NATIONAL QUALITY FORUM

Moderator: Cost and Resource Use
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Quintin Dukes: All righty. I would like to thank everyone for joining us for the call. Today, we'll be speaking about the endorsement on Phase 2 and Phase 3 of the cost and resource measure. We'll be discussing the board conditions and our next steps.

First, I would like to go through the agenda for today. So again, welcome everyone. And next, we'll be going through a (bulk) phases and then we'll do project updates for both phases, custom resource phases, Phase 2 and Phase 3 and also do a background of the board conditions and also go over the sociodemographic adjustment trial period overview and also the implementation of the board conditions for endorsement and next steps in considering the sociodemographic factors for cost measures. Next step – next slide, sorry.

Oh, and again, I would like to introduce myself and the team, I'm sorry about that. This is Quintin Dukes, the Project Manager for Cost and Resource Phase 2 and Phase 3. I'm here with Ann Philips who is a Project Analyst. Also here with Ashley Wilbon, she's a Senior Director. And I'm also here with Marcia Wilson, she is also the new Senior Vice president here at NQF, so welcome.

Female: Taroon Amin is on the call with us as well.

Quintin Dukes: So now, we'll begin with our roll call. First person is Brent Asplin.

Brent Asplin: Here.

Quintin Dukes: Ariel Bayewitz? Lawrence Becker? Mary Ann Clark?

Mary Ann Clark: Here.

Quintin Dukes: Cheryl Damberg? Jennifer Eames-Huff?

Jennifer Eames-Huff: Here.

Quintin Dukes: Nancy Garret?

Nancy Garret: Here. And I'm having trouble getting into the webinar. It's asking me for a co-leader password.

Female: Nancy, I just sent out an e-mail with an updated link to that.

Nancy Garret: Oh, OK. Thank you.

Female: Did you get that?

(Crosstalk)

Female: OK.

Nancy Garret: I'll go look. (Inaudible) I have, but I have not seen it yet.

Female: That makes sense. Let me go resend it to you.

Nancy Garret: OK. I've got it. Thank you.

Female: Good.

Quintin Dukes: All right. The next person is Andrea Gelzer. Stanley Hochberg? Matthew McHugh? Martin Marciniak? James Naessens? Jack Needleman?

Jack Needleman: Here.

Quintin Dukes: Janis Orlowski?

Janis Orlowski: Here.

Quintin Dukes: Carolyn Pare?

Carolyn Pare: Here.

Quintin Dukes: John Ratliff?

John Ratliff: Here.

Quintin Dukes: Andrew Ryan? Joe Stephansky?

Joseph Stephansky: Here.

Quintin Dukes: Lina Walker? William Weintraub? Dolores Yanagihara?

Dolores Yanagihara: Here.

Quintin Dukes: OK. And that will sum it up for the committee for the roll call. Next slide.

Andrea Gelzer: Hi. This is Andrea Gelzer. And I'm also on the call.

Quintin Dukes: Oh, welcome. I want to say welcome to everyone who's on the call again.

Herbert Wong: And this is Herbert Wong with AHRQ and I'm on the call as well.

Quintin Dukes: Oh, OK.

Herbert Wong: And if you can send me that link for the WebEx again, I would appreciate it. It didn't seem like it had gotten on to my e-mail.

Ashley Wilbon: Will do Herbert. Thanks.

Herbert Wong: Thank you.

Quintin Dukes: Great.

Ashley Wilbon: So for those of you that don't have the webinar link yet, we're essentially following along with the memo that we sent. So the slides very much mirror the memo. So if you want to just follow along the memo until we get you the link, that will get you through.

Herbert Wong: OK. Thank you.

Quintin Dukes: All right. Thank you for that, Ashley. Just to provide an update on Phase 2 and Phase 3 of the cost and resource project, the Phase 2 cardiovascular measures, we received an appeal on December 8 from the American College of Cardiology. And they submitted and appeal for the two measures which was 2431 which is the hospital-level risk-standardized payment for AMI, and also, 2436, again, the hospital-level risk-standardized payment for heart failure.

And just to go over, some of their concerns was that they brought up with sociodemographic adjustments and they felt as though core quality of the risk adjustment methodology and the measures and they felt as though they wanted to prefer the stratification by sociodemographic factors with reimbursement tied to performance taking into account each stratum.

And also for the use of standalone cost measures, with that, they felt as though that CMS and other organizations who use these measures, that face the cost crisis and in such circumstances, some quality measures might be applied. But it's not likely that sufficient emphasis will be placed on quality to counterbalance the motivation given provided to lower cost.

And the next concern was attribution and they felt as though it would be difficult to assign accountability to one individual or entity that does not have control over the whole system or the whole patient continuum pertaining to the condition.

And the elements of care coordination that are effective are known and that the care coordination actually controls cost. So largely, they feel as though care coordination would actually encourage hospitals to communicate with one another and to increase the outcomes of care and lower the cost.

And so furthermore, with the Phase 2 cardiovascular conditions, we already went to CSAC that. And on February 4th, the measures will go to the full executive board. And furthermore, CSAC discussed the (bill) on January 13th

and CSAC voted to uphold the endorsement decision with a 92 approval rating.

And with Phase 3, for the pulmonary conditions, the appeal will be closing on January 28. Next slide.

And just to give a summary of the evaluation process, I would like to go back to the member voting period where there was a lack of consensus where for Measure 2431 and Measure 2436, there was a lack of consensus where we have the vote – we received the voting results and it ended up in the gray area with a 40 percent approval rating.

So as our plan of action, what we did was we went out and we reached out to our members and we conducted a call. And we went over the things that contribute to the measures falling into the gray area and we wanted to identify a path forward.

So with that, we took that input and we met with CSAC. And after CSAC reviewed those concerns, we received a 77 percent approval rating on the two measures. And shortly after that, we met the board of directors which ratified the endorsement with the recommended condition which we'll discuss later on in the call. Next slide.

So as part of the recommendations that the board of directors recommended, that will go for the Measure 2431 and Measure 2436 which have a due Phase 2 cost and resource measure. And also, we took the cost and resource measure from Phase 3, 2579 which is hospital-level risk-standardized payment for pneumonia and we (task) that on – so for all three measures, we will be looking at it through the lens of the recommendation that were given by the board. Following these conditions will be a one-year look-back assessment of unintended consequences and also a consideration for the STS trial period.

Would you like to comment on …

Ashley Wilbon: Yes. Thanks Quintin. So this is Ashley. This is the kind of piggyback, the one Quintin was describing. So the board ratified the endorsement of the

three (CMS-EL) cost measures for AMI heart failure and pneumonia only with the following conditions that Quintin just described.

With the one year look-back assessment of unintended consequences, consideration for the (FDN) trial period and there was a third condition around further examination of the attribution issue.

So you'll note in the memo in our discussion today, we'll primarily focus on the second condition which is around the STS trial period. The third condition that's grayed out on the slide and actually, we didn't actually included in the memo is we've kind of taken out of the mix for discussion with the committee at this point, NQF is internally discussing how we're going to address that through feature work and that's something that we'd like to do, a project perhaps on convening some experts and providing guidance to the field around considerations for developing measures that, you know, use attribution or the attribution has a very strong component of the measure construction.

So with that, the first condition around the look-back assessment of unintended consequences, that's also something that we are currently exploring internally on how best to evaluate that, where while it was a major concern of many of the stakeholders throughout the process with even some of the committee members, the NQF membership feedback and at the board level, we're still again, trying to figure out how best to evaluate that given all the mixed multi-stakeholder perspective and which unintended consequences we would actually be looking for.

So more to come on that but again, our call today is really going to focus on the STS trial period which is something that we have been working on actively since the approval of the STS risk adjustment report last year.

So with that, I just wanted to pause quickly to see if there's any questions. We're going to kind of jump into some of the information about the trial period and what that means in terms of what we're thinking right now and how to implement that particular condition from the board.

Any question so far?

Nancy Garret: This is Nancy Garret.

Ashley Wilbon: Sure.

Nancy Garret: So I just have a question about the look-back assessment and the consequences. It seems to me that the unintended consequences are going to become most apparent when there's actually payments associated with these measures, when it's embedded in the, you know, some of the official EMS pay-for-performance programs which I don't think would be in the next year.

So I wonder if you could tell me a little bit more about the discussion there with the one year look-back and how we're going to know after a year if there are unintended consequences, if it hasn't really been fully baked into those programs yet.

Ashley Wilbon: I think that's an excellent observation Nancy and I think that's something that we are still trying to figure out internally. These conditions were developed by the board of directors. And so, you know, and these – I will say these conditions also are shared – many of them are also shared with the readmission measures that are going through the process at the same time.

And so I think the one year – honestly, I don't think that there was a significant kind of discussion around the appropriate time here. And I think the point they were trying to make was that we would like to revisit this measure at some point in time and I think the one year timeframe was just the one that's stuck.

So I think internally as we're looking through this, that one year look-back as we really figure out how best to operationalize that, I'm guessing it may change definitely with the measures that are currently being implemented in report payment and reporting programs. The data won't be there yet to do the look-back. So I certainly, agree with your comment and we're still figuring it out really.

Nancy Garret: Yes. That makes sense, that's fair.

Taroon Amin: Ashley, this is Taroon, if I can add something to that.

Ashley Wilbon: Sure.

Taroon Amin: Nancy, this is Taroon. I would just add sort of two different elements to that question. I think the first is what NQF staff is thinking through is the fact that while many of these measures aren't necessarily publicly reported or used in a program, there is dry run results in terms of the National Dry Run's (spiel) understand performance on this measure based on different hospitals, hospital type or different patient population that we may be interested in studying.

Obviously, that would be dependent on the measure that we're looking at. So for different measures, the state of how the readiness or how far it's been tested is varying. So we are certainly taking that into consideration in terms of how we can actually look at data.

The second question here we're sort of raising is, you know, more complex than the first which is currently, the way the endorsement process is structured as you obviously know, we're looking at the measures for broad payment and accountability becoming accountability and quality improvement application, not specifically for individual programs.

However clearly, the concerns that have been raised by the board and other stakeholders to the process and the endorsement of these measures and the readmission measures have to do with the individual application measures for specific programs.

And so obviously, that goes across the endorsement barrier into something that we traditionally in NQF consider what we do in the measures application partnership work or in the measure selection work as we call it.

So NQF staff is working to try to understand how exactly the question of unintended consequences for use in particular programs specifically payment or penalty programs can be analyzed by the standing committee because typically, that is something that we advise the standing committee members to not really, you know, look at in terms of their consideration. They're typically – we ask you to look at the size of merits and the other three of the criteria specifically usability, feasibility and the importance of the measure.

So those are the two areas that we're looking at. Again, we're still working through this as exactly how this would be operationalized. And it would likely be operationalized differently for different measures based on their – our experience with them and the amount of data that's available to actually do those types of analyses.

Ashley Wilbon: That's interesting. So is the plan that the standing committees would be involved in this assessments of unintended consequences or are you thinking that some of the other NQF offices would take over and look at that or you're working that out?

Taroon Amin: We're still working that out and again, we really need to work collaboratively with our developer colleagues and CMS to be able to understand exactly where they are in terms of testing this and what data is available.

But certainly, at least the first question of the STS factors is primary focus of this point recognizing that as you pointed out, it may take a little bit longer to be able to do the analysis of unintended consequences if again, there is measure used experience from dry runs, we would certainly try to accelerate a review of unintended consequences given the various concerns that have been raised by stakeholders as it relates to, you know, the performance of this measure based on different populations of hospitals or patients and specifically, for specific applications as you pointed out came into penalty programs.

So it's not that we're taking it off the table, we just (inaudible) the measure where it's at in terms of experience. So I know that's not necessarily a satisfying result or, you know, satisfying in terms of our, you know, where we are but we are certainly thinking through all of these things in terms of how to operationalize that particular recommendation by the board.

Ashley Wilbon: Yes. That's really helpful. Thank you. And then as I mentioned readmissions, so did the board have the same three criteria for readmission measures as well?

Taroon Amin: The board – essentially, all of – the board was much more focused on the question of STS and the trial period. So the board has requested that the admissions and readmission standing committee reconsider the measures – there were 18 measures that were recently evaluated in their project. A similar timeline as this committee and the board has asked the standing committee to look at portfolio measures that have just been endorsed and consider which of them have an a conceptual relationship between STS factors and the outcome and bring those directly into the trial period.

In this case, since there's a lower number of measures that first, you know, sort of toll gate has been, you know, bypassed and, you know, these measures would likely just go directly into the trial period.

The question of unintended consequences is much more related to STS as it is for readmission. So it's slightly different as for the board, really asking us to go, you know, do these pulmonary analyses in terms of which should enter the trial period for the readmission measures.

But these two projects has been really the focus of what the board has asked us to focus on for the trial period starting this year.

Ashley Wilbon: Got it. Thank you.

Joseph Stephansky: Actually – this is Joe Stephansky. I understand that the attribution issue is not on the table at this time. But if we have comments we would like to make, is there some other than NQF, we should address them too.

Ashley Wilbon: Sure. You can actually send them to me.

Joseph Stephansky: All right.

Ashley Wilbon: I'll take them.

Joseph Stephansky: And my other question is there's also the issue of the disparities, standing disparities committee and what role that will play in all of this. I assume you may be addressing some of that but if not …

(Off-Mike)

Ashley Wilbon: Yes. Taroon, why don't I start and then you can fill in the blanks to what I might have missed? So there's certainly a part of the rollout of the recommendations of the STS expert panel. It just so happens that these two projects are ongoing and are kind of moving a little bit faster than we have been able to roll out all of the guidance from the report and that expert panel.

But we are looking to hopefully convene a new disparity standing committee that will be more of an oversight body to implementing the recommendations and the report and making sure that they are adequately and appropriately applied in the different standing committees.

We are still planning that individual measures that come through will still be reviewed by their standing committees, that they're based on the topic area that they're in.

So the standing committees will still have purview in terms of reviewing the individual measures, making recommendations for endorsement. But we'll be using the disparities committee kind of as a conduit to make sure that the guidance we're providing each of the individual standing committees is consistent and that it's being applied across the board in all the different topic areas for the measures that come forward that it actually applies to.

So we're certainly working on that and we hope to hopefully convene a committee this year, probably this year. Do you have anything to add to that?

Male: No. I think you characterized it perfectly Ashley.

Ashley Wilbon: OK.

Male: In other words, there's going to be a committee to make sure that the resource committee doesn't go crazy?

Ashley Wilbon: Right. Not just you guys, there's others as well. But yes, there's much more of an oversight body to make sure that all of these guidance related to this topic area are kind of implemented in a different standing committee.

Male: Yes. (Inaudible) are not being draft. OK. Good. Thank you.

Ashley Wilbon: Right. Any other questions before I move on?

OK. Great. So the next slide is just a start to give you an overview of what we really mean when we say STS trial period. It is essentially a two-year period of time that will start this month and run through 2017.

During this particular timeframe, we will be asking that developers consider STS factors as potential factors to go into the risk model if there is a conceptual reason for doing so. Taroon mentioned kind of this conceptual and empirical analysis and we'll go into a little bit more discussion about that in a few slides.

But essentially, we're just asking that it is considered because before as you know, we did not allow developers to include those factors in the risk model and that analysis was really limited them determining how they might want to stratify the measure.

So now, we're saying in addition to clinical factors, you should also be thinking about non-clinical STS factors to include in the model and your consideration to do that should be based on their being some kind of conceptual link of those factors to the outcome that (we're) looking to measure.

And within that trial – within this two year trial period, as I mentioned as measures come forward, we'll be implementing the evaluation of that information on the clinical factors, the non-clinical STS factors that are in the risk adjustment strategy. It will be a part of the validity criterion, that's actually where it resides now. So there's no real change there.

But it will just be a little more information from the developers on the various factors that they have considered. Next slide.

So the next slide I put together was really just – give us side by side. We've had questions about kind of what's different during the trial period. And so this slide is meant to try to illustrate that a little bit.

But again, as I mentioned before or prior to the start of the STS trial period, only clinical factors present at the start of care should be included in the risk adjustment model. That was our criteria before January. And now, starting with the STS trial period, clinical and non-clinical STS factors should be considered for inclusion.

Again, prior to the STS trial period, we only endorse clinically-adjusted measures and they had to be stratified for STS factors.

And now, we will be accepting and endorsing measures that have both been STS-adjusted and those that have been stratified depending on the developer's analysis and rationale for doing so.

Again, both before – prior to and during the trial period, the risk strategy of the measures that are submitted will be evaluated through the validity criterion in terms of the committees that will be evaluating the measures. As I said, we're still going to be using the standing committees to do the assessment and evaluation of the measures as they come through.

In terms of the measure submission, we've always required that the developers provide some type of explanation of the clinical factors there including how they contribute to the empirical – or how they contribute empirically to the performance of the risk model.

And now, during the STS trial period, we'll also be asking for them to provide an analysis not only the clinical factors, and how they contribute to the model but the non-clinical STS factors and how they contribute to the risk model that they ultimately determine – choose to use for the measure.

So I'm going to just pause there and see if Taroon has anything to add, and if there's any questions.

Taroon Amin: I don't have anything to add Ashley.

Ashley Wilbon: OK.

Joseph Stephansky: Ashley, I have one minor question, this is Joe Stephansky again. One of the other things I noticed that it said during the trial period, displays of measure results would include both the risk adjustment only with clinical factors and then again, with the STS factors included, just kind of a transparency thing which I assume it's something the disparity committee would be looking at.

In some of the other work that we have done like (checking) the quality and cost measures, we talked about the transparency and the necessity of a continued display of the factors that went into a final value. Is there some reason why this is only going to be during the trial period? Is there a reason why after the trial period, it would only be the completely risk adjusted numbers that would go out?

Ashley Wilbon: Let me take a stab of that Taroon and then I'll let you chime in. So I think my understanding is that after the trial period and understand that we are so working out all the details of the trial period and what happens when that's done. Obviously, we're going to do some type of evaluation of how that works and whether or not this policy will continue after the two-year period.

But my understanding is that having the two measures in terms of the STS-adjusted measure and then the non-STS-adjusted measure with the stratification was an effort to accommodate the different stakeholders who have concerns about having just an STS measure out there.

And so I would anticipate that we would still continue to have the two but I will (turn) back to Taroon and see if he agrees.

Taroon Amin: Yes. I think part of it depends on the input from this STS expert panel. It will continue to, you know, that we will be feeding later this year and then just seeing the progress, you know, on this work and what it means in terms of disparities.

I think that is still TBD in terms of what's going to happen at the end of this two-year trial period, you know, obviously be in evaluation approach and we'll have to evaluate how successful we've been in terms of mitigating the concerns of various stakeholders.

So, you know, I don't want to speculate necessarily at the end of the two-year trial period. I would just point out though that, you know, the goal here is that measure developers have available data that we really try to advance this field and really being able to understand what data is available. You know, encourage measure developers to test multiple different variables as they're available, and then for us to really understand the impact of these variables on the measure (score) and make a determination empirically and conceptually whether it's appropriate to include these variables to the outcome that's being measured and – for us to go through that process.

And then also, if they are included in the measure – in the final measure score to make the unadjusted, non-STS adjusted measure specification available for the purposes of stratification to ensure that disparity's work continues to move forward.

So, you know, there's multiple objectives here. Obviously, you all understand that, you know, the data available for this type of adjustment is still at its early stages of development. So this is obviously one effort to try to start moving us toward understanding the relationship and be able to, you know, start to make sure we can, you know, make some assessments of different STS factors as it relates to these outcomes that are under evaluation.

So, you know, that's the long winded answer to I guess the short question. But I think we'll obviously see what happens during this two-year trial period and determine at the end of it what the path forward looks like.

Male: These short answer is simply stakeholders. That's good. OK. Thank you.

Ashley Wilbon: So on the next slide, just try to provide a summary of what it means for the developers in terms of what we are going to be asking for them that is different what we've asked from them before in terms of providing some examination of their – additional analysis of the conceptual relationship of the factors that they may be considering.

So some of the questions that we posed for them to think about as they go into this analysis period and trying to figure out which factors should be

considered is to determine what non-clinical STS – I'm sorry, non-clinical STS-related variables or factors have a possible conceptual relationship to resource utilization and cost. What evidence is there – of this conceptual relationship?

Again, to Taroon's point, identifying which of those variables from the (universe) of those factors that could have a conceptual relationship do they actually have access to in terms of data to do additional analysis on. And then for those variables that they have access to and they're able to include an additional empirical analysis, once they include them in the model, how important is it to the risk model. And they do their analysis, is it actually show to be contributory and predictive to the variation in the measure.

And based on those analyses, which factors of the developer ultimately decides to include in the model and the rationale for doing that. And then providing us kind of a summation of what the overall performance of the model is with those factors included.

So that is essentially what we're going to be asking for in addition to what they've already done. It will be – this kind of flow of questions will be very similar to what we'll be asking the committee to think about when they do bring the measures back for additional consideration when they've done that analysis.

Any questions there? OK. Next slide.

So again, we've been throwing around this word, conceptual and empirical analysis. So I just wanted to spend a little bit of time. And this is outlined in the – in a lot of detail in the memo as well, so I won't spend a lot of time here. But just to capture some of the questions that we have again, posed to the developers to consider as they're identifying the STS factors that they will want to consider. Determining whether or not there's prior research to indicate that there is a relationship between the sociodemographic factor and the outcome, is there a logical relationship or a theory about that relationship, whether or not there is a significant passage of time between the healthcare

unit intervention and the measured outcome that may have – that the factors may have an effect on.

Do patients actions or decision influence the outcome of the process? And are the decisions affected by sociodemographic status? And the final question is about whether or not the patient's community can have an influence on the outcome.

In terms of the empirical analysis, what we're looking for is for them to narrow down that field of sociodemographic factors that they're considering. And once they've done that conceptual analysis to figure out which ones actually make sense and to try out in their model, how does it perform in a model? So that's essentially the empirical analysis piece of what we'll be asking for on that part of the analysis. So next slide.

In terms of implementing the board of director's conditions …

Jack Needleman: Can we back up just a minute?

Ashley Wilbon: Sure.

Jack Needleman: Actually, we're on those contextual and empirical concerns.

Ashley Wilbon: Sure.

Jack Needleman: This is Jack. I just want to make sure that – there are a number of issues that I didn't see addressed there that I think are going to be important for NQF to deal with down the road. These may have been picked up by the STS committee you had organized, so I may be saying nothing that's new here.

But on the contextual – I think it's useful to think about three levels of potential STS factors. One is the individual patient STS status. The second is the STS environment of the hospital. And the third as you noted on that are the STS factors of the environment within which the patient lives – the community in which the patient lives which may have implications on – for the availability of service or unmeasured complexity of their disease or their ability to effectively treat and manage their care.

So I think it will be useful at some point to be more explicit about laying out the different levels, all the different STS context within which possible risk adjusters could be introduced into the measures.

The second thing is there are at least two critical – and there's the critical empirical question of what data is available to do these adjustments. And coupled with that, I think at some point, what we've seen in a number of the models that we've looked at as committee is people had been referencing a standardized risk adjustment model.

It may not be perfect but it's the standard risk adjustment model. They are (TSI) risk adjustment model or the work that the Yale people have done with their or the Ingenix model.

So at some point, I think there's going to be a move towards standardizing how the STS risk adjustments are introduced. What data they use, how they're – too early to do that now with all of the trial work would be moving forward with an idea of thinking about down the road sort of having one or several standardized versions of the risk adjustment that had been tested and generally acceptable so the committees are not standing there wondering how good is this risk adjustment.

And the third element I would say is on the empirical analysis is not only which factors are important but I want to know what difference having the STS risk adjusters makes in terms of the relative ranking, in terms of the score as that individuals get.

So I think we'll want a comparison of the measure with – in that risk adjustment in terms of – and that needs to be relative to the kind of use. So we're dealing with a CMS pay-for-performance system where there's this sharp edged cutoff between who gets a reward, who doesn't, who gets penalized, who doesn't where the rankings become critically important and even more important than the numbers. We want to see how the rankings change.

Ashley Wilbon: Thanks Jack. That's really helpful. We've certainly been discussing that latter point to some degree and trying to figure out how to asses that. Taroon, any thoughts on that? I'm not sure that we're ready to share exactly how …

Taroon Amin: Yes.

Ashley Wilbon: … whether or not we'll be asking for that yet but Taroon, I don't you're your (thoughts) on that.

Taroon Amin: I think – yes. Again, I think some of the – so just some initial thoughts on what the caveats of these or initial thoughts. One of the challenges that we have is that, you know, as we were talking earlier, that first of all, it's the burden that we're trying to put on developers. I mean, I think that's the first thing we need to recognize.

Many of the developers that have participated in this project and the readmissions project have exerted tremendous amount of effort up to this point. And one of the elements that the NQF board has asked is that we ensure that there's a level of balance here in terms of what we're asking for from developers and ensuring that we're not, you know, asking for a significant additional load for them in the next year. I think that's one element to consider.

The second element is one that I sort of pointed out earlier which is that the NQF endorsement process does not traditionally look at the question of specific applications. And so some of the points you bring up Jack, which is, you know, the cutoffs that – what CMS is using for cutoffs in terms of the payment program or, you know, relative ranking and how those rankings translate to performance is a little bit difficult to interpret. I mean, one would assume that any addition to – of any element into a risk adjustment model will change the ranking.

Now, it's difficult to interpret what that means of whether that's appropriate or not. And, you know, one needs to really base that decision on its empirical rationale – I mean, the conceptual rationale that underpins the decision for including these factors in the model.

So anyway, you know, I'll just sort of point out the fact that a number of us internally are, you know, debating, you know, what questions that we're really asking the developers ensuring that the burden is not too high and we're still operating within the framework of what the NQF endorsement process is intended to assess, but recognizing and balancing the stakeholder concerns around unintended consequences for specific providers.

And so all that's to be said is we're still working through that, some of these questions are within scope, some of them maybe not and we will ensure to guide the standing committees in a consistent way within the framework and rubric laid out by the expert panel on STS.

Jack Needleman: Yes. Taroon, that's perfect. That's what I really hope for. Let me just clarify. We've seen a lot of the risk adjustment stuff in the matrix that had been proposed, there's been a lot of discussion in the documentation about the R square. How good is the risk adjuster in explaining variance?

But my comment about thinking about the nature of the matrix themselves and the way in which they're used was not for us to decide this is a good use, this is a poor use. But if we know the quality measures are being used in a percentile system with percentile cutoffs various things, or the absolute scores matter, then we ought to be looking at the ways to assess the impact of STS measures on the risk adjustment is not simply how much do they add to the R square explained variance, but how do they change the score that different providers are assigned or the relative – their percentile ranking just so we can understand how big a difference or how small a difference the STS risk adjustment make a lot of the discussion at NQF including in the committee that was formed on this with the conceptual level.

Is it important to do this? Is it appropriate to do this? Do we think conceptually that the sociodemographic context of care makes a difference in the outcomes that we're measuring?

What the trial period offers is not only on these measures but more generally, is understanding how big a difference including these factors into the measures are. If it turns out to be de minimis even though they improve the R

square, then we can be a little bit more comfortable about whether or not they're in or not, if they're making a big difference, it raises the – it moves us from the conceptual argument that STS ought to be considered so it makes a difference whether it's considered. That's my only point.

Cheryl Damberg: Yes. This is Cheryl Damberg. Jack, I agree. I think at least in the 10-page document that was sent, you know, there was a discussion of the conceptual model, there was a discussion of running the risk adjustment model and seeing kind of what the model (fits) statistics were and whether the variable came up statistically significant.

But what I thought absent in that was taking it all the way through to look at what's the impact on performance scores because at least in a lot of the work that I've been doing, you know, you can get a statistically-significant effect let's say, on education. But it really doesn't change people's performance scores around. And really, that is the context in which these measures are being applied. So that's where the rubber meets the road.

Male: Right.

Taroon Amin: That's a really helpful feedback. So we will certainly take that and look at our measure testing attachment form and consider how we might be able to tease that specific question out. I know that that's come up a number of times during our deliberation around, you know, the effect on ranking on the ultimate performance score. So we will certainly take that into consideration as we think about the questions that we're asking from the developers during the trial period.

Nancy Garret: And this is Nancy Garret. And so just kind of a follow-up on those comments, I was on the STS panel and we talked about this quite a bit. We've kind of gotten to the circular issue where the data availability is poor right now. And so it's hard to actually have good empirical tests of what difference the STS variables are going to make because we don't have good data in so many cases.

And we didn't want that lack of data availability to stop us from making a strong recommendation. They – conceptually, there's a link here. We need to

start recommending that we include this, requiring that we include it and then that will inspire us all to actually collect better data.

So that was very much part of the discussion but you're right, we were really focused more on whether we should be conceptually doing this versus the how. And now, we're getting into more of the how and that's going to be difficult.

Ashley Wilbon: Thank you. Very helpful information – feedback. Any other comments before I move on to talk a little bit more about how we're planning on implementing at least the STS trial period evaluation?

OK. So essentially, as Taroon mentioned earlier, for this particular project, because these three measures have been – first of all, the portfolio measures that we reviewed over the last year, so it's much smaller than say, compared to the risk adjustment – I'm sorry, the readmissions committee. So while the fourth condition stated that they wanted the standing committee to consider whether the measure should enter their trial, because the – again, the bucket of measures is so small and these three particular measures were called out with those conditions, that we kind of made a decision to just enter the measures under the trial to have the developers bring them back within the trial period with that additional information, and that there's no need to really have a long discussion about whether or not they should be reconsidered under the trial.

I think there has been enough discussion up to this point with all the stakeholders that we felt comfortable that it is worth doing this additional analysis to see what additional information we can learn about how the measures might perform.

So with that, we will be asking the developers to submit the revised testing attachment that Taroon has referred to. And there are some additional questions to help piece out this information around the conceptual and empirical analysis for the STS factors.

We're still working with the developers to figure out what timeframe that they would be able to get back to us with that information. We are very much, you know, trying to be partners with them in this and understand that, you know,

they have contractual limitations as well and what they're able to do. We're really trying to work with them to figure out the best way to move forward and within the resources that they have to do this additional work.

So more to come on that. We don't have any specific dates or timeframe at this point but we will certainly keep you guys updated. And this information is really for when they do bring the measures back, this is what we will be – the process they will be going through.

So the standing committee will be reconvened once they resubmit hat information for an ad hoc review of the information. They will re-review the measure's validity and make endorsement recommendation. So you'll either recommend continued endorsement of the measure as specified, recommend that they endorse the measure or recommend continued endorsement with changes to the measure, whatever those may be at the time.

Based on those recommendations, we'll put the measures out for comments, the measures and the recommendations out for comments. CSAC will review it, it will go to the executive committee and then out for appeal. So it is basically a shortened version of our regular process but it essentially goes through the same steps again.

Any questions about that before I move on?

So in terms of what we'll be asking the committee for when that does come back for this ad hoc review is to evaluate the validity criterion using the additional STS analysis that is brought back by the developer. And really focusing on whether or not the developer has adequately demonstrated whether there is or is not a conceptual relationship between the risk factors and resource utilization (across).

If there is a conceptual relationship, what data do they have access to to be able to run the analysis? And if the data was available, how the developer adequately demonstrated the empirical relationship between the variables and the model and adequately describe the rationale for how they ended up with that particular model and those factors included.

And then again, kind of make an overall judgment based on the intent of the measure …

(Off-Mike)

Ashley Wilbon: … sorry, and the approach that they decided to go with the risk adjustment, is it valid?

So that's what we're looking at when the measure comes back. Any questions about that or suggestions?

Nancy Garret: Yes. This is Nancy Garret. Something I think we need to think about is the data availability question. Again, in our committee, we struggle with that a lot because there just is not good data right now. And so the question is how do we move it forward to get better data?

And so how can we encourage in this process being creative about thinking of new data sources, doing things with existing data that might help us get to the data that we need. And I'll just throw out an example of what I'm doing here at my own system at Hennepin County Medical Center.

And we're actually creating an indicator of housing instability where we have mapped all of the homeless shelters in our area. And then, if the patient in the medical records reporting general delivery mail address and the community don't necessarily have an address kind of to in their home or an address at one these shelters, we're creating an indicator (inaudible) indicator, a possible indicator of housing instability.

And now, we're doing some work to see how that's correlated with cost as well as utilization and other kinds of outcomes and how it interacts with medical risks scores.

So that's an example of an element address that was in the database and we're trying to use that to get at some of those other data. And there's also a possibility to suggest with census data, other things.

So I think we need to think about how to really encourage that creativity and recognizing again (inaudible) measure developers that take time and money obviously, but how can we encourage that to happen?

Ashley Wilbon: Thanks, Nancy. That's actually a perfect segue into the committee discussion that we wanted to tee up for today.

So I have some discussion from you guys, since we're so far upstream at this point, what factors that you would like to see the developers consider as a part of these analyses? And what we've done is listed some of those factors that were discussed in the STS report where they did an analysis. And I appended the memo with a table from the actual report that gives some pros and cons to each of these factors.

But I just wanted to have a little bit of discussion with you guys about which factors you think should be considered by the developers and you'd like see them come back with potentially at least the conceptual analysis of the factors to utilization and cost.

Any suggestions on how you think they might be – to Nancy's point, any suggestions on how you think they might be able to find or get the data to be able to do the empirical analysis?

Female: Are there developers on the call?

Ashley Wilbon: I think so. I'm not sure if they're on a – they should be on the speaker's line. Is anyone from Yale there?

Female: Hello. Can you hear me?

Female: Hi. This is (Inaudible) from CMS, and I believe all contacted Yale should be in the call.

(Nancy Kim): Hi. It's (Nancy Kim). Can you hear me?

Nancy Garrett: Yes. Yes.

Ashley Wilbon: Yes.

Nancy Garret: Hi, (Nancy). This is Nancy Garrett. I was just wondering if you could describe a bit about what data you have, so that would be a starting point for us to think about how we might get some (additional) data. So …

(Nancy Kim): We have Medicare claim data. So we have – can you hear me? Sorry if there are some feedback.

Nancy Garrett: Yes.

(Nancy Kim): We have Medicaid and dual eligible status. And we have African-American race but we really don't have things like income and homelessness. I'm looking down this list, English proficiency, insurance status, and I'm just wondering how robust income would be in a Medicare population that's already called down to a fee-for-service that we exclude Medicaid advantage folks in most of our measures.

So really, we are working with very blunt instruments.

(Off-Mike)

Male: Yes. Since you raised the issue with income specifically. I just want to point out that it's a poor measure of what's actually – what we're actually interested in here which are the assets, the resources that are available from an individual to, you know, to take care of themselves, to buy additional medical care, to buy drugs, to buy other stuff.

And for our retired population, for a Medicare population, assets are an alternative source of resources to income. And so you're actually right, the income issues are critical here but even a conceptualization of this as an income-related issue as opposed to the resource issue underscore some of the challenges with getting the STS factors right.

Nancy Garret: (Nancy), you have patient level data and I think you said you have whether they're duly eligible. So you know if they're qualifying for Medicaid, right?

(Nancy Kim): Yes. That's correct.

Nancy Garret: And you're excluding people who are in – well, you should also conceivably know whether they receive like a low-income supplement, you know, which overlaps to a large extent with dual status. But, you know, that's another Medicare indicator that says something about their resources.

And then I'm assuming you can do geocoded, sort of mapping to census data since you're going to have access to the – what is it, nine digits of code? So you can get down to the census (quac) level if you decided you wanted to bring in things like education.

(Nancy Kim): I would have to check with our analyst. That's not typically something we would – we have done in the past. So that would be very resource-intensive for us even if we did have those data available.

Nancy Garret: Yes. I know we've done here at (Rand) and we've done it with Medicare data. So, I mean, theoretically, that's possible but it and may be that you don't either have permission to use that or, you know, those data aren't available to you directly.

(Nancy Kim): We can certainly look. We can certainly check.

Nancy Garret: Any other suggestions or thought on how they should approach the conceptual analysis piece and factors to consider?

Female: Well I think the conceptual link, you know, obviously is going to be important to look other deterrents to see what we know. But again, we get into this trap where we don't necessarily know a lot because we haven't had the data.

So I wouldn't want to be (inaudible), I mean, it's great to have some qualitative research (inaudible) so that we can have more rich information on how that conceptual link might be happening and why. I don't know if that qualitative research exists or not and if there would be funding to conduct that in the (inaudible). But that's in some way is what we really to understand then what the variables are that we need to get.

(Leanne Han): Hi. This (Leanne Han) from CMS. I would like to say something about another effort going on about this (STS). I think you probably know. There's

the impact that just got passed. And actually, CMS is working very closely with (ASPI) because (ASPI) is required by the impact to conduct all the same analysis you guys are talking about and also look into the STS data issues.

And they were supposed to give CMS recommendations about how to deal with this STS factors in all measures for our payment programs and quality programs. So I just want to mention this and somehow, there's a coordination needed to be done here within (inaudible) NQF and (ASPI) and CMS about this analysis and resolve these issues.

Female: Thank you, (Leanne). So thank you everyone who's provided input so far. It's actually been very helpful.

Male: Yes. I just want to repeat something I said a few minutes ago, just the concept of thinking about different buckets to the STS variables. Right now, there's a list – sort of – and I'm normally a (lumper) but this combines the sort of the neighborhood effects from the individual effects. And I would encourage thinking about individual effects, the sociodemographic context of the provider themselves payer mix for example, and as a measure of the provider resources and then the community effect.

Those are at least three different buckets. There maybe different measures. Cheryl has already alluded to the whole issue of data and data linkage which I think remains a critical issue, we might want to learn about that over the next year.

Marry Ann Clark: Hi. This is Marry Ann Clark. Sorry, I got cut off for a minute. So I missed part of – the last part of the discussion but I was discussing the different potential data elements and ways to collect that information. I just was wondering if there was anyone who had an update on, you know, the status of some these B-Care documents and things like that that they were going – that CMS was going to implement for some of the other programs because a lot of that information that they were at one point going to collect on like, discharge status such as things like the type of care, the willing caregivers that are available to provide care after they're discharged from the hospital and the types of support systems that they have.

All of that type of information was being – going to – was proposed to be collected. So I just didn't know if anyone had an update about whether that's still going to go through and – because that would be an option for getting some of those information that would have impacted, you know, the socioeconomic status variables.

Nobody has any?

Female: Yes. I'm actually not familiar with that. That's certain – something we can look in to. I don't know if anyone from CMS has any insight on that.

(Nancy Kim): I'm sorry. What was the question? I'm sorry. I was …

(Off-Mike)

Female: In some of the other CMS programs, there was a proposed – a data collection instrument called the B-Care. It was primarily going to be used in bundled payments, you know, to collect additional information on these patients when they're admitted to the hospital. And then after they get discharged, you know, and to help them be able to manage within the episode of care better.

So things like, you know, when they go home or wherever they happen to go. If they go to a private residence or another type of post-acute care setting, what type of support system do they have available like, you know, if they have access to, you know, family caregivers that are going to be able to help them and, you know, the types of support system that they have.

So I just didn't know if – it sounds like that's not really in effect right now. But …

Female: Yes. I think I heard about this care tool. And it might be in the demo project but I am not familiar with this and I'm not sure the implementation plan and when will CMS implement – if what program and will that be nationwide? But certainly, it's an idea, you know. And I'm just not familiar with that. But …

Janis Orlowski: So this is Janis Orlowski. The B-Care tool was attempted to be used in the CMMI bundling program and it's – that effort has just stopped. And I would say that two reasons for it is that it was not data that could be easily obtained from the electronic medical records and instead, required a second sort of hand polling of data.

And I would say the second reason is that they questioned how helpful it was in understanding the efficiency that was needed in the bundled program.

So right now, B-Care is not – it was being used in the CMMI bundle payment program and it's not. And so in light of that, I would suggest a couple of things. There is some literature out right now on those factors that are more highly correlated with readmission. And I think that there's a number of papers that we can take a look at that demonstrates lack of social support as a readmission tool.

And then, I would say the second thing is anything that we look at, we're going to have to see if we can get it pulled from the electronic medical record if there's a field or something that we can poll it with at least for the inpatient stay. Otherwise, I think that it becomes a non-clinical (STS) factors become very, very difficult for us to find and to uniformly collect data.

Female: Thank you.

Female: Thanks.

Brent Asplin: Taroon, this is Brent. Excuse me, yes, I think we're in the heart of the matter here between the conceptual case for STS being important and empirical evidence. And as the board contemplated, what exactly are we going to do when the conceptual case remains strong but we don't have "the right data" because that problem is not going to be solved in two years? And, you know, I'm not sure how we get out of that box in a timely manner.

Taroon Amin: Excuse me. Brent, I mean, that's a really important point. And I think Nancy sort of pointed this out earlier in her comments about where the expert panel had thought through this question quite a bit. And I mean, essentially, the board discussion as it relates to this was – just tried to stimulate creative

thinking about what variables are available and to really start doing additional analysis to just try stimulate additional data collection and understanding about which variables would be appropriate or not.

So there's certainly a recognition that, you know, we're asking for the measurement enterprise to start pushing forward the data collection, the systematic data collection on these existing variables and then move beyond the existing variables to understand what other variables may be more appropriate for adjustment.

But again, you know, certainly that's something that we'll be analyzing as far as the two-year period to understand what data is available and what variables are available to try to stimulate where we may need additional funding or additional efforts with the community to really get this effort kind of moving forward after the two-year period.

Nancy Garrett: And this is Nancy. Also – just so people are aware, if you're not, Institute of Medicine recently released a report on the recommendations for additional data elements to be collected in the electronic medical record including socioeconomic type variables. And that report is likely to be influential in meaningful use Phase 3 and what requirements are for preservation in that.

And so those data – I think the data is going to be getting better over time. Now, that's electronic medical records, not claims data. But increasing of that is going to be a source of a lot of measurements

So is this an awkward time? I think that's a very good observation (inaudible).

Ashley Wilbon: Great. Thanks to everyone for their input. It's been really, really helpful. As I mentioned, we're still internally kind of diligently working and trying to hammer out some of these issues and very carefully think through them.

So this input is really helpful and we're going to keep you guys up to speed on where we are with things and particularly as we work with the develops over the next few months to figure tout what's the best path forward to try to meet the conditions within the limitations that there may be at this point in time.

So thanks again. And in case – unless there's any other final comments, I'm actually going to let Quintin give us a quick summary of the next step which we've talked about already a little bit and wrap up with any final questions and we'll give you about 45 minutes of your day back.

Nancy Garrett: This is Nancy. I was interested in the (ASPI) report that I think (Leanne) from CMS mentioned. That would be really helpful to see if there's any way once that public sort of get back to the committee.

(Leanne Han): Yes. I mean, you can take a look at that impact act and the analysis that they require to do. And I think their timeframe is like one or two years. (Nancy Kim), can you address that? I think it's two years. So we're working closely them right now. And, you know, one of the issues (inaudible) effort here because they are getting all our data to do analysis, try to find out the conceptualization and the empirical analysis, all the same question.

And we are by the, you know, NQF requirement, we should look into that too. So we try to figure out how to coordinate so we don't duplicate effort here.

(Nancy Kim): This is (Nancy Kim). I'm not sure of the timeline but we can certainly get that back too. NQF can e-mail Ashley and Taroon with that information. I don't have that right now.

(Leanne Han): Yes.

Ashley Wilbon: OK. I think this is the beginning stages or are they close to having ready?

(Leanne Han): Yes, they may contact with CMS and then try to layout there and we'll plan right now. And then we are providing them with the data. And, you know, we're going to have ending meeting – workgroup meeting with them to talk about the STS factors and data available, you know.

And as you know, it's a lot of time to empirically – there's a significant, policy-wise, whether this is the right thing to do. And then I heard also people talking about the important thing as whether to make difference in the hospital performance.

So these are the things that, you know, very important for our program. So I don't know what the final product would be look like. I just want to let you know, this is something we're working on.

Female: But (ASPI) is looking broader than just the hospital setting?

(Leanne Han): Oh yes.

Female: Yes.

(Leanne Han): Our measures are part of these – that the committee right now are talking about this hour outcome measure hospitals. Yes. You're right, and post acute care settings. It's more – it's larger than just hospital.

The hospital certainly is a part of the work.

Ashley Wilbon: Great. Thank you.

(Leanne Han): OK. Ashley, do you want us to forward you the impact act or you can forward it to the committee members if they want …

Ashley Wilbon: Yes. That would be great. Thank you.

Female: And I apologize. I think I missed this earlier. I know you were talking about whether you have patient address to be able to link with census data. Do you – is that something you might be able get or not?

(Nancy Kim): This is (Nancy Kim). I'm just not sure how much we have of the code and how much we've done through geocoding and things like that. I know we haven't really done that much for the CMS measures. I just have to check with our larger lab and see if there's any expertise.

(Leanne Han): Yes. I think what I would …

(Off-Mike)

(Leanne Han): Yes. You know, we certainly appreciate a lot of the input here and suggestions and we work with Ashley. It's the (scope and) analysis that we're

not clear yet. And that clearly should be a discussion also with Yale. What is the right variable to look into and how much analysis we need to do?

So we got a lot of measures here. We just want to under – to get a feeling of the scope of the work because our contact right now is not ready to do this trial analysis yet.

So I am here, just try to gather the information to have some idea what it's going to look like for CMS network.

Female: Well, I think its pioneering work. So I don't know that any of us know.

(Leanne Han): Yes. Me either. I mean, I'm sitting here OK, well, I had to look at your plan ahead. So I think that there's a lot to be determined and …

Female: Yes.

(Leanne Han): … the input here.

Female: Yes. I really appreciate this comment because I think it can become an endless fishing expedition.

(Leanne Han): Yes

Female: And I think it really has to be grounded. And, you know, is there some set of hypotheses or some kind of logic or conceptual model that suggests why some particular characteristic whether it's a provider characteristic, a patient characteristic would impact the outcome of interest here.

And so I think, maybe by virtue of reviewing some of the literature and that you can kind of narrow that hunting to places where you think there's going to sort of the likelihood of higher yield because I agree. I don't think that there's merit in sort of testing every possible relationship.

(Leanne Han): Yes. In every level too, right?

Male: Yes.

Female: Yes. I mean, I know MedPAC has been doing some work and, you know, looking at things like disability status which is an indicator you should have ready access too.

Female: Yes.

Female: But again, it's sort of like what is it that we would expect to that disability status that might affect this outcome? So I think getting clear on that. And I guess, you know, I think rather than us opining on a whole raft of things, I think maybe going that step next and then coming back this committee and saying, you know, let's kind of narrow the scope, then this is what we're looking at. I think it would be particularly useful.

Jack Needleman: Yes. This is Jack again. I just want to emphasize, you know, when we were doing our research, we can be pretty opportunistic. We reached, you know, we got access to the American Community Survey, we grabbed data from there. We do – there's a ZIP code level if that's what we've got geocoded in our data. We do it from census level, census track level and somehow we have that. We do it at the accounting level if that's the best data we have.

And I think in this particular work, one of the directions that CMS and Yale and the other four developers here ought to be pushing at is thinking about the move to standardize generally available data and what the standardization of risk adjustment here is going to look like.

So this may be – well beyond the scope of Nancy and her group at Yale but as CMS and Yale and other developers are working here, they should be cautious about doing what the Hennepin County people did which is they'll local data sources and map homeless stability because that's not a generally available data set and we don't want people necessarily constructing ad hoc risk adjusters based upon locally-available data for NQF measures.

So the concept with standardization and standardized data – standardization of the data sources, standardization of the measures I think is maybe an important element of moving this agenda forward.

Female: But I will say, Jack, that I brought that up because there may be some ways to figure out homeless shelters in the U.S. and do that in a standard way.

Female: Yes.

Jack Needleman: And so we should grab them because I think, you know, the V.A., 25 percent are there, you know seriously ill patients are homeless. And when you're talking about them taking drugs home, the providers there struggle to figure out where they're going to keep their refrigerated drugs. And that's a different care environment than the folks who are at Brigham and Women's to be blunt.

So yes, it's absolutely critical, it's important and if there are ways to do this, they can be standardized and continually used by developers. We ought to be encouraging that. But routinely used by developers ought to be one of the benchmarks for – do we have a good measure here (STS) status?

Joseph Stephansky: In the background – this is Joe Stephansky again. All of us who are doing lobbying work are starting on these topics. In other words, the Michigan, the Hospital Association, the Michigan State Medical Society, the Michigan Osteopathic Society are working together as a partnership.

They try and push for EHRs in Michigan to have places set aside for the sociodemographic variables as well as ways to get it to flow through our Michigan Health Information Exchange.

But if we're going to lobby for those things, we got to have some answers about what it is we really want. So we're going to need some answers in the short run if we're going to have better data in the longer run (in mind, please.

Nancy Garrett: This is Nancy. I'm just going to throw out a couple of other ideas as for developers to be thinking about. One is Norbert Goldfield on our STS committee brought up several times and we're to blog about actually the idea of exogenous factors.

So again, trying to be creative about how we might be able to start to measure some of these things. Are there ways to measure characteristics of a patient population that aren't necessarily embedded at the individual level data set,

and that could include characteristics for example of the hospital's patient population.

And if you think about it though, the way that these payments work with this portion is their payment for Medicare is kind of like that. It's a really rough measure of the percent of, you know, it's basically the percent of Medicaid patients the hospital serves. They get the rough measure of how much care they're doing for uninjured people even though that's not the measure.

So it's kind of interesting and exogenous. It works fairly well as a way to structure our payments to make sure that – to address some of those inequities. So that's just something to consider. Are there exogenous factors that aren't in the data that we could use?

And then another thing that Norbert brought up often was making sure that the ways in the clinical risk adjusters are accurate and – are really taking into account those sociodemographic factors.

And just as an example, in the patient population that we serve, substance abuse and mental health are huge issues that are highly correlated with sociodemographic factors. I was talking to a gastroenterologist the other day and he had seen 12 consults that morning. He said it was this over and over again, the effect of alcohol use and, you know, how it affects your health over a lifetime. And that is highly correlated with particular income strata and educational levels.

And so do we have the ways right in our risk adjustment model to account for those things? So that's another thing to think about, that's data that we have already but are we weighing them properly?

Female: Thank you. It's really interesting and helpful discussion. Any other thoughts?

Janis Orlowski: This is Janis Orlowski. I hear your conversation, I think it's very good to say, you know, what can we use that might be readily available? And I think that that's how we should act.

But what I would suggest is that we should take a look at what's, you know, we would say this is the gold standard. These are the four or five things that we would like to measure and we're not able to do it directly. And so we're doing it in this manner.

I think we can be expedient and use the information but I think that we have to document this so that as data becomes available or there's additional available – additional information through other sources or surveys, we all think that we can go back and say, oh, you know, they were using this as the a surrogate, you know, is there a way you can more closely measure X, Y or Z.

Female: I think that's a great point. I mean, if there's a strong conceptual link for some of these variables like homelessness and we don't find it empirically, it doesn't necessarily mean that the relationship isn't there. It might mean the data is not good enough or maybe we don't even have the data yet.

Ashley Wilbon: Any final thoughts? OK. I will let Quintin do a quick wrap up on next steps. And I just want to thank everyone again for a really, really helpful and informative discussion. I think like I said, we're still figuring things out and all these inputs are very helpful to kind of help us figure out and kind of hammer out the path forward.

So we really appreciate that and we will be in contact via e-mail and figure out what's the best way to use you guys and to reconvene you and at what touch point throughout the process to get your input along the way.

So more to come there and I'll let Quintin give us any final steps.

Quintin Dukes: All right. Thank you, Ashley. So next step moving forward, when you look at cost and resource Phase 3, our appeals period will be closing on January 28. We have not received an appeals as of yet but if we do, that communication will go out.

Also for cost and resource Phase 2, the board of directors will be actually going forward with the appeals decision, and bringing the bill to the board of directors on February 4th.

And furthermore, when it comes to the STS trial period, as actually stated before, this is new territory and we're actually figuring out the process and to better operationalize these requests and trying to get information back to the developer.

So we'll be looking out for communication as we get more. We'll have a follow-up call with the measure developer and also a committee webinar to review the STS analysis and that's both to be determined.

Ashley Wilbon: So that's all we have for now. And again, I just want to thank everyone for joining. If you have any thought over the next week or so about, you know, things we should be thinking about or considering as we try to form up this process going forward and having discussions with the developers, by all means, forward them to us.

We are very happy to have that and include that in our discussion. So keep your thoughts coming and we'll be in touch.

Female: OK.

Female: Thank you.

Ashley Wilbon: Thank you, everyone. Have a good afternoon.

END