

NATIONAL QUALITY FORUM
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PATIENT OUTCOMES ALL-CAUSE
READMISSIONS STEERING COMMITTEE
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TUESDAY
DECEMBER 6, 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 8:00 a.m., Sherrie Kaplan, Chair, presiding.

PRESENT:

SHERRIE KAPLAN, Chair
TANYA ALTERAS
BRENT ASPLIN
RICHARD BANKOWITZ
JIM BELLOWS
JO ANN BROOKS

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

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

NQF STAFF PRESENT:

TAROON AMIN

HEIDI BOSSLEY

HELEN BURSTIN

JANET CORRIGAN

ALEXIS FORMAN MORGAN

KAREN JOHNSON

ADEELA KHAN

LAURA MILLER

KAREN PACE

ALSO PRESENT:

DAWN ALAYON, NCQA

ELIZABETH DRYE, Yale University

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

MARA RUBIN, UnitedHealthcare

ROBERT SAUNDERS, NCQA

GRAEME SCANDRETT, UnitedHealthcare

RON STETTLER, UnitedHealthcare

*Participating via telephone

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Senior Director

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

8:43 a.m.

MR. AMIN: Okay, so I will begin by outlining the discussion format for the next two hours. The discussion will begin with the CMS Measure 1789.

The Chair will request that the measure developer will provide a 10-minute response to each of the requests for further information discussed by the Committee yesterday.

For CMS, these requests include, as a preliminary start, although if there are additional questions feel free to ask, details on the distributional properties for small hospitals using HLM, the use of the following covariates in the risk model, including SES and hospital volume, and additional concerns raised this morning, calibration curves, risk decile plots and the usability and use of this measure for quality improvement.

The Committee will then have 30

1 minutes to discuss and ask further
2 clarification questions of the measure
3 developer and then decide whether to move on
4 to a final vote on scientific acceptability
5 and usability and an overall vote of the
6 measure.

7 We will use the same format for
8 the NCQA measure.

9 CHAIR KAPLAN: I would just like
10 the developers -- welcome back and thank you
11 very much for being so responsive, and we have
12 10 minutes you are going to get for an
13 uninterrupted presentation and then we are
14 going to have an additional 30-minute
15 discussion with you about the range of topics
16 that you know, that Taroon just outlined, in
17 addition to any other FOCUSED concerns, all
18 caps, that the Committee has.

19 MS. HORWITZ: Thank you. We
20 really appreciate the opportunity to come
21 back. So I am going to begin with
22 calibration, and let me just, before I show

1 you the slides, let me just orient the group
2 to what this is.

3 So the calibration question, and
4 correct me if I am providing something that
5 you don't want, is a question of how well the
6 model is able to predict risk for aggregate
7 groups of patients.

8 So if you are looking at low-risk
9 patients, how well is a model able to predict
10 their low risk, and if you look at high risk,
11 how well is the model able to predict that.

12 And in the ideal world, we would
13 plot the observed readmission risk for an
14 aggregate group of patients versus the
15 expected, and then -- or the predicted, and we
16 would see a 45-degree line. It should be
17 perfectly aligned.

18 And last night I couldn't quite
19 figure out how to convert our tables into
20 exactly that graph, and so I'm showing you a
21 slightly different graph, the same idea, which
22 is both the observed and the predicted plotted

1 simultaneously.

2 So let's show the first graph and
3 I'll show you how this is shown. So on the
4 bottom here we have risk deciles. So on the
5 far left we have the lowest-risk patients and
6 on the far right we have the highest-risk
7 patients in deciles, and on the left we have
8 the readmission risk.

9 And what we want to see here is
10 not a 45-degree line, because we are not
11 plotting it in that way. What you want to see
12 here is overlap of these two points, of the
13 observed and the predicted, as much as
14 possible, and ideally they should be perfectly
15 overlapped.

16 So this is our medicine cohort,
17 and you will see they are very, very close,
18 all the way through, with a slight
19 overprediction of risk in the higher end,
20 lower end, but really pretty close.

21 And if you look to the next slide,
22 you will see our surgery/gynecology. Again,

1 a slightly bigger spread up at the high end,
2 but generally speaking pretty good, we think,
3 risk prediction.

4 Similarly in the next graph you'll
5 see our cardiorespiratory, where it's
6 identical, really total overlap. I swear to
7 you that there are purple things -- or blue
8 things underneath there.

9 And in our next, we have
10 cardiovascular. Again, slight overprediction
11 at the high end, so we are giving people a
12 little more credit for having higher risk
13 patients than they really do, but pretty
14 close.

15 And in neurology, again very
16 close. So we would make the contention that
17 each model performs quite well on our
18 calibration.

19 So the next topic that you asked
20 us to talk about was the issue of small volume
21 hospitals and hierarchical regression and what
22 this all means.

1 And so we said that we would come
2 back today with some data about how the small
3 volume hospitals perform and so that we could
4 put some data around this discussion.

5 So if you turn to the next slide,
6 this is a distribution of volume, just so you
7 get a sense as to what we are talking about in
8 our data set. Remember, this is all
9 conditions. This is not just single
10 condition.

11 And you can see that our median
12 volume here is 750 patients. These are big
13 volume observations or hospitals.

14 We sort of arbitrarily decided we
15 would define small volume for the purposes of
16 today's discussion at the 10th percentile, so
17 we will just take the 10th, you know, the
18 smallest 10 percent of hospitals in our data
19 set, and even those have 88 or fewer patients.
20 So even our 10th percentile, at 88, is quite a
21 lot.

22 And you will recall that we don't

1 publicly report anything below 25 currently.

2 So the number that's actually between 25 and
3 88 is only about 200 hospitals. It's a very
4 small number that have even this very small
5 number of patients. And this is again about
6 5,000 hospitals altogether.

7 Now, we weren't sure if you were
8 thinking about small hospitals in terms of the
9 actual hospital itself, so we also defined it
10 for today's purpose by bed size.

11 So if you look at bed size of the
12 hospitals. Now, this is using American
13 Hospital Association data, so we don't have
14 data on every hospital, but we have data on
15 4,700 of them.

16 And you'll see again the median
17 hospital in this data set has 100 beds and the
18 10th percentile and smaller hospitals have 25
19 or fewer beds, so these are very small
20 hospitals, hospitals with 25 beds only.

21 And again there's, you know, about
22 400 or so of these, this is 10 percent of the

1 sample.

2 Okay, so let me show you results
3 both for hospitals, small hospitals as defined
4 by volume, and small hospitals as defined by
5 bed size.

6 So in the volume, once we kick out
7 the hospitals that don't even have 25, we are
8 left with 292 hospitals that have 88 or fewer
9 patients a year. So, again, less than, you
10 know, a couple a week.

11 And you'll see -- I don't have an
12 arrow -- but you'll see first of all the
13 medians are the same as you would expect, and
14 that the range, so let's take say the 10th to
15 the 90th percentile, the sort of distribution
16 of it is quite wide, slightly narrower than
17 the overall data set, but not that much
18 narrower, and still a pretty substantial range
19 in performance.

20 And you'll see this even more
21 dramatically with 25-bed or fewer hospitals --
22 all right, so we have got -- there it is. So

1 we've got, you know, if you look at the
2 extremes around 10 percent to 90 percent, they
3 are slightly different but relatively similar,
4 and in bed size, when we are taking less than
5 25, here we have more hospitals -- 400 of
6 them, still about 10 percent of our sample,
7 the smallest 10 percent -- and here you'll see
8 that the 10th percentile and 90th percentile
9 are again very similar.

10 So we still have wide
11 distributions of performance even in -- or
12 similar distributions of performance even for
13 the small hospitals versus the large
14 hospitals.

15 So we would argue that what we are
16 not seeing is a very tight pull to the mean
17 that people are concerned about. So we are
18 not seeing the sort of 10th to 90th percentile
19 all tucked right around that median in the
20 middle which is, I think, the main concern
21 that the Committee was expressing.

22 Despite the fact that we don't

1 empirically see very much to be concerned
2 about, I want to just take a minute to explain
3 a little bit what our modeling approach does,
4 because we didn't really have a chance to
5 explain the issue and I think that there's
6 some confusion about what it is that we are
7 doing with this model.

8 I want to first say that this is a
9 widely-used, pretty standard approach. It's
10 used in the NQF-endorsed public report
11 measures that we have now for the three
12 conditions.

13 But it's also used in many, many
14 other NQF-endorsed measures as well as
15 national registries in Canada and the UK and
16 elsewhere. So this, in many respects, is the
17 standard approach to modeling.

18 There's two things that this
19 approach does. The first thing is that it
20 takes into account the clustering of patients
21 within hospitals.

22 And what we mean by that is that

1 most statistical models assume independence of
2 samples. They assume that the -- any
3 observation's likelihood of an outcome is
4 totally independent of some other
5 observation's likelihood of an outcome.

6 And we know that that's just not
7 true when -- for this data set. Our data set
8 violates that assumption, because we have
9 patients within hospitals, and we believe
10 there's a hospital effect, just like we use
11 the same approach for looking at education,
12 where we are trying to assess student
13 performance, we know that student performance
14 is affected by their teachers' quality, and so
15 the same thing, we use the same kind of
16 modeling approach to look at teacher quality.

17 So because we know that the
18 samples are not independent, we have to
19 account for the standard error that we get,
20 and this model accounts for that.

21 Now, there are other ways to do
22 that as well. This is not the only way to do

1 that. But that's one advantage of this
2 approach.

3 The second thing that this model
4 does is it takes into account the increased
5 variability in small hospitals as well as our
6 knowledge about them up front.

7 And I want to explain that by way
8 of an example. So if I take a quarter out of
9 my pocket and I flip it five times and I get
10 four heads, then I have a heads proportion of
11 80 percent, okay?

12 Now, I'm going to flip it again.
13 And before I flip it again, I want to ask you,
14 what do you think the likelihood of heads is
15 going to be?

16 Now, in a traditional approach,
17 even one that accounts for clustering and even
18 one that accounts for the hospital effect, we
19 would say that, well, the data that we have
20 suggests that it's 80 percent, it's a small
21 volume, so you know we have a wide confidence
22 interval, so we'll say oh, it could be

1 anything from 50 to 100, but with a central
2 tendency of 80. But nobody here would take
3 that back, right? No one here is going to
4 give me four to one odds that I'm going to get
5 heads when I flip this coin again, because we
6 have some knowledge about coins.

7 Right? We know that 99.9999999
8 percent of coins are fair, so we expect that
9 when we flip this coin again, actually what we
10 are going to get is 50-50 heads.

11 So which estimate is closer to
12 truth in the universe, the 80 percent that we
13 get just from the data, from the sort of
14 standard model, or the 50 percent that we get
15 from pulling it towards what we know a priori
16 about coins?

17 And that's what our model does.
18 So our model accounts for the fact that when
19 we have a lot of variability, and when we have
20 small samples, and when we know something
21 about that sample, that it's in fact more
22 accurate to use that prior assumption of what

1 we know about that process to understand what
2 the estimate is likely to be, and that's what
3 our model accomplishes.

4 So if I flip this coin 500 times,
5 and I got 400 heads, and you asked me what I
6 am going to get the next time I flip it, I'm
7 not going to say 50-50, right?

8 Because even though I know
9 something about coins, now I have a very large
10 sample and I am much less inclined to think
11 that this coin is fair.

12 So the larger the sample you have,
13 the more you can trust the data that you have,
14 but in a small sample, it's more accurate and
15 more fair to consider that prior probability.

16 So that brings me to the next
17 question that the panel asked us to address,
18 which is, well, are small hospitals hospitals?
19 So should we treat our a priori assumption as
20 that they have a hospital effect? Or are
21 small hospitals small hospitals, and should we
22 consider instead that their a priori

1 assumption is that of the small hospital?

2 Therefore should we include some
3 kind of volume indicator in our model? And
4 that's an interesting question and a sort of
5 policy question.

6 I will say up front that we don't
7 have data to suggest that small hospitals in
8 aggregate behave differently from large
9 hospitals for the outcome of readmission.

10 We haven't looked at it carefully
11 in our data so I can't speak to our data. We
12 are not aware really of solid evidence about
13 this.

14 Whereas there's a very good
15 evidence base around volume outcome for
16 mortality or for complications, for
17 readmission we don't have that data.

18 So the first thing we would say is
19 we are actually not sure that this is a
20 problem, and it's not obvious that it should
21 be a problem necessarily. Small hospitals
22 might do a pretty good job of taking good care

1 of their patients and doing medication
2 reconciliation because they have fewer
3 patients to handle.

4 So it's not intrinsically obvious
5 to us. And second, even if it were the case,
6 it's not clear to us that all small hospitals
7 are the same and should therefore be polled
8 that way.

9 So we have leaned up until now not
10 to including volume as a separate indicator,
11 not to considering a separate up front
12 assumption for small hospitals, and we'd
13 rather just level the playing field and say
14 look, we are going to treat small hospitals as
15 hospitals and we are going to assume that
16 their baseline is the same baseline as all
17 other hospitals until proven otherwise by
18 data.

19 MR. AMIN: Not to interrupt, but I
20 just want to say you're at 10 minutes, but I
21 know you have a few other slides to go, so we
22 will just give you five more minutes to just

1 finish up and there will be time for a back
2 and forth. But we just wanted to make sure.

3 MS. HORWITZ: Great. So our next
4 slide is about SES, which is the next topic
5 that you asked us to address, and I want to
6 just show you again the data in our data set
7 about how hospitals perform in terms of their
8 proportion of dual eligible patients.

9 So we divided our data set sort of
10 a priori into four quartiles -- less than 10
11 percent of their patient -- of a hospital's
12 patient population having Medicare and
13 Medicaid, all the way up to more than 30
14 percent of their patients being dual eligible.

15 And what we wanted to show you
16 were two things -- I am going to use this
17 crazy thing again here -- okay, so first of
18 all the median result here.

19 So, the median result for the
20 hospitals with the fewest Medicaid patients is
21 16.5 and for the hospitals with the largest
22 number of Medicaid patients it's 16.9.

1 Yes, there is a relationship.

2 It's very small.

3 The second thing is that the
4 hospitals with the highest proportion of
5 Medicaid patients, a quarter of them perform
6 better than the average hospital with very few
7 Medicaid patients.

8 So the overlap is substantial.

9 There is not necessarily a defining sort of
10 destiny around the proportion of SES patients
11 that you have in your hospital, and that's one
12 major reason that we were not that inclined to
13 try to include SES in our models, because, in
14 fact, hospitals can perform very well with a
15 high proportion of the Medicaid patients, as
16 I think, the State Medicaid Directory in
17 Massachusetts demonstrated yesterday.

18 The second thing around -- maybe
19 I'll just leave that as it is for SES and I
20 will just comment lastly, because you wanted
21 us to comment on usability.

22 So there were two, I think, main

1 usability concerns that the panel raised
2 yesterday. One was a question of usability
3 for patients, payors, consumers, around the
4 question of, well, you know, will they be able
5 to use data around small hospitals, will we be
6 able to find a difference, or is it just going
7 to be all these hospitals we can't tell?

8 And I hope that I've demonstrated
9 to you that that's just not a concern for the
10 vast majority of hospitals in our data set,
11 that there are some hospitals with very, very
12 few patients for whom we do pull the results
13 a little bit towards the mean, but I hope that
14 has convinced you that that's actually an
15 appropriate way to estimate their risk rather
16 than a bias.

17 There was another concern raised
18 about how patients and payors could interpret
19 Hospital Compare data, and I will only comment
20 that it's hard to present data in confidence
21 intervals and it probably could be done
22 better, or potentially it could be done better

1 on Hospital Compare, and that would be great.

2 But that's not a function of the
3 measure per se, that's just a function of the
4 way you choose to report the results, which
5 could be reported in many different ways and
6 probably could be done better.

7 And lastly, I wanted to comment
8 that there were questions raised about
9 usability for hospitals, and here I want to
10 comment a little bit about our intention in
11 making the measure also from a personal
12 perspective because I chair the Readmissions
13 Committee at Yale, and we are a high outlier
14 for many of these conditions so we are on the
15 one hand making these measures and then
16 penalizing ourselves for them, and so it's my
17 job to fix that as well.

18 And so let me just comment that we
19 built this measure for two purposes. One is
20 for public reporting and public reporting is
21 a heavy responsibility. You have to be really
22 convinced that you are doing it well and doing

1 it right, so that you are adequately able to
2 compare different types of hospitals, and I
3 think you have all seen and agreed with our
4 risk adjustment and our strategy for defining
5 our outcomes, and our inclusion criteria have
6 really been carefully built to make sure that
7 we are appropriately able to compare
8 hospitals.

9 But the second reason we built
10 this measure was for quality improvement and
11 what we intend this measure to do is to allow
12 hospitals to benchmark themselves against
13 other hospitals to identify areas in which
14 quality improvement is necessary, and then to
15 catalyze activity.

16 And in fact we not only built a
17 hospital-wide outcome but because we have five
18 cohorts we can actually provide detailed data
19 on each of these service lines without a
20 hospital, which increases the usability for a
21 hospital in terms of figuring out which areas
22 it's bad -- it's sort of not doing well in.

1 But what we did not build this
2 measure for was for use in rapid cycle
3 interventions within a hospital. Now I, as
4 the readmission chair, am very preoccupied
5 with my real-time readmission rate, and we
6 track that monthly. We track it across the
7 hospital. We track it by unit. We track it
8 by condition. We are very vigorous about
9 tracking it. We do tons of interventions. We
10 want to know how well they are working.

11 And we don't need a risk-adjusted
12 measure for that because my case mix doesn't
13 change that much month to month. My
14 distribution of conditions doesn't change
15 much.

16 In fact, my raw readmission rate
17 at Yale-New Haven Hospital, I regret to say,
18 has been rock solid stable for three years.
19 It hasn't budged by even as much as 0.2
20 percent. It is exactly the same.

21 So when you are using data
22 internally to track your own results and your

1 results over time, you don't need a risk-
2 adjusted measure and that's not what we built
3 this for.

4 This is really so that we can
5 identify, do we have a problem at all, and
6 what kind of a problem do we have?

7 MR. AMIN: All right, thank you.
8 Thank you very much.

9 CHAIR KAPLAN: Okay, now I would
10 invite the Committee to have a 30-minute
11 discussion along the lines that we discussed
12 in executive session and we are open for
13 comments and questions. Ashish?

14 MEMBER JHA: So, first of all,
15 thank you guys for doing all of that extra
16 work on incredibly short notice. I can't
17 imagine what your evening and morning were
18 like.

19 But I know that the Committee is
20 really grateful that you guys did all of this.
21 So thank you.

22 If you can go back to the slide on

1 volume for a second, or size.

2 So I want to bring up the example
3 that you used with the coins, and you flipped
4 the coin five times and you got four heads.
5 Now, if we all got a coin and we all flipped
6 it five times and we all got four heads, one
7 would not, I think, at that point -- let's say
8 there were 200 of us in the room -- you
9 wouldn't begin by saying that the central
10 tendency here is 50 percent.

11 You would say there's something
12 systematic going on. These coins are funny.
13 And you'd need empirical evidence to show
14 that.

15 So no one, I think, has ever
16 suggested that you take a single, small
17 hospital with five observations and do
18 anything with that. That would be silly.

19 There is actually very good
20 evidence. We had a paper in Annals of
21 Internal Medicine this past year. We have
22 basically done -- and it's out in the

1 literature so this is not unpublished work --
2 so the paper in Annals of Internal Medicine
3 showed a very nice volume readmission rate
4 relationship.

5 We used -- and we have done this,
6 and other people have done this using
7 identical risk adjustment models to what CMS
8 uses. We just don't shrink.

9 And to go back to the coin
10 example, if you individually shrink each coin
11 five flips, everybody comes out at 50 percent,
12 then when you aggregate it, it looks like,
13 hey, these coins are at 50 percent, when we
14 know that if you had not shrunk and looked at
15 them in aggregate, there was something going
16 on.

17 What's really interesting to me,
18 when I look at the numbers you've pointed out,
19 so you didn't run the numbers without
20 shrinking. I understand.

21 But when I look at those, first of
22 all, what's interesting is that small

1 hospitals have slightly lower readmission
2 rates than large hospitals, that the upper and
3 lower quartile performance for the small
4 hospitals is better than the large hospitals,
5 and the 90th percentile and the 10th percentile
6 performance is better for the small hospitals
7 than the large hospitals, and that's really
8 interesting.

9 And then when you think about who
10 the outliers are going to be, what happens
11 when you shrink it in the way that you choose
12 to, is that if you worked at a large hospital,
13 you're far more likely to be labeled as an
14 outlier because the data make it so that
15 you'll -- so the small hospitals can pretty
16 much never make it as an outlier, or your
17 performance has to be dramatically worse in
18 order for that to happen.

19 And so it is a fairness issue but
20 it's also, in my mind, how you use the data,
21 and I guess the question is: what's the
22 philosophical problem with using past

1 performance?

2 I understand that volume raises a
3 series of questions, but what's the problem
4 with saying, in the prediction model, if you
5 have been -- let's say your readmission rate
6 has been 35 percent for five years in a row,
7 we are not going to begin, in year six, with
8 the assumption that you are at the national
9 average again.

10 We have five years of data
11 suggesting that you are where you are. Is
12 there a mathematical problem with that? Is
13 there a philosophical problem with that?

14 Wouldn't that be more friendly to
15 consumers because it would actually use the
16 information that's available?

17 MS. HORWITZ: Shall I respond to
18 that? These are important questions, and to
19 a large extent these are policy questions, in
20 terms of how you want to handle hospitals and
21 how you want to think about leveling the
22 playing field.

1 I want to just first correct one
2 thing, which is these are HDLM results so it's
3 very hard to say what small hospitals are
4 actually performing. You can't use these data
5 for that question, now, because we have
6 already pulled -- we have already assumed an
7 a priori.

8 So I don't really know what the
9 results would look like had we not done that.

10 So these are hierarchical
11 regression results, so we have already done
12 the procedure that I talked about in the sense
13 of assuming the average hospital and it's
14 pulled it in that way, so we don't -- but you
15 were commenting on some differences and it's
16 hard to know if they would be worse or if they
17 would be better without that.

18 The second thing I want to say is
19 that if we -- let's suppose we had picked a
20 different mean to pull small hospitals to.

21 So we would say, okay, you are a
22 small hospital, your average is going to be

1 slightly higher, say, than the hospitals at
2 large.

3 So what does that do? That, first
4 of all -- so now you've got kind of a bumpy
5 playing field instead of a flat playing field
6 -- and we are saying okay, if you are a small
7 hospital who is performing very well, we are
8 now going to pull you higher because your
9 average small hospital performs worse and we
10 make it probably virtually impossible for a
11 small hospital to look like they are better
12 than average.

13 Conversely, we make it much easier
14 for a small hospital to look worse than
15 average because we are pulling them in that
16 direction, and it remains an open question to
17 us whether that's the appropriate measure to
18 take, given that we don't really know that all
19 small hospitals are homogenous in that way and
20 that it is sort of appropriate to change the
21 playing field for them.

22 Now this is a hospital-wide

1 measure we are talking about, not a condition-
2 specific measure, so this is not a sort of
3 condition -- whether there's a volume-outcome
4 relationship for specific conditions is
5 different from whether that's true at the
6 hospital level at large.

7 CHAIR KAPLAN: Okay, what I would
8 ask, though, Ashish, is that we keep the
9 questions concise and the responses concise.
10 Thank you.

11 MEMBER JHA: I'll reiterate my
12 question, which is there are lots of ways of
13 doing it and we don't need to get into a
14 discussion about that.

15 How about the hospital's past
16 performance as -- it's pretty fair, and you
17 could argue that it's probably the best
18 predictor in aggregate of a hospital's
19 performance, is its past performance.

20 MS. HORWITZ: Yes, so, you know, I
21 think that that's a reasonable approach. We
22 have not looked at that so I can't tell you

1 how it would change the outcomes or how it
2 would change the measure.

3 CHAIR KAPLAN: Thanks very much.
4 Other questions? Bruce?

5 MEMBER HALL: I just want to
6 reiterate Ashish's thanks for all the hard
7 work and I am going to ask a slightly
8 different technical question.

9 Your measure represents a volume-
10 weighted geometric mean of these cohorts. Do
11 you have any concerns about individual
12 hospitals still being dominated by a
13 particular cohort and whether that would lead
14 to any sort of out of sample comparisons,
15 where one hospital's evaluation is still
16 dominated by one particular service line, and
17 then you are creating an impression of perhaps
18 more standardization there than there really
19 is?

20 MS. HORWITZ: Well, we debated
21 this a little bit, and our feeling is that we
22 want to represent what hospitals are actually

1 seeing, so that because we volume-weight, we
2 are allowing the patients that hospitals
3 really see to dominate their measure.

4 And so if the hospital is
5 dominated by one cohort, that's because those
6 are the patients it's predominantly seeing,
7 and we think that's actually appropriate.

8 MEMBER HALL: So in effect what
9 you are saying is, if any other hospital in
10 the country had to do what we have to do, this
11 is what the expectation would be?

12 MS. HORWITZ: Yes, so, for each
13 cohort, we are comparing your performance on
14 those -- the patients in that cohort to all
15 other hospitals' performance for patients in
16 that cohort, and then we weight your
17 performance on that cohort by the number of
18 patients you have seen in that cohort, to give
19 you your average result.

20 CHAIR KAPLAN: Thanks. Laurent?

21 MEMBER GLANCE: Thanks again for
22 doing all that work. A quick question, very

1 quick question. For your calibration plots,
2 were those an independent data sample?

3 MS. HORWITZ: Yes, so obviously we
4 can't do it on the derivations sample because
5 then we have perfect, that by definition is
6 perfect.

7 So what we used -- we have a split
8 sample, 2007/2008 combined. We split them
9 randomly in half. These data that I am
10 showing you are from the validation of the
11 '07/'08 validation sample.

12 We have similar data for 2009,
13 which I am not showing you, but I will tell
14 you that they are very similar.

15 CHAIR KAPLAN: Richard.

16 MEMBER BANKOWITZ: Again, thank
17 you for the presentation. In the data on the
18 socioeconomic impact, I have heard a couple of
19 explanations that -- one is that, well, there
20 are other comorbidities involved with higher
21 Medicaid populations, and so what you are
22 showing us is not -- it's not possible to

1 discern the marginal effects of this.

2 To do that you'd have to included
3 it in the model and see. Do you know if there
4 are marginal effects to the Medicaid
5 population, and if so how would you handle
6 those marginal effects?

7 MS. HORWITZ: So you're asking if
8 we added some kind of measure of SES to our
9 model, would our model perform better?

10 We didn't do those analyses and
11 for two reasons. One is, it's actually very
12 hard to come up with a reliable and acceptable
13 proxy for SES using administrative data. We
14 are not really aware of any measure that we
15 think has appropriate validity.

16 The second reason is that, let's
17 suppose we put that in the model and it did
18 improve the performance of the model, we are
19 not sure how to interpret that, because we
20 don't understand still, we can't disentangle
21 what proportion of real outcome difference
22 that's attributable to SES has to do with

1 intrinsic characteristics of the patients that
2 are just totally unavoidable, and what
3 proportion has to do with quality of the
4 hospital, bias, or the ability of the hospital
5 to handle these patients, or the type of
6 health literacy materials you give, or the
7 type of social support or the community
8 relationships you build, and so on and so
9 forth.

10 So even if we found a relationship
11 or an improvement in the model, it's not clear
12 to us how we would interpret that.

13 CHAIR KAPLAN: Thank you. Other
14 questions? Ashish.

15 MEMBER JHA: I have a quick
16 interpretation. Can you go forward a few
17 slides? It was something you guys popped up
18 yesterday showing the distribution. I just
19 want to make sure I understood some of the
20 numbers.

21 There was a slide you showed
22 yesterday that basically showed the

1 distribution of the performance, and it's in
2 the technical --

3 MS. HORWITZ: It's in the
4 technical report, if you have that handy.

5 MEMBER JHA: Right. What I
6 remember is the difference between the 10th
7 and the 90th percentile -- and I'm going to
8 make up the numbers because I don't remember -
9 - it was like 15 to 18 percent, suggesting
10 that 80 percent of hospitals are between 15
11 percent readmissions and 18 percent
12 readmission or a 3 percent gap between the
13 best performers and the worst performers if
14 you think of the 90th and 10th percentile.

15 First I want to make sure I got
16 that right. I understood --

17 MS. HORWITZ: That's about right.

18 MEMBER JHA: I understood it was
19 2.9 percent or something --

20 MS. HORWITZ: I think Elizabeth
21 has the actual numbers.

22 MS. DRYE: The 10th percentile is

1 15.4 and the 90th is 18.2.

2 MEMBER JHA: So it's a 2.8 percent
3 difference between the best and worst. Now,
4 I mean, we have talked about all the shrinkage
5 issues, but it does concern me, I guess this,
6 the question has been: does it raise any
7 concerns for you, in terms of when I think
8 about this as a consumer, that's a pretty tiny
9 difference, because are you going to make a
10 difference -- are you going to choose a
11 hospital based on 17 versus 16 percent?
12 Probably not. And yet, like a third of the
13 hospitals are in that range.

14 So is this going to really give us
15 much information is one question, but that's
16 a philosophical question and you may not be
17 able to answer that, but a question that was
18 raised yesterday was: so what proportion of
19 hospitals will statistically be labeled as
20 outliers based on the overall model?

21 MS. HORWITZ: Right.

22 MEMBER JHA: That you can tell us.

1 MS. HORWITZ: I can answer that in
2 a non-answer way, which is, we have not
3 bootstrapped the data yet, so I don't know how
4 many outliers we have.

5 But I can tell you with some
6 confidence that because we have real volumes
7 here, we are talking about big hospitals, our
8 median of 700-something admissions, we are
9 very confident that even though there's a
10 narrow distribution, that the confidence
11 intervals around any individual point are
12 going to be narrow enough that we will still
13 be able to identify outliers.

14 The question of whether a narrow
15 distribution means that this is not a quality
16 signal or that it is not useful or, you know,
17 is a separate question, and I would argue, as
18 a clinician, that we are all bad at
19 readmissions and so I think to some extent,
20 this is reflecting just general badness and to
21 some extent it's reflecting the fact that
22 nobody has had any incentive to think about

1 readmissions yet.

2 And so primarily it's been driven
3 by utilization and other things. And so I
4 think that as people start to focus more on
5 this as a quality indicator, we will start to
6 see a much bigger spread.

7 MEMBER JHA: Can I just follow up
8 on that? So your median is around 17 or 16
9 percent, does that sound right? And the
10 Jencks paper that kind of got all this going,
11 they use all-cause and they were at around 20
12 percent.

13 Do you have any explanation for
14 why a four-point gap between the Jencks
15 approach and your approach?

16 MS. HORWITZ: So the Jencks data
17 is actually totally different data. You will
18 see that the third or fourth most common
19 readmission for -- or condition leading to
20 readmission is psychiatric disorders.

21 They included psychiatric
22 hospitals and all kinds of other things in

1 that data that we did not. The second thing
2 is that they use DRG and we use conditions,
3 and the third thing is that this is
4 risk-adjusted and his was raw rates.

5 (Off mic comment.)

6 MS. HORWITZ: The mean should come
7 to the same. Right, I think that primarily
8 it's driven by different population.

9 CHAIR KAPLAN: Laurent, is that up
10 delayed down, or oops. Richard, I think we
11 have time for one or two more questions.
12 Richard?

13 MEMBER BANKOWITZ: A quick
14 question. With the hierarchical model, you
15 can take into account hospital effects, so you
16 could create a dummy variable for a safety net
17 hospital, and you could discern if there were
18 any marginal differences, and I just wonder if
19 that had been done, and I think it would be
20 useful to do because we are making policy
21 decisions.

22 So not that we would change what

1 you have done, but just to understand from a
2 societal perspective if there's a difference.

3 MS. HORWITZ: So we never put a
4 dummy variable in for safety net hospital. We
5 did this analysis though, whichever it
6 happened to be, looking into proportion of
7 Medicaid as a proxy for that.

8 Did we ever put that into a model
9 and see how the model changed in performance?
10 We did not do that. But we did see how the
11 performance of hospitals in those quartiles
12 differed.

13 CHAIR KAPLAN: Thank you. Jim,
14 you have the last question.

15 MEMBER BELLOWS: Thanks. You made
16 a nice distinction between measures for
17 accountability and measures for improvement
18 and the fact that an unadjusted measure could
19 be used for improvement.

20 I know in our system, data that
21 really drives improvement is data that we can
22 bring to a local level and stratify and do in

1 a timely way, and that for us it would be huge
2 to be able to do things like know differences
3 in sub-populations by people who are
4 discharged home versus discharged to SNF,
5 people who are discharged to different kinds
6 of different outpatient settings and so forth.

7 All those would require
8 information about the difference on the
9 overall performance on the measure the
10 incorporates the risk as well as the raw
11 readmission rate, and all those are kinds of
12 analyses that a person couldn't do with a
13 model that can only be implemented centrally.

14 So I am wondering how, in the
15 improvement work that you talk about, you
16 would navigate that kind of understanding and
17 provide data that drives, when you can't
18 actually produce the risk-adjusted rate for
19 those different kinds of sub-populations who
20 would let you narrow down in on the problem.

21 MS. HORWITZ: Yes, well you know,
22 we are outliers for heart failure and for

1 pneumonia. We can't reproduce that internally
2 but what we do, is we look at raw rates for
3 heart failure.

4 We have looked at different
5 discharge dispositions and different units and
6 we have broken our data down that way, and we
7 just trust that our raw data from time to time
8 are stable enough, ex our interventions, that
9 we can look at changes and attribute them to
10 our interventions.

11 In terms of this model, we don't
12 have data that we have confidence in to
13 include things like that, like disposition. We
14 don't believe in the administrative data
15 around that point, so we don't include it in
16 our models.

17 But people internally look at
18 things like that all the time, and I don't
19 think that they require being able to match
20 that directly to the risk-adjusted measure.

21 What the risk-adjusted measure
22 does is tell us overall we have a problem, and

1 then it's up to us to figure out what the
2 problem is and how to handle it.

3 CHAIR KAPLAN: Thank you very much
4 and I would like to add my gratitude to the
5 committees for your rapid turnaround, rapid
6 cycle productivity at our request.

7 I think we are on public comment
8 now?

9 MR. AMIN: Yes. April, can you
10 open the lines if there are any public or
11 member comments to address the Committee?

12 OPERATOR: Certainly. All lines
13 are now open.

14 MR. AMIN: Or in the room.

15 (No response.)

16 MR. AMIN: Okay. So, no? So we
17 will move then to voting.

18 CHAIR KAPLAN: Okay, Adeela it's
19 all you.

20 MS. ADEELA KHAN: Okay, so we know
21 the drill yet, scientific acceptability of
22 measure properties. Are they both reliable

1 and valid, reliabilities, precise
2 specifications, testing, validities, looking
3 at specifications consistent with evidence,
4 testing, threats to validity, exclusions, risk
5 adjustment, stratification, meaningful
6 differences and comparability in data sources.

7 MEMBER JHA: Sorry. I am aware
8 that we are voting up and down based on the
9 measure as it is. We have had some discussion
10 about whether there was a possibility to make
11 the vote contingent on any changes.

12 Is that on the table, or is this a
13 -- assuming that no changes can be made to the
14 measure and the measure is going to stand as-
15 is, are we voting up or down?

16 CHAIR KAPLAN: I'm going to leave
17 that to NQF.

18 MR. AMIN: Well, I think there
19 should be a proposal right?

20 DR. BOSSLEY: I think what would
21 be helpful -- we have done this before -- is
22 to have all of you outline what you think you

1 would like to see done and then we'd have to
2 hear from the developer on whether that's
3 possible in the time frame we have, and I have
4 looked at Taroan and Alexis in that.

5 And then you can vote on, based on
6 that contingent, for these changes. We can
7 definitely do that.

8 Yes, what might make more sense is
9 right now have you vote on it as-is, see where
10 we are with that, and then move to the next.

11 MEMBER JHA: Got it. So, and if
12 it passes then there's no opportunity to make
13 proposals to modify it, but if it fails then
14 we have the opportunity to --

15 DR. BOSSLEY: You got it.

16 MEMBER JHA: -- bring it up.

17 DR. BOSSLEY: That's it. Yes.

18 MEMBER JHA: All right. That
19 makes sense.

20 MEMBER GHINASSI: Let me just go
21 on record as saying I think that's the wrong
22 order. If we are going to seriously consider

1 -- and I realize that if the decision is to
2 vote on it as-is, then so be it, we should do
3 that.

4 If in fact the Committee is saying
5 we are open to suggesting modifications, it's
6 my opinion that to vote first does not -- is
7 not in the spirit of that, that this one -- I
8 just want to say.

9 DR. BOSSLEY: Right. Yes. Maybe
10 it would help -- let's do it this way. We go
11 through this every single time. Shall we see
12 what the modifications are, see if you all are
13 willing to entertain them, and then we will
14 move forward. That's fine.

15 CHAIR KAPLAN: Okay. If we are
16 going to go down that road what I would really
17 ask you to do is -- we don't, you know, we
18 don't want to be mobilizing a massive effort
19 here to propose a bunch of things to this --
20 the measures developer, that may or may not --
21 let's focus on -- I'm going to just do this
22 randomly as -- in my -- I mean you can all

1 throw you know, stuff at me.

2 No more than three, okay, so hit
3 your -- get your cards up soon if you, you
4 know, if you've got real issues because I
5 think we are not going to go more than three
6 recommendations.

7 MR. AMIN: So procedurally this is
8 how we will handle it. You -- members of the
9 Committee can suggest a response, a change to
10 the measure. The developer will respond on
11 whether that's feasible. The timeline that we
12 are considering is that the updates need to be
13 sent to the Committee by the 13th. Remember
14 we are dealing with an expedited review. And
15 the Committee will have to have a call to
16 review these updates on the 15th or 16th.

17 So, on our current timeline,
18 that's what we are dealing with. Now, whether
19 we can have some flexibility in timeline will
20 be up to leadership at NQF. But this is based
21 on our current timeline here. So --

22 CHAIR KAPLAN: Okay, and here's

1 the local timeline. The local timeline is we
2 are over time. So I would really ask people
3 to be very concise and very specific and with
4 the measures developers, very -- it's doable,
5 it's not doable and not a whole lot of, you
6 know, delay. Ashish?

7 MEMBER JHA: You know where I am
8 going. I would like hospitals' past
9 performance, and personally I would recommend
10 that we use the last five years of
11 performance, as part of the -- as part of what
12 goes into the model for predicting what that
13 hospital's expected rate should be.

14 MS. HORWITZ: We think that would
15 be a real challenge to get done in a very
16 short time frame, and I would just comment
17 that the downside of that is that it makes it
18 very hard for hospitals that are improving to
19 show improvement.

20 CHAIR KAPLAN: So that's probably
21 not.

22 MS. HORWITZ: I think it would be

1 hard for us to get done in this time frame.

2 CHAIR KAPLAN: Richard, did you
3 have anything?

4 MS. DRYE: Sorry, can I just add
5 that we are developing the measure, you know,
6 for and with CMS and so obviously it's not our
7 unilateral decision at Yale too.

8 So those decisions would have to
9 go back to CMS.

10 MEMBER BANKOWITZ: Well, I mean I
11 think that approach is arguable. I personally
12 would not support that approach for many
13 reasons, so I don't -- I would not ask the
14 developer to do that.

15 You know, listening to the
16 discussion, I am mindful of the fact that we
17 want to uncover disparities and so we don't
18 want to bake them into the model.

19 I just wonder if there's some way,
20 because -- that the developers might suggest
21 a way to at the same time be equitable in our
22 payment. Since we are basing payment on this,

1 is there a way we can both be equitable and
2 reveal the disparities -- your thoughts on
3 that.

4 MS. DRYE: So I would just first
5 separate the measure and then how the measure
6 results are used for any payment, and I think
7 we mentioned yesterday that you know, any
8 hospitals that are struggling that have a high
9 proportion of SES or for any other reason, you
10 know, a policy response can be to support
11 those hospitals and that is part of what's in
12 the Affordable Care Act.

13 But in terms of making a
14 transition on SES, that's, as you know, really
15 challenging and complex issue for -- it's a
16 policy decision and we'd have to -- I can't
17 make any commitment today on whether that
18 would be doable or not, because it's clearly
19 going to be -- that's a decision that CMS
20 ultimately has to make.

21 CHAIR KAPLAN: So as-is, okay, so
22 that's probably not as well.

1 DR. BURSTIN: Just one brief
2 comment on that. Again, any payment issues
3 are outside our purview. CMS could choose to,
4 and in fact I think might, you know, perhaps
5 differentially pay based on the patient
6 population. But that's not in the measure.
7 Right?

8 MEMBER GHINASSI: Yes, thank you
9 for sending the article last night by the way.
10 I just want to read one last bit, two brief
11 suggestions.

12 Mind set for example, while
13 medical comorbidities may account for a large
14 proportion of risk in some populations.
15 Social determinants may disproportionately
16 influence risk in socioeconomically
17 disadvantaged populations.

18 Our review found that few models
19 have incorporated such variables. I agree
20 with that point, and I realize the
21 complexities associated with trying to
22 incorporate that into the model.

1 However, looking for the keys
2 under the light-post, because that's where the
3 light is, isn't necessarily going to help you
4 find the keys.

5 I would suggest that there be some
6 attempt to bake into the model some measure of
7 that disparity whether it's housing stability
8 over time, employment status, payer mix.
9 There are certain things that can be put into
10 the model which could serve as reasonable
11 proxies for that.

12 My suggestion is to, rather than
13 simply dismiss them, to include those as a
14 piece. I do think that the article was
15 correct, and my concern is that the primary
16 focus is to improve quality. We may be
17 missing that opportunity.

18 CHAIR KAPLAN: Can I ask the
19 developers to respond to that quickly. I
20 think you have probably already answered that
21 with respect to Richard, but please --

22 MS. HORWITZ: So it is certainly

1 true that socioeconomic factors play an
2 important role in readmissions, and the
3 question is twofold. First, how would we
4 handle that in a model? We could stratify our
5 results on a patient level. We could stratify
6 our results on the hospital level. We could
7 say, we could report separate results for your
8 low-income patients versus your high-income
9 patients, and I am not sure that the public
10 would like to see that. I think that's a
11 slightly peculiar thing to do.

12 We could stratify our results by
13 hospital, so if you are a hospital that takes
14 care of low-income patients we could compare
15 you only to your peers.

16 And then we have a funny situation
17 of what if you are better than your peers but
18 you are still worse than the national average,
19 how do we report you? Do we say that you are
20 better? Is that really the message we want to
21 give to consumers? It's kind of a -- it's a
22 challenging thing to think through. We've

1 thought a lot about this.

2 And the second thing I would argue
3 one more time, and I feel very strongly about
4 this as a person who is focused on
5 readmissions at my hospital, the impact -- the
6 importance of socioeconomic status on
7 readmission rates is not entirely fixed, and
8 hospitals have a profound role to play in
9 changing that risk and in terms of the way
10 that they perform.

11 We have cut our heart failure
12 readmission rate by 33 percent in the past
13 year, and we have the same low-income patients
14 that we had a year ago, and we have worked
15 incredibly hard with those patients to really
16 improve their outcomes.

17 So I am reluctant to endorse the
18 fact that socioeconomic status is immutable
19 and a risk factor that can't be changed.

20 CHAIR KAPLAN: Thank you very
21 much. We have time for one more. Ashish?

22 MEMBER LAZAR: Sherrie?

1 CHAIR KAPLAN: Yes. Eliot?

2 MEMBER LAZAR: Yes. I don't know
3 where we just left that discussion on SES. I
4 didn't hear the developer say that it was not
5 possible to do.

6 I would echo the comment before in
7 saying that I'd personally love to see
8 something in there addressing SES down at the
9 patient level, certainly not at the reporting
10 level.

11 CHAIR KAPLAN: The way I
12 understand this, and help me if I'm wrong
13 here, is that the answer was, the claims data
14 don't -- beyond Medicaid, the claims database,
15 administrative database does not provide you
16 with enough detail to put a credible SES
17 measure into the model. Is that accurate?

18 MS. DRYE: It would be very hard
19 to define something that people could agree on
20 that we felt comfortable with.

21 CHAIR KAPLAN: Does that answer
22 your question Eliot?

1 MEMBER LAZAR: Okay.

2 CHAIR KAPLAN: Okay.

3 MEMBER ASPLIN: I have a process
4 question, not a -- I understand our purview is
5 up or down on the measure. Do we ever forward
6 measures with any policy recommendations
7 recognizing it's not -- it's up to CMS to
8 determine how they are going to use them, but
9 do those recommendations from a committee like
10 this survive and go with a measure or not?

11 Does it just -- because the
12 stratification by SES seems to be the out
13 here, in how the measure is implemented. So
14 you let the variability flow through without
15 putting SES in the model, but you could
16 stratify your sample in groups.

17 Now, would a recommendation like
18 that survive if it went forward -- the measure
19 got forwarded from NQF to CMS?

20 DR. BURSTIN: Yes, especially if
21 it's something around stratification. Again,
22 something specific to the measure as opposed

1 to the payment policy very much so would be in
2 our purview, and that's a very reasonable
3 request if that's something the Committee
4 wanted to consider, that you know, these
5 measures should be stratified.

6 Again, I don't know how difficult
7 that is to do. I don't know what the
8 implementation issues are. But that would be
9 something I think would be very reasonable to
10 entertain.

11 MEMBER ASPLIN: That to me is a
12 way that we can address this concern. It's
13 not in the measure development. The measure
14 stays as is. But that's what we would
15 recommend, is that we -- that the use of the
16 measure be stratified according to payer mix
17 and either by quartiles or some other -- maybe
18 just two groups over a certain cut point of
19 Medicaid patients and the payer mix is -- and
20 have two different groups. That would be my
21 recommendation.

22 MR. AMIN: The Committee can

1 definitely make that recommendation in the
2 final report. Go ahead Eliot.

3 CHAIR KAPLAN: Okay Eliot.

4 MEMBER LAZAR: I'm sorry. I have
5 to strongly disagree with the idea of
6 reporting in a stratified way. I think it --
7 and again perhaps the public folks, you know
8 the consumer advocates, would like to comment.

9 But I think it sends a very, very
10 negative message in terms of not having one
11 standard.

12 CHAIR KAPLAN: Okay so here's
13 where we aren't. I've heard the measures
14 developers really respond to what's possible
15 and what's doable, and what's -- what their
16 limitations are.

17 So far, correct me if I am wrong
18 Committee, but I haven't heard anybody say --
19 come forward with a revised recommendation
20 that's -- that the measures developers think
21 they can deliver on. Has anybody heard that?

22 (Off mic question.)

1 That's what I'm asking. Is --
2 because I wanted to see if somebody else heard
3 something I didn't, and if so, because we need
4 to vote, and I'm trying to clarify what we are
5 voting on. So Tanya, are you about to say
6 something?

7 MEMBER ALTERAS: Well, I just was
8 going to respond to Eliot since he was asked,
9 you know, he said that it was a bad idea. I
10 would say there -- to me there's a
11 distinction, you know, oftentimes we, from my
12 job, we ask that measures be stratified by
13 race, ethnicity, language, gender, but that's
14 really for process measures, because you know,
15 that's where you kind of can identify where
16 the disparity is.

17 And with outcomes it is a
18 different animal. You know, you don't want to
19 necessarily make those distinctions because
20 you do want to see the same outcomes for
21 everyone. So --

22 CHAIR KAPLAN: Okay, Brent, tight

1 --

2 MEMBER ASPLIN: Can I respond to
3 that?

4 CHAIR KAPLAN: Yes.

5 MEMBER ASPLIN: Well my response
6 is that normally I would absolutely agree with
7 Eliot and the perspective that was just
8 raised, when the outcome is really arguably
9 completely within the purview of whatever
10 entity is being held accountable for that
11 outcome.

12 I just think that there's so much
13 about readmissions that takes place outside of
14 the walls of the hospital, that that's the
15 justification in this case for recommendation
16 that the measure be reported in a stratified
17 fashion.

18 It doesn't, in my mind, mean that
19 there's two standards of quality. Normally I
20 would absolutely agree with Eliot's comments.
21 I just don't in this circumstance.

22 CHAIR KAPLAN: So given what we

1 have heard from the measures developer,
2 because I am now trying to synthesize what I
3 have heard so far, the basic -- the data that
4 you have that most closely approximates SES is
5 Medicaid, and you showed data that there
6 really isn't evidence that there is a
7 distributional difference based on Medicaid
8 stratification.

9 Would you be willing to go along
10 with some reporting recommendations stratified
11 on Medicaid?

12 MS. DRYE: I'm not sure if you are
13 asking would we go along with it, because I
14 think, just, this is a process question, we --
15 I mean, that's, are you, I think that -- the
16 Committee is considering making that
17 recommendation that the measure would be
18 implemented that way?

19 I guess I'm trying to --

20 MR. AMIN: It seems that the
21 question --

22 MS. DRYE: Do you want a

1 commitment from CMS in advance that they would
2 implement it that way?

3 MR. AMIN: It does seem that the
4 question of reporting actually is outside of
5 the scope of what the measure developer would
6 be responsible for.

7 So really, it seems that that
8 would just be a recommendation the Committee
9 would hold in its draft report up to the CSAC
10 and further on in the process.

11 DR. BURSTIN: Yes and no. NQF
12 does have criteria that have actually just
13 been updated by our Disparities Committee that
14 are called disparities-sensitive criteria,
15 identifying measures where there are known
16 disparities, and this, I think, one could
17 argue, it's not clear there are known
18 disparities in this are, where stratification
19 is preferred.

20 And so those measures come out and
21 there's an indication this is a measure that
22 should always be stratified. So I don't think

1 -- again, I think you need to decide if it's
2 the will of the Committee. We haven't heard
3 that yet.

4 But I think it could be an
5 accompanying recommendation that goes along
6 with the measure when it goes out for public
7 comment, that suggests the will of the
8 Committee is or is not that that measure
9 should be stratified, or that CMS should look
10 into other ways, I mean, again, it doesn't
11 have to be decided at this moment. It's more
12 of a reporting issue. But I do think it's
13 something we should get a sense of the will of
14 the Committee first.

15 CHAIR KAPLAN: Okay, so here's the
16 two options now that I hope I am getting
17 right. The two options are one, to go forward
18 with an as-is, no adjustment of hemline, no
19 addition of lace onto the garment, and the
20 other is the accompanying recommendation for
21 reporting if the recommendation for a
22 reporting stratification based on proportion

1 of Medicaid patients.

2 So which do we -- which -- is that
3 -- does anybody hear something I didn't hear?

4 MS. DRYE: Can I just ask also, I
5 don't know how specific you want or need to
6 be, and how you would stratify, quote unquote,
7 for SES, just because, you know, you can do
8 safety net, non-safety net, you can do for
9 example Medicaid, as you know, there's many --
10 you can do ZIP code, income, blah blah blah,
11 and did you mean by patients within a
12 hospital, or by hospitals with a certain
13 proportion.

14 So I think those things all
15 actually -- it's been shown by a number of
16 people that those lead to different groups of
17 hospitals and I just -- I just don't know
18 whether you want to get to that level of
19 specificity, the implications of leaving it
20 open, or that -- those are just very different
21 things.

22 CHAIR KAPLAN: No, we don't want

1 to be too detailed because I'm afraid that if
2 we put too much specification around it, then
3 we are providing guidance that we really -- we
4 really oughtn't to in terms of our various --
5 you know, we can get into whole day's worth
6 debate about what the right marker for SES is
7 and how these data should be reported out.

8 I think a recommendation that they
9 should be reported by stratification would
10 make many committee members more enthusiastic
11 about supporting the measure going forward.

12 But now I am a little bit confused
13 about procedure. Do we vote on the as-is
14 measure and then the addition, or do we just
15 fold that in?

16 MR. AMIN: It's overall -- it's
17 just a recommendation on the measure going
18 forward. Is there really --

19 MS. PACE: But maybe we could just
20 -- we have a simple yes/no question to see how
21 much of the Committee supports that
22 recommendation, I don't know, or maybe there's

1 a better sense than I have.

2 MEMBER JHA: Very quickly, so
3 Medicaid is the wrong measure to use because
4 47, 48 percent of hospitalizations are paid
5 for my Medicare, and so -- and you can imagine
6 that you have lots of poor Medicare patients
7 who are being picked up in these models.

8 And so there are other approaches
9 -- I don't want to get into what those other
10 approaches are -- but I would only argue that
11 the spread in performance we have seen by
12 proportion of Medicaid really does not capture
13 how much variation there is by safety net
14 status if you use other measures, that safety
15 in the hospital is by proportion of
16 minorities, other stuff, tend to do much, much
17 worse than what we see up there.

18 So I would -- it's my way of
19 saying there's a bigger problem than -- one
20 that what these data suggest, and there are
21 lots of ways of handling it, none of which we
22 need to get into.

1 But I would favor that we keep SES
2 on the table as an important issue, and not,
3 in my mind, be affected by those --

4 CHAIR KAPLAN: Okay, I am going to
5 make then the following recommendation, that
6 we vote with a reporting recommendation
7 attached, to include some reporting
8 stratification by SES and it's a
9 recommendation. It is not changing the core
10 scientific content of the measure.

11 How many would favor that vote
12 right now, on the measure plus a
13 recommendation for -- no? We are getting the
14 --

15 (Off mic comment.)

16 CHAIR KAPLAN: Okay, so that's
17 what we are now -- is everybody clear? Do we
18 have any -- okay. Let me try it one more
19 time. We are voting on the measure as is for
20 its scientific reliability/validity, plus the
21 recommendation that the data be reported with
22 some stratification -- go ahead.

1 MEMBER LANGBERG: It seems to me
2 we might want to have two votes. The first is
3 as-is, and then regardless of the outcome of
4 the as-is, either -- the up or down, we can
5 then vote whether we want to make a
6 recommendation on the SES issue.

7 CHAIR KAPLAN: Now are you going
8 to have to do that over again? All right, how
9 many -- let's just do -- let's do a body
10 count. How many people would actually support
11 that recommendation? Hands. Stratification
12 by socioeconomic status, however it gets
13 defined.

14 DR. BOSSLEY: We have -- we
15 actually have slides ready, in the order that
16 everybody just said. So let me -- Adeela is
17 going to project it in just a second. Let's
18 make sure that you all agree with what we just
19 did.

20 And I apologize for the messy
21 process.

22 MEMBER BROOKS: Point of

1 clarification. When we talk about using the
2 SES or the stratification, whatever it may be
3 for reporting, is that just for Hospital
4 Compare whatever, or how CMS may use it, which
5 I know we can't dictate or tell, in any other
6 way, like for pay for performance, et cetera?

7 CHAIR KAPLAN: I don't think we
8 can be specific about that recommendation
9 because again, that would take us another
10 day's worth of whatever.

11 DR. BOSSLEY: Okay, so what we
12 have done, based on the last comment that was
13 said, we can change this again if needed, but
14 we think it's easier to try to do this
15 electronically.

16 We would first have you vote on
17 scientific acceptability of the measure,
18 because right now that's what you have, and
19 then the second one will be does the Committee
20 support the reporting recommendation and
21 that's a yes/no. Does that seem reasonable?

22 MEMBER GHINASSI: Just one small

1 clarification. When you say would report --
2 vote on the measure, first, I am assuming that
3 means as-is --

4 DR. BOSSLEY: As-is.

5 MEMBER GHINASSI: -- without
6 stratification?

7 DR. BOSSLEY: Correct.

8 MEMBER GHINASSI: Why would that
9 be different than the vote yesterday?

10 DR. BOSSLEY: Because you have had
11 new information presented --

12 MEMBER GHINASSI: New information
13 --

14 DR. BOSSLEY: -- to you today.

15 MEMBER GHINASSI: Okay. Thank
16 you.

17 CHAIR KAPLAN: Okay, Adeela.

18 MS. ADEELA KHAN: Okay, so on
19 scientific acceptability of measure
20 properties, was the criterion scientific
21 acceptability of the measure properties met.
22 Vote one for yes, two for no.

1 And you can start now.

2 MR. AMIN: Okay, I will do a roll
3 call for the members on the phone. Eliot,
4 yes/no, on scientific acceptability?

5 MEMBER LAZAR: Yes.

6 MR. AMIN: Patricia McDermott.

7 MEMBER McDERMOTT: Yes.

8 MR. AMIN: And Mark Williams.

9 (No response.)

10 MR. AMIN: Okay. Thank you.

11 MS. ADEELA KHAN: I think we are
12 missing one person.

13 MR. AMIN: Mark, you are -- Mark,
14 are you on the phone?

15 (No response.)

16 MS. ADEELA KHAN: We have 11 for -
17 - or actually, 13 for yes, 6 for no.

18 DR. BOSSLEY: So then the next
19 thing you will vote on is the reporting
20 recommendation.

21 MS. ADEELA KHAN: Again, one for
22 yes, two for no.

1 MR. AMIN: Does the Committee
2 support the reporting recommendation, one yes,
3 two no. Eliot?

4 MEMBER LAZAR: No.

5 MR. AMIN: And Patricia?

6 MEMBER McDERMOTT: No.

7 MS. ADEELA KHAN: We have 8 yes
8 and 11 no. So on usability, to what extent
9 was the criterion usability met, one for high,
10 two moderate, three low, four insufficient.

11 MR. AMIN: That's the usability
12 criteria. Eliot? It's one high, two moderate
13 --

14 MEMBER LAZAR: Low.

15 MR. AMIN: Okay, three, low,
16 insufficient. And -- he said low. And
17 Patricia?

18 MEMBER McDERMOTT: Moderate.

19 MS. ADEELA KHAN: Oh, I think I'm
20 missing one person. Wait -- can you press it?
21 Oh, there we go. So we have 1 for high, 8 for
22 moderate, 11 for low, and 4 for insufficient -

1 - or zero for insufficient.

2 CHAIR KAPLAN: Okay, so we are
3 voting on feasibility again. Remember that
4 these are all in light of the new information
5 so you are re-voting because of the new
6 information provided by the measures
7 developers.

8 MS. ADEELA KHAN: To what extent
9 was the criterion feasibility met, one for
10 high, two moderate, three low, four
11 insufficient.

12 MR. AMIN: This is a feasibility
13 vote. Eliot?

14 MEMBER LAZAR: High.

15 MR. AMIN: And Patricia?

16 MEMBER McDERMOTT: High.

17 MS. ADEELA KHAN: We're short two
18 votes, if everyone wants to vote again. So,
19 14 high, 5 moderate, zero for low and zero for
20 insufficient.

21 CHAIR KAPLAN: Okay, now we do the
22 overall summary vote on the measure.

1 MS. ADEELA KHAN: So we're asking,
2 does the measure meet all NQF criteria for
3 endorsement, one for yes, two for no.

4 MR. AMIN: Overall, Eliot?

5 MEMBER LAZAR: Yes.

6 MR. AMIN: And Patricia?

7 MEMBER McDERMOTT: Yes.

8 MS. ADEELA KHAN: We have 12 yes
9 and 8 no.

10 CHAIR KAPLAN: I truly want to
11 thank the measures developers again for what
12 you have done to help us, and every single one
13 of these Committee members, for really doing
14 the job and being as diligent as you have
15 been, thank you again very much.

16 MEMBER LAZAR: Sherrie --

17 MS. HORWITZ: We thank the
18 Committee as well.

19 CHAIR KAPLAN: Thank you. Eliot?

20 MEMBER LAZAR: Sherrie can I make
21 one comment?

22 CHAIR KAPLAN: Yes.

1 MEMBER LAZAR: And this really
2 gets back to the issue of SES, and I
3 understand you know, obviously we have not
4 gone with the recommendation about reporting
5 stratification, although I suspect many of us
6 agreed that SES has a very important role in
7 readmissions, and somehow ought to be taken
8 into account.

9 For me it was simply the issue of
10 reporting by SES and what the -- what my sense
11 of the public perception of the institution
12 would be around doing that.

13 I would very much like to see, you
14 know, some recommendation statement, assuming,
15 you know, the Committee agrees and it's the
16 will of the Committee, that we do believe SES
17 is important, and that you know, there ought
18 to be some thought given to how to incorporate
19 SES into the model.

20 That's a little bit more of a
21 general statement than talking about -- or
22 them recommending that something be included

1 at the reporting level versus the risk level,
2 and I just wonder if other members of the
3 Committee would agree to that, you know, to
4 such a statement, and if NQF feels that you
5 know, that would be appropriate.

6 CHAIR KAPLAN: Eliot, I'm not
7 going to revisit this at the Committee level,
8 but I am going to ask Helen to comment on
9 drafting a recommendation and circulating it
10 to us afterwards.

11 DR. BURSTIN: I'd be fine doing
12 that but -- okay go ahead.

13 MR. KRUMHOLZ: Can I just say one
14 quick thing? This is Harlan Krumholz. One,
15 just to thank the Committee and everyone who
16 has involved here, but your message will be
17 loudly heard.

18 I just want to let everyone know
19 that the comments you have made, all of the
20 comments, but in addition specifically the
21 comments about the socioeconomic status will
22 go back to CMS. We are taking them and

1 listening to them very carefully. We
2 understand the importance of this issue. We
3 recognize the care with which you have thought
4 about this issue and are expressing this
5 concern.

6 We have heard it from others, and
7 what we are challenged to do is to figure out
8 how to manage it, because we on one hand don't
9 want hospitals to be unfairly characterized.
10 We don't want people chasing quality issues
11 that really represent problems that reside
12 within their communities.

13 On the other hand we don't want to
14 create a -- as you said Eliot -- a two-level
15 system, and we don't want to obscure important
16 disparities that may exist within our society
17 in performance.

18 So this is -- but we have -- I
19 just want to be clear -- we are listening very
20 carefully to you. We will send this message
21 back to CMS. We are sending it back to our
22 group. And we will work hard to try to ensure

1 that this is taken under consideration, and we
2 welcome any suggestions from anyone who is
3 listening or anyone who is in the room, and we
4 want to improve.

5 So it would be great for a
6 statement from the Committee, but the work
7 that you have done has already made an impact
8 and I think that we are going to work to think
9 hard about this and try to figure out how to
10 proceed.

11 But we welcome any suggestions
12 too, because it's not easy.

13 CHAIR KAPLAN: Right. I truly
14 appreciate both comments and I -- it's
15 krumholz@yale.edu is that accurate?

16 MR. KRUMHOLZ: It's
17 harlan.krumholz@yale.edu.

18 CHAIR KAPLAN: There you go.

19 MR. KRUMHOLZ: And send them on.

20 CHAIR KAPLAN: So yes, so I invite
21 anyone to share their recommendations and
22 opinions with --

1 DR. BURSTIN: And just one more
2 process thing, we will be writing a draft
3 report for all of your review and comment very
4 quickly since it's got to get out tout de
5 suite, but we will try to obviously
6 incorporate the spirit of this discussion in
7 there, even if there's not a specific
8 recommendation.

9 But clearly this is a major
10 sticking point for the Committee. We would
11 love to have somebody kind of break this
12 logjam and figure out the right approach to
13 allow us to understand the issues of SES but
14 not obscure disparities. So more work to be
15 done.

16 MR. KRUMHOLZ: And we've listened
17 to all the comments too, SES, but all of them
18 are important to us. So I just want to make
19 sure, it's not like we get approval and we go
20 back and we haven't listened -- we have
21 listened very carefully to all of the comments
22 that have been made.

1 CHAIR KAPLAN: Thank you again.
2 Okay, I think -- right? We are ready to --
3 thank you, thank you very much for coming.

4 MS. HORWITZ: Thank you.

5 CHAIR KAPLAN: Okay, I'm going to
6 take a poll on what -- Bruce. Bruce, do you
7 have something to say?

8 MEMBER HALL: I just wanted to
9 lend my support. I hope that our report, that
10 our draft report could just highlight what we
11 have all thought about in terms of threats to
12 the future value here. I want to lend my
13 support to that.

14 CHAIR KAPLAN: Thank you very
15 much. I'm sure that Helen and the staff of
16 NQF have listened to us very carefully. I
17 would like to do the following, and if I get
18 a massive pushback, please tell me.

19 I would like to go -- push through
20 this break and invite people to take a bio-
21 break or get coffee or everything on an
22 individual level, and keep moving us forward

1 so that we -- is there anyone who finds that
2 offensive or would like me to --

3 MR. SAUNDERS: I would say that
4 unfairly discriminates against the measure
5 developer, who would be talking, and could use
6 one of those breaks.

7 CHAIR KAPLAN: There is no such
8 thing as a five-minute break.

9 MR. SAUNDERS: If I could run to
10 the front of the line --

11 CHAIR KAPLAN: If the measures
12 developer is insisting, then you have got five
13 minutes but tick tock tick tock, I will round
14 you all up and find you individually.

15 (Whereupon the above-entitled
16 matter went off the record at 9:54 a.m. and
17 resumed at 10:01 a.m.)

18 CHAIR KAPLAN: Before we get
19 started on the last measures development, the
20 next measures development piece, I would like
21 to invite Tanya -- and really limit it to five
22 minutes total conversation -- Tanya, Michael,

1 and Leslie to raise issues about the basic
2 accountability/usability issues from each one
3 of their perspectives.

4 Because I really want to sort of
5 flesh this out in terms of getting it in the
6 transcript and, also, the report by the NQF,
7 if you could give us the succinct issues of
8 concern for this measure, and not more broadly
9 than that, this specific measure for use in
10 the national profile for accountability and
11 quality improvement?

12 Michael, do you want to go first?
13 And again, please, if you can, keep your
14 comments tight.

15 On the one that we just passed.

16 MEMBER LANGBERG: I will be
17 succinct.

18 The purpose of our work was to
19 give or not give an NQF-approved or validated
20 measure to CMS for its use. We were
21 instructed in the first day, first part of the
22 day yesterday, that the purpose of that use

1 was twofold. One was accountability, and one
2 was performance improvement.

3 I am not persuaded -- I am
4 certainly persuaded about the statistical
5 scientific validity discussions we have had,
6 and respect to the vote of the Committee. We
7 haven't had, actually, subsequent conversation
8 again about the usability.

9 So, I am still stuck over the fact
10 that the reporting will be one to two years
11 after the event. So, we are basically holding
12 facilities for work or experience that may be
13 one to two years old. And the ability to use
14 that information for performance improvement,
15 knowing how rapidly the fields are moving, one
16 to two years later seems to me to be very
17 limited.

18 So --

19 CHAIR KAPLAN: Thank you. Go
20 ahead. Go ahead.

21 MEMBER LANGBERG: Sorry, I lost my
22 thought. If it comes back, I will let you

1 know.

2 CHAIR KAPLAN: I'm sorry, I
3 interrupted your train of thought there. Are
4 you sure?

5 MEMBER LANGBERG: Ah, the only
6 other comment I have made is that I am not
7 persuaded that the hospital-specific metric,
8 in addition perhaps to socioeconomic status
9 and perhaps others that are community-based,
10 adequately assigns accountability to the
11 hospital for the results of the metric.

12 CHAIR KAPLAN: And that is
13 particular to this specific measure we just
14 passed, right?

15 MEMBER LANGBERG: Sure. Yes.

16 CHAIR KAPLAN: Thank you.

17 Tanya?

18 MEMBER ALTERAS: I think for the
19 purposes of public reporting that this measure
20 will not be very useful to consumers. And I
21 know the argument has been made the consumers
22 don't necessarily use this information to

1 begin with, but our philosophy is, you know,
2 we put the best information out there and,
3 hopefully, we will get them more engaged.

4 And with the advent of an all-
5 condition, all-cause readmission measure, the
6 potential is there for more consumers to use
7 it because the readmission measures that we
8 currently have are not for the types of
9 conditions that people normally go online to
10 check their hospitals for, if they are having
11 a heart attack.

12 But when you are broadening it to
13 all conditions, we really did see this great
14 potential there. So, I am not really going to
15 speak to the accountability issue because I
16 think there's a whole lot of issues there in
17 terms of how well this will work for holding
18 hospitals accountable.

19 But in terms of transparency and
20 public reporting, I didn't really see -- and
21 I apologize that I missed some of this
22 morning's discussion -- I still am skeptical

1 that the results, when reported on Hospital
2 Compare or on other websites, will provide
3 consumers with useful information that they
4 can make choices on.

5 CHAIR KAPLAN: Thanks very much.
6 And Leslie?

7 MEMBER KELLY HALL: My concern on
8 usability is really more recommendations on
9 how the reporting is used and explained well
10 for the public. In rural communities like
11 Idaho, if this information is proved useful to
12 consumers and they seek it out, can a patient
13 who is not reviewing this information with a
14 high degree of understanding make
15 inappropriate self-selections?

16 And the distance factor for
17 hospitals, the lack of community safety net or
18 connectivity of others to provide social
19 support, to provide followup, is even
20 heightened in rural communities where you
21 might have 200 miles between hospitals.

22 So, I just caution the group to

1 take a look, when reporting specifically
2 around rural hospitals, and how do we provide
3 that kind of information that is useful?

4 CHAIR KAPLAN: Thanks very much
5 for those comments. I am sure that Helen will
6 make sure that they are in the report, the
7 Committee's report, as reflected concerns
8 along with lines of accountability, quality
9 improvement, and reporting, as I heard it.
10 Thank you very much.

11 So, should we tee up the --

12 MEMBER GREENWALD: Could I just
13 make one other additional question about that
14 one, just as a process piece, very briefly?

15 I respect the opinions of my
16 colleagues here. The question I have about
17 that, though, is, how were those comments
18 specific to this measure? I think many of us
19 have a healthy skepticism about the utility of
20 an all-cause readmissions measure, generically
21 speaking, in terms of its utility and
22 usefulness at the consumer or hospital level.

1 I am not sure how that reflects this specific
2 measure individually.

3 CHAIR KAPLAN: Right. I am going
4 to invite those with a consumer perspective in
5 general to raise their concerns focused on the
6 specific measure and give them to Helen for
7 the report, because I think that will allow
8 them a little more time than we have here to
9 really develop their issues.

10 MEMBER ALTERAS: In 20 seconds,
11 from the consumer perspective, the issue isn't
12 with an all-condition, all-cause readmission.
13 To us, that is a glide path to system
14 redesign. So, it is really more about the
15 public reporting and the transparency and how
16 it is reported.

17 CHAIR KAPLAN: Thank you.

18 We have the next measures
19 developer. We have 10 minutes allotted. If
20 you could make your presentation succinct?
21 And ready, set, go.

22 MR. SAUNDERS: That would be a

1 first.

2 (Laughter.)

3 So, thank you again for the
4 opportunity to come back here to talk about
5 this.

6 So, while these were generated new
7 this morning to put into the presentation
8 here, we had done these kinds of graphs before
9 in the previous model years. We just hadn't
10 done for the current model years.

11 But these are the plots of the
12 actual versus expecteds for the risk deciles.
13 We have additional sorts of error here. It is
14 my ability to draw a red line at a 45-degree
15 angle onto the graph. But you can see, if you
16 were to assume that that red line were going
17 to the origin, trying to map it out there,
18 that our blue dots are lining up like they are
19 supposed to on the red line.

20 If we can scroll down -- sorry, we
21 want to scroll up here.

22 So, this is the Medicare ages, 18

1 to 64. This is our Medicare 65 and older. I
2 think my line is tilted a little bit here.
3 The bottom should be above a little bit, and
4 you will see that they are in line.

5 If we scroll up again, a similar
6 pattern and a similar drawing error on the red
7 line.

8 But if we scroll up, or sorry, if
9 we go to the tab above, we can see what the
10 actual differences are here, that we are
11 talking less than 1 percent at each of the
12 deciles.

13 To Laurent's comments, this is in
14 the predicted, in the model dataset. So, it
15 is going to be naturally better. We didn't
16 have a dataset to validate on this morning.
17 But, hopefully, this is responsive to your
18 concerns about that. So, we feel like we have
19 adequate discriminate ability in the models.

20 Let's see, our second question I
21 believe we were to respond to is the SES
22 issue. So, I was chatting about this with

1 other folks at NCQA who have been in this
2 business longer than me and said, "You big
3 dummy, there's plenty of examples of high SES
4 variability between plans within the same
5 markets." And so, I retract my overstatement
6 and the Redd Foxx references.

7 I think it doesn't change our
8 opinion that we feel, similarly to Yale, that
9 risk-adjusting out variability due to SES is
10 not appropriate, but we also have heard the
11 feedback of the group that this is important.

12 We feel that we take this into
13 account to some degree through our measurement
14 through separate product lines. So, we
15 measure the commercial groups separately, the
16 Medicare group separately. If we were to
17 build this measure for Medicaid, we would have
18 a separate measurement for them, and would
19 hope that there is sufficient similarity
20 within those groups.

21 I think, apart from the concerns
22 that were raised about the difficulty of

1 actually measuring SES accurately, feasibility
2 is one of the four NQF criteria in this
3 measure. That translates to us in terms to
4 the implementability with the data collectors
5 and the people that are reporting the data.

6 For us, collecting the data from
7 health plans would require the health plans to
8 go beyond their normal data collection
9 processes to collect their readmission rates
10 based on individual patient zip codes. We
11 would have to come up with a way to link,
12 then, Census zip code information, assuming
13 that we even believed those numbers as
14 representative of SES, into that dataset, to
15 then do the adjustments.

16 So, we think that in terms of both
17 kind of the conceptual rationale for the
18 inclusion, which I realize the panel disagrees
19 with, but also the practical burden of that
20 feasibility is an important criterion for the
21 implementation here, that we would argue that
22 it would be necessary to leave SES out of

1 measurement. But we would certainly be open
2 to exploring ways to shoehorn it in, if there
3 are ideas and suggestions.

4 I think in terms of the usability
5 of the measures, I think we have sort of
6 talked about this as the Yale measure is a CMS
7 measure. The NCQA measure is a CMS measure as
8 well.

9 CMS has financed the development
10 of this through our performance measurement
11 contracts for our Geriatric Measurement
12 Advisory Panel. And so, we have built a whole
13 suite of measures for health plan monitoring,
14 for Medicare Advantage plans.

15 So, I think, first cut, we think
16 that the measures are usable and are important
17 because CMS has thought that they are
18 important. It is important to have the
19 accountability both at the hospital level and
20 at the health plan level, and they have
21 recognized that, even if they are funding it
22 through different groups within CMS.

1 We think that there is opportunity
2 for improvement in addressing the problem of
3 readmission from both sides, whether from the
4 hospital perspective or from the health plan
5 perspective.

6 As a second element to that, I
7 think we are in similar line with how Leora
8 had sort of described how they use their
9 performance measures with her hospital at
10 Yale. We think of this as the same process
11 for our health plans. We provide a national
12 standard and benchmark for how to measure
13 things that would allow for consistent
14 comparison across plans, but it is also
15 useful -- and so, that gets at the
16 accountability function -- but is also usable
17 at the quality improvement level as a
18 benchmark to guide your rapid-cycle
19 improvements. No one, I don't think, will
20 ever have rapid-cycle versions of this measure
21 in doing the risk adjustment. There will
22 always be that lag.

1 But we think that for hospitals
2 who are able to look at their real-time
3 results on readmissions, or for health plans
4 to look at their real-time results on
5 readmission behavior, and to link that to the
6 performance on these metrics, HEDIS is a large
7 national program, and health plans invest a
8 significant amount of money to improve those
9 rates. Central to that has been having our
10 metrics as a guide for their individual
11 quality improvement efforts.

12 So, we think that, based upon our
13 experience, that our readmission measures
14 would be in the same vein and have the same
15 utility, and has been the voice of the health
16 plans that have responded in our public
17 comment.

18 MR. AMIN: Robert, we are at 10
19 minutes.

20 MR. SAUNDERS: Okay.

21 MR. AMIN: I know, if you have a
22 few more things, feel free to take another

1 five, but --

2 MR. SAUNDERS: No. I think that
3 the last thing that I would say is that, well,
4 I think the last thing I just would want to
5 mention, because I had been thinking that we
6 were going to talk just about the
7 acceptability, the scientific acceptability,
8 just slide to the feasibility to the
9 component.

10 We would say that the primary
11 evidence of the feasibility of our measure is
12 that we have already collected it for one
13 year; that the measure has been implemented by
14 health plans. CMS is already in the process
15 of using the measures within the star system,
16 that it is both for health plan choice and for
17 incentive processes.

18 NCQA has every intention of using
19 the measure and the results for its own public
20 reporting processes and products, like Quality
21 Compass. And we have the opportunity to
22 include it in other things like our health

1 plan rankings and other types of things.

2 So, this measure is very real,
3 very feasible, and very usable by a variety of
4 folks, and has been in demand by all
5 perspectives, provider and plan and consumer
6 and employer group, and everyone else.

7 We think that there is utility to
8 having this health plan perspective in
9 combination and in complement to harmonize
10 with the hospital-based measure.

11 CHAIR KAPLAN: Thank you very
12 much.

13 Now this measure is open to the
14 panel for discussion. Questions?

15 Ashish?

16 MEMBER JHA: Just a point of
17 clarification, and thank you as well for all
18 the terrific work. It is really helpful.

19 The risk-adjustment model that you
20 guys use -- forget the whole shrinkage issue
21 that we talked about and we have belabored --
22 just the strict risk adjustment, my sense from

1 looking at the data from what you guys
2 presented is it is very, very close to the CMS
3 risk adjustment in terms of the approach, the
4 HCCs, what goes into the straight model.

5 Can you tell me whether that is
6 true, how close it is, if there are important
7 conceptual differences? Again, we are not
8 going to talk about the hierarchical modeling
9 part of it, but just straight risk adjustment.

10 MR. SAUNDERS: Sure.

11 MEMBER JHA: Are there important
12 differences?

13 MR. SAUNDERS: If I could ask,
14 Alexis, if you could skip to the desktop,
15 there is one other sheet that we had put in,
16 the NQF harmonization sheet in the middle
17 there.

18 So, we kind of went through
19 looking side-by-side, the exclusions between
20 the two models -- and I haven't verified this
21 with the Yale folks; they can obviously
22 correct me where I am wrong -- and looking

1 side-by-side, also, on the risk-adjustment
2 strategy, I think for the most part, if we are
3 looking at -- we have obvious difference on
4 accountable entity, but we have similarities
5 on the continuous enrollment criteria,
6 similarities in age. We are looking at acute
7 hospitalizations. We are handling transfer
8 similarly; we want the last place.

9 If we scroll down -- I don't
10 believe they have a restriction to have an
11 overnight stay for the intense hospital stay,
12 but we have you have to be overnight. So, we
13 get around that sort of observation room
14 problem that people were concerned about
15 yesterday.

16 So, I think side-by-side things
17 are pretty similar. We include the behavioral
18 health; they don't. But, for the most part,
19 those types of exclusions about the definition
20 of the denominator and the numerators is
21 pretty consistent.

22 If we go to the risk-adjustment

1 strategy, sort of doing a hasty sort of
2 comparison here between the models here,
3 obviously, they are doing the hierarchical; we
4 are doing the indirect standardization through
5 the logistic model, for the reasons described
6 yesterday. The clustering problem is kind of
7 systematic, and there is not very much that we
8 can do about that.

9 In terms of the risk adjusters,
10 they are using age; we are using age. They
11 have surgery built into their model; we have
12 it as a covariate. They have their index
13 condition. They are using the CCS categories;
14 we are using the CCs from the CMS-HCC system.
15 But there is probably substantial overlap in
16 what those categories are.

17 And then, the comorbidities, I
18 believe looked like they were using the CCs,
19 and we aggregated those to the HCCS. But,
20 conceptually, pretty darn similar.

21 I would sort of yield to the Yale
22 folks, if there is any misstated here.

1 Oh, yes, I'm sorry. So, I think I
2 did have that on the previous tab.

3 So, they do have the exclusion for
4 planned readmissions. I think another
5 difference is that they count readmissions as,
6 allow them to be an index event. When we were
7 developing this, we were modeling after the
8 condition-specific measures. And so, we kind
9 of followed that logic. That is a rationale
10 behind that. There is also a rationale for
11 going the other direction.

12 But I think these are pretty
13 similar processes were looking at.
14 Adjustments for patient demographic attributes
15 that are available, your condition that you
16 are in the hospital for, and what your
17 comorbid conditions are. I think, to that
18 extent, they are pretty darn similar.

19 CHAIR KAPLAN: Thank you.

20 Bruce?

21 MEMBER HALL: I would add that I
22 don't know if you intended to reflect it on

1 the previous, but I would add that the
2 structure of cohorts, of infinite cohort
3 models is a difference between your
4 approaches.

5 So, I took to heart what Sherrie
6 said yesterday, that there is no reason
7 necessarily that we wouldn't expect a plan
8 measure and a hospital measure to need to be
9 different. On the other hand, I am not seeing
10 any axis here where there is a convincing
11 pressing need for these models to be
12 different.

13 And so, I would ask you to respond
14 to the notion that we basically would be
15 putting forward a system where we would have
16 to do calculations one way at the plan level;
17 we would have to do calculations a different
18 way at the hospital level. I think that would
19 be an unnecessary burden. I don't see any
20 pressing reason for the differences in these
21 decisions.

22 I think your measure would work

1 with their decisions, or vice versa. I am not
2 saying it should go one direction or the
3 other.

4 But, again, Sherrie's point was
5 there could be a good reason to need a
6 difference in modeling, but I am not seeing
7 that. And so, I wonder if you could comment
8 on it.

9 MR. SAUNDERS: Sure. I think it
10 comes to the definition of harmonization.
11 Does harmonization mean identity? And so, at
12 least at one level, there is a harmonization
13 in terms of the model that we have age; we
14 have handling surgery. We are handling index
15 conditions. We are handling comorbid
16 conditions.

17 If there is a need to go to a
18 lower level, I think we are certainly open to
19 considering looking at that. And I am sure
20 that they would be open to considering doing
21 that as well.

22 And I think what the harmonization

1 process is is figuring out what makes sense to
2 implement. I mean, from our perspective, we
3 have practical issues that argue for us to
4 continue using the HCCs, and that is sort of
5 built into what our index conditions are and
6 what our comorbid conditions are. We use the
7 HCC risk-adjustment process for our resource-
8 use measures.

9 And so, it is something that the
10 plans are familiar with. They have been doing
11 that for, this is their fifth year of
12 collection on that. This will be their second
13 year of implementation with this measure.

14 So, we are out in the field, and
15 we have a body of experience working with
16 this. And so, we have an institutional
17 pressure to avoid that, but it doesn't have to
18 be super-binding.

19 But, for the practical
20 considerations, as the measure developers, and
21 to do this in the business of accrediting
22 healthcare organizations and standardization,

1 there is a real burden to adjusting the
2 processes from what are in place.

3 So, I think we would argue that it
4 would be judicious to take a level of
5 harmonization that seems appropriate to the
6 purposes. We would think that there is
7 alignment in the comorbid conditions, and
8 there is alignment in the index conditions,
9 and that the numbers and the namings of the
10 things are not going to be all that different,
11 and there will end up being some sort of
12 collapsing and negotiation process for linking
13 those.

14 But I think, for the same
15 conditions, then we are going to get the same
16 results.

17 MEMBER HALL: I actually agree
18 probably very, very strongly that you will get
19 very similar results, which just leads me to,
20 again, push the notion that part of
21 harmonization is about simplicity and burden,
22 and the simplicity and burden for the

1 hospitals and the simplicity and burden of
2 usability for the patients who are going to be
3 told, well, that measure is calculated a
4 little bit differently.

5 MR. AMIN: Bruce, can I just jump
6 in here real quick, procedurally?

7 We won't really go into the
8 discussion about harmonization until this
9 measure is actually recommended for
10 endorsement. We have some segment of the
11 agenda to discuss that. But let's really have
12 the comparison because, ideally, we would have
13 Yale being able to respond to concerns on both
14 sides.

15 MEMBER HALL: Okay.

16 MR. AMIN: So, let's really just
17 sort of --

18 MEMBER HALL: Okay, fair enough.

19 So, the second part of my question
20 is, I wonder if you could again comment on
21 what the significance is of this measure being
22 listed as proprietary. It is listed as

1 proprietary. So, does that mean there are any
2 issues with respect to having this in the
3 public sphere?

4 MR. SAUNDERS: No.

5 MEMBER HALL: Presumably, CMS
6 would have, if it wanted to implement it --

7 MR. SAUNDERS: No, it goes into
8 the public -- yes.

9 MEMBER HALL: -- they would have
10 to make a call for any vendor that could do
11 this. Is that correct?

12 MR. SAUNDERS: So, there may be
13 sort of an interpretation issue of our
14 understanding of how to answer the question.
15 It is proprietary in the sense that NCQA has
16 a copyright on the measure, but, like every
17 other NQF -- we have several dozen NQF-
18 endorsed measures, and they are not only
19 proprietary, but they are all shared out and
20 they are publicly shared and available. That
21 was part of our rationale for using the HCCs,
22 is that it is a freely-available thing. So,

1 we don't have to get into the issues of some
2 of the risk adjustments and those types of
3 things, or things with DRGs and the non-
4 standardization of that.

5 DR. BURSTIN: So, just one final
6 clarification. There is proprietary, meaning
7 it is their intellectual property, but it is
8 without fees. So, just to be clear.

9 CHAIR KAPLAN: Thank you.

10 We are going to go Jim, Paula,
11 Richard, and then Jeff.

12 MEMBER BELLOWS: Thank you.

13 I wanted to do two things. One,
14 speak to the usability and also ask a specific
15 technical question.

16 On usability, you sort of deferred
17 to the same explanation as we had for the Yale
18 measure about accepting a difference between
19 measures for accountability and measures for
20 improvement. And I hypothesized that nobody
21 would be able to bring those together.

22 For our system, where we do have

1 both plan and hospital data, it is huge that
2 we can implement this on our own independently
3 on a per-member basis. And we do provide this
4 in near real-time and do use a version of your
5 measure for performance improvement and are
6 able to report it on both a plan basis and a
7 hospital basis and a discharge clinic basis,
8 and all those things.

9 Maybe in everybody else's system
10 they can hold accountability and improvement
11 in two separate parts of their brain, but in
12 our system there is a tremendous desire to
13 bring those together. The fact that this
14 measure allows us to bring those together
15 gives it just phenomenal properties for
16 usability that other versions don't. So, I
17 wouldn't let go of that.

18 I do have just a fairly-narrow
19 question, which is that I see up there it says
20 the reporting metric is the risk-adjusted
21 readmission rate, the O-to-E ratio multiplied
22 by the national average. And I understand in

1 principle that that is the right treatment.

2 When I looked in the
3 documentation, I couldn't actually find that
4 that is the metric. What is really in the
5 documentation is that the reported metrics are
6 the individual pieces of that, the raw rate,
7 the average adjusted probability, the
8 stratification. There are some little details
9 that are required to produce that risk-
10 adjusted readmission rate that are actually I
11 think not part of the submission, including
12 the exact way that you are aggregating across
13 the age brackets and the exact values that you
14 are using for the national average observed
15 rate, and so forth.

16 So, am I right that actually
17 saying that the reported measure is the risk-
18 adjusted readmission rate on the slide is
19 different than what is in the submission? And
20 if so, are you making all the details for
21 making that final calculation available to the
22 public?

1 CHAIR KAPLAN: I would just ask,
2 in the interest of time, make sure we get to
3 everybody, if you could get your answer to be
4 concise, we would be very grateful.

5 MR. SAUNDERS: So, because we
6 haven't publicly-reported this measure
7 ourselves yet, we have been sort of working
8 out the details. And so, the risk-energized
9 readmission rate is a measure we want to do.
10 We have not implemented that for public
11 reporting yet. And so, we would work out
12 those details.

13 MR. AMIN: Just for a
14 clarification point, if there is a difference,
15 I think we need to know which one is the
16 actual one that is being voted on for the
17 Committee. So, if there is really a
18 difference in the way that it is being
19 reported, it is pretty clear that we know
20 which one it is.

21 MR. SAUNDERS: It is what is on
22 the screen.

1 CHAIR KAPLAN: Okay. Thank you.

2 Paula?

3 MEMBER FOLTZ: Yes, I do have a
4 concern that planned admissions and, well,
5 basically surgeries and rehabs are not
6 excluded. Basically, from a plan perspective,
7 I would think that that would be an efficiency
8 measure for them.

9 Because coming from a hospital
10 with Level 1 trauma and burns, we do an awful
11 lot of staged surgeries and send people to
12 SNFs, and then bring them back when they are
13 eligible for rehab. So, I wouldn't want us to
14 keep people in the hospital until these things
15 -- I think there's a lot of efficiencies in
16 excluding those two populations.

17 MR. SAUNDERS: I believe we have
18 exclusions for the rehabilitation population.
19 We are looking at acute hospitalizations, not
20 rehabilitations.

21 In terms of the planned
22 admissions, I think this is where we get to

1 end up needing a Bonferroni correction for
2 advisory panels. We went through our process,
3 through our Geriatric Measurement Advisory
4 Panel and our Committee on Performance
5 Measurement. And now, we are to the NQF
6 Steering Committee here.

7 We initially had a set of
8 exclusions for conditions that are likely to
9 have planned hospitalizations. So, the active
10 cancer treatment, we would have made a person-
11 based exclusion for that. Organ transplants,
12 things that are sort of likely to have planned
13 hospitalizations or planned readmissions.

14 Our Geriatric Advisory Panel was
15 in favor of that. Our Committee on
16 Performance Measurement was against that. I
17 think the rationale is that to be accountable
18 for all the hospitalizations and that we are
19 going to measure the plannedness of
20 hospitalizations with error either way.
21 Rather than introduce an error of unknown
22 magnitude in our definition of "plannedness",

1 to let the risk adjustment handle it.

2 That is not to say that we can't
3 revisit that. Certainly, if we got to the
4 harmonization stage, we would be open to
5 exploring the handling of planned admissions.
6 So, certainly, the Yale example is a fine
7 method for identifying that.

8 CHAIR KAPLAN: Richard?

9 MEMBER BANKOWITZ: A specific
10 question and then a general. The specific
11 question: how does the HCC method incorporate
12 the present-on-admission flag, if it does? I
13 am wondering if you separate out comorbidities
14 from things that occurred in the hospital,
15 like an iatrogenic renal failure, would that
16 be treated the same way as a patient who came
17 in with renal failure?

18 MR. SAUNDERS: I don't know how it
19 handles present-on-admission. That is
20 something I would ask our coding panel or our
21 coding experts at NCQA. But I could
22 reasonably find out.

1 MEMBER BANKOWITZ: Can I ask you
2 if the Yale method addresses complications and
3 comorbidities? They are two different things.

4 MS. HORWITZ: So, two questions.
5 First, present-on-admission coding is not yet
6 reliable. And so, we don't use it. But as
7 soon as it becomes reliable, we would be glad
8 to use it.

9 And so, in the meantime, what we
10 do is, if there is a comorbidity that is only
11 present on the index admission that we think
12 could conceivably also be a complication, for
13 example, renal failure, we do not count it.
14 But if that comorbidity is present on previous
15 admissions or if that comorbidity is something
16 that we don't think would logically be a
17 complication, then we do count it.

18 MR. AMIN: Sorry. Just, again, as
19 a procedural matter, it is extremely important
20 that we focus this discussion purely on the
21 NCQA measure and its own merits.

22 MEMBER BANKOWITZ: Right.

1 MR. AMIN: I know that there are
2 references back and forth to the Yale
3 developer, but really it is inappropriate. We
4 really should keep this at NCQA at this
5 moment. We will discuss selections around
6 harmonization if this actually passes all the
7 way through.

8 MEMBER BANKOWITZ: And this is my
9 general issue: the issue of harmonization
10 really impacts usability. I am concerned from
11 the provider point of view. I am a large
12 hospital. I have got one, let's say,
13 predominant commercial plan. And the
14 commercial plan tells me, based upon one
15 methodology there is a problem, and CMS tells
16 me, based on its methodology, "You're looking
17 good." This drives the hospitals crazy. This
18 introduces chaos.

19 And so, if it is not harmonized,
20 it is not usable.

21 CHAIR KAPLAN: But we are way
22 ahead of ourselves yet.

1 MEMBER BANKOWITZ: So, I can't
2 even vote on whether it is usable unless I
3 know what is coming down the road in terms of
4 harmonization because, if it is not
5 harmonized, it is not usable, in my opinion.

6 DR. BURSTIN: I sort of understand
7 where Richard is going. I think this is an
8 issue. The question would be, if you are
9 going to vote on this measure, are there
10 issues with this measure as you see it? That
11 would potentially be something you would want
12 to address.

13 Obviously, it is hard to
14 completely disentangle what we saw earlier
15 versus this. But I think, for example, just
16 to put one on the table, I think the issue of
17 the lack of exclusion of planned readmissions
18 is one that I think the Committee should
19 certainly consider. It is in ACA, clearly
20 saying -- you know, again, this isn't subject
21 to ACA -- but I think, just again to Richard's
22 point, it would be very difficult for

1 hospitals to get both measures, one excluding
2 the planned and one not getting excluding
3 planned.

4 PARTICIPANT: Explain what ACA is.

5 DR. BURSTIN: I'm sorry, the
6 Affordable Care Act. So, the health reform
7 legislation specifically indicates that they
8 would prefer they want readmission measures
9 with planned readmissions excluded. Correct,
10 Nancy, my ACA person?

11 MS. FOSTER: They wanted unrelated
12 such as planned. So, all unrelated such as
13 those that are planned.

14 CHAIR KAPLAN: So, other
15 questions?

16 Bruce?

17 MEMBER HALL: So,
18 technical/procedural, for Helen or Taroon, or
19 whomever. So, if the will of this Committee
20 is that these two measures, if both approved,
21 would potentially be competing, what would our
22 obligation then be to call one versus the

1 other? Is that not a relevant issue? Is that
2 how we get over saying, well, we got both of
3 these through, but then do we have another
4 decision where we say, now that they are both
5 through, we can only really endorse one?

6 DR. BURSTIN: I think that is
7 really the discussion, the issue you are going
8 to have to ponder. I mean, the question will
9 be, assuming these both go through, can you
10 justify having both?

11 We specifically asked the Yale/CMS
12 folks last night, can their measure be used to
13 the plan level? The answer was, "Not yet, but
14 maybe."

15 We don't have a health plan option
16 on the table. We have heard from the
17 Committee that having a health plan measure,
18 particularly for purchasers and employers, is
19 particularly useful, and probably large plans,
20 what we just heard from Jim.

21 So, I think the question you are
22 going to decide is, first of all, do they both

1 meet the criteria? Are there harmonization
2 issues? For example, just to throw out that
3 one example of excluding planned readmissions
4 that you might want to grapple with.

5 And then, I think the ultimate
6 question is, are these complementary measures
7 or are they competing measures? That, I
8 think, I something we will work through to
9 follow.

10 CHAIR KAPLAN: I think, though,
11 for me -- and correct me if I am wrong, you
12 guys at NQF -- we have got to stay focused on
13 whether this meets the scientific rigor that
14 we need it to pass before we have the issue of
15 harmonization and putting everything in the
16 blender and coming out with something good.

17 MEMBER HALL: I guess I was just
18 wondering whether we can put it forward. But,
19 then, the harmonization can be a roadblock at
20 that second point. But I think the answer is
21 no.

22 CHAIR KAPLAN: So, we are going to

1 have Jeff. And then were you going to put
2 your -- are you sure? Okay.

3 MEMBER GREENWALD: So, I am
4 curious methodologically about a decision you
5 guys made that isn't wrong; it is just a
6 choice. And I am wondering if you can explain
7 how you came to that decision, which is the
8 choice to exclude hospitalizations within 30
9 days. That is to say, the readmission can't
10 be an index admission within the next 30 days.

11 My sense of that is that lots of
12 studies do exactly that and various models
13 have done exactly that. It has always struck
14 me as less-patient-centered approach and
15 fairly problematic, in my opinion. Because of
16 that, it has its role, but I think probably
17 not here. And I am wondering what your
18 thoughts are.

19 MR. SAUNDERS: So, we have seen it
20 done both ways. We are not ideologues about
21 this in any way.

22 I would say that our defense for

1 how we did this is that, first of all, these
2 are not independent events. And so, we feel
3 like, for an accountability purpose, the
4 mistake was made at the first readmission and
5 that these subsequent readmissions, we have
6 already penalized you on that process.

7 Now you can certainly have greater
8 magnitude and have additional hospitalizations
9 and turn it into a "how many" measure. And I
10 think that that gets at a different aspect of
11 care.

12 I think, let's see, it doesn't
13 have to be perfect here. We made this
14 decision initially that, for accountability
15 purposes, that one of that triggered was
16 enough to penalize, to hold accountable. And
17 sort of, statistically, we didn't want to have
18 the impact of the repeated readmissions and
19 the repeated impact of events influence the
20 scientific validity of the model parameters.

21 MEMBER GREENWALD: Yes, if I might
22 just follow up, I am not sure I agree with

1 that approach. The not significant minority
2 of patients who have multiple readmissions
3 within that time period of concern represent
4 a significant burden, both financially as well
5 as resource utilization. They also represent
6 opportunities for interventions to be either
7 repeated or initiated.

8 And given that the highest
9 respecter for readmission is prior admission,
10 it has always struck me as an odd approach to
11 ignore that repeat-offender cycle as an
12 opportunity to really sort of influence how
13 you approach the process.

14 MR. SAUNDERS: And --

15 CHAIR KAPLAN: Excuse me. I am
16 sorry to cut this off, but if we don't get to
17 one more question, we are short the
18 discussion. So, I am going to give you like
19 really a five-second response to that issue,
20 if you can. And otherwise, we will go on to
21 Laurent's question.

22 Can you give a really concise

1 response to Jeff's issue?

2 MR. SAUNDERS: No, that's fine. I
3 understand.

4 CHAIR KAPLAN: Laurent?

5 MEMBER GLANCE: I just want to get
6 back briefly to Richard's comment. I think it
7 is very important in terms of the scientific
8 validity of this methodology.

9 In order to be able to really
10 determine whether this is a reasonable model,
11 I think we really do need information on how
12 you go about distinguishing between
13 comorbidities and complications. Because, to
14 a large extent, the validity of the model
15 hinges on being able to make that distinction.
16 If you credit complications as if they were
17 preexisting conditions, that has very, very
18 important implications for the adequacy of
19 risk adjustment.

20 MR. SAUNDERS: So, our
21 comorbidities look back at the prior 12 months
22 and the discharges that are on the -- I

1 believe it includes the index hospital stay.

2 MEMBER GLANCE: So, you do have a
3 look-back period of 12 months, too?

4 MR. SAUNDERS: Absolutely. Yes.
5 So, if that wasn't clear, our comorbid
6 conditions is a 12-month look-back, looking at
7 inpatient hospitalization records, at hospital
8 outpatient records, professional services
9 records. We require face-to-face visits for
10 the service, so we don't have rule-out
11 diagnoses being triggered on sort of lab or
12 imaging types of things. So, we are truly
13 getting the comorbid conditions.

14 CHAIR KAPLAN: Thank you very
15 much.

16 I am just going to clarify one
17 thing from yesterday that I was still not
18 certain about. But if the plan contracts with
19 one, and only one, hospital -- let's just make
20 up that scenario -- the plan is the hospital
21 in terms of precision of estimates. You can't
22 distinguish the two.

1 If the plan contracts with
2 multiple hospitals, and it is hospital
3 readmission rate, the assumption is that the
4 attribution is for readmissions at the plan
5 level, but you don't know how much precision
6 you have in that estimate or how many
7 hospitals it takes to get a precise estimate
8 of the plan's performance of readmission.

9 You don't have data on that right
10 now, right?

11 MR. SAUNDERS: We do not.

12 CHAIR KAPLAN: Okay.

13 MEMBER KELLY HALL: Sorry, one
14 question. The plan has the ability to select
15 where they do business. And we talked a lot
16 about socioeconomic issues at a hospital
17 level, but plans have the ability to say, "I
18 want to go after Google because my average age
19 is 32" versus "I want to go after the local
20 bus-driving union where the average age is
21 57."

22 And so, how do you accommodate

1 that sort of self-selection as plans seek
2 business when they do the comparison
3 initially?

4 MR. SAUNDERS: So, I think this
5 will be a problem for every measure in HEDIS,
6 that every health plan is going to face this
7 incentive for every single measure that we
8 have. And it has not been a barrier to
9 endorsement of any other measure.

10 MEMBER KELLY HALL: Are any other
11 measures so tied to hospital-specific
12 activities as well as community activities
13 that the hospitals don't have control over?

14 MR. SAUNDERS: I would wager -- I
15 don't know the entire HEDIS side; Helen might
16 know of a few -- that they definitely hinge
17 upon community-based measures. There are
18 definitely community-based measurement ones.
19 I am not sure that we have any specific to
20 hospital and the separation effect, but
21 definitely the community-based treatment.

22 MEMBER KELLY HALL: So, self-

1 selection is an issue for the plan?

2 MR. SAUNDERS: I think self-
3 selection, plans are always competing on these
4 things, and it is endemic to the process. I
5 think it would be unfair to expect any risk-
6 adjustment model for any particular measure to
7 resolve all of the market selection factors on
8 either the provider side or the health plan
9 side.

10 CHAIR KAPLAN: Okay. We are going
11 to take Ashish, and then that is really it.
12 And I would ask both of you to be concise,
13 concise question, concise response.

14 MEMBER JHA: So, this is just a
15 quick comment. It struck me, as I have been
16 listening to this, that both the challenges we
17 are bringing up for the NCQA model, most of
18 those issues are nearly identical at the
19 hospital level.

20 And all the harmonization issues,
21 which I think Richard brought up, are
22 critically important, but at least my best

1 read of it is there are no huge challenges
2 here that you can't get over, if both sides
3 are willing to work and we do that. So, I
4 think we can get there.

5 And I guess one quick, last
6 comment is one of the things that we have all
7 brought up over the last day and a half has
8 been how accountable at the end of the day is
9 the hospital, when we thought about the
10 hospital for readmission. What I have always
11 found really attractive about the health plan
12 thing is you do get this opportunity to look
13 beyond the hospital at a broader set of
14 activities.

15 And so, in terms of places and
16 people who can actually make a difference
17 -- and whether they will or not is a different
18 issue -- it strikes me that there is a
19 distinct strength of the NCQA health plan
20 approach which make readmissions, at least to
21 me, much more palatable a quality measure than
22 when we were --

1 CHAIR KAPLAN: So, Ashish, what is
2 your question?

3 MEMBER JHA: No, just a comment.
4 No comments?

5 CHAIR KAPLAN: Okay. We are not
6 going to harmonization yet.

7 MEMBER JHA: No, no, no, no.

8 CHAIR KAPLAN: Okay.

9 MEMBER JHA: Right. I was just
10 saying I think the harmonization issues are
11 all solvable.

12 CHAIR KAPLAN: Right, but that is
13 not right now what is in front of us. What is
14 in front of us is, is this measure reliable
15 and valid?

16 MEMBER JHA: Fair enough.

17 CHAIR KAPLAN: Okay.

18 MEMBER JHA: I guess the reason I
19 went down this road, Sherrie, is that I think
20 brought up by at least several people is
21 concerns about harmonization might affect how
22 people think about these issues. And I was

1 just trying to make the point that I think
2 those are all solvable if we go down this
3 road.

4 CHAIR KAPLAN: Yes.

5 MEMBER JHA: That's all.

6 CHAIR KAPLAN: That is an "if",
7 and everybody should keep that in mind. So,
8 as we go forward, this is, is this reliable
9 and valid for estimating the hospital
10 readmissions of plans? Got it, everybody?
11 So, we are focused on, is this a reliable and
12 valid measure of hospital readmissions of
13 plans, and do we have enough information in
14 front of us to make that decision?

15 So, now we are at the point of
16 inviting public comment.

17 MR. AMIN: April, can you open the
18 lines?

19 And anybody in the audience here,
20 anybody want to make a comment or address the
21 Committee?

22 OPERATOR: Absolutely. One

1 moment.

2 MR. AMIN: Please.

3 OPERATOR: All lines are open.

4 MR. AMIN: Nancy Foster?

5 MS. FOSTER: A question of
6 process, Madam Chair. This comment would not
7 be related specifically to this measure, but
8 I would like to make it sometime during the
9 course of the day. Can I make it now or
10 later, your choice?

11 CHAIR KAPLAN: I think for the
12 purposes of this group, Nancy, unless it
13 specifically relates to this measure, I would
14 like to keep it clean. But if and when we go
15 forward, or if this relates to this measure
16 specifically, great. If not, I am going to
17 invite you to do that during the next period
18 of discussion. Is that okay? Or does it
19 relate to this?

20 MS. FOSTER: It does not relate
21 specifically to this measure, but I would
22 request to be able to do it before you break

1 for lunch because I have to leave.

2 CHAIR KAPLAN: Yes.

3 MS. FOSTER: Thank you.

4 CHAIR KAPLAN: We may not have
5 lunch.

6 (Laughter.)

7 So, are there any other issues of
8 pressing concern that would relate to this
9 specific measure that would help you to make
10 a decision about the scientific reliability
11 and validity of this measure?

12 The usability is going to come up,
13 but not until -- I think to be fair to the
14 other measure developers, we should do it, the
15 process, the same way, and then invite those
16 with sort of the consumer perspective to
17 comment in the way we just did for the last
18 measure, just to make equity.

19 Okay. So, Adeela, are we good to
20 go?

21 MR. AMIN: Well, before we get
22 there real quick, as part of the procedural,

1 is there any recommended modifications to this
2 measure, based on the new information that was
3 presented? It doesn't appear so, but I want
4 to offer that as parity.

5 MEMBER GHINASSI: Again,
6 procedural point. There was a recommendation
7 made about adjusting for factors outside of
8 the socioeconomic status, whatever the final
9 label was on that. I don't see any reason why
10 this shouldn't also have that accompanying it,
11 unless I am missing something here.

12 CHAIR KAPLAN: That wasn't part of
13 the measure vote itself. It was a
14 recommendation back to NQF.

15 MEMBER GHINASSI: No, I'm aware,
16 and I guess procedural. I don't personally
17 see any difference in the predictive validity
18 of this compared to the other measure. And
19 since the group spent considerable time, and
20 the Committee was generous enough to
21 acknowledge that, I just want to make sure
22 that we are not failing to include that for

1 this, as we did the other one.

2 MEMBER ALTERAS: This was raised
3 before, but I would just pull out the issue of
4 excluding planned readmissions and looking
5 into that more carefully.

6 MR. AMIN: Is that a recommended
7 modification or a condition? Or is it just
8 something to make note of in the report?

9 MEMBER ALTERAS: For me, I would
10 say a recommended modification.

11 CHAIR KAPLAN: So, how many, a
12 straw vote, how many believe that that needs
13 to be included in what you are actually voting
14 on right now?

15 Specify it again, Tanya, what you
16 want included.

17 MEMBER ALTERAS: Well, this is a
18 recommendation that NCQA look into excluding
19 planned readmissions from the measure.

20 CHAIR KAPLAN: So, I will sharpen
21 it up. NCQA should move forward with only
22 unplanned readmissions. Is that the

1 recommendation? Okay.

2 So, how many think --

3 MR. SAUNDERS: We are happy to do
4 that.

5 CHAIR KAPLAN: So, how many thing
6 that should be added to what we are voting on?

7 (Show of hands.)

8 Okay. Can I confirm with the
9 developers that that is doable?

10 MR. SAUNDERS: It is.

11 MR. AMIN: And the same time
12 restraints that we discussed before. I can
13 read them off. All those modifications would
14 need to be available to the Committee by the
15 13th of December.

16 Adeela, do you have that vote,
17 voting slide?

18 MEMBER BELLOWS: It is almost
19 impossible to exclude just all unplanned
20 readmissions, no matter what technique you
21 use. If we could just modify it a little bit,
22 so they are not forced into failing, that

1 would be good.

2 CHAIR KAPLAN: No, it is planned
3 readmissions we are excluding, not unplanned,
4 right? Planned.

5 MEMBER BELLOWS: Right, but maybe
6 I phrased it wrong. But there is no
7 methodology anyone has developed to exclude
8 all planned readmissions.

9 MR. SAUNDERS: As an analogy, that
10 plannedness is a concept that is measured with
11 error, and we will get as much as we can.

12 CHAIR KAPLAN: As a measurement
13 scientist, everything includes error, just so
14 you know.

15 (Laughter.)

16 Okay. Are we ready to vote? No.

17 MEMBER McDERMOTT: Can there be a
18 second recommendation explored?

19 CHAIR KAPLAN: Okay.

20 MEMBER McDERMOTT: Related to the
21 group readmission factor of a case after it
22 has been identified as a readmission, the

1 sequential readmission. There was good
2 discussion about the error associated with
3 that and the bias associated with that. I
4 would bring that as a second modification,
5 that they would remove that stipulation from
6 this measure.

7 CHAIR KAPLAN: So, the question is
8 whether repeated readmissions, the way I
9 understand the issue, are not counted as
10 readmission; it is part of the same profile.
11 So, it is a dichotomous variable as opposed to
12 the readmission then counts as the primary
13 admission, and then, subsequent admissions are
14 readmissions for the first readmission.

15 MR. SAUNDERS: That is correct.
16 It is treated as an episode of
17 hospitalizations.

18 MEMBER GREENWALD: So, the
19 question is, would we change that from
20 allowing a readmission to serve as an index
21 admission for subsequent readmissions. And I
22 would support that as well.

1 CHAIR KAPLAN: Are you comfortable
2 with that, Measure Developer?

3 MR. SAUNDERS: We believe that we
4 could deliver a specification by December 13th
5 that included that.

6 CHAIR KAPLAN: All right. Now we
7 have a bunch of confusion in the group.

8 So, Ashish, do you want to try to
9 articulate what the confusion is?

10 MEMBER JHA: For me, I would argue
11 that -- and again, this is harmonization,
12 which we are not talking about -- but what I
13 don't want to do is ask them to do something
14 that is inconsistent with what CMS is already
15 doing. And so, I would push to move that
16 discussion, that stipulation off, and say that
17 if, and, or when we get the harmonization, the
18 group feels that these things should be
19 harmonized.

20 CHAIR KAPLAN: Okay.

21 MEMBER JHA: And leave it at that.

22 MS. DRYE: The hospital-wide

1 measure does allow readmissions to be counted
2 as index admissions. Sometimes they are in
3 the same model because it is the same kind,
4 but sometimes they are in different models.

5 And it is just as Robert
6 articulated. It is just a statistical versus
7 sort of actionability tradeoff. And for this
8 measure, we allow them to be counted. Our
9 other measures we don't. We set a 30-day
10 window, and we don't. But in this measure,
11 for the reasons articulated by the Committee,
12 we felt it was important.

13 MR. SAUNDERS: We would think of
14 it as a harmonization difference, but --

15 CHAIR KAPLAN: All right.
16 Bruce?

17 MEMBER HALL: Sorry, I'm lost.
18 So, I don't feel comfortable voting on
19 something we are asking them to revise and
20 bring back. So, in my mind, we either vote as
21 is or we say we would like to see revisions
22 and then we postpone voting. And I want a

1 clarification, what are we doing?

2 MR. SAUNDERS: And I would think
3 that the planned readmission thing, again, is
4 a harmonization issue. And so --

5 CHAIR KAPLAN: Yes, I think we
6 need to vote on the -- just because there is
7 such confusion, I am going to ask us to vote
8 on the measure as is. That includes planned
9 admissions.

10 So, all of the previous discussion
11 -- let's just vote on it the way it is with
12 planned admissions. And if there is call to
13 do that, have those issues resolved in the
14 harmonization discussion.

15 We are now ready to vote on the
16 measure as proposed by NCQA in terms of its
17 reliability and validity for estimating plans'
18 performance based on hospital readmissions.

19 MS. ADEELA KHAN: So, scientific
20 acceptability of measure properties was the
21 criterion. Scientific acceptability of
22 measure properties met? Vote 1 for yes, 2 for

1 no.

2 And I think the number is 18 we
3 are looking for.

4 (Whereupon, a vote was taken.)

5 MR. AMIN: So, Eliot Lazar,
6 scientific acceptability?

7 (No response.)

8 Patricia McDermott?

9 MEMBER McDERMOTT: No.

10 MR. AMIN: And Mark Williams?

11 (No response.)

12 MS. ADEELA KHAN: So, that is 12
13 for yes and 7 for no.

14 CHAIR KAPLAN: Okay. So, now we
15 are at almost 11 o'clock. Because it looks
16 like we are going to get into some
17 harmonization questions, for the record, I
18 have to leave at noon. So, you will be absent
19 a Chair as of noon.

20 So, to broaden the discussion, I
21 really want to be fair to everybody. I would
22 like you to do what we did before, which is

1 vote on usability and feasibility, recognizing
2 that there are some issues on the consumer
3 side with respect to that, that we really need
4 to be reflected in the report.

5 So, to parallel the same process
6 that we used for the other measure, I would
7 really like use to vote on this issue first
8 and then come back and ask you to comment for
9 the record, and then put the comments in the
10 report.

11 MEMBER ALTERAS: I mean, this is
12 nothing different from what I said yesterday,
13 but just to make another advocacy question;
14 that's what I do.

15 To consumers and purchasers, this
16 is a very usable measure. We don't have a lot
17 of measures that can give us information, and
18 especially since information on what health
19 plans are doing to help give you coordinated
20 care while you are still in the hospital, what
21 they are doing for you after you leave the
22 hospital, how this is going to affect your

1 quality of life when you go into the hospital.

2 Again, I know I am repeating
3 myself, but with health insurance exchanges
4 coming onboard, we are hoping and praying that
5 consumers start using this type of information
6 more than ever before, since they are going to
7 have to make all these decisions that they
8 have never had to make before.

9 And we also are trying to bring
10 into the spotlight what health plans are doing
11 to coordinate care when you are in the
12 hospital, you know, how they have nurses come
13 into the hospital to provide that transition,
14 and to address all the issues of care
15 coordination and care transitions that are
16 driving costs up.

17 I just think that this is a
18 measure that could really bring light to all
19 those things and find it extremely usable.

20 CHAIR KAPLAN: Thank you.

21 Leslie, do you have -- Christine?

22 MEMBER TRAVIS: I will just say

1 "ditto" to what Tanya said, but from the
2 purchaser's perspective this is a critical
3 measure that is very usable, and we are
4 already beginning to use this measure at the
5 plan level for accountability and selection.

6 MEMBER KELLY HALL: I have changed
7 my mind. I guess it is back to usability,
8 too, and it is harmonization, because the
9 confusion never benefits the consumer. It
10 always just increases more confusion and makes
11 any measurement invalid to the consumer.

12 So, in an effort for harmonization
13 and usability, and then, also, recognizing
14 that markets do vary greatly in the level of
15 involvement of a plan. I am in a State where
16 we legislated out managed care and we are at
17 a 9 percent readmission rate. The plans are
18 not actively involved.

19 Just an interesting aside, how do
20 we eliminate confusion as we report these
21 things and eliminate burden?

22 CHAIR KAPLAN: Okay. It is my

1 understanding that reporting, right, it is
2 reporting an issue for us or no?

3 MR. AMIN: It is outside of scope.

4 CHAIR KAPLAN: Reporting is
5 outside of the scope of this Committee. It is
6 clearly an important problem, but it is beyond
7 the scope of this Committee.

8 So, now I would like us to vote
9 on -- I am going to have to take the Chair's
10 perspective, and I am sorry about going beyond
11 sort of a more full-throated discussion of the
12 usability issue, but I am afraid that we
13 aren't going to get issues, critical issues,
14 involved in harmonization unless we get
15 through this process.

16 So, let's vote on usability.

17 Adeela?

18 MS. ADEELA KHAN: To what extent
19 was the criterion usability met? Vote 1 for
20 high; 2, moderate; 3, low; 4 for insufficient.

21 (Whereupon, a vote was taken.)

22 MR. AMIN: Usability vote, Eliot

1 Lazar?

2 (No response.)

3 Patricia McDermott?

4 MEMBER McDERMOTT: Low.

5 MR. AMIN: And Mark Williams?

6 (No response.)

7 MS. ADEELA KHAN: We're at 16. We
8 need two more people. One more.

9 CHAIR KAPLAN: Keep pushing.

10 (Laughter.)

11 MS. ADEELA KHAN: There we go. We
12 have 5 for high, 4 for moderate, 9 for low,
13 and 1 for insufficient.

14 CHAIR KAPLAN: Okay. Now we are
15 going to go on to feasibility, make a vote.

16 And again, Adeela?

17 As is on the measure. We are
18 voting on its feasibility.

19 MS. ADEELA KHAN: To what extent
20 was the criterion feasibility met? Vote 1 for
21 high; 2, moderate; 3, low; 4, insufficient.

22 (Whereupon, a vote was taken.)

1 MR. AMIN: Feasibility, Patricia
2 McDermott?

3 MEMBER McDERMOTT: Moderate.

4 MR. AMIN: Eliot Lazar?

5 (No response.)

6 MS. ADEELA KHAN: One more person.
7 Can we just have everyone enter it in again?
8 There we go.

9 Eight for high, 6 for moderate, 4
10 for low, and 1 for insufficient.

11 Does the measure meet all the NQF
12 criteria for endorsement? Vote 1 for yes, 2
13 for no.

14 CHAIR KAPLAN: Hang on a second.
15 We are feeling the drumbeat of moving this
16 Committee too fast through this measure, and
17 I want to make sure everybody has time to
18 raise any issues they are finally concerned
19 about, about the overall suitability for
20 endorsement, before we go forward with this
21 vote. So that I am not pushing you guys to
22 run fast on the treadmill and then you bonk.

1 Jeff.

2 MEMBER GREENWALD: Just a
3 procedural question. The implications of
4 getting a low usability piece has been the
5 same in the prior as now. What are the
6 implications of that as a Committee? Does
7 that pass, because it's low? I thought if it
8 didn't pass --

9 MR. AMIN: If it doesn't pass
10 importance or scientific acceptability, the
11 measure does not move forward. The other two
12 criteria should be weighed depending on your
13 evaluation of the overall measure. It could
14 be weighed differently depending on which
15 stakeholder you are, but it is just weighed in
16 the overall.

17 MEMBER GREENWALD: Because the
18 next question asks, this one says, does it
19 meet all the criteria? And if we say it is
20 low, then does that not pass? Is that sort of
21 definitional?

22 MR. AMIN: It is not a -- I will

1 look to Heidi and Helen on this one -- but
2 usability is not a must-pass criteria. So, it
3 can pass overall with a measurement on --

4 MEMBER GREENWALD: Then I might
5 recommend that we reword the question because,
6 if it doesn't pass all four, it doesn't pass,
7 is how I read that.

8 MR. AMIN: Yes, that is duly
9 noted. Thank you.

10 If it doesn't pass here, then it
11 doesn't go on to a continued discussion or,
12 yes, there is no harmonization discussion. It
13 is not recommended for endorsement.

14 CHAIR KAPLAN: So, it is my
15 understanding, however those go together in
16 your own minds, however you prioritize, and
17 some people may put -- NQF puts the first two
18 as the primary go-forward issues. But if the
19 somehow reshaping of the last two, in your own
20 mind, colors your overall rating, then it
21 does.

22 Frank?

1 MEMBER GHINASSI: Procedural
2 question. Given that we are voting on this
3 measure as it stands, and then there is a
4 subsequent harmonization discussion, how does
5 that impact what has already been voted on?
6 Does that mean they are not immutable at that
7 point? Does that meet that, once the
8 Committee has approved it independently, does
9 harmonization imply potential change?

10 CHAIR KAPLAN: Karen, do you want
11 to --

12 MS. PACE: Yes. Well, basically,
13 what we say is the final recommendation
14 depends on assessment of any related and
15 competing measures. So, basically, the final
16 recommendations are based on the next step of
17 looking at, are there harmonization issues
18 that need to be fixed in order to make it
19 final or is there an issue of selecting one
20 out of the two before the final
21 recommendation?

22 MEMBER GHINASSI: So, there is

1 another vote after this?

2 MS. PACE: Well, we have to
3 discuss those harmonization issues and what
4 the implications are. There could be a vote;
5 there may not be a vote. It depends on -- so,
6 this will stand as your recommendation unless
7 the issues that come up in looking at the
8 comparison really call into question whether
9 the measures can go forward.

10 CHAIR KAPLAN: All right. Hearing
11 no other nascent issues before this vote,
12 let's go ahead and vote, Adeela.

13 MS. ADEELA KHAN: So, again,
14 overall suitability for endorsement. Does the
15 measure meet all the NQF criteria for
16 endorsement? Vote 1 for yes, 2 for no.

17 (Whereupon, a vote was taken.)

18 MR. AMIN: Eliot Lazar?

19 (No response.)

20 Patricia McDermott?

21 MEMBER McDERMOTT: No.

22 MR. AMIN: And Mark Williams?

1 (No response.)

2 MS. ADEELA KHAN: We need two more
3 votes. Yes, can you all resubmit one more
4 time, please? The receiver is actually right
5 here. So, if you point over here -- there we
6 go.

7 So, we have 10 for yes and 9 for
8 no.

9 CHAIR KAPLAN: We have to go to
10 public comment.

11 MS. FOSTER: Thank you, Madam
12 Chair, and I will be brief.

13 Because my comment is to be made
14 generally about the process and the questions
15 you are addressing today, and I am also
16 embarrassed to make it, given the expertise
17 around this table and the seriousness and work
18 that has gone on in this Committee.

19 But I think that, in fact, this
20 work is being done based on a serious
21 misinterpretation of the Affordable Care Act
22 language. I just want it on the record that,

1 at least as I read the Affordable Care Act
2 language, CMS must be implementing measures
3 that are condition-specific. It is instructed
4 to look for measures that include all patient
5 data and can be done condition-specific for
6 readmissions, but it is not instructed, nor is
7 it encouraged, nor is there any language in
8 the Affordable Care Act that allows CMS to
9 implement an all-patient, all-condition
10 measure.

11 And so, I think there is a
12 challenge here to the work and to the
13 interpretation that this work will lead to
14 something CMS can use.

15 I raise that as a --

16 MS. PACE: Nancy, could you
17 introduce yourself and who you are
18 representing?

19 MS. FOSTER: Oh, sure. Sorry.

20 I am Nancy Foster with the
21 American Hospital Association.

22 So, I just wanted to lay that out

1 for the record. And again, I stand in
2 admiration of the work that has gone on so
3 far.

4 CHAIR KAPLAN: However flawed it
5 is.

6 (Laughter.)

7 DR. BURSTIN: And we would be
8 happy to share with the Committee the specific
9 -- and I did find the emails directly back
10 from CMS -- the specific citations they cited
11 within ACA. I want to get them back and
12 forth. But we will share that broadly,
13 including with you, Nancy.

14 CHAIR KAPLAN: Okay. Now
15 harmonization -- go ahead.

16 MEMBER HALL: So, Helen, would you
17 mind saying, NQF, do you interpret that way as
18 well? Obviously not.

19 MEMBER BELLOWS: We actually got
20 information directly from CMS where they cited
21 actually multiple portions of the Affordable
22 Care Act to justify why they needed this

1 measure and the timeline in which they needed
2 it, specifically wanting to have it in advance
3 of a dry run this spring. So that hospitals
4 would have a chance to review it.

5 Again, we did rely on CMS's
6 interpretation of the guidance. I did not go
7 and read the legislation in the detail that
8 Nancy did, obviously. But we will go back and
9 clarify that with CMS.

10 And again, if there is not truly a
11 justified need for expediting it, we will
12 consider whether we can extend the period of
13 time a bit.

14 But, just to be clear, we were
15 clearly asked to do this in a timeframe with
16 specific citations of three different sections
17 of ACA to justify that timeliness.

18 CHAIR KAPLAN: I would just like
19 to add, for the purposes of this group, I
20 think that is more NQF's problem. Our
21 considerations are for these measures, what
22 are we looking at with respect to -- whether

1 NQF is correct or incorrect or somewhere in
2 between about its interpretation or CMS is
3 correct or incorrect, we are just giving our
4 best-possible guidance about the three
5 measures we considered, and the end.

6 So, now harmonization, but I am
7 informed -- and again, I am sorry, you are
8 going to lose this Chair at noon. But I would
9 like to offer us a very, very, very brief bio
10 and caffeine break to kind of get us to move
11 forward on the harmonization issue,
12 understanding that is really does have to be
13 very, very brief, five minutes. Go.

14 (Whereupon, the above-entitled
15 matter went off the record at 11:14 a.m. and
16 resumed at 11:23 a.m.)

17 CHAIR KAPLAN: We are going to
18 start.

19 And the issues are: travel and
20 logistics, format of the discussion from now
21 forward, travel and logistics handled by
22 Alexis, and then Taroon is going to give us

1 the agenda for this discussion. And then, we
2 are going to go into a discussion at which
3 time -- and I truly, again, apologize to the
4 group; I do have to leave at noon. So, at
5 noon, I will exit this chair and hopefully we
6 will either have a decision or we will have a
7 replacement Chair by then. Or Bruce Hall will
8 step in.

9 All right. So, Alexis, do you
10 want to go?

11 MS. FORMAN MORGAN: Yes. So, just
12 very quickly, for those who want to rebook
13 their flight for an earlier flight, if you can
14 call our travel agency -- and here is the
15 number posted -- they will work with you to
16 rebook your flight.

17 MR. AMIN: Okay. So, the format
18 of the discussion going forward is that what
19 we would like to do is identify the specific
20 differences between the two measures that were
21 recommended to ensure that they are
22 harmonized.

1 There are four specific issues
2 that were identified during the past
3 discussion, but we will obviously welcome the
4 Committee to identify further differences that
5 should be clarified.

6 What we would also like do during
7 this discussion to facilitate and reduce the
8 number of conference calls that we would have
9 to have subsequent to here is to really
10 identify which one is preferred and get an
11 agreement in the Committee on which approach
12 is preferred.

13 To help facilitate this
14 discussion, in the prep materials that Alexis
15 had sent out there is a side-by-side table of
16 competing measures that we could -- I am
17 thinking of the best way. Okay. So, we could
18 also post that. We will figure out the best
19 way to run that.

20 So, the four issues that were
21 identified during the previous discussion were
22 the handling of planned readmissions, whether

1 or not a readmission can be identified as an
2 index admission for subsequent readmissions,
3 the handling of behavioral health in both of
4 the measures, and also an issue that was
5 raised in the risk-adjustment group
6 methodology. And the condition category, one
7 uses HCCs; another uses CCs.

8 So, if we just clarify the
9 approach in each and see if we want to
10 understand why there is a difference and
11 whether that difference should be justified in
12 moving forward.

13 And I will turn it over to the
14 Chair to identify other major harmonization
15 issues and then facilitate a discussion on
16 preferences of the Committee.

17 The planned readmissions,
18 subsequent readmissions serving as an index,
19 HCCs or CCs, and behavioral health.

20 CHAIR KAPLAN: It is my
21 understanding from the group -- and correct me
22 if I am wrong -- the measures developers do

1 not have to agree on the details of how they
2 are work this out. They just have to agree
3 here that the will work together to solve this
4 problem. Is that accurate?

5 MR. AMIN: Well, we would like, if
6 there is a difference in the methodology, what
7 we would like to do is identify which one we
8 are going to forward with. Ideally, they
9 would be harmonized across the two measures.
10 That level of detail would be needed, so we
11 can cut down on future work.

12 CHAIR KAPLAN: Okay. All right.
13 So, we are putting these in the blender. Both
14 are going into the Cuisinart and we have to
15 come out with some merged product, which at
16 least, although the exact details of how they
17 do this don't necessarily have to be worked
18 out with us, the issue has to be somehow
19 resolved that they can. Is that --

20 MS. PACE: Right. I think one of
21 the things that hopefully will be facility
22 this is that both of these measures are under

1 contract with CMS. So, to a certain extent,
2 it would be in everyone's interest to have
3 harmonization to the extent possible.

4 So, what we would like to do is
5 identify the issues. If there is a preferred
6 approach, obviously, they are going to have to
7 get together and with CMS decide what is
8 practical across both measures. And
9 ultimately, then, if there are any issues that
10 can't be resolved at this stage, what the plan
11 would be for the future.

12 So, I think to a certain extent
13 they are going to have to respond back to us,
14 not today, but we want to at least identify
15 the issues, and if there is some kind of
16 preference, and knowing that they are going to
17 have to look at that and see whether that can
18 actually happen.

19 CHAIR KAPLAN: So, I just exercise
20 the Chair's priority, and I hope doing these
21 in reverse order from the easiest to probably
22 the most controversial.

1 Oh, yes, okay. So, now we need to
2 add anything that is not here that is burning
3 a hole in your pocket.

4 Brent? Bruce? Bruce and then
5 Brent.

6 MEMBER HALL: Just issues that
7 need to be addressed. I think that structured
8 cohorts and straight logistic versus a
9 hierarchical approach.

10 CHAIR KAPLAN: Brent?

11 MEMBER ASPLIN: I would make an
12 argument that they are competing and that we
13 shouldn't even be talking about harmonization.
14 I don't feel incredibly strongly about it. We
15 can certainly just move forward with the
16 discussion. But, really, it comes down to,
17 what are your thoughts about accountability;
18 what are your thoughts about the populations
19 that the measures address, and how do we want
20 the public to respond to that?

21 I was really struck by Tanya and
22 Sherrie's comments about -- or excuse me --

1 Christie's comments about the enthusiasm for
2 the usability of the NCQA versus the hospital-
3 based one. I actually think in some cases
4 shared accountability is no accountability.
5 And I think if we need to make progress on
6 readmissions, it is delivery system
7 responsibility.

8 If you have both of these measures
9 active in your marketplace, I think there is
10 going to be a lot of confusion because they
11 don't address the same populations. There's
12 no fee-for-service Medicare in the NCQA one.
13 There's no Medicaid managed care in the NCQA,
14 which could be. And I would argue that they
15 are competing.

16 Sorry to throw a curve ball, but
17 that is where I would sit.

18 CHAIR KAPLAN: Yes, we had a
19 similar discussion last night.

20 Jeff?

21 MEMBER GREENWALD: Just a quick
22 question for both developers maybe. Is the

1 handling of cancer patients the same in both
2 models? It was clearer in one than the other
3 to me.

4 MR. SAUNDERS: It is not. We
5 include the cancer patients, and so their
6 planned readmissions would be included. And
7 so, it is something we can address by removing
8 that population. There are a variety of ways
9 to implement removing that, but they have made
10 that exclusion.

11 MS. DRYE: Right. Specifically,
12 we exclude from the cohort patients admitted
13 for medical treatment of their cancer.
14 Patients who have cancer admitted for surgery,
15 for example, are in the measure.

16 CHAIR KAPLAN: Anyone else?

17 MEMBER KELLY HALL: I would go
18 back to Bruce's original question and ask the
19 developer or Elizabeth to comment. When you
20 asked, "Can this be used," she said, "Not
21 today." Then, what would be required to have
22 a single measure? What is the gap that you

1 feel that exists?

2 MS. DRYE: The gap is, well, we
3 have tested the measure and provided to NQF
4 the measure's -- the measure works well in the
5 18-and-over population. So, we just provided
6 that in the last week.

7 So, the gap is actually in just
8 having data to test it. We don't have health
9 plan data to test the measure, and I think it
10 would be important just to demonstrate it.
11 But our expectation is that it would work.

12 MEMBER KELLY HALL: Thank you.

13 CHAIR KAPLAN: Tanya?

14 MEMBER ALTERAS: Yesterday, when I
15 left here, I thought that these measures
16 really couldn't be harmonized, but I didn't
17 really see them as competing. I saw them as
18 two different measures in two different
19 settings. I could see them both co-existing
20 in implementation because I didn't actually
21 see them being reported in the same place or
22 being used by the same people.

1 But, after today's discussion, I
2 do feel like they could be harmonized,
3 especially after hearing the responses from
4 NCQA, and the fact that they are both funded
5 by the CMS definitely helps.

6 And what Richard was saying about
7 the burden on hospitals to provide data in
8 different ways, well, it seems like there are
9 ways that that could be streamlined and
10 aligned.

11 So, I am definitely in the camp
12 that sees this as a harmonization issue and
13 not a competing measure issue.

14 CHAIR KAPLAN: Let me just ask you
15 a question because I think, unless I have gone
16 completely daffy in this discussion, that you
17 did raise the issue of confusing consumers,
18 and that having both was a problem.

19 Or you raised the issue of
20 confusing consumers? Okay.

21 So, you don't think it confuses
22 consumers?

1 MEMBER ALTERAS: Well, I see the
2 Yale/CMS measure being reported on Hospital
3 Compare. I don't see the NCQA measure being
4 reported that way, unless they were harmonized
5 in some way, because Hospital Compare doesn't
6 report at the health plan level.

7 MR. SAUNDERS: We would use Plan
8 Compare.

9 MEMBER ALTERAS: Yes. So, I don't
10 see the confusion there because I just think
11 that they would be used in different venues.

12 MEMBER KELLY HALL: As health
13 information exchanges and health data
14 exchanges, or HIEs, are being merged, I think
15 we will see single sites being used by
16 consumers because the economies of scale in
17 the states, as they look at trying to fund
18 both of those data consolidation efforts, you
19 are seeing them come together more.

20 So, I would think that it is a
21 matter of time where you will see comparison
22 as a payer and a provider being considered

1 either in a plan selection or a provider
2 selection both.

3 MEMBER ALTERAS: Yes, and let me
4 clarify then. And I agree. I mean, I have
5 been the one tooting the health insurance
6 exchange this whole time.

7 But I just think it is different
8 levels of decisionmaking. I think you would
9 use the NCQA measure when you are trying to
10 decide your health plan and use the hospital-
11 level measure when you are going in for
12 something else, when you are actually choosing
13 your hospital. I know on the hospital side
14 the accountability is different as well. But
15 I guess I don't see this as being a confusion
16 issue.

17 CHAIR KAPLAN: Okay. I am going
18 to pull us back to, does anybody have anything
19 that is not on the list right now that needs
20 to be on the list? Because I really want to
21 make sure that the topics get covered rather
22 than getting into the discussion ahead of

1 time.

2 Laurent?

3 MEMBER GLANCE: I am going to ask
4 for the group's forgiveness because I think
5 the point that I am going to make may not be
6 adding one particular category.

7 But when I look at this, the big-
8 picture to me is that we are trying to fit a
9 round object in a square hole. I think that
10 when you have an outcome that you want to
11 risk-adjust, you want to have one single risk-
12 adjustment model. And you can use that model
13 at different levels, whether it be at the
14 hospital level or whether it be at the plan
15 level.

16 The idea that we should be trying
17 to take two really very different models and
18 somehow getting these folks to sort of come
19 together and make them look alike, I mean we
20 should just have one model. Unfortunately,
21 the forum that we have used today to sort of
22 discuss these models hasn't really allowed us

1 to sort of decide which model is better. And
2 we may not even have enough data to decide
3 which -- I don't think we do -- to decide
4 which model is better.

5 But these are two very different
6 models. You have one model which is a single
7 model, another model which incorporates five
8 condition-specific models. You have one model
9 that is hierarchical; the other one is non-
10 hierarchical. And they have different
11 respecters.

12 And we know, and there is a lot of
13 empirical data out there, if you use different
14 models, you will come up with different
15 results in terms of which hospitals are high-
16 quality and which hospitals are low-quality.

17 And I think -- and I am going to
18 finish right now -- the point that Richard
19 made earlier was a really important one. You
20 are a hospital; you have one primary plan, and
21 you get two different grades. That is going
22 to be very confusing and is really going to

1 kind of, I think, affect the face validity of
2 what we are doing here, the whole benchmarking
3 enterprise.

4 And I don't have a solution,
5 unfortunately. But I think it would be best
6 if we had one measure, one model, not two
7 different competing models.

8 CHAIR KAPLAN: Remember that,
9 again, just to make sure that we stick to the
10 sort of measure itself, rather than how it
11 gets reported. I know that your issue is a
12 little broader than that, but I wanted to rein
13 it in here, to not have reporting issues come
14 up.

15 Okay, Frank, is this something
16 that is not on here yet?

17 MEMBER GHINASSI: It is on here.

18 CHAIR KAPLAN: Okay. Jo Ann?

19 MEMBER BROOKS: It just kind of
20 adds onto this comment. If we ask, let's say,
21 NCQA to make changes into the population that
22 they are planned, to take those planned

1 admissions out, isn't that, then, changing the
2 psychometrics of their model that it was built
3 upon? So, we would be basing it on something
4 different than what we have that we voted on.

5 CHAIR KAPLAN: Robert?

6 MR. SAUNDERS: I agree that if we
7 change the specification that it is different.
8 But I think that is the nature of this
9 process. You voted at one stage. We are at
10 the harmonization phase. We will try to get
11 agreement. And then, you will vote again
12 after that: have we harmonized enough, and
13 that you go forward with both measures.

14 So, is your question, then --

15 MEMBER BROOKS: I guess my
16 question was just, we looked at the data, the
17 psychometrics of your model as it was
18 initially developed. And now, if we change
19 some of those parameters and the population,
20 taking out the planned, et cetera, that were
21 in your model development, does that change
22 the psychometrics and make it a different

1 model?

2 MR. SAUNDERS: It clearly makes it
3 a different model, and I would think that you
4 would have to -- I would say you would have
5 to. I mean, I think you would want to look at
6 the results of that model, and I think that
7 would be a fair issue to sort of say, when do
8 you need to see that in order to make your
9 decision, and whether we can do that. We can
10 certainly modify the specification.

11 MEMBER BROOKS: Yes, and I guess
12 my question was not to hold things up, but
13 just that, in fact, that would change the
14 model, and we would need to look at that, and
15 that has to be considered.

16 CHAIR KAPLAN: Okay. Let me
17 intervene here a little bit because I think we
18 have an issue to resolve that has a procedural
19 quality to it.

20 So, do you want to, Taroon, take
21 over and tell them what they need to do?

22 MR. AMIN: Okay. I know the

1 Committee is probably frustrated, thinking
2 that they have made final recommendations a
3 number of times already.

4 (Laughter.)

5 However, the final recommendation
6 is based post-the-discussion around competing
7 or harmonized measures. Unfortunately,
8 actually, Brent isn't here for this part of
9 the discussion because he is actually the one
10 that raised this.

11 But the Committee will first have
12 to evaluate whether or not these measures are
13 competing. And if they are competing, there
14 may be a justification for why you do need two
15 measures, a conversation that Christie brought
16 up around really needing it potentially for
17 purchasers, or arguments of that nature.

18 There may be reasons why you need
19 two measures. In that case, measure
20 components would need to be harmonized, which
21 is sort of the kind of discussion we are
22 getting at here.

1 We are really, first, as sort of
2 the conversation will go, we will first have
3 a discussion around whether or not they are
4 competing, have a vote on that. If they are
5 competing, if they are defined as competing,
6 as having the same measure focus and have the
7 same target populations, then there will have
8 to be a selection of best in class, where you
9 will select one of the measures as recommended
10 to go forward.

11 If they are competing, and you
12 still feel like there needs to be two measures
13 because they are measuring two different
14 levels of analysis, and there's a
15 justification based on the Committee's
16 deliberations, then we will decide what are
17 the components that need to be harmonized
18 across the two different measures.

19 Helen, Heidi, others that want to
20 sort of procedurally clarify this for the
21 group?

22 So, Brent, this is a direct

1 response to the question that you are asking.
2 So, there will be a vote on whether or not
3 they are truly competing measures. And based
4 on that, there may be a justification, as I
5 just explained.

6 CHAIR KAPLAN: So, how many are
7 confused about what we are voting on? A lot
8 of confusion.

9 Okay. So, here's the way I
10 understand this: there's three possible
11 options. One is there is a best in class,
12 which means there is one class. So, there is
13 one class of measure and there are two
14 possible measures as awardees for that best-
15 in-class designation.

16 Another consideration is there are
17 two classes, in which case we don't need to
18 vote on anything because we have two measures,
19 one in each class. Correct?

20 MR. AMIN: A best-in-class
21 definition would mean that these two measures
22 would compete head-to-head and you select one.

1 I just want to make sure; procedurally, yes,
2 that is correct.

3 So, if you decide that they are
4 competing, you will select one for final
5 endorsement. If they believe that they are
6 competing but you feel that both measures are
7 needed, then there would need to be a
8 justification and a discussion around how
9 these two measures will be harmonized.

10 And if they can't be harmonized at
11 all, then they just stand as they are.

12 CHAIR KAPLAN: Yes. So, I think
13 you just heard the three options, I think, and
14 let me try to get them right.

15 MR. AMIN: Okay. No, please do.

16 CHAIR KAPLAN: Okay.

17 MR. AMIN: I want to make sure
18 everyone is clear on this.

19 CHAIR KAPLAN: So, best in class
20 is there is one winner, right? So, there is
21 a single class; there is one winner, period;
22 the end.

1 The second consideration is there
2 are two possible classes because these aren't
3 competing; therefore, they represent two
4 different distinct, but related issues, in
5 which case --

6 DR. BURSTIN: So, basically, they
7 are competing is a yes/no. And then, if you
8 decide that they are not competing, they still
9 are likely related. It is the same measure
10 focus, essentially, potentially the same or
11 vary in population. And then, you would get
12 into the issue of harmonization.

13 So, your first discussion, I mean,
14 really, to Brent's point earlier, is: are
15 they competing? Should there be only one of
16 these? And if so, which one? And if not, we
17 will get into the harmonization discussion.

18 MR. SAUNDERS: I would draw the
19 decision tree if we had a piece of paper.

20 CHAIR KAPLAN: So, let's just do
21 this in phases, so I don't get messed up.

22 Are these competing measures, is

1 our first vote. We are going to do it in the
2 Adeela specialty way of posting the vote, and
3 we are going to vote on this issue.

4 And Bruce has an issue.

5 MEMBER HALL: So, I don't feel
6 that these measures are competing. In terms
7 of reporting at different levels, I don't feel
8 they are competing. Where I feel they are
9 competing is they are putting forward two
10 different methodologies that creates an undue
11 and unjustified burden.

12 I don't have a problem to have a
13 measure that reports at the plan level and a
14 separate measure that reports at the hospital
15 level. But we have highlighted six or seven
16 differences in methodology. That is where I
17 feel they are competing.

18 And I would like to say, tell me
19 why they have to be different on that method?
20 I don't mind that you are going to report one
21 on Plan Compare, report one on Hospital, and
22 so forth. But this creates a burden for

1 consumers to understand and for hospitals to
2 pull off or plans to pull off.

3 So, I feel they are competing
4 methodologically, and that is what I would
5 like the developers to comment on. In a prior
6 NQF project where there was a similar issue,
7 the decision was have the developers either
8 harmonize the approach and say, "You're right,
9 we didn't need two different approaches.
10 We've decided collaboratively on one approach
11 to that," or justify the necessary difference
12 between the approaches. That is my
13 perspective.

14 MR. AMIN: So, in that, the logic
15 of how that will play out is, in that case,
16 you would vote that the measure is not
17 competing, but they are related and the
18 components of the measures should be
19 harmonized. And all these components that we
20 were discussing, we will have a discussion
21 around which should be harmonized and actually
22 potentially selecting one versus the other, if

1 there are two.

2 So, that is how that scenario
3 would be voted through our process. Is that
4 fair?

5 CHAIR KAPLAN: So, you put them in
6 the blender if they are related, and there's
7 two separate blenders if they are not and they
8 don't need to be blended because they are two
9 really distinct things.

10 So, the first vote is, are these
11 measures competing, in which case we put them
12 in the blender and make them harmonized, or
13 are they not competing and they are measuring
14 two really different things?

15 No. I just created a -- okay, so
16 go back to whatever it was that was the issue
17 beforehand, and vote that way.

18 So, reiterate it Taroon.

19 MR. AMIN: Okay. Competing means
20 you have to select the best in class and there
21 is only one at the end of this project.

22 If they are not competing, they

1 are related and need to be harmonized. And
2 the components of harmonization are before
3 you, and they will be entertaining -- you
4 know, we will all discuss this. And then, we
5 will select which components need to be
6 harmonized, in a very short period of time.

7 (Laughter.)

8 Okay.

9 CHAIR KAPLAN: Okay. Apologies
10 for the -- my excuse is I have no excuse.

11 So, are these measures competing,
12 yes or no, is how we are voting. Is everybody
13 ready to do that? Are they competing, yes or
14 no?

15 So, Adeela?

16 MS. ADEELA KHAN: So, are these
17 measures competing. Vote 1 for yes, 2 for no.

18 (Whereupon, a vote was taken.)

19 MR. AMIN: Eliot Lazar?

20 (No response.)

21 Patricia McDermott?

22 MEMBER McDERMOTT: Yes.

1 MS. ADEELA KHAN: So, we have 7
2 for yes and 12 for no.

3 DR. BURSTIN: I actually would
4 like to have Bruce restate what the basic
5 question was because that actually might
6 simplify our issues a bit. The two questions
7 that I think you asked might be a way for us
8 to kind of work this through.

9 MEMBER HALL: My most recent
10 comment was just that I didn't think that they
11 are competing in terms of reporting or
12 reporting level. I feel what they do is they
13 create an undue burden to calculate something
14 two different ways.

15 If there is a very good reason, an
16 absolutely necessary reason for any of those
17 six or seven items, then that is what the
18 developers have to tell us. But if there's
19 not, then they should bring back an approach
20 they have agreed to do collaboratively and in
21 a similar methodologic fashion.

22 MEMBER KELLY HALL: I have a

1 question. So, do we, then, have to state what
2 bias we have of the methodology and the biases
3 we have, so that we don't come up with
4 something that is blended in the blender, but
5 now a third option or now something that was
6 against the bias of the Committee?

7 For instance, if we say that
8 planned readmissions need to be excluded, we
9 have said that, and that the group comes back
10 to something now new, how do we incorporate a
11 bias in this process?

12 CHAIR KAPLAN: I would think it is
13 our discretion to say we would like comments
14 from the developers on these issues, and we
15 have a bias that planned should or shouldn't
16 be included on any one item. But, beyond
17 that, it is up to the developer to come back
18 with a response.

19 DR. BURSTIN: But I think the
20 Committee, then, needs to state a preference
21 on some of these before they go back to the
22 blender.

1 MR. AMIN: So, I am attempting to
2 put all these considerations into a few
3 buckets, and then we can sort of walk through
4 them individually.

5 We have three major risk-
6 adjustment issues: the HCCs or CCs, the
7 logistic versus hierarchical, and the
8 structured cohorts.

9 For the inclusion criteria: the
10 handling of planned readmissions, using
11 readmission as a subsequent index,
12 hospitalization for subsequent readmissions,
13 the handling of behavioral health patients,
14 and then there's exclusion of cancer patients.
15 And this one is repetitive. So, I will take
16 that one out.

17 Are there any other major concerns
18 that the Committee wants to raise? We will
19 make sure they get on there, and then we could
20 start to state preferences and have some
21 discussion around that.

22 So, I will turn it back to

1 Sherrie.

2 CHAIR KAPLAN: So, now I am even
3 confused. We are talking about the
4 possibility of now -- we have decided these
5 are not competing measures, correct? Okay.
6 So, now they need to be harmonized.

7 All right. So, if these are not
8 competing measures, then they are measuring
9 the same animal, and now they need to be put
10 in the blender and we need to resolve these
11 issues.

12 So, I mean, I think the best way
13 to do this, unless somebody has a different
14 preference, is to start at the top and work
15 these through one-by-one, unless you have got
16 an issue that you think is probably easily
17 resolvable.

18 So, go ahead.

19 MEMBER BANKOWITZ: I think this
20 last one, exclusion of cancer patients, none
21 of the models excludes cancer patients. One
22 tries to exclude cancer patients that are

1 admitted principally for cancer, which is
2 related to planned admissions. So, to me, it
3 is a subset of the plan. Maybe that is a
4 nuance we don't need to deal with, but --

5 MR. SAUNDERS: Yes, that was my
6 interpretation.

7 CHAIR KAPLAN: Good point.

8 We want to start the discussion on
9 risk adjustment and the assessment of
10 comorbidity.

11 Do you want to handle this so that
12 we ask the person who raised the question to
13 -- all right, I am just asking the measures'
14 developers to tell us whether this is a
15 resolvable issue?

16 DR. BURSTIN: I'm sorry, I think
17 at this point we just want to get a sense of
18 the Committee: on any of these issues, is
19 there a clear stated preference one way or
20 another? So we can give that information to
21 the developers as they do their work.

22 MS. PACE: And understand that

1 they are going to have to really look at these
2 and see what is possible. You know, we have
3 heard a lot about these individual issues in
4 the context of these measures and this
5 timeframe. So, again, it is going to have to
6 go back to the developers to really then
7 examine what is possible and preferable, given
8 the two measures.

9 MEMBER ALTERAS: Okay, I will
10 start. I would just say my preference is
11 against hierarchical risk modeling, if there
12 is going to be harmonization on that bullet.
13 The risk adjustment, the hierarchical risk
14 adjustment versus logistic. I am looking at
15 the second bullet.

16 DR. BURSTIN: That is one of the
17 differences.

18 CHAIR KAPLAN: Okay. We are going
19 to shift leadership. Thank you all, again,
20 for all your hard work. It really was a
21 privilege to be able to sit in on this
22 discussion. And with so much talent in the

1 room to address this issue, I think there
2 stands a reasonable shot at coming out with
3 something very, very good.

4 (Laughter.)

5 Thank you again.

6 ACTING CHAIR HALL: So, I will
7 just suggest a default that we can work off
8 of. The default would be that this Committee
9 would be agnostic to stating biases, but that
10 for each item we want the developers to
11 convince us of their ultimate decision.

12 But there was just one comment
13 where there was a clear preference for a bias
14 in one direction, and so that is what we are
15 looking for right now, is any clear
16 preferences that would veer from the default,
17 the default being the developers convince us
18 of their ultimate decision.

19 Anything you want to bring up from
20 the whole list? Ashish?

21 MEMBER JHA: So, I am going to say
22 a couple of things that I think reflect the

1 broad view of the Committee. But I think
2 planned readmissions, there should be some
3 effort to get rid of them from the NCQA
4 effort. Do they need to be perfect in terms
5 of exactly the same patients excluded?
6 Ideally, yes. If we can get very close, that
7 will be a big step forward.

8 I am also going to put in that, on
9 the index readmissions, I actually
10 misunderstood what CMS is doing, I mean what
11 the Yale group is doing. But the preference
12 would be what Jeff suggested, which is that
13 readmissions should be able to count as an
14 index hospitalization for further
15 readmissions.

16 And I guess maybe one last thing,
17 which is I know there was a preference for
18 logistic. You guys probably guess where my
19 preference on this is.

20 I would only argue that we don't
21 end up with hierarchical models for both. I
22 think it is unnecessary at the plan level.

1 So, if the decision by the developers is to
2 stick with hierarchical model for the
3 hospital, that is one place where I can live
4 with a divergence between the two.

5 ACTING CHAIR HALL: And again,
6 that would be something where the developer
7 would come back and say, "Here's a difference
8 that we think deserves to be preserved for the
9 following reasons."

10 Leslie? I'm sorry. Frank?

11 MEMBER GHINASSI: Thank you.

12 I would also support the concept
13 of including the structured cohorts in a
14 homogenized model.

15 And second, as I had indicated
16 yesterday, the reason stated for excluding
17 behavioral health was that most of these folks
18 are treated in specialized psychiatric
19 facilities or rehab hospitals. I don't agree
20 with that statement and do not believe that
21 they should be excluded. Many, if not the
22 majority of patients, are treated in acute

1 care facilities.

2 I just don't see a reason for
3 excluding that. I think it would be a
4 disservice to that whole population group, and
5 I also think it is a key comorbidity factor.
6 It ought to be able to be studied both as a
7 primary diagnosis and a comorbid diagnosis.

8 ACTING CHAIR HALL: And so, if the
9 developers were to come back with preserving
10 the exclusion, we would want to see that
11 further justified, the exclusion justified.
12 Frank is listing our default as inclusion. We
13 would like to see better or further support
14 for excluding.

15 Richard?

16 MEMBER BANKOWITZ: I support the
17 recommendations. The last one, I think there
18 could be a structured cohort in itself.

19 The one recommendation I heard,
20 that we might have one logistic and one
21 hierarchical, I am uncomfortable with. I
22 think that the hierarchical is trying to

1 account for hospital effect, and I would like
2 to move away from having two different
3 results. The closer we can get to one unified
4 method, the better, and we should try not to
5 diverge on this.

6 ACTING CHAIR HALL: Thank you.

7 So, Taroon, if you could, under
8 behavioral health, just add there "consider
9 cohort". And then under HCC versus CC, would
10 you put "default, one approach", "single
11 approach"?

12 Jim?

13 MEMBER BELLOWS: Yes, thank you.

14 Did we lose the cancer thing
15 further down in there, medical treatment of
16 cancer? Well, I want to get it back on the
17 list because it remains a difference. But I
18 think from a perspective of many users,
19 exclusion of medical treatment of cancer is
20 problematic, and I would like to see it re-
21 included in the direction of the NCQA measure.

22 MEMBER ASPLIN: Jeff?

1 MEMBER GREENWALD: I am just
2 wondering as a process if this is a
3 potentially not-very-efficient approach. I am
4 worried that, if we don't go through these
5 sort of line-by-line and get a group consensus
6 around this, we are going to give them very
7 mixed messages.

8 And so, I wonder whether it would
9 be better to just sort of go line-by-line and
10 say, "You guys figure it out" or "We think it
11 should be this way."

12 ACTING CHAIR HALL: Okay, well-
13 taken. I think that is a great point. So,
14 now that we have got some thoughts up there,
15 let's do exactly that.

16 Under risk adjustment, the two
17 separate approaches to structured data, does
18 anyone want to add or change to the notion
19 that our default would be single approach,
20 unless the differences are well-justified?
21 Does anyone want to add to, modify that?

22 Is this what you had in mind,

1 Jeff?

2 MEMBER GREENWALD: Yes, and I
3 don't know if we can do the voting or not, but
4 I am just worried that there will be a few
5 people speak up and we have potential
6 conflicting, and that is going to be very
7 mixed messages to our users.

8 So, I would suggest that we
9 propose sort of an A, B, or C. Either we keep
10 A, we keep B, or we throw it back to them to
11 figure out how to make it work together or
12 justify not working together, as a third
13 option.

14 ACTING CHAIR HALL: Would everyone
15 be comfortable with us saying, you know, our
16 real default is that we are agnostic and we
17 are trying to indicate a potential bias, and
18 that we are still going to rely on the
19 developers to say, "We think that bias you put
20 up there is just off the wall."

21 Is that close enough, Jeff, or do
22 you think for each line you want to vote on

1 three options?

2 MEMBER GREENWALD: I'm flexible.

3 I think the three options is just the least
4 cognitively-challenging for my simple mind.

5 ACTING CHAIR HALL: Because I
6 don't know that we are going to be doing this
7 sort of automated response voting. We can do
8 show of hands or we can just do our best to
9 say, you know, be courageous; speak up.

10 Under HCC versus CC, we are sort
11 of saying our default is a single approach,
12 but speak up if you have issues with that.

13 MEMBER KELLY HALL: I have a
14 question.

15 ACTING CHAIR HALL: Yes, Leslie.

16 MEMBER KELLY HALL: And I don't
17 mean to be inflammatory, but we have one group
18 -- maybe I am mistaken -- that has
19 intellectual property associated with a
20 measure and one group that does not. Does
21 that matter?

22 Okay. Thank you.

1 ACTING CHAIR HALL: So, either I
2 need procedural guidance on whether people are
3 comfortable or want to try to respond more to
4 Jeff's concern, or is there a separate point
5 of input?

6 I am very sensitive to what Jeff
7 said. Let's see if we can go line-by-line,
8 indicate any minor or major bias we might
9 have. But, at the end of the day, we are
10 relying on the developers to make comments on
11 each of these points.

12 Jeff, please tell me if I am not
13 addressing that adequately.

14 So, anything else on the first
15 line, HCC versus CC, and the attendant issue?

16 Richard?

17 MEMBER BANKOWITZ: I would add a
18 recommendation that the developers try to
19 account for hospital-acquired conditions.

20 ACTING CHAIR HALL: So, provide us
21 with information on prior-to-admission
22 handling?

1 MEMBER BANKOWITZ: Handling those
2 things that occurred in the hospital as a
3 complication of care.

4 ACTING CHAIR HALL: So, some
5 additional comments on that perhaps.

6 Laurent?

7 MEMBER GLANCE: I would just like
8 to point out that what we are doing here is we
9 are calling this harmonization, but what we
10 are really doing is we are asking the measure
11 developers to go back and really completely
12 revamp their models. This is very different
13 from what we talked about the first day, where
14 we said: look, you've got to kind of take the
15 models as they are. I mean you sort of vote
16 them up and down. But your job as a Committee
17 is not to send these folks home and redo the
18 entire models.

19 I think that what we are doing
20 right now is just that. We are changing the
21 very nature of the models.

22 Before we go on with this process,

1 if this is what we want to do, I would just
2 like to hear some comments from the measure
3 developers themselves on how feasible this is
4 going to be for them to go back and go through
5 this process.

6 ACTING CHAIR HALL: So, I think
7 what we are doing is we are putting some
8 topics up for the measure developers to
9 provide feedback to us. It will be within
10 their authority to say, "That's not something
11 we are willing to or able to change."

12 On your first point, we have voted
13 on them as they are and we have reached a
14 decision as they are. But I do believe -- and
15 the NQF staff and leaders can correct me -- I
16 do believe it is within the realm of authority
17 for the NQF to say, "You've been approved, but
18 we are demanding some attention to the
19 following issues."

20 I have been in a project before
21 where this has happened. So, I do believe
22 that is within authority or within scope.

1 DR. BURSTIN: And that is
2 certainly a change from a couple of years ago,
3 when you were last engaged with NQF. So, we
4 actually now are actively pushing developers
5 after measures are both approved to actually
6 change their measures and harmonize.

7 Actually, Bruce is referring
8 obliquely to a rather painful process of the
9 CDC and the American College of Surgeons to
10 actually combine their surgical site infection
11 measures into one. So, this is some
12 precedent. We have been really trying to say
13 let's not create cacophony out there. Let's
14 try to actually be value-added.

15 ACTING CHAIR HALL: And even on
16 that background, again, the developers have
17 the right to come back and say, "That's not
18 feasible. We are not willing to change on
19 that." And then, this Committee would have to
20 reconsider what they said.

21 Do we want to move down the list?
22 Logistic versus hierarchical, I think we have

1 -- I'm sorry -- HCC versus CC, are we set?

2 MS. DRYE: Do people want to know,
3 just a clarification, what that difference is?

4 ACTING CHAIR HALL: Sure.

5 MS. DRYE: Okay. We both use CMS-
6 maintained grouper for the ICD-9 codes that
7 groups 15,000-plus ICD-9 codes into condition
8 categories. There is a hierarchical component
9 of that that is used in payment. And NCQA
10 uses that hierarchy. After you have grouped
11 conditions into clinically-coherent
12 categories, they apply a hierarchy.

13 We don't use it because we are
14 really interested in just grouping those codes
15 into clinically-coherent groups. When you
16 apply the hierarchy, things happen like your
17 hypertension gets cancelled by a higher
18 essentially cost condition. We don't want
19 those changes happening, and we want to be
20 able to report the frequency of the risk
21 variables in each hospital's population to the
22 hospital, and the application of the hierarchy

1 changes those.

2 So, we use the condition
3 categories, but we don't apply the hierarchy.
4 NCQA applies the hierarchy. That is just in
5 essentially taking the ICD-9 codes and
6 accumulating risk-adjustment variables.

7 ACTING CHAIR HALL: Thank you.
8 That is very helpful.

9 So, I think that would be the sort
10 of issue around which you could make an
11 attempt to either convince us to preserve your
12 differences or agree to treat it one way or
13 the other.

14 On logistic versus hierarchical,
15 it is listed as preference logistic. Is that
16 how the Committee feels? Or preference,
17 single approach? Or how would people prefer
18 to list that?

19 Laurent, are you still up?
20 Leslie? Richard?

21 MEMBER BANKOWITZ: I would prefer
22 a single approach. I don't think we should

1 dictate which one it should be.

2 ACTING CHAIR HALL: Single
3 approach?

4 Jim?

5 MEMBER BELLOWS: I guess my
6 preference would be preserve logistic, which
7 means either logistic or both, but not a
8 single approach that is hierarchical.

9 ACTING CHAIR HALL: Okay. So, I
10 think we have -- Ashish?

11 MEMBER JHA: I was going to
12 basically say what Jim said, which is I don't
13 think there is any reason to do hierarchical
14 for the NCQA measure. So, either we split it
15 or we go logistic for everybody.

16 MEMBER TRAVIS: And I would agree
17 with that.

18 ACTING CHAIR HALL: Okay. Is
19 everyone comfortable listing that as a bias
20 that they can respond to? We are dictating
21 the response necessarily yet.

22 Okay. Then, moving on to

1 structured cohorts, the notion that there
2 should be some division, separation of models
3 in the analysis versus not. It looks like
4 there is preference for inclusion that is
5 listed so far. I don't know if that reflects
6 people's will.

7 Any comments?

8 (No response.)

9 Okay. We will let them respond to
10 that.

11 Inclusion criteria: planned.
12 Have we hit that already? Any additional
13 modifications or comments?

14 (No response.)

15 I'm not seeing anything.

16 And including the cancer issue?

17 MEMBER JHA: Can I just get a
18 clarification --

19 ACTING CHAIR HALL: Yes, Ashish.

20 MEMBER JHA: -- because I think it
21 is a little complicated. So, I think where we
22 came out as a Committee, but please tell me if

1 I got this wrong, is, in general, we think
2 planned readmissions should be excluded.
3 However, I think what we heard earlier was
4 that the cancer patients should be included.
5 So, planned readmissions excluded; however,
6 cancer patients and that cohort included.
7 That is the default preference of the
8 Committee.

9 MEMBER BANKOWITZ: It is not my
10 preference.

11 MEMBER JHA: It is not? Okay.

12 MEMBER BANKOWITZ: No. Because I
13 think we should understand what that decision
14 does to the model. If it includes quite a few
15 planned admissions, then I don't think we
16 should insist upon it.

17 ACTING CHAIR HALL: Yes. So, I
18 mean, our option is to kind of remove what we
19 are stating any bias might be and let them
20 respond.

21 Mark?

22 MEMBER SCHUSTER: I thought there

1 was a way to do both. I mean, cancer patients
2 don't be kept out completely, but
3 chemotherapy, repeat visits, are left out.
4 So, I thought --

5 MS. DRYE: Yes. Can I just
6 clarify the difference? Because this happens
7 in our own discussions all the time.

8 When we are using inclusion, we
9 are really talking about what index admissions
10 are we evaluating for readmission. We don't
11 include index admissions for cancer patients
12 admitted for medical treatment of their
13 cancer. There are many cancer patients in the
14 measure otherwise.

15 The issue of planned readmissions
16 applies to how we are defining the outcome.
17 And so, there we specifically have an
18 algorithm, and we don't count admissions for
19 chemotherapy. I mean we call those
20 readmission planned. So, they do not count as
21 a positive outcome in the measure.

22 ACTING CHAIR HALL: Right, right.

1 Thank you. Thank you for that clarification.

2 And I would just reiterate, on
3 behalf of the other measure developer,
4 something that they stated before, which is,
5 in their approach, using the categories that
6 they use, they will capture some endogeneity
7 of readmission to a particular diagnosis. And
8 so, some of that is controlled for.

9 But, again, where we are is, are
10 we comfortable with what is up there for them
11 to respond to or not?

12 Jeff?

13 MEMBER GREENWALD: I guess this is
14 a question for the Committee. Are we asking
15 them to -- I think it is fairly clear the
16 message is we need to work on excluding
17 planned readmissions.

18 One group has a methodology for
19 that. Are we asking them both to adopt the
20 same methodology or would it be acceptable if
21 the NCQA group came back with a different
22 methodology for excluding planned

1 readmissions?

2 ACTING CHAIR HALL: I think we are
3 asking them to respond to this concern. I
4 don't think we are dictating what the response
5 has to be.

6 MEMBER GREENWALD: I guess part of
7 my concern would be, if they came back with a
8 different methodology, we would then add to
9 the confusion question again.

10 ACTING CHAIR HALL: No, falling
11 back on the notion that the two measures have
12 been approved as is, we are not asking them to
13 independently come back with two measures that
14 are not harmonized. We are asking them to
15 either say this is our new approach to
16 harmonization or we are justifying our
17 difference.

18 So, Mark, are you still up?

19 Okay. On the planned
20 readmissions, is there anything more we want
21 to add?

22 (No response.)

1 Not seeing anything, the index
2 readmission, we have sort of discussed.
3 Anything to add? Handling what is called an
4 eligible index.

5 (No response.)

6 Behavioral health, any further
7 comments?

8 (No response.)

9 Does the list go on? Or is that
10 the whole list? Okay.

11 Jeff, more comment?

12 MEMBER GREENWALD: Yes, just on
13 the behavior health side of this, I also want
14 to make sure that how we are identifying
15 substance abuse admissions is similar between
16 the two groups and that they are both being
17 handled in the same way.

18 ACTING CHAIR HALL: So, perhaps
19 they could comment on that or explain to us
20 any difference.

21 Okay. So, any larger, bigger-
22 picture comments?

1 Again, what we are saying now is
2 both measures have been approved as is. We
3 feel very strongly as a Committee that
4 important attention should be turned to
5 harmonizing the approach to measurement and
6 calculation, including, not necessarily
7 limited to, these issues.

8 And we would like the developers
9 to respond collaboratively to this list.
10 Respond collaboratively means respond to us.
11 We are not dictating whether that means one
12 changes, the other changes, neither changes,
13 or what.

14 They come back and they say,
15 "Here's something we have agreed to do the
16 same way" or "Here is how we are justifying
17 this difference, and we think it is important
18 to preserve the difference."

19 Any additional comments? Yes,
20 Tanya?

21 MEMBER ALTERAS: Just a quick
22 process question. So, before this goes out

1 for public and member comment, we are going to
2 get to see the responses, right? Okay.

3 ACTING CHAIR HALL: Jeff?

4 MEMBER GREENWALD: Sorry. I want
5 to just spend a second on the substance abuse
6 question, since we haven't gotten over this
7 yet.

8 It is a major predictor of
9 readmission in many populations studied. And
10 so, the question is, does this group recommend
11 that it be excluded, as some of the protocols
12 have?

13 ACTING CHAIR HALL: When you say
14 "this group", you mean our Committee?

15 MEMBER GREENWALD: Our Committee.

16 ACTING CHAIR HALL: Okay.

17 MEMBER GREENWALD: Because it is a
18 different kettle of fish for sure in terms of
19 the interventions that are appropriate. But
20 from a hospital and health plan perspective,
21 it is a major driver of cost and utilization.

22 And so, the question is whether

1 excluding it would then take out of the
2 limelight a major utilizer of resources and a
3 potential opportunity to improve quality of
4 care.

5 ACTING CHAIR HALL: Other
6 Committee members want to comment?

7 MEMBER JHA: I would keep it in.
8 I don't know --

9 ACTING CHAIR HALL: Jeff, you are
10 in favor of keeping it in as well?

11 MEMBER GREENWALD: I am in favor
12 of keeping it in.

13 ACTING CHAIR HALL: Okay.

14 MEMBER GREENWALD: And I recognize
15 that that is potentially problematic at the
16 end-user level, but it also, I think, has some
17 serious benefits that I think from the
18 national perspective we ought to be
19 acknowledging.

20 ACTING CHAIR HALL: And, Ashish,
21 you support that?

22 MEMBER JHA: I do. And I think it

1 is going to be less of an issue for the Yale
2 model for now because it is people over 65,
3 but when people decide to apply that for a
4 broader population, it will be more of an
5 issue. But I do think, in my mind, we should
6 keep it in.

7 ACTING CHAIR HALL: Okay. So, at
8 the moment, we are just asking for a response
9 on this topic.

10 Leslie?

11 MR. AMIN: Bruce, can I just
12 clarify?

13 ACTING CHAIR HALL: Yes.

14 MR. AMIN: The CMS measure,
15 additional testing has been provided to extend
16 the measure to 18 and over. It is not an over
17 65. Okay. I just wanted to make sure.

18 MEMBER KELLY HALL: I have a naive
19 question, I'm sure, for those expert in the
20 psych area.

21 But so much of psychiatric care is
22 not covered by a plan. Do we have any issues

1 with the fact that that plan data doesn't have
2 it and it is now comparing against hospital
3 data that might? I mean, is that part of a
4 harmonization issue? Or the plans don't have
5 to report something they don't cover.

6 ACTING CHAIR HALL: I am not an
7 expert on this. So, I would say at the moment
8 we are asking the two developers to comment on
9 this issue.

10 I think Richard was next.

11 MEMBER BANKOWITZ: I do recommend,
12 if we keep it in, that it become a separate
13 cohort because the comorbidities in that
14 group, the risk adjustment for that group is
15 quite different. Comorbidities don't apply to
16 that group in the same way. And so, I think
17 that if we are going to compare, we need to
18 compare apples to apples.

19 ACTING CHAIR HALL: Jim?

20 MEMBER BELLOWS: I'm sorry if I am
21 the only one who lost the thread, but I am not
22 clear on whether we are only talking about

1 inclusion of admissions and readmissions where
2 substance abuse is the principal diagnosis or
3 whether we are talking about substance abuse
4 as a risk adjuster for all readmissions. And
5 if so, I am worried about gaming and data
6 capture and completeness and all kinds of
7 other things that we haven't begun to talk
8 about yet.

9 ACTING CHAIR HALL: I think we
10 were talking about whether to include these
11 admissions as eligible index admissions. Is
12 that correct?

13 All right. Leslie? Okay.

14 Would each developer mind in one
15 sentence restating how they handle behavioral
16 health admissions?

17 MS. HORWITZ: So, I want to
18 clarify how we handle this because it is
19 actually a little more complicated.

20 In our dataset we have 21,483 of
21 the 8 million admissions that are for purely
22 psychiatric admissions. And by that, I mean

1 schizophrenia, mood disorders, personality
2 disorders, adjustment disorders, the kinds of
3 things you would be admitted to a psych
4 hospital for.

5 And the reason we have so few of
6 those is because we have sort of an acute care
7 hospital measure and we just don't have data
8 for those. However, we have many, many, many,
9 many, many patients with substance abuse
10 disorders with alcohol dependence, with
11 alcohol withdrawal, with all of those things,
12 in our measure, because they get admitted to
13 acute care hospitals, as you said. And we
14 have them; we put them in our medicine cohort
15 because they are typically cared for on
16 medicine units.

17 So, we do include all of those
18 patients. The small subset that we excluded
19 are the patients really admitted for true
20 psychiatric treatment who are generally
21 admitted to psychiatric hospitals, and a few,
22 21,000, somehow slipped into our 8 million

1 admissions.

2 And that is why we sort of report
3 that we have a psychiatric exclusion. But I
4 think the majority of the patients that you
5 are talking about actually are in the measure.

6 ACTING CHAIR HALL: Robert?

7 MR. SAUNDERS: We include
8 psychiatric disorders as an index condition,
9 and we include it as a comorbid condition for
10 risk adjustment.

11 ACTING CHAIR HALL: Okay. So,
12 what I am hearing is -- Jim, I'm sorry, do you
13 still have a question?

14 Okay. So, what I am hearing is
15 that there is a minor difference there, and we
16 would like to know if the two developers can
17 agree one way or another or if they feel that
18 difference should be preserved. And
19 hopefully, that response would get to Jeff's
20 and some of the other concerns.

21 Okay. Any other larger --
22 Richard?

1 MEMBER BANKOWITZ: The question
2 for NQF, now when we emerge, if we emerge with
3 this harmonized model -- and I hope we do, and
4 I think this is a great process, so I applaud
5 it -- then who will be responsible for
6 maintaining the model? Will it be a
7 consortium of these two? Because we wouldn't
8 want to see it sort of diverge as we go
9 forward.

10 DR. BURSTIN: That is an excellent
11 point. I think we would endorse both of those
12 measures, and the expectation would be, as
13 those measures come up for maintenance, we
14 would again look to see, are they staying
15 harmonized or is there any divergence?

16 But, again, this is pretty new
17 territory for us. So, again, we are open to
18 other suggestions if you think there is a
19 better process.

20 MEMBER KELLY HALL: Yes, that was
21 related to my intellectual property question.

22 ACTING CHAIR HALL: But, at the

1 same time, they are both sponsored by CMS.

2 So, that is potentially in their favor.

3 MEMBER KELLY HALL: Right, right.

4 ACTING CHAIR HALL: Yes, Laurent?

5 MEMBER GLANCE: Just so I

6 understand, in theory, it would be possible
7 for both measure developers to respond to each
8 one of these points and state that they feel
9 strongly that there are reasons why they need
10 to keep the measure as presented. Is that
11 correct?

12 DR. BURSTIN: We are going to ask
13 them to put forward a joint response where
14 they are going to clarify each of those
15 issues. They could justify and provide
16 justification for why they think it needs to
17 be different. But, again, they have already
18 heard the stated preference of the Committee.

19 I'm sorry, one other point. I
20 also think there are also opportunities to
21 think about sort of short-term as well as
22 longer-term harmonization here. So, I think

1 in the short-term here we are really saying
2 there is an opportunity for harmonization, but
3 we certainly heard from Yale that there was
4 sort of potentially some interest in thinking
5 about getting to the health plan level,
6 potentially some interest in NCQA, again both
7 sponsored by CMS. One question might be, the
8 longer-term strategy I think, ideally, is this
9 does become one measure usable as cascaded up
10 and down.

11 I don't think we are there yet.
12 That would be pretty radical changes to the
13 measure, and neither developer is ready to do
14 that. But I also think that might be a stated
15 preference of the Committee in the longer-term
16 as well.

17 ACTING CHAIR HALL: Thank you,
18 Helen.

19 Jeff?

20 MEMBER GREENWALD: Just to
21 reiterate a point, I am sorry, from early this
22 morning, and for all the reasons that Helen

1 just brought up and some of the other concerns
2 that have been brought up during the day, I
3 wonder, given that this is an expedited
4 review, whether we ought to think about an
5 expedited re-review and not go the full
6 distance at three years.

7 I understand that there are
8 opportunities shorter than that to bring up
9 concerns that would bring it back to review,
10 but I think a structure process around that
11 would be helpful, given the timescale that we
12 have been talking about as well as the
13 national implications of these numbers that we
14 are dealing with.

15 MEMBER JHA: So, I am going to
16 second that. And specifically given that
17 neither of these, I mean both of these
18 measures were initially voted down yesterday.
19 Neither of them got super-majorities. I mean,
20 they both won comfortably. So, there is
21 enough concern on the Committee that I think
22 a one-year checkup seems like a very

1 reasonable thing to do.

2 ACTING CHAIR HALL: I want to
3 third that second. Great.

4 (Laughter.)

5 Thank you, Frank.

6 It has been clear through our
7 discussions, obviously, that there is still a
8 fair amount of discomfort on a number of
9 aspects of this entire approach.

10 So, I don't see any other cards
11 up. Going once, going twice.

12 So, I will turn to the NQF and ask
13 how we move forward.

14 MR. AMIN: Okay. Thank you very
15 much for leading that on the fly. It was a
16 great job.

17 So, this was a great session. I
18 think we got a lot of the preference of the
19 Committee through this harmonization process.

20 So, we are going to ask for this
21 response by the 13th. That is the timeline
22 that we are dealing with. Again, we apologize

1 for the short turnaround time, particularly to
2 the developers. But, as we discussed, it is
3 an expedited review.

4 And I will turn it over to our
5 leader here, Alexis, to give us some
6 description on the next steps, and then we
7 will go from there.

8 MS. FORMAN MORGAN: Sure. As
9 Taroon stated, for the measure developers, we
10 need your responses to the Committee's
11 suggestions by next Tuesday, December 13th.

12 And then, we will send out an
13 availability survey, so that the Committee can
14 meet either next Thursday or next Friday via
15 conference call. Then, we will go from there.
16 We will have the final vote on endorsement, if
17 needed, at that point, over SurveyMonkey.

18 MR. SAUNDERS: Could I ask a
19 clarification question?

20 MS. FORMAN MORGAN: Yes.

21 MR. SAUNDERS: So, your
22 expectation for us is a joint response to

1 these questions, and that is our deliverable
2 for Tuesday? We are not delivering to you a
3 full implementation of the specification? We
4 are not presenting to you the rerun weights
5 and everything? Okay.

6 ACTING CHAIR HALL: That is
7 correct. We are looking for a response that
8 says, "We believe we could adopt the same
9 approach on this item" or "We would like to
10 justify and explain why we have a different
11 approach on this item."

12 PARTICIPANT: Unless you want to
13 run all those models by next Tuesday, and we
14 would be happy to look at those.

15 (Laughter.)

16 ACTING CHAIR HALL: CMS in the
17 room, is there a bank account open right now?

18 (Laughter.)

19 While they are talking, Jim?

20 MEMBER BELLOWS: Oh, I don't know
21 procedurally what is the right time, but I
22 just wanted to thank NQF and the Committee.

1 If this harmonization goes as planned, I think
2 it will be just a tremendous win for this area
3 that I personally did not anticipate walking
4 into this process. So, thank you.

5 MS. FORMAN MORGAN: Thank you.

6 So, we are now at the end of our
7 two-day meeting.

8 And staff would like to thank all
9 of you for your great participation.

10 We do have lunch available for you
11 all. If you would like to stay here and eat
12 it, that is perfectly fine. It is in the back
13 room. Or if you would like to take it with
14 you, it is boxed.

15 So, once again, we thank you for
16 this two-day meeting, and we will see you next
17 week via conference call.

18 ACTING CHAIR HALL: And on behalf
19 of Eliot and Sherrie, I want to thank
20 everybody as well.

21 MEMBER LAZAR: Yes, this is Eliot.

22 First of all, I want to obviously

1 thank all of you, thank Sherrie, and
2 particularly thank Bruce Hall for stepping in
3 without any preparation whatsoever and
4 handling the finish with real aplomb.

5 (Whereupon, at 12:24 p.m., the
6 meeting was adjourned.)

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In the matter of: Readmissions Steering Committee

Before: NQF

Date: 12-06-11

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