2 criteria as well as an overall assessment of  
3 does the measure meet all criteria for  
4 endorsement. You will not make a recommended  
5 decision until after your side-by-side  
6 repeating measures decision tomorrow.

7 MS. ADEELA KHAN: Does everyone  
8 have a clicker?

9 MEMBER McDERMOTT: So, this is  
10 Patty McDermott on the phone.

11 We are voting on the first  
12 question? Is there a way that I will vote  
13 based on being on the phone?

14 DR. BURSTIN: We will just ask for  
15 your vote after the fact.

16 MS. ADEELA KHAN: Okay. So, the  
17 instructions are on the PowerPoint. So,  
18 voting won't start until -- there is a timer.  
19 We are actually going to do a test vote, so we  
20 know that the voting is working properly.

21 You have 60 seconds to answer the  
22 question. You only have to press the

1 corresponding button once. The last button  
2 you press is the one that we will be  
3 capturing. So, you can change your answer, if  
4 you would like. Whichever one you press last,  
5 that is the one that is sustained. You don't  
6 need to use the Send key. You can change an  
7 answer.

8                   Once all the ratings have been  
9 captured, the timer will stop and the results  
10 will appear on the screen.

11                   So, just as a test, we wanted to  
12 ask you, isn't the weather in Washington,  
13 D.C., great today?

14                   (Laughter.)

15                   So, you have 30 seconds. So, if  
16 we can have everyone enter their responses?

17                   (Whereupon, a test vote was  
18 taken.)

19                   CO-CHAIR KAPLAN: How do you know  
20 if the thing worked? Is there some light?  
21 Does it light up?

22                   MS. ADEELA KHAN: No. It did work



1 because we got everyone's responses.

2 MS. PACE: When you press it, you  
3 will get a little green light, and that means  
4 it is working. If you would get a red  
5 flashing light, you need to let us know. That  
6 means the battery is low.

7 MS. ADEELA KHAN: So, the weather  
8 is great today.

9 (Laughter.)

10 Well, I guess those from up north  
11 think the weather is great here. Okay.

12 So, we are going to move on to  
13 then vote on importance.

14 So, again, we have the same  
15 procedure. Once I start the clock, you will  
16 have 60 seconds to enter your vote, and we  
17 will start right now.

18 (Whereupon, a vote was taken.)

19 We have two people holding out.  
20 So, if everyone could just try it one more  
21 time?

22 MR. AMIN: Final vote of 17 to 1.

1                   And the member on the phone?

2                   MEMBER McDERMOTT: I'll go with  
3 the majority.

4                   MR. AMIN: Eighteen to 1.

5                   So, what I will do is I will start  
6 to move the discussion into the scientific  
7 acceptability, reviewing the -- oh, we have  
8 the measure developer who joined us. We will  
9 offer you five minutes for an introduction to  
10 the measure, specifically focusing on areas  
11 that were updated post the initial submission.

12                  MS. DRYE: Hi. I'm sorry to be  
13 late.

14                  So, I am Elizabeth Drye from the  
15 Yale Center for Outcomes Research and  
16 Evaluation. We developed this measure for the  
17 Center for Medicare and Medicaid Services, as  
18 you know.

19                  In this five minutes, I wanted to  
20 give you a quick overview -- I think you know  
21 the features of the measure -- and review the  
22 NQF application and the technical report. But

1 I wanted to highlight as well the goals that  
2 were behind the work that we did that explains  
3 why we put the measure together the way that  
4 we did.

5 So, in brief, as you know, this is  
6 a measure that divides into patients -- I'm  
7 sorry, can I use this thing?

8 Okay. So, we divided patients  
9 into five different patient cohorts: a  
10 surgical cohort, a cardiovascular, a  
11 cardiorespiratory, neurology, and medical  
12 cohort. The medical cohort includes patients  
13 not falling into the other areas.

14 And then, we developed a risk-  
15 standardized, a separate model for each of  
16 those five patient cohorts that estimates a  
17 standardized readmission ratio. We rolled  
18 those up into a summary score. Either the  
19 individual scores or the summary score could  
20 be reported, but our emphasis is on the  
21 summary scores, although we tested all the  
22 individual five models.

1                   And then, I just point out a  
2                   particular feature, which is we only count  
3                   readmissions in the measure that are  
4                   unplanned. And so, we have a specific  
5                   algorithm that identifies planned readmissions  
6                   and doesn't count those in the outcome.

7                   And so, what were we trying to do  
8                   in developing this? You have already touched  
9                   on our main goal, which was to develop a  
10                  measure that reflects quality of care. In  
11                  addition, we wanted to develop a fair measure  
12                  that could adequately characterize or purely  
13                  characterize very diverse U.S. hospitals and,  
14                  also, a useful measure.

15                  To address the concern which we  
16                  had many, many long discussions about as well,  
17                  about how to capture readmission, the quality  
18                  signal that readmission provides, we  
19                  specifically shaped both the cohort of  
20                  patients in the measure as well as the  
21                  outcome. And let me just give you an example.

22                  So, the measure is very inclusive.

1 It includes almost all patients admitted to  
2 the hospital, but we do carve out patients for  
3 which readmission we don't think is a quality  
4 signal. We identify, in particular, a group  
5 of cancer patients admitted for medical care  
6 of their cancer. These patients just looked  
7 very different. They seemed different  
8 potentially clinically, but lots of patients  
9 differ clinically, but they looked different  
10 in that they have very, very high mortality  
11 rates. When we developed a model for that  
12 group and compared it to the other groups of  
13 patients, it didn't move with the rest.

14 We hypothesize, and there is some  
15 evidence, that there is a hospital-wide signal  
16 of quality captured in a hospital-wide  
17 readmission measure, and we should see some  
18 relationship across these groups of patients  
19 in the quality signal. We, as we report in  
20 our application and our technical report,  
21 didn't see that for this group of patients.  
22 So, they are not in our measure, although many

1 cancer patients are in the measure; for  
2 example, cancer patients admitted for surgical  
3 care.

4 In addition, for the outcome, as I  
5 mentioned, we carve out planned readmissions.  
6 And here, we were really not trying to, we  
7 didn't want to create a measure that  
8 discouraged routine patient care just because  
9 it happened to be occurring within 30 days of  
10 a prior admission.

11 So, for example, a patient  
12 admitted for gastroenteritis three weeks  
13 earlier, but they had a gallbladder removal or  
14 something scheduled, we didn't want to  
15 discourage that. So, we identify those  
16 admissions that are for planned care, and we  
17 don't count them as readmissions.

18 Finally, we chose a modeling  
19 strategy, hierarchical logistic regression,  
20 that really tries to separate what part of the  
21 outcome is due to patient factors that we can  
22 risk-adjust for, what is due to case-mix

1 differences, what is due to chance, and what  
2 is due to quality. And this is particularly  
3 important for small hospitals where chance is  
4 a factor.

5 One thing that is great about a  
6 hospital-wide measure is there is a lot of  
7 volume. So, the measure functions really  
8 well.

9 But we did think it was really  
10 important to characterize the amount of the  
11 outcome that is due to random variation and  
12 not count that as a quality signal.

13 And then, in addition, our second  
14 principle was fairness. There, we were just  
15 trying to make sure that all the hospitals and  
16 patients we included we can truly risk-adjust  
17 for, and the hospitals, their case mix could  
18 be accounted for. And we have pulled out a  
19 couple of groups of patients there.

20 We do not apply the measure to  
21 PPS-exempt cancer hospitals because, really,  
22 their patients are just fundamentally

1 different. They don't have a representative  
2 mix of patients. In addition, we don't  
3 include admissions for patients who leave  
4 against medical advice. And there are some  
5 patients, like patients admitted for primary  
6 psychiatric treatment, that we don't include  
7 because they are variably admitted in acute  
8 care hospitals; in general, they are not taken  
9 care of in acute care hospitals.

10 And those differences that we felt  
11 we would really have a fairer measure, it was  
12 just easier to take them out. It is  
13 relatively few patients and very few  
14 hospitals.

15 And then, lastly, we really wanted  
16 to build a measure that was useful for both  
17 public reporting and consumer information, as  
18 well as for quality improvement. So, we tried  
19 to be very pragmatic in constructing the  
20 measure. We just used inpatient data to build  
21 the measure. We used one year of data.

22 We think that the measure's



1 feature where we have separated patients into  
2 five cohorts is really useful because it gives  
3 hospital subpopulations that are essentially  
4 cared for, often cared for by different  
5 clinical care teams. So, they can have more  
6 resolution in their measure results, if they  
7 want to look at that, or if CMS or others  
8 using the measures want to report, want to  
9 provide those separate results.

10 And then, more recently, actually,  
11 since we submitted this application, we tested  
12 the measure in all-payer data, and like  
13 another measure before you, it actually  
14 performs even better in this 18-and-over --  
15 when we say "all-payer", we limit it to the  
16 18-and-over population, so that it can be used  
17 in a much broader range of patients.

18 So, to summarize, we really were  
19 trying to develop a measure that captures a  
20 quality signal associated with readmission  
21 that is fair and that is useful, and we are  
22 really looking forward to your comments.

1 CO-CHAIR LAZAR: Any general  
2 comments or perhaps some questions for the  
3 presenter?

4 (No response.)

5 Okay. So, shall we move to the  
6 issue of scientific acceptability?

7 MEMBER JHA: I don't know if this  
8 is a reasonable question to ask the presenter,  
9 but I guess I was wondering, can you talk  
10 about the advantages or disadvantages of using  
11 risk-standardized readmission rates versus  
12 risk-adjusted?

13 MS. DRYE: The terms are used  
14 pretty interchangeably. We use risk-  
15 standardized here because we are using  
16 hierarchical logistic regression, which is  
17 technically risk-standardizing, but it is  
18 very, very much like a more traditional with  
19 just at the patient-level we are adjusting for  
20 patient factors using logistic regression,  
21 just like many other risks. So, that is our  
22 first step. We use logistic regression to

1 adjust for patient factors.

2 You will hear the word "risk-  
3 standardizing" in the other models; it is a  
4 very different approach. So, that is a good  
5 distinction.

6 And I meant to note, in this  
7 model, which is different than other models  
8 that we have put in front of NQF, which have  
9 been more condition-specific, we adjust for  
10 both patient comorbidities and for the  
11 condition for which the patient is admitted,  
12 because we are trying to account both for  
13 differences in how sick the patients are, but  
14 also in what they are coming in for, what  
15 kinds of services the hospital provides, since  
16 the proportion of those services varies so  
17 much across hospitals.

18 MEMBER JHA: Let me try it a  
19 different way. People do use those terms  
20 interchangeably. I think that the general --  
21 I guess, let me get more specific.

22 Can you talk about the advantages

1 and disadvantages of using the hierarchical  
2 model versus a straight logistic regression?

3 MS. DRYE: So, I have Jeph here,  
4 and he is our statistician, here in the back,  
5 too. But I will give you a definition or an  
6 explanation I think that sets up the juncture  
7 between -- it is where most of us work between  
8 clinical and statistical considerations.

9 The patients that we are using to  
10 assess quality are clustered within hospitals,  
11 and their outcomes are related by the fact  
12 that they are being treated at the same  
13 hospital. So, that is called the clustering.

14 The data is, in a sense,  
15 hierarchical. We are evaluating hospitals,  
16 but we are using patients within those  
17 hospitals to assess quality.

18 And so, one advantage of the  
19 hierarchical model is that it accounts for  
20 clustering. There are other ways to do that,  
21 but that is one of its strengths.

22 Another advantage is that it

1 treats smaller hospitals different than large  
2 hospitals, in that it weighs the number of  
3 cases in calculating the risk-standardized  
4 rate. If there are very, very few patients,  
5 say five or ten, the model does not make as  
6 much of an inference from those patients'  
7 outcomes, whether they are readmitted or not,  
8 as it does if there are hundreds of patients  
9 in that hospital.

10 So, the uncertainty there, the  
11 hospital weights -- and this is different than  
12 some other approaches -- an assumption that,  
13 if we don't know anything about the hospital,  
14 we will assume that this hospital is a typical  
15 hospital. And all of the cases that we see  
16 will help us pull away from that prior  
17 assumption.

18 So, smaller-volume hospitals in  
19 our model tend to have more average estimates,  
20 and, also, the model allows us to characterize  
21 the uncertainty around the estimate, which is  
22 another very important thing. So that, when

1 we are reporting, we know how confident or how  
2 not confident are we in the rate that we are  
3 seeing.

4 If you have any more detailed  
5 questions, Jeph Herrin is here and can get  
6 into the mechanics of the statistics.

7 MEMBER JHA: I think we all  
8 understand this importance of clustering of  
9 patients within hospitals and you have got to  
10 account for uncertainty. There are lots of  
11 ways of doing it.

12 Without getting into the details  
13 of the modeling, which we might need to do in  
14 the scientific discussion, I was trying to get  
15 on a broad level what the advantages or  
16 disadvantages are that you guys see of using  
17 the hierarchical model versus just a straight-  
18 out logistic with clustering and showing  
19 uncertainty around that.

20 But I can wait until the  
21 scientific discussion.

22 CO-CHAIR LAZAR: We are right

1 about there. So, I think a number of us, just  
2 from the expressions around the room, would  
3 like a little more discussion about this and  
4 a little better understanding. So, I don't  
5 know whether it is your statistician or how  
6 you would like to get to this, but I think we  
7 need to really understand it. I'm sorry about  
8 that.

9 MR. HERRIN: So, you are correct,  
10 there are many ways to model these kind of  
11 data. I don't understand your specific  
12 question. I mean, do you want to know -- I  
13 mean, if you were to compare our method to  
14 some other specific method, we could adjust it  
15 for comparison.

16 But our assumption is that there  
17 is some latent signal of quality in hospitals  
18 to do a measurement. The approach that we use  
19 specifically models that sort of leading  
20 factor of quality.

21 I hope that is helpful.

22 CO-CHAIR KAPLAN: Jeph, can I

1 follow that up? In other varying shrinkage  
2 estimator-type models, the random effects  
3 model without volume is a poor estimate,  
4 especially of the lower-performing hospitals.  
5 Can you talk a little bit about how the  
6 approach -- and I understand hierarchical  
7 models that take account for variations in  
8 reliability associated with lower volume --  
9 but can you talk about the specific effect of  
10 volume on this particular problem?

11 MR. HERRIN: The specific effect  
12 of the hospital's volume on which --

13 CO-CHAIR KAPLAN: On all-cause  
14 readmissions as in random effects in shrinkage  
15 estimator-type problems, random effects  
16 models.

17 MR. HERRIN: Well, in any such  
18 model, the volume of data, the number of  
19 observations you have within a cluster affects  
20 how well you know --

21 CO-CHAIR KAPLAN: Right.

22 MR. HERRIN: -- for that cluster.



1 So, certainly, whether or not you are using a  
2 random effects model, if you have a small-  
3 volume hospital, you know the readmission rate  
4 for that hospital with less precision than if  
5 you --

6 CO-CHAIR KAPLAN: Right.

7 MR. HERRIN: -- had a bigger  
8 hospital.

9 The random effects model  
10 acknowledges that, but also incorporates other  
11 information you have about readmission rates  
12 in general. So, we know that or we can expect  
13 that a hospital, without knowing anything  
14 else, has an average readmission rate.

15 CO-CHAIR KAPLAN: Right.

16 MR. HERRIN: We can combine that  
17 information.

18 CO-CHAIR KAPLAN: Right.

19 MR. HERRIN: So, I don't know if  
20 that answers your question or if I even  
21 understand your question.

22 CO-CHAIR KAPLAN: Well, what I

1 would like to ask is, more specifically, what  
2 is wrong with adding volume to your model as  
3 a hospital characteristic, for example?

4 MR. HERRIN: Oh, what's wrong? I  
5 don't know that it is specifically wrong to do  
6 that. I think it is a positive question  
7 whether you want to --

8 CO-CHAIR KAPLAN: Yes, why  
9 wouldn't you do it?

10 MR. HERRIN: -- look at that.

11 MS. DRYE: Just to kind of expand  
12 on that, because I think if you haven't been  
13 having this discussion recently, it may be  
14 hard to follow.

15 When we are building these models,  
16 we are trying to adjust for, we are trying to  
17 level the playing field across hospitals. So,  
18 we are adjusting for patient comorbidities,  
19 and in this case we are adjusting for  
20 differences in the kinds of services a  
21 hospital provides. Like a surgery has a much  
22 lower readmission risk than, say, you are

1 taking care of very sick heart failure  
2 patients or running an ICU. So, we are  
3 adjusting for those things.

4 There are many more things we  
5 could put into the model to make the model  
6 better predicative of readmission. And one of  
7 them would be potentially volume.

8 But if we did that, small-volume  
9 hospitals, this is a big area of demand, and  
10 there are small-volume hospitals that have a  
11 level worse. And so, we would be saying,  
12 well, gee, for you, we are going to make your  
13 -- you are going to look worse on this  
14 measure, essentially, just because you are  
15 small volume. And so, it is a fairness issue.

16 You could do that. You could  
17 separate hospitals out and say, well, we will  
18 set a separate prior assumption about how good  
19 you are, and we will weigh it. In our  
20 numerator, we do a calculation; we don't do a  
21 body count or a readmission count.

22 So, we could weigh a prior

1 assumption about their quality and that they  
2 are worse than an average hospital because  
3 they are small. I think you would hear back  
4 from small hospitals that that is not fair,  
5 but it is probably, if you are a consumer  
6 looking on the other end, you might say, well,  
7 gee, that may be more accurate.

8 And so, we are not trying to get  
9 the most accurate model. This will come up  
10 when we talk about adjusting for -- you know,  
11 you could throw in lots of things that make  
12 the model predict readmission better. We are  
13 just trying to level the playing field. That  
14 is why we don't do it. But it is not good or  
15 bad; it is just a policy decision.

16 CO-CHAIR LAZAR: Tanya?

17 MEMBER ALTERAS: This bleeds into,  
18 I think, the usability evaluation that we will  
19 get to later. But when it comes to what you  
20 were just saying, a consumer -- and there is  
21 a smaller hospital. They might look worse.  
22 The fact is, if you go into Hospital Compare,

1 all the hospitals look the same when you are  
2 using a hierarchical regression model. You  
3 know, they are all in that no different from  
4 the national average, which is useless to  
5 consumers.

6 And so, I also don't really know  
7 if it is very useful to the hospital, if they  
8 are trying to improve quality internally.  
9 They do have the actual data.

10 I know that, in theory, a consumer  
11 can drill down on Hospital Compare and see the  
12 actual readmission rates. They're not going  
13 to do that. You know, it is hard enough just  
14 to get them on Hospital Compare in the first  
15 place.

16 So, my real concern, and I think  
17 this is an ongoing issue that we are not going  
18 to solve today, is trying to get away from  
19 this hierarchical risk model, which doesn't  
20 really -- I don't know how to balance the  
21 fairness versus the providing useful  
22 information conflict. But I think we are

1 tipping very far into fairness. I know you  
2 are very far away from providing information  
3 that is useful, and we are not supposed to be  
4 thinking about the commercial message, but I  
5 think we can't really get away from that.

6 Then, how is this type of modeling  
7 going to play into creating useful information  
8 to fulfill the requirements? That is a big  
9 concern for me when I think about this  
10 measure.

11 MEMBER JHA: So, this is very  
12 helpful. I guess I have two kind of broad  
13 thoughts on this.

14 One is whether you choose to  
15 account for volume or not in a model is a  
16 decision that has real implications. But by  
17 choosing not to, the assumption is small  
18 hospitals are no worse than large hospitals,  
19 which we know from countless studies to be  
20 just not true. And so, by shrinking the rest  
21 of it to be a national average, basically,  
22 what you do is you take all the small

1 hospitals and make them look about the same.

2 I understand there are political  
3 considerations, but I guess my bias is, if I  
4 have to come down on one side or another, this  
5 as a quality improvement tool and this as a  
6 tool for consumers trumps any unfairness that  
7 you might introduce to some small hospitals  
8 that actually do pretty well.

9 And so, we are not going to come  
10 up with a perfect choice. But, on the one  
11 hand, it seems to be that the choice is give  
12 a number to consumers that is the actual  
13 number for the hospital. And even if you  
14 drill down on Hospital Compare and looked at  
15 the actual readmission rate, for a small  
16 hospital that is mostly coming from the  
17 national average, not the hospital's actual  
18 performance.

19 It also makes it sort of  
20 uninteresting for hospitals to focus on  
21 improving because they look at their numbers  
22 and say, "We're doing fine."

1                   And so, if the goals are quality  
2                   improvement and consumer engagement, the kind  
3                   of model strikes me as problematic. If the  
4                   goal is extra fairness to small hospitals, I  
5                   think it succeeds quite well.

6                   CO-CHAIR KAPLAN: Let me just sort  
7                   of focus, refocus this. These are questions  
8                   for the developer, and we are kind of moving  
9                   into the group discussion about scientific  
10                  acceptability.

11                  So, are there any more questions  
12                  for the developer?

13                  MEMBER LANGBERG: I have a couple  
14                  of questions not all statistically-related.  
15                  The first question is whether or not any of  
16                  the data is risk-adjusted for socioeconomic  
17                  status.

18                  MS. DRYE: We did not adjust for  
19                  socioeconomic status. We present data in the  
20                  application where we show that across  
21                  hospitals with a different proportion of  
22                  Medicaid patients there is a wide range of



1 performance on the measure.

2 We did look at and think about  
3 options, but didn't feel like it was necessary  
4 in this case.

5 MEMBER LANGBERG: I have three  
6 questions. Is that okay?

7 CO-CHAIR KAPLAN: That's okay.

8 MEMBER LANGBERG: The second  
9 question is that, if a patient is admitted to  
10 a hospital other than the one that did the  
11 original discharge, that will count as a  
12 readmission. So, that is a statement. My  
13 question is, is there any way in the  
14 methodology that you used that that specific  
15 information about readmissions to other  
16 hospitals would be available to the original  
17 hospital, so that they can use that for  
18 performance improvement?

19 MS. DRYE: That is a great  
20 question. CMS decides how to report that. To  
21 date, they haven't provided that in the  
22 publicly-reported, condition-specific

1 measures, but there is ongoing dialog about  
2 it. So, I would just encourage you to keep  
3 pushing CMS to give that data. Initially, it  
4 is just the barrier to privacy, reporting what  
5 happened to that patient and where they ended  
6 up.

7 I know many hospitals have said it  
8 would be useful information to have. It  
9 doesn't get reported in our rate, but it is  
10 potentially information CMS could provide.

11 MEMBER LANGBERG: My third  
12 question has to do with timeliness of the  
13 information available to the hospital for  
14 performance improvement and to the consumers  
15 for their engagement in whatever use they want  
16 to have. How soon after a discharge period  
17 would the information be available to the  
18 hospitals and the public? If it is the next  
19 month, let's say, that would be pretty  
20 current. If it is a year or two later, then  
21 it is pretty useless for performance  
22 improvement from the hospital point of view,

1 and I'm not sure what the consumers would do  
2 with it. So, it is somewhere between one  
3 month and two years, I'm guessing. Can you  
4 answer that?

5 MS. DRYE: Yes. We built the  
6 measure on Medicare fee-for-service claims  
7 data, and we built it using one year of data.  
8 So, typically, to have really good, quality  
9 data -- the claims are in, and CMS has done  
10 their quality checks -- you would want the  
11 most recent admission to be within a year.  
12 So, it would be basically a year to two years  
13 from the date of reporting, which is longer  
14 than people want. The tradeoff is, if you use  
15 more recent claims, the claims are a bit less  
16 complete.

17 So, I would just say that, for  
18 this measure, for really having confidence in  
19 the claims, it is probably between 12 months  
20 and 24 months prior, which is a lag. It would  
21 be great to identify ways to provide other  
22 kinds of information that show more current

1 trends. And our group is thinking about that,  
2 but it is not part of this measure.

3 MEMBER LANGBERG: I have a fourth  
4 question. So, given that we are dealing with  
5 data that is two years old, the focus of our  
6 view of the measure is on accountability and  
7 performance improvement. Do you have  
8 information about the utility of the measure  
9 in those settings that spur performance  
10 improvement and accountability?

11 MS. DRYE: I would defer more to  
12 measure users and hospitals, but I would just  
13 say at the Hayman Hospital these numbers get  
14 looked at and they are real and they are acted  
15 upon.

16 It has only been a couple of years  
17 that the results have been in place. So,  
18 there really hasn't been, for the condition-  
19 specific measures, I don't think we have  
20 studies showing how quickly people are  
21 reacting to them.

22 CO-CHAIR LAZAR: Okay. We have a

1 number of questions on the table. We just  
2 want to make sure that they are all questions  
3 for the developer.

4 So, Frank, Tanya, Brent, and then  
5 Richard.

6 MEMBER GHINASSI: Thank you.

7 Just two specific questions. One  
8 was about the decision to exclude psychiatric  
9 patients. I believe it quotes, the reason was  
10 that many or most are treated in, I think you  
11 said, rehabilitation facilities or specialized  
12 psychiatric hospitals.

13 I am not sure about the accuracy  
14 of that statement. I think if you look at the  
15 numbers, you may find that there are a lot of  
16 folks treated in single units within acute  
17 care hospitals. There are data available on  
18 that. I don't have them immediately at my  
19 disposal. But I am not sure I agree with that  
20 reason for exclusion, No. 1.

21 And therefore, I have concerns  
22 about that, especially since it may also have

1 implications for how you factor comorbidity of  
2 psychiatric disorders into admissions for  
3 other medical conditions, which may seriously  
4 affect readmission rates.

5 The second question is about, I  
6 believe you had a 12-month continuous  
7 eligibility clause built in prior to the index  
8 issue. While I understand that, because of  
9 claims issues, I am wondering how you factored  
10 in the potential differential impact of  
11 excluding those individuals, given that there  
12 are many factors which could be acuity linked  
13 that would account for discontinuous  
14 eligibility.

15 MS. DRYE: On the psych patients,  
16 it is a relatively small number of patients  
17 coming out of the measure. I am going to have  
18 to look it up. I apologize that I don't have  
19 that number off the top of my head.

20 But, really, is it just patients  
21 who are admitted for an acute psych diagnosis?  
22 There are other psych patients in the measure

1 who come in for medical problems or who come  
2 in for surgeries.

3 And it was just a small number,  
4 really not evenly distributed across  
5 hospitals, that was the concern. Like the  
6 smallest hospitals would code them in  
7 different ways. So, I mean, it would go to a  
8 rehab part or a psych part of the hospital and  
9 not show up in our data.

10 So, I think just given the  
11 Medicare fee-for-service data, it didn't seem  
12 like it would be accounting for it uniformly  
13 across hospitals to include them.

14 I can look for that number for you  
15 in a minute, but I don't want to hold up the  
16 group.

17 MEMBER GHINASSI: And I just  
18 wanted to add, I don't think the statement  
19 that they are usually treated in rehab  
20 facilities or specialized psych hospitals is  
21 accurate.

22 MS. DRYE: Right. Let me pull the

1 information up. Whatever is easiest, I can  
2 probably get it for you at the break.

3 But, again, they are coming in for  
4 primary psychiatric care. If they come in for  
5 something else, then they are in there, and  
6 those are the ones that are usually not at  
7 least spending very much time in acute care  
8 hospitals, if going there at all.

9 And I forget your second question.  
10 Do you mind?

11 MEMBER GHINASSI: You chose a 12-  
12 month --

13 MS. DRYE: Oh, right.

14 MEMBER GHINASSI: -- eligibility  
15 clause prior to the indexed admission.

16 MS. DRYE: Yes.

17 MEMBER GHINASSI: And I wondered  
18 if you had accounted for potential  
19 differential in their discontinuous  
20 eligibility on acuity.

21 MS. DRYE: I don't think we looked  
22 at that specifically for this measure. We



1 looked at it in other measures, but I don't  
2 think we looked specifically at who was  
3 falling out. You know, we had the proportion  
4 of patients falling out, but not their  
5 diagnosis.

6 We could go back and look at that,  
7 if you are interested.

8 MEMBER GHINASSI: I am.

9 CO-CHAIR LAZAR: Okay. Tanya?

10 MEMBER ALTERAS: Just another  
11 quick question. In the surgery/gynecology  
12 cluster, does that include obstetrics?

13 MS. DRYE: No, we did not include  
14 obstetrics in the measure because we built the  
15 measure on patients 65 and older. But when we  
16 tested it on all-payer data, we still didn't  
17 build an obstetrics in that group. In all-  
18 payer data, we used California's all-payer  
19 dataset. But we could. It is just that,  
20 given our development data, it really wasn't  
21 applicable.

22 MEMBER ALTERAS: When you say that

1 you could have something that could happen,  
2 you know, is it feasible to include obstetrics  
3 data?

4 MS. DRYE: I am just saying that,  
5 as measure developers, we are open to  
6 including that in an all-payer-specified  
7 measure, but we really haven't had time to  
8 explore it at all.

9 CO-CHAIR LAZAR: Brent?

10 MEMBER ASPLIN: I wonder if you  
11 could speak to the use of the specialty  
12 cohorts in general. Just a broad question  
13 about that. The rationale cited in the  
14 document was that conditions, "cared for by  
15 the same team of clinicians are expected to  
16 experience similar, added, or reduced low  
17 levels of readmission risk".

18 I understand that the categories  
19 from a claims perspective are mutually-  
20 exclusive, but my guess is that the care  
21 teams, it is going to be much grayer as far as  
22 those different categories when you look at

1 hospitals across the country. And I just  
2 wonder if you can speak to that.

3 MS. DRYE: Yes. When we started,  
4 and we spent a lot of time thinking about it  
5 looking at data about it, what should we do?  
6 One, a model that puts everybody in one cohort  
7 or 150 models? You can kind of find examples  
8 of everything out there.

9 And we were wondering whether we  
10 needed to break up the cohorts quite a bit to  
11 adequately account for the amount of variation  
12 and service mix across hospitals. We can  
13 risk-adjust, but we just didn't know, you  
14 know, like there are specialty surgery  
15 hospitals, all these different types of  
16 hospitals. Do we really need to break the  
17 cohorts up so it would be fairly assessing  
18 hospitals?

19 And actually, we are balancing,  
20 also, consideration of sample size. One thing  
21 great about the hospital-wide measure is you  
22 get a lot of sample size. So, you only need

1 one year of data, and the shrinkage concerns  
2 are not very big. I mean, it is great to have  
3 fewer cohorts to get more sample size. So, we  
4 could share more with you.

5 But, basically, when we looked at  
6 the statistical issues, and it looked like we  
7 could get really good risk adjustment just  
8 with our five cohorts. In the end, we felt  
9 like we have slightly better model performance  
10 if we keep it in five cohorts. Particularly  
11 surgery has a much lower readmission rate, and  
12 we didn't want to blend that in.

13 But the arguments weren't mostly  
14 statistical in the end. I mean, we could have  
15 forced everybody into one cohort. It is just  
16 that we felt that the measure would be more  
17 useful, even though it doesn't approximate  
18 care teams exactly, that's for sure, it would  
19 be more useful to hospitals, and it performs  
20 slightly better statistically to keep it at a  
21 level of five cohorts.

22 CO-CHAIR LAZAR: Okay. Richard?

1                   MEMBER BANKOWITZ: Yes, I want to  
2 ask a question about the decisions regarding  
3 socioeconomic status. You presented in your  
4 technical paper some data about the percentage  
5 of Medicaid patients in the hospital, and it  
6 looked like there were pretty substantial  
7 differences between the low Medicaid hospitals  
8 and those with greater than 30 percent  
9 Medicaid. So, given those differences, why  
10 did you decide not to make that part of the  
11 model?

12                   MS. DRYE: So, this is a really  
13 tough issue. I don't think we know how much  
14 socioeconomic status, you know, what the sort  
15 of cause/effect sequence is between that and  
16 readmission rates. And we don't want to  
17 adjust away differences in socioeconomic  
18 status if it is fair not to, because we want  
19 to elevate disparities. We want this measure  
20 to highlight disparities across hospitals.

21                   If hospital surveying lowers the  
22 SES patients to really lower quality, we want

1 to highlight that. If we adjust for it, we  
2 won't see that difference.

3 So, I think both consistent with  
4 NQF guidelines and with our own philosophy, we  
5 don't want to adjust for SES unless we have to  
6 because it makes that difference invisible.

7 And so, then, when we looked at  
8 these performance differences for SES, we do  
9 see some hospitals with a high proportion of  
10 Medicaid patients doing very, very well in the  
11 measure. And so, we think it is fair to hold  
12 them to a benchmark as a group of sort of an  
13 average hospital. And that was our rationale.

14 MEMBER BANKOWITZ: So, what do you  
15 think accounts for that, the difference you  
16 demonstrated? You did demonstrate quite a  
17 difference? So, what accounts for that? Is  
18 it, do you believe that those hospitals are  
19 systematically biased against Medicaid  
20 patients?

21 MS. DRYE: I personally think it  
22 is a mix of factors, and some of it may be --

1 you know, the part we don't want to hide is  
2 quality, but some of it may be resource  
3 availability, both at the hospital and then  
4 the patient's own support as they transition  
5 from the hospital into the community. But  
6 trying to figure out how much is what, it is  
7 not really -- I mean, we are people who are  
8 doing research; we are thinking about, but we  
9 can't pinpoint it.

10 So, really, again, at this stage  
11 we didn't want to hide those differences. I  
12 think we feel like, if there are hospitals  
13 that are having a hard time doing well on the  
14 measure, the policy answer is not to adjust  
15 away their differences, but it would be to --  
16 and I am getting outside the measure developer  
17 realm -- but it would be to respond to those  
18 hospitals with the support they need to do  
19 better, not sort of give them a different  
20 measure result.

21 MEMBER BANKOWITZ: Yes, I guess it  
22 really depends on the cause of that

1 difference, which I think at this point is  
2 pretty much unknown.

3 CO-CHAIR LAZAR: We just want to  
4 give everybody a little bit of a process check  
5 in terms of the time. And also, just remember  
6 that the questions for the developer are  
7 really on the technical, should be really more  
8 on the technical nature. We are starting to  
9 edge toward the issue of debate around the  
10 measures. And obviously, we have got a  
11 specific format for that.

12 So, we notice a number of hands  
13 are up. We would just ask you to please keep  
14 those specific to technical questions that the  
15 developer needs to answer. We will have  
16 plenty of time to express opinion on the  
17 measure.

18 So, I think, Mark, you were next,  
19 and then we will just try to close out the  
20 rest of them and then move on.

21 MEMBER SCHUSTER: Thanks.

22 So, I was wondering, I couldn't



1 find in there how you picked the five service  
2 lines that you focused on. But, then, more  
3 importantly, it seemed like you were saying in  
4 the materials that the risk-adjustment  
5 variables were forced to be identical for all  
6 five. And I realize that makes it easier to  
7 present to the outside world, but I could see  
8 ways in which the risk-adjustment variables  
9 might be appropriately different across the  
10 five.

11 And as a part of that, some  
12 adjustment variables that sort of acted one  
13 way once and one way another time were just  
14 dropped, when that may be exactly the kind of  
15 variable you want to include if it is  
16 different in the way it acts when different  
17 service lines.

18 So, if you could help me  
19 understand better the risk-adjustment process,  
20 that would be great.

21 MS. DRYE: Okay. Sure.

22 So, we used AHRQ's condition

1 categories to group patients into condition  
2 and procedure categories, into condition and  
3 procedures. And we started by doing a giant  
4 spreadsheet where we looked at how all the  
5 risk variables that we typically used -- we  
6 used a different grouper to group ICD-9 codes  
7 into risk adjusters.

8 But, anyway, we looked at how  
9 those typical variables, when used in other  
10 outcome measures, related, just like you are  
11 saying. What we saw was a lot of uniformity.

12 We are trying to balance -- I  
13 mean, there were some variables that just  
14 looked really, that didn't seem to be heading  
15 in a way that we would think made clinical  
16 sense at all. And some of them we just took  
17 out as potential risk adjusters. We had so  
18 many risk adjusters that we had a lot of  
19 stronger, consistent risk adjusters to choose  
20 from.

21 And we were trying to balance,  
22 again, for usability. It wasn't so much more

1 for complexity. But if you are going to do  
2 this measure, you need to collect data on the  
3 risk adjusters, and maybe eventually out of  
4 electronic records. We just sort of wanted to  
5 get down to some reasonable set.

6 When we looked at the ones that we  
7 ended up with across the five cohorts,  
8 surgical, medical, et cetera, they behaved  
9 similarly. I mean, sorry, let me back up.

10 They all were effective as a group  
11 in risk-adjusting. Because we fit the models  
12 individually, so we take those risk adjusters,  
13 but we allow them to go in different  
14 directions, depending on what the outcome is,  
15 because we fit five different models. So, we  
16 used the same comorbidities, but the value of  
17 the beta-coefficient and the risk adjustment  
18 varies depending on its relationship to the  
19 outcome in that cohort.

20 CO-CHAIR LAZAR: Okay. Jeff, we  
21 will make this the last one. I know there are  
22 some others that are up, but we are starting

1 to run tight on time. We suspect a lot of  
2 this will come forward during the subsequent  
3 discussion.

4 So, Jeff, if we can make it a  
5 quick question, then we will move on after  
6 that.

7 MEMBER GREENWALD: I hope this is  
8 quick, at the risk of another slight Pandora's  
9 box.

10 I was very pleased to see an  
11 attempt to remove planned readmissions from  
12 your measure. That was very nice.

13 The methodology for it, however,  
14 was less transparent to me. And I wondered if  
15 you could comment more on the methodology for  
16 how you determined and how valid that has been  
17 shown to be, because I couldn't find that, in  
18 terms of identifying a readmission that was  
19 planned?

20 MS. DRYE: Okay. So, we started  
21 with conceptually just that, essentially,  
22 procedures and routine chemotherapy and rehab

1 are planned and almost nothing else is. And  
2 so, that was conceptually one leap that we  
3 made.

4 And the other is admissions -- in  
5 this case, we are thinking about readmissions  
6 -- for any acute diagnosis, like an actual MI  
7 or sepsis, those things are unplanned. Then,  
8 we used those two considerations and we looked  
9 at, given our data, what are people being  
10 readmitted for? What procedures are they  
11 being readmitted for? And we pulled those out  
12 and we looked at the conditions associated  
13 with those procedures.

14 So, this is a multi-step process.  
15 It is a little complicated, but we tried to  
16 write it out very carefully in our technical  
17 report.

18 So, we took the common procedures  
19 -- I think there are about 30 or more -- and  
20 then we looked at the acute conditions, and if  
21 those acute conditions -- from the acute  
22 condition, or, sorry, the diagnosis associated

1 with the procedures, we decided whether that  
2 was an acute or non-acute. Let me just give  
3 you an example.

4 If you are getting a gallbladder  
5 removal and you are admitted for sepsis, we  
6 are not going to call that planned. But if  
7 you are getting a gallbladder removal and your  
8 diagnosis is cholestasis or something, that is  
9 planned. If you are getting a PCI and you  
10 have coronary artery disease, that is planned.  
11 But if you have an acute arrhythmia, that may  
12 not be planned, if you are having an MI, that  
13 is not planned.

14 So, the framework we came up with,  
15 which we try to be very transparent about it,  
16 pairs procedures with diagnoses. And the ones  
17 that we addressed were the ones that appeared  
18 in the data.

19 I would just add that we did put  
20 the measure out for public comment briefly.  
21 We got some comments and revised it, and we  
22 are actually in a process now of just

1 consulting one more time with surgeons from  
2 specialty societies on these calls, because we  
3 want them to be as sort of well-vetted and  
4 transparent as possible.

5 MEMBER GREENWALD: Yes, I think  
6 this has a lot of gut validity and makes sense  
7 from the description that you provide. I just  
8 wonder, have you done any analysis to see, if  
9 you eliminate that concept, how that affects  
10 the model of planned? Because there is,  
11 obviously, some squishiness in these gut valid  
12 processes that are sort of judgment-based like  
13 that.

14 MS. DRYE: Maybe I can come back  
15 to the Committee with a little more detail on  
16 this, if you need it, because I am not sure I  
17 can think of analysis that is addressing the  
18 squishiness factor per se.

19 So, we looked at who falls out and  
20 what percentage, and do those percentages make  
21 sense. But I am not sure that gets totally at  
22 your question.

1 CO-CHAIR LAZAR: Okay. Good. We  
2 will move on now to reliability and validity.

3 Taroon, you will take us through,  
4 and then Sherrie is going to make some  
5 comments as well.

6 CO-CHAIR KAPLAN: I will go first  
7 because, as a psychometrician, forgive me if  
8 I am insulting anybody in the room, but people  
9 often confound and confuse reliability and  
10 validity.

11 So, reliability is precision. It  
12 is the replication over and over again of  
13 this; if you did it a bunch of different ways  
14 or if you did it over time with the same  
15 measure, would you get, more or less, the same  
16 answer?

17 I love my bathroom scale because  
18 my bathroom scale tells me the same, exact  
19 answer every day. It is completely wrong, but  
20 it tells me the same, exact answer.

21 (Laughter.)

22 So, that is reliability.



1                   Validity is accuracy. Are you  
2                   measuring what you think you are measuring?  
3                   So, just remember that reproducibility is  
4                   reliability, and accuracy is validity.

5                   MR. AMIN: That was a great  
6                   introduction, Sherrie.

7                   I am just going to talk through  
8                   the various components of reliability and  
9                   validity that we are asking the Committee to  
10                  consider.

11                  And procedurally, one of the  
12                  things that I would recommend to the  
13                  Committee, this would be the time to sort of  
14                  focus the discussion internally. If there are  
15                  further questions of the developers, those are  
16                  appropriate. But this is really the time for  
17                  you, as the Committee, to come to some  
18                  consensus on the information that was  
19                  presented in the measure. And, really, the  
20                  evaluation of the measure is on what was  
21                  presented to you in the measure packets.

22                  So, as we look at reliability and

1 validity, we are really looking to assess the  
2 precise specifications, how precise the  
3 specifications are, and the extent of the  
4 reliability testing, either at the data-  
5 element or the measure-score level. And as we  
6 move to voting, where you really would  
7 evaluate a measure as high is whether they  
8 actually evaluated the data elements and the  
9 measure score.

10 Looking at the validity, we are  
11 really looking to see if the specifications  
12 are consistent with the evidence, the extent  
13 of the validity testing at the data-element  
14 level or at the measure-score level -- again,  
15 if the developer has actually demonstrated  
16 both, that would be rated high -- the  
17 justification for the exclusions, the risk  
18 adjustment, and whether it is identifying  
19 differences in performance.

20 Some things to keep in mind as we  
21 are evaluating the testing is -- on the next  
22 slide -- was the appropriate method used to

1 consider the level, the data source, the  
2 conceptual relationships, and the scope of the  
3 testing, whether it was accurate -- or  
4 adequate? And are the results within the  
5 accepted norms?

6           Actually, if we could go back,  
7 that would help sort of get the discussion  
8 started.

9           So, I will turn it back to the  
10 Committee Chairs on the preliminary  
11 evaluations and anywhere else you would like  
12 to take the group.

13           CO-CHAIR LAZAR: Okay.

14           MR. AMIN: To the process check,  
15 just quickly, we were set to end this session  
16 at around 12:00, but feel free to take a  
17 little bit more time, if you would like to do  
18 that.

19           CO-CHAIR LAZAR: Okay, let's open  
20 the floor for discussion on scientific  
21 acceptability.

22           CO-CHAIR KAPLAN: Why don't we

1 march through with reliability first and then  
2 go to --

3 MR. AMIN: Yes, and they will be  
4 voted on separately.

5 CO-CHAIR KAPLAN: Yes. So, do you  
6 want to start? Let's start with reliability.  
7 So, precision, replication, reproducibility.

8 MEMBER JHA: I think it is  
9 excellent. I have no concerns based on any of  
10 the stuff that has been submitted that there  
11 are any issues with reliability of the data,  
12 of the measure.

13 CO-CHAIR LAZAR: Bruce?

14 MEMBER HALL: I think the measure  
15 as specified is very reproducible; it is  
16 impressively so. But I am not sure that that  
17 satisfies my concerns about whether we are  
18 reliably learning what we think we are  
19 learning from this specification. But I think  
20 reproducibility is amazingly high.

21 CO-CHAIR LAZAR: Okay. Does  
22 anybody feel differently?

1 (No response.)

2 Okay. So, should we move to the  
3 topic of validity? Who would like to open the  
4 discussion?

5 MEMBER HALL: Well, I will. This  
6 is a major concern. I know, in my mind,  
7 validity really derives from the  
8 specification, from of the methods.

9 And this group does impeccable  
10 work of the highest quality. As a measure  
11 developer, wearing a measure developer hat, I  
12 look at every decision and I say that was  
13 rational and that is the same decision I would  
14 have made.

15 But, sitting here as a patient  
16 advocate, with that hat on, again, my overall,  
17 big-picture concern is, are we really learning  
18 what we think we are learning here? I have a  
19 long list of specific questions that I feel  
20 affect the validity of whether we are learning  
21 what we are learning.

22 One is I am still not sure of what

1 actual time horizon is being specified.

2 Two, the discussion we just had  
3 about whether the planned algorithm is working  
4 as proposed is a concern.

5 Three, technically, the approach  
6 to calculating a geometric mean on the  
7 individual model results has some advantages  
8 and disadvantages to it.

9 Fourth, the definition of cohorts,  
10 again, as a measure developer, I say that is  
11 exactly the same decision I would make. But  
12 when I look at the cohorts, I see several  
13 conditions that are listed as both medical and  
14 surgical. Looking at the medical cohort, I  
15 see fractures. Looking at the surgical  
16 cohort, I see things that I, as a surgeon,  
17 don't consider surgical disease.

18 And I am amazed that the cohorts  
19 functioned statistically as well as they did.  
20 I mean, as a closet statistician/economist, I  
21 am thrilled that they did, but I am amazed  
22 that they did. Because when I look at the

1 condition lists, I can't believe that that  
2 fell out, that those advantages fell out.

3 So, again, to back up to the big  
4 picture, I think the work of this group is  
5 amazing. I think I would have made all of the  
6 same decisions. But, as a patient advocate,  
7 I am concerned that several of these issues  
8 are not resolved.

9 CO-CHAIR LAZAR: Okay. Other  
10 comments?

11 MEMBER JHA: So, I guess I made  
12 some of my points a bit earlier. But I will  
13 just say I want to echo a lot of what Bruce  
14 said about the quality of the thinking that  
15 went into the decisions I think that the  
16 measure developer made.

17 On almost all of the specific  
18 aspects of validity, approaching risk  
19 adjustment, whom to exclude, validity testing,  
20 I think it is actually pretty terrific, and  
21 they have done really an outstanding job.

22 To me, the fundamental issue

1 is -- I shouldn't say "the fundamental issue";  
2 that overblows it -- but the place where I get  
3 stuck is at the hierarchical model and the way  
4 it deals with a large number of hospitals. It  
5 essentially gives us a number for that  
6 hospital that, in my mind, is not a true  
7 representation of what is happening in that  
8 hospital.

9           And so, you can have a small  
10 hospital with a couple hundred of patients and  
11 the model will predict out that their  
12 readmission rate is 12 percent. But much of  
13 that data comes from the national average and  
14 not what that hospital actually did.

15           And so, from a validity point of  
16 view, I think it raises real concerns. That  
17 is the place where I think it leads us awry in  
18 terms of both as a quality improvement tool  
19 and, much more importantly, as a tool that  
20 consumers can actually make sense of.

21           CO-CHAIR KAPLAN: Can I follow up  
22 with you, Ashish? How would you know what the



1 hospital really did? The problem with  
2 validity is, if you don't have criterion  
3 validity, you don't have something out there  
4 that is the true answer, then you are kind of  
5 in trouble. You get construct validity, which  
6 that it overlaps with some other  
7 characteristic of the hospital like volume or  
8 something else. And then, you are  
9 confounding; you are in kind of a continuously  
10 confounding of the problem. So, how do you  
11 know what the hospital actually did?

12 MEMBER JHA: So, that is a great  
13 question, to which I obviously don't have an  
14 answer that is easy.

15 But I guess, if you are stuck  
16 trying to make choices around this without a  
17 clear gold standard, it seems to me that this  
18 is why we have estimates based on the data  
19 with confidence intervals. So, you can say  
20 for this hospital that was small their  
21 readmission rate was 20 percent, and our 95  
22 percent confidence interval is 10 to 40, big,

1 but that is all the precision the data give  
2 you.

3 And you are now letting the data  
4 completely drive. So, that really is what the  
5 hospital did. There really was a 20 percent  
6 readmission rate.

7 Based on the risk-standardized  
8 hierarchical model, as I understand it, a  
9 hospital that gets a number of 20 percent  
10 didn't actually have 2 out of every 10  
11 patients get readmitted. That is what the  
12 model predicts, based on the choices that have  
13 gone into the modeling.

14 And so, if you are stuck on this  
15 issue, my inclination is just be as  
16 transparent as possible with the data, and be  
17 as circumspect as possible about the precision  
18 of that.

19 CO-CHAIR KAPLAN: Okay. I think  
20 we just, again, are moving precision and  
21 validity back and forth over some kind of  
22 transom. So, you want to make sure -- I

1 understand heterogeneity and confidence  
2 intervals, but, again, validity is about  
3 something that we have to demonstrate that is  
4 related to something else that is truly  
5 related or some criterion that we know for  
6 sure measures the overall hospital quality  
7 with respect to readmissions.

8 So, I have one question to the  
9 group. How many of you have actually done  
10 risk specification modeling?

11 (Show of hands.)

12 Okay. How many of you have no  
13 clue what we have been talking about for a lot  
14 of these shrinkage estimators and risk  
15 specification or at least they know the  
16 principles, but truly how many of you would  
17 like a little more English version of this?

18 (Show of hands.)

19 Okay. Brave souls.

20 So, I would just like to ask us to  
21 now, are there any other validity issues that  
22 you all have concerns about? Because risk

1 stratification, risk adjustment, and that sort  
2 of thing strikes me as something that came up  
3 in the last round of discussions a lot. Are  
4 there any other burning questions of the other  
5 six criteria other than risk specification  
6 that people are concerned about?

7 MEMBER LANGBERG: Since I raised  
8 my hand as a brave soul, I am not sure this  
9 applies here. But in looking at the  
10 submission, under validity, the submission  
11 included, I think, three assumed-to-be-related  
12 measures of quality or performance that  
13 validate, I think, or attempt to validate,  
14 this question we have just been discussing.  
15 There are the HCAPS scores, the Thomson  
16 Reuters top 100 hospitals, and the Joint  
17 Commission's top performers, and key quality  
18 measures programs. Those are offered, I  
19 think, as validity of the outcome of the work  
20 if it is connected to those in some way.

21 I am just a little mystified  
22 myself since some of these things are black

1 boxes in terms of how they are created. And  
2 there are hospitals, I would expect, not to be  
3 on there that are on there, hospitals that are  
4 not on there that should be on there. And it  
5 was mystifying to me that those were  
6 identified as the standard by which the  
7 validity was being compared, if I understood  
8 that correct.

9 CO-CHAIR KAPLAN: Is that a  
10 question? Well, what else would you have  
11 offered?

12 MEMBER LANGBERG: I think that is  
13 a really good question. I am sure we can all  
14 get that question. Virtually, everything is  
15 being asked. I haven't thought about that  
16 because I didn't get at the validity of the  
17 whole metric anyway. And that is not my  
18 expertise.

19 So, I wish I could offer a  
20 constructive comparison. I don't know that  
21 those three are. That I can't offer a  
22 suggestion by itself does not validate or

1 invalidate the observation.

2 CO-CHAIR KAPLAN: Sure.

3 Absolutely.

4 Does anybody else have some  
5 criterion that they could propose as possible  
6 validity variables, other than those in HCAPs  
7 and Reuters and the other one?

8 MEMBER HALL: I mean, there is a  
9 quandary here because what is being put  
10 forward is better than anything we have. So,  
11 to compare ourselves to other things that we  
12 don't think can do what we are proposing to do  
13 as well as we do, it is, you know, we are  
14 chasing tails. So, I don't know that there is  
15 an answer. I don't know that there is a  
16 resolution to trying to find some gold  
17 standard when there isn't one.

18 MS. PACE: I will just offer a  
19 comment in regards to our criteria about  
20 testing and validity testing. Actually, this  
21 is more validity testing than we often see  
22 with measures submitted to NQF because we

1 still allow some face validity as a  
2 consideration for NQF measures.

3 But, in general, validity testing,  
4 there is usually not one definitive validity  
5 test. Validity testing is usually very  
6 conceptual and is built over time, and you  
7 look for consistency of results.

8 And so, ideally, you would like to  
9 have a gold standard that you could say, yes,  
10 we have another valid measure of quality that  
11 we know is a measure of quality, and we can  
12 compare this new measure to it. We just don't  
13 typically have those in this field of quality  
14 performance measures.

15 So, I think part of this is you,  
16 as experts in the area, to understand these  
17 conceptual relationships, and I think it is  
18 definitely a good question that we don't  
19 necessarily know how those other measures were  
20 built. But I think it is looking at this not  
21 as there's going to be any one definitive  
22 answer for the validity.

1                   And, Sherrie, you may want to add  
2                   to that.

3                   MEMBER GHINASSI:   So, I want to be  
4                   clear.  For this part of the discussion, were  
5                   you excluding as part of the validity the risk  
6                   adjustment or is that still on the table?

7                   CO-CHAIR KAPLAN:  No, I was  
8                   proposing that we come back, that we focus on  
9                   risk adjustment, but if anybody has any other  
10                  issues in the one, two, three, five, and six  
11                  categories, we should discuss those as well,  
12                  and finish off with maybe a little bit, if  
13                  possible, a little bit longer discussion, a  
14                  more robust discussion of risk adjustment.

15                  MEMBER ALTERAS:  I just wanted to  
16                  ask if, when we are talking about risk  
17                  adjustment, we group it with the  
18                  identification differences in performance.  I  
19                  think in this case they are very closely-  
20                  linked.

21                  CO-CHAIR KAPLAN:  Right.  That is  
22                  a good suggestion.



1                   So, does anybody else have issues  
2 with the validity testing, and whatever?

3                   MEMBER KELLY HALL: I just had a  
4 question with regard to justification of the  
5 exclusions. Does that relate to any time of  
6 a patient preference or is that included as  
7 well? For instance, advance directives where  
8 all extraordinary measures would be taken, and  
9 the patient might be readmitted based on that  
10 preference from a palliative care setting or  
11 another setting?

12                  CO-CHAIR LAZAR: Any other  
13 comments? Mark?

14                  MEMBER SCHUSTER: Yes, I mean,  
15 just because the CAPS example was brought up,  
16 when I read that, I didn't know how to  
17 interpret it because a lot of those people I  
18 think would have been filling out the CAPS  
19 survey after the readmission, based on the 30-  
20 day readmission time point and the range of  
21 time when CAPS surveys were filled out.

22                   So, it seems very predictable

1 that, if you are filling out a survey on an  
2 admission and, then, in the interim you have  
3 had yet another admission, your experience  
4 ratings are going to go down. So, I wasn't  
5 sure what methodology was used and if you  
6 excluded people who filled out CAPS surveys  
7 after that readmission, but it seemed like  
8 almost an intentional setup to get the desired  
9 result.

10 MEMBER HALL: I guess, with  
11 respect to your question about what other  
12 issues are on the table, I do think I would  
13 like some clarity on the time horizon, the  
14 implications of using a geometric mean  
15 calculation with potential differential  
16 variance of each of the components, and some  
17 clarity about the definition of cohorts,  
18 because many of the conditions seem to be  
19 represented repeatedly.

20 CO-CHAIR LAZAR: Okay. Other  
21 comments on either reliability or validity?

22 CO-CHAIR KAPLAN: Apart from risk-

1 based.

2 CO-CHAIR LAZAR: Right, other than  
3 risk?

4 (No response.)

5 Okay. Taroon, hearing nothing  
6 further, is this the time to vote on  
7 scientific acceptability?

8 MR. AMIN: So, what we will do,  
9 actually, because the further discussion  
10 around risk adjustment is yet to be had --

11 CO-CHAIR LAZAR: Okay.

12 MR. AMIN: So, what we could do  
13 is, if the Chairs are okay with this, we can  
14 go to public and member comment, then break,  
15 and come back at 12:30 for the risk-adjustment  
16 discussion, and finish up with usability and  
17 feasibility before the lunch break.

18 CO-CHAIR LAZAR: Okay. Everybody  
19 agree? Okay. Terrific.

20 MR. AMIN: So, Nicole, if you can  
21 open up the lines for any public or member  
22 comments?

1 OPERATOR: Certainly. That is \*1  
2 for any public comment at this time.

3 (No response.)

4 MR. AMIN: Any comments from  
5 members?

6 (No response.)

7 CO-CHAIR LAZAR: Comments from  
8 anybody else in the room?

9 (No response.)

10 CO-CHAIR KAPLAN: Okay. So, we  
11 have a 15-minute break, and then we are going  
12 to come back and discuss risk adjustment and  
13 then usefulness and feasibility.

14 (Whereupon, the above-entitled  
15 matter went off the record at 12:01 p.m. and  
16 resumed at 12:16 p.m.)

17 MEMBER GHINASSI: Yes, just a  
18 couple and I'll be brief. I didn't see it.  
19 It might be there. But some of the issues  
20 that I think might effect the level playing  
21 field because I think at the end of the day,  
22 that's probably the most --

1 CO-CHAIR KAPLAN: Right.

2 MEMBER GHINASSI: -- one of the  
3 most important variables here because if  
4 quality of care is going to be improved, it  
5 has to be not only timely but it has to be  
6 valid in that sense.

7 But I don't see any way to, at  
8 this point, account for differences in  
9 locally, regionally, by state, or nationally,  
10 in differential ability of that region to  
11 provide timely and quality follow-up care. So  
12 access issues following inpatient care, how  
13 long the wait is for the next level of  
14 treatment, whether or not that's a regional  
15 variable that is differentially impacting  
16 people, I think it's a fact. I don't see that  
17 built into the model at all.

18 So if you're looking at rural  
19 North Dakota how does that compare to inner  
20 city D.C.? How does that compare to Memphis?  
21 And since they're not using ambulatory care  
22 claims, I don't see any way to adjust for

1 that.

2           Second, I don't see -- it's been  
3 raised by several but I don't see any  
4 adjustments currently for patient variables  
5 that are not diagnostic codes. So issues  
6 around homelessness, domestic violence, issues  
7 that are going to effect the ability to follow  
8 through, childcare issues that are going to  
9 effect transfers from people getting from home  
10 to an ambulatory care treatment when they've  
11 got two kids to worry about and have to do a  
12 bus transfer.

13           These are intangibles but I've  
14 been in hospital systems for almost 30 years  
15 and know that these drive ability for people  
16 to follow up for care. And not followed up  
17 care often effects inpatient.

18           The other thing I'm not sure how  
19 they're adjusting for was specified in one of  
20 the other measures that we'll get to, I didn't  
21 see it in this one -- transfers between  
22 hospitals occur fairly regularly. It is rare

1 that you see a transfer go from a -- how can  
2 I put this -- from a hospital that's likely to  
3 be dealing with more high acuity patients to  
4 hospitals where there was more acuity.

5 It appears, from my experience, it  
6 is always in the other direction. That lower  
7 acuity, community-based sometimes facilities,  
8 will transfer cases mid-treatment that are  
9 going wrong to facilities that are more known  
10 for specialty care.

11 And yet I believe the readmission  
12 model only accounts for the receiving  
13 hospitals' performance, not the sendings'.  
14 And I don't see that built in anywhere.

15 I'll stop at that.

16 CO-CHAIR KAPLAN: So I would  
17 actually like Elizabeth and then Karen to talk  
18 about adjusting a way versus, you know, making  
19 a level playing field -- adjusting the way the  
20 variants you're trying to explain in terms of  
21 some of these issues like, for example, the  
22 safety net hospitals are for tertiary care

1 facilities versus assuming that what you get  
2 is what you treat. And you should be doing a  
3 good job.

4 MS. PACE: I'll talk a little bit  
5 about, in general, the NQF criteria regarding  
6 risk factors. And we really do not recommend  
7 that factors that are generally associated  
8 with disparities in care, such as race,  
9 ethnicity, and socioeconomic status or  
10 Medicaid as a marker for socioeconomic status,  
11 be included in risk models. That's our  
12 general approach.

13 If they are included, they have to  
14 be strongly supported in terms of analysis to  
15 be included. And the general philosophy about  
16 that is that if you include them in the risk  
17 model, you're kind of accepting the assumption  
18 that outcomes should be different based on  
19 those factors.

20 And so what we're trying to do  
21 with risk adjustment is to account for  
22 variability in the patients' conditions as



1 they present to the provider that's giving  
2 care, whether it's a hospital or physician, or  
3 health plan.

4 Some of the other things you  
5 mentioned about homelessness and, you know,  
6 you could add patient education and those  
7 kinds of things, certainly they would be fair  
8 game for risk models. The problem that we  
9 often run into is the balancing the burden of  
10 data collection with risk models.

11 And so a lot of times we don't  
12 have that information in a systematic way  
13 available for these various types of risk  
14 models. So that's always kind of, you know,  
15 a waiting thing in terms of balancing what  
16 data you have with what you are able to do  
17 with risk models.

18 The other thing that I'll just  
19 mention that Elizabeth talked about earlier is  
20 that when you are doing risk adjustment or  
21 risk models, you're not trying to -- it's not  
22 like a model where you are trying to identify

1 every factor that influences the outcome  
2 because we're actually trying to separate out  
3 the things that the patient comes with  
4 hopefully then differences in quality of care.

5 So, you know, we could include a  
6 lot of other things in the model, which you  
7 would have a better predictive model. But  
8 that's not what we're doing with risk  
9 adjustment in these various risk models.

10 So, you know, risk adjustment is  
11 not a perfect science. I don't know that it  
12 ever will be. But, you know, these are all  
13 things that need to be weighed. And it's not  
14 just statistical questions. A lot of it is,  
15 you know, conceptual relationships and what  
16 we're trying to make distinctions about.

17 In terms of the question about  
18 area resources, I'll make a comment. And then  
19 you guys certainly chime in and make any other  
20 comments here. But so if you're -- you were  
21 mentioning resources in different geographic  
22 areas, if people are going to be, you know,

1 looking at Hospital Compare, for example, most  
2 of the times they are going to be doing a  
3 comparison of hospitals within their  
4 geographic areas.

5 So even though you may have  
6 comparison to a national standard or a state  
7 average, in terms of using this, most of the  
8 time it would be done on a geographic area.  
9 So some of that will play in a geographic  
10 area.

11 But the other this is about -- as  
12 I mentioned earlier about these readmission  
13 measures, they really are seen as driving more  
14 coordination and collaboration of care. And  
15 so they are really purposefully not trying to  
16 isolate only the hospital because part of what  
17 they are trying to do is drive hospitals to  
18 help with transitions.

19 And if those things aren't at play  
20 in a particular community, then those kinds of  
21 collaborations need to be developed in order  
22 to really make an impact on readmission. So,

1 you know, there's a lot of different things  
2 that play here in terms of what the measures  
3 are trying to drive and the realities of data  
4 and what we're trying to do with risk  
5 adjustment.

6 But that's probably more than you  
7 wanted. But I'll stop and see if you guys  
8 want to add anything else.

9 CO-CHAIR KAPLAN: Let me just  
10 interject and ask Elizabeth if there's -- I  
11 mean it is my understanding that you are  
12 adjusting for disparity, the index condition,  
13 and also for comorbidities. So to the extent  
14 that those absorb a lot of this other  
15 variability, they're already in your risk  
16 model.

17 Is there anything else you want to  
18 add to that?

19 MS. HORWITZ: No, that's actually  
20 what we would have said. They are precisely  
21 the reasons that we elected not to adjust for  
22 either of those conditions.

1                   MEMBER GHINASSI: Just one follow-  
2 up statement. I just want to reiterate that  
3 I believe that while comorbidity is essential  
4 and that an adjustment for that is clearly a  
5 great idea, I think that the amount of  
6 variance accounted for by factors that are not  
7 included in the comorbidity lists may drive  
8 far more of the variance that we'd like to  
9 acknowledge in this case.

10                   And to leave it off the table  
11 because it is a burden is tempting. And as a  
12 provider, trust me, I understand about the  
13 burdens of new mandates for measurement, at  
14 the same time, I just want to caution all of  
15 us to remember that leaving certain things off  
16 the table leave us with an easier-to-measure  
17 product of questionable validity, much like  
18 your bathroom scale.

19                   MS. PACE: I totally agree. And  
20 remember that every variable you include in  
21 the risk adjustment level also has to be  
22 subjected to reliability and validity evidence

1 in order to make the case for including it.  
2 And a lot of times those variables have really  
3 incomplete evidence to put it generously.

4 MEMBER BANKOWITZ: I wanted to  
5 agree with Frank on this issue of the fact  
6 that complex suicidal factors can really  
7 impact the readmission rate. And I agree with  
8 the aspiration to have equity. I also agree  
9 we need to push hospitals to have better  
10 coordinated care. I don't disagree with that.

11 But I don't think it is quite as  
12 simple as saying well, we aspire to equity so  
13 therefore we won't look at socioeconomic  
14 status because we know that factors like  
15 healthcare literacy, access to care, the  
16 complicated lives of the dual-eligibles, also  
17 even things like access to healthy food and  
18 access to healthy playgrounds, these are all  
19 important.

20 And I don't think we can simply  
21 say well they are important. They might, in  
22 fact, influence the readmission rate but we

1 were not going to look at them because we want  
2 to highlight disparities.

3 This is not a measure of  
4 disparity. This is a measure of quality. At  
5 least that's what we said at the beginning.  
6 And the stakes are quite high here. We are  
7 going to direct consumers, based upon public  
8 reporting, and we're going to redirect  
9 resources, based on payment, to these  
10 hospitals.

11 And I don't think we should start  
12 off with the assumption that well, there are  
13 differences between the hospitals who have  
14 high Medicaid populations. It must be a  
15 quality issue.

16 No, I think we should say look,  
17 there are complex issues at play. If we're  
18 going redirect resources, we'd better get it  
19 right. Why do we want to withhold resources  
20 from those hospitals that may need the most?

21 So I think we need to pay some  
22 attention to this assumption about being sort

1 of blind with regard to socioeconomic status  
2 in this particular issue, which is a very  
3 complicated social issue as well as a health  
4 issue.

5 MEMBER GLANCE: So I generally  
6 agree with all of the comments that are being  
7 right now. It's not at all clear to me how  
8 much of readmission is being driven by  
9 admission diagnoses versus comorbidities  
10 versus some of the SES factors that we're  
11 talking about.

12 And although I generally agree  
13 with Karen's comment that in many of the risk-  
14 adjusted quality metrics that we use, SES  
15 should not be incorporated into those models.  
16 For example, for mortality models, you know,  
17 we can collect some pretty good data on  
18 comorbidities. And comorbidities and  
19 admission diagnosis and quality is what drives  
20 mortality.

21 Now for readmission, it is a  
22 little bit different. For readmission, yes,



1 comorbidity and submission diagnoses drive  
2 readmission. But also SES, what happens in  
3 the community access things.

4 And what I haven't really seen  
5 here is a discussion of the relative  
6 importance of those various factors driving  
7 readmission. And if, in fact, access and SES  
8 are incredibly important factors, maybe they  
9 do need to be included in these models despite  
10 the data collection burden that we're  
11 discussing.

12 MEMBER FOLTZ: I'm going to join  
13 the bandwagon here. Harborview is a safety  
14 net hospital and a tertiary center. And one  
15 thing, by excluding the socioeconomic factors,  
16 I think we may see unintended consequence of  
17 cherry picking.

18 I mean we've certainly seen it in  
19 the past where hospitals refer patients or  
20 transfer them to public hospitals or tertiary  
21 hospitals. And they're not the commercial  
22 payers I'll tell you that.

1 CO-CHAIR LAZAR: (Speaking from an  
2 unmiked location) Let me just see if we can  
3 sum this discussion of SES up. And I think,  
4 Karen -- with you before we have further  
5 consideration.

6 Is there anybody who feels -- oh,  
7 I'm sorry -- is there anybody who feels  
8 strongly that SES should not be included in a  
9 proposed all-costs readmission measure?

10 Ashish?

11 MEMBER JHA: So we've done a lot  
12 of empirical work. My research group has done  
13 a lot of empirical work on this. And the  
14 empirical work is overwhelming that safety net  
15 hospitals have much higher readmission rates,  
16 that African Americans have higher readmission  
17 rates than whites, and that white patients who  
18 are in predominantly minority-serving  
19 institutions have high readmission rates than  
20 black patients in non-minority serving  
21 hospitals.

22 So that seems to be a funny

1 prologue to saying why we should not include  
2 this. But let me kind of make the point --

3 PARTICIPANT: I'm on the edge of  
4 my seat.

5 MEMBER JHA: -- or I'm about to  
6 give you something completely illogical. But  
7 it sort of goes back to whether you think this  
8 is a good quality measure or not.

9 If you fundamentally believe that  
10 readmissions are a good way to measure  
11 quality, they're a good way to measure an  
12 important health outcome, then I think there  
13 is no way we can justify including SES because  
14 basically what you're saying is it is okay  
15 you're lousy. You just take care of poor  
16 people. And that's not, I think, where we  
17 want to go.

18 I think the tension here and the  
19 reason why a lot of us are struggling with  
20 this is because we all believe -- I shouldn't  
21 say this -- some of us might believe that at  
22 the end of the day this is not a great measure

1 of health outcome or quality for the hospital.

2 And that factors outside of the  
3 hospitals' control are driving so much of why  
4 people get readmitted. And the socioeconomic  
5 status of your patient population is such a  
6 major driver that it sort of fundamentally  
7 gets back to do you really believe this is an  
8 important quality measure.

9 But I don't want to re-litigate  
10 that because we've already concluded and  
11 voted, I think, 18 to 1 or 19 to 1 that it is.  
12 So I think once we've made that decision, it's  
13 hard, in my mind, to justify then including  
14 socioeconomic status if at all.

15 MS. DRYE: Hi. I just wanted to  
16 make one more technical point that -- on  
17 Karen's construct, which is the alternative.  
18 There's an alternative.

19 I'm not recommending it at all  
20 because we do see a whole range of performance  
21 across hospitals with a high proportion of low  
22 SES patients. But an alternative to risk

1 adjusting is to stratify your population into  
2 hospitals with a lot of low SES and hospitals  
3 that don't have a lot of low SES patients, for  
4 example. There's no clear-out put.

5 Imagine that you could make one.  
6 So then you really would exclusively be  
7 holding those hospitals with more low SES  
8 patients to a different standard potentially.  
9 And -- but you wouldn't be burying their  
10 difference in a risk adjustment variable.

11 And I just wanted to say that is  
12 the NQF guidance, that if there's really  
13 differences for whatever policy, fairness,  
14 philosophical reasons, you note them and you  
15 don't think that it is fair to report without  
16 adjusting them, it's not that you adjust --  
17 you would stratify the measure.

18 CO-CHAIR LAZAR: Okay. We have a  
19 number of other comments. So we're back to  
20 front.

21 Brent?

22 MEMBER ASPLIN: Well, I just would

1 ask -- didn't you answer you own question  
2 though about why there would be an exception  
3 because I think you laid it out very nicely.  
4 And why you would normally not want to include  
5 this.

6 But I thought you answered -- you  
7 gave the justification for why we would  
8 include it this time because it is -- we're  
9 saying yes, it is a quality measure. It is a  
10 quality measure of the system that happens to  
11 be focused on one aspect of the system, which  
12 is the hospital.

13 And there's the crux of the  
14 matter. And that's why we would normally not  
15 include. There is a reason why we need to  
16 include it this time.

17 So I don't -- I mean I don't  
18 really have anything else to say beyond what  
19 I've said. As you can, I've struggled with  
20 this. And I continue to struggle with this.  
21 I guess sort of just for intellectual  
22 consistency, I sort of believe that if we

1       decide this is really a quality measure for  
2       hospitals, then I fall back to we should not  
3       include SES.

4                   But -- and I've already sort of  
5       said how I feel about that in general.  So --  
6       but I clearly am not very clear in my own head  
7       about having this.

8                   CO-CHAIR LAZAR:  Okay.

9                   David?

10                  MEMBER POLAKOFF:  I know we, with  
11       the introduction, simply represent ourselves,  
12       not organizations.  But I am the Chief Medical  
13       Executive of a Medicaid Agency.  So the  
14       population we're debating right now are sort  
15       of our exclusive concern.

16                  And I, too, like Ashish, I have  
17       concerns about including SES for the same  
18       reasons.  I'm really concerned that it could  
19       adjust away very real differences that we  
20       would like to see.

21                  I'd also like to just add one  
22       little bit of empiric evidence to the

1 discussion, which is that we recently went  
2 through an exercise in Massachusetts Medicaid  
3 of evaluating all the hospitals that we  
4 contract with, that we pay in the state.  
5 There about 70 hospitals with one readmission  
6 measure. And then are rating them by rates.

7 And interestingly, it didn't track  
8 very well with their level of participation in  
9 Medicaid at all, with their volume of Medicaid  
10 patients. There were high Medicaid hospitals  
11 that had low readmission rates. And vice  
12 versa. There is a bit of trend but there  
13 wasn't -- there really was not a consistent  
14 trend at all.

15 So I'm concerned about losing  
16 differences that would be very, very  
17 meaningful.

18 CO-CHAIR LAZAR: Okay.

19 Tanya?

20 MEMBER ALTERAS: I agree. So that  
21 was a great segue for that. I think the --  
22 going more towards stratification is the way



1 I would feel much more comfortable.

2 And I just wanted to make a  
3 comment. I'm kind of laughing inside even  
4 though this isn't funny at all. But three  
5 years ago I was on the NQF Hospital Outcomes  
6 and Efficiencies Steering Committee. And we  
7 had many of the same conversations about SES  
8 and also about how much of the readmission is  
9 really due to the hospital care versus what  
10 happens after the hospital -- after the  
11 discharge.

12 And, you know, I think that -- I  
13 think, Frank, you said, you know, there are a  
14 lot of issues about care coordination, what  
15 happens after the hospital discharge, you know  
16 all the statistics we know about, you know,  
17 the high percentage of patients who are  
18 readmitted having no family or other care  
19 giver support locally, you know, and how that  
20 plays into a readmission.

21 But that doesn't take away the  
22 hospitals' role in this. So I just wanted to

1 bring that back up to the surface.

2 I know we all know that since  
3 we're all here. But I just -- and, you know,  
4 in an ideal world, we would have a measure  
5 that included lots of ambulatory care data,  
6 data on care coordination. We're not in the  
7 world yet. And so, you know, we do want to  
8 focus on the readmission and what the  
9 hospital, you know, what the hospital data  
10 says about that.

11 CO-CHAIR LAZAR: So just to sort  
12 of, you know, bring everybody back to the task  
13 at hand, our charge for this particular  
14 section is to simply vote on the scientific  
15 acceptability of, you know, the measure the  
16 processes, vis-a-vis reliability, validity.  
17 And obviously risk adjustment being a part of  
18 it.

19 I just want to make sure that we  
20 don't, you know, try and create the perfect  
21 measure. We're really here to simply make  
22 some kind of a, you know, recommendation. And

1 obviously, you know, some kind of a assessment  
2 of the particular characteristics of this  
3 measure.

4 So I know there are a lot of cards  
5 up. I anybody has a comment that is  
6 critically important to making that decision,  
7 please keep it up. If not, I'd like -- I  
8 think Sherrie has one last comment. And then  
9 we need to vote on this section and then move  
10 on if that's okay.

11 It sounds like a couple of cards  
12 are still up so --

13 CO-CHAIR KAPLAN: Well, wait a  
14 minute, if you don't mind, let me just  
15 interject something here, which may or may not  
16 help.

17 But a recent, a very recent  
18 systematic review of risk stratification  
19 models by Ken Sagar et al., and I forget what  
20 the Journal citation is, say most of our risk  
21 stratification for readmissions don't work.  
22 Mortality, these risk stratification models

1 work. There are some good ones out there,  
2 different approaches that work.

3 But we are nowhere near  
4 scientifically sound risk stratification  
5 models. And if you think SES is an easy -- we  
6 are all glibly tossing it around, you should  
7 sit in on some of social scientist-kind of  
8 meetings about socioeconomic status and how  
9 the complexities in measuring that.

10 So in the database, it is not  
11 consistently agreed that there any variables  
12 remotely touch on the issues they raise,  
13 including race and ethnicity.

14 So just to kind of give you a  
15 little guidance on is there something in  
16 everybody hip pocket, absolutely not. There's  
17 not anything out there right now that is the  
18 appropriate approach to risk stratification.

19 CO-CHAIR LAZAR: Okay. So  
20 critical comments now that are going to be  
21 essential for us to cast a vote on the  
22 scientific acceptability. If you don't have

1 one, please drop the card. If you do have  
2 one, then we will get around to you.

3 Laurent?

4 MEMBER GLANCE: So I think as we  
5 were talking about the validity of the risk  
6 assessment, because I think it is the question  
7 at hand, one of the things that I did not hear  
8 discussed at all were statistical measures of  
9 performance.

10 So we've look at the -- the  
11 measure developers do talk about  
12 discrimination and give us a little bit of  
13 information on that. If I recall correctly,  
14 I think a C statistic was in a .65 range,  
15 which seems to be pretty good for this kind of  
16 a model, not so good when you're talking about  
17 risk adjustment models in general. And that  
18 doesn't really add a lot of information to  
19 this discussion.

20 But the point that I do want to  
21 ask about is model calibration because that  
22 really is critically important when you are

1 going to use risk adjustment models for bench  
2 marking. And I don't recall seeing anything  
3 about model calibration in the technical  
4 manual. And I was wondering if we could find  
5 out about that before we vote on this.

6 CO-CHAIR KAPLAN: Elizabeth or  
7 Jeph or anybody? Is it in the technical  
8 report?

9 MS. DRYE: It is in the technical  
10 report.

11 CO-CHAIR KAPLAN: Can you tell us  
12 a page number?

13 MS. DRYE: It's 53 of the  
14 technical report. That's the model  
15 specifications, including calibration and  
16 discrimination for each of the five submodel  
17 group measurement. That goes through to page  
18 55 -- 52 to 55.

19 And did you want us to speak to  
20 those results?

21 CO-CHAIR LAZAR: Briefly.

22 MS. DRYE: Can you guys bring it

1 up on the screen? So do you want to --

2 MR. HERRIN: So there, you know,  
3 you've got the technical report there. A lot  
4 of results here because we had five models.  
5 But the full results -- we do have the  
6 calibration results here. They are --  
7 typically one calibration would be the two  
8 calibration numbers would be close to zero,  
9 close to one.

10 And pretty much across the board  
11 we found that we couldn't find any central  
12 calibration results for any of our models.  
13 You know it is a lot of detail. I don't want  
14 to go through all the numbers.

15 But I think if someone wants to  
16 look through these and has specific questions  
17 about how I calibrated --

18 CO-CHAIR KAPLAN: So I think one  
19 of the things that we often ask as far as like  
20 risk deciles, can you just describe a little  
21 bit more -- I'm not sure what the calibration  
22 numbers in here, the zero, one -- I'm not sure

1 what --

2 MS. HORWITZ: So we provide a  
3 little detail on the bottom where the gamma  
4 zero we expect to be as close to zero as  
5 possible and one -- as close to one as  
6 possible. And it is set that way for the  
7 development sample. And then we compare the  
8 validation -- the two validation samples to  
9 them. And as you can see, that's very close.

10 The risk deciles we present in the  
11 next row here, so we're looking to see what is  
12 the predicted risk for patients at the lowest  
13 decile of risk versus what's the predicted  
14 risk for patients with the highest decile of  
15 risk.

16 And you like to see, again, as  
17 wide a spread as possible because you want to  
18 show that your model is able to discriminate  
19 levels of risk.

20 And so as you can see, these range  
21 from a very low risk of readmission of 9  
22 percent in the lowest decile to the highest



1 risk or readmission being around 33, or 35  
2 percent in the highest decile. And that's  
3 pretty consistent across all of our measures  
4 four to 27, five to 31. So it's on that  
5 range. And that's a pretty reasonable  
6 discrimination of risk for our models.

7 CO-CHAIR LAZAR: Good. Can we  
8 move on?

9 Okay, Brian, do you have a  
10 comment?

11 MEMBER ASPLIN: Real quickly.

12 CO-CHAIR LAZAR: Four more and  
13 then we're going to move on.

14 MEMBER ASPLIN: Just need to  
15 understand better the validity threat that was  
16 mentioned around how volume is treated in low-  
17 volume hospitals in this model. So I  
18 conceptually get that basically if you have a  
19 very low end, it's the national average that's  
20 somehow -- almost -- not necessarily being  
21 substituted. But if somebody could just  
22 explain that link a little bit better, that

1 would help me.

2 CO-CHAIR KAPLAN: Jeph, you want  
3 to respond to that for your measure?

4 MR. HERRIN: Yes. First of all  
5 I'd like to point that since this is all cause  
6 readmission, we don't have any hospitals that  
7 have very small volumes. Certainly for the  
8 condition-specific measures, we do often have  
9 hospitals that are publicly reported that have  
10 25 admissions. In our case, we don't have --  
11 every hospital has at least several hundred.  
12 So we're not talking about the same kinds of  
13 small volume.

14 The idea is that if you don't --  
15 there's always a tradeoff when you're trying  
16 to measure things. There's always lots of  
17 tradeoffs. And in this case, the tradeoff, I  
18 think, is between precision and accuracy.

19 And it may be that if you took,  
20 you know, a small hospital and you just took  
21 the number of readmissions, you would get a  
22 nice number which everyone agrees that's their

1 readmission rate. But certainly everybody  
2 should know that it would be very wide.

3 As Ashish was saying, you know, it  
4 could be -- there's a very wide confidence  
5 interval. And how helpful that is to someone,  
6 I don't know. You know it is between 10  
7 percent and 40 percent. Maybe it is not very  
8 useful.

9 One way to improve the precision  
10 of the estimate is to combine other  
11 information yo9u have. This hospital is not  
12 operating, you know, in a vacuum. We know  
13 that, you know, our best guess without  
14 measuring it is not zero percent. It's not  
15 100 percent. Our best guess before we measure  
16 it is the national average.

17 And so the logic is to factor in  
18 the information and the degree to which it is  
19 factored in is different than the byproduct  
20 though. I think that there -- well, I'll stop  
21 there.

22 CO-CHAIR KAPLAN: You could --

1       excuse me, you could add that if the Committee  
2       felt strongly that hospital volume turns out  
3       to be one of those issues that we'd like you  
4       to address, it could be added is my  
5       understanding to your model as it exists now?

6               MS. HORWITZ: Do you mean an  
7       indicator for just sort of the decile of  
8       volume of the hospital?

9               CO-CHAIR KAPLAN: If you -- at the  
10       hospital level, in the model if you wanted to  
11       include hospital volume, it could be included  
12       if the Committee felt strongly that that was  
13       some kind of marker that we wanted to take  
14       into account?

15              MS. DRYE: Yes, I mean technically  
16       you could add it, if, again, as we talked  
17       about before, it is a policy in measurement  
18       decision about whether you should add it. So  
19       if you want the technical answer, yes.

20              MS. HORWITZ: I do just want to  
21       reiterate the point that, you know, a lot of  
22       this discussion, I think, derives from the

1 publicly-reported measures we have now that  
2 are, you know, that are very volume limited  
3 because of the open issues. We just do not  
4 have that problem in this measure. They are  
5 not very small volume hospitals.

6           There will be much less of this  
7 kind of averaging to the mean for these  
8 hospitals because we have real data and real  
9 census outcomes for these hospitals.

10           MEMBER JHA: (Speaking from an  
11 unmiked location.) -- so I agree that this  
12 will be less of a problem with the current  
13 measure as it is thought through. I mean I  
14 guess first of all one could look at this  
15 empirically. And the way to look at it  
16 empirically is look at just the small  
17 hospitals and see how much -- how different  
18 the average is based on your hierarchical  
19 model versus a non-hierarchical, straight out  
20 logistic regression that handles clustering.

21           And that would actually tell us  
22 are we biasing it by two percent, are we

1       biasing it by six percent. And we'd actually  
2       have some sense of how off it is.

3               Because the work that we've done  
4       with looking at AMI, CHF, and pneumonia,  
5       especially for AMI, but for heart failure and  
6       pneumonia as well, says that for small  
7       hospitals, the predicted readmission rate  
8       based on the hierarchical model way  
9       underestimates these hospitals readmission  
10      rates because volume is actually related to  
11      readmission rate.

12              High volume hospitals on average  
13      actually have lower readmission rates. There  
14      are more practice, volume, outcome  
15      relationships are well established. So the  
16      fact that the model remains agnostic to volume  
17      is, in my mind, not a justifiable position to  
18      take, given what we know about hospital  
19      performance.

20              MEMBER GHINASSI: Michael, and  
21      then Frank, and then Richard. And then we've  
22      got to move on.

1                   MEMBER LANGBERG: My comment,  
2                   unrelated to any of this, has to do with  
3                   validity. And when I think about validity  
4                   non-statistically, I think about variables in  
5                   the measure. And if those variables are not  
6                   included, then it makes me wonder whether or  
7                   not the measure is valid.

8                   So the variable I'm thinking about  
9                   -- I've been thinking about it for the last  
10                  10, 15 minutes, is mortality rate. So we know  
11                  that mortality rates do vary. CMS publishes  
12                  that, at least the three conditions, that can  
13                  statistically be variable.

14                 And when I think about a variable  
15                 like mortality, I go to the extreme. And I  
16                 realize we can bring readmission rates to zero  
17                 if everyone dies in 30 days. Since everyone  
18                 dying in 30 days is not necessarily a  
19                 preferred outcome I think the public would be  
20                 happy with and perhaps others, then I have to  
21                 wonder how it is that mortality is not  
22                 considered as potentially influencing the

1 validity of the measure.

2           So is -- are differences,  
3 statistically differences in mortality rates,  
4 considered in this? If not, does that or does  
5 not influence the validity of the metric. We  
6 do know that based upon hospital-prepared  
7 website that has a statistic on this, I was  
8 involved -- actually the Chair was involved in  
9 a six-hospital study that looked at difference  
10 in mortality through a process of kind of  
11 severity adjustment that showed up to a 50  
12 percent difference potentially in mortality  
13 for heart failure patients. And also a  
14 related association between heart failure  
15 mortality and readmission rates. The higher  
16 your mortality, the less likely it is you have  
17 a population of people being readmitted.

18           So I was wondering whether or not  
19 that is consider. And if not --

20           CO-CHAIR LAZAR: Do the developers  
21 want to make a brief comment about that? Very  
22 brief.



1 MS. HORWITZ: Yes, we think this  
2 is a really important issue, too. And  
3 wherever possible, we think it is good to pair  
4 the admission measures with mortality  
5 measures. And so whenever somebody comes up  
6 with an all-condition mortality measure, that  
7 would be a useful thing to pair with.

8 When we've looked internally at  
9 our data, comparing the hospital performance  
10 on readmission with hospital performance on  
11 mortality, we do not find a consistent  
12 relationship. So it is not true that if you  
13 are a hospital with high mortality, you are,  
14 therefore, a hospital with low readmission or  
15 vice versa.

16 But that said, you know, it is  
17 always important to think about that. And for  
18 that reason, that's why we omitted the cancer  
19 patients from our model because they do have  
20 such high competing risk, we thought it was  
21 unreasonable to include them.

22 And so whenever possible, we did -

1 - we just sort of tried to consider that for  
2 the situations that were dramatic. But again  
3 for the existing publicly-reported measures,  
4 there really is not a consistent relationship  
5 between readmission and mortality. So it  
6 doesn't necessarily follow that way.

7 CO-CHAIR LAZAR: Okay. Frank, and  
8 then Richard, and then we'll close this  
9 discussion out.

10 MEMBER GHINASSI: Just briefly,  
11 given that the fundamental purpose of this is  
12 to improve the quality of care across  
13 institutions, I just want to be clear that  
14 we're judging the validity of this based on  
15 the current set of variables that have been  
16 included in the model.

17 CO-CHAIR LAZAR: That's correct.

18 MEMBER GHINASSI: I want to also  
19 be clear that there have been a number of  
20 variables raised in the room that are not  
21 included in the model, decided against, some  
22 of which may have burden issues, some of which

1 don't, many of which in the model itself have  
2 been pointed to as possibly effecting  
3 potential outcome.

4 So I guess part of it is given  
5 that this is an expedited review, we're  
6 attempting to assess the current validity of  
7 this model based on the variables they are  
8 adjusting for, not are we looking at is this  
9 the best we've got given what we've got to do.

10 We're looking at the validity of  
11 the model as it stands. I just want to be  
12 clear.

13 CO-CHAIR LAZAR: That's correct, I  
14 think.

15 MEMBER GHINASSI: Okay.

16 CO-CHAIR LAZAR: Richard?

17 MEMBER BANKOWITZ: I guess on that  
18 note, I think there is no perfect measure.  
19 And we can't let the perfect be the enemy of  
20 the good.

21 But in this case, we are presented  
22 with evidence in the technical document itself

1 that as Medicaid increases so does the  
2 readmission rate. Now you could argue that  
3 the dispersion of the data is there. And  
4 there is. But the central tendency of the  
5 data shows Medicaid goes up, readmissions go  
6 up.

7 So I think the burden, the  
8 scientific burden is to explain why that is  
9 excluded on the basis of a scientific reason,  
10 not an aspirational reason. And I do think we  
11 need to be careful we're measuring the  
12 performance of the hospital, not the  
13 population whom it serves.

14 And if you do a little thought  
15 experiment to think about taking a high  
16 performing hospital and just changing its  
17 population overnight to a very complex,  
18 chronic, Medicaid population, do you think the  
19 readmissions rate will change.

20 If you think it will change, then  
21 you've got to figure out do you want to  
22 measure the hospital? Or do you want to

1       measure the population whom the hospital  
2       serves?

3                   CO-CHAIR LAZAR:   Okay.   Time to  
4       vote.

5                   Taroon?

6                   MR. AMIN:   Can you just read off  
7       the vote?   Can you do that, Adeela?

8                   MS. ADEELA KHAN:   So we're going  
9       to vote on scientific acceptability of measure  
10      properties.   So we want to consider are both  
11      reliability and validity rated moderate or  
12      high.

13                   So looking at subsection 2a,  
14      reliability, including 2(a)(1).   This is  
15      looking back at your measure submission form.

16                   So 2(a)(1), we have precise  
17      specifications; and

18                   2(a)(2), testing are appropriate  
19      methods and the scope with adequate results.

20                   And then looking at 2b, the  
21      validity, including:

22                   2(b)(1), specifications consistent

1 with evidence;

2 2(b)(2), testing appropriate  
3 method and scope with adequate results, and  
4 threat stability adequately addressed;

5 2(b)(3), exclusions;

6 2(b)(4), risk adjustment and  
7 stratification;

8 2(b)(5), meaningful differences;

9 and

10 2(b)(6), comparability data  
11 sources.

12 So if we want to vote, was the  
13 criterion scientifically acceptable -- was the  
14 criterion scientific acceptability of measure  
15 properties met.

16 So we can start voting now.

17 CO-CHAIR LAZAR: Okay.

18 MS. ADEELA KHAN: Yes, could we  
19 have Patricia as well?

20 CO-CHAIR LAZAR: Patricia, are you  
21 on the line?

22 MEMBER McDERMOTT: My line is

1 disconnected.

2 MS. ADEELA KHAN: Oh, okay.

3 (Laughter.)

4 CO-CHAIR LAZAR: Okay. So just  
5 from a process point of view to refresh  
6 everybody, we've got to meet sort of the four  
7 broad criteria. And if the answer is no for  
8 any one, the discussion essentially gets  
9 truncated and the measure cannot be advanced.

10 Obviously here we're tied. And,  
11 you know, we'll take it forward and see what  
12 happens when we get to usability. But had we,  
13 you know, had this been a more a -- or had  
14 this been a no, then the discussion probably  
15 would have stopped right there.

16 So why don't we move on to  
17 usability? We'll get some brief --

18 MS. FORMAN MORGAN: So for --

19 CO-CHAIR LAZAR: Okay.

20 MS. FORMAN MORGAN: Oh, go ahead.

21 CO-CHAIR LAZAR: Yes, I was just  
22 going to say Alexis will give us some brief

1        comments.  And then we'll essentially have  
2        another discussion.

3                The only thing we would ask is  
4        that we try and keep the comments as tight as  
5        we can.  And we try not to repeat them.

6                The point here, of course, is to  
7        simply make a judgment on what is before us  
8        rather than trying to create, you know,  
9        perhaps a better model.

10               Mike?

11               MEMBER LANGBERG:  I just have a  
12        procedural question.  This is clearly an  
13        unexpected and probably uncommon experience.  
14        Maybe you have had this experience before, I  
15        have no idea.

16               I was just wondering what the  
17        criterion was for moving forward.  Is the  
18        question is yes we move forward?  Or if no, we  
19        don't move forward?  Do you have to achieve a  
20        threshold yes to move forward?  Or do you have  
21        to achieve a threshold no not to move forward?

22               CO-CHAIR LAZAR:  We'll let Taroon



1 answer. But my understanding -- my picture of  
2 the understanding is that a yes, we continue  
3 and no we get stopped.

4 MR. AMIN: If it does not pass  
5 scientific acceptability, it does not move  
6 forward. So since it is inconclusive, we  
7 would continue the discussion. So it's if no,  
8 we don't move on to answer the question in  
9 particular. And it is by simple majority.

10 CO-CHAIR LAZAR: Okay.

11 Alexis?

12 MS. FORMAN MORGAN: Okay. Looking  
13 at our third criterion, usability, for this  
14 criterion we were looking at can the audience,  
15 the intended audience, whether it is  
16 consumers, providers, health plan, can they  
17 understand the results of the data? And also  
18 is this measure useful and meaningful for  
19 public reporting, quality improvement, and  
20 accountability?

21 All right. So the issue is is  
22 this measure meaningful, understandable, and

1 useful for public reporting? And is it  
2 meaningful, understandable, and useful for  
3 quality improvement, and accountability, which  
4 means that it has got a dual purpose in this  
5 case, which some of us would worry about.

6 But for the discussions on the  
7 interpretability, the extent to which  
8 audiences, the intended audience -- and it is  
9 a broad one, consumers, purchasers, providers,  
10 and policymakers can understand the results  
11 and are likely to find them useful for  
12 decisionmaking?

13 MEMBER JHA: So I think there are  
14 some real challenges here to the usability.  
15 And they are a couple-fold.

16 The primary issue here, in my  
17 mind, is that -- well, there are two different  
18 issues. One is at least on what we've seen  
19 for the AMI, CHF, and pneumonia measures, most  
20 of the hospitals fall within expected range or  
21 don't fall out of the expected range.

22 And so as a quality improvement

1 tool, that's a real challenge. If we're all  
2 pretty good, it's really not clear that it is  
3 a motivating force.

4 It would be interesting to see,  
5 and I assume that the measure developers  
6 probably know this, what proportion of  
7 hospitals fall out of expected range based on  
8 the hierarchal model.

9 The second issue which kind of is  
10 related is, again, how -- what happens to  
11 small hospitals. And here if the issue is  
12 comparison, it is really easy to see a  
13 scenario where you have a large hospital with  
14 a readmission -- let's say the national  
15 average is ten percent -- you have a large  
16 hospital with 14 percent and a small hospital  
17 whose actual underlying rate was 20 percent.  
18 But the way the shrinkage model handles it,  
19 their small hospital gets back to 11 percent  
20 because it gets averaged out to the mean.

21 So what you end up doing is giving  
22 information to consumers saying the small

1 hospital is better than the big one when, in  
2 fact, you don't really have, I think, adequate  
3 evidence to make that. And so you get numbers  
4 that are not meaningful, not understandable,  
5 and, in my opinion, not useful for public  
6 reporting.

7 So that's the challenge with  
8 restandardized rates with hierarchical  
9 modeling is for a lot of small hospitals, it's  
10 not the hospital's actual data. It is a  
11 series of judgment calls about what is the  
12 best amount of information we have about those  
13 hospitals.

14 And we can quibble about whether  
15 that is, in fact, the best set of information  
16 we have about the hospitals. But ultimately  
17 it is not the hospital's own performance.

18 CO-CHAIR LAZAR: Okay.

19 Bruce?

20 MEMBER HALL: Thank you.

21 I just have a question maybe for  
22 the developers. Whether there is an actual

1 specification about the degree of acceptable  
2 certainty. So in my mind, trying to decide  
3 whether a consumer can make sense of this, I  
4 need to know when are we going to tell them  
5 that that performance was good enough? And  
6 when are we not going to tell them that?

7 And what that means is despite  
8 whatever method we choose to reach our point  
9 estimate what are we telling the consumers  
10 about the uncertainty of that estimate? And  
11 when that uncertainty says this is acceptable  
12 performance or this is not? Because I think  
13 the consumers need that to make the  
14 interpretation.

15 And then irregardless of how I may  
16 or may not have voted on the prior issue, I  
17 would raise the general question if we have 18  
18 experts in this room who couldn't decide  
19 whether the specifications meet criterion then  
20 how do we expect the consumers to make use of  
21 the information?

22 CO-CHAIR LAZAR: Leslie and then

1 Mark.

2 MEMBER KELLY HALL: Just following  
3 up on Bruce's comment, to make it useful to  
4 the consumer, it has to be easily understood.  
5 And I think that the idea of readmission or  
6 not is an easily-understood concept until you  
7 get into the detail.

8 My concern is that does the public  
9 always equate a readmission with bad versus  
10 good. And the unintended consequences, if not  
11 explained well, could be patients self-  
12 selecting two inappropriate care settings.

13 And so my concern is really about  
14 making this understandable and meaningful  
15 requires more education and not necessarily  
16 always the idea that something is bad because  
17 it is being reported. Just a general comment.

18 CO-CHAIR LAZAR: Mark?

19 MEMBER SCHUSTER: I wanted to go  
20 back to the shrinkage issue. And I'm assuming  
21 you are a consumer expert. But I would think  
22 that a consumer, a potential patient, would do

1 better with seeing 10-40 than an average  
2 number with a little asterisk that may or not  
3 be in the report but maybe it will be in the  
4 newspaper someday that say that average isn't  
5 really accurate.

6 I think it is more usable if the  
7 information is more accurate and complete.  
8 But in terms of consumer testing, and I may  
9 have just missed this in the materials, but it  
10 looked like -- well, first of all I couldn't  
11 tell what the consumer testing was but it  
12 looked like what's been studied is disease-  
13 specific measures. And I wasn't sure if we  
14 know how people use all-cause measures. If  
15 that had been studied, I couldn't find that it  
16 had. And that would be useful.

17 CO-CHAIR LAZAR: Do any of the  
18 developers have any comment on that?

19 MS. HORWITZ: Well, to address  
20 these points so far, to me it seems to do the  
21 consumer a disservice, to give them a number  
22 that's highly contingent on random

1       variability.  And I don't think it is useful  
2       to tell a consumer that a hospital's  
3       readmission rate is 20 percent when really it  
4       could be anything from ten to 40.

5                 And I think actually consumers are  
6       not that great at understanding reporting.  
7       That sort of makes it difficult to understand.

8                 I think it's much more -- it's a  
9       much more accurate representation of reality.  
10       It's not a bias.  It's a genuine  
11       representation of reality to use this measure  
12       to determine the most reliable rate for a  
13       small hospital, which in many cases will be  
14       the median.

15                Now second, people had asked what  
16       is the rate at the point in which we call  
17       something better than or worse than average.  
18       And that's a policy decision.  So currently  
19       CMS sets that at the 95 percent confidence  
20       interval.  And it's a tool that could be set  
21       at other confidence intervals.  That's not  
22       intrinsic to this measure.  That's a policy



1 decision about reporting.

2           So one would take this measure and  
3 report it at the 80 confidence interval and  
4 have more outliers. That's, again, not  
5 intrinsic to the way the measure is developed.

6           The measure is developed to be as  
7 fair and as unbiased possible with the actual  
8 results. And then the way in which you chose  
9 to interpret that for the consumer is a public  
10 reporting issue and not a measure issue.

11           And finally you had asked have  
12 consumers been tested for this particular  
13 measure or for the public report measures. We  
14 have not tested this measure with consumers  
15 for this measure. And I'm actually not aware  
16 of what testing has been done for the public.

17           MS. DRYE: Yes, CMS did consumer  
18 testing to evaluate the understandability of  
19 the data on Hospital Compare and make  
20 revisions. And so, for example, a revision  
21 that was prompted was in the first year  
22 reporting, hospitals -- all hospitals that

1 were fewer than 25 cases, almost all of them  
2 ended up in the middle bucket because they  
3 were not better or worse by a criterion.

4 Now those hospitals that are  
5 smaller report as a fourth column, which is  
6 just too little information to assess quality,  
7 which is more accurate reporting for the  
8 consumer. I think it is much clearer for  
9 people.

10 But we haven't looked at anything  
11 with respect to this hospital-wide measure at  
12 this point.

13 CO-CHAIR LAZAR: Okay.

14 Tanya?

15 MEMBER ALTERAS: I would agree,  
16 you know, having something that says the  
17 readmission rate is between ten percent and 40  
18 percent isn't useful. But I just think that  
19 this speaks to the usability of this measure  
20 as a whole.

21 And whether, you know -- and what  
22 you're saying about the consumer testing, I

1 think that the previous way of displaying this  
2 data and the current way of showing, you know,  
3 not enough cases, those aren't usable either.

4 And, you know, this all comes down  
5 to my concerns about the hierarchical risk  
6 modeling in general. And I note these are two  
7 different issues. There is the measurement  
8 issue and then there is the data display  
9 issue.

10 There's -- you know confidence  
11 intervals have nothing to do with what the  
12 measure is but I just -- you know, my concern  
13 is about this measure and how it is specified.  
14 And what the results are going to be in terms  
15 of the data display just based on the history  
16 that we have with Hospital Compare.

17 CO-CHAIR KAPLAN: Let me just -- I  
18 know there are a lot of people to get to but  
19 let me just raise the issue of who is the  
20 consumer because it is kind of an insult to  
21 consumers to assume that they are a homogenous  
22 entity as well. I mean they come in all

1 stripes and all flavors.

2 And also the proportion variation,  
3 how often a patient chooses the hospital  
4 versus chooses the doctor who chooses the  
5 hospital is maybe an issue that's worth  
6 entertaining here when we're talking about who  
7 is reading this data.

8 CO-CHAIR LAZAR: Mike? Do you  
9 want to make a comment?

10 MEMBER LANGBERG: Thank you.

11 I'll focus for a moment on the  
12 usability of the information from a hospital  
13 point of view. And then maybe we can talk  
14 about the consumer.

15 For the purpose of performance  
16 improvement, data that is 12- to 18-months old  
17 is largely useless. That doesn't mean that we  
18 can't learn something from it. But if the  
19 purpose of the information is to allow a  
20 hospital to apply improvement strategies and  
21 retest to see whether the strategies have had  
22 an effect, if the cycle for doing that in a

1 dataset that is so old is so slow that the  
2 ability to make real improvement would be  
3 virtually impossible on that data.

4           So secondly, the ability for a  
5 hospital to understand the full extent of the  
6 opportunities for improvement when evidence  
7 currently -- in the current version of this --  
8 there is shielded from the hospital  
9 information about other hospitals the patients  
10 may have been admitted to is again a deficit  
11 with regard to usability of the information  
12 for hospital improvement.

13           Then as far as the -- if I can say  
14 about both the hospital and the consumers, the  
15 biggest problem I have with the usability is  
16 the title. It's about hospital readmission  
17 rates. It's about a hospital quality measure.

18           For those of us who live in that  
19 world, there are variables well beyond the  
20 license of the hospital and even the function  
21 of its medical staff that we know, and I can  
22 share with you if you want to, that have

1 impact upon readmission rates.

2           So it's less, to me, a measure  
3 uniquely of hospital quality and more about  
4 community health quality. And I think the  
5 confusion for the consumer and certain the  
6 frustrations for a hospital would be that  
7 tagged to hospital, whether it was  
8 socioeconomic status, whether it's resources  
9 available in a community such as effective  
10 nursing homes, or whether it is distance to  
11 the hospital.

12           A significant number -- proportion  
13 of patients we admit into my hospital live 40  
14 to 120 miles away. What's the reach of the  
15 hospital to be able to manage patients once  
16 they have been discharged. What is the  
17 expectation that the hospital should be  
18 accountable? And from the point of the CMS,  
19 financially penalized if they can't manage  
20 these things?

21           Those, to me, raise questions as  
22 to the usability from the hospital

1 accountability perspective.

2 CO-CHAIR LAZAR: Thank you.

3 Karen?

4 MS. PACE: Yes, I just want to  
5 make a couple clarifications about our  
6 criteria on usability. And NQF really does  
7 make a distinction between endorsing a measure  
8 versus how the measure ultimately is  
9 implemented and displayed because measures can  
10 be used by a variety of implementers and how  
11 they display the information at this point in  
12 time is not part of the NQF endorsement.

13 So I just wanted to mention that.  
14 And actually NQF has a current task force  
15 looking at the usability criterion. And, you  
16 know, if they're -- and I think this has been  
17 alluded to already but how measures are  
18 explained is something that is easily  
19 correctable by experts in how to communicate  
20 performance data to consumers if that's an  
21 issue.

22 So we do not require that they've

1 done some testing. If they have done some  
2 testing with consumers, that's fine to  
3 provide. But we do make a distinction of  
4 endorsing the measure and ultimately how it  
5 might get displayed on the website or in the  
6 report.

7 The other thing about quality  
8 improvement that I'll just mention is that the  
9 criteria is about facilitating quality  
10 improvement. And so the -- and the specific  
11 issue came up when the CSAC and task forces  
12 were looking at our criteria and specifically  
13 about outcome measures because it often is  
14 questioned about how is an outcome measure  
15 helpful for quality improvement.

16 Basically we talk about  
17 facilitating quality improvement, which means  
18 that if you have data on performance on  
19 outcome measures, whether it is this measure  
20 or some other outcome measure, and have  
21 information that your hospital is doing more  
22 poorly than another hospital, that in and of



1       itself, that information identifies that it is  
2       an area for your hospital to pursue to look at  
3       what are the issues in your hospital.

4               An outcome measure will never tell  
5       you exactly what you need to do. But it  
6       should tell you where you have areas to pursue  
7       opportunities for improvement.

8               So I just want to make those  
9       clarifications based on what our criteria  
10      actually are at this point.

11              CO-CHAIR LAZAR: Richard?

12              MEMBER BANKOWITZ: I echo  
13      Michael's comments. And I do want to say this  
14      issue of timing is very important because  
15      hospitals are not in the position where they  
16      can understand these rates across all  
17      readmissions. They can only see their own.  
18      And it makes it very, very difficult to do a  
19      rapid cycle test to change when the data are  
20      two years old.

21              And the second point -- and I  
22      don't know where this fits but I would like to

1 see somehow us think through unintended  
2 consequences and perhaps as part of usability,  
3 try to elicit whether or not those are  
4 happening like if all we do by decreasing  
5 readmissions is increase the number of  
6 observation stays of 23 hours and returns to  
7 the ED through a revolving door, that's not  
8 very patient-centered care.

9           So I'd love to somehow work that  
10 in. I don't know how we can do that.

11           CO-CHAIR LAZAR: Perhaps not.

12           Laurent?

13           MEMBER GLANCE: I think there has  
14 been a lot of discussion about hierarchical  
15 modeling today. And Ashish you made a point,  
16 again, about usability with regards to  
17 hierarchical versus non-hierarchical.

18           And I just wanted to say that I  
19 think because this is an all-cause readmission  
20 where you are kind of folding in all the  
21 patient populations into one model versus  
22 looking specifically at specific cohorts like

1 AMI, pneumonia, I don't think that the  
2 shrinkage is going to give you that much of a  
3 bias here.

4 I mean certainly we could ask the  
5 developer group if they've looked at that in  
6 terms of comparing shrinkage versus non-  
7 hierarchical modeling. But my gut feeling is  
8 that may not be much of an issue here. And so  
9 it probably wouldn't effect usability as much  
10 as it would if we were looking say at AMI  
11 alone or CHF readmissions alone.

12 CO-CHAIR LAZAR: Okay.

13 Frank and then Jeph and then I  
14 think we're going to call the question.

15 MEMBER GHINASSI: Yes, just  
16 addressing the idea of usability, I was trying  
17 to put myself in the position of using this as  
18 a hospital administrator, which is one of the  
19 roles I have now. And I agree with Michael,  
20 I think, about the time lag on this makes this  
21 very difficult. So I question the usability  
22 around that.

1 I was trying to imagine myself in  
2 the role of a consumer of services, which I  
3 am, too, and I would find it confusing I  
4 think. And in fairness of advertising, I  
5 would presume that if we endorse this and it  
6 moves forward, it would forward, I have to  
7 presume this, with the list of caveats about  
8 what the measure does not measure.

9 So I would have to assume that the  
10 consumers would have to be told we didn't  
11 adjust for this, we didn't adjust for that, we  
12 didn't adjust for -- these were things that we  
13 didn't do because of either burden or  
14 complexity.

15 And I have to also assume that  
16 consumers would have to be told in fairness in  
17 advertising -- and I agree with Karen's point  
18 completely -- that what we're doing is we're  
19 assessing a continuum of care, which includes  
20 hospitals, it includes the bifrost between  
21 hospitals and ambulatory and also includes  
22 ambulatory.

1                   And we'd have to tell people  
2                   consuming this that although we're talking  
3                   about that continuum, we're only measuring one  
4                   part of it. And I'm just trying to imagine at  
5                   the end of that list of caveats, what would I  
6                   make of it as a measure of the facility  
7                   itself.

8                   I personally would probably be  
9                   confused by the time I got to the end of the  
10                  list. So in terms of usability, I'm just  
11                  trying to imagine are we going to include all  
12                  of those caveats? And what does that do to  
13                  the audience? That's all.

14                  CO-CHAIR KAPLAN: And Taroon, you  
15                  want to comment on that? It's my  
16                  understanding that that's outside of the scope  
17                  of this committee.

18                  MR. AMIN: Well, and I think the -  
19                  - Karen can probably speak to this as part of  
20                  usability task force -- but I think there was  
21                  strong sentiment that no matter how complex  
22                  some of these measures, that they can be

1 constructed and reported by people who are  
2 experts in this area.

3 But, Karen, if you have anything  
4 else to add?

5 MS. PACE: Well, that's true. And  
6 Tanya can probably speak to it more than any  
7 of us, but the other thing to keep in mind is  
8 that we really are, you know, public reporting  
9 just one aspect of accountability. And we're  
10 in the process of broadening our thoughts  
11 about usability. And it's really public  
12 reporting and other ways of accountability.

13 Public reporting is not just  
14 directed at consumers. Probably those of you  
15 who are providers have looked at public  
16 reports. And those of you who are referring  
17 to other providers have probably looked at  
18 public reports as well.

19 And just in terms of performance  
20 improvement, public reporting not only informs  
21 consumers or people who are choosing but also  
22 provides some external motivation to improve

1 in activities.

2 So there's, you know, the public  
3 reporting piece is complex. NQF really  
4 recognizes more than just public reporting in  
5 the accountability realm. And public  
6 reporting can be targeted at more than just  
7 consumers.

8 CO-CHAIR LAZAR: Jeff and then  
9 we'll turn it over to Adeela.

10 MEMBER GREENWALD: So, you know,  
11 as I think about the kinds of usability here,  
12 it's really -- at least one element of that is  
13 the impact of the use of this measure. And,  
14 you know, just like so many other measures  
15 that we see in public reporting, it certainly  
16 can be used. The question is to what end.  
17 And I'm struggling a little bit with that A,  
18 because in an all-cause readmissions is  
19 extraordinarily blunt.

20 And as a hospital administrator,  
21 if I were putting on that, you know, given  
22 that it is so lumbers, not splitters in

1 approach, it is very difficult to know what I  
2 would use that information for. And two is --  
3 and that's not a reflection on this groups  
4 measure but the concept in general.

5 Number two is -- and I think if  
6 were using this, getting back to the whole SES  
7 discussion, I might in the precarious role of  
8 saying, as a hospital administrator, well, my  
9 patients are different. I have a large  
10 Medicare population. I have a large research  
11 population. I have a population in the middle  
12 of North Dakota that doesn't have primary care  
13 doctors or all the other issues that we've  
14 begun to address.

15 So I'm struggling a little bit  
16 with those sort of -- those paradoxes. And we  
17 discussed this. From a patient perspective,  
18 again, because it is so blunt as an all-cause  
19 readmission, again not reflecting the specific  
20 measure but the concept, the usefulness,  
21 again, becomes somewhat more limited.

22 And it becomes more of an elevator



1 speech in some ways at the consumer level or  
2 something that gets advertised rather than  
3 something that is truly useful. So I'm  
4 struggling -- I starting to struggle with  
5 this. I'm not sure how much of that is a  
6 reflection on the metric proposed as a  
7 conceptual model of all-cause readmissions.

8 MR. AMIN: Can I just add just a  
9 procedural thought as we sort of move into  
10 voting for usability and feasibility and  
11 really thinking through the fact that this  
12 question of -- the criteria is really asking  
13 about this measure in particular, about  
14 whether or not it is usable and  
15 understandable.

16 And starting with the assumption  
17 in the first criteria of importance to measure  
18 as the measure was constructed about all-cause  
19 hospital readmission, we want to keep in mind  
20 what's at hand, which is this measure as  
21 specified.

22 So not to necessarily bring all

1 those larger questions that we spent a lot of  
2 considerable time thinking about at the start  
3 of measure -- discussion. So -- because that  
4 would have the implications for all the  
5 measures going forward.

6 MS. ADEELA KHAN: So we're for  
7 measure usability, we're looking at:

8 Subcriteria 3(a), is it  
9 meaningful, understandable, and useful for  
10 public reporting and accountability; and

11 3(b), meaningful, understandable,  
12 and useful for quality improvement.

13 So to what extent was the criteria  
14 usability met? And you guys can start.

15 CO-CHAIR LAZAR: Patricia, are you  
16 on the phone still?

17 (No response.)

18 MS. ADEELA KHAN: I think we're  
19 waiting on one more person if you want to put  
20 in your vote again. There we go. And we have  
21 seven to 11 low.

22 MR. AMIN: We have seven moderate

1 and 11 low.

2 MS. ADEELA KHAN: Okay. Moving on  
3 to our fourth criterion, feasibility. And  
4 that's the required data is readily available  
5 or could be captured without undue burden.

6 So looking at it for clinical  
7 measures, the clinical data is generated  
8 during care process, which could be the blood  
9 pressure or lab samples.

10 All data elements are in  
11 electronic claims. And if they aren't, a plan  
12 for the data elements to get to electronic  
13 collection.

14 Susceptibility to inaccuracies and  
15 unintended consequences identified.

16 And the ability to audit the data  
17 to capture any of these issues.

18 And the last one, data collection  
19 strategy can be implemented.

20 CO-CHAIR LAZAR: Okay. So do we  
21 expect much discussion on this one? Does  
22 anybody want to make any comment on this one?

1 It's pretty clear where the data comes from,  
2 I'm guessing by the expressions around the  
3 table.

4 MS. PACE: Just the one follow-up  
5 comment I think that Richard made earlier. If  
6 the data is collected at that secondary  
7 hospital and it is not available to the first  
8 hospital, there is a void immediately to know  
9 whether you have a problem or not to be  
10 addressed.

11 So from a consumer point of view  
12 then is that measure effective and  
13 understandable? And can it be actionable?

14 If it is not actionable by the  
15 prior -- the first hospital because they don't  
16 even know it exists, how is the data  
17 available?

18 CO-CHAIR LAZAR: Yes, so I'll try  
19 to answer that but I think the issue is that  
20 measure as it is specified now either would or  
21 would not pose difficulties with feasibility,  
22 whether that information gets to wherever one

1 thinks it should go, to another hospital, to  
2 the consumer, to the, you know, the  
3 practitioners, the hospital leadership, I  
4 think that was really all wrapped up in the  
5 discussion of usability.

6           So from a pure feasibility  
7 standpoint, the issues of inter-hospital  
8 transfer of information are not really -- at  
9 least if I understand it, are not really  
10 germane. It's essentially billing data that  
11 is essentially transmitted. Frankly, CMS has  
12 it at present.

13           Any other comments?

14           MS. HORWITZ: Can we just correct  
15 a factual issue? So as currently done with  
16 public reporting, you, as a hospital, get a  
17 full list of readmission no matter what  
18 hospital they go to. So you are given that  
19 information no matter what hospital the  
20 patient goes in.

21           CO-CHAIR LAZAR: But what you  
22 don't get --

1 MS. DRYE: You get whether your  
2 patient was readmitted -- sorry -- but not to  
3 what hospital.

4 MS. HORWITZ: But you know how  
5 many of our patients get admitted to other  
6 hospitals.

7 MS. DRYE: And that's a CMS  
8 decision. And as we mentioned before, you  
9 know, CMS could give you the hospitals to  
10 which they are admitted if there is a  
11 clamoring for the data.

12 CO-CHAIR LAZAR: Okay. Other --  
13 yes, Karen?

14 MS. PACE: Yes, and I would just  
15 again clarify that that's not a function of  
16 the measure. That's a function of data  
17 availability.

18 So the idea of creating a measure  
19 that wouldn't include readmission to another  
20 hospital would be the alternative. And I'm  
21 not sure that that would really serve the  
22 purpose.

1           So as has been stated, that data  
2 exists. And certainly hospitals are given  
3 what patients are readmitted. And, you know,  
4 definitely can push for the additional  
5 information of identifying the specific  
6 hospital. But it's not necessary a measure  
7 property that's how it is implemented.

8           CO-CHAIR LAZAR: Right. Okay. I  
9 think, Adeela, we can move directly to vote on  
10 feasibility unless anybody has something very  
11 pressing to offer.

12           (No response.)

13           CO-CHAIR LAZAR: Okay.

14           MS. ADEELA KHAN: Okay. So again  
15 we're looking at:

16           4(a), data done during care;

17           4(b), electronic sources;

18           4(c), susceptibility to  
19 inaccuracies identified, unintended  
20 consequences identified; and

21           4(d), data collection can be  
22 implemented.

1                   So to what extent was the  
2                   criterion feasibility met? You have high,  
3                   medium -- high, moderate, low, and  
4                   insufficient.

5                   You can start your vote.

6                   And we're -- is Patricia online?

7                   (No response.)

8                   MS. ADEELA KHAN: Well, we're  
9                   short one person. Can you all enter your vote  
10                  in again please?

11                  So 11 for highs, six for moderate,  
12                  one for low.

13                  CO-CHAIR LAZAR: Okay. All right.

14                  We now have to move to an overall  
15                  vote on the measure itself. And I'll just to  
16                  reiterate what I think a number of folks said  
17                  earlier. And that is the topic for the two  
18                  days is all-cause readmissions.

19                  And what we're looking at now is  
20                  an evaluation of the specifics of this  
21                  particular measure. So as Karen said earlier,  
22                  it is less about your -- or any of our



1 philosophic views on whether all-cause  
2 readmissions are a good thing or a bad thing  
3 but really on the particular characteristics  
4 of this measure. And obviously tomorrow we'll  
5 have some comparative discussion.

6           So I think we've discussed this,  
7 you know, in great depth and, you know,  
8 repeatedly on some of the issues. Certainly  
9 we can open the floor briefly if anybody has  
10 got something new to add to the discussion  
11 that we have not considered before. But I  
12 think we'd all probably want to try and avoid,  
13 you know, rehashing the same points and same  
14 arguments that have been so cogently made  
15 earlier.

16           So let's open the floor.

17           CO-CHAIR KAPLAN: Well, let me  
18 just add here at the risk of reiterating  
19 myself, as a measurement scientist, you always  
20 have a better mousetrap. You know people in  
21 my biz have been estimating intelligence for  
22 over a hundred years. Even the SAT scores are

1 now new.

2                   So in sort of where we are, is  
3 this a good representation of what could be a  
4 terrible concept but at least it is trying to  
5 estimate all-cause readmissions. Whatever you  
6 think, as you've just said, whatever you think  
7 of the concept itself, if we're trying to  
8 estimate this construct, whatever it is works,  
9 all-cause readmission, is this measure a good  
10 measure.

11                   MEMBER JHA: Excuse me. So I'm  
12 not interested in going -- reiterating any of  
13 the arguments I made earlier. It seems to me  
14 that a bunch of the issues that were raised  
15 are essentially empirical questions that if we  
16 had better data we could answer.

17                   And I'll just give a few -- and  
18 these are not even things that we need six  
19 years of data collection. These are things  
20 that potentially the measure developer could  
21 give us relatively quickly.

22                   So one thing certainly is how much

1 does a hierarchical model -- so Laurent, to  
2 your question, I agree with you. This may not  
3 be as much of an issue. And actually the data  
4 will tell us that. So there are keys that  
5 could be done.

6           The second one about whether  
7 consumers are more likely to understand on the  
8 usability issue confidence intervals or if  
9 they are more likely to understand hierarchal  
10 models with predicted rates based on a series  
11 of assumptions is an empirical issue. I mean  
12 you can decide which is more usable based on  
13 surveying people who would use these data and  
14 saying which is more transparent and more  
15 understandable to you.

16           It seems to me that my vote on the  
17 overall might very well change based on the  
18 answers to those questions. And I suspect  
19 that there may be other people who might feel  
20 differently if the model -- if the hierarchal  
21 model really effects small hospitals in a big  
22 way or if it is trivial and doesn't have much

1 of an impact at all.

2 So I understand we're voting.  
3 I'll vote. But I guess it is almost a process  
4 question. Is there a way for the measure  
5 developers to come back with more information  
6 to clarify these issues? Or is that really  
7 out of the scope of what we could ask?

8 MR. KRUMHOLZ: Can I ask Taroon  
9 and Karen to ask the question of do we -- if  
10 we do something now, how long are we approving  
11 this measure for? And are we going to revisit  
12 some of these issues and ask these questions  
13 at some point as part of our constant  
14 improvement process on your end for these  
15 measures?

16 MR. AMIN: Well, I'll start and  
17 Karen, feel free to jump in.

18 So measures that are evaluated  
19 through this process will be reviewed under  
20 maintenance in a three-year cycle to evaluate  
21 as one of the measures that you'll consider  
22 today by United Healthcare. So there will an

1 opportunity to revisit the measure and some  
2 comments from the field on the implementation  
3 of it.

4 The question on hand of whether or  
5 not we can ask the measure developers for  
6 further information and then they'll reply, I  
7 think I'll sort of leave this to Karen and  
8 Alexis. In some ways, this is the first time  
9 we're going through an expedited review.

10 As part of the expedited review,  
11 there would have been -- we would have liked  
12 to have more back and forth with the  
13 developers not only for this measure but for  
14 others. But for the sake of time we just  
15 didn't have that flexibility.

16 I'm not sure that we -- I'm pretty  
17 confident that we will not have the  
18 flexibility to have the measure developers  
19 respond to comments back to the committee  
20 because we just don't have that much time in  
21 the cycle.

22 There was another comment that I

1 wanted to make but I think I'll leave it with  
2 that. If you have anything to add Karen?

3 MS. PACE: Well, I mean, I think  
4 we're going to have to see where we're at at  
5 the end of today. And see what makes sense  
6 for moving forward before we, you know, some  
7 of these things could probably be answered in  
8 a relatively short turnaround. I think we'll  
9 have you vote on the measure as it is  
10 currently specified. We'll do that for all of  
11 the measures.

12 And, you know, we'll -- tomorrow  
13 maybe we'll end up identifying questions that  
14 we want more analysis about. And then come  
15 back and vote on the measures again. So, you  
16 know, we are on a pretty short time frame but,  
17 you know, we'll have to see where we're at.

18 The only other thing I just want  
19 to mention, just because it is about the  
20 distribution and the shrinkage, in the  
21 technical report there are some graphs. And  
22 I don't know if you can bring those up on page

1 58 -- and Elizabeth, if you want to refer us  
2 to another place -- but I think it does  
3 demonstrate that there is a spread of scores.  
4 It's not that everyone -- every hospital is  
5 looking average in this data.

6 MS. DRYE: And just quickly from  
7 the applications on the bottom of page 38 and  
8 the top of page 39, which is --

9 PARTICIPANT: What item number?

10 MS. DRYE: The number is 5(b) --  
11 2(b)(5.3) but the range is 12.5 or 12.6 to  
12 22.8. And then it tents the 90th percentile,  
13 which I think is more helpful. It's 15.4 to  
14 18.2. And so this is the range of the point  
15 estimates.

16 But I want to want to emphasize  
17 what others have emphasized, which is we have,  
18 you know, really a much higher volume for  
19 these cases so we haven't presented a  
20 confidence interval or an interval estimate  
21 around these. But we expect it to be much,  
22 much tighter than for other measures.

1                   For AMI, there are over a  
2                   thousands with one patient. That's why we see  
3                   a lot of hospitals with too few cases to  
4                   assess the underlying, you know, inherent  
5                   quality of the hospital. But for this measure  
6                   we don't have that problem at all.

7                   And whether we could come back  
8                   with some numbers on it, I mean I think we  
9                   can. We'd just have to talk about the time  
10                  range.

11                  MS. PACE: But are we -- those are  
12                  the distributions of the --

13                  MS. DRYE: Yes, the left is the  
14                  overall -- where the five cohorts are rolled  
15                  up. And the other is for the individual  
16                  cohorts. So, again, if those are the point  
17                  estimates but the precision of the point  
18                  estimates in this model versus condition-  
19                  specific models is expected to be much higher.

20                  So a narrower confidence interval  
21                  and choice around when you take 95, 90, 80,  
22                  etc. In other words, we think that it will be



1 easy to find a lot of outliers with this  
2 measure.

3 CO-CHAIR LAZAR: Okay. Bruce?

4 MEMBER HALL: I think Jo Ann was  
5 first.

6 MEMBER BROOKS: Oh, no, my  
7 question was answered. Thank you.

8 MEMBER HALL: I was just wondering  
9 technically if the NQF side could advise us on  
10 -- I realize, for instance, that reporting by  
11 stratification and SES or whatever is an  
12 implementation issue more than a measure issue  
13 to speak.

14 So do we as a committee have an  
15 ability to say -- you know whether we vote or  
16 yes or no -- to say if this were to move  
17 forward, we would strongly advise  
18 implementation with a consideration for  
19 stratification and so on? Do we have --  
20 what's the limit of our ability on that?

21 MS. PACE: I think -- well, first  
22 of all, we do have a mechanism to recommend

1 measures on certain conditions. And, you  
2 know, a condition could be stratification.  
3 But then the measurer developer would need to  
4 respond to that whether -- what their response  
5 to that condition would be.

6 Our process would be we want you  
7 to vote on the measure as is. And then if  
8 someone wanted to propose a particular  
9 condition, we could certainly entertain that.  
10 And then we would ask the developer to respond  
11 to that.

12 So stratification can be an  
13 implementation issue. But it can also be a  
14 measure specification. And in, you know, if  
15 it were an implementation issue, it might be  
16 comparing like hospitals. If it were a  
17 measure specification issue, it might be for  
18 each hospital stratifying the results by a  
19 particular factor.

20 So, you know, doing this on the  
21 fly, you know, generally steering committees  
22 are not developing measures as they go along.

1 But it is something that you could request  
2 more information from the developer about  
3 possibilities in that regard.

4 But I think the first thing is to  
5 vote on the measure as it is specified. And  
6 then if there are conditions or questions, we  
7 can certainly ask the developer to respond to  
8 those. Not necessarily today unless they want  
9 to briefly. But again I think we're going to  
10 have take stock of where we're at at the end  
11 of the day and see how we want to move  
12 forward.

13 CO-CHAIR LAZAR: Sherrie?

14 CO-CHAIR KAPLAN: I just want to,  
15 as we go forward and vote, remember that it is  
16 usually a bad idea to try to measure weight  
17 with a rule, you know? And the sort of  
18 calibration issues, are they measuring all-  
19 cause readmissions? That's the validity  
20 question. You're not using a ruler to measure  
21 somebody's weight.

22 How it is calibrated and all that

1 other stuff is a precision issue. And it  
2 depends on the purpose of measurement.

3 Those of us in the measurement  
4 business get freaked out when you don't bring  
5 that into the discussion. But because NQF has  
6 decided to separate those two, my  
7 understanding -- correct me if I'm wrong,  
8 Karen, this is a measure for whatever  
9 purposes, for accountability and quality  
10 improvement, that's the purpose of  
11 measurement. And we're hoping we have a ruler  
12 to measure height. Right? Is that -- okay.

13 CO-CHAIR LAZAR: Mark and then  
14 Tanya.

15 MEMBER SCHUSTER: Yes, Elizabeth,  
16 I thought these graphs were really helpful and  
17 I'm wondering if you happen to know if it is  
18 the case that the small hospitals are all sort  
19 of in the middle and the outliers are the  
20 larger hospitals?

21 And to get to what Ashish and  
22 maybe someone else asked earlier, do we know

1 what percentage of hospitals actually do fall  
2 below the cutoff and our low end so if the  
3 whole shrinkage is even effecting them? Do  
4 you have -- like it is five percent? One  
5 percent? Do you happen to know roughly that  
6 number?

7 MS. DRYE: I don't think we have  
8 right in front of us this second the  
9 distribution of volume at these hospitals but  
10 we can come back with that easily. And,  
11 again, this is the distribution of the risk  
12 standardized rates. And so then the construct  
13 -- those can be used in themselves. And  
14 there's quite a bit of range. There's a ten-  
15 point range there.

16 But the construct CMS uses on  
17 Hospital Compares is to put -- you know, use  
18 a confidence interval around that to assign  
19 hospitals to better, worse, or no different.

20 And we're just saying with this  
21 measure, even with the 95 percent number,  
22 which is high and, you know, you could use 95,

1 90, 80, whatever. It's not really specified  
2 in the measure. We would expect to see many,  
3 many more outliers and many, many fewer  
4 hospitals in the too few category, if any.

5 You know I don't know if there are  
6 hospitals that don't have fewer than 25 cases  
7 but we can come back to you with those  
8 numbers. And I apologize we don't have that,  
9 you know, exactly for you at this second when  
10 you have to vote.

11 CO-CHAIR LAZAR: Tanya?

12 MR. KRUMHOLZ: Well, I just want  
13 to elaborate one second because --

14 CO-CHAIR LAZAR: Could you  
15 introduce yourself?

16 MR. KRUMHOLZ: Yes, I'm Harlan  
17 Krumholz. I'm one of the developers.

18 The -- I mean I think what you  
19 have to think about is I don't think you  
20 should be thinking so much about empirically  
21 what counts but what are the volumes. And  
22 what does this mean to address? And how does

1 this extend what we've been doing so far?

2           So if you are interested in a  
3 hospital signal and you know that a lot of  
4 readmission measures, they track each other.  
5 That's what the group has been able to show.  
6 And you know that by looking at the hospital-  
7 wide, you're going to increase your volumes  
8 for any specific period of time that you're  
9 looking at, then you can be confident that in  
10 that particular aspect, it is a much better  
11 situation than what you've currently got.

12           And you can look empirically and  
13 we can provide you the evidence about what the  
14 numbers are, the outliers. But more  
15 importantly, looking at the volume shows you  
16 that this allows the small-volume hospitals to  
17 be in the game because truly, I mean I would  
18 expect this conversation to be more relevant  
19 if we're talking about MI, heart failure, and  
20 pneumonia, where really what we've done is  
21 suck those hospitals into the middle and we've  
22 made it very hard for you to be an outlier,

1 high or low, in those conditions.

2 And that's a problem that we've  
3 struggled with for a long time. And it's  
4 because of the amount of information that is  
5 available. But in this particular case, I  
6 think you guys should -- I mean from our point  
7 of view, this is much of an advance in terms  
8 of being able to discriminate performance and  
9 be fair to the small hospitals by being able  
10 to draw on their experience. We just didn't  
11 have enough experience because so many  
12 hospitals see fewer than one a month in this  
13 nation for some of those particular  
14 conditions.

15 MEMBER ALTERAS: Is there any way  
16 we could hold off on voting until we get the  
17 information that Elizabeth was talking about?  
18 Just because -- I mean I've been critical of  
19 this measure during the discussion. But, you  
20 know, underlying all of that, I'm a big  
21 advocate for the all-condition -- all-cause  
22 readmission measure.



1                   And so I would hate to then vote  
2                   against this if it turns out that the whole  
3                   issue that I've been concerned about isn't  
4                   really an issue at all. And that's pretty  
5                   important information for us to have I think.

6                   MS. PACE: Well, we probably can.  
7                   I'll see what the Chairs think about this. I  
8                   think we have to be very specific about what  
9                   question you have and whether that is  
10                  something that can be provided in a short  
11                  time.

12                  But we may want to get a sense of  
13                  the group whether people want to get that  
14                  information before they vote. And I think  
15                  then we can be flexible.

16                  CO-CHAIR KAPLAN: In just chatting  
17                  with Eliot briefly about this, it is my sense  
18                  that we should take a vote now. And that in  
19                  the comparison, because it may very well help  
20                  the group make these decisions when we come  
21                  back to compare the other two measures  
22                  tomorrow, because if the consensus of opinion

1 at that time is this is not a perfect measure,  
2 this is not a perfect world, but it's doing  
3 the best we can with what we have now.

4 So I think that discussion is  
5 probably a better reflection of, you know,  
6 maybe we -- in NQF history and vote that  
7 nothing is appropriate for measuring  
8 readmissions tomorrow. But my sense is that  
9 that kind of relativity will help us  
10 understand where we are and aren't. And is  
11 this an okay measure in this worst of all  
12 possible worlds?

13 CO-CHAIR LAZAR: So I think what  
14 you're hearing is a recommendation from us  
15 that we vote now with the option of sort of  
16 revisiting. We don't have to make it -- you  
17 know, we don't want people to feel that it is  
18 an absolute.

19 MEMBER SCHUSTER: Well, I guess  
20 that's just a clarification. If the vote were  
21 no, would we still compare tomorrow? I think  
22 that's important to understand.

1 MR. AMIN: So procedurally, as we  
2 set out the competing measure discussion for  
3 tomorrow, it would not go to tomorrow. Now if  
4 you feel that we really need to bring them all  
5 back for the head-to-head comparison, which we  
6 will have to do because most of these measures  
7 are competing, that's the will of the  
8 committee. Right.

9 I mean you would have to -- well,  
10 I guess it is a question. I mean the true  
11 procedural decision would be is if it doesn't  
12 move forward, then there is no competing  
13 discussion tomorrow.

14 However, if the committee felt  
15 otherwise and wanted to suspend, you know,  
16 that rule and then have that brought up for  
17 tomorrow, I mean that's up to the will of the  
18 Chairs and the committee.

19 But procedurally, strictly  
20 speaking, if it does not pass overall  
21 recommendation for endorsement today, it does  
22 not go to a competing measure discussion

1 tomorrow.

2 CO-CHAIR LAZAR: Okay. Let me  
3 make a suggestion and see if everybody agrees  
4 to it. Why don't we go through the three  
5 measures, you know, according to the protocol  
6 as it stands? And then depending upon what  
7 those results are, we can make a decision  
8 tomorrow about whether to revisit or do a  
9 competing analysis or what have you?

10 I think, you know, here sort of  
11 common sense and the desire for a good product  
12 ought to prevail. Is everybody comfortable  
13 with that? Okay.

14 CO-CHAIR KAPLAN: Let me propose a  
15 quick alternative, Eliot. I think maybe could  
16 we suspend the vote on the individual measures  
17 until the end of the day and then vote each  
18 one of them at the end of the day?

19 MS. PACE: So that kind of implies  
20 that you want to do some comparison?

21 CO-CHAIR KAPLAN: Why don't we  
22 call the committee on those two options

1 because the two different options. So if  
2 you'd rather vote now and then if you vote no  
3 understand that you don't have the option to  
4 compare tomorrow procedurally or --

5 MS. PACE: Let me just clarify. I  
6 think we have much more flexibility. I mean  
7 generally we, you know, if a measure doesn't  
8 pass, then it doesn't go into competing  
9 measures. We have kind of a unique situation  
10 here with having only three measures, all of  
11 them competing, and trying to address a  
12 Congressional mandate.

13 So obviously although it's not  
14 required, we would like to see a measure that  
15 is good enough to come out of this process.  
16 And that may take some back and forth with the  
17 developers.

18 So I don't think we want to  
19 present it as such an absolute thing. I think  
20 we should vote on the measure as it is. We'll  
21 do that for each measure.

22 And at the end of the day take

1 stock of where we're at. Regardless of how  
2 measures are voted up or down, we'll take  
3 stock, see if there are any issues that need  
4 to be revisited.

5 So we've not going to make this  
6 like -- this is not a final, not revisit vote  
7 at this point. And we want this vote to be  
8 based on, you know, given the measure and not  
9 think about either the other measures that are  
10 on the table or any kind of hypothetical  
11 measure in your mind because those don't  
12 exist.

13 So we're just looking at the  
14 measure as it is specified and with all of the  
15 analysis and data that were presented to you.  
16 Would it be suitable for endorsement? And  
17 this is just a preliminary, as I said, you  
18 know this can be revisited if more information  
19 would help you.

20 CO-CHAIR LAZAR: Is everybody  
21 comfortable with that?

22 Okay. So let's move to a vote.

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Adeela?

MS. ADEELA KHAN: Okay, voting on the overall suitability for endorsement, does the measure meet all the NQF criteria for endorsement? And this is -- the final recommendation again will depend on the assessment of competing measures. So we're voting yes or no. And you may start.

We have one person left. You might want to try it again. And that's eight for yes and ten for no.

CO-CHAIR LAZAR: Okay. It's time for lunch break. Let's come back in 30 minutes and we'll start again.

(Whereupon, the above-entitled meeting went off the record at 1:49 p.m., and resumed at 2:22 p.m.)

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (2:22 p.m.)

3 CO-CHAIR LAZAR: Okay. Everybody  
4 set? Terrific. So we're going to move the  
5 afternoon portion of the meeting to  
6 Introduction of Measure 0329, Risk-Adjusted  
7 30-Day All-Cause Readmission. And the  
8 developers are here to give us a very brief  
9 overview.

10 MR. STETTLER: Thank you. So I'm  
11 Ron Stettler, from UnitedHealthcare. And to  
12 give you guys a little bit of a background, we  
13 submitted and got approved the original --  
14 this original metric in 2008, and this was  
15 intended as an update.

16 And in general, what we're going  
17 to propose is a relatively major update. So  
18 over the last three or four years, we have  
19 determined that the metric can be improved,  
20 and what we're proposing is the improved  
21 metric.

22 And what we want to focus on, and



1 what we've been focusing on, using this metric  
2 internally, is for quality improvement. So  
3 we've had great success with this metric  
4 internally for quality improvement, both at  
5 individual facility levels, but generally  
6 across our markets and across our states.

7 And the other reason we wanted to  
8 make a change to this metric was, we were  
9 approached by NQF about making this capable of  
10 being applied to electronic data. So  
11 electronic health records, and so on. So in  
12 order to do that, we had to make a few  
13 modifications to the process.

14 The other thing I'd just like to  
15 point out is that within -- and just by using  
16 the historic metric, we have been able to  
17 increase and improve our results tremendously.  
18 About a 7 percent improvement in our Medicare  
19 readmission rate over the last three years, 3  
20 percent in our commercial readmission rate.  
21 Again, mostly thanks to our partners at the  
22 hospitals, but in general based on a lot of

1 the quality ensurement programs we've  
2 implemented.

3 So our focus in the metric is to  
4 make it transparent and usable, as well as  
5 making it accurate enough to adjust out as  
6 much of the variation as possible that's due  
7 to case mix. So the idea on this metric is  
8 really a case mix-adjusted, weighted process  
9 that will eliminate a lot of the  
10 characteristics of the initial admission from  
11 the outcome, the outcome being the risk of  
12 readmittance.

13 And we tested it using kind of  
14 classic hold-out samples, and using our own  
15 internal data set, which -- about 20 million  
16 members, 4 to 5 million admissions. We used  
17 it to develop the actual factors themselves.  
18 And what we would propose is, we will make  
19 public our factors.

20 And those factors would, in a  
21 sense, replace the current factors that are  
22 out in the existing metric. So the existing

1 metric attempts to use the CMS DRG consumption  
2 weights. We propose replacing those with  
3 weights internally developed, specific to  
4 readmit. And we think that it improves -- in  
5 fact, we know it improves the accuracy of the  
6 model tremendously.

7           The categorization process we are  
8 going to employ is a -- is based on the AHRQ  
9 procedure and diagnostic groups. And there  
10 are two different sets of categories, one for  
11 0-64 and one for 65+. And there's about 220  
12 groups for the commercial population. We'll  
13 have a little less than 200 groups for the  
14 Medicare population.

15           And again, in our testing, what we  
16 found is that once you apply those weights,  
17 you can basically predict the ultimate results  
18 in the hold-out sample, or in the next year on  
19 a longitudinal basis, to a great degree. And  
20 we tried to make it simple. We tried to make  
21 it easy to implement.

22           It's implementable based on only

1 the admission that you're looking at  
2 individually. You do not need longitudinal  
3 data to create, or to calculate your risk at  
4 that point. So a facility can use it  
5 concurrently, without a lot of look-back.

6 Our implementations usually  
7 require a six-month run-out period. You need  
8 to have some run-out to let the lag for the  
9 readmit to actually occur.

10 But in general, we think that it  
11 really does give you an advantage in terms of  
12 the practical implementations of quality  
13 improvement. It doesn't rely on older and  
14 staler data.

15 In our implementation, we do share  
16 all the readmit information back to the  
17 facilities when requested. So if you have a -  
18 - you know, if you're a facility that does get  
19 a lot of tertiary care referrals, and so on,  
20 and transfers from others, you do get to see  
21 where those go and where they come from.

22 And I guess I'll stop there and

1 just open it up for questions. Or I'm not  
2 sure what the process is.

3 CO-CHAIR LAZAR: Okay. So are  
4 there specific questions for the developers?  
5 Any specific questions for the developers?  
6 Laurent?

7 MEMBER GLANCE: So if I understand  
8 correctly, your methodology is based on direct  
9 standardization, correct?

10 MR. STETTLER: Correct.

11 MEMBER GLANCE: And so for any  
12 individual, for any specific hospital, you  
13 have roughly these maybe 200 bins or so, and  
14 you determine the proportion of patients that  
15 were readmitted within each one of those bins,  
16 right? And then you apply those proportions  
17 to the standard population in order to obtain  
18 a standardized readmission rate.

19 And my question is, are you  
20 concerned that, within specific hospitals,  
21 that those cells may be very sparsely  
22 populated, and that that could lead to some

1       instability of the estimates that you derive  
2       based on those rates?

3               MR. STETTLER:   So the weights are  
4       definitely developed across the entire  
5       population of data initially, and then they're  
6       applied at the individual facility, at the  
7       individual bucket level.

8               MEMBER GLANCE:   So the rates are  
9       not based on the individual hospital rates.

10              MR. STETTLER:   No, the rates are.  
11       The actual -- so, we do calculate an actual  
12       readmission rate for each individual facility,  
13       and we calculate an adjustment factor for each  
14       facility based on those admissions.   So you  
15       get -- it's very similar to applying the CMS  
16       consumption weights, to get a risk-adjusted  
17       length of stay, or a risk-adjusted cost per  
18       admission or cost per case.   The logic is  
19       really very similar to that process.

20              And depending on the case mix of  
21       your admissions in that time period, you will  
22       generate an average weight.   And that average

1 weight may be higher than average, lower than  
2 average, or average. And you use that to  
3 adjust your actual value to get an adjustment  
4 mark.

5           And that adjustment mark is what  
6 you would use to compare yourselves to  
7 yourself over time. So if you had a large,  
8 changing case mix over a two or three year  
9 period, it wouldn't be right to say "Yes, I've  
10 done a great job with readmit reduction" or  
11 "I've done a poor job with readmit reduction."  
12 You would want to be able to adjust for a  
13 change in that mix over time.

14           And that's basically what this  
15 would do. And it also allows you, of course,  
16 to compare yourself to the other facilities  
17 with potentially different mixes.

18           You know, we don't solve the  
19 problem of low volume. If you have a really  
20 low volume, then obviously the validity of the  
21 result's going to be -- you're going to have  
22 a higher confidence interval in the results

1 than you would if we had a very large, very  
2 high volume facility.

3 MEMBER GLANCE: But it would just  
4 -- just to -- I just wanted to clarify, but  
5 again, you're using direct standardization,  
6 and the rates for the bins -- for those  
7 individual cells -- are calculated for each  
8 specific hospital. That's very important,  
9 because you're not basing those rates on the  
10 entire population. You're basing those rates  
11 for the individual cells on individual  
12 hospitals.

13 MR. STETTLER: The rates of cells,  
14 the actual rates of a given --

15 MEMBER GLANCE: Within each cell

16 MR. STETTLER: Based on the  
17 individual facility's report.

18 MEMBER GLANCE: Thank you.

19 CO-CHAIR LAZAR: All right. Well,  
20 let's move to the four areas that we have to  
21 cover. And obviously in the comments,  
22 particularly around scientific acceptability,



1 there may be other questions that come up that  
2 would require a concise response from the  
3 developer.

4 But let's start with the  
5 importance to measure and report. Have we --  
6 you know, we did this earlier. I think we've  
7 gotten past the issue of, "Is this a valid  
8 outcome, this measure, or not?", and come to  
9 some accommodation on that issue. Does  
10 everyone feel comfortable with the criteria  
11 within this question, and are we ready to turn  
12 it over to Adeela for a vote?

13 (No response.)

14 CO-CHAIR LAZAR: Hearing no  
15 dissenters, Adeela, take it away.

16 MS. ADEELA KHAN: Again, on  
17 importance to measure and report, we're  
18 looking at high-impact performance gap in  
19 evidence. Was the threshold criteria,  
20 importance to measure and report met?

21 And we're voting yes or no, and  
22 you can start now.

1 (Whereupon, a vote was taken.)

2 MS. ADEELA KHAN: So we have 16  
3 for yes. We're missing two people.

4 CO-CHAIR LAZAR: Okay. I assume  
5 we're comfortable with a substantial majority  
6 and we can move forward. Yes?

7 (No response.)

8 CO-CHAIR LAZAR: Okay. So let's  
9 move to the issue of scientific acceptability.  
10 And as we did earlier, why don't we tackle  
11 reliability first, and then we'll talk about  
12 issues of validity. Discussion around  
13 reliability?

14 DR. GHINASSI: I think this is in  
15 reliability. I hope it is. If not, then just  
16 keep moving. There was a phrase where -- and  
17 I'm paraphrasing, but it said "Risk adjustment  
18 calculation happens two ways: retrospective  
19 analyses of hospital performance  
20 determination, and real-time EHR environment."

21 I'm just unclear, in terms of  
22 reliability, how those two methods are going

1 to occur simultaneously across the concurrent  
2 national landscape, where there's such a mix  
3 between paper-based systems and electronic  
4 systems. And how does that play out,  
5 methodologically.

6 MR. STETTLER: That's a really  
7 good question. We've implemented it on our  
8 notification area. So UnitedHealthcare gets  
9 notification data from most of the hospitals  
10 in the country, and we get it in real time, or  
11 close to real time.

12 And so we've actually implemented  
13 it and compared the results to the claims-  
14 based version. One of the goals in this  
15 process was to make a single metric that could  
16 be applied in both environments.

17 And all of our reliability testing  
18 that you're seeing in the documents are based  
19 on the claims-based side. We have not yet  
20 completed the electronic portion, but we do  
21 believe that the weights may very well be  
22 different, because the data is -- may be less

1 complete, or at least it's going to be  
2 different on the electronic medical records  
3 side than it would be on our claims data.

4 And we think that, chances are,  
5 you will need a different set of weights for  
6 the EHR sources. So that was the main thing  
7 we were trying to get to with that statement.

8 CO-CHAIR LAZAR: Karen?

9 MS. PACE: So I think -- we didn't  
10 get these specifications, correct? So you're  
11 evaluating this measure as a claims-based  
12 measure, because that's what's before us now.

13 MR. STETTLER: Correct.

14 MS. PACE: All right.

15 MR. STETTLER: The documents that  
16 you have before you -- again, the point was  
17 that, in theory, it can be applied to the e-  
18 side.

19 MS. PACE: Right.

20 MR. STETTLER: That was one of the  
21 changes we made.

22 MS. PACE: Okay. The thing is, we

1 have some very specific requirements for  
2 electronic health record specifications and  
3 testing, which we don't have. So I think,  
4 just to get everybody on the same page, you'll  
5 be evaluating this measure as a claims-based  
6 measure.

7 CO-CHAIR KAPLAN: Can I ask a  
8 point of clarification from Karen? It's  
9 supposed to change to be translatable to an  
10 electronic environment as well. How much of  
11 a handicap for this measure is that criteria?

12 MS. PACE: I'm sorry, could you --

13 CO-CHAIR KAPLAN: Yes. If we are  
14 evaluating this measure on its electronic  
15 venue, if you will, how much -- as well,  
16 without data or evidence to support or plans  
17 for -- or specific detail of plans for, as we  
18 saw in other applications, how much are we  
19 valuing -- is that a limitation of the  
20 documentation that's been provided?

21 MS. PACE: Well, I think -- what I  
22 was saying is that I think that, although they

1 mentioned that it could be done in an  
2 electronic health record environment, we don't  
3 have the kind of specifications for that, or  
4 it hasn't been tested that way.

5 So I think we just won't even  
6 consider that, for purposes of this discussion  
7 and evaluation of this measure.

8 MR. AMIN: So this measure would  
9 have recommended for endorsement, it would be  
10 only applicable for administrative claims  
11 data, as specified in their submission, that  
12 the data source is administrative claims.  
13 It's been tested in administrative claims.  
14 There are plans, as described by the  
15 developer, although what's in front of you is  
16 a claims-based measure and should be evaluated  
17 as such.

18 CO-CHAIR KAPLAN: Can I ask one  
19 other follow-up question, procedurally? To  
20 what extent does the Congressional mandate  
21 include electronic health records? Or does  
22 it?

1 MS. PACE: To my knowledge, it  
2 does not at all include them.

3 CO-CHAIR LAZAR: Okay. Ashish?

4 MEMBER JHA: So kind of staying on  
5 that theme, I guess, should we factor in at  
6 all the ability or the fact that we may be  
7 able to move towards electronic sources of  
8 data at all into our thinking about this, or  
9 would you -- I'm seeing from Eliot the answer  
10 is no. Is that right?

11 CO-CHAIR LAZAR: I think the  
12 answer is no. I think we're strictly looking  
13 at this in terms of its criteria as a claims-  
14 based measure. And the promise of  
15 translatability or applicability to an  
16 electronic record, I think we're going to have  
17 to keep entirely separate, as tantalizing as  
18 that may be.

19 Other comments? Bruce?

20 MEMBER HALL: So I take that  
21 instruction to mean that this paperwork would  
22 actually need to be edited, that if we did

1       decide to pass 0329, we would not be passing  
2       the portions of it that are discussing the e-  
3       submissions, so to speak.

4                   MS. PACE:  That's correct.  I  
5       mean, most of that discussion is descriptive,  
6       versus actual specifications or testing, so --

7                   DR. HALL  Right, but I wouldn't  
8       want there to be confusion about us -- we're  
9       sort of tacitly saying "0329 has been  
10      approved," and then someone going back and  
11      saying "Okay, well, there it is."

12                   CO-CHAIR LAZAR:  Yes, I think you  
13      make a very good point.  Other comments about  
14      reliability?

15                   Okay, Sherrie.

16                   CO-CHAIR KAPLAN:  I have a  
17      question, actually, about the precision using  
18      your past experience with this information.  
19      Because we didn't get as much information on  
20      that topic.  What is your experience with the  
21      measurement error of what you're doing?

22                   MR. SCANDRETT:  So again, as Ron



1 said, we tested -- are you talking about the  
2 new measure, or the old measure that this is  
3 replacing?

4 CO-CHAIR KAPLAN: That's a  
5 confusion to me. I guess we're talking about  
6 the new measure in front of us, yes.

7 MR. SCANDRETT: I mean, we did  
8 testing that was very similar to what was  
9 shown under the previous, the last  
10 presentation, in that we tested to see how  
11 well it fits in terms of the intercept of one  
12 slope. I mean, it tests very well, whether  
13 you're comparing the actual path of the data  
14 to a hold-out sample, it tested very well.  
15 Whether you're comparing a two-year look  
16 versus a subsequent third year that was not  
17 included, in terms of a longitudinal ability  
18 to fit, it seemed to fit very well.

19 We also tested national versus  
20 regional, specific factors, and those matched  
21 out very well. So is that sort of what you're  
22 getting to, or --

1 CO-CHAIR KAPLAN: Well, let me  
2 push you a little bit on what "very well"  
3 means. Because what we've got so far, or what  
4 I heard you say, was test/retest reliability.

5 MR. SCANDRETT: Yes.

6 CO-CHAIR KAPLAN: So what is the  
7 measurement error proportion of what you get  
8 at the hospital level? Do we know what's the  
9 true score variability at the hospital level,  
10 and what belongs to measurement error?  
11 Because you've had some experience using this,  
12 right?

13 MR. SCANDRETT: Yes. I mean, that  
14 stuff we got to we didn't -- wasn't part of  
15 the original question. We have looked at that  
16 subsequently. Again, I guess this comes to  
17 how much of -- when you fit to a hospital-  
18 level result, how accurate do you want that to  
19 be?

20 I mean, you could create a model  
21 that takes out all the variance between  
22 hospitals and it would fit them very well, but

1 that naturally doesn't tell you much about  
2 relative quality performance of those  
3 hospitals, if you could exactly predict how  
4 that hospital performs.

5 CO-CHAIR KAPLAN: I wasn't  
6 actually asking the validity question, which  
7 is next.

8 MR. SCANDRETT: Oh, okay.

9 CO-CHAIR KAPLAN: I was asking the  
10 precision question, which is the reliability  
11 issue. You talked about test/retest, but I  
12 was wondering, what part belongs to  
13 measurement error of what you've done, and  
14 what's the real probable true score variation  
15 that you're seeing at the hospital-level  
16 measure?

17 MR. SCANDRETT: Yes. We did not  
18 test that at the hospital level. We were  
19 focusing on testing the individual buckets,  
20 the RRC categories that we divide everything  
21 up into, and then comparing those to see if  
22 those were accurately predicted over time,

1       repeatable over time, rather than at the  
2       facility level.

3                   CO-CHAIR LAZAR:   Okay.   Comments  
4       about -- any other comments about reliability?

5                   (No response.)

6                   CO-CHAIR LAZAR:   Let's turn to  
7       validity.   Comments or questions about  
8       validity?

9                   CO-CHAIR KAPLAN:   Let's read the  
10       criteria again, just to make sure.   Can you  
11       read them?

12                   MR. AMIN:   Yes.   Validity is  
13       assessing whether the specifications are  
14       consistent with the evidence.   The extent of  
15       the validity testing at the data element or at  
16       the measure score level.   Basically where you  
17       just were.

18                   Justification of exclusions,  
19       whether they relate to the evidence.   Risk  
20       adjustment, the risk adjustment model.  
21       Identification of differences in performance  
22       and comparability of data sources and methods.

1           If there -- this is a procedural  
2 matter. If there is anywhere in the measure  
3 that you want us to focus on and bring up in  
4 this reading, we're happy to do so. Also,  
5 obviously, there are the preliminary  
6 evaluations here that you can reference in  
7 your discussion as well.

8           CO-CHAIR LAZAR: Okay. Comments  
9 about validity. Frank?

10          DR. GHINASSI: Just a point of  
11 clarification. On the document that we were  
12 sent, which was sort of a summary document --  
13 it was on page 6 -- you go into a fair amount  
14 of detail -- great detail, by the way -- on  
15 quoting verbatim the specific guideline  
16 recommendations for what looked like process  
17 verification, aimed at obviously facilitating  
18 an effective transfer of care.

19           And it's a great list. I mean, it  
20 goes on to page 7, and there are ten or eleven  
21 sub-bullets. I was just confused about how  
22 that -- how the inclusion of that plays into

1 what it is you're measuring, and how does that  
2 relate to the validity of the measure that's  
3 being presented?

4 It's a wonderful set of processes,  
5 I'm just not sure how it all fits into what  
6 this particular instrument's going to do.

7 MR. STETTLER: So that's page 6,  
8 the specific guideline recommendations?

9 DR. GHINASSI: Yes, it starts on 6  
10 and ends about midway through 7.

11 MR. STETTLER: I'll be quite  
12 candid. I mean, we put in the guidelines that  
13 our clinicians use. We tried to follow the  
14 form, and tried to apply it here.

15 DR. GHINASSI: But I mean, does  
16 that play a role in this particular measure?

17 MR. STETTLER: I would have to  
18 read through them, honestly. I didn't put  
19 these in. The clinicians part of our team  
20 did.

21 DR. GHINASSI: I guess the  
22 technical question is if you could tell us

1 what role, and if it does, how we'd be asked  
2 to evaluate the measure with the testing.

3 MR. SCANDRETT: Yes, I think these  
4 are just references to what the guidelines are  
5 for, I guess, quality of care to avoid  
6 readmissions.

7 MS. PACE: That would just be  
8 information about the relationship between  
9 this outcome measure and positive instructions  
10 of care. So it's back on the idea of it being  
11 a health outcome, and are there structures and  
12 processes of care that can influence the  
13 outcome.

14 So that's just the list --

15 DR. GHINASSI: I just want to be  
16 clear that, as defined, the measure -- I  
17 didn't see it, anyway -- doesn't suggest any  
18 way for any of these variables to be included  
19 in the measure.

20 MR. STETTLER: That's correct.

21 DR. GHINASSI: So I was just  
22 confused about why they're there. That's all.

1 CO-CHAIR LAZAR: Okay. Other  
2 comments or questions on validity.

3 (No response.)

4 CO-CHAIR LAZAR: Okay --

5 CO-CHAIR KAPLAN: Mark is --

6 CO-CHAIR LAZAR: Mark, I'm sorry.  
7 I missed you.

8 MEMBER SCHUSTER: I don't know if  
9 I should bring this up now or at usability,  
10 but I was curious about the decision to go  
11 from -- zero to 64 seemed like a very wide age  
12 range, and I'm just not used to seeing such a  
13 wide range. And I'm just wondering how that  
14 played out with case mix adjustment, how this  
15 plays out for children's hospitals versus  
16 general hospitals.

17 Often it seems like case mix  
18 adjustment, just in general, not in particular  
19 to all-cause readmission, is just very  
20 different for pediatric populations.

21 MR. STETTLER: Yes, and that's one  
22 of the things we've actually -- we wanted to



1 make sure it was inclusive of pediatrics,  
2 because our prior method actually wasn't. It  
3 specifically disallowed under 18.

4 So we wanted to make this more  
5 specific. I will tell you that the OB and the  
6 peds diagnostic categories work out very well.  
7 They test well. I do think that one  
8 modification we may want to make is to split  
9 it into three, to add a 0 to 17 set of  
10 factors, as well as a greater than 65 and an  
11 18 to 64.

12 But the way it works now, they  
13 actually do test pretty well, and they  
14 actually work pretty well. Again, I would go  
15 to stratification, would be my main emphasis  
16 there. Would I want to compare a pediatric  
17 hospital in with the rest of the general  
18 hospitals in my measure? I think I would go  
19 into a stratified process and compare them to  
20 others of the same build. That would be, I  
21 think, the way to implement it. But again,  
22 that's kind of a process question for who's

1 going to implement it, so --

2 CO-CHAIR LAZAR: Okay. Michael?

3 MEMBER LANGBERG: I'm the one  
4 asking this question, which makes me suspect  
5 the answer's really easy, but it's on 2.b.4,  
6 on the risk adjustment strategy. The increase  
7 that was in the packet we got was simply this  
8 measure itself is a risk adjustment. And I  
9 didn't really understand what that meant. I'm  
10 sure others do, but I didn't understand what  
11 it meant.

12 MR. SCANDRETT: Yes. I mean, I  
13 think that may have just been how we sort of  
14 interpreted the questions. The answer to that  
15 is that the questions were actually placed in  
16 there, but that is the entire purpose of what  
17 we've done here, to create these factors based  
18 on the categories, the diagnosis categories  
19 and so on -- the sole purpose of that is to,  
20 in fact, risk adjust everything.

21 And that's sort of -- risk  
22 adjustment data is probably spread out

1 throughout the other sections. It's not  
2 really -- creating a 30-Day readmission rate  
3 without impacting adjustment would, I guess,  
4 not be that useful. So it's really -- all the  
5 risk adjustment -- the entire purpose of all  
6 these calculations, and creation of these  
7 buckets, is to do the risk adjustment, so it's  
8 spread elsewhere in the answers in this  
9 document.

10 CO-CHAIR LAZAR: Okay. Paula?

11 MEMBER FOLTZ: I didn't see a risk  
12 adjustment for AMA or transfers, or rehab. Is  
13 there a reason for that?

14 MR. STETTLER: For transfers, do  
15 you mean same-day transfers? So, one of the  
16 most important methods about this, obviously,  
17 is defining the case itself, and making sure  
18 that you're looking at unique admissions and  
19 so on.

20 So one of the most important  
21 aspects is to try to remove, or to group the  
22 transfers together. So our recommendation is

1 that a case that's transferred isn't a  
2 readmittance, it's excluded. You have to have  
3 a space between the discharge and the admit in  
4 order to be considered a readmission.

5 I don't think that we -- so rehab  
6 is in there. And I don't think we excluded it  
7 specifically.

8 CO-CHAIR LAZAR: Just so I  
9 understand, so a patient who is transferred  
10 from, or discharged from an acute care  
11 hospital and admitted to a rehab facility,  
12 which is bureaucratically the way you have to  
13 do it, is considered a readmit.

14 MR. STETTLER: As long as it was  
15 done on the same day as discharge, it would  
16 not be a readmit.

17 CO-CHAIR LAZAR: Okay. It would  
18 not be a readmit. Okay. So I think that was  
19 the question. Okay, that's helpful, then.

20 MEMBER FOLTZ: But patients who  
21 went to a nursing home and then came back when  
22 they were ready for a rehab admit, would be --

1 MR. STETTLER: That would be a  
2 readmit.

3 MEMBER FOLTZ: Okay.

4 MR. STETTLER: As long as it's  
5 within 30 days.

6 MEMBER FOLTZ: Yes, we're being  
7 consistent with that.

8 CO-CHAIR LAZAR: Karen? Karen,  
9 did you want to --

10 MS. PACE: I'll wait until --

11 CO-CHAIR LAZAR: Okay, Bruce and  
12 then Richard, and then Tanya, and then Warren.

13 MEMBER HALL: Well, I raised my  
14 card to slow down the discussion, because I'm  
15 not that comfortable with the sophistication  
16 of the risk adjustment approach. I think I  
17 understand it, and I know Larry was asking  
18 about whether this was really direct or  
19 indirect standardization, and whatnot.

20 And I'm just going to speak  
21 bluntly. Frankly, it seems to me that this is  
22 a more crude response than we've been

1 presented with earlier this morning, and that  
2 because the discussion was more detailed  
3 earlier this morning, I think we were  
4 discussing at a different level of rigor.

5 As I understand, you've created  
6 several hundred categories, interacting age  
7 and procedures and diagnoses and whatnot, and  
8 then calculated a rate for those categories,  
9 and then I think you're crediting each  
10 institution with the appropriate rate based on  
11 case.

12 But it's not a hierarchical  
13 approach, and this morning we were talking  
14 about some relative merits of hierarchical  
15 approach, in which we were actually kind of  
16 condensing hierarchical approach with the  
17 aspects of shrinkage, which we probably  
18 shouldn't have done. But this does not sort  
19 of meet what I consider current standards of  
20 treating clustered data in a clustered  
21 fashion.

22 So I want to slow down this

1 discussion, and say I don't feel like we're  
2 holding this to the same level of rigor that  
3 we did this morning, and I would like to say  
4 I feel this is a less informed -- I feel like  
5 we're looking at a less informed, insightful  
6 approach.

7 CO-CHAIR LAZAR: Well, I want to  
8 be careful. Because the volume of discussion  
9 does not necessarily reflect the assessment of  
10 the measure. It could be that people have  
11 come to some kind of impression one way or the  
12 other.

13 MEMBER HALL: I agree.

14 CO-CHAIR LAZAR: I just want to be  
15 careful here that we don't --

16 MEMBER HALL: And for that express  
17 reason, I didn't want discussion to only be 10  
18 seconds, and create an impression that  
19 everybody was, in fact, comfortable.

20 CO-CHAIR LAZAR: Richard?

21 MEMBER BANKOWITZ: Yes, I wanted  
22 to, along the same lines, just make sure that

1 I understand correctly when you use the term  
2 risk adjustment. It may be semantic, but it  
3 really is a case mix adjustment. We're  
4 adjusting to discharge -- diagnosis or  
5 procedure, right?

6 MR. STETTLER: Diagnostic,  
7 procedure, and --

8 MEMBER BANKOWITZ: But in terms of  
9 the co-morbidities, planned versus unplanned,  
10 other status -- other factors are not going to  
11 be in, by definition, those boxes, right?  
12 It's just age and discharge.

13 MR. STETTLER: Our understanding  
14 of all causes, it should be all causes. So we  
15 want to include all admissions.

16 MEMBER BANKOWITZ: No, I  
17 understand this. So I guess, to turn this  
18 back to validity, base validity is one aspect  
19 of validity, and we've had this in use. What  
20 have been the responses? What have been the -  
21 - what's the impression of the providers?

22 MR. STETTLER: We have -- I can't



1 remember the exact number, but we have a few  
2 dozen contracts signed that use this  
3 methodology in a performance-based construct.  
4 And we are very keen to make sure that it is  
5 linked with risk-adjustment, because we think  
6 that's important to balance it. We don't want  
7 people to start too early or late, and we have  
8 it be stable. So I think it's a good balance.

9           So we have it -- again, it's  
10 improving our internal readmissions, and we  
11 have convinced hospitals to contract with us  
12 based on this methodology. Whether or not --  
13 I don't know how to -- obviously, we contract  
14 with thousands of hospitals, so it's a pretty  
15 small number at this point.

16           MEMBER BANKOWITZ: Okay, not to  
17 make too fine a point of it, but secular  
18 trends are decreasing. So for example, we  
19 can't just look at one population before and  
20 after, and say "Well, we've impacted the  
21 readmission." Or do you have any other  
22 external data to suggest that this actually

1 was important in reducing the readmission  
2 rate?

3 MR. STETTLER: We can't control  
4 for the secular variables, as far as -- you  
5 know, I don't think --

6 MR. SCANDRETT: Yes, I mean, it  
7 also depends on the interventions. You try  
8 and target it. I mean, this can be used to  
9 identify facilities that may be not  
10 performing. But then, once you've identified  
11 them, there's no sort of cookie-cutter  
12 solution to say "This is what we have to do  
13 for all these facilities."

14 It's really just a matter of using  
15 this tool to identify places where there may  
16 be room for improvement, and then you have to  
17 look at the specific case, to sort of say "How  
18 do we improve things?" So it's part of the  
19 package that we're doing.

20 CO-CHAIR LAZAR: Okay. Tanya?

21 MEMBER ALTERAS: This is a really  
22 dumb question, so I apologize, but on page one

1 of the Measure Submission Form, it says at the  
2 bottom "Note to committee: the measure  
3 includes planned and unplanned readmissions,"  
4 but then it doesn't say it anywhere else. I'm  
5 just curious, why is it including planned? Or  
6 how does it include planned, in the way --

7 MR. STETTLER: Our basic -- again,  
8 we want to make the method be claims-based and  
9 dependent. Doing matched pairs, in our  
10 opinion, is a very difficult and time-  
11 consuming and almost impossible thing to do  
12 for individual facilities. Again, we wanted  
13 to include all cause, all readmissions.  
14 There's just no good way to determine what's  
15 a planned readmit on the claim, as far as our  
16 experience goes, that's reliable enough to be  
17 used in this context.

18 CO-CHAIR LAZAR: Okay. Laurent?

19 MEMBER GLANCE: At the risk of  
20 being redundant, I just -- my impression in  
21 looking at this particular measure is that it  
22 really doesn't level the playing field. There

1 essentially is no adjustment for comorbidities  
2 other than age. And with age, the patients  
3 are divided up into two age strata, which is  
4 incredibly crude.

5 So that is my major concern with  
6 this measure is: there is extremely limited  
7 risk adjustment.

8 CO-CHAIR LAZAR: Brent and then  
9 Ashish. And Bruce, are you still up, or is  
10 that from before? Great, thank you.

11 MEMBER ASPLIN: I'm just following  
12 this through. So essentially, just primary  
13 diagnosis and primary procedures. So Patient  
14 A, both had a STEMI and both had angioplasty,  
15 or something, but Patient A also had COPD,  
16 diabetes and major depression, and Patient B  
17 didn't. They would both be in exactly the  
18 same weighted risk readmission category. I'm  
19 just playing out what Laurent was saying.

20 MR. STETTLER: Again, we wanted to  
21 make it based on the individual hospital  
22 admission. And the secondary diagnoses, we

1 think, are not needed for the measure. If you  
2 want to do comorbidities, you should take a  
3 historical timeframe, pull all claims for the  
4 member, and identify every criteria they have.  
5 That's the only way to be fair in doing those  
6 comorbidities adjustments. If you only base  
7 it on the claim, you run the risk of being  
8 inaccurate.

9 CO-CHAIR LAZAR: Yes, I just want  
10 to be careful that we don't get into a debate  
11 about this. We're simply trying to clarify  
12 what the methods are, and then the committee  
13 members simply have to opine on them. So I  
14 just urge my colleagues to have caution.  
15 Ashish?

16 MEMBER JHA: I'm not going to get  
17 into a debate. I just want to understand and  
18 maybe ask a question about it. It seems  
19 absolutely right that if you get claims just  
20 from the hospital, it's going to be incomplete  
21 and it's not going to be perfect.

22 But I would think, based on the

1 other modeling data that are out there, that  
2 you get better than not doing it at all. And  
3 I guess the question is, can you talk a little  
4 bit more about your decision to opt out of  
5 that?

6 And just, since we were exploring  
7 options, is that a fixable issue? Is that  
8 something that you guys can consider going  
9 back and seeing if you could do this? And I  
10 realize that's not necessarily on the table.  
11 We're not here to recommend how you should  
12 build your measure.

13 But we're just trying to  
14 understand the thinking behind saying "Well,  
15 it's not perfect, therefore we're going to opt  
16 out of doing it at all."

17 MR. STETTLER: No, I think it's  
18 definitely something we'd consider. Again, I  
19 think it comes back to a balance between  
20 usability, feasibility, validity, and  
21 reliability. I think there's got to be some  
22 kind of balance. If you make it too robust or

1 too refined, then we hear "Well, two years old  
2 data isn't good enough. We can't wait that  
3 long. We need to see the other admission."  
4 And then nobody uses it, right?

5 And then on ours, we don't have  
6 enough of that, so we don't want to use that  
7 one either. So maybe there does have to be  
8 some middle ground here that we can agree to  
9 and get a model that works and is feasible.

10 CO-CHAIR LAZAR: Mark?

11 MEMBER SCHUSTER: Yes --

12 DR. BURSTIN: Put your mic on.

13 MEMBER SCHUSTER: Sorry. I'm so  
14 used to thinking about removing chemotherapy  
15 as an example, as an effort to sort of get at  
16 planned readmissions, is that something that  
17 you guys tried in the earlier version of it?  
18 Did you try it?

19 And we'll get to usability later,  
20 but has there been any push-back in the  
21 existing measure for not having removed -- or,  
22 we can never remove all planned readmissions,

1 of course, but to make an effort to remove  
2 some of the more obvious ones, I guess?

3 MR. STETTLER: Yes, there has been  
4 some push-back, absolutely. I think that, if  
5 you think about the way the factors work, the  
6 factors by default already include adjusting  
7 for planned readmits. The chemotherapy risk  
8 adjuster is very high, so there's a very high  
9 likelihood of readmit if you have a  
10 chemotherapy admission.

11 We have had some facilities who  
12 want to stratify and isolate out portions of  
13 the readmissions: transplants, chemo, and some  
14 of the peds and NICUs and things like that.  
15 So we have had some push-back there, but the  
16 nice thing about the metric is, you can  
17 simply, you know, choose to stratify the  
18 population and exclude it from the metric on  
19 a go-forward basis if you need to.

20 So it is flexible in that way. To  
21 completely exclude it and not even have it  
22 included as a way, as an ability to use,



1 means, I think, that a cancer hospital can't  
2 be compared to their peers, because we don't  
3 provide weights for the cancer hospital's  
4 admissions. So we just think it's a good idea  
5 to include them all at the initial outset.

6 CO-CHAIR LAZAR: Leslie?

7 MEMBER KELLY HALL: Just for  
8 clarification, you've only tested this on  
9 hospitals that have contracted with you? Is  
10 that what you just said?

11 MR. STETTLER: Correct, yes.

12 MEMBER KELLY HALL: And so it's  
13 only your data --

14 MR. SCANDRETT: Well, they have to  
15 be contracted with us to --

16 MR. STETTLER: Well, we have non-  
17 par data in as well. But the vast majority is  
18 going to be participant.

19 MEMBER KELLY HALL: And is there  
20 anything proprietary about the data that  
21 you're collecting, versus the claims data that  
22 would be collected by CMS?

1 MR. STETTLER: As far as we know,  
2 no. CMS has done a really good job of helping  
3 us standardize the data submissions, so the  
4 data coming in on the claims look very  
5 similar. We used a five percent sample, and  
6 no reason you couldn't do that, but we don't  
7 think that there's anything in our method that  
8 would be non-standard, that you couldn't deal  
9 with on anybody's claims data.

10 MEMBER KELLY HALL: Thank you.

11 CO-CHAIR KAPLAN: I just have one  
12 quick question for you. Somebody like me --  
13 I'm a psychometrician, so my use of the term  
14 "factor" means a little bit different than it  
15 sounds like you're using. So by "factor," do  
16 you mean a variable? Do you mean a composite?  
17 Is there some method you use to approach the  
18 derivation of those whatever-they-ares?

19 MR. STETTLER: Yes, it goes back  
20 to the calculation of the risk factor for the  
21 readmit, into those 220 groups. And that's  
22 basically what I'm referring to. So it's: how

1 often do admits that look like this, that have  
2 this clinical grouping, get readmitted? And  
3 that's how we create the factor in the first  
4 place, and then we apply it to the hold-out  
5 sample to see how well it predicted it.

6 CO-CHAIR KAPLAN: In terms of what  
7 we call sampling from the domain of  
8 observables, what exactly -- if those clusters  
9 vary, those clusters of characteristics vary,  
10 how confident are you that those clusters  
11 reflect the same overall construct?

12 MR. SCANDRETT: Not sure I follow.  
13 So, in terms of the clusters of each of the  
14 condition buckets, is that what we're talking  
15 about?

16 CO-CHAIR KAPLAN: You  
17 collectivized, in my understanding, 200 or  
18 some odd number of buckets.

19 MR. SCANDRETT: Yes.

20 CO-CHAIR KAPLAN: So that, in  
21 order to sort of adjust away whatever it is  
22 you think is an unfair contribution, that's

1 not a reflection of quality of care, to that  
2 hospital's readmission, if you're going to  
3 vary the clusters, similar to sampling  
4 different questions for a math test, they have  
5 to at least all measure math.

6 MR. SCANDRETT: Yes.

7 CO-CHAIR KAPLAN: So to what  
8 extent do you think that that -- and have you  
9 tested that that kind of clustering isn't  
10 measuring something that you didn't intend to  
11 measure for one hospital, and something very  
12 different for another hospital?

13 MR. SCANDRETT: We have not tested  
14 that.

15 CO-CHAIR LAZAR: Okay. No further  
16 discussion or questions? Bruce, you had one  
17 more?

18 MEMBER HALL: I just want to know,  
19 quickly -- so again, here, there's no SES or  
20 other resource consideration with respect to  
21 the population, the community. That's also,  
22 again, completely absent from these

1 discussions.

2 CO-CHAIR LAZAR: Okay. Karen?

3 MS. PACE: Again, I just want to  
4 make a couple clarifications for the steering  
5 committee.

6 Although this measure is an update  
7 or change to a previously endorsed measure, as  
8 Alexis pointed out earlier, our current  
9 process of endorsement maintenance is that  
10 whether a measure was endorsed previously or  
11 is coming in new, it's held to the criteria  
12 that currently exist.

13 So you know, we have more guidance  
14 on reliability, validity, and looking at the  
15 risk adjustment methodology. Just to make  
16 sure that the committee's clear on what was  
17 presented, because it looks like some of the  
18 risk adjustment testing was actually put into  
19 the reliability and validity, so I'm not clear  
20 exactly what the reliability and validity  
21 testing were, but just to make sure that the  
22 steering committee has all that cleared in

1 terms of what gets presented.

2 CO-CHAIR LAZAR: Understood.

3 Adeela, I think we're ready to vote. So this  
4 is the scientific acceptability of the measure  
5 properties, and I think we read through the  
6 criteria before. And the question is, was the  
7 criteria in scientific acceptability of the  
8 measure properties met?

9 MS. ADEELA KHAN: So you guys can  
10 go ahead and vote yes or no. Nicole, is  
11 Patricia back online yet?

12 OPERATOR: Not yet.

13 MS. ADEELA KHAN: Okay, thank you.  
14 So we have 18 nos, zero yeses.

15 CO-CHAIR LAZAR: Okay, Taroon,  
16 would you like to tell us where we are?

17 MR. AMIN: So the normal process  
18 here is to give a little bit of a rationale on  
19 the vote. What I'll do to try to move things  
20 along -- not to be complete, but at least to  
21 signal to the measure developers and for our  
22 own internal reports, as we sort of move

1 forward with this project, is to summarize a  
2 little bit at a high level what some of the  
3 major concerns were.

4 Some of the concerns were raised  
5 around the age range, the dealing with the  
6 planned readmissions, additional details about  
7 the risk adjustment model would have been  
8 warranted, questions about the reliability and  
9 validity testing, and SES considerations which  
10 were similar to previous measures.

11 So, as part of our procedure, if  
12 the measure does not pass scientific  
13 acceptability, it would not move on, move  
14 forward. And with the clear consensus here,  
15 we would not move on with this measure. So I  
16 believe we're at public comment.

17 CO-CHAIR LAZAR: So before we go  
18 to public comment, is there any rationale that  
19 a steering committee member would like to be  
20 put on the record supporting the no vote that  
21 Taroon has not already expressed? My sense is  
22 he gave us a pretty comprehensive list of the

1       comments that he heard, and I didn't hear  
2       anything that -- well, there's nothing I heard  
3       earlier that I think was missed, but I just  
4       want to give the committee an opportunity to  
5       express that, if somebody has a very strong  
6       opinion that was not captured.

7                       (No response.)

8                       CO-CHAIR LAZAR:   Hearing none, or  
9       seeing none --

10                      CO-CHAIR KAPLAN:   Well, I have one  
11       comment, which is, in general, I thought that  
12       there wasn't enough -- we weren't given enough  
13       data.  And so I think I heard a lot of  
14       questions that suggest, in the absence of  
15       data, we simply don't know.  And that's one of  
16       the criteria for our vote.  So if that is  
17       informative, great, if it's not --

18                      MR. STETTLER:   The one thing I  
19       would guess that the developers -- and I'm not  
20       what the other developers would say, but we  
21       were given three weeks warning to submit this.  
22       And again, obviously we should have had more



1 of our ducks in a row and so on, but I thought  
2 the process was very challenging, especially  
3 when you have a business to run. It's not as  
4 simple to get this stuff out as you would  
5 think.

6 And I know we had a lot more  
7 information we would have liked to have  
8 presented, but we did not have the time to do  
9 it. So I would say in the future, if you can  
10 give your developers just a little bit more  
11 time to actually prep for it, that would be  
12 very beneficial.

13 MR. AMIN: I mean, this is the  
14 first project NQF is doing which is an  
15 expedited review. We recognize that the  
16 timelines are very short for everybody  
17 involved in this project, including the staff,  
18 the developers, and the committee members who  
19 probably would have liked a little more time  
20 to review the measures.

21 We respect that concern. We'll  
22 take that back, and as we review further

1 measures for potential expedited review we'll  
2 consider that as well. And other measure  
3 developers had a similar timeline as the  
4 measure developers here.

5 CO-CHAIR LAZAR: Taroon, do we  
6 need to go for public comment?

7 MR. AMIN: Yes, so we'll ask  
8 Nicole to open up the lines for any public or  
9 member comment.

10 OPERATOR: Certainly. For public  
11 comment, please press \*1 at this time.

12 MR. AMIN: And if there's anyone  
13 in the room who would like to address the  
14 committee?

15 (No response.)

16 CO-CHAIR LAZAR: Okay. We're  
17 scheduled for a break, but is everybody  
18 comfortable just working through? Okay, so  
19 why don't we do that?

20 MR. AMIN: Our measure developer  
21 needs five minutes.

22 CO-CHAIR LAZAR: Five minute

1 break, but only five minutes.

2 (Whereupon, the above-entitled  
3 matter went off the record at 3:11 p.m., and  
4 resumed at 3:19 p.m.)

5 CO-CHAIR LAZAR: Could I ask  
6 everybody to grab their places, and we are  
7 going to start with our third measure, and we  
8 are looking at 1768, Plan All-Cause  
9 Readmissions, from the National Committee for  
10 Quality Assurance.

11 So why don't we begin with the  
12 importance to measure. I am hoping, as the  
13 third go-round on this one, we can dispense  
14 with this rather quickly, and then get  
15 directly to the issues of scientific  
16 acceptability.

17 Does anybody have any comments or  
18 questions they would like to make around the  
19 issue of importance to measure. Is the  
20 threshold criterion, importance to measure and  
21 report, met? Any comments or questions about  
22 that? I think we have discussed this quite a

1 bit twice before. Are we ready to take a  
2 vote?

3 MS. ADEELA KHAN: Okay. On  
4 importance to measure, again high impact,  
5 performance gap evidence. Was the threshold  
6 criterion, importance to measure, met? You  
7 have a minute.

8 CO-CHAIR LAZAR: Feels like we  
9 have jeopardy music in the background

10 MS. ADEELA KHAN: Okay, we have 18  
11 for Yes, and zero for No.

12 CO-CHAIR LAZAR: Okay. Why don't  
13 we move into the issue of scientific  
14 acceptability, and perhaps you could just --  
15 Oh, I am sorry. Would you like to introduce  
16 yourselves?

17 MR. SAUNDERS: We would. So my  
18 name is Robert Saunders. I am a research  
19 scientist at NCQA. I am the technical lead  
20 for the development of this, and I have with  
21 me Jerry Gottlich.

22 MR. GOTTLICH: I am a senior

1 health care analyst at NCQA who helped develop  
2 the measure logic with Robert.

3 MR. REHM: This is Bob Rehm, the  
4 Assistant Vice President for NCQA for  
5 oversight of our measure.

6 MS. ALAYON: This is Dawn Alayon.  
7 I am a senior health care analyst. I manage  
8 all of the NQF measures for NCQA.

9 MR. SAUNDERS: I didn't know if we  
10 are still doing the three to five-minute  
11 comment, if that is still permissible.

12 CO-CHAIR LAZAR: Sure, absolutely.

13 MR. SAUNDERS: So I think we have  
14 had a very informative and enlightening  
15 conversation this morning as we have gone  
16 through the two previous measures here. I  
17 think, as we transition into our measure, one  
18 thing we wanted to highlight is the fact that,  
19 in the preceding measures, there is a hospital  
20 based all-cause measure, and the unit of  
21 accountability is the hospital.

22 As we look at the measure in this

1 round, we are an organization that is about  
2 monitoring health plan as the unit of  
3 accountability here. So one of the first  
4 things we wanted to point out is that there  
5 are hospitals that are the unit of analysis  
6 within the health plan, but the measures are  
7 aggregated across health plans. So multiple  
8 hospitals are reporting to health plans.

9 We think that this is really an  
10 advantage of this measure, because it starts  
11 to move us up from the hospital as the unit of  
12 accountability to a more population based  
13 approach.

14 I think some of our earlier  
15 conversations about who is accountable for  
16 this focus on that there are issues related to  
17 transitions of care, and we think that health  
18 plans are certainly a key component to doing  
19 that. They are also key to understanding the  
20 totality of services that may happen to  
21 prevent readmissions. So we think that a plan  
22 based approach is an important distinction to

1 make.

2 I think the other thing Taroon has  
3 mentioned at the beginning is that we should  
4 clarify some of the information that we have  
5 presented.

6 In terms of the supplemental  
7 information is that our measure development  
8 process has gone on for over three years. So  
9 we started the initial testing and development  
10 of this measure back in 2009. Our initial  
11 testing with commercial and Medicare Advantage  
12 plan based data was in 2010 using 2008 to 2009  
13 data.

14 We have since gone into the field.  
15 So we have collected first year measurement  
16 from health plans to Medicare Advantage plans  
17 and commercial health plans. Those data are  
18 already in use at CMS, for the commercial  
19 side, for the 65 and older population, and we  
20 are in the process of -- At the time that this  
21 call came out, we were in the process of  
22 updating our models for our second year of

1 implementation.

2           So I think the initial tables that  
3 may have been in there might have reflected  
4 the first year regression weights for  
5 conditions, and then we now have data from  
6 2008 through 2010 for Medicare weights, and so  
7 we have also modified the risk adjustment  
8 model to have separate risk adjusters and  
9 weights for the Medicare under 65 and the  
10 Medicare 65 and older population.

11           I think that would be it, I think,  
12 in terms of the clarifications about the  
13 measure and the material that you have. Thank  
14 you.

15           CO-CHAIR LAZAR: Thank you.  
16 Bruce?

17           MEMBER HALL: Could I immediately  
18 just ask you to clarify your last statement.  
19 So are you saying that there is information  
20 that we are not looking at which you would  
21 like us to consider?

22           MR. SAUNDERS: So we had submitted



1 separately an additional package with  
2 regression coefficients for the current  
3 specification model for a second year of data  
4 collection. I am not sure where that is in  
5 terms of the packeting.

6 MR. AMIN: That information was  
7 sent to the Committee subsequent to the  
8 original measure specification that you see.  
9 So the risk weights as referred to were --

10 MEMBER HALL: Okay, great. I  
11 didn't know if you were -- if there are other  
12 changes to the approach that are not  
13 incorporated here.

14 MR. SAUNDERS: No.

15 CO-CHAIR LAZAR: Okay. Should we  
16 open the discussion around the issue of  
17 scientific acceptability?

18 MEMBER BANKOWITZ: Can I ask a  
19 quick process -- or just a quick question to  
20 the developer. The measure type is listed as  
21 a process measure. Was this measure intended  
22 to be a process measure or an outcome measure,

1 because that would be the difference in the  
2 evaluation?

3 MR. SAUNDERS: I think, given the  
4 conversation we have had here, I think outcome  
5 is appropriate. We were torn. We see the  
6 readmission as a process. Naturally, that  
7 occurs within the system, but I think the way  
8 we have talked about the measure conceptually,  
9 I think we would revise our answer to be  
10 outcome. We think it is consistent with that.

11 CO-CHAIR LAZAR: Ashish?

12 MEMBER JHA: I have just got a  
13 couple of clarifying questions. So this is a  
14 health plan level readmission rate, not a  
15 hospital level readmission rate?

16 MR. SAUNDERS: That is correct.

17 MEMBER JHA: Okay. And so I  
18 realize we are going to evaluate it based on  
19 that. Just thinking about sort of what we  
20 talked about in the morning around the sort of  
21 Congressional requests or requirements for  
22 developing a measure, that is really at the

1 hospital level.

2 MR. SAUNDERS: Correct.

3 MEMBER JHA: So this measure would  
4 not meet those needs, but we can still  
5 evaluate it for its validity, etcetera,  
6 etcetera. Do I understand that?

7 CO-CHAIR LAZAR: Yes, exactly  
8 right. Helen, clarified that for us offline.

9 MEMBER JHA: Okay. Can I just ask  
10 as a follow-on -- I sort of feel like I keep  
11 doing this, which is keep asking what else  
12 could you do with this measure, which is not  
13 the purpose. But could you potentially  
14 develop a hospital level readmission rate,  
15 given that you do have for the patients who  
16 are in the plans that you guys are covering or  
17 that are participating -- you have all the  
18 data. Could you do that?

19 I am not even sure why I am  
20 asking, outside of you probably know why I am  
21 asking, but --

22 MR. SAUNDERS: So I think that the

1 short answer is probably not. Given the way  
2 the data -- this just sort of speaks to sort  
3 of how we collect our measures.

4 So we are sort of a hands-off  
5 organization in terms of the data collection.  
6 Plans take our specifications and implement  
7 them either themselves or through their  
8 software vendors that calculate how many  
9 hospitalizations, all the transfers and so on.

10 They then submit to us the  
11 aggregated performance information, the  
12 numerators, the denominators, those expected  
13 rates. So we never see the data to know which  
14 hospitals are performing well within the  
15 health plan.

16 The hospital -- or the health plan  
17 itself certainly has that data, and they are  
18 in a position to do that, plus a variety of  
19 other investigational things, the way the  
20 measure is constructed having the CCs for the  
21 risk adjustment, categories for the index  
22 condition. They can certainly look at whether

1 psychiatric hospitalizations have a higher  
2 readmission -- propensity to readmit than  
3 other kinds of hospitalizations, and so on.

4 We treat that as a health plan  
5 responsibility. Our job here is to create a  
6 standard metric for quality monitoring and  
7 accountability of the health plan, and then  
8 leave to the health plan to work with its  
9 network of hospitals and providers or medical  
10 homes and other entities to figure out what  
11 quality improvement strategies will work, and  
12 help move that metric.

13 CO-CHAIR LAZAR: Jeff.

14 MEMBER GREENWALD: I appreciate  
15 the sort of different approach that you took  
16 relative to the prior two. I think it has  
17 some interesting implications. I wonder if  
18 you could comment, however, as to why we would  
19 want that to be the measure that we would  
20 endorse, given there are some practical  
21 limitations to having health plan level data  
22 in terms of -- and this is perhaps jumping a

1 little bit ahead in terms of usability, but  
2 conceptually and philosophically why we would  
3 want a health plan level approach, if we are  
4 going to, hopefully, find something that is  
5 intervenable.

6 MR. SAUNDERS: Absolutely. so I  
7 think the critical issue is, given that we  
8 were in a context of thinking in terms of 30-  
9 day readmission rates -- there are a variety  
10 of other ways you could go about measuring  
11 readmissions and thinking about that problem.  
12 There are certainly people that are going  
13 beyond that now that think about what that is,  
14 but if we start from the premise that 30-day  
15 readmission rates is what you are after, one  
16 might think that the accountability function  
17 might decay as you get further from the  
18 discharge date.

19 So if we are thinking about the  
20 kinds of things that happen within the first  
21 five to seven days of a hospital discharge are  
22 likely to be more in the hands of the

1 hospital, there is probably a role for primary  
2 care. There is probably a role for the health  
3 plan. There is probably a role for a variety  
4 of other people. But I think the underlying  
5 premise for most of the hospital readmission  
6 rates is the hospital is the unit to have.

7 As you get further out, in 14 days  
8 and 30 days, the health plan is in a greater  
9 position to act to deal with the coordination  
10 issues between primary care, the coordination  
11 between the nurse care manager who is -- or  
12 whoever is going to follow up about did you  
13 make your appointment, are you taking your  
14 medications in the right way, are you having  
15 problems getting your medications, those types  
16 of issues.

17 So we think that the health plan  
18 base measure is a complement to hospital based  
19 measurement. Certainly, we don't think of it  
20 as a substitute. We certainly use the Yale  
21 approach to the condition specific measures  
22 which were already in place and already

1 endorsed as our initial model for testing of  
2 this measure, but we look also at the United  
3 model and the DRE based risk adjustment.

4 We certainly -- You know, standing  
5 on the shoulders of people that have been very  
6 successful at this and looked at endorsed  
7 measures as their starting point, but we think  
8 there is a world separately for the health  
9 plan.

10 What we think sort of more broadly  
11 is that we are trying to -- if we are trying  
12 to effect improvements in quality of care,  
13 that you can come at it from multiple angles,  
14 that it is not simply a measurement issue of  
15 readmissions and is it hospital for  
16 readmissions; is it plan? There are a variety  
17 of other metrics that would be important to  
18 look at that would, hopefully, relate to any  
19 of our readmission measures.

20 So we had care transition  
21 measures. Linking that with service support  
22 and validity of the measures, that, we think,



1 is a field where to that stage adds in the  
2 development of readmissions, but we certainly,  
3 as a measure developer developing things in a  
4 variety of these areas, as we accumulate,  
5 think that those relate.

6 CO-CHAIR KAPLAN: I would like a  
7 little clarification, because I wasn't privy  
8 to the conversation that Eliot and Helen had.  
9 But for the purposes of those of us who are  
10 trying to serve -- We don't want to be  
11 comparing apples and airplanes here. We want  
12 to really sort of stick with fruit.

13 So if we are comparing the purpose  
14 and utility and validity and scientific rigor  
15 of a measure for one purpose, and we are  
16 trying to transport it to another purpose, and  
17 usability, certainly feasibility, and making  
18 that leap for some of us, I think I am getting  
19 a little bit confused about -- I can  
20 understand the unit of analysis here, but I am  
21 sort of trying to understand the unit of  
22 reporting, and to what extent are we

1 evaluating apples and airplanes?

2 DR. BURSTIN: Yes. So we did a  
3 broad call for all-cause readmissions  
4 measures, not just for the specific hospital  
5 program they have talked about. So we saw  
6 these as potentially complementary, although  
7 I think one question was raised is whether one  
8 of the other measures at the hospital level  
9 will be aggregated up to health plan. So  
10 those could be potentially competing.

11 So that is the way we have been  
12 thinking about it. I would, again, evaluate  
13 the measure on its merits, and we will return,  
14 I think, to those issues to follow.

15 CO-CHAIR KAPLAN: So it is merits  
16 for --

17 DR. BURSTIN: Endorsement as a  
18 national consensus center is all-cause  
19 readmission, and in this case for health  
20 plans.

21 CO-CHAIR LAZAR: More discussion?

22 MEMBER GLANCE: Just a quick

1 comment on that comment. I think, as we  
2 certainly consider harmonizing these measures,  
3 it might make a lot of sense to pick the best  
4 of the best, because two different risk  
5 adjustment models -- I mean, it is not that  
6 difficult to take these models and aggregate  
7 them either at the hospital level or at the  
8 plan level. If we get one model that does it  
9 at the plan level and one model with those at  
10 the hospital level, and these are different  
11 models that have different risk factors, it  
12 may end up giving us somewhat conflicting  
13 information which may not be very useful for  
14 benchmarking purposes.

15 MEMBER JHA: So the way I am  
16 reading it is the risk adjustment, not the  
17 hierarchical shrinkage issue, but the risk  
18 adjustment seems to me very, very similar  
19 between what you guys have at the plan level  
20 and, let's say, what the Yale-CMS group had at  
21 the hospital level. Is that right? Are they  
22 identical? Are they very close?

1 MR. SAUNDERS: They are not  
2 identical, but it was our intention to mimic  
3 as much as possible their work.

4 MEMBER JHA: I couldn't tell a  
5 difference, but maybe there is.

6 MR. SAUNDERS: I am sure that we  
7 will be able to tell you the difference.

8 CO-CHAIR LAZAR: Is there anymore  
9 discussion?

10 MEMBER GLANCE: Well, I was going  
11 to make a comment on that comment. The Yale  
12 group has got five different models, and this  
13 is one model. So the coefficients are going  
14 to have to be different, I would think.

15 MEMBER JHA: My understanding is  
16 that the Yale group has one model, meaning one  
17 set of covariates. They let the coefficients  
18 vary across the five models.

19 So the coefficients in this will  
20 surely vary, but that is because at the plan  
21 level different things matter to a different  
22 level in terms of adjustment, but as long as

1 the same covariates are in, I feel like the  
2 signaling value to everybody about here are  
3 the things that matter for risk adjustment  
4 gets achieved, which I think was sort of your  
5 goal. Right?

6 MEMBER GLANCE: Yes. I think  
7 that, if you have five different models,  
8 although the covariates are going to be the  
9 same, the coefficients are going to be  
10 different. So you are probably going to see  
11 different results based on whether you are  
12 using their model or the Yale model when you  
13 are looking at the same unit of analysis, and  
14 I think that is where things may get a little  
15 confusing for benchmarking purposes.

16 CO-CHAIR LAZAR: Further  
17 discussion? Frank?

18 MEMBER GHINASSI: Just a question,  
19 again to be clear about what we are voting on.  
20 We are not voting yet, but the way it reads it  
21 says "results about the quality of care."  
22 This is at the health plan level. So we are

1 not really talking about the quality of care  
2 directly anymore. We are talking now about  
3 the coordination of care by a payer within a  
4 given market.

5 Is that what we are -- I just want  
6 to make sure I understand. That is what this  
7 sort of measures. Right? How a payer  
8 coordinates care through incentivizing  
9 interaction, care management, on and on,  
10 within a market or within the reach of their  
11 payee group. Is that what we are now voting  
12 on or considering? Right?

13 DR. BURSTIN: Care, though -- I  
14 mean, care management programs, that is care.

15 MEMBER GHINASSI: Those are all  
16 debatable. I would think of it less as care  
17 than I would the coordination of others' care,  
18 but you could argue both.

19 MS. PACE: Well, it is quality of  
20 care for the enrollees in a health plan, which  
21 could be done by a few number of hospitals or  
22 lots of hospitals, depending on who that

1 health plan contracts with. But it still is,  
2 I think, supposed to be indicative of quality  
3 of care. It is just that you are looking at  
4 it across a health plan now instead of at  
5 individual hospitals.

6 MEMBER GHINASSI: And so the data  
7 would be useful then -- Again, I am just  
8 trying to think about the validity of using  
9 it. It would be useful first to the plan in  
10 how they would go about setting their quality  
11 improvement methods, and then we would be  
12 relying on those plans to make that useful by  
13 the individual institutions?

14 MR. SAUNDERS: That would be our  
15 expectation for it, that the health plan would  
16 know the information about who they are  
17 contracting with, and they would have detail  
18 in their own data system to identify which  
19 hospitals are responsible or which individual  
20 providers are potentially contributing to  
21 that.

22 CO-CHAIR LAZAR: Christine, then

1 Leslie, then Tanya.

2 MEMBER TRAVIS: I want to be sure  
3 that I understood the last discussion. The  
4 way I looked at this was that it was really  
5 looking -- because it is a health plan  
6 measure, that it is looking at the underlying  
7 contracting and network provisions through the  
8 hospitals as well as those services and  
9 programs that health plans may lay on top of  
10 that to manage the population.

11 So, to me, it is still looking at  
12 the quality of care provided in the hospital  
13 arena, but it does add that additional layer  
14 of looking at what the health plan itself does  
15 to manage the population within it.

16 CO-CHAIR LAZAR: Leslie?

17 MEMBER KELLY HALL: And just to  
18 clarify, this would be just for those covered  
19 members within your system, and so would be  
20 then further stratified to cover people in  
21 your system. Correct?

22 MR. SAUNDERS: That is correct.



1 So our measure is focused on Medicare  
2 Advantage enrollees, and we have a separate  
3 model for the under 65 population, the non-  
4 elderly disabled, Medicare 65 and older, and  
5 then the commercial 18 to 64 population. Yes,  
6 they would all be treated separately. It is  
7 contingent upon having one of those class of  
8 coverage.

9 MEMBER KELLY HALL: Thank you.

10 CO-CHAIR LAZAR: Tanya.

11 MEMBER ALTERAS: This gets more  
12 into the usability discussions. So I will  
13 save this for later, but I think this would be  
14 hugely useful for purchasers and for  
15 consumers, and especially with the  
16 implementation of the health insurance  
17 exchanges, and having quality information to  
18 consumers at this level, I think, is just  
19 going to be enormously meaningful.

20 CO-CHAIR LAZAR: Richard?

21 MEMBER BANKOWITZ: So I am trying  
22 to put myself in the position of a plan

1 administrator. So this is going to be an  
2 exercise in imagination here for me.

3 It would seem to me that I would  
4 be worried that, if you are going to compare  
5 my plan to Laurent's plan here, I would want  
6 to know that my service mix of patients was  
7 about the same, so that I had the same number  
8 of conflicts, chronic patients, and the same  
9 number of patients, chronic disease, and the  
10 same number of sort of well patients. But I  
11 don't think in your model you accounted for  
12 any of that. Is that true? And if not, then  
13 why not?

14 MR. SAUNDERS: So we have -- To  
15 the extent that we have accounted for that, we  
16 have accounted for it in -- So we are  
17 adjusting for the patient attributes of care  
18 or other patient attributes, demographic in  
19 particular, that are likely to contribute to  
20 readmission. So we have the age. We have  
21 gender. We have presence of major surgery.  
22 We have the index condition, so why you were

1 in the hospital in the first place, and then  
2 your past year's worth of comorbidities.

3 So to the extent that we are  
4 comparing plans, we are adjusting for that set  
5 of attributes.

6 MEMBER BANKOWITZ: And what about  
7 looking at the specific hospitals, because I  
8 would be -- I mean, again as a plan, I would  
9 be concerned. Well, I've got this one rogue  
10 hospital that I just can't control, but I've  
11 got 99 that are doing real well, but I am  
12 going to be dinged because we've got some  
13 differences of opinion about how to manage.  
14 Did you look at that?

15 MR. SAUNDERS: For the data we  
16 have, certainly, the data submitted to us by  
17 the health plans in the first year of  
18 submissions, we don't see that level of  
19 detail. In the development datasets, we have  
20 the two data warehouses we use for Medicare  
21 data, we did not investigate that.

22 That is, I think, more strictly

1 sort of an NCQA sort of thinking bout the  
2 problem as the health plan has to decide how  
3 to handle the rogue hospitals or rogue  
4 providers. They have the option to contract  
5 with that hospital or they have the option to  
6 take some other corrective action, if it is  
7 through some quality improvement area.

8 Eventually, we are going to target  
9 resources doing that.

10 MEMBER BANKOWITZ: Last question:  
11 Did you consider looking at admissions in  
12 addition to readmissions, because I am  
13 thinking of, if I have 100 asthma patients,  
14 and so does Laurent have 100? I might admit  
15 quite a few, but not readmit any, and there  
16 might be three chronic patients that tend to  
17 get readmitted, and his look worse than mine  
18 even though I might be really using much more  
19 of a hospital than he was.

20 MR. SAUNDERS: We definitely think  
21 -- We did not specifically task that, but we  
22 definitely understand that the readmissions

1 issue is not an independent entity, that there  
2 is a whole complex issue of awardable  
3 hospitalizations generally, and the  
4 hospitalization we are going to award is the  
5 index hospitalization as much as the  
6 readmission hospitalization.

7 I think we have a series of  
8 resource use measures that focus on  
9 hospitalization. We are looking at risk  
10 adjustment and specific clinical condition,  
11 diabetes, cardiovascular care, that are coming  
12 online this year.

13 So we feel like that is measured  
14 in other aspects of our portfolio. That  
15 portfolio is not treated as part of the scope  
16 here.

17 CO-CHAIR LAZAR: Sherrie?

18 CO-CHAIR KAPLAN: I have a sort of  
19 follow-on question to that. To the extent  
20 that you choose hospitals, hopefully, that  
21 provide good care for your health plan  
22 recipients or clients, the selection bias

1 seems to me like a real concern here.

2 The other issue we had a rather  
3 lengthy discussion about here is the  
4 variability in the precision of your estimates  
5 by hospital.

6 So, one, can you talk to us a  
7 little bit about selection bias and what that  
8 does from an NCQA standpoint, and the other  
9 thing is, for the precision of estimates, how  
10 are you taking that into account in your  
11 potential for feeding back to the hospitals  
12 about their readmission rates?

13 MR. SAUNDERS: If I might ask you  
14 to sort of go a little bit further on the  
15 selection issue. I want to make sure I am  
16 answering correctly. Selection for an  
17 individual patient looking to select a  
18 hospital or a selection issue for comparison  
19 between health plans?

20 CO-CHAIR KAPLAN: Plans,  
21 hopefully, channel their patients to hospitals  
22 that provide good quality and efficiency, but

1 quality is one of the hopeful criteria that  
2 they channel their patients to.

3 So plans are then selecting  
4 hospitals for patients that provide high  
5 quality care. We know that there is a  
6 volume/outcomes relationship. Hopefully, the  
7 plan is thinking about that, too.

8 So I am worried a little bit that  
9 the selection bias here when you are talking  
10 about providing this at the hospital level or  
11 feeding back to hospitals information, that  
12 that gets taken into account along with the  
13 variability, potential variability, in that  
14 information at the hospital level.

15 MR. SAUNDERS: I think what I  
16 will probably fall back on may not be  
17 satisfactory, but I think for us it is for the  
18 health plan, that is who we are feeding the  
19 information back to or we are feeding back to  
20 the consumer the information about what that  
21 health plan's performance is on handling  
22 readmissions, and it is both a measure of the

1 quality of care provided by that health plan  
2 and is both a measure of accessibility,  
3 services, that we would not -- not thinking  
4 specifically about how that would feed back  
5 directly to the hospital.

6 We think that is a conversation  
7 between a hospital and the health plan, and we  
8 think that they would have those discussions  
9 and would certainly make those arguments about  
10 whether they are being unfairly penalized in  
11 some way.

12 Let me jump to the precision  
13 question. Could you repeat the precision  
14 question?

15 CO-CHAIR KAPLAN: Well, depending  
16 on how the plan level data are sampled -- for  
17 example, you get n patients per plan to  
18 estimate the plan's performance. It gets  
19 pretty thick, if that number is 400, to the  
20 extent that you can give any kind of  
21 stratified data.

22 Again, if your intent is not to



1 feed back to the individual hospital, I  
2 understand, but you sort of said that in your  
3 opening remarks, that that was a potential  
4 something you could have done.

5 One, the selection bias with  
6 respect to participation in NCQA and, two, you  
7 know, how does this hospital readmissions  
8 issue play out with respect to your current  
9 sampling structure?

10 MR. SAUNDERS: I am not sure of  
11 the specific numbers of the proportion of  
12 health plans that have reported to NCQA, but  
13 it is quite high. It is high like it is --  
14 You know, we've only got 20 percent of health  
15 plans here. I think it is in the neighborhood  
16 of 90 percent of health plans. We don't think  
17 there is going to be a systematic bias in that  
18 form or fashion.

19 In terms of precision, you are  
20 right. We are definitely worried about  
21 comparisons on small numbers for -- you know,  
22 if we think about special needs plans, and we

1 will get those individual contracts. Some of  
2 these have maybe 100 hospitalizations and,  
3 certainly, would be reluctant to make those  
4 kinds of comparisons.

5 We are in the process of figuring  
6 out where to set that threshold for public  
7 reporting. We are not setting a threshold,  
8 though, for submission to us. We are not  
9 saying, if you have -- you have to have at  
10 least 500 hospitalizations to calculate this  
11 and send it to us. We are saying, submit it  
12 to us, and if there is a lower end for what is  
13 reliable, whether that is 100 or 500 or 2,000,  
14 whatever that threshold is, we will set that  
15 for reporting.

16 We think of that as a reporting  
17 issue. We certainly understand it as directly  
18 influencing the reliability issue for the  
19 fairness of the comparisons between health  
20 plans, but I think that it may be in the data  
21 that we presented, just in terms of the actual  
22 denominator size of our health plans, that

1 almost 75 percent of our Medicare Advantage  
2 contracts were able to report at least -- I  
3 think it was -- We know that at least 96  
4 percent were able to report, but I think at  
5 least 75 percent of our Medicare Advantage  
6 health plans had at least 7500 enrollees, so  
7 having a decent volume of hospitalizations  
8 within that group.

9 We are not so concerned about  
10 small numbers on the commercial side.

11 CO-CHAIR LAZAR: Ashish, and then  
12 Jeff.

13 MEMBER JHA: Because we torture  
14 our Yale colleagues on this, I figure I can't  
15 let you guys go without talking about SES.

16 How have you guys thought about  
17 it, given the variations in SES make-up of the  
18 different plans? It sounds like you came out  
19 against including that in your model, but if  
20 you could just sort of give us some of your  
21 thinking about that, it would be really  
22 helpful.

1 MR. SAUNDERS: Sure. We are  
2 saying that there is likely a relation between  
3 SES and performance on this measure. For most  
4 NCQA measures, we don't do any risk adjustment  
5 at all. We have such a good denominator that  
6 we think of the quality issue as, if you don't  
7 do this, you are doing something wrong.  
8 Readmissions is one of the first of our  
9 measures that has kind of gone beyond that, to  
10 worry about it.

11 So as a procedural issue for us,  
12 we don't have a really good way to evaluate  
13 the SES within the community. The health  
14 plans don't report that information to us.  
15 There are a variety of things that I would  
16 like for them to report as well that are not  
17 in there, doesn't seem to be in their capacity  
18 to do.

19 So there is a technical limitation  
20 to we can't get the SES data, but I think as  
21 a practical issue in terms of the comparisons,  
22 you know, this would mean something if you

1 were comparing a health plan in Minnesota to  
2 a health plan in Florida, but those decisions  
3 that are being made are on a more local scale.

4 So if we are comparing the health  
5 plans in the Washington Metropolitan area, we  
6 don't have any reason to believe in advance  
7 that there is a SES difference between the  
8 health plans unless they are particularly good  
9 at dumping or identifying ways to dump their  
10 people into other plans. They are certainly  
11 able to deny them-- or used to be able to deny  
12 them coverage, I think. We will see how far  
13 ACA gets along here, but we don't think that  
14 there is likely to be SES differences between  
15 health plans.

16 To the extent that we have the  
17 market segmented between Medicare Advantage  
18 plans, commercial plans, we did not specify  
19 this for Medicaid. There are a variety of  
20 issues we could sort of go into about that,  
21 but we think that there would be, certainly,  
22 homogeneity within those product lines.

1           The real issue is we don't have  
2           the data to do anything about it.

3           MEMBER JHA: That sounds  
4           reasonable. I personally think there probably  
5           is a lot of heterogeneity in most plans, but  
6           we have had a conversation about why it might  
7           be reasonable not to include it anyway, but it  
8           doesn't matter. But thank you.

9           MR. SAUNDERS: And we don't,  
10          certainly, have the data to know about it, but  
11          the plans are probably jealously guarding  
12          that.

13          CO-CHAIR LAZAR: Okay. Jeff, and  
14          then we are going to have to come to a  
15          decision about scientific acceptability.

16          MEMBER GREENWALD: Earlier there  
17          was discussion about this concept of the rogue  
18          hospital that had sort of outliers in  
19          performance. It strikes me that, when you  
20          have aggregated data essentially at the plan  
21          level, you might have rogue hospitals that  
22          would, in fact, not stick out and might get

1 buried in the data.

2 I wonder how -- Since you have  
3 frequently argued that, on a population health  
4 level, that there is a lot that the health  
5 plan can do in the health care access and  
6 follow-up pieces that you pout out, but the  
7 hospitals individually play a big part in  
8 that, and if there is a rogue hospital and it  
9 does get buried, how does your measure help to  
10 allay those concerns?

11 MR. SAUNDERS: Well, I think, if  
12 most of -- Certainly, NCQA is a voluntary  
13 measurement process. So I think we are --  
14 That is an issue where we have to rely upon  
15 the diligence of the people that are being  
16 measured or volunteer to be measured on the  
17 issue, that they are looking to ferret out  
18 these types of issues.

19 I think our thinking is that, to  
20 the extent that there is a way to distinguish  
21 yourself on performance, and whatever  
22 incentives it takes to do that, whether it is

1 an incentive that I want to be a high quality  
2 provider on readmissions or a financial  
3 incentive to get that performance, that  
4 somebody is monitoring the measure and doing  
5 the additional quality improvement activities  
6 at the health plan level to identify those  
7 where, if the administration is kind of asleep  
8 at the wheel, then that is a problem for  
9 everybody and for any measurement strategy.

10 I think our -- I will just stop  
11 with that.

12 CO-CHAIR LAZAR: Let me make some  
13 sort of summarizing comments and, actually, I  
14 am going to borrow a phrase that Sherrie used  
15 before, and that is you can't measure weight  
16 with a ruler.

17 I think the point here, at least  
18 that I have taken away from this, is that the  
19 call was for all-cause readmission measures.  
20 Obviously, that did not exclude measures that  
21 were not at the hospital level.

22 So what we have before us is a



1       measure that is at the plan level, and our  
2       task is to decide whether it meets scientific  
3       acceptability and feasibility and the other  
4       criteria for what it is.

5                 Now we may have issues with it --  
6       maybe; maybe not -- as to whether there  
7       should be, as Laurent said before, different  
8       methodologies with a measure we might expect  
9       to be used at a hospital level versus  
10       something at a plan level but, frankly, that  
11       is something that probably can be discussed  
12       tomorrow in terms of the comparisons across.

13                So I just want to make sure we  
14       don't trap ourselves into thinking about this  
15       in terms of answering questions that it really  
16       wasn't designed to answer. It is really at a  
17       plan level.

18                I do have, if I may, just one  
19       quick closing question, and it may have been  
20       discussed on occasions, and I missed it. But  
21       does it account for the movement of patients  
22       from plan to plan? So is there the equivalent

1 of a universal PIN or patient identification  
2 number or some such thing?

3 MR. SAUNDERS: It does not.

4 CO-CHAIR LAZAR: Okay.

5 CO-CHAIR KAPLAN: I just have one  
6 more question. I apologize. I forget your  
7 response to Larry's question about the  
8 hierarchical modeling, because now you have  
9 added another tier to an already complex  
10 nested issue. And your decision was?

11 MR. SAUNDERS: So it is actually  
12 even worse than that. It is not even another  
13 level above. It would be nice if it was all  
14 nested. In fact, it is pretty extremely  
15 cross-classified here.

16 So we have patients going to  
17 multiple hospitals, multiple hospitals  
18 contracting with multiple health plans. So it  
19 would be -- First of all, it would be quite  
20 beyond my means and my HLM ability to get the  
21 cross-classified model to estimate. I think  
22 I could do it, if I had the data.

1           The second issue is don't put out  
2           the data. So if we think about where kind of  
3           Yale's model is working off of the 100 percent  
4           CMS file, so at the totality of  
5           hospitalizations and the totality of  
6           admissions and readmissions going on here.

7           We have a development database  
8           that has, in the case of the commercial  
9           population, a million hospital admissions. It  
10          is nationally -- It contains cases across the  
11          nation, but is not the universe of commercial  
12          hospitalizations.

13          Likewise, for Medicare Advantage,  
14          we have a database that has about -- the first  
15          year it was 22 percent of Medicare Advantage  
16          enrollees. For the second year, we have about  
17          45 percent of Medicare Advantage enrollees.

18          So we are taking a data model that  
19          is not the universe here, and then trying to -  
20          - It is not the universe of health plans, is  
21          not the universe of Medicare Advantage  
22          enrollees. So we couldn't come up with an

1 estimate that would apply to each and every  
2 individual health plan coming in.

3 So what we have to rely upon is  
4 the fact that we have a large enough  
5 proportion of Medicare Advantage enrollees  
6 that we are avoiding serious selection issues,  
7 having these half-enrollees represented in  
8 this, that we are not doing something crazy  
9 untoward in our inferences, and likewise for  
10 commercial. We don't think that there is  
11 reason to prefer a market scan to the Ingenix  
12 warehouse that we use for estimating on the  
13 commercial side.

14 So we are putting the best number  
15 that we can, given that we don't see hospital-  
16 specific hospital numbers and have the ability  
17 to link hospitals to their specific health --

18 CO-CHAIR LAZAR: Okay. Two last  
19 two quick questions, Leslie and then Laurent  
20 -- okay, Laurent, and then we are going to  
21 call the question.

22 MEMBER GLANCE: So one of the

1 questions I asked earlier -- and I didn't  
2 quite get the answer that I wanted, and I am  
3 going to ask you this question: Did you look  
4 at calibration curves when you were evaluating  
5 -- when you were validating your model?

6 The reason I ask this is we really  
7 haven't talked about this too much, but I  
8 really do think it is very important, is that  
9 if you are going to do proper risk adjustment  
10 and level the playing field and compare apples  
11 to apples, it is really important that you  
12 look specifically at the model performance at  
13 different levels of risk.

14 So, for example, if a model  
15 systematically under -- or, say, over-  
16 estimates mortality -- or not mortality;  
17 readmissions, excuse me -- readmissions in  
18 high risk patients, and different hospitals  
19 have different case mixes, then that model --  
20 the poor model calibration may lead you to  
21 make conclusions about hospital quality that  
22 are completely unwarranted.

1                   In our last discussion we looked  
2                   at a summary measure of calibration, and those  
3                   summary measures can hide an awful lot of  
4                   information; whereas, calibration graphs  
5                   really do a great job of showing us how well  
6                   the model works at various risk levels. So  
7                   did you look at that?

8                   MR. SAUNDERS: I do not have that  
9                   available, but I could certainly pull that  
10                  out. I think, if there is discussion of  
11                  additional material to put forward later, I  
12                  think we can put that together, but we did not  
13                  look at that.

14                 CO-CHAIR LAZAR: Okay. Adeela?

15                 MS. ADEELA KHAN: Okay. So  
16                 scientific acceptability properties: Are both  
17                 reliability and validity rated moderate or  
18                 high? Again, we are looking at 2(a)(1) for  
19                 specifications, 2(a)(2) testing; 2(b)(1)  
20                 specification consistent with evidence;  
21                 2(b)(2), testing; appropriate methods and  
22                 scope with adequate results, and threats to

1 validity are adequately addressed, 2(b)(3)  
2 exclusion; 2(b)(4) risk adjustment and  
3 stratification; 2(b)(5), meaningful  
4 differences; 2(b)(6) comparability of data  
5 sources.

6 Was the criterion scientific  
7 acceptability of measure properties met? Vote  
8 one for Yes, two for No, and you can start  
9 right now.

10 Patricia, are you online now?

11 MEMBER McDERMOTT: Yes, I am.

12 MS. ADEELA KHAN: Did you want to  
13 cast your vote?

14 MEMBER McDERMOTT: I will listen  
15 to the response.

16 MS. ADEELA KHAN: So we have eight  
17 for Yes, and 10 No. Sorry, can you repeat  
18 that?

19 CO-CHAIR LAZAR: Well, I think  
20 that leaves us in a position where we are  
21 essentially stopped for the moment at this  
22 point. As we did for the second measure, I

1 think Taroon and the staff have been collating  
2 some of the comments that they have heard, and  
3 in terms of rationale. Taroon, I don't know  
4 if you are ready to go over that.

5 MR. AMIN: We have some. Just for  
6 the sake of completion, I will hold off on it  
7 until tomorrow's discussion when we sort of  
8 collate all of the information together.

9 CO-CHAIR LAZAR: Okay. What we  
10 have talked a little bit about is, you know,  
11 what to do at this point, and we have one  
12 measure that we voted and sort of decided we  
13 were going to hold in abeyance, if I read the  
14 sentiment correctly. I forget exactly what  
15 the numbers are.

16 We have two other measures where  
17 we were sort of stopped at this particular  
18 point in the process. We certainly need to  
19 have the comparison discussion tomorrow.

20 Sherrie and I think that a fair  
21 bit of the comparison discussion, particularly  
22 in view of some of NCQA's comments around a



1 fundamentally similar methodology to what the  
2 Yale folks presented earlier, is what  
3 flexibility is there and, based on some of  
4 your very detailed recommendations this  
5 morning, what tweaks and modifications to the  
6 system you heard in depth or detail from Yale,  
7 and then essentially here as well, can be  
8 made?

9 I think one of the things I heard  
10 Laurent say at the outset of this conversation  
11 was concern about approving a methodology at  
12 one level, i.e., the health plan level, and  
13 then having yet a different methodology at the  
14 hospital level.

15 So if tomorrow some of the  
16 concerns that the group have or had about the  
17 Yale methodology can be addressed and perhaps  
18 fine tuned a little bit to make it a more  
19 acceptable model, then we can probably revisit  
20 a discussion with NCQA in the hopes of  
21 harmonizing the two, with the understanding  
22 that you need something at the plan level, and

1 we, obviously, would like to get something at  
2 the hospital level.

3 Have I been clear about that? I  
4 hope I am not too convoluted. I tried to lay  
5 it out as crisply as our discussion from  
6 before. That would put us in, I guess, the  
7 enviable position of finishing early.

8 What we would do is adjourn now,  
9 give the staff some time to talk, possibly  
10 with NCQA and certainly with the folks from  
11 Yale, so that we could start tomorrow morning  
12 with an informed discussion about what  
13 flexibility there is in addressing some of the  
14 concerns from the group.

15 CO-CHAIR KAPLAN: I was just going  
16 to reiterate what you were going to say  
17 anyway, but in the sort of spirit of a fully  
18 throated discussion, I think Helen wants us to  
19 continue on the last two criteria, since there  
20 was a close margin on this criterion.

21 CO-CHAIR LAZAR: Okay. Yes?

22 MEMBER SCHUSTER: Could you

1 explain a little bit about -- I mean, I read  
2 the materials about what harmonization means,  
3 that in the end there is a single measure or  
4 is it NQF has endorsed a combination, but the  
5 two entities might still sort of put their  
6 measures out there separately?

7 CO-CHAIR LAZAR: Well, I am going  
8 to free associate here a little bit, because  
9 I think, you know, NQF has to decide how they  
10 want to handle it, but what I think I heard is  
11 that there may be need for a plan level  
12 measure as put forth by NCQA.

13 There certainly is a need for a  
14 hospital measure, as put forth earlier by the  
15 folks from Yale, in that at least some of the  
16 members of the committee expressed earlier  
17 that, if we are going to have either or both -  
18 - if we are going to have both measures, that  
19 it would be nice to have a methodology that  
20 harmonizes.

21 So it would be, I am assuming,  
22 eventually two separate measures but,

1 hopefully, two separate measures using very  
2 similar methodologies, to the extent that they  
3 can be used. Does that sound reasonable?

4 MS. PACE: Yes. I think, you  
5 know, to the extent possible, when we talk  
6 about harmonization, we are talking about the  
7 measures being as closely similar as possible  
8 on definitions, who is included, who is  
9 excluded, risk factors, those kinds of things.

10 Now how close we get on any two  
11 measures is a factor related to the data  
12 availability, may be special circumstances  
13 with a special population, but generally, we  
14 would like to have measures be consistent when  
15 we need more than one measure.

16 So as was brought up earlier, you  
17 know, sometimes you -- We ultimately would  
18 like the broadest applicable measure. So  
19 ideally, if you had a measure that could be  
20 used at multiple levels, that would be great.  
21 Sometimes that is just not possible, and then  
22 we try to get measures that will be as

1 consistent as possible.

2 CO-CHAIR KAPLAN: I have a follow-  
3 up question for Helen and NQF. If you are  
4 estimating different levels of performance of  
5 a health care system, the idea that you can do  
6 one size fits all may be a sketchy assumption.

7 So to the extent that these risk  
8 stratification issues are different, how much  
9 -- I am a lumper by training. I do lumping.  
10 That is what I do, but this may be a real  
11 splitter kind of issue.

12 MS. PACE: And then it is much  
13 more dicey with outcome measures that we are  
14 talking about with some methodologies. If you  
15 have a straight process measure where there  
16 has been a risk adjustment, it is simpler,  
17 even though they are terribly difficult, maybe  
18 simpler than outcome measures. So each one  
19 presents differently.

20 CO-CHAIR LAZAR: Richard?

21 MEMBER BANKOWITZ: Is it time to  
22 start a discussion of feasibility?

1                   MEMBER FOLTZ: I had one more  
2 question. The other thing that I wanted to  
3 talk about in the harmonization is, looking at  
4 these two, the burden is going to be on the  
5 hospital either way, and both, because the  
6 health plans will come back to hospitals if  
7 they are not performing.

8                   We just don't want it to be a  
9 double impact to the hospital. The hospital  
10 has to look at it this way, and now this way.  
11 So I just want to put that out there.

12                   MEMBER JHA: I guess, given that  
13 scientific validity is such a key part of  
14 this, and I am a little -- It sort of shows  
15 how in tune I am with our group here. I am a  
16 little surprised at the vote.

17                   Were we going to get a sort of a  
18 synopsis of what the main issues were on  
19 scientific validity before we move on to  
20 usability, just even like two or three points  
21 of what were the main concerns, because I  
22 didn't hear them in the discussion as clearly.

1 MR. AMIN: And I think that was  
2 actually one of the -- So I do want to like at  
3 least have some time to go through some of the  
4 notes, but some of the main issues that were  
5 brought up that I heard -- actually, Sherrie  
6 made a lot of them, and maybe she can  
7 elaborate -- but concerns around selection,  
8 potential selection issues; the precision  
9 questions around the liability testing of the  
10 measure; and potentially additional more  
11 information around the measure performance at  
12 various levels of risk.

13 That isn't intended to be the  
14 complete list. I mean, I am sure there is  
15 more, but that seemed to be the sentiment of  
16 the group. So I will leave it at that.

17 CO-CHAIR LAZAR: Okay. Shall we  
18 move on to usability? And again, remember, we  
19 are not talking about usability at the  
20 hospital level here. We are talking about  
21 usability at the plan level, and for the  
22 public it would also be at the plan level,

1 presumably in the region. Rich?

2 MEMBER BANKOWITZ: So my  
3 fundamental concern with this measure would be  
4 usability, because at the plan level we really  
5 do have a potential to make an impact in terms  
6 of consumer choice. Consumers often don't  
7 choose the hospital, but they often do choose  
8 the plan. Sometimes they can't choose the  
9 plan, but oftentimes they can choose a plan.

10 So I sit here and think, would  
11 this actually help me choose a plan? I know  
12 it is -- you know, measuring readmissions is  
13 involved as a surrogate of coordination of  
14 care, but coordination of care goes beyond  
15 coordinating those patients who were admitted  
16 to a hospital. We would like to coordinate  
17 care so patients don't have to get into the  
18 hospital, and so they don't have to get into  
19 the ED.

20 To me, it would be more  
21 fundamentally useful to know if, let's say, I  
22 had asthma or CHF, how good are you at keeping



1 me out of the hospital? How good are you at  
2 keeping me out of the ED? A plan can measure  
3 at that level. A hospital can't.

4 So it just strikes me that this is  
5 perhaps not unimportant, but it seems like a  
6 very small component of how I would use a  
7 plan.

8 MEMBER JHA: So you are basically  
9 saying that you think that readmissions is not  
10 that important of a measure at the plan level?  
11 The sort of importance of this measure is the  
12 fundamental issue as opposed to its fuller or  
13 its -- Maybe it is the informational content  
14 of the measure.

15 I am not sure that -- Again, to me  
16 as a consumer, it conveys a lot of  
17 information, because I would certainly want to  
18 know that the plans are comparable in terms of  
19 the underlying populations, which we don't  
20 know, and I would certainly want to know for  
21 my particular condition how good are you  
22 overall in coordinating the care, not just

1 once I get into the hospital, because I really  
2 don't want to go to the hospital in the first  
3 place. So it is more informational content.

4 CO-CHAIR LAZAR: Tanya?

5 MEMBER ALTERAS: Well, I  
6 respectfully disagree. I think that, this  
7 measure would be reported low. I am assuming  
8 it would probably be reported as part of the  
9 greater HEDIS measures, which does give you  
10 information if you have asthma or CHF or some  
11 other chronic disease.

12 I think, for patients with  
13 multiple chronic conditions that really have  
14 to make some significant calculations in their  
15 mind about cost and just their health status  
16 when they are choosing a plan, that having  
17 this type of information would be critically  
18 important and usable to them, if they do have  
19 a choice.

20 As I mentioned before, you know,  
21 in 2014, hopefully, people will have greater  
22 choices in health plans through the exchange.

1 You know, there aren't that many -- There  
2 aren't too many measures right now that are  
3 really relevant to purchasers, especially  
4 private purchasers. I think that private  
5 purchasers who are making decisions about  
6 contacting a health plan, to find a measure  
7 like this is really important as well.

8 It will raise all sorts of  
9 questions for them to be able to talk to  
10 health plans about, to talk to brokers about,  
11 in terms of what type of care coordination  
12 strategies are you using; how are you going to  
13 make sure that my premiums are -- you know,  
14 those sorts of conversations, as well as  
15 giving important information directly.

16 So I think that the usability, to  
17 me, I never questioned that on this measure.

18 CO-CHAIR KAPLAN: Can I follow up  
19 that with you, Tanya? Will Manning, when we  
20 were at RAND, did this -- in those days, the  
21 old study. If you plan changed by three  
22 dollars in terms of the premium, you will dump

1 it. It doesn't matter, these quality issues.  
2 You will change plans on the basis of a three  
3 dollar difference in premiums.

4 So I am wondering, do consumers  
5 really get it, the high readmission rates?  
6 Consumers might look at that and say, oh,  
7 good, if I need to, if they send me back to  
8 the hospital, oh, that is a great plan. Do we  
9 really know a lot about how consumers use  
10 readmission to hospitals?

11 MEMBER ALTERAS: Well,  
12 unfortunately, I think what we do know is that  
13 people do look at it as rationing care, if you  
14 are trying to reduce readmissions. You are  
15 right. That is a big flaw, and there is a  
16 greater concern here, which is how do you  
17 engage consumers in understanding the quality  
18 information that is out there, and we are  
19 trying to push for that with all the  
20 information about the exchanges coming out.

21 It is all part of a great  
22 continuum, but you are right. My theory is,

1 if we get the best information out there that,  
2 hopefully, people will get engaged.

3 MR. SAUNDERS: We have done some  
4 work on this, not specific to readmissions but  
5 in terms of looking at resource use in  
6 combination with quality. It is the same type  
7 of problem of perception that more is better  
8 and indicative of quality, which we know is  
9 often not the case.

10 Judith Edwards' work has sort of  
11 looked at the impact of the context of  
12 information and how you present it. So if you  
13 can provide the information in a qualitative  
14 way, provide it in the way that is nuanced to  
15 emphasize the direction that you want to be  
16 nudging people, that there are ways to present  
17 the information to encourage the right type of  
18 behavior.

19 We think that our measure would be  
20 capable of doing that.

21 CO-CHAIR LAZAR: Thank you. Brent  
22 -- or let's just go right up the line this

1 way. Are you done?

2 MEMBER ASPLIN: Yes. I am with  
3 Richard on the usability of this. You know,  
4 at the big picture level, we are talking about  
5 a three-legged stool, and we haven't even  
6 talked about the third leg at all today, which  
7 is probably as important as the hospital. It  
8 is the ambulatory care system.

9 I think the hospital and  
10 ambulatory care are much more important than  
11 the plan. To the extent that plans have  
12 historically been important, it is because the  
13 ambulatory care has failed in some of these  
14 coordination issues.

15 So just philosophically, I am not  
16 sure this as a complementary measure would be  
17 all that usable. If it was usable, you would  
18 really need to know -- to look at this  
19 hierarchical analysis and understand for each  
20 -- not only the final outcome, which is plan  
21 to plan comparisons, but for each plan look at  
22 the hospital level data.

1                   That would be the only way to  
2                   really make a meaningful conclusion, I think,  
3                   about not only how the different plans in your  
4                   market support this work, but now for health  
5                   partners, what do the different hospitals look  
6                   like versus -- because they are not apples to  
7                   apples at all, because it is not a nested  
8                   analysis. It doesn't have fee for service  
9                   Medicare. It doesn't have a lot of different  
10                  populations in it.

11                  So if you have the hospital  
12                  measures for your market sitting here and the  
13                  plan measures for your market sitting there,  
14                  you make a lot of, I think, erroneous  
15                  conclusions, because they are not nested.

16                  CO-CHAIR LAZAR: Right.

17                  MEMBER ASPLIN: So that, to me,  
18                  from a usability standpoint doesn't work that  
19                  well. I am having a hard time getting my head  
20                  around that part of it.

21                  MR. SAUNDERS: If I can just  
22                  quickly respond to that, that has not been an

1 issue that was raised in our any of our public  
2 comment by any of our health plans. They are  
3 not concerned about those types of comparisons  
4 or unfairness.

5 CO-CHAIR LAZAR: Thank you.

6 MEMBER ASPLIN: The other biggest  
7 thing is then we get this. We get this. So  
8 readmissions aren't improving in our market.  
9 This measures is saying it is a plan issue,  
10 and that is because the plans aren't doing  
11 their job. WE have this issue saying that the  
12 hospitals aren't doing their job, and we don't  
13 get any better. That, to me, is even a bigger  
14 philosophical concern.

15 CO-CHAIR LAZAR: Yes, I concur.

16 That, for me, is an NQF issue, because that is  
17 beyond the scope of our charge, I think. But  
18 thank you for raising that issue. Frank?

19 MEMBER GHINASSI: A very short  
20 series of ifs. I've only got this halfway  
21 formulated myself.

22 One of the concerns I had about



1 the previous measures were everything you have  
2 already heard about the focus on one part of  
3 this complex system, so hospitals,  
4 readmissions.

5           There is something compelling  
6 about the focus now on the plan level where,  
7 within at least that universe that the plan  
8 represents, you've got this compilation of  
9 data that includes both the senders and the  
10 receivers and this overlay that was described  
11 before by Christine, which, I think, has  
12 promise.

13           There have been a relatively  
14 finite number, although they are very  
15 important. I don't want to minimize this, but  
16 there has been a finite number of  
17 methodological recommendations that we heard,  
18 the specific round, you know, the way that the  
19 data has been massaged. You have asked the  
20 calibration kinds of questions, I think.

21           I don't know that any of those are  
22 not addressable, and there seems to be

1 something potentially compelling about finding  
2 a way to address those for both of these in a  
3 way that allows for the identification  
4 possible at the hospital level which locates  
5 data where it needs to be for quality  
6 improvement activities, and harmonizing that  
7 simultaneously with data at the plan level.

8 The devil is going to be in the  
9 details on this, but I am hoping that enough  
10 was captured in all the recommendation -- I'm  
11 sure it was -- but specifically around trying  
12 to remediate these, that there may be a win  
13 here if these can be modified in a way to  
14 address those to the satisfaction of this. I  
15 just don't know if that is doable in a day and  
16 a half.

17 CO-CHAIR KAPLAN: Right. I  
18 thought you were headed for a best in class.  
19 It is different classes. So, you know, I  
20 thought that is where you were headed, but I -  
21 - Respectfully, I think that is for  
22 comparability tomorrow as a question.

1                   Christine, and then Leslie, and  
2 then let's call it a day.

3                   MEMBER TRAVIS: Yes, I appreciate  
4 this. I think usability is usability by whom,  
5 and I do think that Tanya brought it up, that  
6 from the purchaser's standpoint, their primary  
7 relationship and contracting relationship is  
8 with the plan.

9                   Therefore, looking at the plan's  
10 performance, looking at this measure at the  
11 plan level, is a critical component, because,  
12 to be quite honest, they don't want to have to  
13 get down into the thousands of hospitals that  
14 may be in the plan across the country, down to  
15 that level of detail.

16                   We have started using readmission  
17 measures and Evaluate, which is a health plan  
18 performance tool that from the National  
19 Business Coalition on Health, and it has just  
20 been using some NCQA data that is really just  
21 now descriptive data versus really analytical  
22 data. But I will say, in the first year of

1       trying to use this information, it has been  
2       very important to the purchasers to say this  
3       is a measure of really population management  
4       around this one issue.

5               To Tanya's point, this isn't the  
6       only measure we would look at. We would marry  
7       this with other measures, but it is something  
8       that, I think, employer purchasers especially  
9       will hold their plans accountable, because it  
10      is more of a population based approach where  
11      we layer the plan's programs on top of the  
12      hospital's. So this is very important to the  
13      purchaser community.

14              CO-CHAIR KAPLAN: Thanks very  
15      much. Leslie?

16              MEMBER KELLY HALL: I think the  
17      question is which population. My concern is  
18      that, if a hospital is being measured in one  
19      way and then the plan can reflect a different  
20      measurement about that hospital, perhaps that  
21      hospital with limited resources only attacks  
22      those patient populations that are covered in

1 both entities.

2 So what happens to those patients  
3 that aren't covered in any plan or are  
4 underserved or are in a safety net  
5 environment? Do they put resources only again  
6 where there is high coverage and high  
7 visibility and not resources where there is  
8 underserved?

9 CO-CHAIR KAPLAN: Excellent point.  
10 Okay, I think it is time to vote. Adeela?

11 MS. ADEELA KHAN: Okay. On  
12 usability, we are looking again: 3(a) equal,  
13 understandable and useful for public reporting  
14 and accountability; and 3(b) meaningful,  
15 understandable and useful for quality  
16 improvement.

17 So was the criteria on usability  
18 met? You can go ahead and start voting. We  
19 have one high, two moderate, three low, four  
20 insufficient.

21 We are missing one person. So we  
22 have three for High, six for Moderate, seven

1 for Low, and one Insufficient, and Patricia,  
2 did you want to cast your vote?

3 CO-CHAIR KAPLAN: Duly noted.

4 Okay, now we are moving on to the feasibility  
5 issue. Feasibility, the criteria are:  
6 Clinical data generated during the care  
7 process. All data elements are in electronic  
8 claims. How susceptible are they to  
9 inaccuracies and unintended consequences, and  
10 the data collection strategy can be  
11 implemented.

12 Comments? No comments from this  
13 group? You are tired. This is fatigue. So  
14 if I can ask one quick question. So to the  
15 extent that NCQA is a known entity, they  
16 clearly can deal with clinical data. What  
17 happens with electronic claims? Are you --  
18 There's vendors all over the place in  
19 electronic claims.

20 How confident are you that all the  
21 data elements you need to estimate  
22 readmissions, including the risk

1 stratification variables or risk adjustment  
2 variables, are in the various bunches of  
3 claims vendors that you are dealing with?

4 MS. SAUNDERS: We are very  
5 confident that we -- So as I mentioned before,  
6 we have collected our first year data with the  
7 health plans. We were able to get 424  
8 Medicare Advantage contracts submitted, 314  
9 commercial health plans. So we know that they  
10 are able to calculate and submit that  
11 information to us.

12 How we know that it is of high  
13 quality and reliability, first of all, is we  
14 have our certified software vendor program.  
15 So we have 12 test datasets for the commercial  
16 software vendors who are certified by NCQA to  
17 come up with can you implement the measure  
18 specifications? Are they getting the right  
19 calcs out of the test dataset to evaluate, and  
20 the implementation of all the programming  
21 logic and identification of all the related  
22 services, and how they are handling the

1 primary data, as I said, is transferred from  
2 this setting to this setting types of issues.

3 The second layer of quality  
4 control that we have is our auditing process.  
5 So we have certified auditors throughout the  
6 country that attest to the performance of the  
7 health plans and the submissions.

8 They were key to us in our first  
9 year analysis. We weren't sure that they  
10 would implement the risk adjustment process  
11 correctly, that they would apply the wage or  
12 that they would find all of the comorbid  
13 conditions and the professional services, that  
14 they might just focus only on the hospital  
15 sets.

16 Through our auditing process and  
17 our discussions with -- We had focus groups  
18 with certain other key auditors around the  
19 country, so that there were no problems in  
20 terms of implementation by identification of  
21 the services or the calculation of the  
22 measure.



1                   That gave us some confidence to  
2                   proceed on with the improvements that we are  
3                   making in the second year to divide the risk  
4                   adjustment process for the Medicare population  
5                   and to have separate plans. We felt that they  
6                   were capable of doing the work before, that  
7                   they were able to do this next step.

8                   CO-CHAIR KAPLAN: Thank you.  
9                   Other questions? Go ahead.

10                  MEMBER LANGBERG: Does the data  
11                  collection that the -- I will say at the  
12                  hospital level require CPT codes in addition  
13                  to ICD-9?

14                  MR. SAUNDERS: It does. They are  
15                  using CPT/UB codes. It's everything.

16                  MEMBER LANGBERG: So would this  
17                  represent a different class of data collection  
18                  and coding?

19                  MR. SAUNDERS: I don't know  
20                  whether the hospitals do but, hopefully, we  
21                  will be able to identify that for all the  
22                  other settings of care that you receive

1 treatment in. So there is still the  
2 opportunity to get those comorbid conditions.

3 CO-CHAIR KAPLAN: Okay. I think  
4 we are ready for a vote. Adeela.

5 MS. ADEELA KHAN: Okay. So  
6 feasibility: 4(a) Do they generate that  
7 during care; 4(b) electronic sources; 4(c)  
8 susceptibility to inaccuracies, unintended  
9 consequences identified; and 4(d) data  
10 collection can be implemented.

11 So to what extent was the criteria  
12 on feasibility met? One, high; two,  
13 moderate; three, low; four, insufficient  
14 information. You can start your vote.

15 So we have six for High, nine for  
16 Moderate, two for Low, and zero for  
17 Insufficient, and Patricia, are you online?

18 CO-CHAIR KAPLAN: Okay. So that  
19 wraps it up for today. Right? So for  
20 tomorrow -- Oh, we need an overall vote. We  
21 need to summarize.

22 So now we give an overall vote.

1 Correct? So we are going to review the  
2 criteria briefly for an overall vote, and give  
3 our response. Wait, Bruce had a question.

4 MEMBER HALL: I am confused about  
5 that, because we have -- for scientific  
6 acceptability, we said no, and then we did  
7 three and four at Helen's request, but why are  
8 we doing an overall vote?

9 CO-CHAIR KAPLAN: Helen?

10 DR. BURSTIN: I think it just  
11 still wasn't clear where the committee was  
12 really landing on this measure. I think it  
13 was so close on scientific acceptability. I  
14 just wanted some clarity between what we did  
15 for CMS and NCQA. That's all. Just you can  
16 have your discussion tomorrow.

17 It is not binding. It is not as  
18 if you are saying you recommend the measure.  
19 It is just basically does it meet all the  
20 criteria.

21 CO-CHAIR KAPLAN: So the way I  
22 understand it, if the usability/feasibility

1 discussion shaded over your overall vote to  
2 move it beyond our discussion of scientific  
3 acceptability, then --

4 DR. BURSTIN: Right, although  
5 scientifically it must pass criteria. This  
6 was so close that we thought it was worth at  
7 least finishing up the analysis.

8 MS. PACE: No, I was just going to  
9 say -- I mean just reiterate that. You know,  
10 basically, if you felt it wasn't  
11 scientifically acceptable, then that should be  
12 reflected in your overall vote.

13 MEMBER LANGBERG: Could you re-  
14 read and see what the votes were?

15 MS. PACE: In terms of overall?

16 MS. PACE: Or maybe we don't need  
17 to do the overall.

18 DR. BURSTIN: Maybe we just don't  
19 do the overall, and we will just deal with it  
20 tomorrow. That is fine.

21 CO-CHAIR KAPLAN: Okay. All  
22 right. Everybody is fine with that? We are

1 not going to give an overall.

2 DR. BURSTIN: We will summarize  
3 the vote.

4 CO-CHAIR KAPLAN: Okay. So now we  
5 have another option, but I think this is the  
6 right option.

7 MR. AMIN: For consistency with  
8 the preliminary votes that we had for CMS, we  
9 should do the same for NCQA. There is a clear  
10 will of the Committee on the UHC measure. So  
11 that is just justifying the process there.

12 What we are doing here is going  
13 all the way through. We will put the  
14 preliminary vote in, and then we will have the  
15 discussion about competing and/or harmonizing,  
16 if that is what the Committee feels, tomorrow.

17 We have -- If you could read off  
18 the votes, that might be helpful. We will  
19 read them out.

20 MS. FORMAN MORGAN: Sure, I can  
21 read them. For importance, it is 18 Yes; No,  
22 zero. For scientific acceptability, it was 8

1 Yes, 11 No. For feasibility it was three for  
2 High, six for Medium, seven for Low, and one  
3 for Insufficient. For feasibility, it was six  
4 for High, nine for Moderate, two for Low, and  
5 none for Insufficient.

6 CO-CHAIR KAPLAN: Okay, Adeela.

7 MS. ADEELA KHAN: So if we voting  
8 on overall suitability for endorsement: Does  
9 the measure meet all the NQF criteria for  
10 endorsement? And again, it will depend on  
11 competing measures.

12 So one for Yes, two for No. You  
13 can start your vote. I think we have  
14 everybody. The vote is six Yes, 11 No.

15 CO-CHAIR KAPLAN: Okay. So  
16 Taroon is going to give us a little bit on  
17 tomorrow's agenda, because many of us are very  
18 intrigued by the process so far, and have  
19 reached some fuzzy, if that is the right word,  
20 conclusions about what is going on.

21 MR. AMIN: So the two measures  
22 that were evaluated all the way through the

1 process -- What we will do is that we will  
2 actually have a discussion around the  
3 comparisons.

4           Really, what we evaluate is, first  
5 -- actually, if you have the slide. This is  
6 the sort of the box on how we think about  
7 related and competing had harmonization of  
8 different measures. Really, if you are  
9 looking at the same target process, which this  
10 would be readmissions, hospital, and the same  
11 target populations, these measures in theory  
12 would be competing. However, based on today's  
13 discussion, if the Committee feels strongly  
14 that there needs to be different measures for  
15 the health plan versus the hospital, and also  
16 having discussion with both measure developers  
17 on whether the Yale measure -- I mean the CMS  
18 measure could be rolled up to health plans,  
19 all those types of discussions will occur  
20 tomorrow.

21           If you do decide that both  
22 measures are appropriate, then we will -- Then

1 we will have the justification for that  
2 decision.

3 The structure of tomorrow's  
4 discussion: We will collaborate here and try  
5 to figure out how we are going to run that,  
6 and we will give you a briefing on that  
7 tomorrow.

8 CO-CHAIR KAPLAN: Any final --  
9 Laurent?

10 MEMBER GLANCE: I don't know if  
11 this is really feasible, but in my mind -- and  
12 I think the fact that we are still talking  
13 about both measures tomorrow -- Is that  
14 correct?

15 MR. AMIN: That is correct.

16 MEMBER GLANCE: so both measures  
17 are still in play, and what I would find  
18 extremely helpful in terms of personally being  
19 able to make a decision comparing both  
20 measures would be if we had a little bit more  
21 information on model performance.

22 Specifically, what I would love to



1 see from both measure developers are just  
2 calibration curves. Okay? I think that would  
3 be extraordinarily helpful. Thank you.

4 MS. PACE: Let's just ask the  
5 measure developer, is that something that you  
6 could discuss with us in the morning,  
7 calibration curves?

8 MR. SAUNDERS: We will do our  
9 best. If it is in our existing output, we  
10 probably will be able to, but we are dependent  
11 upon our programmers at the software vendors,  
12 and they may not be on the plat right now. so  
13 we will do our best to have the answer for all  
14 of that. I think we probably have the output  
15 from something to give a calculate.

16 CO-CHAIR KAPLAN: Thank you. It  
17 is my understanding now that we have to go to  
18 public comment before we wrap up.

19 MR. AMIN: Nicole, can you open up  
20 the lines, if there are any members of the  
21 public that would like to address the  
22 Committee?

1 OPERATOR: Certainly.

2 MR. AMIN: Any members here in the  
3 public that would like to address the  
4 Committee?

5 CO-CHAIR KAPLAN: Okay. Thank you  
6 very much for all your hard and diligent work.  
7 This was not an easy task, at least on my end  
8 of the table, and I am sure everyone is about  
9 at the point of cognitive exhaustion.

10 So I would welcome you back  
11 refreshed and ready tomorrow morning at eight  
12 o'clock sharp to begin our work on this  
13 competing measures kind of issue.

14 Thank you again.

15 (Whereupon, the above-entitled  
16 matter went off the record at 4:39 p.m.)

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