NATIONAL QUALITY FORUM

Moderator: Alexis Forman
December 16, 2011
12:00 pm CT

Operator: Ladies and gentlemen, welcome to the conference. Please note today's call is being recorded.

Please stand by.

Female: Hi everyone. Welcome back.

We're just going to take a really quick roll call. So if you can just let me know if you're here.

(Sherry Kaplan)?

Eliot Lazar?

Tonya Alteras?

Tonya Alteras: Here.

Female: Hi Tonya.

(Brent Afflin)?

Richard Bankowitz?

Richard Bankowitz: Here.

Female: Jim Bellows?

Joann Brooks?

Joann Brooks: Here.

Female: Frank Ghinassi?

Frank Ghinassi: Here.

Female: Larry Glance?

Larry Glance: Here.

Female: Jeffrey Greenwald?

Jeff Greenwald: Here.

Female: Bruce Hall is here.

Leslie Kelly-Hall?

Leslie Kelly-Hall: Here.

Female: (Ashish Ja)?

(Michael Langburg)?

Patricia McDermott?

Patricia McDermott: Is here.

Female: Paula?

Paula Minton-Foltz: Here.

Female: (David Polokoff)?

Bruce Hall?

Bruce Hall: Here.

Female: Christie Travis?

Christie Travis: Here.

Female: Mark Williams?

Taroon, you can go ahead and start.

Taroon Amin: Excellent. Thank you all for taking the time on this Friday afternoon to join us on short notice after our meeting last week.

So to orient everybody to the purpose of this call, The Steering Committee reviewed three measures. Two measures that were evaluated on - preliminary votes were recommended for moving on for meeting the four criteria for endorsement. The two measures were considered had additional conversation around harmonization issues. And we'll discuss the responses of (Gail) and (Anthony) ((inaudible))'s response.

If there are no substantial changes to the ((inaudible)) on the responses for the Steering - based on the ((inaudible)) of the developers, we will keep the preliminary results that were voted on by the entire Steering Committee.

If any Steering Committee members feels like after this - today's discussion that there is required to be a revote on any of the measures, we'll - we can have that conversation later on. However if there are not substantial changes on the measures based on the ((inaudible)), we will keep the vote going in - as the final vote for recommendation.

Based on the preliminary evaluation of the response that was given, seeing that there were two major buckets of consideration that really revolved around risk adjustment, which appear to be much more on the longer-term horizon based on the feedback that we got from ((inaudible)). And the second stage which included a lot of discussion around ((inaudible)) criteria, which in addition many of the developer's responses included the fact that it will require three years to measure ((inaudible)).

One of the strategies of the Steering Committee may employ is a (stage) approach requiring that the measure ((inaudible)) provide some improvements based on what's feasible within one year of when their measure comes up for measure maintenance.

So I will turn it back to Alexis and the (Adeal), and if there's anything else that (Helen) and (Karen) want to add to that preliminary to set the stage as we go into this discussion, (Adeal) and Alexis will sort of give a high level overview of today's discussion.

Now I'll turn it over to Bruce Hall to lead the discussion on the various conversations - issues that were raised during the ((inaudible)) discussion ((inaudible)).

Female: So Taroon, I think you raise a great overview of today's discussion, so I think we can just - I can go through these next steps fairly quickly, and then I think we can go ahead and move into the discussion of the harmonization issues.

So as Taroon stated, during our in-person meeting last week, the Committee raised some harmonization concerns, and NCQA and (CMSUL) did submit their joint response to NQF by the deadline date of December 13th, and we did send that out to the Committee to review and prepare for today's call.

Based on today's call, we will need to decide if the Committee will vote on final recommendation of the two measures. And if so, we will send that Survey Monkey voting tool out to you this afternoon summarizing today's discussion so that you can vote.

If there are any - if the Committee decides that there can be some revisions made and the developers agree on this timeline, we have outlined when those revisions need to be submitted to NQF and to the Committee, and that's in early January, and then we'll go from there.

Please keep in mind that our public and member comment on the measures that were submitted to this project will open up on January 9th and will end on January 20th. And the Committee will have a conference call on January 31st to review the submitted comments.

So at this time I'd like to turn the call over to Bruce Hall to lead the discussion of the

harmonization concerns.

Bruce Hall: Thank you. I don't have a, you know, prepared speech. Do you just want you just want us to

go item by item and solicit Committee feedback? That'd be the best approach?

Taroon Amin: Yes, that would probably be the best approach. And also just keeping in mind of what if -

what we might - the sort of options that we have, the ((inaudible)) are sort of that there are some

near-term issues that could be resolved within sort of the one year measure maintenance period.

And then some longer-term considerations that the ((inaudible)) developers should considered at

the time of measure maintenance for the future.

Bruce Hall: Okay, so you know, as everyone on the Committee and on the call knows, I think there were

you know, maybe roughly 40 pages of response, so hopefully everyone's had a chance to peek at

that. And I guess we can just start with Item A. Choose either (HCC)'s or (CC)'s. You know, the

hierarchal or non-hierarchal classification systems.

And as everyone has seen, both the developers feel that their approach is relevant to their

measure and appropriate. Does anybody on the Committee want to comment on those

responses?

So again, what they've - basically what they've proposed for harmonization in the I think more

intermediate or longer term is for each of the measures - each of the developers to further

investigate what the impact would be if they were to both migrate towards a single approach on

these categories.

But - and Taroon, my impression is this is intermediate or longer-term work...

Taroon Amin: Right.

Bruce Hall: ...and would fit into the notion that there are several things that these developers would look into on the one year timeframe.

Taroon Amin: There would be a one year or the three year measure maintenance, depending on the complexity of the change. And I guess the question we would ask the Committee is whether the developers have sufficiently addressed the concern and have a full plan ((inaudible)).

Bruce Hall: So anyone on the Committee want to comment at all on the responses from the developers? My own reaction was that each developer gave a reasonable rationale for their approach, and I would agree with their stated conclusion that they would look into the impact of any of these changes over the timeframe we just mentioned.

But the realistic implication is that the measures would go forward currently as they are.

Eliot Lazar: Yes, this is Eliot. I'm okay with that as well. I would like to see them you know, address the issues sooner than three years though. And Taroon, I don't know if there's a way to craft this so that that would happen?

Frank Ghinassi: Frank Ghinassi here. I want to just echo that. I seem to recall that there was sentiment in the room at the time that there was going to be - that folks there would - at NQF would look into whether there was a way to shorten that review period, just given some of the questions that came up.

Female: Yes. And Frank, ((inaudible)) and I think that that certainly was an issued raised. I think some of it really depends on what the capacities of the developers to make those changes in that timeframe. We do already have a one year annual update. So as we were having an internal

discussion earlier, the question is are there some of these changes that are not quite as complex? Like the removal - potential removal of unplanned readmissions, for example, that could be done on a shorter timeframe, like perhaps by the one year update.

And certainly, I think that some of the discussions around the risk adjustment broader issues sound like something that would take several years. You know, more than that.

But I think one thing that might be helpful for the Committee to talk about is which of these changes potentially could be done sooner with the -- I know the developers were on the call -- and which ones should be done sooner if at all possible.

But we certainly recognize that the risk adjustment piece is going to be more complex and longer term.

Larry Glance: So this is Larry Glance. I have a comment. I think that we should think about the framework for the reassessment, meaning if these two measure developers are going to assess the impact of such changes on their models, it may make sense to ask the measure developers to come up with a common dataset which would allow them to address the implications of using their original risk adjustment strategy versus possibly a modified strategy.

And meaning, what would be the impact in terms of the level of agreement or concordance in terms of identifying say high quality and low quality outliers. Would it really make a difference if you use the HCC's versus the non-hierarchical co-morbidity conditions?

And in order to level the playing field, I think it'd be important for both the measure developers to work from the same data set that they may be - they could work on creating together.

Jeff Greenwald: This is Jeff Greenwald. Can I just ask about this? I'm sorry. I'm not as methologically

sophisticated as many of you are on this one. But I'm struck by the fact that the populations

measured and the level of measurement -- one being hospital level and one being plan level --

introduced so many variables into this that I'm wondering how leveling - how level a playing field

there'll ever be in terms of seeing the impact of these changes that we're requesting?

It feels more theoretical than practical in some ways because it's going to be hard to know - the

coefficients and the variables are going to change, but I don't know that we're going to feel

anything tangibly that's going to be obvious to us at the end of this.

So I'm hoping someone can explain you know beyond the theoretical reasons to exclude planned

readmissions and to do an (HCC) versus (CC)-based approach, et cetera. How we're going to

know at the end of a year or three years that this was the right decision, other than its theoretical

implications.

Male: So my concern - I don't think it's that theoretical. My condition - my concern is that if you use two

different risk adjustment models, you will end up identifying two different groups of high quality

and low quality groups. And I think that if you were to create a data set, you could decide, for

example, to use either hospital groupings or network grouping, and then you could apply the two

different measures to the same data set and see if it really makes a difference. Specifically,

whether you're using the non-hierarchical or the hierarchical co-morbidity conditions.

And the reason I said (hypothetical) is because if you get too totally different results, then you're

basically accepting two quality measures for the same outcome, which I think is potentially

problematic.

Richard Bankowitz: And this is Richard Bankowitz. And the one thing I'd like to add is that there are kind

of two issues here. One is the issue of the risk adjustment model, and we can ((inaudible)) for the

moment, but there's a second issue which is these issues use different methodologies to come up with a - what's known as a readmission. So there's a decision made in one model to exclude planned admissions, and that's not in another.

There's a decision made in one model to count a readmission as a potential indexed admission. That's not in another.

And then there's a third decision in one model not to include medically treated cancer patients that are not in another. And those are all methodologic decisions that are not part of risk adjustment.

And I'd like to say that perhaps we can at least harmonize some of those decisions, and then explore what nuances the hierarchical versus non-hierarchical (HCC)'s will add.

Leslie Kelly-Hall: This is Leslie Kelly-Hall. There was also I thought a strong bias in the meeting that - towards the provider-based measure in general, and that the harmonization was a requirement to even accept the plan-based approach. So I'm not sure whether we need to address first of all is the harmonization enough to continue, or are we going to go line by line? And I - please correct me if I have the impression.

Taroon Amin: So let me actually jump in there real quick. This is Taroon. The goal of the discussion today is really to evaluate, because both of the measures were evaluated for their - across the four criteria; ((inaudible)) scientific acceptability, feasibility, and (feasibility) individually. And both of them passed all those - passed those four criteria and were recommended contingent on the discussion of harmonization.

So really the goal of today's call is to evaluate if the developers had sufficiently addressed the harmonization issues. Granted, as is being discussed right now, some of the risk adjustment

issues may be longer term, but really what I'm sure is the Committee members are comfortable that the developers had sufficiently addressed the harmonization issues that were raised or at least have a plan for addressing the harmonization issues within ((inaudible)) period.

So it's really not necessarily saying that there shouldn't be a health plan level measure, but it's really more to say going forward, which of the concerns then could be addressed, one year time period as measure maintenance, as (Helen) pointed out, and which one - which of the issues ((inaudible)) future and to ensure that all the concerns are raised by the Committee with ((inaudible)).

Jeff Greenwald: So I'm going to agree with the prior comment. I think some of us, certainly I was left with the impression that there was sort of a contingency plan here, and that the harmonization piece had to be sufficiently adequate before the sort of preliminary endorsement that was given at the meeting would be carried forth.

So I share the prior comment that endorsement in my mind was contingent up adequate harmonization and not a if that doesn't happen we just move forward with it anyway kind of approach...

(Helen): And this is great Jeff - thanks Jeff. Just one response, Jeff. This is (Helen). I think it was not so much contingent upon adequate harmonization, but it was contingent upon their responses to the issues raised. You have you know, a very detailed letter back with at point-by-point discussion on - and I think it's - you know, I don't know that there's a you know, wholesale decision up or down based on the fact that some of these issues I think simply can't be addressed in the short-term.

But I think at least my read of the letter and in talking to the developers is that there's a significant willingness to continue to work together and continue to harmonize these measures.

(Karen): So in that case -- this is (Karen) -- you know, you'd have to weigh whether the value versus any potential burden or problem in terms of, you know - and certainly I think there was a lot of discussion about the value of having provider level and plan level measures. And you know obviously at this point in time, it looks like reasonably so, that to make you know, big adjustments to a risk model in a week is not very realistic.

So I think that you know, that's still a discussion point that's open to you in terms of you know if you think there's a lot of harm that would come from having two measures out there at this point with working on - working towards harmonization in the future.

So certainly you can discuss that, but it's not that they have to be totally harmonized in order to move forward.

Female: This is ((inaudible)). In terms of - they could end up not being harmonized at all. It appears from the discussion here that there still is a - there still may - if there's no change for three years, for example, you would end up having two measures out there that are very different with very different standards, and therefore very different rates. If nothing gets changed for three years, that's really long time.

And now I would suggest that something - when something gets out there and is out there for three years to then change it. Whatever the standard is, can be difficult to adjust too for health plans or providers because you've already established a baseline for over three years, whatever that - whether that baseline is right or wrong. And then you've got to go through and recalibrate based on whatever the next standard is.

I think that's not going to fare well when you think about how all of us are trying to track and trend quality measures.

Female: Right. But keep in mind that there won't be two different scores for hospitals.

Female: Right.

Female: One of the measures is constructed at present to give a hospital level score, and the other measure is constructed only to give a plan level score.

So I totally understand what you're saying, but just keep in mind that right - that's not how they'll be operationalized at this point. But even having said that, all of the issues that you guys have brought up about harmonization I think are important to resolve if possible. But it's not like we're going to have two measures out there with hospitals getting two scores.

Leslie Kelly-Hall: This is Leslie Kelly-Hall. I think that that somewhat breaks down in a state like Idaho where you have only two plans and two hospital systems.

Female: Oh, well...

Leslie Kelly-Hall: So...

Female: Yes.

Leslie Kelly-Hall: ...I think that we still have to be sensitive to that.

Female: Good point.

Paula Minton-Foltz: This is Paula. And I think also the burden to the hospital to provide information - I mean, I think there will be a burden to the hospital from contracts and things like that. I think there always is.

Female: I believe the health plan level measure would be done by the health plans, not by the hospitals.

It's all claims-based.

Paula Minton-Foltz: But they always - I mean if you're not a hospital-based person, then - from a hospital-based person, I can tell you they always want something in the contract then that will help them do the job of figuring out what's going on in your hospital.

Female: Yes.

Frank Ghinassi: Sort of a calibration - Frank Ghinassi here. Sort of a calibration question and I think somebody raised this before, or at least partly raised it. As part of the work, and I agree completely with the folks who are saying that you're not going to be able to do the ((inaudible)) metrics involved in trying to clarify the (CC) in each (CC) question in weeks and months. That's going to be a lengthier process over time.

But I just want to be clear that I understand. Since one of these focuses on plan level data, and the other focuses on hospital level data, but we all know that plans are comprised of pairs under whom hospitals live and exist...

Female: Right.

Frank Ghinassi: ...is part of the - whether they're you know 2 system and 2 plans, or whether they're you know 50 plans and 100 systems, there is still a natural relationship between these two measures.

And is part of the calibration that's going to take place over the next six months to a year, or however long it's going to take realistically to do this, is it to use the data as - for calibration in such a way that they're going to be checking whether or not the way the one system is measuring

it compares reasonably well with the outcomes that then accumulate up to plan level data? So that there's at least a reasonable believe that the method, the system, the methodology, the computational message that drive the hospital level measures - that when they accumulate up under plans, and the plans are using the alternative measure, that those two things are representing the same reality over time?

Is that part of the plan?

Bruce Hall: Frank, this is Bruce. I haven't heard any specific request or delineation of those analyses, and I'm not sure whether it's within our authority to recommend that or not. Perhaps NQF folks again have to guide us on that.

(Karen): Well this is (Karen), and I guess it seems like that would be potentially an analysis that could support not making changes if they decided that you know for whatever reasons that things needed to stay more the way they are. That would be an analysis that might support that approach in terms of - well, you would - could make the same conclusion if this were rolled up.

So I don't know. Like Bruce said, it was specifically addressed, but you know it's certainly a request that could be made.

And again, I think you know the idea about what do the measures represent, I think that's the question that was posed in terms of are there things on a shorter term that should be addressed, such as the unplanned admissions, the indexed readmissions, et cetera, versus the risk ((inaudible)).

You know, so that gets more at - kind of at the conceptual basis. Are they trying to measure the same thing?

But that's what we wanted to hear from the Steering Committee about, what your thoughts are. If three years didn't seem reasonable to you, are there things that are - should be on a shorter-term?

Joann Brooks: And this is Joann Brooks and I don't want to move to that question yet, but just kind of to reinforce. When we look at the payor level and then at the hospital level, you know things that are coming across my desk right now have to do with you know, the payers having their own scorecards of their own ways to decide what your contract's going to look like. And we know that United's coming out one, Anthem has one, et cetera.

You know, are they going to be using - you know, when they come up with here's the criteria or the threshold you have to meet for readmissions, you know, using the payor plan model versus what you know, the hospitals are dealing with, which is the hospital level data?

I mean, I just think it - you know, they are two different groups using them, but they will intersect multiple times. And I think to have them looking at very different - not very different, but having a cancer versus non-cancer patients, different types of unplanned admissions, not unplanned admissions; I just think it becomes very difficult to be able to really understand the readmissions.

Bruce Hall: This is Bruce again. If I can, I'm going to go to the last paragraph of the summary of responses from the two developers. And it says, "In summary," - this is page 12 of the material that was distributed. It says, "In summary, we expect that many of these issues can be harmonized in the long run. In the short-term, we do not expect these issues to cause much confusion, given that we expect there measures would rarely, if ever, be reported on exactly the same patient population."

Female: Yes.

Bruce Hall: "And that the measures have a fundamentally different focus what hospitals can do to readmit - reduce readmissions and what health plans can do."

"We appreciate the opportunity to respond." So I guess what I'm banging into here for all of us is what is within our authority to do or say here? Again, I'm looking to the NQF for guidance. Because what I see is - and we can go through each of these items item-by-item, A through H, but basically I think there were two where the two developers agreed to be identical.

And all the others, they basically said, "Look, we think there's a reasonable reason for us to be different right now, but we're very happy to work on this in the longer-term and reevaluate it."

So I guess I'm again asking the NQF and everyone on the call what exactly is the limit of what we're going to be able to say or do today in making this judgement?

My sense - my feeling is basically today, we have to reach a conclusion that says we feel the responses have been adequate, and we're willing to let these two measures go forward for now. And if we're allowed to request or recommend or mandate that they be reviewed in one year instead of three, it sounds like there's a lot of enthusiasm for that. I don't know if that's again formally within our authority, but that's kind of where I feel like we are.

And I guess I'm looking to all of you to say either disabuse me of that notion, or we decide how to move forward with that notion.

Jeff Greenwald: Bruce, this is Jeff Greenwald. I think you summarized it really nicely. The one additional option that I would wonder about is do we have the option, given that these are not likely to be harmonized before a rollout for very good reasons, do we have the option of saying we're going to go forward with one of them? The - perhaps the hospital-based ones, since that's the sort of CMS - that's the mandate, and put the other one on hold for that initial year of evaluation while

those other analyses are being done to see once rolled out, if they can be more harmonized at

initial rollout? That would be my ((inaudible)).

Bruce Hall: Yes, I think that's a great comment Jeff. I don't know if NQF can make a - give us any

guidance on that?

(Karen): This is (Karen). I mean essentially it is...

Tonya Alteras: This is Tonya. Can I just make a comment on that?

I guess I don't understand why the CMS one would be rolled out and not be ((inaudible))

measure? More like a - is it just because of the Congressional mandate? Because if that's - I just

don't see why they both wouldn't go forward as recommended ((inaudible)) continue on the path

to try and seek harmonization.

(Karen): Right. So - go ahead.

Male: Well, I guess - I think that's a point well taken. I guess the question is whether the legislation

requiring CMS to act on this would make that avenue more pressing.

Female: Yes. CMS has clearly indicated this is part of the mandate they have for getting up to 20

outcome measures accumulated. So it's not specific I think to the ((inaudible)) readmission

measure itself.

I think just if you look at the responses, most of the requests for harmonization were actually

directed to NCQA.

(Karen), do you want to just respond to the question raised earlier?

(Karen): Right. So basically the - you know, the question that was brought up is you know, is it within the purview of the Committee to put one of the measures forward? And yes, that's a possibility. It's certainly a possibility for you to ask for something to occur at the one year measure annual update that's possible as well.

And then of course you know, we typically have the three year measure maintenance cycle, which is you know, the whole thing again.

So I think all of those options are on the table, and you should discuss the pros and cons of those. And then what we would have to do is if the - if it sounds like people want to take a vote on those, you know, we have to have something that you would agree to vote on. But perhaps, you want to just have some more discussion about you know those options? Or if someone has another suggestion...

(Helen): You know, and just one other thought. This is (Helen). And whether there are actually some of these issues that would really you think be required to be assessed in the shorter-term, and which of these we recognize -- certainly the risk adjustment issue is not something you could turn on a dime and do -- could be a longer term pathway. And maybe splitting that out might be helpful as well.

Taroon Amin: So Bruce, this is Taroon. Just from a process standpoint I think you've laid it out exactly correctly. To go through each of them to evaluate whether or not they've been sufficiently addressed by the - as a developer.

And then it would be good if there are specific issues potentially in the inclusion criteria discussions around the planned readmissions and others that the Committee could request. Sort of a re-review around the one year measure update cycle.

And so if we can get some clarity around each of those issues potentially one by one across the call, I think we would be in a good place at the end of the call.

Frank Ghinassi: Frank Ghinassi here. I do think the - just in support of what you had said just now, and also what (Helen) had said earlier, I think some of the other issues might be easier to get I'm guessing consensus on issues like the planned readmissions and the inclusion of some of the subpopulations in there .

I think we did - I think we picked one of the more thorny and longer-term ones to discuss first. It's the way it came up in the order of things. So I'm wondering are we doing this in the right order?

Bruce Hall: It's Bruce. I'm not hearing anything back. I'm happy to take however people want to proceed.

Richard Bankowitz: Well I - it's Richard Bankowitz. I agree with the approach you're trying to look at where the low hanging fruit might be in terms of the harmonization of these measures. And I think just to remind ourselves why it's important to do this means that we are - we're trying to hold organizations accountable. We're trying to hold hospitals accountable. We're trying to hold the plans accountable.

Often times when we hold the plans accountable, they react by then turning to the provider because that's the only way - the most ((inaudible)) they can affect the change. So it comes back to the provider.

So we don't want to hold people accountable for different things, and I don't know how - I don't know what other body can harmonize this besides NQF? Because if there is no mechanism to do it, we will just have a proliferation of measures of different things and will be holding people accountable for - basically for nothing because there's nothing ((inaudible)).

So I think that's - I think it's essential we get this right, and for precedence sake if nothing else.

Bruce Hall: Okay. Well I certainly also agree with those comments, and I think the sentiment on the call sounds like everyone does. So shall we go item-by-item, at least at some level, and take comments on Item A? Was it the - either (HCC) or (CC) risk adjustments? And the plan from the developers there is basically that they would look into this in the longer term and report back.

It sounds like - again, please everyone and anyone correct me if I say anything wrong, but it sounds like the sentiment in the Committee is very forcefully that we would like to see a one year response, not a three year response, on probably everything we're going to talk about.

Female: Yes.

Male: Right.

Male: Correct.

Male: Yes.

Bruce Hall: So for Item A...

Female: Correct.

Bruce Hall: Thank you. For Item A, (HCC) versus (CC), the response from the developers is, "We're staying put and we will be happy to look into this and report back," and so we'll put this in the one year category. Comments before we go to Item B?

Female: This is just a, you know, looking forward question. Can NQF staff think about you know, what our response will be in a year if they come back again and say they can't harmonize this development so that we don't have to have a - you know, revisit the same conversation, just what the plan would be? And it probably is something that would you know, be useful in other discussions like this for other measures.

Bruce Hall: I think it's a great point, and hopefully - I would hope - although you know obviously, maybe this may be pie in the sky, but that after that period, we'd have some participants from the field complaining about the burden if this turns out to be an operational problem. So hopefully, that would also be in the mix by that point

Female: Okay.

Patricia McDermott: This is (Patty McDermott). I'm also wondering as we - I believe the process here is that we will either approve or not one or two measures that would then go out for public comment. How do we frame the concept of harmonization and what we think might or might not happen in one or three years based on whatever is agreed? That we would - how do we frame that in the public comment arena?

And are we at all worried about how that will be seen by the public as we're asking them to give comment? Just some thoughts.

Has this ever been done before?

Female: Oh, yes.

Female: Yes. And the draft report would outline those issues that you all identified and asked the developers to respond to. And you know, the report will then reflect what your discussion is here

about you know, whether - you know, what should be done in one year versus three years. And then, we'll ask for comments on that, which - at which - after which you all will get to review those comments and see how you want to respond to that. Whether that changes you know, what your recommendations were, or whether it reinforces what you thought.

So - but it will be laid out in the report, you know these issues about harmonization and where things are at, and what your recommendations are.

Bruce Hall: Okay. That's great. That's very helpful. Thank you.

Larry Glance: Bruce?

Bruce Hall: Yes, Larry?

Larry Glance: Yes. I'd just like to raise a point, and I don't want to - this is - I think one of the things that we're a little bit uncomfortable with as a group here I think is that we're coming up with two different measures to try to essentially measure the same thing. And again, it's unlikely that those measures would necessarily agree.

You know, as a matter of process, would it be appropriate for the group to reconsider whether we want to have two separate measures that we try over the next 12 months, possibly three year period to harmonize, or should we reconsider whether or not we want to revisit the issue of best of breed?

Meaning for the NQF or this committee to try to identify one best measure as opposed to two separate measures? That we try to kind of control folks to making them look more like one another?

So I raise this as a process issue, not necessarily for us to have a whole debate as to whether or not we - you know, one approach is better than the other. But would it be possible to kind of revisit that issue at this point in time?

Bruce Hall: Yes, Larry, I'm trying to scratch some notes about how we get through this call, and I agree with you. And I think it was Jeff that suggested that shortly ago as well. And I think we're down to about an hour and 15 minutes already. I would like to propose that we at least mention for each lettered response what the developers have said the plan is, that we cast that in terms of an immediate change, a one year change, and so on.

And when we get through A to H, then resurface the question of whether there's enthusiasm to move only one measure forward. Does that sound acceptable to everyone at the moment?

Male: Yes.

Female: Yes.

Bruce Hall: Okay, so for Item A, which is (HCC) versus (CC), both developers have justified their current stance, and both have indicated they're willing to reexamine on a short timeframe, which we are going to make a recommendation for a one year or less.

On Item B, logistic versus hierarchical. Again, the developers have requested to model differently without necessarily indicating that they even particularly want to revisit that. So I'm sensing that our sentiment would be nonetheless to ask for further information on comparing these on a one year time frame.

I think here is where it might be particular relevant and also make a comment about Larry's suggestions for a standard dataset for them to perform some comparisons on. So maybe we could incorporate that within this recommendation.

Additional thoughts for Item B?

Male: The only thought I have on Item A - B in addition is if the developers look at the hierarchical model, they're going to need to decide if they're going to model on the level of the hospital or the level of the plan, or possibly both. And that might introduce some confusion.

(Karen): Isn't that somewhat dependent on the measure and what they're intending to measure?

Bruce Hall: As it is now, the NCQA measure does not - is not hierarchical, so it does not have you know, a hospital and plan level. And again, it wouldn't be the hospital's job to calculate this unless they're trying to project how they might perform.

But I - you know, I think that's - I think it's a good point to incorporate in our comments that the Committee's concerned about...

Male: I'm just - I'm looking it from the NCQA plan perspective if I were the developer. I would like to - if you were telling me this more hierarchical model, I would ask, "Okay. Would you like to model on the level of the plan then? Or, do you want me to model of the level of each hospital? Or, do you want me to model on both?" And I - you know, I'm not sure what we would be asking to do personally.

(Karen): Right. So you're saying - what you're saying is that when you're looking at plan level, you have hospitals nested within plans and patients nested within hospitals. So there are...

Male: Correct. Correct.

(Karen): ...((inaudible)) level and whether that needs to be addressed. I don't know if you have a

recommendation. I wouldn't know what to tell them at this point.

Male: I don't have a recommendation. I just think it's an issue.

Bruce Hall: Yes. I think we should - we can note this in our comments that this issue has been raised.

And unfortunately, it's not quite as simple as (Janet) was that you, or (Karen)? Sorry, I think...

(Karen): It was (Karen). Sorry.

Bruce Hall: (Karen). Because in fact, patients may nest at hospitals, but hospitals may nest in more than

one plan.

(Karen): Exactly.

Frank Ghinassi: They almost certainly will nest to more.

Bruce Hall: Yes.

Frank Ghinassi: Yes, clearly. So it becomes - and that's one of the things we talked about before.

You know, as we speak about this more and more -- it's Frank here -- I too am becoming more - I

find myself questioning exactly how these two might ever actually dialog with one another as

measures.

I mean, they're both measuring very important things. We talked about that. I think the real appeal of the plan level data was that it included services that are visible to the plan that extend beyond simply in some cases just one level of care. Like just the hospital level data. They're able to see larger networks of things.

But for the reasons that you just said, you know set aside for just a minute all the methodological issues and set aside the modeling, hierarchical or linear. But just for what you said just now, the very fact that these plans are going to be drawing from individuals nested within hospitals across multiple payers, and they're going to be - the ability of these two to be seen as a calibration tool that are going to line up neatly is really quite a - that's quite a task.

Male: Just as a point of information, for the purposes of quality reporting, no one has ever created a performance report based on two different - or three different levels of hierarchy. So in this case, hospitals within plans. And, that would be extraordinarily difficult to do. I don't think that's really what we're talking about though when we talk about hierarchical versus non-hierarchical.

I think if you were to operationalize this using hierarchical regression, you'd either use the hospital as a level of reporting, or the plan as a level of reporting. You would not try to do both of them within the same model.

Female: Right.

Bruce Hall: Right. And in theory, that's possible obviously. But it becomes...

Male: In practice, really.

Bruce Hall: It becomes cumbersome. Right. Exactly.

So I'm sensing then for Item B, what we're going to accept a response at the moment, which is both developers want to stick with their approach, we're going to express some concerns nonetheless about having two different approaches. Also acknowledge that this may be justified, but ask for whether there's any additional information that could be provided after one year, and in particular whether it would be relevant to raise the question of a standard data set on which to test any of the changes.

Item C, which is the cohorts. Again, CMS - Yale CMS is very comfortable with the cohort structure, and NCQA has offered to evaluate whether restructuring into cohorts would - how it - or if or how it would impact their ((inaudible)). Again, I'm just going to sense that our default here is that we would like all this information in one year's time versus a longer time period.

Other comments on Item C?

Frank Ghinassi: It wasn't specifically stated. Frank here. It wasn't specifically stated, but was it - in service to what you're just saying now about the one year, is that the kind of project that NCQA felt was a year-long endeavor, or did they feel that that was an unreasonable time? It just - it wasn't specifically addressed in terms of the year.

Bruce Hall: That's correct Frank. It - basically the response just says we will be happy to look at it during the measure maintenance cycle. So I was assessing...

Frank Ghinassi: Does that mean - is that one year?

Bruce Hall: No, it's not necessarily...

Female: That's in three.

Bruce Hall: ...but I was assuming that this was going to be within our authority to recommend shorter than the regular three year cycle.

Leslie Kelly-Hall: Bruce, this is Leslie Kelly-Hall, and there was something in the memo that stated that there could be an alternative to have a hospital use a code to specify there is perceptively planned re-hospitalization that will occur within a 30-day procedure as some way to normalize this? Is that - I couldn't tell whether that was a recommendation or consideration, or what that - because that was a new piece of information since our meeting.

Bruce Hall: Are you on Item D Leslie?

Leslie Kelly-Hall: Yes.

Bruce Hall: Okay. Sorry, I was just taking other comments on C and then we'll resurface your...

Leslie Kelly-Hall: I'm sorry.

Bruce Hall: That's all right. We'll resurface your remark in just a second.

Leslie Kelly-Hall: Thank you.

Bruce Hall: For the cohorts, any additional comments on the cohort issue?

Jeff Greenwald: Bruce?

Bruce Hall: My sense was that - I personally think that would be an issue they ought to be able to respond to within a year.

Jeff Greenwald: Bruce, this is Jeff Greenwald. I don't want to jump ahead, but the comments from the

Yale group about the cancer population question also seems to roll a little bit into this, where they

talked about essentially looking at that as a separate cohort?

Bruce Hall: Sure. Yes.

Jeff Greenwald: So I wonder if it's worth sort of linking those two in our thoughts as we discuss this?

Bruce Hall: Great. Yes. So under this item, let's make a note that this is related to the issue of the cancer

patient cohort. Yes.

Any other comments on Item C?

We can revisit any of these that anyone wishes to, but let's just try to get an initial reaction to

each one.

So Item D, the plan from the developer says that the plan is for NCQA to incorporate the CMS-

type approach if you will in further testing, and evaluate the impact. Is - again, measure

maintenance cycle is mentioned, but I'm assuming we'd like to see that in one year - within one

year.

Female: Yes.

Male: Right.

Female: Yes.

Bruce Hall: Any other comments for that?

Leslie, do you want to restate your comment?

Leslie Kelly-Hall: There was a recommendation in the memo and I could not tell how that related to the

two recommendations, which was the alternative for hospitals to use a code that basically

identifies planned readmits, rather than doing either the exclusions or risk adjustment. I couldn't

tell where that - what that recommendation was specific to, so I'd like to hear some comment.

And is that an alternative?

Bruce Hall: Yes. My reaction to that is that it would not be feasible to mandate an actual change in

hospital reporting for that purpose.

Leslie Kelly-Hall: Okay.

Bruce Hall: I mean, it's akin to the present on admission type of reporting, and I don't think it's within our

authority, or even within these developer's authority to mandate that. But if anyone - if NQF can

fill us in or guide us on that?

Analytically, it makes perfect sense, but I mean as I'm sure everybody knows, even the POA

implementations have not been straightforward. So I think the ((inaudible)) group also

commented that it was very unreliable as it stands presently anyway.

Female: Yes.

Richard Bankowitz: It's Richard. I agree with that. And perhaps in the (ICD-10) nomenclature, there might

be - I'm not sure, there might be. But there's certainly no way to do it now with (ICD-9)

nomenclature.

Bruce Hall: So what we're faced with on Item D is that the NCQA is offering again to examine how the adoption of Yale's approach or coming much closer to Yale's approach would have an impact on their metric? And I'm sensing that that's basically the extent of Item D.

Item E, include patients with cancer, and item which we talked about in some detail in which they've responded to in some detail. The response is that the major developers do not plan to harmonize on this point. Yale has obviously provided their rationale, and the bottom line is the two developers feel that they each have a strong position.

Reaction?

Male: My reaction is - this is a subset of the planned versus unplanned question, because the reason Yale introduced this, it was because they thought most of these admissions were actual plans.

Female: Right.

Female: We agree.

Female: Right. So if - so actually, maybe if - maybe this issue or difference would go away if the planned readmissions were aligned. Is that what you're saying?

Male: I probably would be less of an issue, and it looks like Yale demonstrated there'd be a probably a 2% or 2.3% of the population would be effected by this. So it might be less of an issue if they're better harmonized.

Male: Does this obviate the question about creating a new sixth subset as they talk about - as we talked about ((inaudible))?

Female: Yes.

(Leora): This is (Leora) from Yale. Am I allowed to comment briefly about this?

Female: Sure.

(Leora): I just wanted to clarify that we already exclude planned cancer readmission. So readmission for cancer, chemotherapy, and so forth. This is a different question about how to consider admissions, not readmissions.

Bruce Hall: Right.

Female: Right.

Female: Right.

(Leora): Thanks.

Male: So...

Bruce Hall: Thank you. (Leora). So yes, I guess - so in the - for those of us on the Committee in the face then of the notion that the developers are saying they each want to stick with their approach, how do we respond to that?

Can everybody mute who's not talking? I'm getting some background somewhere.

Any comments on Item E?

Male: Maybe the person from Yale better explain why the admissions are excluded? Is it the indexed admission then that's being excluded?

(Leora): Yes. This discussion in this point is about indexed admissions for medical cancer or treatment.

Now regardless of whether they're included or excluded, if they had a readmission subsequently for something planned, like cancer or chemotherapy, that readmission would not count. So that's not relevant to this point. This point is about whether we should consider admissions for medical cancer or treatment in the denominator of the - you know, of this measure.

And the reason we suggested not including them is because we are not convinced that readmission, even excluding planned readmissions, we're not convinced that unplanned readmissions for this population is an adequate quality signal for a variety of reasons that we described, primarily because they're post-discharge mortality is so extraordinarily high that the competing mortality versus readmission that interferes with our ability to measure unplanned readmission as a quality signal.

Female: Yes.

Lein Han: And hi. This is Lein Han from CMS. Is the Committee's concern is that whether CMS will sort of overlook the quality of care for this cancer patient, well we have one bullet point here. We explain that CMS is currently developing quality care measure for cancer patients in other - in another project with another contractor. Actually, both psychiatric cases and also the cancer.

Is just one thing for you to consider.

Elizabeth Drye: This is Elizabeth ((inaudible)). Sorry to be tag teaming here, but I did want to just highlight for you that 86% of the cancer patients admitted to the hospital are still in our hospital-wide measure, and that's over a million admissions. So we're capturing the cancer patients who are coming in for surgery and other care. It's just not ((inaudible)) diagnosis is cancer, they're only coming in for medical treatment of their cancer. Just to make that distinction.

So the vast majority of cancer patients are - their indexed admissions are in the measure.

Male: Thanks.

Bruce Hall: So this is Bruce again. Committee members, would we want to take the stance that despite NCQA's initial response here, we would like NCQA to reexamine or reconsider? I'm trying to sense on the phone what the sentiment is, so guide me folks.

Joann Brooks: Yes. This is Joann Brooks. I would like NCQA to reconsider their stance on the cancer patients.

Bruce Hall: Great. Thank you. Anybody else?

Richard Bankowitz: I would agree with that. Richard Bankowitz agrees.

Bruce Hall: Okay. Anyone disagree with the sentiment that despite this response, we would prefer NCQA to reconsider this issue over this - again, one year timeframe if that's what we're going to stick to?

Any objections to that?

Jeff Greenwald: Well actually, this is Jeff Greenwald. Just have a point of clarification again.

Bruce Hall: Yes.

Jeff Greenwald: In the discussion at the meeting, their response to this previously that they don't really outline in the written version is that their modeling already sort of plays down the cancer admissions. The coefficients are constructed to play down cancer - these patients - they sort of exclude them through the model.

I don't know methodologically if that is sufficient, but I believe that was their response at that time.

Bruce Hall: That's right Jeff. So methodologically what they basically benefit from is classifying these patients into one of the cohort groupings, and then that cohort grouping will have an endogenous level of readmission.

So you're very correct in stating that that will partially control for this effect, but I think analytically, the CMS/Yale approach is...

Male: Cleaner.

Bruce Hall: ...probably has an additional level of refinement on top of that.

Okay, so in the absence of a strong objection, I will - I'm going to phrase our sentiment here that we would like NCQA to reexamine and reconsider that issue.

Point F is allowing readmissions to count as indexed admissions, and the response was that NCQA will reexamine and retest, so to speak, and look for impact. Any comments or comfort level with that?

Male: I think that works.

Bruce Hall: So again, we'd be looking for - we're accepting that, but we'd be looking for one year response, so to speak.

Male: Yes.

Bruce Hall: Anybody want to object or give an alternate view?

Male: Yes.

Bruce Hall: Okay. On Item Growth, both - as you can see, both Yale and NCQA agree that these patients should be included and they both feel that they currently do so. So I don't - it sounds like everybody's on board there, unless I've misread something.

Female: I think that's right.

Male: I agree.

Leslie Kelly-Hall: I had - this is Leslie Kelly-Hall. I just had one question, and that is because some plans do carve out, is there a possibility for you know, results to be somewhat skewed when plans themselves carve out populations as it compares to a hospital-based result?

Bruce Hall: I'm not sure we'll know the answer Leslie to be honest.

Leslie Kelly-Hall: Okay.

Bruce Hall: Anybody else Item G, or anybody who's more informed on I am on Leslie's concern?

Female: (David), can I ((inaudible)) one response?

Bruce Hall: Okay. Hello?

Female: I'm not sure there's anybody on the line.

Bruce Hall: Oh, okay. All right. Item H is including patients admitted for psychiatric treatment. And as you can see, the response there is a little bit longer. Basically, Yale offering to reexamine this issue over the - over whatever our recommended time period is, and perhaps even construct a cohort for these patients, which sounds to me like an appropriate response, and I think also probably touches somewhat on Leslie's concern that she just expressed.

Other comments? Reactions?

Frank Ghinassi: No, I agree with your comment, and it was Frank here.

Bruce Hall: Okay, great. Thanks Frank.

Anyone else on Item H?

Okay, so on Item A, we'd like one year feedback.

Item B, the same also talking about potentially considering a standard dataset to test some comparisons on.

On C, we particularly like the NCQA, who has offered to provide that information over time.

On Item D, again one year feedback.

On Item E, again one year feedback, primarily from NCQA.

On Item F, one year feedback.

Item G appears to be largely resolved.

And Item H is again - in this case, Item H is more or less a Yale - an emphasis on Yale's one year feedback.

Having given that very crude summary, and I apologize for the crudity of it, does anyone now want to raise overarching issues? I think Jeff previously raised the very important issue of whether it would be comfort or enthusiasm for moving forward with only one of the two measures?

So comment and feedback?

Does anyone want to build a sentiment for moving forward only one measure?

Jim Bellows: I think - this is Jim Bellows. I'd be interested in understanding, and don't know, what the implications would be for the NCQA measure if it was not moved forward, give it's already being reported?

Bruce Hall: Can our NQF colleagues guide us on that? What would happen to the NCQA measure if we were to try to say that?

(Helen): I don't know that anything would happen to it directly if they came to us seeking endorsement. It

is already in use in the Medicare program - Medicare (Stars) program. But, I don't know that

there's any direct implications.

But I do think one of the issues the Committee needs to consider is whether or not in this you

know one year period, if that works out, while the measure developers are trying to further

harmonize you know, what is the risk versus benefit of just having the measure out there if it's

already in use. So we can sort of learn more from the experience.

Bruce Hall: That's a great point, (Helen). Other comments?

So on...

Richard Bankowitz: It's Richard. Oh, I'm sorry. I would - Richard Bankowitz with a comment that I think

there is a benefit from looking at this from the plan's point of view, so I would hate to eliminate

that opportunity. And I think if we recommend strongly that this harmonization be pursued, I would

be comfortable with that.

Bruce Hall: You would be comfortable moving them both forward? Keeping them both at a high profile

drumming up the public interest, building the case for harmonization if important issues are

identified?

Richard Bankowitz: That's right.

Bruce Hall: Okay, great.

Larry Glance: Larry Glance. So I also raise this issue, and you know, I don't want to be - well, I think this is a very important issue because sort of imagine a hypothetical scenario. So Bruce you head up the ACS ((inaudible)). So let's do a thought experiment.

Supposing that the member hospitals in ACS ((inaudible)) were getting two different report cards. One based on your model, and a second report card based on a significantly different model, and therefore, getting two measures of quality.

Now this is not identical to the scenario that we have currently, because on the one level we're giving hospital reports. On the other level we're getting - we're giving plan reports. But there is going to be quite a bit of overlap.

And I think it makes a lot more sense in this setting to have a best of the breed as opposed to two competing measures that we're trying to harmonize.

I think that - and this is - you know, this is a very difficult issue to raise at this point in time, and it may be too late to really be able to manage this satisfactorily. But I'd still like to raise it.

Bruce Hall: Well Larry, I'm very empathetic and I agree with much of what you said. But on the - I'll provide a little counterpoint also, as (Helen) pointed out. You know the NCQA measure is largely in use by many organizations. And if we at least at present call these best in class at the levels that they're at - best in class at the hospital level, best in class at the plan level but move forward with our request for further refinement over time, is that - does that come anywhere close to satisfying you or not?

Larry Glance: I don't think it's a matter of whether it satisfies me. I think that as a general rule, I think that - I think NQF should try very hard when we have separate measures that essentially look at the same outcome, to really go with best of breed as opposed to different measures.

And I fully appreciate the fact that they're being used at two different levels. But they're still essentially measuring the same outcome.

Patricia McDermott: Well philosophically - this is (Patty McDermott) from Aetna. They're actually very different because one is truly looking at all comers and whether there was a readmission; whereas this is looking truly at unplanned. It's getting rid of planned surgery, planned - things that we know as we look at the quality of care. There's already a high anticipation for example, with cancer patients that they're going to return if they're having medical treatment for cancer.

I very much agree with those exclusion, and so I find them to be two very different measures. It's almost - you actually would conceptually if they go through the way they are right now, there are two approaches to readmission, but they're very different, and for that very specific difference, that one is truly an all cause and one is an unplanned readmission measure. They're very different and giving you very different rates.

Tonya Alteras: This is Tonya, and I just wanted to go back to Richard's comment before. I think that both of these - well, I still very much support the NCQA measure. I'm not opposed to the CMS/Yale measure going through, even though I didn't support it on the (wing nut).

But you know, I think that these are two different measures. I think they ((inaudible)) differently. In the event - you know, we talked a lot about usability at the Steering Committee. We have a ((inaudible)) here, because that's not what those ((inaudible)) efforts is about necessarily.

But when you get down to the usability aspect of it, these are two very different measures to use in different ways by consumers and by employers. And I would just be very disappointed if we didn't continue to - you know, if the NCQA measure did not continue down the consensus development process path.

Bruce Hall: Thank you very much for those comments.

So again crudely, I'm going to summarize. Everybody correct me. Sounds like the general sentiment is we feel there are enough differences - that there is enough separation between these measures that we would be okay moving them both forward.

We nonetheless very much would like to see efforts towards harmonization that could reduce the burden on institutions and plans along the lines of the points we've already run through, but that we're - fundamentally, we're at some level of comfort with both of them moving forward.

So correct that if it's wrong please.

Male: I agree with it. I don't want to correct it. If I just may augment it. It also is true that the plans have data and the whole continuum of care and the - that might prove very useful. And we won't know that if we have two separate methods.

If we have one harmonized method, we may very well learn that that plan data is important. And so I think it's a great opportunity to actually learn something new if they're harmonized.

Bruce Hall: So we really would like to emphasize in our recommendations and comments moving forward that despite the fact that we're recognizing some separation between these measures, we as a committee feel very strongly that every opportunity to harmonize should be taken.

Jeff Greenwald: Bruce, this is Jeff Greenwald. Can I just ask - you use the term sort of burden on the hospital and the plans. I guess the question in my mind is is it truly burdensome since it's - they're not going to be reporting differently for different purposes, so it's not like you have to fill out two different forms for the two different measures.

As we've said in most cases, they're not going to overlap because most, though not all, hospitals have multiple plans, and most plans have multiple hospitals. Not true everywhere for certain. But I'm just trying to understand the sense of the burden component here.

The burden may be on the interpretation of the data that comes out, but even there, again the same caveat comes that most hospitals have many plans, though not all do, and most plans have many hospitals. And so I don't think most users of the data are going to be going - are going to be holding them side-by-side and say, "I got a B+ on this one, an A- on that one. I wonder why they're different?"

Bruce Hall: I agree with you. I agree with you Jeff. I may have overused...

Jeff Greenwald: I just don't understand the first component.

Bruce Hall: Yes, I agree with you. I may have overused the term. What I was thinking of was the notion that you know, my hospital might get feedback from eight plans. Some of those grades from certain ones might be better, some might be worse; whereas, my hospital readmission measure may just say, "Oh, you're fine." And I got eight plans, some of them telling me I'm fine, some of them saying I'm not. Then as you said, it's an interpretation burden.

But also realistically in one of the hats I wear, we try to proactively keep track of how we're doing on measures. So actually at my institution, we probably would be generating some kind of effort to try to predict how we are going to do on this, which means we would have a burden of understanding the analytic approaches and trying to reproduce some proxies for them. So that in that sense, there might be. But I agree otherwise largely with what you said Jeff.

Jeff Greenwald: ((inaudible)) we're more getting into sort of the philosophical difference that you know, we believe that plans should be excluded. That certain patients should be included or excluded, and that strikes me as more of a do the right thing argument that the Committee seems to have opinions about more than a user burden question. And I just wanted to make sure that I'm on the right page with that comment.

Bruce Hall: I think you are.

Eliot Lazar: Bruce, this is Eliot. I agree with what's been said about the issue of user burden. I don't think - you know, at least for us and the facilities we're familiar with, you know, that's not a major issue.

I am very pro-harmonization, you know in every way possible. And part of that is that I think some hospitals will take a look at a sort of global measure, and then at measures from individual plans. And - you know, to try to understand are there - you know, are there differences? I think the point was made earlier that you know, the plan data represents a continuum and so on.

So you know again, every - I think I'm reiterating what's been said already, and I don't want to be repetitious, but I'm certainly you know, a little disappointed that you know, we're going to have two measures on broadly the same topic go forward that have very different specifications.

Bruce Hall: Eliot, thank you for that comment, but said you were a little disappointed. But am I correct you're a little disappointed, but you're willing to live with it?

Eliot Lazar: Well, yes. I'm - I'll certainly go with the group, but you know, with a message of a desire for harmonization and you know, my own little bit of disappointment, which you know is my problem.

Bruce Hall: As for my...

Leslie Kelly-Hall: ((inaudible)) this is Leslie again. The other comments that we had were about usability

as part of the harmonization issue. So one was the burden of harmonization that's already been

discussed, but the other was how do we make sure that there is no confusion for the public when

you're reporting something that's called the same thing and there may different results presented

to the public?

So I would also support going forward, but that that issue be specifically addressed.

Female: And your line is interactive. And if you should need further assistance from...

Bruce Hall: Thank you Leslie, I agree. And I think that's very - a critical part, and I would like to see that

reflected in our recommendations, that the burden on public interpretation is ((inaudible)).

Christie Travis: This is Christie; can you hear me?

Operator: Ms. Travis, your line is open.

Christie Travis: Thank you.

Female: …steering Committee, and I just want to make it again here. I see these measures being

reported in different places, and one would be on hospital compare and other hospital reporting

type sites. And then the other is you know, at the health plan level. So I would see it being

reported on health plan Web sites and also on the exchanges.

And you know, I truly believe that with the proper contextual information, that that type of

confusion could be avoided. And that you know, the health plan level measure is extremely

usable for consumers. I just think it's a matter of how it's displayed. And I know we don't get into

that in this process, but I just - I was getting a little frustrated when measures get discounted because of concerns about confusing the consumer.

You know, I think if we had meaningful measures, we can figure out how to display them in a way that people can use them.

Jim Bellows: This is Jim Bellows from Kaiser-Permanente. I really disagree about the confusion element, and I would go to something as simple as the overall rates being quite different because of the inclusion or exclusion of such additional readmissions from a ((inaudible)) indexed admissions. So they're not even calibrated to ((inaudible)) the same rate.

So to me, I would want to include a specific message back to the developers that the Committee isn't impressed with the level of their harmonization. And that there's thing like the ((inaudible)) (HCC)'s versus (CC)'s where they have underappreciated the importance of really coming to harmonization. And it's just repeating the original ((inaudible)) why they think their ((inaudible)) method is better isn't adequate, and the next time around we expect more.

Bruce Hall: Great. Thank you both. Those were outstanding comments.

Christie Travis: This is Christie Travis. I just wanted to add that I support Tonya's comments around confusion, at least at the consumer and the purchaser level with having a health plan as well as a hospital measure. And I think that those are totally addressable, and I don't see them as significant issues from a practical standpoint; although, I do support trying to get these measures as harmonized as possible.

Bruce Hall: Thank you, Christie.

Richard Bankowitz: Hi, it's Richard. I did have a comment, but I got bumped off for a moment.

I personally don't shy away from using the word burden when it comes to this, because when hospitals have to contract with multiple plans, and have to explain multiple different results, it is quite a burden.

Bruce Hall: Great. Thank you, Richard.

Jeff Greenwald: So I think give - this is Jeff Greenwald. Given that the comments from our colleague from Kaiser is - are we at a point where we ought to wonder about the question of saying - I mean, it seems to me like we have three options, or four options. We can either go forward with none, go forward with both as is with recommendations for a one year follow-up, or go forward with one and say the other one - come back to us in a year with the harmonization process under a better control and then we'll reconsider that. Is that sort of what's on the table at this point?

Bruce Hall: Jeff I think that's on the table, but my gauging the sentiment is that there is strong enough sentiment that both these things ought to go forward. That the - you know, the plan level information. That there are multiple reasons to think that that's going to be extremely valuable. So again correct me folks if I'm wrong. I'm going to put the bogey up that this general sentiment is that we would move both forward with the one year follow-up request that we have discussed, and that's a bogie.

Paula Minton-Foltz: Well this is Paula, and I think from the very first vote of this, we did not vote this in. And I think we have been bent on it ever since it came back. And I don't think that we do have a clear, consistent opinion on this. I think we need to vote again.

Bruce Hall: Okay, thank you Paula. Okay.

Christie Travis: Well this is Christie, and I guess I'm just trying to be sure I understand. You know, it was 10 to 9. I mean, I guess that could be considered close, but it did pass and meet the NQF criteria according to our vote. And none of the measures it looked like, if I remember correctly, really got the first pass vote. I mean, it was kind of like you know, we had to come back and look at things.

So it just seems to me that it did - at least my account was that it did pass.

(Helen): Yes. And this is (Helen). Just to weigh in on that point. Both did pass. They were fairly close votes. And just keep in mind where we are in the endorsement process. We're still quite early, so what you're really determining is whether - is how you want this to be presented for public comment. You'll get plenty of public comment. We will actually put all these issues in the responses from the developers. So it's not as if this is a final decision to recommend or not. It's really a decision of how you would like this information to flow out for public comment.

Bruce Hall: (Helen), can you walk us through then what happens once that public comment comes in in terms of final, final, final, final, final wording?

(Helen): ((inaudible)) final, final. So ((inaudible)) lines are getting a lot of feedback. ((inaudible)).

Operator: Actually, it's coming from Mr. Hall's line.

(Helen): It's coming from where?

Operator: Mr. Hall's line.

(Helen): Oh Bruce, it's coming from your line. If you could mute for just a second.

Bruce Hall: I am muted. I'm not sure what's going on. I will hang up and call back.

(Helen): Okay.

Bruce Hall: I'll hang up and call back.

(Helen): Okay, thanks Bruce.

So while Bruce is gone, I'm telling secrets.

No we - at this point in the process of the measure, we will then draft a draft report to go out for comment. We'll include all this information, all the deliberations of the committee. And just keep in mind, NQF is incredibly transparent, so every single vote will all - you know, the actual votes on the criteria and the overall votes will be put out for public comment as well. All of the issues we've raised about the two measures, the response from the developers.

We'll then get public comment back. We'll schedule a call with the Committee to go over those public comments. See if those public comments sway you in one direction or another.

You will then have an opportunity to make your final determination for how the measures then flow out before member voting on the measure.

And at that point, only the measures that are recommended will be voted upon. And even after that, the ultimate - the next decisions goes to Consensus Standards Approval Committee, the standing committee of NQF, who then makes a final recommendation to the NQF Board to ratify the decision.

So I would guess we're at best one-third of the way through the process with two-thirds to go. We also ((inaudible)) at times do put out reports without a clear decision, without clear consensus. So

I think you know, we do have a fair amount of opportunities, or at least to think about this over the longer-term.

Bruce Hall: Okay.

(Helen): Are you back, Bruce?

Bruce Hall: I am here.

(Helen): Okay, excellent.

Bruce Hall: So thank you for clarifying the rest of the process there.

Jeff Greenwald: Bruce?

Bruce Hall: Yes?

Jeff Greenwald: This is just a question to (Helen).

(Helen), would it be an option for us if we as a group preferred to - and again, this is completely hypothetical. If we preferred to have a single measure to go to one of the two measure developers and say, "Look. We recognize the value of reporting hospital readmissions on two different levels. At the hospital level and at the plan level. And we would like you to take your measure and modify it so that you could do those two different levels of reporting. Is that something that there's a precedent for doing? Could that be done?

(Helen): It has been done. It tends to take a very long time. The one experience we've had recently with surgical site infections took nine months. These are not short-term events, certainly.

The other thing is we - this is one of those questions we posed to both developers as you recall, and they currently don't have the capacity to do that - to actually flex up or down in terms of the level of performance.

I think that to me is a much longer-term horizon in terms of you know, perhaps the ultimate goal is wouldn't actually want a measure that truly flexes up and flexes down in that way? But I don't think they have the capacity or the data to do that yet.

Jeff Greenwald: Thank you.

Bruce Hall: Yes, this is Bruce. I'm sure Yale CMS can tell us, but I don't think for instance that they would - they have all the plan level data.

So (Helen) and/or the other colleagues from NQF, where we are at now in this discussion is the next step that you would survey out to us, each Committee member's comfort level, perhaps with the options that Jeff mentioned, which were to move both forward with the comments we've developed. To move neither forward, but again they've each already passed. To move one or the other forward? Again, they each already passed.

So I'm just sort of asking what is the next step? Do we need to take a voice vote on this call? Will you survey us, or how do we get to where we need to be?

(Helen): Yes. I think I sort of mentioned at the beginning of the call I think the major question is you know, do you feel comfortable leaving the votes as is with the discussion we just had about - that provides those that - you know, the list you ran through, Bruce, of each of the individual items and the harmonization proposal with a one year horizon is acceptable.

If that's acceptable, I don't believe we need to go out and actually survey you again. If there's another question on the table that you think would change potentially the recommendation vote, then we would do a survey to follow this call. We don't usually do voting on the call. Too difficult, but...

Bruce Hall: So wouldn't it be then that you would just survey us, including those members of the Committee who couldn't make the call? You would survey us out and say, "In consideration of the responses that have been received, in consideration of the discussion that was had by phone on the 16th, we're asking you yes or no, are you comfortable with moving both measures forward?" And you know whatever the options are. Is that what's going to happen, or do you want us to voice vote now?

Or - I don't want to over-speak everyone's opinion. I'm in danger of doing that by being talkative, so I don't want to.

(Helen): Yes. I don't think you're in danger of doing that. I am - I think again, we could certainly go either way. We could certainly go back out with a Survey Monkey request to have people just weigh in on a - you know, a simple set of questions like that. We'd have to go into the nuances of what you just did going through the harmonization responses I found personally very helpful letter by letter.

And I guess I thought at the end of that discussion Bruce, there is at least a general sense based on a lack of significant discomforts from those on the phone that there was general sense that it was okay to move both forward with a one year horizon to try to focus in on the issues that had not yet been you know, fully addressed.

Female: So I guess given that, the question is is there anyone on the Committee that feels that we need to go back to a vote? You know, with the caveat that (Helen) just said in terms of the - both measures with the you know, response back about the one year horizon.

But certainly, if it's an issue it's possible. So I guess that's what we should ask.

Male: (Helen)?

(Helen): Yes?

Male: Yes. So what I'm sitting here trying to juggle is really two things. Number one, the notion of putting

this out for - you know as you indicated earlier, full transparency and you know, robust public

opinion, which would make me think that we ought to advance both measures. And then you

know, have a strongly worded commentary about the Committee's concerns regarding the lack of

harmonization.

I guess the second is you know practically, if the recommendation is going to really serve as you

know, a predictor of what ultimately happens, are we really serving ourselves well, you know

without - you know, with two different measures being advanced and the uncertainty of

harmonization? And I'm struggling with you know, which has a greater imperative?

And I just wondered if either you or any of the other Committee members would want to

comment?

Richard Bankowitz: Well, this is Richard. I have a question for (Helen). If after the public comment is

received, will we have another meeting to...

(Helen): Yes.

Richard Bankowitz: ...then reconsider this question, because I might be swayed by the...

(Helen): Yes.

Richard Bankowitz: ...nature of the public comment.

(Helen): Yes. And that's actually the intent of the public comment. We'll put it all together for you in a

table of all the comments received - who sent them forward. And you know, usually staff for

example ((inaudible)) will even theme them for you of the key issues that were raised. We'll then

have a call with you to go over those comments.

And then I think the question is you know, is it - would it be - would that help inform your

decision? Rather than voting now, would you rather vote then, I guess is one question I would

have. And it's not clear to me there's a significant downside to - again, this is just thinking logically

here. Not an opinion per se. I'm not sure there's a large downside to putting out a report that

clearly details all the issues, the response for harmonization, the Committee's continued concern

putting both measures out there for comment.

I just - I'm not sure I see much of a downside there when you know there's another chance to

review it after the public comment.

Richard Bankowitz: I'm comfortable with that.

Female: I'm comfortable.

Christie Travis: I am too. This is Christie.

Female: Yes.

Female: I agree.

Eliot Lazar: Yes. ((inaudible)) Eliot. As am I.

Male: That makes sense.

Frank Ghinassi: Frank here. Yes.

Male: Yes.

Male: I agree.

(Helen): Sounds logical. Okay, good, so...

Female: So there's no need for another vote I don't think.

(Helen): I don't believe so. I mean I think if people are generally comfortable with that approach - and

again, we'll put all this out there. This memo, the details of this call. All of that will go out there for

public comment, and it also gives us an option. ((inaudible)) two weeks though. Is that right?

Female: Yes.

(Helen): There'd be a two week public comment period. We'll also then have a chance to you know, look

- move back to you after we have the comments and determine if at that point we feel like we

need to have another vote for a final recommendation before it goes out for voting.

Frank Ghinassi: No, I like that (Helen). Frank here. Because it really does then give a chance for the

group - this discussion I think today has been extraordinarily helpful. I think it's really laid out a lot

of these points. And it's also helped for me at least to clarify some of the ways in which these two

measure - both do line up and don't line up.

(Helen): Great.

Frank Ghinassi: I think it' going to be even more helpful to see what you get back once you put not only

the measures out there, but also the kind of thoughtful arguments. That's going to be helpful I

think in the next round.

Jim Bellows: This is Jim Bellows. I'm also thinking about how to use this conversation today, which I

agree has been extraordinarily helpful, and use that to position the work for the next year to

incentivize the developers to really address the harmonization.

And it seems like one aspect of that would be to remind people that a good choice for the

Committee a year from now might be to choose the best ((inaudible)) with the idea that if some - if

the developers haven't moved strongly enough on harmonization, then one of them is at risk of

being eliminated from the pack and perhaps with a preference towards maintaining whoever

moves most strongly in the direction of harmonization because it seems like a lot of the really

hard work and heavy lifting will be done between now and a year from now.

(Helen): That sounds very reasonable. This is (Helen). And we'll also be in contact with the developers

and get a better handle on the capacity for the one year timeframe you recommended.

All right. Anything else we need to do?

There was - if we need to do public comment, I'll just - maybe while the operator is opening up

the lines for that, there was one question that came in via the text chat on the Webinar, which

was what users should follow during the period of the measures of - while they're harmonizing,

which measurement specification should they use for day-to-day operations? And again, I think that would depend on the level of analysis.

And again, we're still fairly early in this process, so hopefully we'll have more clarity as we go forward.

Any other public comments operator?

Operator: Not at this time. The other two lines are open.

(Helen): Great and if people haven't seen it, (Ashish Ja), one of our Committee members has an article today in the New England Journal on the relationship between the hospital admission rate and rehospitalization that's quite interesting.

Male: Yes. Excellent.

(Helen): All right. So next steps Alexis?

Alexis Forman: Hi. Just very quickly. Next steps. Project staff will work to draft the draft report for comment and make sure we capture your discussions adequately. And comment will open on January 9th and close on January 20th. And we will have a Committee conference call on January 31st to review the comments. And we will definitely send those comments to the Committee prior to the call.

We will also ask the measure developers to respond to any of the comments as well so you could see their opinion on the comments, especially if there are any comments related to the measure's specifications.

And so we'll send out an agenda with the dial in information, and I'll send out a reminder with the time and date of the call as well.

Taroon, did you have any other announcements?

Taroon Amin: No, that's it. Thank you, Alexis and thank you, Bruce, for pinch hitting for us on this and your leading the discussion.

Eliot, is there anything else that you wanted to add as Chair of this group?

I guess not.

Male: Do we know yet what the time on the 31st is going to be?

Female: I believe it's 2:00 to 4:00. I'll send that out today so you'll have that and you can mark your calendar.

(Helen): All right thanks everybody. Have a good weekend. We'll talk to you soon.

Female: Thanks.

Female: Thank you.

Male: Thanks.

Male: Thank you everybody.

Male: Thanks. Take care. Bye-bye.

Female: Happy holidays.

END