NATIONAL QUALITY FORUM

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DISPARITIES STANDING COMMITTEE

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THURSDAY
JUNE 15, 2017

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The Disparities Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Marshall Chin and Ninez Ponce, Co-Chairs, presiding.

PRESENT:

MARSHALL CHIN, MD, MPH, FACP, Co-Chair
NINEZ PONCE, MPP, PhD, Co-Chair
PHILIP ALBERTI, PhD, Association of American Medical Colleges
SUSANNAH BERNHEIM, MD, MHS, Yale New Haven Health System Center for Outcomes Research and Evaluation (CORE) *
MICHELLE CABRERA, SEIU California
JUAN EMILIO CARRILLO, MD, MPH, New York-Presbyterian, Weill Cornell Medical College
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RONALD COPELAND, MD, FACS, Kaiser Permanente
TRACI FERGUSON, MD, MBA, CPE, WellCare Health Plans, Inc.
KEVIN FISCELLA, MD, University of Rochester *
NANCY GARRETT, PhD, Hennepin County Medical Center
ROMANA HASNAIN-WYNIA, PhD, Denver Health
DAVID NERENZ, PhD, Henry Ford Health System
YOLANDA OGBOLU, PhD, University of Maryland Baltimore, School of Nursing

ROBERT RAUNER, MD, MPH, FAAFP, Partnership for a Healthy Lincoln
EDUARDO SANCHEZ, MD, MPH, FAAFP, American Heart Association *
SARAH HUDSON SCHOLLE, MPH, DrPH, National Committee for Quality Assurance *
THOMAS SEQUIST, MD, MPH, Partners Healthcare System
CHRISTIE TEIGLAND, PhD, Avalere Health

NQF STAFF:

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ELISA MUNTHALI, MPH, Vice President of Quality Measurement
TARA MURPHY, MA, Project Manager
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

IGNATIUS BAU, JD, Consultant

*** present by teleconference**

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

9:03 a.m.

CO-CHAIR CHIN: Good morning. So we can get started now. And so just in terms of an overview of the agenda, so you notice at 12:30 that's where we have the item about the social risk factor adjustment discussion. And so that's fixed, because the public knows that that's happening at 12:30. And a number of people are going to be calling in for that. So we have that sort of as a fixed element of the agenda.

This morning, we have two or three main items to cover. One is that overnight the staff did work their magic. And so that we do have sort of a draft of the policy recommendations for us to go over as a committee and to spend time on. So we'll talk about that in a moment.

A second item then is, like, somewhat a deeper dive into that in terms of also then are there any practical suggestions we have in terms of implementation and any concrete examples we

can give that will help flesh out the report.

A third item that is, if we have time, we can go revisit the disparity-sensitive condition criteria, disparity-sensitive measures criteria that was raised yesterday. And hopefully we'll have some time to basically revisit that in terms of potentially improving those criteria.

And so, again, what happened after our meeting yesterday, then Erin and Drew, they took the notes that Tara had made. And then they did some initial correcting of the wording of policy recommendations.

Ninez, Ignatius, Helen, and I reviewed and edited it a little bit. And so you'll see that there are going to be two documents. One is going to be shown on the screen, which is going to be a one-pager, which is sort of the editing and final result of that in terms of the draft.

The second is a hard copy you have in front of you where Ignatius, he basically made this table where you have, like, three different

columns where one are the ASPE recommendations, and then there are the National Academy of Medicine recommendations.

And the third then are our draft NQF recommendations. And so you'll see how they compare and complement one another.

I think at the end of yesterday we mentioned that one of the first things we would do is we would revisit the five different original policy recommendations in our conceptual model.

This was the one where there's that diagram with the quality, well, the measurement and quality circle in the top part and the latter part with then what you do with the measures.

We're going to incorporate it into this discussion in that the five are either headers or else subdomains within, like, the most current draft recommendations. So we can cover that also in the course of this discussion.

But maybe first, Tara and Judy, anything you want to talk about in terms of,

like, your first crack at things. Then we'll turn it over to Ignatius to describe that file he created?

CO-CHAIR PONCE: Can we check first though on who's on the phone, who is joining us?

CO-CHAIR CHIN: Great, yes. Ninez made a comment, who's on the phone also?

MEMBER BERNHEIM: Susanna's here.

MEMBER COOPER: Lisa's on the phone.

CO-CHAIR PONCE: Good morning, Lisa.

MEMBER COOPER: Morning.

CO-CHAIR CHIN: Good morning.

MEMBER SANCHEZ: Eduardo Sanchez is on the phone.

CO-CHAIR PONCE: Hello, Eduardo.

CO-CHAIR CHIN: Great.

MEMBER BERNHEIM: Susannah's also on the phone. I'm not sure if you heard me.

CO-CHAIR CHIN: Yes, great.

CO-CHAIR PONCE: Thanks. Good morning.

CO-CHAIR CHIN: Okay. So we'll turn

it over to Erin and Drew and then to Ignatius just in terms of overview.

DR. ANDERSON: Good morning. So I'm just going to walk through the revised recommendations based on your input yesterday. Right now, we've distilled it to four main strategies.

And so the first strategy is to implement health equity measures. So this is a big bucket that includes a number of recommendations. And I'll just briefly run through it.

So the first one is investing in the collection of social risk factor data through electronic health records, surveys, et cetera.

The second is stratifying performance scores by social risk factors to proactively include equity in payment programs and quality improvement.

The third is to include the five equity domains that the committee came up with. So that's the culture of equity, structure,

access, quality, and collaboration and partnerships.

The next is to prioritize outcome measures over process and structure measures; implement health equity measures into existing programs, aligning health equity measures across payers, so this one of the recommendations that were previously there; and then to reduce the use of measures that don't promote health equity to reduce measurement burden. And then we'll make sure we clean up some of this language, too.

So the second strategy is to incentivize health equity through payment reforms. So this includes all of the payment discussion that we had yesterday.

So the first is investing in preventative care and primary care for individuals with social risk factors.

Directly adjusting payment for organizations serving individuals with social risk factors, so that's one of the NAM --- lines up with one of the NAM recommendations.

The third here is a larger bucket which is to redesign payment models to support health equities so it includes some of the recommendations for mixed model payment programs, advanced payments, equity bonuses, pay-for-performance for equity.

The next one is looking at linking health equity measures to accreditation programs, then supporting outpatient services and enabling services with additional payments.

The third strategy is supporting organizations that disproportionately serve individuals with social risk factors. So this was considering comparing organizations to peer organizations, so peer comparisons, ensuring safety net organizations have fair playing fields in the value-based purchasing programs, and then considering additional payment for organizational factors that are not under the control of safety net organizations, providing coaching and quality improvement disparities education. And this is related to building equity into the quality

improvement process.

The next is prospectively monitoring the financial impact of value-based purchasing on organizations caring for individuals with social risk factors.

And then, lastly, the last one here is ensuring safety net providers are included in incentive programs. So this goes back to that conversation about certain organizations or like a safety net not being included in an accountable care organization. So the example here we have is also rural health or rural hospitals.

The last strategy is developing and implementing a research agenda for achieving equity through the use of equity measures and payment and quality improvement. So this goes back to the conversations that we had about evidence and developing an evidence base for a lot of the concepts that the committee has come up with from the beginning of this project, really, to support these recommendations.

So building that out, it's funding

your demonstration projects, conducting policy simulations to demonstrate how community interventions mediate drivers of disparities, assessing the economic impact of disparities from multiple perspectives. We talked about looking at the impact of quality of life rather than just monetary units.

And then, lastly, we have rewarding health plans and providers who invest in data systems that capture the linkages within its services and across social services.

So what we wanted to do was kind of walk through, get your initial reaction to the recommendations and then walk through different parts of it to build out some more examples and kind of flesh out what the committee really means by each one of these strategies.

CO-CHAIR CHIN: Wonder if, before we do that dive, if it would be helpful to have Ignatius do the overview of the other document, too. Then we'll dive into it.

MR. BAU: So what you have is sort of

a crosswalk. The first column is the NAM recommendations, obviously limited to Medicare, which was the charge. And then second, the middle column are the recommendations from the ASPE report, also limited to Medicare. And so it will use the word beneficiaries rather than patients or individuals.

And then I tried reorganizing the list -- I missed one in the editing process -- into where the parallel recommendations are similar recommendations to NAM or ASPE, where it doesn't show on the printout. But what the shaded points are are the original five strategies that were in the original framework. And so again, I'm not prioritizing; I'm just putting them into those relative buckets.

And so generally the first strategy that Drew just walked through, the measurement and the inclusion of the equity measures, generally fit into Strategy 1 for ASPE.

And then the second strategy that Drew walked through that the committee came up with

yesterday around incentivizing through payment reform generally crosswalks to Strategy 3 for ASPE.

And then the third strategy that the committee came up with focused on safety net organizations crosswalks to Strategy 3, Consideration 2.

And then the final strategy that the committee came up with, Strategy 4 around the research, crosswalks to the ASPE Strategy 3, Consideration 3.

So there is a lot of synergy. Again, one of the things folks might want to consider, there were no strategies that ASPE proposed that the committee didn't touch on in one way or the other. And so at least there's that consistency.

MEMBER BERNHEIM: I don't think that people on the phone have access to that document. Could it be emailed to us?

MS. JUNG: Hi, this is Madison. Yes, I'm drafting an email right now to send out to you all.

CO-CHAIR CHIN: Good point. So thanks, Ignatius, Tara, and Drew. So before we dive into this in more detail, maybe go slide by slide, but do people have any initial just over-arching sort of impressions on is this generally on the right track or off base or whatnot? So Romana has her hand up first.

MEMBER HASNAIN-WYNIA: I actually have a question. So yesterday when we ended with looking at the five topics for the roadmap and discussed not really diving into some of those topics, is this the kind of revised version of the roadmap then? Is this the roadmap, the strategies? I'm just trying to frame this so I understand where we are. Or are these components of the roadmap?

MS. O'ROURKE: Sure. So we took the five strategies and revised them based on your feedback and then tried to work them into some of the other parts of the conversation. So I think the vision would be that those five high-level strategies could go into the roadmap diagram.

And then in the report, we include all these details about the substrategies and considerations.

CO-CHAIR CHIN: So for example, if you have the old diagram, again, the one that had the circle at the top and at the bottom, and originally there were five things at the bottom there, those five would be replaced by --- I think that there were four major headers we'll march through. All the five are actually somewhere in here. Some of them are now, like, subheaders as opposed to main headers.

MEMBER HASNAIN-WYNIA: So these are not replacements. These are just kind of drilling down on those ---

CO-CHAIR CHIN: It's both a drill down as well as a recategorization.

MEMBER HASNAIN-WYNIA: Okay.

CO-CHAIR CHIN: Bob?

MEMBER RAUNER: I had kind of a comment and question. Actually, I really like where a lot of this is going. And I have a

question. And maybe it's for -- Christie will maybe be able to answer this.

It's that I like the fact that we're pulling out of EHR data. Because if you're uninsured or have a high-churn environments, your stuff isn't in claims data. So by pulling it out EHR's, where there's more continuity, that's sometimes a better source actually than claims data.

And Christie, are there other --- when you do your research, is it almost always on claims data, or do you have a --- what other sources do you use?

MEMBER TEIGLAND: Yes. We've basically used that Axiom data that we are able to match to every member in the claims database at the nine-digit ZIP Code level.

We are able to pull in just some minimal information from the CMS MMR files, monthly reports, monthly member reports. But that's really just dual status and low-income subsidy status which are available elsewhere.

So yes, the EHRs really do not have this information for the most part. We have access to lots of EHR data. We have relationships with the five big ones, and it's just not there. It's not populated in our experience.

CO-CHAIR CHIN: So we'll do Emilio, Philip, Michelle, and Nancy, and then we'll cycle through the phone folks.

MEMBER CARILLO: Yesterday we, at different times and from different angles, we talked about the importance of promoting the collaborations' and partnerships' collective impact. You know, the healthcare sector has their core priorities in healthcare and clinical work, social agencies, legal aid agencies, et cetera, how they could all, kind of, work together.

And to what extent can we strategize or recommend that, to the extent that Medicare is involved in the payment of some of these other social agencies, that there be an effort to try

to promote these partnerships, to create links.

Like, we know how difficult it is with dual eligibles and trying to get Medicaid and Medicare to kind of get their act together in terms of how the payment structures are done so that there's one set of services for the patient. So if we can kind of find a way to recommend that payment structures promote collaboration among different types of agencies.

CO-CHAIR CHIN: So maybe we can brainstorm a little bit about some of the wording, Emilio. Like there's some of it's in here, but more generally. So for example, under strategy -- I'm not looking at the written document -- so under, oh, it's this bucket that's on the second page that talks about redesigning payment models to support health equity. There's one that talks about upfront payment to fund infrastructure for achieving equity and addressing social determinants of health.

CO-CHAIR PONCE: There's also the, reward health plans providers who invest in data

systems that capture linkages.

MEMBER CARILLO: It's all there.

CO-CHAIR PONCE: Yes.

MEMBER CARILLO: But in terms of the intent ---

CO-CHAIR CHIN: Right.

MEMBER CARILLO: In terms of --- because the intent gets lost. This is all very true and germane. But to just ---

CO-CHAIR PONCE: So have it as a second, maybe have it as a separate --

MEMBER CARILLO: -- trying to promote collaboration, integration, partnerships through payment redesign, as you have spelled out here.

CO-CHAIR CHIN: So maybe it's a subbullet or --- so that we have, again, still very generally, addressing the social determinants of health. But maybe one of the subbullets is to dive deeper specifically trying to encourage those partnerships and collaborations.

Okay, good. So Philip, Michelle,

Nancy, then we'll cycle through the phone.

MEMBER ALBERTI: Great. Just one comment on the conversation that Bob and Christie had. So we talk a lot in this document about social risk factors. And the things that we call out, EHR surveys, are really only going to be able to capture patient-level social risk factors.

And I think when we talk this afternoon, we'll all discuss the absence of community- or neighborhood-level social risk factors. So I would also urge us to call out partnerships or working with public health departments to capture neighborhood-level social risk factor data as well. Because I think that's really crucial.

And then the only other really small point, when we're talking about the accreditation programs, I think I'm going to beat Nancy's drum a little bit. It's very specific to health equity measures in accreditation programs. I think it needs to be broader than that. I think

it's health equity or quality improvement-related equity activities into accreditation, because that's what they're really focused on.

CO-CHAIR CHIN: Thanks, Philip. One issue that we haven't really talked about in detail in the committee is this issue of the patient-level versus community-level risk adjustment.

I mean, right now in the current draft, we kind of waffle here in this last one, because we know we're having the afternoon discussion. But we may need to revisit that. I'd like to put it upon the afternoon discussion, what do we say specifically about patient-level and community-level. Okay. So Michelle ---

MEMBER TEIGLAND: One comment.

CO-CHAIR CHIN: Go ahead, Christie.

MEMBER TEIGLAND: I just wanted to say that you could easily take the Axiom data which is, you know disaggregated to the nine-digit ZIP Code level and aggregate it up, even to the ACS block level, right. So you could get whatever

circle of community you wanted by picking the right configuration of nine-digit ZIP Codes.

So we have a tiny neighborhood, average of five households. You could have bigger neighborhoods, and you draw them differently for different purposes. But it's doable, very doable with the kind of data, with that granular level of data.

CO-CHAIR CHIN: Thanks, Christie. So we have Michelle, then Nancy, then the phone.

MEMBER CABRERA: Okay, so just confirming, we are talking about the trial period this afternoon, right? And I have, on my brain, that report. And I do want to flag one thing. And it's kind of got one foot in right now and one foot in the later conversation.

But the fact that we are not allowing for race as an adjustment factor, one concern I have is that we're putting out sort of this call to collect better data. But in order for data to be collected, we have to have a purpose for it.

And if the purpose is sort of more

policy-oriented, like, let's have a conversation about this versus actionable, we're going to actually do something with it, I think that there's going to be less of an impetus for people to focus on collection of race/ethnicity data in their systems, again, if it lacks a purpose.

And so I think it's important for us to connect the collection of race/ethnicity data to some action and need. And so I'm just throwing that out there as a question and a concern.

DR. BURSTIN: And thank you for bringing that up. Because I think it's, based on so much of the discussion yesterday, discussing racism, et cetera, there are real reasons to look at race/ethnicity language, et cetera.

I think the point of the Disparities Committee, that we have woven into the evaluation report for this afternoon, is it shouldn't be used as a proxy for social risk. We're not saying you shouldn't look at it, but don't use it as a proxy.

I think we just need to be more clear. Because you're right, this really just keeps saying social risk. And it doesn't really discuss a lot of the rich discussion yesterday about the importance of race and ethnicity.

CO-CHAIR CHIN: And what we may be able to do, help alleviate the concern also is that, like, we have one of the recommendations about stratifying performance data by social risk factors. One of the examples that's been used in the report is race, ethnicity, the inappropriate stratification purpose for that quality improvement purpose as opposed the social risk factor adjustment being a proxy. So good point, okay. So we have Nancy and then the phone.

MEMBER GARRETT: So could you put the recommendation up about the research again, further research?

CO-CHAIR CHIN: And maybe we'll march through each of the different ones in more detail. We'll march through if we need more detail.

MEMBER GARRETT: Okay, thank you. So I'm not a big fan of this one. And I think my reaction is that saying further research is needed feels like not the action of this committee, really, that we want this committee to be taking.

I feel like the discussion yesterday, we were talking about the need for demonstration projects. And we need to just try some things and see what works.

But research in the connotation of kind of the policy world often means randomized control trials. And we're not going to have that kind of gold standard for a lot of this work. It's going to be observational; it's going to be trying some things, tweaking, fast tests of change.

It's really not research in that traditional sense that I think we need next. And so it just makes me nervous to have this as a recommendation. It doesn't feel actionable enough.

CO-CHAIR CHIN: Maybe as we're going to the next commenters, any discussion about that, like, Nancy's point, that's an important point to sort of figure out. Ninez?

CO-CHAIR PONCE: Sorry just ---

MEMBER COOPER: Well, this is Lisa on the phone. And whenever you guys can get to me, I'd like ---

CO-CHAIR PONCE: I want to, Lisa, this is Ninez. I'm going to just comment on Nancy's. And then we'll get to you next. Is that okay? I think this was, the elements under this research tried to think out of the RCT trial. Because that's what was raised yesterday.

And I just want to clarify, the policy simulations which I suggested was actually kind of to work with ASPE, who's doing some policy simulations for Study B.

So that's --- not that we're going to do it, but that we think of innovative ways of getting at these, for example, collaboration and community engagement that doesn't necessarily

populate the data sets or systematic reviews of whether it works or not. So I think this is an appeal to thinking out of the box.

MEMBER GARRETT: I wonder if there's just a different word other than research agenda that we could use for the title of it? Maybe it's Tests of Change or ---

(Simultaneous speaking.)

MEMBER GARRETT: Yes.

CO-CHAIR CHIN: How about if you put -- basically substitute demonstration in for research. And then maybe the bullets will be the same, but the strategy is basically demo projects which would include things like policy simulations, economic impacts, and whatnot.

So I see nodding. Let's go to Lisa and then Romana on this particular topic. Lisa first.

MEMBER COOPER: Okay. So I actually want to push back a little bit on not using research. I think that maybe the recommendation isn't so much that health systems or payers do do

the research, do research research.

But I do think it's important to encourage collaboration with researchers so that these demonstration projects are done in a rigorous way, so that we actually get the answers we need about whether or not these efforts are effective.

And I don't think it's --- I think it's a problem that we continue to have research be a bad word when we're talking to people who are systems change people and policymakers. I think that we should encourage partnerships with researchers and rigorous methodology in testing out these different approaches.

So actually, I don't know whether research agenda should be the term, but I think it's okay to have research in there and to actually be explicit about encouraging partnerships with health equity researchers who can help to inform the evaluation of these projects.

CO-CHAIR CHIN: So another possibility

would be to have demonstration and research in the title. So development, demonstration projects, and research for achieving health equity, et cetera. Romana?

MEMBER HASNAIN-WYNIA: So I'm kind of in between Lisa and Nancy on this one, honestly. So I completely understand Nancy's point. And I do think we, again, need to think about the audience. But I also don't want to shy away from research.

So I'm actually wondering whether we should just say something along the lines of: develop and implement demonstration programs with rigorous evaluations of those programs, partnering with researchers.

Because I do think, again, who is the audience? And there is this kind of, oh, if it's research, then it's very diffuse, and we get back into thinking about randomized control trials.

And I just think there might be a little bit of a, almost a knee-jerk, negative reaction to it from the end audience. I'm a researcher. I

don't like that. But I think it's true.

So I'm wondering if we could just tailor it a little bit to say, demonstration, rigorous evaluation, partnering with researchers. There are demonstrations that just don't get evaluated.

CO-CHAIR CHIN: So what I'm hearing --

MEMBER CARILLO: Can I chime in on that really quickly?

CO-CHAIR CHIN: Yes.

MEMBER CARILLO: The NIMHD has that mission and goal on purpose. That's what they do, you know, try to bring the two worlds together. So, you know, we might make some mention of that, given that that's a body that's trying to do that, to bring research into disparities in minority health.

CO-CHAIR CHIN: I think I'm hearing general consensus that people want to have the ideas of demonstration, evaluation, and research in it. People are attuned to some insensitivity regarding language and that -- maybe we won't

wordsmith here. Maybe staff gets first crack, but like, language that encompasses everything in a way that is most appealing to some of the target audience. Is that the general --- okay. Do you want to say something, Ninez?

CO-CHAIR PONCE: I think that's fine. I just think that if demonstration projects is the top line, then kind of the innovative, quasi-experimental, simulation approach, the use of Axiom data, then I think I don't want that to get lost.

Because also there's -- I think all of us around the room know of really innovative projects going on right now that aren't under the umbrella of a demonstration project but then could, with good partnerships with researchers who understand the context, could come up with something faster.

Because the other thing, too, with demonstration projects is I think it's going to take some time. So that's just --- I hope that doesn't get lost in the top header. Romana has a

rejoinder and --

CO-CHAIR CHIN: Okay. Well, I still have Tom ---

CO-CHAIR PONCE: And Tom.

CO-CHAIR CHIN: -- Tom and Romana on this topic. Tom? Okay, Romana?

(Laughter.)

MEMBER HASNAIN-WYNIA: So I guess my question, based on Ninez's point, is are we, with this strategy, are we trying to set something for the future, or are we trying to be real time, current?

Because I was reading this strategy as something akin to developing, and Ignatius wrote down the evidence base for what we're proposing.

So I guess, you know, I guess there's --- I have a little bit of a disconnect in terms of is this strategy forward, or is it what's happening now? Or are we trying to gather information from what's already happened that may be innovative, community-based interventions, et cetera? That might ---

CO-CHAIR CHIN: It's probably all of the above.

MEMBER HASNAIN-WYNIA: Yes.

CO-CHAIR CHIN: That they're going to want to have something, also just sooner rather than later. And some of it's going to be more fundamental.

MEMBER HASNAIN-WYNIA: Well, this reads as future.

CO-CHAIR CHIN: Yes.

MEMBER HASNAIN-WYNIA: So I'm just ---

CO-CHAIR CHIN: Okay, okay. Helen, phone, Tom, Christie.

DR. BURSTIN: I was being so, so patient. I think what was tripping me up I think is this term research agenda. And I think, having been at AHRQ for a long time, research agenda sounds very passive. And I think that's part of what we're hearing in this room.

And I agree with everybody who's spoken, to be perfectly honest. I think at the end of the day, we want to be able to have real

generation of real-time evidence, implementation research to drive and push this forward, not to develop another research agenda.

So maybe some of this is just to maybe really just make that first --- that strategy more action-oriented, and drop the word agenda. Because that just sounds very AHRQ-y passive to me.

CO-CHAIR CHIN: So where we'll leave this is that we'll leave it in the hands of the capable staff to come up with first crack with this. And then maybe by email, we can do, like, the wordsmithing by email once staff has its first crack at it. I'm confident that you'll come up with a very close next draft. Yes.

MEMBER COOPER: Do you think implementation and dissemination research still has a negative connotation?

DR. BURSTIN: No, that's better.

CO-CHAIR CHIN: And maybe, Ninez, if you could email staff then, for the bullet about policy simulations, some wording that you think

would work well.

Okay, we said the phone folks. Then we'll circle back to Tom and Christie. So anyone on phone want to make a general comment? We're going to march through each slide in more detail, but this is like the overall impressions, overarching thoughts.

MEMBER BERNHEIM: This is Susannah. I have two quick comments. One is we refer a lot in here to health equity measures. And I just want to, on the definitional front, I think we mean sort of anything that falls in the five categories that we created.

But we talked a fair amount yesterday about whether some of those should be prioritized, whether groups should have to cover all categories, whether some are -- precede others.

So I just want to not have lost some of that conversation. I don't think we came to any consensus, but to just sort of lump them as one thing, we should just be really clear what we

mean by health equity measures and if there's any other guidance besides to use them. So that's one. And maybe we can talk through that when we talk about slide 1.

And then the other thing for me is I just --- I worry in all of this work about us ever being in a place where we are promoting things that essentially create a sort of tiered system of healthcare.

So I want us to be cautious about language that suggests that safety net hospitals always need sort of a handicap. There are lots of measures and lots of situations in which safety net hospitals perform as well or better than other hospitals. So I want to just, in those places where we're sort of saying, like, oh, let's make the comparison more fair, I'd like us to add language that says sort of based on a circumstance, or a particular measure, or a context, right.

Because that's going to be appropriate in some cases, but if what comes out of this

committee is sort of a deepening of the good, rich people's hospitals and the bad poor people's hospitals, we're really doing ourselves a disservice. I just want to express a note of caution for things that might lead us in that direction.

CO-CHAIR CHIN: So I take it, like, the second point is more, almost like language in framing, so not disagreeing with the idea that a safety net may need special consideration in certain times. So it's more sort of a language/style issue.

And your first point about, like, the five domains, I think you're right. It wasn't total consensus, or we haven't explored it in enough detail. And when we go to the first slide, we'll talk about that in more detail.

MEMBER BERNHEIM: Thanks.

CO-CHAIR CHIN: Others on the phone besides Susannah?

MEMBER SCHOLLE: Good morning, it's Sarah. And I'm sorry, I joined a little bit

late. It's early. Which slides are you referring to right now? Is it slide 67?

CO-CHAIR CHIN: Right now, we're looking at everything as a whole, just like general questions about everything as a whole. We're eventually going to march through each of the different four domains and go over each point in more detail.

MEMBER SCHOLLE: Okay.

MS. JUNG: I believe it's slide 69.

CO-CHAIR CHIN: Anyone else on the phone before we go to Tom?

MEMBER SANCHEZ: Yes, this is Eduardo. I just want to underscore the discussion about the comment made about not characterizing one set of the system or one part of the system as always being the part of the system that needs help.

One good example is immunization rates. And federally qualified health centers are as good or better than they are in the private sector. And there's a couple of other examples.

And I would bet, that if we looked at

cultural competency as a measure, we'd also find it's a little bit stronger in the safety net hospitals. It certainly has been my experience.

And then the whole conversation that's been had about "research" and the words that we need to use, I think it's really, really important that we talk about all the elements that have been discussed.

So I also, like Helen, agree with everything that everyone has said. That's kind of easy to do. And the challenge is going to be finding the words that convey the importance of rigor around evaluation that adds to evidence base. And that's it. Thanks.

CO-CHAIR CHIN: Thanks, Eduardo. Anyone else on the phone?

(No audible response.)

CO-CHAIR CHIN: Okay. So we have Tom, Michelle, Romana.

MEMBER SEQUIST: So I wanted to go back to the --- this has nothing to do with research, the research discussion --- just the

discussion of individual-level and community-level risk factors. I think that --- so as I, I mean, it depends on if our --- it depends on the use of the measure. It sort of gets to, like, is it a useful measure to say you are a Medicare expansion state or not? Not if you're a hospital. It's not that useful. Because you --- unless you're going to pick up your hospital.

So community --- as I have been envisioning, as we've been talking about community-level risk factors, they are still an exposure for an individual patient.

So if I say I used geocoded data or other sources of data to identify food deserts or lack of availability of pharmacies, walkable sidewalks, anything that sort of predicts that, you still apply it to a patient and say --- so going back to, like, the electronic health record discussion and how we can collect and store that information, I think you still want to store that for a patient.

Like you want to know if your patient

does live in a neighborhood where there are not grocery stores, where there are not safe venues for exercise or where -- whatever the thing is that we are measuring, so that's sort of an individual use of a community risk, sort of a built environment factor for that patient.

That's different, I guess, than --- not I guess, but that's different than a community-level assessment that you might apply, that health plans might use, that big hospital systems might use, that public health officials might use.

So there are --- I don't want us to feel like community-level risk is not an individual --- it should not be sort of available and recorded for individual patients. Because it should be part of the care plan that we're delivering for patients.

And so it should be -- we should still push on the EHR vendors and others to help us store that information, even though it's not a factor about that patient or that that patient

created. It is something they are experiencing.

CO-CHAIR CHIN: The whole value really of showing that, independent of individual patient effects, there are neighborhood-level or geographic-level factors that impact the outcome of a given patient. Yes?

MEMBER SEQUIST: Right. And we still, importantly, want to record that for that patient.

CO-CHAIR CHIN: Yes. So we'll come back to that maybe when we do the risk factor discussion, in terms of what this then translates to in terms of recommendations and all. Yes. So it was, what, Michelle, Romana, then Philip. Yes?

MEMBER CABRERA: I just want to comment on the safety net provider conversation earlier. And I think this shows up actually in the NAM and ASPE reports in talking about low-quality safety net providers.

I think there's a real difference between how you score on a certain test and

whether or not you're actually delivering quality of care. And I don't think we actually know enough yet to be able to draw that conclusion. I haven't said anything about it yet.

But this baked-in assumption that -- and Bob and I were having this conversation about safety net clinics, if you don't have the data system or the staffing to appropriately collect the data, you might just be sending whatever you have. And then that gets interpreted as, wow, you suck on quality, right.

And I know this is true for some of our county-based public hospitals in California as well. They're in the process of trying to update their data collection systems. But purchasing some of these systems is really expensive. And they don't have the extra money to buy the system to collect the data to show whether or not they're on par or not with their competitors, right.

And so in California, for example, we have no certificate of need, zero. It's all

market-based where you cite a facility or not. I know a lot of other states still have certificate of need. I don't know how that works in those states.

But all I'm saying is that, if you're interested in having healthcare resources that are located in and around communities that --- vulnerable communities, and you're operating in a completely market-based system, what happens to those providers who are still left in those communities matters.

Because otherwise, just like their ability to pay for rent, their ability to access healthcare services is just going to go somewhere else. And it's just going to be another barrier to care.

So I think that, in saying they are low quality, they're low quality based on the scores that we have. We do have an interest, in the equity conversation, in ensuring that those resources are there/available. Yes, high quality, but there's a distinction between how

you're scoring, how things are impacting you, and whether or not you're good quality.

You know, I do think that it's an important goal. I'd like to maintain it. Maybe we can massage the language to make sure that we're clear again in underscoring. We don't want to give a people a pass, but at the same time, we do want to figure out a way to support the safety net.

CO-CHAIR CHIN: So that whole topic is another one where we'll have to be very careful with the wording. Because there's a lot of nuance. There's important nuance in the discussion. And so we'll need to flag that as an area that may need some special attention.

So in terms of, like, general comments, we'll finish with, like, we have what, Romana, Philip, Emilio, Bob. And then we'll march through, like, the slides starting at slide 1 for Strategy 1 for more details. Go ahead, Bob.

MEMBER RAUNER: It's actually, it's

crazy for me to look at this and realize it's exactly what we're trying to do with our FQHC project in Nebraska right now. So we have a quality improvement project, seven FQHCs.

Most of them have bad data, honestly. And that's what they're reporting to HRSA. So if you go to the HRSA website and look at all these FQHCs, most of that's really bad data. And the prevalent challenge we find, and what I really like about this report is one of the problems they have is they don't have a good quality person.

And of the seven FQHCs we're working with, five have had turnover of key staff in just six months. And that turnover is partly because they don't have an infrastructural payment to support that person. And it keeps turning over, the kind of the grant to grant thing.

And so I really like the fact that there's writing or explicit that they need upfront payment for that infrastructure to actually get good data out of the FQHCs.

And since we have funding, so we're actually working with our state department of HHS to change the way they've structured their grant in the past to address those actual issues. And it's amazing to me this actually just parallels what that's coming up with.

And the other thing is the long term. It's a five-year grant now because of what happens with the FQHCs. They get the quality improvement next year, and then they get another one next year, another next year, and they've got 12 different things running at the same time with no general plan to it.

And this, I think, really helps inform that issue with the FQHCs in collecting the data and maintaining the staff to do that. Because a lot of them just don't have that. Like, say Henry Ford Health Center has that staff in place. But a lot of FQHCs just don't have the funding for this kind of thing. But they really need it. So I really like where this is going, partly because of that.

CO-CHAIR CHIN: Thanks, Bob. So we have Romana, Philip, Emilio, then we'll go to slide 1. So Philip, then Emilio.

MEMBER ALBERTI: Just a quick comment about Tom's comment. And of course, you're right in terms of individuals live in neighborhoods. Those characteristics are appended to them in some way in this multi-level model.

But so just a couple of experiences from New York City. The meaningfulness of geography doesn't always fit with a five or a nine-digit ZIP Code. So I think, you know, public health departments actually play a real role in doing that kind of community engagement to understand where boundaries tend to be. I don't see that as the role of a hospital or a health system to kind of do that geocoding.

So if we assume that we can get a good address in an EHR and have the linkages that you can then make to public health data sets alleviate some of the data collection burden for the health system, which I think is also

something that you raised yesterday in terms of we're going to ask more work to do this, where can we actually alleviate some of that burden?

So thinking about that kind of partnership then also speaks to, I think, what you and Emilio were getting at in terms of really formalizing the kinds of collaborations and partnerships necessary to do this work both in a data identification way across individual characteristics, hospital characteristics, community characteristics, but then also the interventions that you develop to address those kinds of SDS differences within communities.

So I think there's a lot of benefit for calling out the role of public health agencies and other government agencies and kind of identifying meaningful geographies where we can append individuals.

MEMBER SEQUIST: It's Tom. I don't know if this comes through in any of the stuff we're doing, but maybe we need to sort of call out, like, the audience that we're -- that the

measures that we're talking about when we make specific statements?

Because everything you're saying is totally right. And so, like, as we're thinking about these measures or these recommendations, are we talking about state public health departments? Are we talking about hospitals, or are we talking about payers?

Because, and I know you could probably say that for every quality measure, like, regardless. But just because we're getting to this social risk factor space, it's even more clear.

Or there are even, I think, bigger implications around who is the audience that we're directing these particular recommendations at, just so that we're --- because this conversation has been great in sort of sorting out when we say community risk factors are we talking about patients experience of them? Or are we talking about public health departments and how they should be enabling the measurement

of them?

So I don't think we do much of that in our documents right now. But maybe that's, because we're talking about social risk factors, we need to be doing more of that?

CO-CHAIR CHIN: Yes, it's a great point, Tom. We were brainstorming with staff at the end of it yesterday a little bit about this, that we're not sure what the right way is going to be with this yet.

For example, is there like a document similar to what's in front of us right now which were, like, the global recommendations or the amendments that, like, for each one, to say who's the perspective. Or do you have, like, different versions of these recommendations, one for payers, one for providers, one for the government, or who knows.

But, yes, I think the general point, there needs to be clarity somehow, whether it's in the format or in the text or whatnot, so you know what's applying to what or who's --- the

attendant thing needs to come through.

So Emilio, then we're going to go slide 1.

MEMBER CARILLO: Yes. Again, staying on topic with the community-based measures, neighborhood measures. We have the PQIs, the prevention quality indicators.

AHRQ measure, which, you know, endorsed by NQF, discussed a lot in other committees of the NQF. And the problem is that these prevention quality indicators, which are widely used by state departments and researchers and everybody else, they basically address the geography in terms of the outcomes.

And everybody says, well, wait a minute, what about the SES social determinants in those geographies that the PQI is measuring?

So I think that, in terms of tying things together, I mean, we may want to be thinking in terms of some of those existing measures, how we can tie this in, understanding that the PQI, the number of people that are

involved on the geography is -- that's too broad. But nevertheless, how we can begin to make some of these things connect.

CO-CHAIR CHIN: Yes. It's coming up again and again, the patient level, community level. So maybe when we do get to the specific slides, we can sort of, where appropriate, sort of try to drill down a little bit in terms of this.

So let's go to slide 1. And Sarah is first in line. So we'll, for people on the phone, we're going back to, and we're going to march through each of the different recommendations.

So slide 1 was the Strategy 1, implement health equity measures, where the first bullet is: invest in the collection of social risk factor data. So we're going to look at this slide, so people can comment on whatever they want to on the slide, or ways to improve it, and whatnot. But, Sarah, you have first crack.

MEMBER SCHOLLE: Okay. My comment was

on a different slide, so I'll hold off.

CO-CHAIR CHIN: Okay, Michelle and Bob, just from the past few, yes.

(Off the record comments.)

CO-CHAIR CHIN: Philip.

MEMBER ALBERTI: It's a question, maybe a proposition. And I think this gets back to something that Susannah mentioned earlier. We have all this health equity measure. We have health equity measures and then kind of health disparities measures. And they're not the same thing.

So I think we just need to be really explicit when we're saying, if we're stratifying performance scores, is that an equity measure or a disparities measure? I think being just very clear about those two terms is crucial.

CO-CHAIR CHIN: And so this is, maybe it's in the text, and it's a point that Susannah raised yesterday also. Right now, in the current document or the conceptualization, what you're calling a disparity measure, so a general measure

stratified by a social risk factor, that's under the quality/equity domain. But again, we can clear it based on the language.

That may be a place to start, because this is where we had discussed -- so that third bullet about include five equity domains: the culture, structure, access, quality, and partnerships, so people like that general framework.

Remember yesterday we had this discussion about the five and what can we use for accountability and what can we use for quality improvement and whatnot. I think it was Sarah who mentioned, the way she worded what's on the slide here, access and quality are in some ways the end goals. Culture, structure, and partnerships are means to the goals.

That's about as far as we got in terms of, like, well, accountability measure or a measure for quality improvement.

And so, do people have any suggestions on ways to make this clearer? Or do we want to

be more specific, or is this the level of specificity which we feel comfortable with? Michelle?

MEMBER CABRERA: I do think the one thing that's missing, if we break it out by the goals and then the means, is something on data or transparency in the means to the end, right.

CO-CHAIR CHIN: And we can make sure that it's in there. But I think it's in the structure domain that there's a sequence that ranges from collecting the data to then having the quality improvement process to look at the disparities in the root cause analysis and then the reporting and transparency. That was intended to be there, so we can go back and make sure, but that would be ---

MEMBER CABRERA: Yes. You're right.

CO-CHAIR CHIN: Yes.

MEMBER CABRERA: Yes, okay.

CO-CHAIR CHIN: Ninez?

CO-CHAIR PONCE: Just a point of clarification from the group, what aligning

health equity measures across peers means, what does align mean?

CO-CHAIR CHIN: So we'll get to that in a moment. But if we can drill down first on this third bullet, this one about, like -- it's come up, and we haven't really sort of resolved this.

There were questions, for example, like, well, you'd use them as a whole, all five, or can you look at a subset of ones? Are the ones that you use for accountability are the ones that you use for purely a quality improvement purpose? A general discussion, but I don't know if we came up with any sort of consensus. So this was as far as the thought we had in terms of where there was agreement.

MEMBER HASNAIN-WYNIA: Marshall, what was your question? Can you clarify your question?

CO-CHAIR CHIN: Well, okay. On one hand you can say, well, we're done with point 3. There's conceptualization of these five different

areas. And then when they are later bullets that are relevant, they can just be more specific and operationalized by CMS or others in terms of, well, what are they going use then for an equity measure, versus do we think --- is there any guidance we want to provide to them?

So, for example -- if we thought, for example, well, the only way you're really going to get improvement in an organization is if you truly do address all five of those, well, then you need to think about, well, do they become accountability measures or not?

Or it may turn out, for example, there's some special examples. Like, some of the ones like culture can be easily gamed in terms of the surveys. So maybe not great for accountability. So I mean, that was the nature of some of the discussions.

And it may be that this is the best we can do. But I guess I just want to throw out there, do people feel this is the best we can do, or do we want to get more specific or more

prescriptive in our recommendations?

So we had I think we had Ron, we have Traci, Bob.

MEMBER COPELAND: So I think in part, in recapping yesterday's conversation on this topic, you've already provided the answer. I mean, I think what's missing here is just the fact that this breakout of access and quality are end goals, that the surrogate for that was they are distinctive, and they are probably appropriate measures to go down the accountability path.

Whereas these other three were not because of some of the nuance you talked about. But from the overall five components framework kind of roadmap, all five are relevant.

So I think if we're having a roadmap conversation, it's all five. And if we're talking about distinguishing those that are more amenable to accountability metrics versus something else, this was the breakout I think that came out in conversation.

So that distinction is not evident if you just look at what's captured here. So I would just say, if you have access and quality are end goals, in parentheses something that connects that to eligible or suitable for accountability and this notion of all five still relevant from a roadmap standpoint, I think that was the distinction we made yesterday.

CO-CHAIR CHIN: Okay. Yes, so that's maybe the current edit. So I see nodding of the heads. So that access and quality, some language there about appropriate for accountability. The other three appropriate for the overall roadmap and quality improvement purposes. So Traci and Bob on this point.

MEMBER FERGUSON: So I think that -- I'm a visual person. So that if we could use sort of the five domains which, I think, are all-important and all-necessary when you're evaluating organizations or evaluating the process of how adding an entity is going to get to a point of addressing disparities and moving

towards healthcare and health equity, that we sort of utilize, and maybe we describe how an organization or individual will rate themselves on each of those elements and say whether, in terms of culture, structure, access, quality, and partnerships, are you high or low?

And so you can see if you are -- you just put it, almost sort of label those vertically and then horizontally. You can see where you score.

So they can get a quick assessment of where they stand to say, well, where do I need to focus on? And that could help, again, whether it's an individual group practice or a larger community of where they need to focus so that it is --- all of those are important.

And that when you see organizations or you see a microcosm of the member, the physician, and all of the concentric circles working together, all those individuals will all score very high on all those domains.

And so until you have that at each of those concentric circles, you're going to see those

gaps. So I think that it's -- be able to describe it in a little bit of detail in terms of examples.

And then as Dr. Copeland said about being able to say that these are -- access and quality are sort of the measurements that we're going to sort of hold you accountable, but if you want to assess --- just like you do cultural competency, doing an assessment or a survey, they'd be able to do, well, how would you assess yourself as an entity in terms of healthcare, health equity?

CO-CHAIR CHIN: So one of the things -- thank you, Traci. One of the things I like about Traci and Ron's comments, which I think are also reflected in some of the NCQA reports that Sarah presented yesterday and in the second NAM report on best practices for at-risk populations, is that they talk about, like, the process of improvement also.

So it's not just like the accountability process, which of course is very

important. But how do you help organizations get there? And I think that's embedded in what work we've done. That also, in our text, we can make sure that we have made that clear also.

Bob and Philip, you're also on this point? So Bob and then Philip.

MEMBER RAUNER: I was going to talk about the alignment of health equity measures across peers and so ---

CO-CHAIR CHIN: Yes, we're going to finish on this point, and then we're going to back to Ninez's point. And then just lead your -- that was perfect there.

MEMBER ALBERTI: So yes to everything that Traci and Ron said. I think that was exactly right, and I think that we also talked yesterday about, in terms of the upfront payments, where those could be used, right.

So is it contingent upon having the culture and structure in place to then do the work? Or is it contingent on not having that and using that equity bonus to develop a piece of the

structure?

I think if we could take Traci's idea, a depiction of this across the next set of recommendations in Strategy 2 and show how each of these domains are involved in those different kinds of proposed value-based purchasing schemes, when it's highlighted for accountability, when it's a, we must do this in this domain to get into this new structure, I think that could be a way to kind of merge those two ideas.

CO-CHAIR CHIN: Right. So we'll come back on the next slide. I can't remember if it was you or someone that made the recommendation on the bonus payment, for example, that people need to basically be at point where they've demonstrated they have, likelihood to succeed, almost.

MEMBER ALBERTI: Yes.

CO-CHAIR CHIN: Anyone else on this particular bullet before we go to Ninez and Bob regarding the aligning issue? Okay, Ignatius?

MR. BAU: I just wanted to underscore

that, while I agree that access and quality are what we should hold organizations accountable for, if we just say that culture or structure and partnerships are only a means, then they potentially lose out on this sort of notion of value.

Because if you're not demonstrating improvements on the access and quality, then you don't get to the other domain. So somehow in the language to make sure that we see, when it comes to designing a value-based payment system, that the other three means are also part of that equation.

So in other words, that we don't drop them as sort of preconditions that you're on your own for but that we see this as a unified whole.

CO-CHAIR CHIN: So please pipe in if you see other bullets along the way, Ignatius, where that can be operationalized. Anyone else on this bullet before we go to the aligning one?

MEMBER FISCELLA: Yes. This is Kevin. Just a comment on access. I guess, in the text,

will we be referencing work that's going on with existing access measures? Since access and quality are the end goals, we want to make sure that we have good measures of access in a comprehensive sort of way. And I know a lot of work has been done by others on that.

CO-CHAIR CHIN: That'd be great, Kevin. If you can email staff the things you may have in mind. The current conceptualization, there was, like, these three or four As: like affordability, accessibility, and one or two other As. That was the working model right now. So if there're other things that you think could be added, that'd be helpful. Please email staff.

MEMBER FISCELLA: Okay.

CO-CHAIR CHIN: Okay, great. Let's move to to ---

CO-CHAIR PONCE: Sorry, just one quick --- to make sure that our note writers are in this, from what I heard from Ron, it's include all five equity domains. So that it's clear, the word all in front of the five.

CO-CHAIR CHIN: Then correct me if we're interpreting you wrong, Ron. I think you said that all five are essential for the overall roadmap. For accountability purposes, access and quality seem suitable.

The other three, and here's where Ignatius' point -- and it's kind of tricky, is that, all should be part of this overall roadmap. They're necessary to achieve equity, but for various reasons whether measurement or gaming or whatnot, they may not meet the same criteria for accountability, with a caveat then that, like, I guess whatever -- viewing some of these later bullets, like, Philip had the point about, like, for example, do we have an infrastructure upfront payment?

Do you need to demonstrate that you have a reasonable culture of equity at that point in time. So that part's a little bit sort of, kind of vague. And I think we need to sort through. Is that fair, Ron, in terms of the ---

MEMBER COPELAND: Yes. I mean to

integrate all those thoughts, I think it's a very strong verbal endorsement of these five as the way, the pathway, so all critical and complementary, and so forth.

But as it comes to the specific question of what's ready for prime time accountability, because the metrics are available, more robust, et cetera, that's why those other two are separated, not because they necessarily, at least so in my mind, carry more weight than the others.

It's just where the state of data collection, maturity of information, availability, and so on, that's not there yet. So that says not only are all five important, but a statement could be said, as this process matures, the expectation would be that, as these other areas become more mature in terms of readiness for accurate measure, they should be considered for accountability as well.

But we're really endorsing the package. It's just timing of where each one of

those areas is at this stage of the game. That's my view.

CO-CHAIR CHIN: Very good. Thank you, Ron. You're on a roll these past couple of days, by the way.

(Laughter.)

CO-CHAIR CHIN: Yes. So Ninez has been very patient. We had a 15 minute digression. Can you restate your question or point about aligning? And then Bob wanted to speak on this also.

CO-CHAIR PONCE: It's just a question for help from the committee to exemplify -- clarify that for me.

MEMBER RAUNER: So one of the things that drives the clinics crazy is that all the co-payers want something slightly different, you know, classic being diabetes. Some want, was it tested; some want was the A1c under control? In some of them, the A1c was 9. Some it was 8, and that drives the clinics crazy trying to report these separate things.

So when we create a health equity measure, we need to do the same thing. It's like some people ask for race and ethnicity separately. Some will conflate the two. Whatever comes out needs to be consistent so that, hopefully, CMS and HRSA and your Medicaid MCO are asking you for the same information, not having you run it differently for HRSA, for CMS.

Because a lot of the UDS measures have not always aligned with NQF. They are now starting to align, finally. That's been a challenge, because of the lack of alignment between different programs.

CO-CHAIR CHIN: And besides the burden issue, there's been the issue that if, like, 20 percent of your patients are Medicare, maybe that's not enough to drive you to do a lot of infrastructural changes. If 80 percent of your payer mix is using the same equity measure, then all of a sudden it gets more of an impetus for you to say I've got to do something about it.

MEMBER RAUNER: Yes.

CO-CHAIR CHIN: Any other comments on alignment? Michelle.

MEMBER CABRERA: Just to double down on Bob's comments, I mean, I think one thing that I hear a lot, whenever we bring up sort of the intersection of reducing disparities in payment reform, is significant pushback, even from people who seem to be aligned with your end goal on, please don't make me do more, right.

And then, when we try to do a trial period, it's, like, we don't have the data. So I think that whatever we do, we have to figure out a way to make sure that it is clear that the burden question can't prohibit us from getting to that end goal.

And I think yesterday, some folks threw out some ideas about how to get around that. But it would be nice if we had a sense of what we think some core health equity measures are to start to sort of push that out as this is kind of the gold standard for what you should be collecting, right, across different payers so

that there's a sense of, this would be the gold standard that we are striving toward if we could get there, right.

So I feel like that's a whole other level of work, but it's important, nonetheless, because that's going to continue to be a barrier otherwise.

CO-CHAIR CHIN: Thanks, Michelle. So one other thing, a question is, I just want to point a thing that Philip had raised earlier about disparity measures. The other ways in here is that you look at the second bullet. It's the point that, I think, it was Susannah had raised about -- it was when she was talking about, well, her view was that risk adjustment, you're trying to avoid the negative unintended consequences. Whereas, the stratification by risk factor, she phrased as being, like, more proactively achieving equity.

So that's the other place, besides the third bullet that we specifically talk about the stratification by risk factor of a given

performance measure then to be used in payment and for quality improvement. Nancy -- okay, I think it was Ninez, Nancy, and then Helen.

CO-CHAIR PONCE: Again, just for clarification and for our diligent note takers, the alignment -- so for the safety net slide bullet, we talk about rewarding for improvement. So does aligning mean we won't look at improvement for the non-safety net? So just want to make sure that's -- I assume that that's not the case, but just so that that's implicit.

CO-CHAIR CHIN: It's a great question. And I think there's another bullet where there's a mismatch between Ignatius's table and what's on these slides. Let's listen to the whole issue, like, improvement, absolute threshold, disparity reduction. So let's maybe deal with that bullet and then we can think about this. Yes, Nancy, then Helen.

MEMBER GARRETT: So I just want to offer a few thoughts on the first one, invest in the collection of social risk factor data through

EHR surveys, et cetera.

I just feel like we need to be more specific with that one. It feels a little bit too general, like, yes, that's true, but it's really not specific as to who should invest and why? And what's the benefit? And what social risk factor data? And in what form should we collect it? It feels like we have an opportunity to be more specific and have more of an impact.

And so just walking you through how my organization has been thinking about this, I brought forward an initiative last year to start universally screening everybody in our organization on -- outpatients on food insecurity.

And in order to do that, in order to get support for the organization, I really had to bring forward, okay, well, what's the reason we would do this? And the reason that really resonated with people is, if we understand who has an issue with food insecurity and we can get them connected to resources, then we can have

more of an impact on health.

It's this whole idea that we all understand that medical care is a very small part of what really influences health. That's what really motivates providers. We're trying to do the right thing for our population and trying to improve care.

And then a side benefit is that eventually, if we can demonstrate, that by having this investment, that we have better outcomes, then potentially we can make the case of payers, that we should have additional payments for if we have food insecurity coded or if we have homelessness coded, et cetera.

And so that's the argument for the standard collection. But it's really the, can we make a difference with our population and improve health, that resonates.

And so I'm just wondering do we want to be more specific here? Are we saying that we think CMS should have incentives for collecting social risk factor data? Should we put forward a

set of standards that we think should be used, whether it's the IOM questions, the Accountable Health Communities questionnaire.

Because right now, everyone's doing it differently. And so we don't really have the ability to standardly report, as we are saying in the second bullet. So I just feel like we should seize the opportunity here to be more specific and have some action on that one.

CO-CHAIR CHIN: A little discussion on this topic. So at a minimum, it sounds like the text, we need to make points about it's not just, like, demographic features, but it's like some of these sort of functional things that you're mentioning, like the food insecurity.

We can reference some of these, the state of the work, some interesting tools, and stuff that's compared for the efficacies and all in the text. So let's just --- a suggestion to think about, should we add more specificity, more teeth to this? And if so, how would you reword it, or what would you want to convey? So

Ignatius?

MR. BAU: So I was just pulling up the reference. So in the Oregon Medicaid Coordinated Care Organizations, the coordinated care organizations have a 1 percent withhold unless they do complete data reporting that includes stratified race/ethnicity and stratification of their quality measures by race and ethnicity.

So again, that's already been improved by CMS. I don't think you want to be that specific. But that could be a full example.

CO-CHAIR CHIN: Thanks, Ignatius. Michelle, you have a lot in your head, so do you have any specific suggestions on ways that you might bolster this?

MEMBER CABRERA: I agree with everything Nancy said. I just think it's a project, frankly, that flows out of this, to figure out what our recommendations would be and who you could hire, hearing from a lot of folks about, and particularly the measure developers on what could be helpful to them, us, and sort of

figure out what that middle ground is.

CO-CHAIR CHIN: Well, one more possibility is the wording is sort of general like this. There are a lot of specific examples in the text. And so, Nancy, if you had a menu of examples, like the policy tools that are possible, so it may not be that we'd want to have a specific recommendation from our committee, but here's a list then of things that have been tried that need to have further consideration, that type of thing. So if you email staff, that'd be great. Anyone else on slide 1? Oh, Helen, yes.

DR. BURSTIN: I actually had a different comment, but I do want to build on what Nancy said. And I do think invest is, again, quite a passive verb for something this important in a roadmap.

So I mean, whether it's, you know support and incentivize the collection and use of, or something like that, I think something stronger here, even without a lot of specifics, I think is required. Because otherwise, it just

looks like --- it doesn't feel much of a roadmap.

CO-CHAIR CHIN: Yes, support and incentivize, guys. Okay.

DR. BURSTIN: Right. Support, collect, and figure out verbs, but just --- and I think incentivize is important. The comment I actually going to make is a small one, but I think it's important. And it'll sound strange coming from me, but it's really not about measures, it's about measurement.

And then a lot of this isn't just about saying here's a measure, here's a measure, here's a measure, here's a measure. It's really about a whole approach, that equity needs to get woven into measurement, so small but I think important. Yes.

CO-CHAIR CHIN: Maybe this sort of dovetails with the point about the roadmap and the five equity domains, Romana's point about it being sort of a process of improvement. Again, reflecting both the NCQA report as well as well as the NAM report. Anyone else for ---

MEMBER SCHOLLE: This is Sarah.

CO-CHAIR CHIN: Go ahead.

MEMBER SCHOLLE: Yes. This is Sarah. On that point about data collection, one way to strengthen that would be to tack it up to the collection of standardized data, collecting it directly from individuals rather than imputing it or --- so that the information is both collected directly from the individual and updated regularly if it's something that could be updated, like the food insecurity or something you don't just ask once. You ask that over a period of time.

CO-CHAIR CHIN: Thanks, Sarah. Anyone else on the phone for slide 1 before we go to 2? It's one of these.

Sorry, I thought that was an old one up there.

MEMBER NERENZ: Sorry, on the bottom bullet, two questions. One is I just have a little caution that in some ways this is out of our scope. Now, we can go ahead and make the

point anyway, but if we say that Measure X, Y, or Z should not be used, that may conflict with the recommendation from a different standing committee saying that more of X, Y, or Z should be used. So there's just going to have to be a little care and caution with how we frame that.

And I'm just wondering, do we have a couple of tangible examples in mind of measures that would be under this concept? Which measures specifically do we have in mind that do not promote equity? Now, if the answer is 80 percent of them don't, then, oh, okay.

CO-CHAIR CHIN: Yes. It was Tom Sequist who made the point. And I think his point was more generally that -- because Bob's point about measurement burden so that -- and Michelle's made the same point, that it's going to be an uphill battle getting anything added.

So I wonder if, it may be the easy fix is basically reduce the use of measures that basically no longer are serving a core --- equal in value because they've been maximized, topped

out, or ---

MEMBER NERENZ: Okay. But that's different.

CO-CHAIR CHIN: Yes, yes.

MEMBER NERENZ: I'm much more comfortable with that. Then we just say how do you make room for more? Well, you get rid of something.

CO-CHAIR CHIN: Yes.

MEMBER NERENZ: But you don't necessarily get rid of it specifically because it doesn't promote equity. You get rid of it because it's bad for three other reasons.

CO-CHAIR CHIN: I think Tom would agree, yes.

MEMBER NERENZ: Okay.

CO-CHAIR CHIN: Yes. Anyone else on the last bullet?

MEMBER CARILLO: Yes.

CO-CHAIR CHIN: Emilio?

MEMBER CARILLO: Although it's implicit it the various bullets, I think it'd be

good to specify that we're talking about implementing health equity measures for the individual and the neighborhood community geographic area population, to make that --- to ascertain that we're looking not just at individuals, but at the aggregate that carries all these social determinants.

CO-CHAIR CHIN: So to get into this issue of, like, who's the target audience for different bullets or points and all. So maybe that could be sort of embedded, and the solution, as that's being worked out, of being careful about clarity, about the status of, like, to whom that applies.

I don't think we've sorted that out yet, Emilio. But I think your point's really important that that will need to be figured out, yes. Yolanda, then Bob, then we'll go to the second slide.

MEMBER OGBOLU: Yes. I just wanted to piggyback on what Nancy was saying. Because it sounded like she was also speaking to a real

issue for providers in terms of buy-in related to this whole idea of collection of social risk factor data.

I think many reports for years have been saying collect data. But we haven't really addressed a real issue in terms of investing in getting provider buy-in to understand how to use that data in a meaningful way.

So we do need to collect data, but we also need to work on helping providers and other organizations understand why this is important. And that may not fit in here perfectly. But I think that's really the root of the challenge of collecting data.

CO-CHAIR CHIN: I think that gets into the wider points that both Ron and Michelle have made about the overall roadmap. In some ways, embedded in that is the quality improvement process by which there needs to be, as you said, like, people realizing why there is this data and what do you do about it.

And so, Bob, and then we'll go to the

second slide.

MEMBER RAUNER: Yes. Just going to follow-up a little bit on David. And I don't know if you necessarily have to, like, retire a measure, but the clinics regularly struggle with burden where every different organization wants a different report. And they complain almost every time I meet with them about the numbers of things to do. Even in a commercial ACO, you know, you've got Medicare wanting its measures; you've got Blue Cross-Blue Shield wanting its measures.

A clinic can really only focus on maybe two to five quality measures at a time. And so you just have to be --- groups have to be constantly aware of that, that if yours doesn't align with anybody else's -- it goes back to the alignment, actually, quite a bit too. There's only so much you can ask a clinic to do at any one time, especially an FQHC that's understaffed.

And I think that's, for me that's probably one of the biggest things, is just making sure that you're not --- because it's rare that a

statistician or a regulatory body will ever request less data. It's almost always more.

But you have to realize that what the people on the ground are having to work with sometimes now is probably one of our biggest pushbacks from our FQHCs from our state of Nebraska, what they're asking for.

CO-CHAIR CHIN: Let's go to slide 2. This is another big one where there's a lot that's embedded in this.

So while people are thinking about it, start off with one that Ninez raised. And it'll also fit the category of -- we had talked about it some, but there wasn't absolute clarity.

And so if you look up from the bottom, like, three bullets up, there's a sub-bullet that says: reward some combination of improvement over time, absolute threshold, and reduction disparities. If you use reduction disparities they must also include absolute thresholds.

This is a hard one. Like, I think there was clear agreement that people wanted to

include, like, improvement over time as part of things. I also heard that, at least Susannah made a point that if you do look at disparities reduction -- I think Philip made the same point -- that you also have to look at the absolute threshold, because you don't want to have a race to the bottom. But it's, like, the high performing group performing lower so you reduce your disparities that way.

How about mixing this together? I don't think we had clarity about that. So the last one is currently the vague worrying about reward some combination, improvement over time, absolute threshold, reduction of disparities, and then the point about the protection of, if you use the disparity reduction, then you also have the absolute thresholds. Can this be improved?

Okay, so I think Michelle had --- Michelle, then Nancy, then Bob.

MEMBER CABRERA: So a couple of comments. One, on Bullet number 2, I'm wondering if our intention is to say for an organization

that serves any individual with a social risk factor, or is this intended to speak to those organizations that have volume on folks with social risk factors? So it's just a question on our intention.

The other one is, and I think this is --- I think it's entirely missing. But I could be wrong. I think we need to include evaluation of existing or proposed payment reforms for their impact on disparities and equity.

So it's a very different thing. Because, again, it goes to that notion that for some folks, in pursuing the triple aim, they assume that elevating quality includes, you know, means elevating quality for everyone when we know that's not necessarily the case.

CO-CHAIR CHIN: Yes. So the second one first. So I think, like, my guess is that we can all agree that that should be done, the existing programs, looking for whatever the consequences are, with some stronger statements that --- but really what should be done is sort

of these things about proactively trying to reduce disparities. But we can make sure that the text has that in there also.

Your first point then, about, like, the second bullet, does it mean any institutions serving individuals with social risk factors or those with large percentages? So any discussion upon that particular point that Michelle has raised?

MEMBER GARRETT: I think it's an interesting question, Michelle. I feel like yesterday we were often discussing about organizations with a high proportion of people with social risk factors. The fact is that healthcare is very stratified in our country. And so you end up with high concentrations of at-risk populations. So it's kind of the reality that we're dealing with.

However, policies that would provide augmented payments of some sort, regardless of your threshold level, actually would probably be more likely to be passed. Because then

everybody, you know, benefits in some sense. Or everyone can participate.

So if you think about, like, the DSH payments there's, you know, even if you have a fairly low level of Medicaid patients, you still might be getting some small amount. So I think it's kind of a policy question. And maybe we leave that open. Because I could see both arguments.

CO-CHAIR CHIN: Helen, you want to comment on this issue?

DR. BURSTIN: So, I mean, I think it's somewhat related. I mean, number 2 we took directly out of the NAM report, as I recall. And so that language, in some ways is very duplicative of Bullet 3 which was, I think, our original thinking. And I wonder if we're trying to sort of fit a square peg into a round hole here.

I think we're seeing the same thing in the third bullet, maybe more simply without trying to get into this issue of, you know, what

proportion of people with social risk factors. I mean, it's just redesign payment to support health equity. And then, you know, I'm not sure the adjust payment is necessary.

CO-CHAIR CHIN: I think they are different. But, I mean, the equivalent of the NAM was, like, they had one about, like, redesign the incentive programs separate from direct payment.

DR. BURSTIN: Okay. I'm not sure I changed that.

CO-CHAIR CHIN: So, so far I hear, like, the discussion with Nancy is maybe pass in terms of a formal recommendation.

MEMBER GARRETT: Recognition that, again, because of the way the population's unevenly distributed across providers, we really do have to pay attention to the safety net providers where they have a high proportion of people with social risk factors.

And I mean, the fact is that low levels of reimbursement through Medicaid is a

health equity issue. We are not spending the same resources on those populations that we are on commercial populations. And that's a health equity issue. So what can our committee do to make recommendations to start to remedy that?

CO-CHAIR CHIN: Do you think, like, later on when we have a, like, I think it's the third strategy about the safety net organizations, that adequately addresses that issue? Or do you think any wording needs to be changed in the second bullet?

MEMBER GARRETT: I really like that it's consistent with the National Academy of Sciences report. I think that's a really important recommendation. And it's different than risk adjustment. I agree with you. So I think we should leave it and keep it consistent.

And then I haven't had time to digest the next one. So when we get there, we can talk about it.

CO-CHAIR CHIN: Okay. Okay, why don't we move on to, I guess, I think it was Ron and

Bob then.

MEMBER COPELAND: Yes. I was just going to concur with what Nancy just said regarding, really, 1 and 2. And then I think there is a distinction between number 2 and number 3. At least in my mind, in number 2, we were talking about an organization at any level having to demonstrate how much of its population that it manages are folks that have measurable social risk factors, however that would be defined.

And on the basis of that adjustment, payments would be to the organization just on what you're starting the game with. When you get to this redesign stuff, now you're talking about, okay, you've already gotten paid or you're adjusted for having a more high risk population, if that's the case. And now our focus is switching to what are you doing for improvement of care outcomes?

And then what's the process or what's the framework we use to evaluate or compensate

you for performance improvement as opposed to you have a higher risk population. There are two aspects -- but one based on the makeup of your population. The second one is rewarding and recognizing performance improvement and what aspect of performance improvement do you want to particularly incentivize?

CO-CHAIR CHIN: Now to, what you mentioned, this redesign payment model, so any of those subbullets, do people have any suggestions or comments on any of them? Bob?

MEMBER RAUNER: Yes, that's what I was going to comment on. One thing I would add is we talked a little bit yesterday about prioritization of the measures with the greatest impact.

Eduardo Sanchez mentioned blood pressure control as probably, if you could pick one measure of all the UDS measures or all of the MSSP measures, it probably would have the greatest impact on health. So I think some prioritization on blood pressure control,

obesity, or vaccinations, or the focus of the things that would make the biggest impact to control health or improve health.

CO-CHAIR CHIN: So there is this issue of, like, I believe we have some time to go back to those disparity-sensitive criteria. So you're suggesting that, somewhere in one of these strategies, what's the most appropriate to prioritize health equity measures based upon some criteria such as it provides a disparity sensitive measure? Do people want to do that?

So basically, saying that we should prioritize health equity measures that meet some type of criteria that, hopefully, we'll have a chance to go back and revisit? Romana?

MEMBER HASNAIN-WYNIA: Yes. I support that 100 percent. I think that's a great idea. I think we should have, like, you know, two, three at the most, that we actually prioritize. Because I think organizations will respond to that, especially if they already have some level of infrastructure in place. So, David and I were

talking about this last night.

So whether it's on blood pressure control or thinking about something like diabetes and looking at individuals with pre-diabetes, and moving them into some kind of a DPP or -- Medicare is paying for that.

So, I mean, something along the lines where there is a broad impact and reach on measures where we know disparities are very prevalent, I think it would go a long way.

Because what I worry about with the roadmap, and having a lot of aspirational goals, is aspirational gets read as, we don't have to do this right now, versus, Here's something that you can do right now.

So, you know, you asked about, based on certain criteria. I think obviously, you know, prevalence of disparities, potential for impact, and whether there are processes and maybe some payment infrastructure already in place, such as paying for DPP.

CO-CHAIR CHIN: Well, why don't we

have separate bullets. Because Bullet 6 here, which is use high priority equity measures, and there could be some additional language about what makes it a high priority measure based upon the existing prior NQF report. And hopefully, we'll have a chance to basically update that later in the hour. That work, Bob? Okay, great.

On the comments upon Bullet 3, so turn back to that last subbullet, the one about the combination of improvement, threshold, reduction of disparities. Can that be improved, that statement? Or is that where we ended up?

David, you're sort of, like, an auctioneer in terms of, like, the subtle so ---

(Laughter.)

MEMBER NERENZ: Well, this is about the third bullet in general, not one of the subpoints. One thing that's missing here, but I almost hesitate to bring it here, it could be some sort of adjustment to the fundamental building blocks of payments themselves, DRG payments, outpatient fee-for-service payments in

Medicare, episode payments, I don't see it implied here.

But in a lot of our thinking about, you know, how we see the equity and disparity problems we see, we have very commonplace examples.

It takes two days longer to discharge a patient who has no place to go. And now that's a DRG payment issue. Or you've got a patient with low literacy in the office, you're explaining the new drug regimen, and it takes you a half hour longer, and you still don't necessarily get it. You know, that's a visit complexity issue.

So we have very tangible things. You could say, you know, maybe the criteria for billing a Level 5 E&M visit could be tweaked so that social risk factors become acceptable criteria.

But we're just not talking about that here. Now, maybe we say that's not in the NQF scope, but we're talking about changing opinion

models. So it seems like it's in the game somewhere.

CO-CHAIR CHIN: Do you have some draft language, just as a starting point, that the staff can play with?

MEMBER NERENZ: I'll give you one in 30 seconds.

CO-CHAIR CHIN: Okay. Yes, whatever.

MEMBER ALBERTI: So I agree with Romana in making sure that we have a limited number of metrics or measures that we're targeting.

And I think another additional layer, in addition to thinking about, you know, the potential impact and prevalence of an inequities in the evidence-based interventions, already exists.

It could be to crosswalk those domains with where healthcare distributors are currently getting hit the hardest in terms of the penalties or the lack of money they're receiving to actually double the incentive to do this work.

Because there's a real chance that they'll save some cash.

And then something that's missing that was on, I think, previous versions of this slide, was ensuring that the flow of these payments go towards SDOH. Or there was something about that.

And so rather than bring that back, I wonder if it's an opportunity to, you know, tie the advanced payment to the culture/structure, the partnerships, to make sure there's some contingency on the money that's going towards the kinds of things that support the appropriate, you know, the ability to measure or, you know, whatever those things might be.

CO-CHAIR CHIN: Support for the -- so that things could be added. On this conception, you think about, like, you have P4P, you have the capitated or upfront payments to do general infrastructure, and then a sort of -- related to that is what you're saying in terms of the upfront or capitated payments to address some of these broader social determinants. But we can

make it explicit.

Any other thoughts on slide 2? I'm going to assume then that that last bullet about combinations, that's the best we can do in terms of that. Yes, Christie?

MEMBER TEIGLAND: Yes. I'll just make one comment on, you know, the absolute thresholds. I think they're still sort of built in. I mean, if you think about how CMS does the quality measures, the five star quality measures, or URAC is doing their accreditation, for example, you know, they have -- you still have your rates from worst to best, right.

And so that whoever is doing the best is your top threshold. And you're still measured against that. But what the improvement measures are trying to get at are those people who are more in the lower levels.

And they're making progress, but they're not up at the top. Their goal is the top. And the top keeps shifting up, by the way, as long as you have, you know, constant attention

to it.

And then the bottom, you know, the threshold kind of takes care of itself or CMS, for example, is saying you're not going to get -- you're not going to be a -- you can't be a contract anymore, right. They're taking away their rights.

So maybe the bottom is important. But I don't know if we need to put that here. You know, I think it's baked in. So I don't know that we -- we can probably clean that up, I think.

CO-CHAIR CHIN: Well, like, there are other programs, some end-stage renal disease programs. They do the same thing, where some is absolute, some is improvement. So they have these combinations out there. So go to slide 3, actually on the health ---

MEMBER FISCELLA: Can I have one more comment.

CO-CHAIR CHIN: Sure, go ahead, Kevin. Anyone on the phone for slide 2? Kevin?

MEMBER FISCELLA: Yes. Invest in primary care and preventive care for individuals with social risk factors, that seems a bit vague. I mean, that could be construed in lots of ways, obviously. You know, it'd be great if we could invest more in the infrastructure and primary care. And I think that's an important point.

But I think an additional point beyond that is the issue I brought up yesterday about, you know, value-based design. And, you know, it's at-risk right now with the ACA, and, you know the potential repeal, which is that proven and effective cures right now don't have deductibles, or co-payments, and the whole issue of applying that to drug payments gets out of the way to reduce financial barriers for patients who are low-income.

And I think that's an important strategy, particularly as we move into higher deductibles. I saw something the other day that said that the current plan on the books that the House approved would raise deductibles by 51

percent. And I think it's likely that deductibles, for whatever reason, will continue to go up.

So I think we need to say something more explicitly about that in terms of use of value-based design to address the cost issue for proven interventions, including access to primary care.

We want more people to come into primary care. And access to primary care in this country is not as good as it is in other countries and probably has lots of downstream effects because of that.

CO-CHAIR CHIN: Yes, Kevin, thanks for raising that point. And could you also email staff some draft language for that? Kevin's point was, like, these value-based payment plans where if it's good evidence base, then it's better covered by insurance plans, so lower out of pocket costs for the beneficiary.

So Kevin's point being that then high quality care can be more affordable, then, to the

beneficiary. So that'd be great, Kevin, if you can email staff some language.

MEMBER FISCELLA: Will do.

CO-CHAIR CHIN: Anyone else on the phone for --

MEMBER BERNHEIM: This is Susannah.

CO-CHAIR CHIN: Yes. Go ahead, Susannah.

MEMBER BERNHEIM: The, just quickly, on the second subbullet under the third bullet, the pay for performance on equity measures piece, I don't think anybody said this again. I mentioned it yesterday.

I think it's important that we have a caveat for this, that we somehow say, you know, pay-for-performance on equity measures but ensure that we don't reward, you know, narrow gaps in care when there's overall poor quality so, again, trying to avoid the situation where you do terribly with all of your patients, right.

So if an equity measure is a --- this really about when we're using stratification as

an equity measure, but I think it's an important concept sort of to balance equity with avoiding incentivizing poor care for everyone.

CO-CHAIR CHIN: So, Susannah, you'll be very proud that, if you look at the third bullet from the bottom, there's the Bernheim clause: If you use reductions in disparities they must also include absolute thresholds.

MEMBER BERNHEIM: God. Okay, so I didn't understand that that's what you meant by absolute thresholds. But that's fine. I think that works fine. Great, sorry I missed it.

CO-CHAIR CHIN: Oh, no problem. If it's not clear, if you have better language, please email staff.

MEMBER COOPER: So this is Lisa. I just wanted to say one more thing. And it might have been said, and I missed in all of what was going on with that third bullet from the bottom.

I think, if they use reductions in disparities, and/or they use improvement over time, they should also include absolute

thresholds. Don't you think? I mean, if you have improvements over time, but you're not reaching a threshold, you still need to use the absolute threshold, right?

CO-CHAIR CHIN: Here's the discussion that I was hoping that we'd have. So the argument against that is that say you're --- a safety net hospital has a really high population. There's just no way you're going to be able to get up to ---

MEMBER COOPER: For them to ever reach the ---

CO-CHAIR CHIN: Right. So if you required both, well, if you have what you suggested, Lisa, where if you improve, but you don't improve enough, and you devolve down to the absolute threshold level, that would be a disincentive. I can imagine combinations where you reward a combination of improvement over time, plus something for absolute threshold.

MEMBER COOPER: Yes.

CO-CHAIR CHIN: So it's where that's

pretty complicated. That's why that first phrase is kind of vague there about some combination of.

MEMBER COOPER: Okay. I got it.

CO-CHAIR CHIN: Michelle?

MEMBER CABRERA: I mean, in some ways, I think this is about trying to encourage folks to go aspirational, right, and the fact that we don't really know what we are going to be able to fix with this tool of payment reform.

And so I do think we have to have a little bit of an open mind. And while the absolute threshold goals are important, it's going to take some time to understand what's moving the needle on some of this stuff and what the impacts are going to be. And that's okay. I mean, this is ---

CO-CHAIR CHIN: Okay. So, Nancy, was yours from the --- pass, and then you're up. Okay. So Nancy, Philip, and then Traci.

MEMBER GARRETT: So I just --- I think this is that concept of add-on payments for social risk for the outpatient setting. I think

that's what this is supposed to be. So I guess I would just more specific that CMS should add on payments for social risk for outpatient-enabling services.

So it's not --- so this just doesn't mention social risk. And that was kind of --- that was the concept is it's an add-on payment for social risk just like they did for hospital.

CO-CHAIR CHIN: Yes. I think, like, those are two related and different concepts. Remember, like, at the end of yesterday, there was this general discussion about outpatients. And I remember Bob made the point that, like, all the money's in inpatients, so that just outpatient is just not a priority for different folks. And so they are two related but separate points, so let's see.

MEMBER GARRETT: So maybe there should be a different bullet about add-on payment concepts. I'm not sure if it appeared anywhere else yet.

CO-CHAIR CHIN: Sure. So it'd be add-

on payments for patients with social risk factors?

MEMBER GARRETT: Yes, in the outpatient setting.

CO-CHAIR CHIN: Okay. So let's see, so is it a separate one is just sort of a subbullet under either the last one or the first one. Or maybe it applies to so many of them that we just have a separate bullet?

MEMBER GARRETT: It could be a subbullet under the second one, definitely. But it's a specific example, but I just don't want it to get lost. Because I think it's something --

CO-CHAIR CHIN: Yes.

MEMBER GARRETT: -- that would fit into the current policy context that we should really be talking about.

CO-CHAIR CHIN: So is it a subbullet under the second one or, like, an example in text type of thing? Maybe a subbullet under the second one?

MEMBER GARRETT: Yes. I think under

the second one.

CO-CHAIR CHIN: Okay. Maybe a subbullet in the second one. Okay. Philip and Traci.

MEMBER ALBERTI: Just an idea for that final subbullet, the combination one. Maybe it would make sense for us to give two or three different scenarios, like, concrete scenarios of threshold improving disparity, not disparity improving threshold saying the same. And just, we don't have to append dollars to it, but to give some texture to what we actually mean by this might be helpful.

CO-CHAIR CHIN: And can you describe your example in more detail?

MEMBER ALBERTI: So what would the reward be for an institution where the absolute threshold is unchanged or minimally changed? But we actually see some reduction in the disparity metric, right. So what would that look like?

Or a situation where there is, you know, overall quality improvement for everybody

in the population, but the disparity is just as wide as it always was? So, I mean, we could just give two or three different scenarios and think through what that kind of reward system would be.

CO-CHAIR CHIN: So maybe it's, like, most examples of the third from the bottom subbullet, the one about rewards and combination improvement over time, absolute threshold, reduction of disparities. So there, talking about examples of how you might reward more for certain --- okay. Traci, then we'll go on to the third slide.

MEMBER FERGUSON: So this is more so a comment. And I don't know if this is something that we would be able to do for the report. But with the linked health equity measures to accreditation programs, would it be possible to include statements or their prior strategies, if it's NCQA, URAC, where they are already aligned with this, so that we have a better buy-in?

That we will speak to them to include as of, you know, better uptake to the end

customer, CMS, that we've already gotten, you know, this aligns with what NCQA is already doing with patient-centered medical homes and, you know, things like that. Could we add a little bit more to that section?

CO-CHAIR CHIN: That's a great example of, like, what staff has asked for, any specific examples, or practical implementations, suggestions we have. So when they write the report, it could be more actionable and more practical. So that would be a good example where you'll --- maybe you could email staff those specific examples, and that could be included in the text on that particular part.

So let's go to slide 3.

MEMBER SCHOLLE: This is Sarah.

CO-CHAIR CHIN: Go ahead, Sarah.

MEMBER SCHOLLE: I wanted to make a comment about slide 2 and slide 3. Because I'm looking -- I've been looking at them in tandem and wanted to just try to understand, if we can clarify for the audience of this report, why some

things return in slide 2 and others in 3. Because if you look at it, in some ways it could seem like it's not contradictory but it's not a complete sent message.

So, for example, the first bullet under the Strategy 3 slide says risk adjust for social risk factors and stratify performance score. Where, in the previous one it was about risk adjust for payment. So is this different from the previous slide?

And the same thing about the comparing organizations to peer organizations. This could apply. It's not just for safety net organizations. It applies more broadly for organizations that are serving the proportion of their membership or their patients who have social needs.

So I wonder, I guess I missed the conversation about having a separate strategy that focuses just on organizations that disproportionately serve individuals with social risk.

I like that. What I wonder though is whether some of the things that are in this Strategy 3 slide should be in Strategy 2. And instead, in Strategy 3, it should focus more on supports that would only apply to those organizations that serve a preponderance of people with social needs. I'm trying to understand the logic here.

CO-CHAIR CHIN: That's a great point. I think you're right, that the intent was that the committee thought that the safety net might need additional support or that the general provisions that might apply to a broader set of organizations may not be sufficient for the safety net. I mean, that's the intent.

Maybe what we can do is we can go through Slide 3 so people understand Slide 3. And then we can revisit your question about does it make sense. All the points you made, Sarah, I think are very important. So let's look at Slide 3, march through it, and then revisit Sarah's point about does this really make sense now, or

does the way it is need to be reconfigured. So Slide 3 is open now for discussion. Ninez?

CO-CHAIR PONCE: Well, perhaps an easy fix, from hearing what Sarah said, would be to move the first two bullets to Strategy 2. I don't know exactly where. But we would --

Because that's a, those two are general approaches, and not necessarily what I think Strategy 3 is, is about being protective of institutions in this country that serve predominantly vulnerable populations who have social risk factors. Whereas one -- since the first two are a general approach.

CO-CHAIR CHIN: So, the number one in some ways I think that would be not controversial at all. That's already in there. The number two, we haven't really talked about regarding everyone, the one about like comparing organizations to other organizations.

This came in like Susannah's discussion, where she talked about like the, I guess what's in the Cures Acts, for the

readmissions. How there's comparison of hospitals within peer groups.

So, we didn't talk about that as a group. So, maybe that's, so maybe flesh out that second bullet. So, like what do people think about the second bullet, as it pertains to the safety net, as well as more generally, in terms of should it apply to all organizations? And, Ninez, go ahead.

CO-CHAIR PONCE: Go ahead.

CO-CHAIR CHIN: Yes. Who was on the phone who spoke up?

MEMBER BERNHEIM: It's Susannah. But I can wait. It's always hard to know how to get in queue. But just let me know when it's a good time.

CO-CHAIR CHIN: Why don't you go. We'll then have Ninez. And I think Nancy's on a different topic. Or, okay, we're going to Susannah, Ninez, and Nancy.

MEMBER BERNHEIM: So, I would, I'm not sure who just spoke about the idea that these

first two bullets belonged on Slide 2. But I'm concerned about that.

And this comes back to a common theme. But it's one that I think is important, which is risk adjusting for risk factors doesn't promote equity, except to the extent that it is protecting safety net institutions, right.

It's not encouraging anyone to do a better job. It's just preventing us, if we think that the measure is unfair. And so, it belongs more with a concept around supporting these organizations.

And similarly, doing peer grouping. Again, it's more around who your comparison group is. And in certain circumstances, when it makes sense, to make the comparison group related to the kinds of patients you serve. And I would argue that that sometimes makes sense, and it sometimes doesn't make sense.

But when we're doing that, and we're changing the comparison group, it's not promoting health equity except under this topic, which is

that it is supporting the organization that serves those individuals. So, if we're going to have these two bullets, I feel pretty strongly they belong under this strategy, rather than the first one.

And the other thing I said earlier that I'll just repeat here is, I would like to see us say something about the context in which you use these strategies. Because I think these are the strategies that risk us veering down a path that's around sort of classifying certain organizations.

And mostly feeling like our health equity strategy is to sort of separate the safety net hospitals and protect them, which I don't think is -- you know, the best way to improve equity is to strain some safety net organizations, and create incentives. You give them support through some of the other things that are here and incentives.

And so, the slide before is around the incentives. And this, I think these two bullets

belong on this slide. And they belong with something that says sort of, you know, as a secondary approach, in addition to, you know, direct support and incentives, which are stronger approaches. What we're really aiming at is health equity. So, I'd like to see these kind of conditional.

CO-CHAIR CHIN: Can you go back to slide 1 and 2. Can we go back to 1 and 2, just to make sure we know where things are? So that -- - yes. So, Slide 1, you see the second bullet is the one about stratifying measures for payment and quality improvement. And then the next slide. So, the second bullet has the direct adjustment.

MEMBER BERNHEIM: And maybe that belongs on Slide 3.

CO-CHAIR CHIN: Which got back to Christy's, Christy and Michelle's question about, like we're talking about disproportionate share hospitals, or any hospital that takes care of patients with social risk factors, which at that

point we punted and said, let's keep the language as it is, because it was the same language that was used in the NAM report

MEMBER BERNHEIM: But maybe it goes under support, which is Strategy 3, as opposed to incentivize.

CO-CHAIR CHIN: So, what do people think? So, Philip? Actually, first Ninez, Nancy and Philip. Get some more thoughts out here.

CO-CHAIR PONCE: Yes. Just, Susannah, that was me who suggested to move those two. But again, open to hearing what others have to say.

I just wanted to point out for clarification, the peer -- If you can go to Strategy 3, please? The second bullet, and consider comparing organizations to peer organizations was one of the strategies we proposed for the SDS, not social, and Risk Adjustment Report.

I can see that that applies more for protecting safety net providers. Because then you're comparing, you know, within the peer

organizations. But I think there's going to be some cleanup afterwards.

But I just have a sense that it's, the first two are different. They're strategies across the health system to look at fair payment. And so, that's why I think that could be incorporated in either 2 or 1.

MEMBER BERNHEIM: But they aren't strategies that incentivize equity. They're strategies that support the safety net.

CO-CHAIR PONCE: I think, sorry, this is Ninez again. I think it could also reveal that, you know, that hospitals that are being paid without the social risk factor adjustment could do better if, you know, are not doing as well in accounting for social risk factors.

So, it's not just are we unfairly valuing the work with the current reimbursement mechanism? But it's also I think illuminating where some of the other providers who are doing well currently, could be doing better in addressing social risk factors.

CO-CHAIR CHIN: Let's get some additional thoughts out here. So, we have Nancy and Philip.

MEMBER GARRETT: Yes, this is Nancy. I just wanted to kind of follow on Ninez's point. I think I disagree with what Susannah, with what you were saying about the risk adjustment for social risk factors is not a health equity issue.

And the reason I say that is because plain and out, the reason for the original NQF Committee was a lot of rising concern that money is being moved away from safety net providers, and to other providers.

And if you play that out the impact is that the populations that are most vulnerable are not getting the investment that they need to improve their health. And so, to me that is a health equity issue. It's not about the provider. It's about the patients.

And that's the reason that it's such a concern, and why we opened up the door to start looking at this. So, I think I would just kind

of disagree with that overall point. But --

MEMBER BERNHEIM: I want to let other people talk But I want to make sure that what I said was clear. Because I don't want to be misunderstood.

Protecting safety net providers, and making sure people feel like measures are fair is absolutely a health equity issue. I'm saying, it's not a mechanism to incentivize decreasing disparities. It's not a mechanism. It will support health equity by supporting those institutions.

So, I absolutely agree with the health equity issue. I'm just suggesting that it's under the correct strategy. That it sits as part of how we support these providers. That it doesn't create a new incentive.

And Slide 2 is about incentives. So, I'm just, I'm not saying it's not a health equity issue. I'm going, I'm trying to separate incentives versus support.

CO-CHAIR CHIN: So, one edit right

now, so go back to Slide 2. So, do people agree then with moving, Susannah's suggestion to move Bullet 2, directly adjust payment for organizations serving individuals with social risk factors, to Slide 3?

What you gain by that is that it's not really an incentive. It's more support for the safety net. What you lose is that if we want, if you wanted vagueness about whether, you know, Michelle's question about does it apply just to safety net, or to all hospitals? We lose that. That goes now to three.

So, that's the proposed sort of switch on that one. How do people feel about that, moving Bullet 2 to Slide 3? Romana?

MEMBER HASNAIN-WYNIA: I don't really know that we should.

MEMBER COOPER: This is Lisa on the phone.

MEMBER HASNAIN-WYNIA: Oops.

MEMBER COOPER: When you have time.

CO-CHAIR CHIN: Romana, and then Lisa.

MEMBER SCHOLLE: Yes. And Sarah too.

MEMBER HASNAIN-WYNIA: Okay. So, I don't think that we should move Bullet 2 from Strategy 2. Because I think that we should be incentivizing healthcare organizations, even if they're not safety nets to, you know, be addressing social factors.

But to Nancy's point, I think that we also need to, we need to do both. So, I don't think this is an either or. It might be an addition, right.

So, I don't think that this is a move this away from this, and put it in another strategy. Because I think the intent for both is appropriate, so long as the intent in Bullet number 2, Strategy 2 is to incentivize across the healthcare system.

And then I think it was Strategy 3, or wherever it was around the safety net, to support the safety net. Because I agree with what Nancy said, and said very well.

CO-CHAIR CHIN: Well, we have, we'll

do Lisa, and then Philip, who's cool. He's, as I said, he's down, right.

MEMBER COOPER: So, I basically agree with what Romana was just saying. I'm, you know, thinking about the organization that I'm, where I work. And even though some of the practices may not be considered technically the safety net, they do serve a lot of individuals with, you know, that are socio-economically disadvantaged.

And if that got moved to a different place, you know, it might get lost. I don't, I also don't see any problem with kind of reiterating certain principles across different strategies. I think it's okay to, you know, because there's some overlapping sort of concepts. And I think they can be reinforced.

CO-CHAIR CHIN: So, for example, if you --

MEMBER SCHOLLE: This is Sarah. I'd like to get in.

CO-CHAIR CHIN: So, if we ask you to just duplicate it. So, we copy Bullet 2 and move

it to Slide 3 so it's in both, does that work? What does Slide 3 look like again, Slide 3?

It's a little different. It's, there's some overlap with number, Bullet 1 and Bullet 3. But a little bit different.

MEMBER HASNAIN-WYNIA: You did say in addition to, and reference the bullet on Strategy 2.

(Off microphone comment)

CO-CHAIR CHIN: Okay. So, Philip has, I've been ignoring Philip for the past five minutes. So, Philip.

MEMBER ALBERTI: Thank you. So, I think part of the issue is that maybe the overall buckets are unclear, right. And so, I think that's one issue. And I think the other issue is maybe that some of these strategies actually dip into both buckets, right.

So, I think, if I understand Susannah correctly, if we keep Strategy 2 towards things that actually incentivize action, right, and those actions are focused on promoting equity.

So, that's the idea of tying some of these advance payments to the culture and the structure.

This idea of actually rewarding the closing or the minimizing of a gap, that's actually incentivizing action that is focused on promoting equity.

In bucket 3 we might want to just rename it, right, in assuring fairness and building capacity or something, right. These are things that, I think calling our fairness is really important.

And so, the strategies that promote fairness might also incentivize action. And I think it's okay if things appear in both buckets. But we then have to sub-bullet it out to say how this strategy ensures fairness.

And in the other bucket, how this strategy will incentivize action. So, maybe bucket 2 is action, and bucket 3 is fairness and capacity building.

CO-CHAIR CHIN: What do people think

of Philip's idea? So, if you basically reword the headers on two and, well, two is essentially the same header. Three becomes more of a fairness header. What do people think of that? Nancy?

MEMBER GARRETT: Well, I really think it's important that we have a strategy that calls out protecting the safety net. So, I don't support changing that.

I think given all the discussion, and all of what's going on in healthcare, and again, how populations are unequally distributed across providers, I think that that's a really important thing for us to do. So, I would not favor that. But I also wanted to make one other point. Should I wait? Unrelated.

CO-CHAIR CHIN: We'll come back to you in a moment. So, both Hennepin County, and Denver General, Denver Health, yes.

(Off microphone comments)

MEMBER HASNAIN-WYNIA: So, I completely agree. I don't want to lose the focus

on the safety net. In terms of, I'll just stop there. I don't want to lose the language that focuses on the safety net.

MEMBER ALBERTI: To clarify, what I meant by ensuring fairness was ensuring fairness for the safety net. I mean, we could be, exclusively say that. But I'm thinking about how these things in unfairness, that's what I had in mind.

MEMBER HASNAIN-WYNIA: So, I agree with that, with the motive there. But I think that this kind of, without saying the safety net, speaks to the safety net. But it also speaks to other entities that may not be the safety net, or be recognized as part of the safety net.

So, you know, you can look back at Rushefsky's work and, you know, others that show that primary care practices that are in under resourced communities, and serve a high number of patients with, you know, many social risk factors, may not be part of the formal safety net.

So, I like the language here because it implicitly calls out the safety net, but leaves it open also to others that --

CO-CHAIR CHIN: So, thinking of timing. We're supposed to break at 11:45 a.m. And I think we should probably devote at least 15 minutes to the, going back to the disparities sensitive measure issue, in terms of updating those criteria.

So, we need to finish like these four slides in the next 20 minutes. So, we'll do Ignatius, Ninez, Tracy, Nancy.

MEMBER SCHOLLE: And Sarah.

CO-CHAIR CHIN: Sarah.

MR. BAU: So, I wanted to piggy back on that comment, and propose that we actually use safety net providers, rather than organizations. Again, in MACRA there's a recognition of the role of solo and small group practices, which historically, again, especially minority and under resourced communities have been part of the safety net and never recognized.

And then I did want to call out, if smaller practices are sort of included potentially in these kinds of considerations, there is precedent in the CMS value-based modifier that they phased in by practice size.

So, at first there was, it applied to everybody in groups of 100 and larger, and then to groups ten and larger, and then finally everyone. And so, that notion of again doing even a time phasing of how incentives might work would be another strategy to consider.

CO-CHAIR CHIN: Okay. So, a cut in the place slide of where it says organizations, providers, and organizations for safety net. Okay. Tracy, Nancy, Sarah.

MEMBER FERGUSON: Yes. I just wanted to just ensure that what we are proposing is for all organizations. Because we have some commercial organizations, very large commercial organizations that they have a large commercial book of business, but they're also now expanding into the Medicaid population.

So, I don't want them to believe that this is not, they're not a part of that. That they can't necessarily benefit from doing this. Because we see more and more of them going into the Medicaid space.

So, you know, we are supporting those smaller organizations. And those are truly safety net. But these recommendations are for all individuals. And I think we should just need to claim that.

CO-CHAIR CHIN: So, sort of say the, bolsters Romana's point of like making sure things apply to both. The prior slide, the incentives slide, that was more any organization. This one was more specifically the safety net.

But then it argues there for some degree of duplication between some of the points on the slides if they apply to both situations. Nancy, Sarah.

(Off microphone comment)

MEMBER COPELAND: Can I just get a clarity on that? Because --

CO-CHAIR CHIN: Go ahead. Go ahead, Ron.

MEMBER COPELAND: -- one of the conversations is, what are we defining as safety net? Is it who you take care of, this disproportionality of individuals with high social risk factors? Or some other designation?

If you're shaped this way, and if you have this label. Or if you get funding from a source, that's a safety net. So, I think we just need to clarify who we're talking about here.

Because if it's an inclusive organization, then any organization that's doing this work, and has those criteria, disproportionate service of individuals with social risk factors, that's who this would qualify for.

CO-CHAIR CHIN: Yes.

MEMBER COPELAND: Because it's the disproportionality, those who are in that mission space, that you want to make sure don't get hurt by these incentives, and the whole process.

CO-CHAIR CHIN: Yes. But understand, it's what's in the header, disproportionally served individuals with social risk factors. So, that could be the definition of the text, like how it's being defined for use, safety net. Okay. So we have Nancy, Sarah, Ninez.

MEMBER GARRETT: I just wanted to comment on your question, Marshall, about the second bullet, and the peer comparisons. And I would favor a little bit different wording. Rather than having a fair playing field, something like, to improve comparability with MVBP programs.

Because as we talked about yesterday, the peer grouping does not solve a lot of the issues. It, you know, like you were saying, Christy, within the dual population you might have two equal proportions of duals across two hospitals, and really different populations underneath that.

And so, you know, it's a technique that's going to potentially help improve

comparability. But it doesn't get to fairness. And I feel like the, I'm a little struggling with the word fair. Because we're so far from that.

And what is fair? Is it, right now we have a situation where we're investing a lot less in populations that are most vulnerable. If we invested the same amount in those populations, is that fair? Maybe it's not.

Because we probably need to invest more in those populations. So, that whole concept of equity is like giving people what they need, which is not the same across everybody.

And so, I'm just reacting a little bit to the word fair. And I'm not sure it's the right word for our work.

CO-CHAIR CHIN: So, does it work for your, so in that first part, the first sentence, so considering for parent organizations to peer organizations to ensure safety net organizations have something comparatively, have --

MEMBER GARRETT: To improve comparability within --

CO-CHAIR CHIN: To improve comparability --

MEMBER GARRETT: Within MVBP --

CO-CHAIR CHIN: -- in MVBP programs?

MEMBER GARRETT: Something like that.

CO-CHAIR CHIN: Now, the second question was, the Philip Alberti clause may need to risk adjust within comparison groups to ensure fairness.

MEMBER GARRETT: So, you could say something like, risk adjusting within peer groups may also help with comparability, or something. I just --

CO-CHAIR CHIN: Okay.

MEMBER GARRETT: I think the fairness is too aspirational right now. I don't think we're going to get there.

CO-CHAIR CHIN: Okay. So, replace fairness with comparability language. Okay. Sarah, then, Sarah.

MEMBER SCHOLLE: Sorry. I didn't take it off mute. So, I understand the concern about

the safety net population. I support that. But I think to the extent that the strategy should apply across organizations is stronger if we make it part of how things work overall, and not as a separate piece.

So, I think I disagree with other members of the Committee on that. Because what I can see is that if we do this comparison to peer organizations, then we'd be saying to organizations that serve a high income, or advantaged populations, we expect to, we're going to compare you to your peers serving that same population.

So, you're not going to deserve as much of a bonus as others. Because we can tell your population's advantaged. And then that allows more resources to go to people, organizations that are serving a more disadvantaged population.

So, I think that by segregating this into a separate piece, and you're saying we're advantaging, we're trying to advantage the safety

net populations.

But really what we're trying to do is say, let's readjust where the incentives go. And that's a whole system strategy, not a strategy just for safety net organizations.

So, that's one comment where, which I actually would like to see the first two bullets combined into Strategy 2. Because I think it's part of an overall payment reform strategy to support equity.

And I also am, I'm just looking for some clarity here. In Strategy 1 we said, it says that there should be stratification, stratify performance measures. Strategy 2 says directly adjust payment. And then Strategy 3 says risk adjust for social risk factors when appropriate, and stratify performance scores.

So, what I, so are those all saying the same thing? Are they different? So, I'd like to read that as stratify and directly adjust payments.

And then, so that the, I'm not sure

what the risk adjustment, where that's necessary, if it is. And are we saying something different just for safety net organizations about risk adjustment?

CO-CHAIR CHIN: Thank you, Sarah.

MEMBER SCHOLLE: Is it still about risk adjustment payments?

CO-CHAIR CHIN: Let's do this. That we have Nancy and Philip for comments, or just Philip at this point. Then we'll go back to your original question of looking at two and three.

Are there ways to combine or move things around? Or should we duplicate? We'll go back to your original question. So, Philip, and then we'll address as a Committee this risk question you had.

MEMBER ALBERTI: I just want to make a quick last plea for the word fairness. So, I agree. And Romana and I had a nice off line conversation about kind of the danger of aspirational thinking when we really want to actually do things. And I get that.

Our members though, talk in the language of fairness on this issue. Like, we want, why are our hospitals being unfairly penalized? We hear that over and over again.

And so, I think this is actually an attainable aspiration, that we can move the way in which we incentivize, reimburse, et cetera, towards fairness. We hear that language all the time. So --

CO-CHAIR CHIN: Maybe intermediate language should be the comparability language. And instead of the stronger ensure, something like improve fairness. Okay. So, comparability language, and then improve fairness.

Now, back to the original question Sarah mentioned about now to interrelate. And can things be condensed, removed, or should they be duplicated? And I just don't think we've come to a sort of clear consensus on this yet.

So, if people can take a crack at that, of trying to answer Sarah's question of what should we do about two and three, and the

degree of overlap. So, Ninez.

CO-CHAIR PONCE: I guess the, I agree with Sarah again. But what I heard, as you just said is, it doesn't, you know, limit us from keeping the first two bullets here. So that it's moved also in other sections that are appropriate. And I can't remember now what Strategy 1 and Strategy 2 is. But to move it up into those other strategies.

CO-CHAIR CHIN: No, Ninez is sort of the, two separate sessions, and then, but duplicate where warranted. So, for example, the comparison group, Ninez and Sarah are suggesting duplicate that in two.

Or something like the coaching quality improvement and disparage reduction. Well, potentially everyone could benefit from that. Another one, well, maybe those are the two that are most relevant for potentially duplicating in two. So, that's one --

CO-CHAIR PONCE: And sorry. And another amendment, listening to both Helen and

Philip is, because the first two are about fairness, and fairness is, as well as comparability for the peer organization comparisons, that fairness should also be in the first bullet.

So then, it's an explicit signal that that's why we're repeating it here. Because it's about fairness. To improve fairness, risk adjust for social risk factors when appropriate, and stratify performance score.

CO-CHAIR CHIN: As the, well, the risk adjustment, this -- Well, it's tricky.

MEMBER SCHOLLE: I would just say that there are those who will argue that risk adjustment makes them less reasonable. I would just echo, though, Nancy's concern, fairness is a controversial term. And it may not make our work stronger. And it may bring more controversy. So, I would use it strategically, not over use it. Because I think it's going to bring us more trouble.

CO-CHAIR CHIN: You cool with keeping

it in two and not in one?

CO-CHAIR PONCE: I don't want to get us in trouble.

CO-CHAIR CHIN: Okay. Okay. Okay, Michelle.

MEMBER CABRERA: I almost feel like we need a like little statement that follows, like between the strategy and the bullets, that explains ourself a little bit, you know. Sort of like the, what's the, you know, walk people through it.

And I think a lot of this under Strategy 3 is about the concept of accountability. I mean, I think that's what we're dancing around here. And accountability in the context of underlying inequity, right.

And so, if we could just say, put a statement out there that's sort of helping the ground people a little bit, I think that would help ease some of this confusion.

MS. O'ROURKE: Absolutely. And that's all, something you'll see in the report. There

will be statements under each of these bullets explaining the Committee's discussion and thinking, and capturing all of this conversations.

So, it will not go out in the report with just this list. But we want to make sure there's consensus on what the list is. And then we can add in all of the discussion.

CO-CHAIR CHIN: And what I'm hearing generally is that in theory Sarah's right, that like this could be subsumed under Strategy 2 for the safety net. However, the safety net is so important.

And there are a number of the bullets that are, I guess there's Bullet 3 and Bullet 6 are specific to the safety net. That people think the message will be stronger with sort of a separate bullet. But then, duplicating in two and three those things which apply to both. So, go ahead, Helen.

DR. BURSTIN: I just had one though. And actually Michelle's comment queued it for me.

It's less about, I think, from where I sit, putting things underneath these, Erin, as opposed to potentially something on top.

So, one question might be, could you have something about to improve fairness here, you know, consider the first two bullets. Because in some ways what we're really saying is, those are potential strategies. And the goal here is to improve fairness.

CO-CHAIR CHIN: Okay. So, anyone on the phone want to make any comments? So, the current draft now is to have separate two and three, duplication where warranted. Yes. That's the card. Anyone on the phone first?

MEMBER CABRERA: And again, I don't know if it's helpful to sort of like bracket it out by accountability strategies, right.

So, there's public reporting. And as it relates to public reporting there's this. There's, you know, payment reform. And as I relates to payment reform there's that. I don't know.

I mean, I'm just trying to think about why these things are included here at all, is because of how we're trying to hold folks accountable for different things. And there are different accountability applications.

So, it's just, I don't know. Trying to think about ways to make it easier for people to digest the information, and understand why these things.

CO-CHAIR CHIN: So, we're about to go to Slide 4. So, does anyone want to make an argument or amendment that is different than separate Slide 2, separate Slide 3, and duplicating where warranted?

Okay. So, let's go to Slide 4. So, we'll try to do this before 11:30 a.m., and hit the disparities sensitive condition discussion.

So, we had an early discussion. So, the header's going to be reworked to something having to do with some combination of demonstration and evaluation, and rigorous evaluation, and research. And so, staff's going

to take a crack at that. Getting rid of the word agenda. Ninez was going to reword the policy simulation bullet.

CO-CHAIR PONCE: With Phil. With Philip. We're going to reword it.

CO-CHAIR CHIN: Excellent. Why is four under demos and research, versus -- I wonder if that's now embedded under the one that Nancy wanted to bolster, the one about, we had like a vague invest language.

And then it became support incentive last I think was the -- So, we may be able to delete four. Because it's in there. Or else a sub-bullet within that one.

CO-CHAIR PONCE: This is Ninez. I don't want to delete it. I hope it goes somewhere.

DR. BURSTIN: I think it should go where we talked about it.

CO-CHAIR PONCE: Oh, okay.

DR. BURSTIN: It's good language.

CO-CHAIR CHIN: Okay. Why don't we

move to, well, can you hold Slide 1?

MEMBER COOPER: So, Marshall, it's Lisa. Why is the economic impact under like the research? Is that because it's like something that needs to be studied in the demonstration projects, or --

CO-CHAIR CHIN: Okay.

MEMBER COOPER: I mean, I'm just --

CO-CHAIR CHIN: Yes.

MEMBER COOPER: I'm just wondering why it's like its own bullet for, I mean, there are lot of other things that we could be assessing in terms of the impact. So, why is it only the economic impact?

CO-CHAIR CHIN: Right. So, first Ninez's point. That's currently Bullet 4 under Slide 4. That will be like a sub-bullet under Slide 1, Bullet 1. It's the one about, it's now support and incentivize social respecter data.

A good point, Lisa. So, is there a different place to put it, or a way to reword it so it's more integral, as opposed to purely the

research?

MEMBER COOPER: So, I mean, if we're funding demonstration projects we should be assessing like the impact. A variety of different ways of looking at impact, right? Not only economic but --

CO-CHAIR PONCE: I am --

MEMBER COOPER: -- you know, I guess other.

CO-CHAIR PONCE: Well, that would, let's give Ron a chance to --

MEMBER COPELAND: Yes. That probably I think is the staff's attempt to capture something we discussed yesterday. And I don't know if you were on that part of the conversation or not.

But I was making the case that, as it relates to how you put together the business case for why any organization needs to take on the issues of health and healthcare equity.

I said one of the things that's missing, because of the economic and financial

implications for supporting any major initiative is, what's the financial gain from taking on equity and achieving health equity?

And that starts with an understanding of what, how much is it costing me to ignore it now? How much is that impacting me in terms of cost of people showing up in emergency rooms, readmission rates, or whatever?

And when you look in the research, when you look in the data today there's no recent studies at all that try to quantify what the economic price we're paying for not taking on equity as our base case to start with.

And so, the conversation was, could we somehow incentivize research into this space with a specific purpose to quantify what is the price we're paying now? What is the cost of ignoring equity, and not eliminating disparities so that we have that as a base case, primarily to incentivize and motivate folks in a resource strapped environment, to say, here is some loss that can and should be captured with a quality

improvement agenda?

But nobody's quantified it. So, most folks just kind of say, the only reason to do this is because it's the right thing to do. There's some social, moral aspect. But it doesn't impact finance at all. And I don't think that's true.

There's some studies done many years ago that tried to quantify it. And it was in the billions, if not trillions of dollars. But nothing has really been done on a substantial research basis to try to quantify it. So, that's where the idea came from.

So, wherever we want to put it, it's fine with me. It was put in the research area because it was trying to acknowledge that there's research and data generation that needs to be captured that doesn't exist today.

MEMBER COOPER: All right. Yeah, no, I mean, I was there. And I agree it's really important. I just wondered why if we were going to be talking, getting specific about the types

of things we would be looking at, whether we would want to include other things that we want to have people assess, you know. That's all. But I agree 100 percent that it's important and needed.

CO-CHAIR CHIN: Well, maybe too, I can see the point, like why it was a separate bullet, because of its importance to, a driver of change. But maybe under the fund demonstration projects bullet we could have additional language, whether in the bullet or text, that talks about how, just a point about --

MEMBER COOPER: What we want to, and what we want to look at in those demonstration projects. What, you know, what --

CO-CHAIR CHIN: Right.

MEMBER COOPER: -- kinds of things are we looking for, you know.

CO-CHAIR CHIN: So it can be a variety of various clinical, economic outcomes, implementation, science issues, that kind of stuff. So, we can flesh that out in more detail,

Lisa.

MEMBER COOPER: Okay.

CO-CHAIR CHIN: So, I think it was David, Philip, and Emilio.

MEMBER NERENZ: Yes. I have some of the same concerns about whether the bullets actually follow the heading. And I think the problem may be part of the heading is, the way that's worded. And maybe we can tweak that a little bit.

CO-CHAIR CHIN: Oh, yes. David, you weren't here. But there's a, when you, the very beginnings of the discussion that that's going to be amended. So, it's going to be some combination of, in the header, demonstration projects, evaluation, and research. And the word agenda being taken out.

MEMBER NERENZ: Okay. That's not the part I was going to change.

CO-CHAIR CHIN: Oh. Okay.

MEMBER NERENZ: The part --

CO-CHAIR CHIN: Go ahead. Go ahead.'

MEMBER NERENZ: Well, but the problem is that the things that follow that suggest to me that they were talking about a very narrow research agenda, where use of measures is the independent variable of the intervention. And health equity is the presumed result.

Bullet 3 is not really about that. Bullet 4 is certainly not about that. So, I'd say do what you just said. But also, just say, it's a research agenda about health equity. Unless I'm misinterpreting what the rest of those words mean. But, you know --

CO-CHAIR CHIN: Here's, maybe Helen And El can guide us with that. So, for the peer audience, like a CMS or whatnot, as opposed to an AHRQ, how should we address David's concern, which is a good one?

CO-CHAIR PONCE: I think it's yes and, right? I think it's about health equity and, as well as measurement equity. I mean, research around equity and measurement. So, I think it's both.

I think there's a way we can capture that. But I think you're right. I think if you just focus it on the research around the use of measures in payment for equity, it's too narrow for the bullets below it. Got it. Okay.

CO-CHAIR CHIN: Okay. To broaden that part of the language. It was Philip, and then Emilio.

MEMBER ALBERTI: I think this might also be a place to call out the kinds of patient and community engaged research that we had talked a little bit about yesterday. To really make that a focus here, to ensure that we're understanding kind of how this work impacts a lived experience of those that we're serving.

CO-CHAIR CHIN: Thanks, Philip. So, Emilio, Ninez.

(Off microphone comment)

CO-CHAIR PONCE: Mic, please, Emilio.

(Off microphone comments)

CO-CHAIR PONCE: Emilio, your mic, please?

MEMBER CARRILLO: To just amend some of the wording to a socioeconomic impact of disparities in the immediate impact and the long term impact. I think that that gets at the core of the question. And CDPR, should we say anything about that?

CO-CHAIR CHIN: So again, we have the immediate and the long term. And maybe under Philip's point about the patient perspective, and all, we can include some CDPR language also. Ninez, Ignatius, and then we'll go to, at that point we'll call it quits and go to the disparity sensitive discussion.

CO-CHAIR PONCE: So, I saw this as a way of creating new knowledge on the domains where we don't have as much information on. And one of those domains was community engagement in partnerships. So, that was sort of the impetus of some of the bullets here.

CO-CHAIR CHIN: You mean like, maybe something about, like, I don't know if you want to highlight this or not, but like the different

five equity domains. And some of the areas basically we don't have great measures at this point in time. So, the need for more development of those areas.

CO-CHAIR PONCE: We need, this was spurred by Romana's comment on Kara's comment that she wants evidence. And so, if we're going to promulgate the five domains, then we also want to make sure we have the evidence base, to have teeth behind it..

CO-CHAIR CHIN: So, some type of bullet about developing the evidence, better measures basically, better equity measures. So, Ignatius, and then we'll go to the, improving the --

MR. BAU: So, I wanted to look back to Ron's comment about whether we actually want to say something explicitly about the business case. Because again, part of this, we're making these recommendations in the context of this shift to value.

And I think we want to be explicit to

say that both disparities reduction, and then the more aspirational achievement of equity is actually part of that value equation. And so, it's not an add on. It's not a, you know, post hoc rationalization. It's actually part of the formula.

And so, I think part of what this is trying to get is, it's a little more abstract in that way. But we want to make sure that this conversation is part of every conversation about value.

And then, especially in the context of exploring alternative payments, and other kinds of ways that healthcare is paid for, that again, equity is part of that conversation, in every alternative payment conversation, in every, where again, we're going to have the flexibility to do a lot of this additional funding I think. So, some way that, to tie business and value into the conversation.

CO-CHAIR CHIN: Thanks, Ignatius. That's an important comment. So, it's great that

we have a little bit of time to revisit those disparities sensitive condition criteria. Especially as it's come up that, and Bob and I just made a point that, and Romana, that when it comes down to it we're going to have to prioritize.

And there's going to be one of the bullet recommendations about using high priority disparity measures, which goes back to, what do we mean by a high priority disparity measure?

And so, I think Drew's going to give a quick background for people on like the disparities sensitive measure work of the past, which is a great start, but which needs to be updated because it has weaknesses. And so, that's what we hope to do over the next ten minutes or so.

DR. ANDERSON: Sorry, we're just working on screen sharing. I'm trying to remember, who here was on that particular committee? Romana? So, Romana and I, Ignatius.

(Off microphone comments)

DR. ANDERSON: I think Kevin was, yes. So, what we wanted to do was look at the protocol that we have for the disparities. And so, we're going to screen share that. And I, yesterday I went over a little bit about what those categories are.

But just to review. So, it's Page 7. That's a table. So, you can -- Oh, right. There we go. So, the first one is prevalence. This criteria was mapping it to the Medicare top 20 conditions, which included the conditions that we were looking at originally on this project, like cardiovascular disease, cancer, mental illness.

DR. BURSTIN: As well as the elimination of some conditions as well. So, some of this --

DR. ANDERSON: Right.

DR. BURSTIN: -- is just getting at which areas would be most important to focus on.

DR. ANDERSON: Right. So, prevalence just has to do with what do we know about where the disparities exist, where are the largest,

what's the prevalence of disparities in these conditions?

So, the second one is quality gap. And the Committee chose a certain width of that gap. So, this is, how big is the disparity between the comparison group and the group with social risk?

The second one was impact. And then this was, these are mapped to the National Quality Strategy and the NPP goals. So, some of these included that it had to affect, the disparity had to affect large numbers, was a leading cause of morbidity and mortality. There was a high resource use, severity of illness, those kinds of things.

And then, the next criteria is that there's a high degree of discretion. So, does it produce a lot of, is there less of a standard of care? Does it produce more variation in practice?

And then the fifth one was the communication sensitive services. So, care that

is more sensitive to language barriers. And then the last one here was social determinants.

And so, this one was more tied from the report to behavior. But it was, it is really just a general bucket of care that is more sensitive to social risk factors.

And then there was a waiting schema for how to assign whether or not the measure was actually, like how to rank the measures in terms of how sensitive they were to disparities. Yes, please, jump in..

DR. BURSTIN: It's great. Thanks, Drew. So, this is, I just want to be honest that the scoring came after the Committee. We tried to operationalize this after the good work of the Committee, that really gave us the initial criteria.

And essentially, one of the hardest things when we tried to do this, we did this with about 400, 300 or so measures within the NQF portfolio, is how difficult it was to find information back to the research person on

whether there was a quality gap, and whether there were known interventions with which to address them.

Very difficult to use the ones like communication sensitivity and social determinants. So, really, in essence we wound up focusing on the first three as being the ticket ones.

Is this an area really of importance to the populations at risk? What's the quality gap? And that 13 percent was truly just where the data seemed to be an empiric cut point, based on what we saw, a split in the data. It has no basis in anything, just to be honest.

And then lastly, impact was just the idea that this could have a big impact. And at the time we were using it, linking back to our national priorities goals.

We could link that to the National Quality Strategy, et cetera. Or could link it back to the domains you just laid out, right. So, there's that, there's a nice opportunity here

to think about a refresh.

I'll also say at the time this was very invested in the idea of which measures you had identified that should always be stratified. That you couldn't just look at the rate of low birth weight, for example, in the U.S. It made no sense. You had to look at low birth weight by race and ethnicity. Because we knew those differences were profound, and met every one of those criteria.

But in this day and age, you know, we're not necessarily talking about this being always about stratification. And so this, the idea was to call attention to areas where we knew there were disparities. And simply looking at the overall rate would not give us the information we needed to act on reducing disparities.

CO-CHAIR CHIN: Yes. Thanks, Helen and Drew. So, in some ways this is a restart. And I don't know what your impressions were, Romana. But I remember being on the Committee.

And I wasn't very satisfied with sort of the end. And so, that, it's, you can't say, Helen, in practice then it devolved down to what you actually used for the top three.

DR. BURSTIN: Absolutely.

CO-CHAIR CHIN: Okay.

DR. BURSTIN: Yes.

CO-CHAIR CHIN: Okay. So, I guess let's get back to the question of how we're going to operationalize that bullet recommendation about use high priority disparity measures, equity measures. How do you people think we should then describe this in text of how we're defining high priority?

MEMBER GARRETT: Well, I'm just reacting to the social determinants criteria. The scoring is interesting, because it was, you're trying to look for measures that were not socially determinant dependent, right? Am I understanding that?

CO-CHAIR CHIN: That also was my impression too. In some ways that is like one of

the big updates where your point's going to be that, well, it's broader than what we think of, the healthcare system should be responsible for.

MEMBER GARRETT: So, I think, and I think we talked about this on our first day. But one of the ideas in the National Academy of Science's Report was that perhaps we should start to have a scale or a categorization of measures to understand how sensitive they are to social determinants, as a way of really helping understand better how they should be used.

So, if it something like diabetes outcomes, where we know that if you live under a bridge it's much harder to have blood sugar control, that that, maybe use that differently in pay-for-performance programs, than a measure that's much more in the provider's control.

And so, I just wonder if that should be pulled out as a new categorization system that our Committee could recommend be put in place.

CO-CHAIR CHIN: So, the point being that, just trying to think about what measures

may have, be on a range of susceptibility to social determinants. And then some consideration then of issues, like read that an organization should be accountable.

There's somewhat, you don't want to give people a free pass of like, well, okay, anything having to do with the community is out of our control. Because it pushes towards more of that encompassing. Yet, you want to be fair, I guess. So, some type of language that discusses that conundrum, okay. Bob, then Romana.

MEMBER RAUNER: Yes. I just kind of sent an article I had mentioned last year about expressing in qualities what these preventive strategies would hurt. Because I think that kind of helps talks about the prevalence in quality of that gap. Because that's how they came up with the article. So, I just sent it back to the group in this.

But that, yes, they expressed in quality just in life's years. If you could go

from where we think we are right now to a certain level, what you could achieve in population health, in fact in life.

CO-CHAIR CHIN: Okay. So sort of like part of I guess impact. So, in terms of like, I guess what, about quality and impact, and the degree of which there were interventions that can improve. Yes. Romana.

MEMBER HASNAIN-WYNIA: So, in terms of the social determinants, I think that we need to be very explicit that in some ways, and I think, Helen, you even said, you know, some of the work that we did earlier, so those 2012, business in 2012 report, is a bit dated.

Part of it is because it was focusing primarily on healthcare disparities, and the dialogue, and also, you know, a little bit of the science. And also value based purchasing, and all that was not really part of the conversation.

So, the Committee really focused on disparities in the context of the healthcare system, in a sense. So, I think we should be

pretty explicit in terms of the work that this Committee has done, the NAM report.

That we recognize the importance of social determinants, and not be passive about it, and pull this up, you know, to a high level. So, we include prevalence, quality gap, impact, and social determinants explicitly, because of the evolution of the work in health disparities and healthcare disparities.

CO-CHAIR CHIN: Yes. You got to finish the change too, a point that Emilio brought up a couple times about, like greater appreciation of the structural determinants of disparities, and structural racism, and all.

Basically when I teach students, they get that part about like implicit bias. And they get the part about the communication sense of things. The thing they have the hardest time seeing are, the way we accept the system that leads to the results we get. But it's just a powerful driver, yes. Michelle.

MEMBER CABRERA: I'm just going to

keep going back to, I think this is really about how we're applying things, and the accountability applications, right.

So, you know, I can see how you could look at are you, we would give guidance or recommendations around, are you going to be withholding or penalizing on this basis? Caution. We don't think you should. Here's why, right.

Are you incentivizing, or providing more funding to people? So, for that, you know, diabetic who lives under the bridge, you shouldn't actually be dinging a provider who has lots of those people. You should be providing them with additional resources. Because their diabetic is qualitatively significantly different than your diabetic, right.

And then there's also the accountability application of public reporting. And again, this has significant applications for health plans and providers, both of them.

In our state Medicaid health plans are

ranked on aggregate HEDIS and CAHPA scores. And then your aggregate score is the driver for default patient assignment, okay, which matters to people.

And if you're looking at an aggregate score one of the things we've asked the state to do, for example, is for those commercial plans who do both Medicaid and non Medicaid, when you're going to be using it for accountability, desegregate their Medicaid book of business. And let's see how they perform on quality compared with other health plans, not just --

So, there are all kinds of dimensions of how this stuff is playing out. But I want us to be really firmly anchored in not just the measure that sort of sits out there as its own thing, but the application, and the accountability pieces of all of this.

And, you know, I think that requires a bit more work. But I think it's worth it. Because that is the real world scenario, and how these things are playing out.

CO-CHAIR CHIN: So, we'll turn to the people on the phone now. And you don't have it in front of you. But like the slide that, right now it's a slide from this old disparities criteria from five years ago.

And Helen had just mentioned that in practice the criteria that the, you know, that NQF has used, the first three prevalence of condition, the quality gap, the impact.

We just had a little bit of discussion by Romana about social determinants, Nancy also. Their point being that this broadened in terms of the conception of the past five years of what the healthcare system's responsible for.

So, are there thoughts from people on the phone about updating of the criteria?

MEMBER COOPER: This is Lisa. I like the three, you know, the top three I think are, you know, are great. For the quality gap piece, is that going to be replaced with a disparity gap? Or are we going to keep it at a quality gap?

Are we going to add something related to the disparity gap, or equity gap? Are there any thoughts around that? And, you know, and I agreed with what Romana said about the social determinants piece.

DR. BURSTIN: You know, it's just mislabeled. I mean, we mislabeled it. I mislabeled it. So, way back when. So, the idea here was that there was actually a gap in quality between populations. So, probably is more --

MEMBER COOPER: Okay.

DR. BURSTIN: Agree at this point to actually call it an equity disparity, whichever word you think is better, gap. So, essentially we're looking at, what's the performance for the non-at-risk population, versus the at-risk population, when we could find it. And again, that was part of the issue was, so often difficult to do, to map that out.

CO-CHAIR CHIN: Okay. Thanks, Helen. And so, it sounds like so far we're basically evolving for a simplified, actually a simplified

version of what has actually been practical use.

DR. BURSTIN: Right. So, just one more question if I could. And I'm glad Romana walked back in. So, the social determinants, if we bump it up to the top, is the idea, meaning you would preferentially want measures that address social determinants? Or, how, I want to make sure I understand the, how we might prioritize measures around social determinants. I'm looking at you.

MEMBER HASNAIN-WYNIA: So, in my mind what I was thinking as we were thinking about if we were going to limit let's say two or three measures, that we would limit the measures to those that had clear connections to what, that have an impact related to social factors.

So, you know, so if we were to focus on blood pressure measures, or measures related to diabetes, we know that, you know, I think Dave was making this point yesterday that, you know, healthcare organizations can, you know, test for cholesterol, and A1cs.

But actually, you know, controlling is a completely different, you know, it's a completely different ballpark. Because it impacts, it's, the impact is driven by what happens where people live, neighborhoods, communities, et cetera.

So, what I was, when I made the comment a few minutes ago about bringing social determinants, that we focus on those, at least those conditions, and then the measures related to them where, you know, we know there's prevalence, there's a quality gap, the potential impact of the action related to that measure, and where they're, where we know that social factors play a big role. So, that was the intent.

CO-CHAIR CHIN: So, maybe related to what you just said, Romana, bringing in the Committee's recommendation from yesterday, that outcome measures really should be prioritized for this.

DR. BURSTIN: Yes. And I think one thing to mention. I think I've shared this with

Marshall. We've also got a prioritization schema that we put forward, discussed at our annual meeting have a setup for criteria overall, not specific to this, for prioritization criteria.

One of, there are four. The first one is that it's outcomes focused. So, an outcome or a measure very strongly linked to an outcome. The second is that it's improvable and actionable. The third is that it reflects care that crosses settings, clinicians, and providers, to have more of that patient focused view. And the fourth, of course I'm, I always forget the fourth. What's the fourth?

(Off microphone comments)

DR. BURSTIN: Poor Jean Luc, he's like ohhh. Ahh, I'll bring it up in a second. But anyway, essentially outcomes orientation is part of that already.

And just so you know, part of what we also did as part of this measurement framework is identify that top outcomes, the top high impact areas for the nation that we want all measures to

drive toward. And equity is one of those.

So, we have already put that at the top of that pyramid as something we want to drive toward. So, this actually nicely fits in with all the rest of this.

CO-CHAIR CHIN: So, we're going to ask first, any public comments? Anyone on the phone, or here in the audience would like to make a public comment?

OPERATOR: If you would like to make a public comment, please press *1 on your telephone keypad. Again, that's *1 to make a public comment. We have no one at this time.

CO-CHAIR CHIN: Okay.

(Off microphone comment)

CO-CHAIR CHIN: So, thanks very much everyone. I think we got a lot done this morning.

(Off microphone comment)

CO-CHAIR CHIN: So --

DR. BURSTIN: Sorry. This last, the very last, the fourth criteria, which I think is

important in this context is that the results would be meaningful to patients and caregivers. So again, I think logically it would, this would fold in nicely, I think, which we've put forward here.

CO-CHAIR CHIN: If staff can email the Committee then those criteria, that would be good to see. And so, first, thanks, everyone. This was a challenging conversation to get through, and tough issues. And I think we ended up in a good place.

And so, what we're going to do is we're going to break 15 minutes to get lunch. Then we're going to have a working lunch where, before the 12:30 p.m. trial period discussion we're going to talk a little bit about the final portent of the heal affairs opportunity we have, that's based upon, partly upon the work that we've done, as far as we want to brainstorm a little bit about that as a Committee, about what we might do with that. So, why don't we reconvene at, well, 12:10 p.m.

MEMBER HASNAIN-WYNIA: Sounds good.

CO-CHAIR CHIN: Okay. Great.

(Whereupon, the above-entitled matter went off the record at 11:52 a.m. and resumed at 12:11 p.m.)

CO-CHAIR CHIN: So, we're going to get started because we have the 12:30 agenda item on the trial period. And so we want to spend this time talking a little bit about a Health Affairs journal article opportunity.

And so Health Affairs, every so often they have a theme issue. And equity has been one of the recurring theme issues. So actually this month's issue is an equity theme issue, and September is also going to be -- well actually not in September but in 2018 they're going to have another equity issue.

And some of you have seen that there was fairly recently a call for papers where they want to have people submit an abstract of a paper that they've proposed. Then there's this, like, a limited number of those folks to then submit a

full paper. No guarantee on publication but you're in the mix in terms of it being accepted.

So we still have that opportunity. And then right around the deadline, Susannah actually encouraged us to apply also. And so Erin drafted an abstract which basically talked about how we propose talking about the work of this Committee and what NQF is doing in the disparities, really focus upon the work of the committee and the framework and the recommendations.

And so there was good news and bad news with the response from Health Affairs. The good news was that we did make the cut in terms of being asked to submit a full paper. The bad news is they didn't want us to focus solely on sort of what we're doing, that they want it to have data and all.

So maybe I turn to Erin just in terms of, like, the exact wording from Don, that's the editor. And what we're looking for from the group is if you have suggestions on given, like,

the editor's response, what do you think then we should do as a committee in terms of what would be a worthwhile paper that would be important, impactful, and that would be in response to what the editor wants? Yes?

MEMBER HASNAIN-WYNIA: So this is for Health Affairs? This is the, so you had one paper that was published, and this is for the second round of the equity journal?

CO-CHAIR CHIN: Yes, so the paper for June, that was sort of separate from NQF. But this is, like, they have another RFA out there for some time in 2018 it's going to be an issue.

MEMBER HASNAIN-WYNIA: Yes, I'm on the committee for Health Affairs.

CO-CHAIR CHIN: Excellent.

MEMBER HASNAIN-WYNIA: So, I mean, I don't think there's any conflict here, I'm just saying.

CO-CHAIR CHIN: Why don't we have Erin first read Don's reply and then your input and why would be very helpful.

MS. O'ROURKE: Sure. So just to highlight I think some of the guidance you provided and that we would like the Committee's input on was they seemed to like the premise of our paper, that we could, incentive to reduce disparities can be built into payment policy and performance measurement.

But they would like to see the argument developed a bit more than just expert opinion and would like us to support it with some examples and illustrations, arguments and analysis, and empirical evidence rather than just based on the Committee's deliberation.

So this language is more along the lines of a standard paper. So we've been brainstorming a little bit about what evidence we can use to support this. I think throughout the meeting the Committee's provided some great, illustrative examples we can look into and build out.

As far as empirical analysis, just some quick brainstorms where if there's anything

in the trial period data that we've generated that you'll see this afternoon and was in the paper we shared.

Perhaps something along the lines of what Susannah talked about with an example from the re-admissions program. Maybe not that one since that's a bit of a flash point, but the idea of, Susannah put it nicely, of once you started measuring and incentivizing something, you reduce something people didn't think could be reduced.

So I wanted to open it up for some brainstorming on what might help us support these arguments to get the paper more broadly accepted.

CO-CHAIR CHIN: And we'll start with Romana.

MEMBER HASNAIN-WYNIA: So the paper that was submitted was submitted as more of a, I don't want to call it empirical because it's not necessarily, it's not an empirical paper. It's more of a commentary thought piece, but they wanted, but it came back with more he wanted more empirical evidence within the commentary.

DR. BURSTIN: Evidence. I mean, I think what he was really saying is something along the lines of a standard paper. So don't assume that you can put something forward purely based on the expertise of your committee.

MEMBER HASNAIN-WYNIA: Right.

DR. BURSTIN: But that there should be some, you know, the incentives to reduce disparities for example. So the Committee's works would better be viewed as a starting point for the paper rather than an end in itself.

You can use insight from the Committee's work, of course, but it can't be the sole source of input, and it may only play a minor role in the narrative.

MEMBER HASNAIN-WYNIA: Okay.

CO-CHAIR CHIN: Bob?

MEMBER RAUNER: Yes, I got thinking about this after reading David's article last time is that you could take a hypothetical for a medium sized ACO essentially, and then take what that percentage reduction in quality measures

based on what David saw in his article, how that would financially impact an ACO.

That you could run, you know, a base case and then run a similar case that if you brought in all safety net clinics and their colorectal cancer treating numbers were all that amount lower using that case, what is the financial impact. And I think that would make a pretty concrete example of how this is potentially messing with FQHCs or safety net clinics.

CO-CHAIR CHIN: I guess, I don't know if I mentioned, but we have a time limitation. We're due in September, so there's not a lot of time. And frankly part of it too, I mean, it's because we're NQF that we've probably reached this particular stage.

And so even though his email sort of downplays NQF, I don't think we want to sort of, like, throw, I mean, the core probably still has to be like the work this Committee and the things that are going to be embedded in the conceptual

model, equity domains and the recommendations in the final report.

I mean, that's why we're invited probably. But you hear Erin's comments about, like, so it's a little tricky needle and thread in terms of what we can contribute as NQF and as a committee, and then fitting the material that he puts down. Michelle?

MEMBER CABRERA: I just want to promote, if it's relevant, the examples of covered California as well as California's 1115 waiver, both of which incentivize both collection of SDS data, or social risk factors, and then pay-for-performance to close gaps or reduce disparities. So is that kind of one of the things you were thinking of as part of the evidence base, or no?

CO-CHAIR CHIN: Well I guess part of it can be, like Erin and staff as well have given many examples as possible for the actual report in terms of making things come alive. And then maybe sort of one of the text also that take

examples, like what you mentioned or like Bob mentioned today some examples form the ACO world.

You can't out do a publication, but I do think, like, some degree of overlap in terms of the report that the staff's writing anyway. I mean, that's what's probably realistic.

MEMBER CABRERA: And, well on that, so I had a second question which is I think core to a lot of the work that we're doing here is this concept that if you're trying to improve quality but you're not looking at disparities, you're actually messing up or, you know, missing the ball on something.

So I think if there are examples, and I know there have been some but I'm not aware of, like, the best of where a quality improvement effort may have failed because it didn't look at equity or disparities. Would that be an example of the kind of thing that might help?

CO-CHAIR CHIN: Your guess is as good as mine. I'm not sure.

MEMBER CABRERA: Okay. Well, one

suggestion.

CO-CHAIR CHIN: Yes. You could consider it though, yes. Emilio and Romana?

MEMBER CARRILLO: I think that there would be great interest across the board on the issue of these disparity sensitive measures which is something everybody's, you know, kind of thinking about, and which is something that we're working on and kind of touches a lot of the work that we've done.

And going back to some of the foundational stuff like the Weisman paper from '12 or '13 that lays out the characteristics and does a brief analysis of the portfolio of NQF which is thousands of measures. Which of those measures, what type of measures would fall into the category of disparity sensitive?

So maybe some just looking at NQF measures and how this particular approach would point out those that are disparity sensitive.

CO-CHAIR CHIN: I guess really what you're saying, Emilio, one approach is to really

still have it fairly NQF centric where if the overall issue is well, how do you improve equity with a huge lever being equity, well performance measurement and then the use of public reporting and payment.

Well, here's a brief history of what NQF has done in the past with disparity sensitive conditions, one of them. Here's the current work, here's the evolving type of questions. Here's some data from the trial period with some risk factors being, like, one important piece of that.

So we have some data for that, so it's not just expert opinion. And then the policy regs. I mean, that keeps it in our wheelhouse of what our strength is. I mean, I don't know how much he's really asking for a review paper because, I mean, others can do review papers as well or better than us, so that's not really our strength.

I mean, the strength is the work that we're doing, and that's what makes it interesting

to, I would presume, the audience. Anyway, Romana?

MEMBER HASNAIN-WYNIA: So I'm on the editorial board and I was on both the committees for the special issues or the specific issues on equity. And I think if it's purely focused on the disparity sensitive measures, it won't get a lot of play at health affairs.

What I do think is that that could be a component of it, but it has to tell an overarching story, and that story has to be bigger than NQF. But NQF's role in driving, in this case measurement, is important.

So in some ways, you know, if we think about even the conversation today, where we were with disparity sensitive measures, where the role of social determinants kind of, you know, where it fell back in 2010, 2011, 2012, I would bring in some of the work with NAM because there's so much crossover, and reference that.

So showing some level of cohesion which I think the reports that staff have

written, you know, have already started to do showing kind of like this critical mass of work that connects the dots, but then honing in on what NQF is specifically doing around the measurement piece.

And you know, so bringing in the disparity sensitive measures, but kind of maybe really emphasizing where that intersection now, the social risk factors and social determinates plays out and how NQF and this Committee has been thinking about that integration.

That would be a new contribution in my, at least in my opinion based on the conversations of the Committee that was trying to focus on, you know, what is the ask of authors who would be submitting to this issue.

CO-CHAIR CHIN: That makes a lot of sense. Emilio?

MEMBER CARRILLO: Just to continue on that train of thought that you proposed, the fact that cultural competence over the years has evolved and now the social determinates coming

together in a way that is measurable, I think that that force, those forces that are evolving and how NQF is basically turning those into measures would be, in terms of development of the field, would be an important statement.

CO-CHAIR CHIN: Ninez?

CO-CHAIR PONCE: Yes, I think both Romana and Emilio have helped us with an outline for the paper. And, but just to get into specifics, in terms of moving the field, I think what I've heard here a lot is the importance of community level factors that have not really come to play in the operationalization of measures.

And also, again I always call out Christie's work on emergence of new data sources to get at more granular community level factors. So, and that's all content that happened here.

And then Dave presented at NAM again something on community level factors as well. So where it's the place. So some of that I think can help populate the outline that Romana said with the overarching evolution and thinking that

Emilio noted. I think we have a paper.

CO-CHAIR CHIN: Anyone on the phone, any thoughts about this?

MEMBER BERNHEIM: Yes, I think imbedded -- this is Susannah -- in what you all have already said is, or maybe supplementary, is to the extent that we're getting to specific strategies, you know, we don't have complete evidence on what strategies are effective.

But among this group we have built some evidence for what strategies at least are feasible. You know, there's lots of examples now that have been sort of scattered through our discussion. And I think it's going to make our report stronger and the paper stronger if we can lean on those.

CO-CHAIR CHIN: Thanks, Susannah. Anyone else on the phone, any thoughts? So moving ahead, like, in terms of process, so I guess quickly timelines. So we can talk to the journal about what's possible.

But one think we may be able to do is

if you have any particular interest in working on this, maybe let Erin know so that we may be able to do something, like, again if the journal allows.

But we may be able to do something where there's both a group authorship in terms of the disparity standing committee listed, and then also if there's a subset of people that want to work on it enough to be listed as individual authors also. But we'll have to sort of talk to the Health Affairs about that.

But if you have any particular interest in working on it, knowing Susannah wants to work as one person. Any particular interest, maybe just let Erin know and we'll figure things out. Okay.

Anything else, Ninez or Helen?

DR. BURSTIN: It's great.

CO-CHAIR CHIN: Okay, great. Thank you. We have maybe five minutes before the 12:30 general item starts. Erin wanted to know, if we're starting to end the work of this contract

of CMS and we're talking about dissemination.

And so of course it's going to be the final report, this is going to be -- well, we'll see what happens in terms of the Health Affairs paper.

Do people have other thoughts regarding dissemination in terms of maximizing the impact of the work of this Committee?

MEMBER COPELAND: Is there a planned distribution map already? And you're looking for additions? Or is this starting with a blank sheet of paper?

CO-CHAIR CHIN: Great question. So Erin and Helen, what is the default dissemination plan?

MS. O'ROURKE: So generally we post it on our website, deliver it to HHS, we notify anyone who's expressed interest in the paper that it's been published. We do put everything out for comment, let all of the members of NQF as well as people who have signed up who are not members to follow the project to please weigh in

and share the results.

But I think that we're hoping to get some more input from all of you on how we could be more impactful and get more uptake of this than necessarily just putting it on our channels, and would love to know what you think might be useful.

MEMBER FERGUSON: There might be an opportunity if you have sort of a template for a press release where we can link it to so that if there's members that are really involved and frequently do send out press releases, and if you have some of the templates, information that can go out then, you know, our organizations can -- you might want to get a list and make sure that it's in line. But you know, organizations will be able to disseminate that. You know, I've been giving dates so we'll just have a mass population in terms of a press release, a news release.

CO-CHAIR CHIN: That's a great idea. Romana?

MEMBER HASNAIN-WYNIA: So, because

there is a strategy that focuses on demonstrations, research, evaluation, et cetera. I would recommend that, and I'm going to actually ask Ron to help with this. So I would recommend trying to get a session at the annual meeting which is in DC.

And Ron sits on the addressing disparities advisory panel. So this is something Ron can recommend. I know advisory panel members have a lot of weight in terms of their recommendations because it's a committee focused on equity. If it's squarely into their priority for addressing disparities, so that would be an opportunity to present and say, you know, this is NQF saying we need more evidence on X, Y, and Z. So that's just a very specific recommendation.

CO-CHAIR CHIN: Great. So maybe Erin and team can follow up with Ron there?

MEMBER SANCHEZ: Hey Marshall, this is Eduardo.

CO-CHAIR CHIN: Go ahead, Eduardo.

MEMBER SANCHEZ: With regards to

dissemination, a couple of thoughts. One is that we all, and I've heard mention of this already but I represent a -- I work in a large organization that's got its own communications channel.

And so it might be a way to amplify the message. And if I were to know who to work with in advance, we can do both our more traditional communications, but then also we, like many others, have a whole social media presence that we're trying to grow even more.

And then I just wonder if there isn't opportunities for blogging and commenting about the importance of not just the notion of equity and disparities, but the importance of measurement and the value of measurement to move us towards the elimination of health disparities and the achievement of health equity.

CO-CHAIR CHIN: Thank you, Eduardo. So quick comments from Nancy and Philip, then we'll turn it over to Ninez for the afternoon discussion.

MEMBER GARRETT: Well, I wonder if there's some way to team up with the other two efforts that are so related, the NAM report and the ASPE report and show the similarities between them and have some kind of common press release across all three, that would be one idea because it is a little confusing when these things come out singly and then everyone has to try to connect the dots themselves, so that would be one idea.

And then I just, I really liked this kind of four page thing that they did for the NAM report. It makes it a lot easier than handing somebody a 50 page report. So something like this I think is helpful in dissemination as well.

CO-CHAIR CHIN: Thanks, Nancy. So Philip, and then we'll turn it over to Ninez.

MEMBER ALBERTI: Just briefly, you know, AAMC has dozens, many dozens of different kinds of communication channels and venues, meetings, annual meetings, quality focused meetings, distribution lists with tens of

thousands of people. So I'm sure there's a way that we can coordinate and amplify the word.

CO-CHAIR CHIN: Same thing. So Erin and staff, be in contact with Philip in terms of getting on a panel for AAMC shared by Philip Alberti. Okay, Ninez.

CO-CHAIR PONCE: Okay, we're at the point of our meeting where we will discuss the report on the review and evaluation of the NQF on, it still says SDS trial period but I think it's now renamed Social Risk Factors, risk adjustment for social risk factors.

I just want to check on the folks on the phone. I know we've gotten an email that Lisa Cooper has left the meeting for a nephew's wedding, very important. Is anybody else on the phone, just to make sure we get your comments.

MEMBER BERNHEIM: This is Susannah, I'm still here.

CO-CHAIR PONCE: Okay, great. And Sarah dropped off, she was in Alaska.

DR. BURSTIN: And Tom thought he would

be on by 1:00 p.m., but he'll join us in a little bit.

CO-CHAIR PONCE: Okay, great. So I give it to Helen and to Erin.

DR. BURSTIN: Perfect. Thank you, everybody. So this has been a long time coming. We're delighted to have the chance to talk with you today about really what our experience has been over the last couple of years, and a lot of this work goes all the way back to the expert panel that Kevin and David chaired for us back in 2013, 2014.

And at that time, our expert panel really, I think in many ways, started the ball rolling on this issue that has now become so prominent across many different groups which is exciting to see, and really was the idea that for years, NQF had had a prohibition about including race, ethnicity, any of those kinds of factors in risk models, really because of fears that we might be masking disparities.

But ultimately, somewhat I think to

the surprise of some of us at the start of the panel, ultimately the panel recommended including social risk factors with a pretty high bar as we've now discovered over the last two years of having both a conceptual and an empirical basis for doing so.

Given the concerns we were still hearing out in the field, there was a decision that we should move and do a two year trial period and see if we could share the learning over this two year trial period. And during this trial period, allow these social risk factors to be included.

And we very much set up this trial period to follow the guidance of the expert panel, and I think probably five or six of you were on that expert panel as well. And the first, and I think much of this very much resonates with I think what we heard just the other day from the National Academy of Medicine as well.

So first, we had recommended that each

measure really needed to be assessed individually. This was not intended to be a blanket statement that all measures be adjusted. And that in fact there really needed to be a conceptual basis, a logic, a rationale, a theory behind why you would do it as well as empirical evidence that adjusting for it mattered.

And I say those words easily. Actually defining those was harder than I think any of us thought, and we'll certainly come back to that. And we gave some examples in the report of what wouldn't be adjusted, for example safety events in hospitals are unlikely to require adjustments for these factors, things that have the longer time periods where patient engagement and their environment were particularly important are the ones that logically have that conceptual basis.

We also didn't just limit it to hospitals, although that's where the heat was certainly at the time, and still around readmission measures. It would really be to any

level of analysis, health plans facilities, individual clinicians.

And that during this trial period, if adjustment was appropriate, we would endorse one measure with specifications also to compute both the adjusted measure as well as the stratification for whatever was significant. And we thought this was important, we felt like it gave us the ability to have our cake and eat it too.

Yes, adjust for fairness, but at the same time, provide the transparency that continued to be an issue many had raised concerns about over the years.

So what ultimately happened is we took that great guidance from many of you in this expert panel report and we packaged that for all of our standing committees. So all of our standing committees now have the opportunity to look at measures in this way.

And specifically had them consider these specific questions, each of them. Is there

a conceptual relationship between any of these factors and the measure focus, and some of these just relate to really just good guidance around risk adjustment.

Was the factor present at the start of care, is there enough variation in the prevalence of some of these factors across measured entities. Does the empirical evidence show that the factor has a significant and unique effect on the outcome in question. And I think we'll come back to that one as well.

And finally, is the information available and generally accessible for the measured patient population, and that is the other one obviously we will come back to as well. I think those were prescient questions when we wrote them two years ago, and they're clearly at the core I think of what we found over the last couple of years.

So over the last two years, really just ending April 15th, so pretty recently, any measures submitted for endorsement, whether new,

maintenance, any of those measures could be included in the trial period.

For the most part though, and I want to emphasize this because the expert panel report did not say focus only on risk adjusted outcome measures. It could be really anything, intermediate outcomes, other issues were certainly raised.

I think for the sake of the trial period we were talking about adding factors to an existing model for the sake of simplicity, we mainly focused in on those risk adjusted outcome measures.

I will tell you at these tables, many committees raise issues about other measures that did not yet have risk adjustment as part of them at all and said what about social risk. So I think it's something again we've teed up for you to come back to at the end.

And you know, the measure developers were required to provide this information on a conceptual relationship. And if they found a

conceptual relationship, we then asked them to conduct the empirical analyses between the risk factors and the outcome of interest.

And we had each of our standing committees evaluate risk adjustment under the validity criterion where all of that is looked at across all of our committees.

So at the start of this, we worked internally with CSAC and actually this group as well to start thinking about what will we even track over the course of these two years. And this is a list of some of the questions that we tracked and drove some of the analysis. You've probably already seen the report, and I'll go over it today.

So first, which measures had a conceptual relationship? Something you guys added at your last in-person meeting was the suggestion that we not just look at which measures had it, but how did they come to that point, how did they arrive at that conceptual basis. So for example, was it largely

literature, or data driven, how did they come up with that conceptual basis.

Which variables and social risk data were available and analyzed? What was the final dispensation for those measures that were submitted with conceptual basis, were they ignored, what was the concerns, what issues were raised?

And then finally, if they were included in the risk model, if these social risk factors were endorsed in the model, were we seeing developers following through on the submitting the specifications for stratification.

We also went ahead and realized this wouldn't be sufficient, and we also decided we needed to go back and do some qualitative assessments as well. So in fact Drew and Erin and other staff sent a survey to every one of the 300-odd committee members who had been part of this process over the last couple of years to get their input as to what they thought about the trial period, what they thought worked well, what

information would have been better to have where they felt like they needed more clarity.

And in addition, we also looked to see what measure developers perspectives were about being part of this trial period. How onerous was it, how difficult was it to get the data, for example. One of the great limiting steps, as we've discovered.

And then we also did a qualitative assessment of all the public comments that came in on those measures to see if there was some similar themes that were emerging around this.

All right, so I think we're on to the next one. No, we missed something. Okay, now it's up. Next slide. Oh, I have it. It's been a long few days. It's like three days of sitting and talking about disparities.

So this is sort of, this is the slide that really summarizes what we learned over the last two years, just really with numbers more than anything else.

So overall, over the last two years,

303 measures came in to NQF that could have been considered for the trial period. 126 of those were outcome or intermediate outcome measures. And of those, 93 of those utilized some form of risk adjustment.

65 of those, and we included a long table for you at the end that we'll do a little cleanup for the final report, actually had a conceptual basis for adjusting for social risk factors. And then this continues to go down to the narrower part of the cone here.

Measures that had the conceptual relationship, 43 of them, so this is 43 out of 65, from the number above, were deemed to be, have a significant effect. There was a statistical significance in the model. But the differences were very, very small. Did not have any effect on model performance and did not appear to change the performance of the entities as measured. We'll get into more depth on those.

21 were submitted and had social risk factors included. Of those, 17 were actually

endorsed. And the five, the four that didn't make it through actually failed on criteria other than validity. It wasn't the issue of social risk that really came forward.

So that's kind of how we saw this play out over the last couple of years. And I'll go into each of these in a bit more detail.

So the first ones, which measures were adjusted for social risk. So of the 21 of the 65 that were submitted with the review, I may have already mentioned this, 17 were endorsed. The CSAC, the group that oversees all of our evaluations didn't overturn any standing committee recommendations around inclusion of these factors.

And concerns about the inclusion of risk factors in the measures that were endorsed with them was not a theme in any public comments. I think there was in general some comfort there.

These tended to be, as you'll see if you look at the list up there, a number of those are things like patient self report, CAHPS,

coordination of care for kids with special healthcare needs which are frequently adjusted for things like parental education or education or language. Not as much about adjustment for things like income or other social factors.

We then had this fairly large bucket of measures that had a conceptual relationship to the social factor being examined, but no adjustment was done. And this is, I think, where the heart of the discussion will logically lead us.

So of those 93 risk adjusted measures, about 70 percent had a conceptual basis, about 29 percent of those there was no conceptual relationship or it wasn't supported. These are the things like the classic safety events where you wouldn't expect there to be a conceptual basis.

So from a positive perspective, it was good to see the conceptual bases in fact did not support adjustment for the measures who would not have -- the expert panel would likely not have

recommended be adjusted.

Of the 43 of the 65 measures though with a conceptual relationship, the developer did note, there were multiple developers here, but many of these, I know Susannah's talked about them, many of these measures were submitted by Yale CORE or other CMS contractors.

Was the effect of the social risk variables was significant, but that the addition of the social risk factors did not meaningfully change results or improve the performance of the risk model. Do you have a question, Bob, about that?

Or do you want to wait until the end. Okay. I'm sure lots of cards will go up as soon as I stop talking. And this is definitely the place where I think we need to have conversation. There was a lot of comments that did come in about these measures should still be adjusted, there was a significant effect. And I'll go through some of that as well.

A little bit about consistency with

what the expert panel had told us. So many of you had said social risk factors, only include them if both the conceptual and empirical bar are met. We should use the same guidelines for selecting risk factors, whether they're clinical or social, and we followed that.

Generally, measure developers did exactly what was recommended here. They did not include factors that would not have met some of the key selection criteria on this slide.

The conceptual basis was interesting. We did try to go back, and thank you to Erin who I think after I asked her to do this, I think this consumed a good portion of her weekend last weekend, so apologies to Addy and her husband, to actually dive back in and figure out exactly what people were using for this conceptual basis because this, even the conceptual bases of some of these measures was quite contentious.

So about 65 percent of them used literature to go back and say there was a relationship in the literature. About 19 used

prior data. Commenters frequently identified issues with the development of the conceptual model.

Some concerns that sometimes the factors that were selected were the factors available as opposed to truly thinking about at a conceptual basis of the large universe of things that could really relate to, for example costs, which factors were you're looking at.

So again, I think this was a little bit of a looking for your keys under the lamppost story. But again, it's pretty hard to find any keys in this world, so I think that was part of what happened. And it is definitely we've identified, we would very much like your guidance here as a potential area for greater specificity potentially going forward.

The next one was the empirical analyses, and this was the other biggest place where we very much would love your further thoughts. Analyses definitely followed the guidelines for variable selection as we have

those risk factor selections we had mentioned.

But there was significant variance in the way the approach to inclusion of factors. Some relied on statistical significance. If it was statistically significant and there was a conceptual basis for it, it went into the -- it was in the model and then endorsed by our committees like that.

Some made the point the effect size was so small that including it in the model did not make sense. And we're talking of, you know, odds ratios sometimes and the, you know, 1.08, 1.04 kinds of odds.

And then a third argument was that it didn't improve the performance of the model, the calibration or the discrimination statistics. These statistics didn't move at all, so this isn't truly improving the performance of the model.

And then finally Yale in particular, and Susannah could speak to this if there are any questions, specifically looked at if you looked

at the social risk factors versus the clinical risk factors, the relative contribution of patient level versus hospital level was very different.

And for the social risk factors, they were much more oriented toward hospital effect rather than patient effect. And as you recall in our last discussion when we asked you about some of the unanswered questions we were encountering, there was a fair amount of discomfort about inclusion of provider level factors. So that was another issue that was raised when those measures came forward.

But certainly as you'll see, none of these were done with great comfort. This was all a sense of we're learning, we're trying to understand, but this is where we are right now.

And the other big finding of this, no surprise given the discussions we've had for some of us the last three days, there was really limited data on social risk factors. We were not prescriptive about saying which data sources had

to be used or explored.

We specifically expected data was going to be used as a proxy for individual risk factors, but that many of our committees like readmissions and others really made the point that if you're going to use these individual risk factors, they had to be as granular as possible.

So initial submissions of income by six digit, income by six digit ZIP code became income by nine digit ZIP code. And you know, efforts to, I mean, we pushed pretty hard.

I have some of the developers didn't appreciate it but again, I think we felt like we had an obligation to try to go as far as we could here, get more and more granular data. But even the more granular data, unlike some of the things we saw, you know, from Christie and others over the last couple days, did not show large effects.

The focus to date has been patient level factors, that was actually what was in the expert panel report was a focus on patient level factors primarily. Very limited exploration of

these more community level factors we spent a lot of time talking about in the last couple days.

And overall, the variables that got the most analysis were race, ethnicity, and payer, including Medicaid, uninsurance, and used specifically as part of our discussion. This last time we talked about this this morning we then recommended to the developers not to include race as a proxy for social risk.

Some developers included it as a comparator because at times it was more significant than some of the other social risk factors that were examined.

Relationship between conceptual basis and empirical bases. This is again I think, I have raised this, this has been I think the most prominent feature of what we found, significant number of measures with a strong conceptual basis that then did not find an empirical relationship, or at least a stronger one.

Generally, the conceptual basis was broader than what could be tested empirically.

The literature would suggest you could look at all these different factors and there was a relationship, but when they were faced with the actual data in front of them, the data used to do the analysis which was available generally did not show that effect.

And again, I think as I've said on the prior slide, developers sometimes differed in their interpretation of the empirical relationship. And I think there was some disagreement on endorsing measures when a measure was analyzed for social risk and ultimately significant but not included. That was definitely a pretty significant point of concern.

So a little bit about the qualitative feedback we heard, and we've got, I think Sarah dropped off, we've got Susannah who participated pretty fully in this. Some of the challenges, it was pretty hard to develop the conceptual model if you hadn't already done it.

It was difficult to appropriately identify variables that could affect the outcomes

without potentially masking disparities. I think that issue was raised a lot by the developers in particular as we were going through this process.

And developers had mixed opinions about how hard it was to get data on social risk factors. Some worked really hard, some took a long time to keep trying and trying. But they did all highlight the need for better data on social risk factors to support future analyses.

And finally, the majority of developers agreed that examining this question was important. So I think that was an important factor for us.

Committee members, again we surveyed, we got about how many of these back, like 70 or so?

PARTICIPANT: 69.

DR. BURSTIN: 69, I was close. 70 of our committee members, actually 69 came back and actually filled out this pretty extensive survey to give their feedback which was great.

And many of them said we needed more

consistency across developers in the way this was done. They wanted more, potentially more standardization of the kind of variables tested, the data source to help with their review.

They noted significant challenges in evaluating measures, it was just really hard to know what to do with it. I mean, the struggles for example of some of the most high profile committees who sit in this room like readmissions and costs in particular where lots of discomfort.

And the information tended to focus on statistical significance as opposed to what would be the real world impact of these measures as used in a particular payment program.

And some of this is the schizophrenia of NQF of endorsement being about the measure properties, the measure's application partnership, the MAP being more about the financial impact and understanding the broader implications of programs, of measures selected for programs.

But I think, you know, there was a lot

of discussion back and forth. Okay, it may be statistical significance, there may be a small affect size, but what affect does this have out there in the world, particularly since we've been talking a fair amount about the safety net for the past couple days on even if it's a small sub-sample of safety net institutions.

And there was a lot of concern there. And suggestions were made. Should we have, for example for this particular area, external methodology reviews rather than relying on our usual standing committees. Definitely better data on social risk factors was what they wanted, and we all do.

And a closer tie between understanding the conceptual model presented and the empirical analyses then presented to the committee. That disconnect was hard for many of them, and they raised that.

And just as an aside, and we put this in the report, Elisa has just led a large kaizen improvement effort we just did across all of our

consensus development work. And one of the recommendations you put out for public comment was the idea that we would actually have measure testing reviewed by a separate methods panel just because I think there's a level of expertise there and a look of deer in the headlights when people start talking about split samples and things that, you know, maybe it's time to just move that to a panel more comfortable with that data, with that information.

When we did an analysis qualitatively of all the public comment feedback we had gotten, it was a recurring theme in some projects, particularly readmissions and cost and resource use. Public comments highlighted concerns that the measures didn't, you know, generally did not include adjustment, that they thought was adequate for social risk.

Public commenters raised concerns that social risk factors were frequently statistically significant, but the developers did not include them. And then finally, commenters expressed

concern that the social risk factors empirically tested didn't align as I mentioned earlier with the conceptual models presented.

And so then it felt like yes, it's conceptually logically related by the literature and everything else, their prior research, but what you're presenting doesn't meet that because you're giving us a different set of data on social risk factors mainly just due to the availability of social risk factor data.

So a couple key challenges and I'll wrap up and I'm sure there will be lots to talk about. Data availability is certainly the biggest one I think we encountered. There is really limited availability of patient level data here.

Variables that were examined empirically didn't always align, as I mentioned. And an issue that has come up repeatedly is should we move to this consideration of community level factors and what does that exactly mean.

I mean, for example, if Yale used the

AHRQ deprivation index which is linked to the American Community Survey at the nine digit ZIP, isn't that essentially a community factor, or are there others that we want to expand beyond that might get a richer set of data.

Consideration of race we talked about already so I won't spend much time on this. But, you know, at times there was for example one ESRD measure that was adjusted with race. And some of this does get back to the fact that sometimes there are reasons where race may be appropriate. But it wasn't used as a proxy for social risk.

And I took a picture of this, so apologies for the weird placement of the slide, but I really liked this slide at the NAM the other day. And I had Patrick Romano in front of me whose head is right in the middle of my picture.

I love him. I've known him forever, but he was right in the middle of my photos. But I thought this was a great, in many ways, summary of I think at least on the data side the

struggles we are obviously collectively having between ASPE, NAM, and us of, you know, if you think about worst outcomes for beneficiaries with social risk factors in the center.

Quality of care drives that certainly, we know that. That's why we're doing this. But social support and environment matter. And then I like the way they laid it at the top that there is oftentimes higher medical risks that leads to worse outcomes that's measured, but there's also higher medical risk that's unmeasured and this issue of complexity keeps coming up.

I always talk about the NAM meeting, and we've talked about it as well. Patient frailty, poor functional status, is that really what we're potentially trying to capture with some of these social risk data, or is it different?

And then also -- a picture of my bad picture. And then this question of also that there is higher social risk that could potentially lead to these worse outcomes that's

measured. But then that, you know, that light blue-gray box there I think summarizes a lot of the concerns at the end of this two year trial period which is potentially higher social risk that's unmeasured.

And I think this is, I thought, just a very nice summative piece, at least for us, around some of our learnings over the last couple years.

Couple of other challenges. I think this role on stratification was complex. We did ask developers to provide these instructions for calculating it. We got some inconsistency in the way that instructions would be laid out, and again there weren't that many adjusted variables. But something we would need to be more consistent potentially for in the future.

Pretty limited implementation, right? None of the measures that we've now endorsed over the last couple of years that have social risk factors included are out in the field. So we can't really assess the impact of adjustment

without implementation.

You know, all the concerns raised about what would happen if you put this, you know, mass disparities. We have no way in a two year trial period to really answer that question, and we just want to be honest about the fact that we can't.

Now the flip side of that is we do have a fair amount of information from many stakeholders that there may be some negative concerns about measures implemented and its effect on the safety net that don't have adjustment.

And so this is really where we are. We would love to discuss with you which issues you feel like we've somewhat resolved, or at least come close to resolving through the last two years. And you'll notice I didn't put any examples under there, although I think there are some.

I think we've, you know, in many ways shown this can be done. We could logistically

make this work and would certainly love your guidance there. But really I think the main issues we would love to explore with you today, which issues need further consideration. I've highlighted a couple of ones I mention in the slides as well as the report we sent you.

And do we need a more consistent approach to conceptual model. How will we consider adjustment versus stratification, statistical significance versus effect size for inclusion is some of them.

And what data sources or factors should be potentially used or explored further like community factors or these unmeasured clinical and social complexity.

So we're not asking you to make a recommendation to us today around whether we should continue the trial period, stop the trial period, or weave it into our criteria, you know, weave it into our process. That's really a board level decision.

We very much want to get input from

you, we will also seek input from the CSAC early next month, and then we'll produce an options paper for the board taking all this consideration into hand for the board meeting on July 23rd.

You should know that NQF funded this trial period out of its internal dollars which was not funded by CMS. So you know, there are considerations of us moving forward, we just want to be honest about that we need to consider. And I think with that I will see if Erin, Drew, or Alicia have anything else to -- oh, the board meeting is on July 20th. And I think that's all I got. Thank you.

CO-CHAIR PONCE: Thank you, Helen. Rob was out first and then Romana, Nancy, David, Emilio, and Christie. And also on the phone, Susannah also if you would like to be in the queue.

MEMBER RAUNER: I would like to propose that we move to a phase two that studies not new measures but the currently in use measures for Medicare Shared Savings Program and

UDS.

David's article already has three of those measures, colorectal cancer screening, A1c poor control, and blood pressures control that showed significant differences on income and unemployment and race in his study.

So we know those are in use and already potentially affecting, and so I think we need to confirm from other sources how much those measures are affected by these measures because they are going to affect all these incentive programs.

And so I think that's the next phase, not new measures which I think are often very minute little tweaky measures, blood pressure control, those are big ones. And we should move to those.

DR. BURSTIN: Those are great points, Bob. And I should point out we did look at both new and maintenance, new and old measures were included. What we didn't do though is we didn't look at some of these measures that are more

process measures.

And so I guess another question would be if we did continue this, how do we handle looking at measures that don't even have an existing risk model at all to add social risk. So we would very much --

(Simultaneous speaking.)

MEMBER RAUNER: Although most of his were the outcome measures actually that the process were less affected was the outcome measures, those three.

DR. BURSTIN: The A1C, the blood pressure, and the --

MEMBER RAUNER: Colorectal acted like an outcome measure and you might want to comment on that.

MEMBER NERENZ: Yes, I mean, and we don't want to belabor this but we had a kind of a blend of let's say distal outcome measures most affected by SES, either intermediate outcomes or process things that involved a fair amount of personal investment, time commitment, support

like getting a colorectal screening more moderately affected, and then the directly under control provider measures less affected.

So it's -- there's a little bit of a spectrum there that I think just reflects the underlying dimension that we talk about all the time of provider scope of control.

CO-CHAIR PONCE: Thanks. Romana?

MEMBER HASNAIN-WYNIA: Helen, I had a question about you talked briefly about the patient level factors and kind of decomposing the hospital level and the patient level. I was just curious about what the hospital level factors were. And could you just again state what was the issue around the hospital versus patient level decomposition analysis?

DR. BURSTIN: Yes, let me take the first part if it and then maybe let us even ask Susannah since it's her analysis to give you a bit more of a flavor of the decomposition analysis.

So the first one, hospital factors

were things like do you look at percent uninsured, do you look at percent minority patients within your institutions. And I think the concerns that have been raised there is does that necessarily then say those hospitals have a different standard potentially?

MEMBER HASNAIN-WYNIA: Were there other measures like nurse staffing ratios and things like that?

DR. BURSTIN: No. No.

MEMBER HASNAIN-WYNIA: Kind of the -- no, okay.

DR. BURSTIN: No, this was really around, I should have been more clear, you're right. This is really about hospital factors as they relate to social risk. Right, so very specific there. Susannah, do you want to give a thumbnail on decomposition so I don't butcher it?

MEMBER BERNHEIM: Yes, I will try to give a thumbnail and hope that none of my statisticians are listening. I may butcher it but I want to be brief. The concept is that we

know that social risk factors also travel, cluster in certain hospitals.

And so if you just put a patient level social risk factor into a model and you don't account for that cluster, and this came up in our original report as well, you could be essentially adjusting away part of the hospital quality system.

So we use a statistical technique called decomposition that essentially separates out the portion of that seemingly patient level variable that is really about the kind of -- not the kind but the hospitals that have a lot of these patients compared to the patient themselves.

And this, and as Helen said, when we do that, we show with some of our measures that the hospital portion of that seemingly patient level signal is much stronger than the patient level so that the risk of putting a patient level variable in is that you essentially lose information about quality which this measure is

intended to illuminate.

So what we did was we then looked at whether that plays out similarly with clinical variables and show that the SES variables behave very differently, that the clinical variables are primarily, although not entirely, you know, something about the individual whereas often what looks like a patient level variable is carrying more information about the hospital.

And so really, and that sort of quality measurement science mind set, it shouldn't be put in without that decomposition. And the one last thing I'll say, I was really glad that Helen mentioned it, is a lot of times our teams' results got framed as there was a conceptual approach.

But because the factor didn't make a big difference, we didn't put it in. But it was really more that this decomposition speaks to our conceptual framework which is that SES plays out in two ways.

One is things that individuals carry,

and the other is the kinds of hospitals that they are at. And that we needed to use an empiric method to try to separate those, and that those empiric results really suggested that it was more problematic to include them than not.

I know that is controversial, but it is important to know for this committee that we didn't rest just on it doesn't make a big difference. So that's the concept behind the decomposition. I'm happy to share more if people want.

CO-CHAIR PONCE: I think some of us would want to look at that more closely, Susannah. Nancy?

MEMBER GARRETT: So I really appreciate the evaluation. Thank you, Helen, for the nice summary. It's a really good report and helpful to kind of understand what's been happening.

So as a member of the original risk adjustment committee, one thing for you to be aware of is that we didn't recommend the two year

trial period. So that came about I think at the board level.

We recommended that the door will be open to risk adjustment, and then when it got to the board, that's when the two year trial period got introduced. So that wasn't in the original recommendation of the committee.

And I think that happened because of this fear of masking disparities, et cetera. I think now two years later we have even more of an understanding of the importance of social determinates of health on overall health and also, you know, we're grappling.

It's really messy, but I think opening the door is the right thing to do, I think. So I would really strongly recommend that the trial period be ended and that this just become part of what we do is trying to do the best we can with measurements. So that would be my recommendation.

In terms of the conceptual basis, one thing I've been thinking about is whether that's

really an appropriate task to ask the measure developers to do to figure out the conceptual model.

So are there other options? For example, should the endorsing body for that particular measure grapple with that question and whether there's a conceptual relationship that should be investigated further.

And it doesn't necessarily have to be a literature review. It doesn't have to be, you know, something that's published to understand. It could be qualitative information based on going and observing a patient population and seeing what factors are important in that kind of care.

So that conceptual basis, I think we need to be careful about that it's not just a quick literature review. There's nothing published so there must not be something there because we're so early in the science on this. So I think we should be careful with how we do that, and maybe reframe or redo the process of

how that happens.

And then the question of what happens if there's a conceptual relationship but there's no empirical evidence? That is a tough one. And so one thing that we talked about in the cost and resource use committee is should we consider having a category.

So if, you know, there's either endorsed or not endorsed right now. But is there something like endorsed but social risk plays a role but we can't measure it, and so be careful how you use this measure.

Maybe you should just be cautious because you might be inadvertently creating some incentives that you don't want to create because of this. So that's an option as well to have another kind of category of endorsement.

CO-CHAIR PONCE: So Nancy, so your recommendation is end but implement, that was your first -- end the trial period but just do it, but with a lot of cautionary notes. Yes.

MEMBER GARRETT: And again, you guys

don't even need to worry about, I mean, specifically those kind of recommendations are things we're going to have to figure out. I would much rather have you help us with this tougher, muddy, difficult disparity science issues.

CO-CHAIR PONCE: David?

MEMBER NERENZ: I do have a few points, and a couple things just for background context. You know, I was one of the co-chairs of the panel. And during the course of that work and in the time after I came to take on a very personal strong interest in this work and really felt like I owned it.

So as I look at this now, I sort of have a paternalistic feel. It's sort of like when your child goes to school, you want to know how he or she is doing, or is your kid's soccer team winning the soccer game. So whatever I say is kind of filtered through that.

But I would have to say first of all the broad thing, I think this is all really good

in the sense that now there's an opportunity to learn about the conceptual models, to learn about the data relationships, to learn about what happens with the measures when you try to adjust them.

And you know, when we first released the report, we started using, at least I started using the metaphor of opening the door. And I keep coming back to that, that I think the really important thing that the NQF Board did and CSAC in changing the policy was to open the door to this kind of exploration.

Before that people, you know, who was going to look because if somebody wanted to go in and really dig in on social factors and the measures, where was it ever going to go? You know, policy said you're not going to do it anyway.

So I think this change I'm so happy with, and then it's been reinforced now by the NAM report, it's been reinforced by the ASPE report. So it's good.

Now I've been asked occasionally, you know, am I disappointed in some way with the results of what we're seeing here meaning fewer measures with profound changes in risk adjustment or the fact that all of the measures are now not coming through with robust social risk models to them.

And my answer is no, I'm not disappointed because that, you know, if we go back to our committee recommendations we said you do adjustment when the conceptual model says yes and the data say yes.

And then there's sort of the third thing, as a practical matter can you actually make it happen with the data available. So I think we're learning.

Last couple things, I think it's early days in this. So on terms of the first question, issues being resolved, it may take a whole before any issues are really resolved other than in general. I think the current, the new/current NQF policy is a good one.

I'm thinking for example, at least according to the history I read, how many times did it take Edison to get a light bulb that worked? What, 98 fails before one ever. So, you know, people have to try things. And the first tries aren't necessarily fully successful, so we do it more.

Also, for those of you who like video, there are these wonderful examples of late '40s and early '50s tests of rockets where, you know, the rocket would be sitting on the launch pad and they would press the button and the thing would get about ten feet in the air and then it would go down on its side and blow up.

And you know, eventually we -- well, yes. But still recently. But you know, eventually we figure out how to put things to wherever we want them to go. So I'm not discouraged by the fact that not everything just clicked and happened. I think we learn this.

If there's any, last thing I'll say about, say the consistent approach to conceptual

model, you know, I haven't been in and looking at every single one of these that has come through, so I don't have the rich sense that some of you have about how the different approaches have come.

But I personally have always liked the idea of the boxes and arrows diagrams that we've seen. You know, we had an example up here a few minutes ago. Alan had one at the meeting yesterday.

You know, to my visual taste they run from left to right with it but, you know, you can do it different ways. But it's conceivable to me that we could offer that to measure developers at least as a suggested template and say do something like this.

They don't have to. Maybe it doesn't lend itself. But I always find it easy to understand. And if we go all the way back to our panel work, and one of the things where I think we found common ground among us early on in our process was this idea if you take, you know, and

I'll sort of draw it up here in the air.

If you've got a measure or an outcome over on the right hand side and you say okay, quality of care is one box that feeds that. And then you talk about socioeconomic factors, you can either draw an arrow from socioeconomic to quality and then to the outcome.

And you know, everybody said that's the pathway you do not want to adjust away in our adjustment. That's where the socioeconomic factor is influencing quality. You don't want to adjust that away.

But then it's the other arrow going straight from socioeconomic to the outcome that does not go through quality. That's what you do want to adjust. So somehow it just seems to create a clarity about, you know, what matters.

Now that's just as simple as simple can be. And in the real context of measures you would have more factors and you would have a breakdown of which socioeconomic factors. But as a prototype for how to think about this

conceptual model, I think we could do worse.

CO-CHAIR PONCE: Thanks, David. And I'm going to turn it to the other dad. I know Kevin is on the phone for that committee. Kevin, are you on mute?

MEMBER FISCELLA: Oh yes, I was on mute. I was. Yes, I agree with the comments, with the previous comments from David and Nancy. I think this is a work in progress. Obviously it would be premature to say at this point to abandon the effort.

I think this is much too complex an issue with lots of work to be done. So I would agree with the others, with continuing. I mean, I think the results so far suggest I think that likely, a lot of the social factors are being included in many of the hospital risk adjustment measures.

So in essence, we are in fact adjusting for social risk via that added morbidity and the ICD-10 codes and the procedures that are included in these risk models.

And at the end of the day, that given the crude levels and the crude measures we have for SES, that there isn't that much change when you add that one measure to this fully adjusted model.

So it very well could change if we have better measures. But I think it also is important to keep in mind that in fact we are doing probably most of those effects already being adjusted. So the incremental effect in terms of actually changing things is not going to be great.

The one thing I do think that needs to be added perhaps during the continuation is the impact on safety net providers and the change in ranking that that has.

I think that's an additional point beyond the additional criteria that we have because even if it's only a handful of hospitals or other entities who are affected, they're going to be very, very upset and feel like it's very unfair.

And certainly they're caring for large numbers of patients. So I think that should be part of the data that's being collected, and ask developers to look at that.

CO-CHAIR PONCE: Thanks, Kevin. Emilio?

MEMBER CARRILLO: Thinking outside the hospital environment, again this is not in direct response to the immediate. When we think about the neighborhood, the community, you have a lot of these social risk factors which appear to many of us that are synergistic and you get an enhanced outcome, adverse outcome.

So that's just something to put in the parking lot as we, you know, go forward thinking about this, we might want to consider.

CO-CHAIR PONCE: Thanks, Emilio. Nancy? Oh, you already did. Okay, sorry. Christie?

MEMBER TEIGLAND: Yes, I want to talk a little bit about the data, number one, and the fact that, you know, it really isn't very

precise. So it shouldn't be surprising to us that we're not finding some of these effects.

Even if you talk about the ACS data at the nine digit ZIP code level, remember what the ACS data is. It is a sample of about two and a half percent of the United States population. So in an area like Washington, DC, you might get one person in a nine digit ZIP code, you might get no people, right.

And even if you aggregate that over three years, which then the populations change. There's just so many issues with using that data. Ideally we would have this data at the person level but we don't.

So we have found some very different results using some much more precise but more comprehensive covers a lot of the population. You know, 95 percent of the population in the country or something like that.

The other thing I want to talk about is these effect sizes and what these models mean because we tend to look at these coefficients

separately and we say oh, the odds ratio's only 1.04, the odds ratio is -- what you forget is that you add up those effects for people who have a lot of these, you know, risk factors.

So if I have five of those risk factors, you got to look at all five of those combined effects to see the effect on my risk for having that outcome. You can't just look at those individually.

What those individual odds ratios are telling you is if everything else is equal, right. So if I have cancer and you have cancer, you know, the overriding thing is cancer. That's going to make me more likely to be admitted to the hospital or have some bad outcomes or die or whatever.

But if I'm poor and have cancer, and you're rich and have cancer, my risk is higher, right? But what happens is cancer, you know, these clinical chronic conditions are much more prevalent in the disadvantaged population. And so the decomposition analysis that Susannah's

talking about, you know, what you see is that a lot of the disparity is actually attributed to the chronic conditions because they're far more prevalent. They're absorbing some of that social risk factor stuff, right?

And so if you took those chronic conditions out, those social risk factors would be much more significant.

And the other thing I wanted to comment on was just, you know, in terms of the affect size, was looking at the differences in quality, the outcomes, the actual quality gaps that you see.

And what people also forget is, you know, what are you comparing, what populations are you comparing. Are you comparing the unadjusted rates to the adjusted rates and there's not a very big difference?

The reason for that is because some plans are doing a worse job so they actually come down, right? And some of the plans that serve a lot of disadvantaged people are coming up. So

the overall effect, the differences in actual outcome rates for that measure might be zero or very, very small.

You need to look at the impacts on the individual plans, some of whom are going to do a hell of a lot worse, some of them who are going to do a heck of a lot better. Those rankings in between are the ones that really count, not those aggregate outcomes.

You can't just look and say well there's no difference so we didn't. No, no, no. It's all about those individuals. You know, what CMS and RAND actually did was control for the contracts, the actual MA plans, right?

And so what all they were looking at were disparities between duals and non-duals within the same contract. We already talked about the fact that number one, they're skewed really differently. These plans are either lots of duals or very few duals.

And so if you were looking at a plan that has only a very few duals, lots of non-

duals, you're not going to see a lot of differences in their outcomes. Why? Because that plan has the resources to put to those duals.

They're probably going to, they may do better. They may also look a lot more like those non-duals. Right? And also if you look at, you know, those high dual plans and they have a handful of non-duals, you're probably not going to see a lot of difference in their outcomes because the handful of non-duals might be a dual if they were in a Medicaid managed, you know, Medicaid expansion state.

They probably look more like those duals. So again, I'm not surprised you don't see a lot of difference within plans. You know, and the statement that the between plan differences represent true differences in quality, I completely disagree with. So those are my comments.

CO-CHAIR PONCE: Thanks, Christie. I think you would be a good candidate for this

methods subcommittee.

DR. BURSTIN: She's on our list.

CO-CHAIR PONCE: Okay, good. I also just wanted to clarify one of your points about the decomposition analysis since Susannah's on the phone. So the distribution of the effect, which is what the decomposition does, which attributes the effect to the patient versus the hospital level and then showing that in terms of the social risk factors, the distribution was greater in the hospital, in this particular case, hospital factors versus the patient.

Susannah, so my understanding is that includes where you include these clinical factors. And I think Christie's proposition is what would happen if you took away the conditions that are in the clinical, the traditional clinical risk adjustment.

And I think that also resonates with ASPE's approach where they started out with the social risk factor adjustment and then they incrementally added clinical factors. So I

wondered if you could comment on that, Susannah.

MEMBER BERNHEIM: Yes, I've never quite understood, in all honesty, how people -- there's some amount of getting concerned about these bordering. I mean, I don't think anybody is proposing that we would risk adjust these models only for SES and ignore the effective clinical factors.

So ultimately you're going to have a model that has both and it is true that in general the patients with social risk factors have more clinical comorbidities, particularly by the time they're 65 and in Medicare and they've had sort of a lifetime accumulation often of social risk factors.

So if you have one in there and you don't have the other, they may soak up some of the, you know, they may capture some of the signal. So I mean, I don't quite ever know how to respond to that.

Yes, it is true that we examine the impact of social risk after the clinical factors

are already there. But given that we would never have a model that didn't have the clinical factors, I don't really know why that matters.

You could do it the other way and you would see exactly what ASPE saw which is social risk factors look stronger. And when you add the clinical risk factors, they account for a large proportion of what's attributed to the social risk factor when it's just in there alone. So I don't know if that's helpful.

CO-CHAIR PONCE: Yes, I think it's just something -- no, that is helpful, thank you. That's something to consider. And also my recollection of the committee that Dave and Kevin chaired is that I thought we suggested that you would show unadjusted, then clinical adjustment, and then adding the social adjustment.

MEMBER BERNHEIM: And that is what our team does. But can I make one other quick comment on this which is I think it has been a challenge to be somebody who is more cautious about the fact -- I think the trial has been a

good thing. I think David said it really well, that there's been a lot of learning.

I think it has generated a lot of exploration in important areas and a call for better data which we all agree upon. So I'm a fan of having the policy of NQF changed to be more open.

So, but I've definitely been a voice of being more cautious. And it hasn't been fun because many people see things differently than I do. But there's two things that I've noticed that I want to question with you.

One is people who are scientists who I know well seem to be very strongly driven by an underlying belief about this, that sort of no matter what evidence comes forward, the response is there must be something wrong with that evidence.

And so I want us as a committee to be careful. I mean, I think that we are learning and we should pay attention both to what our ongoing beliefs are and what the data ends up

showing us.

And part of the reason I think it is so different than what people anticipate is that we tend to think about for an individual, the risk of social risk factors. But in these measures, patients are aggregated.

And David Nerenz has actually said this really well often. And once you account for clinical risk factors and you have an aggregation of patients with relative degrees of these social risk factors, in the end they often don't have as big an impact as we anticipate ahead of time.

And we then may think we have the wrong data and other things. And sometimes we probably do have the wrong data, we certainly don't have good enough data. But I think we get confused between the sort of quality signal issue of an aggregated group being seen by a provider and what we believe about individual patient prediction. So that's my one other just piece of caution.

CO-CHAIR PONCE: Yes, we really

appreciate your cautiousness and also your work on this. I also want to acknowledge that the way David drew out the conceptual framework where you don't want to control for the pathway where it goes through the healthcare provider is in line with the way you conceptualize the decomposition analysis where you're trying to sort that out.

MEMBER NERENZ: I just ran out of gas in talking. But Susannah, what I was going to say, what I was describing visually with my hands in the air, I thought it was just a graphic version of what you had said perfectly well about the decomposition. It's the same idea.

CO-CHAIR PONCE: Sorry, Susannah, did you have -- go ahead.

MEMBER BERNHEIM: No, please. I want to make room for other people. I was just agreeing with David.

CO-CHAIR PONCE: She was agreeing with you, David. Philip?

MEMBER ALBERTI: I'm trying to organize my thoughts on the fly and not repeat

many of the great points that have been made. So in terms of what issues have been resolved, I think it seems like we're all in agreement that we need to continue to explore this.

I think the fact that the vast majority of developers were able to develop conceptual models, and that committees during the review said what about these measures that you haven't -- I mean, there's a sense I believe that the resolution is we need to move forward in some way.

In terms of conceptual further considerations, when it comes to conceptual model guidance, I think it would be really important for the NQF to kind of delineate explicitly the potential patient, hospital, and community factors that could be incorporated.

And I think that if we don't include community factors, we have missed the boat entirely. There are many, many validated, well validated models that show the vast majority of health outcomes are actually due to those

variables.

And I think that any conceptual model that doesn't include neighborhood level factors as I'll just say potentially incorrect. And I think our last meeting, we had some debate and discussion about when we talked about community or neighborhood.

I just want to make it clear that I think we're all talking about the neighborhoods to which we are discharging patients, and not the neighborhoods in which the hospitals are located. I think there was some confusion before at our last meeting, and I think that's a really crucial point that if we're going to include hospital level factors, it's not necessarily the characteristics of the neighborhood the hospital is in.

I also want to talk a little bit about the disconnect between the conceptual and the empirical models. You know, there is this huge lack of data. Right? So you specify these beautiful conceptual models that have variables

at patient and maybe hospital, but certainly community levels. And then you don't have any of them.

So it actually turns up the empirical test, we're using everything in there as a proxy. Right? We're using dual eligibility as a proxy, we're using race as a proxy, we're using everything becomes a proxy because you don't actually have the precision of the variables that we need.

And so I think we just need to be aware of that. And so I, like Christie, am just not surprised that we don't see these movements once we adjust because we're not adjusting in the right way for the right things.

I also think I really, I read Sarah's email, kind of her plea for flexibility and continued flexibility in terms of how measures are adjusted and what developers propose. And I think in this learning mode, that's really crucial.

But I also do think that there needs

to be some guidance at kind of high levels on how we input some of these adjuster variables. So you know, we'll see models, empirical tests that adjust for white, not white. It's not great, we're lumping a whole lot of groups together in the not white group, but sometimes that's all the data will allow us to do.

I've also seen tests that adjust for black, not black. And I think that's unbelievably problematic because that not black has all kinds of different groups of varying degrees of privilege in.

And so I would not be surprised we would not see differences when it comes to black, not black. So I think that we could actually provide some guidance on model development at a very high level.

And then the last point has to do with this issue of statistical versus clinical significance. My question is who's the arbiter. Who gets to decide how you translate an odds ratio of 1.04 into the lived experience of a

provider on the ground.

You know, so if only three percent of payments would shift as a result of doing this SES adjustment, what three percent of hospitals, where are they located, who are they serving, and how much cash does that translate to?

I mean, it might not be in the omnibus a hugely meaningful shift, but for those three percent of hospitals, it very well could be. And unless we have some transparency and someone in charge of deciding what a threshold is for a clinically or an on the ground significant, I don't want to leave that up to measure developers. Those are some of my points.

CO-CHAIR PONCE: Thanks, Philip. I think you gave some specifics on stronger language on measurement, empirical model inference, and subgroup analysis. Yolanda?

MEMBER OGBOLU: I would just like to add that I agree with much of what Philip just said. When I hear the results that you just described of the evaluation, it sounds like

although we're talking in the language of social risk factors now, when this trial period started, we were talking social demographic status, and they're not the same thing.

And so when you think about social risk factors, we're missing a bunch in this common definition that's going forth now in terms of social risk factors, in terms of cultural contacts, social relationships, community contacts.

None of that has been measured by this trial period. So I think switching the language around that is problematic because this really wasn't a trial period of social risk factors. It was a social demographic status.

And then it only focused on very limited data points which was race, ethnicity, and payer. And so it really doesn't capture what we need to measure. Some things as a group I think we've already identified that there are some measures about that could be looked at long term, and then some things that we don't have

measures for.

And then I wanted to piggyback a little bit on what Christie mentioned about the cumulative of those odds ratios. And so thinking about things again, we've talked about this is behind what intersectionality accounted for, and some of the methods that are used in terms of doing these studies.

And I hear people talking about why there's something mediates or moderates or if we need to do some kind of path analysis type research as well. And I just don't have enough information.

Maybe there's more information available in terms of the methods that were used to do some of, to evaluate whether these risk factors should be accounted for. So those were the additions I had.

CO-CHAIR PONCE: Thanks, Yolanda. So you note again that this is, the thinking has evolved. So it's not just a label change to social risk factors, but that thinking is

involved and what that means. Bob and then Michelle, I haven't forgotten you.

MEMBER RAUNER: I just going to add to what both Phil and Christie were saying that we might add a third category. There's statistically significant, there's clinically significant, and then there's financially significant.

And the way the Medicare shared savings program works is that you can achieve savings, but then the Medicare calls back a certain percentage based on your quality score. And most score between 80 and 99 percent, so you're losing between 1 and 20 percent of multiple millions of dollars.

And so if you added one or two points down because of colorectal cancer screening, one or two points down for blood pressure control and that starts adding up, that could be the difference between an ACO getting 93 percent of that or 97 percent of it, and that becomes a significant amount because the mean savings was

$5.4 million. That ends up being hundreds of thousands of dollars of potential loss.

And then a couple of programs like our, unfortunately our commercial plan, it's all or nothing. So the difference between 49 and 51 percent is the entire $4.7 million.

And so those small effect 1.08s, if you add them up, can be a big deal for an ACO. And so I think we need to consider that financial significance too.

CO-CHAIR PONCE: Thank you. Michelle?

MEMBER CABRERA: So I have a combination of questions and comments. First one is on the, sorry. I had them and now I lost them. Oh, okay.

CO-CHAIR PONCE: You were waiting so long.

MEMBER CABRERA: That's okay. So on the issue of the sequencing of the adjustment, SDS first versus clinical, I actually do think it matters to do SDS first because a lot of the heated conversations are around things that are

happening in Medicare.

And you assume that by the time someone is in Medicare, they're likely to be sicker either because they're older or because they have a disability, right?

And so that's where, yes, those things come. They kind of converge and they compound. But they're both present. I think if you're looking more broadly across different pairs, then the up-front, you know, social factors followed by the clinical makes a little bit more sense of it.

I don't know, just a thought on sort of the Medicare as our kind of anchor on that part of the conversation. I do think that a lot more guidance would be useful, and I think we just have to have an open mind that this is going to be an iterative process and that it's not sort of set in stone forever.

But, you know, we should, NQF should give people guidance on a whole number of things. I have a ton of questions which I'm happy to take

offline about, you know, what kind of training, what kind of information was rolled out.

And one basic question, do we, does NQF require conceptual bases and empirical analyses on non-SDS? No. So there's all kinds of -- maybe? Okay. So yes, okay.

So I mean, I guess what I'm trying to figure out is I think that there's a culture shift too within the measure developer community around what it means to do this, and that's really playing out in the readmissions space.

And I actually found it helpful to go to, like, some of the comments in that discussion because I don't know this stuff very well. But you know, AHA was commenting on the decomposition issue.

And they said, you know, there, it's a mixed effects model which means that they combine hospital level and patient level factors for, they roll that up into a single performance score.

So for clinical they mix, but for SDS,

we're doing that separating out by pure patient versus hospital. And they've called the question, why. And I call the question about I thought our intent was to inoculate to some degree that hospital which by virtue of their serving, you know, large numbers of uninsured people, was facing low reimbursement rates, or not uninsured but, I'm sorry, uninsured, under insured, you know, again, understanding social risk factors.

The people who serve a lot of them might also be facing similar challenges, and that we were trying to mitigate for some of that effect. I think that's why there's sort of concern about how this is playing out. This isn't how it was supposed to go. This isn't what it was supposed to be.

And I think there are some legitimate questions in that mix model thing which, you know, makes sense to me at least.

But I also want to ask, I mean, I'm not sure it's not appropriate to adjust even if,

you know, we're looking at hospital level factors for something because of the impact on the broader community and the fact that again, my understanding was that we were supposed to stratify in order to have the conversation about disparities, not massive disparities, and keep the door open to that ongoing conversation.

And it's almost as though when folks are talking about the adjustment piece, they're forgetting that we required the stratification piece and that it was about finances. But all of a sudden now it's about assigning poor quality when again I don't know.

You know what I mean? So I just think I would like to register those concerns. I can't remember if I had others.

CO-CHAIR PONCE: Ignatius. Thank you, Michelle.

MR. BAU: So two very practical suggestions. Again, since the list got narrowed down to 17, there were ultimately endorsed with adjustment at least to do a little more analysis

of what the conceptual models were and sort of tease them out more in the lines of technical assistance to say that these were the kinds of literature reviews that were done and here's the kind of evidence that created that conceptual relationship.

And then the same thing with the empirical evidence. Given all the challenges and data that again, if respondent education came up as, you know, what was the data source for that and how easy is that so that again, for future measure developers, they at least have something to point to.

So I'm sure all that's available if people did their research. But again, since it's only 17, it just might be nice to have a handy little chart just to show either as an appendix or something else for people to see that.

CO-CHAIR PONCE: And before I call on you, Michelle, so on the 17 I actually thought wow, 17, that's actually really good. And so this first part seems to be a feasibility test,

like can it be done.

But what about what happened with these 17? Like, how sort of the impact of changing the, you know, the way that we're risk adjusting, how does it compare? Kind of like one of Christie's charts when she shows when you change it, like, what happens to hospital A and B, where do they fit.

So I think that could, that requires more time. You need more of a runway of time to see what happens. But then that would be kind of a, you know, we did, I mean, this first part seems like more of a feasibility. You know, can it be done?

Although, of course, it was a mixed bag on how it was done and that's where we're going to give guidance. But then of those that were endorsed. Michelle.

MEMBER BERNHEIM: Can I ask for one request?

CO-CHAIR PONCE: Sure, sure.

MEMBER BERNHEIM: Which is that we are

-- Susannah again, sorry. That we're careful again in our language about assuming good and bad. I just heard you say oh 17, that's pretty good. Well maybe 17 is the perfect number.

I mean, obviously I don't think it is perfect, but I don't think that this committee should be on record as assuming that a measure being risk adjusted is a better thing.

I think the science has to drive that. And it may be that we disagree about the science, but we should be more equal in our assumptions about what is good and bad as the outcome of these measures.

CO-CHAIR PONCE: So what I mean by good is it's empirically good. It's good that we have a sample to look at.

MEMBER BERNHEIM: And that makes a lot of sense.

CO-CHAIR PONCE: Yes. Michelle?

MEMBER CABRERA: Yes, I remembered one other point which was I again have this weird question about whether given that we have such

limited consistent patient level data sources, should we push out here's what we do have and ask people to look at it in the interest of being data driven for the, you know, anything where we've figured out, like, okay this is now a data set we can play with, asking people to play with it in terms of stratification.

And then having that be a component or a driver of a conversation about whether there might be a need or a desire to adjust for that. So again, not knowing as well as folks like Christie and others whether that even exists.

But I think that should be one goal or aspiration to compile that and then just say across the board do it so that more people are doing it.

CO-CHAIR PONCE: Thanks, Michelle. Christie?

MEMBER TEIGLAND: Yes, I just want to draw a parallel between this hospital effect that we're seeing and, you know, maybe it's not appropriate to adjust for the hospital because

the hospital is really a reflection of the people it's serving.

And in this case we have better data about the hospital because that's an entity and we know exactly what that population, we know a lot more about what that population looks like.

Whereas the patient level data is still poor, right, related to the social risk factors. So it's not surprising that the hospital effect --

But again, it's just absorbing, just like those clinical chronic conditions are absorbing a lot of the risk factor, you know, income and education factors in some of the risk adjustments estimates we did because it's more powerful because it's way more prevalent in people who have low income, low education. They have more diabetes, they have more heart conditions, they have --

So it's pulling away from the effect of the social risk factor, and I think we're seeing that same thing with this hospital effect.

So it's really muddying the waters. And so we just have to be really careful about that.

CO-CHAIR PONCE: Thanks, Christine. Also I think it speaks to and calls out the unmeasured, its effects of community context. Emilio?

MEMBER CARRILLO: Yes, it makes sense. However, recall the VA system had a big study, and the disparities really reduced in the hospital. Again, that might reflect on the VA as opposed to say you know, Harlem hospital.

But the hospital does, because of all the standardized guidelines and the way that the care is delivered, they tend to shave down somewhat. Again, the condition is still moved, but it's really reduced, I think.

CO-CHAIR PONCE: Mic please, Christie.

MEMBER TEIGLAND: That's what we want these models to do is to really which organizations are doing it better. So when we adjust for the organization, we muddy that, right, we mess that up. So that's all I'm

saying.

CO-CHAIR PONCE: Those on the phone, would you care to comment? If you're talking right now, you're on mute. Okay, go ahead. Was that Susannah?

MEMBER FISCELLA: No, this was Kevin.

CO-CHAIR PONCE: Oh Kevin, sorry.

MEMBER FISCELLA: Yes, I just wanted to respond to an earlier comment that the same standards are applied to clinical risk factors as they are to social risk factors.

I mean, I think if you were to take out any single clinical risk factor and then add it back into the model, you would see that it really didn't, you know, probably 95 percent of the cases have any more affect than a single poorly measured social risk factors.

So I don't think it's equivalent in that sense. You're taking a well-developed clinical model and adding one risk factor to it. And if you were to do the opposite, I think in most cases you would have a very similar minimal

effect.

CO-CHAIR PONCE: Okay, thank you. So I think we've given a lot of guidance on the statistical inferences that also include clinical and financial significance. We had a lot of guidance on the conceptual framework, do's and don'ts too on some strong language and what should be a proxy and not a proxy.

We offer a template. I think I heard that. We didn't really touch on the specifics of data, but I think we can continue that with recommendations offline.

One appeal that Helen had was the measures that were not currently risk adjusted, but the feeling that there should still be under an equity lens of social risk factors. Philip?

MEMBER ALBERTI: I actually want to take the data conversation online for a minute.

CO-CHAIR PONCE: Okay, take it online.

MEMBER ALBERTI: If that's okay.

CO-CHAIR PONCE: No, take it online, yes.

MEMBER ALBERTI: You know, I think there's just been a general agreement, at least in this room over the last two days and three meetings of the importance of these neighborhood community level factors.

And I think that this group with this opportunity that we've pointed out so often these two days, to propose a path forward to collect the data that we need to collect to do this right.

And whether that's through demonstration projects in areas like California or New York City where it might be possible in a limited way to do some of those tests, or have, you know, four or five different options. Again, I'm not going to suggest new data collection requirements for hospitals, I would lose my job.

But you know, so if, but that's one option right there. Is CMS going to collect these data, is it CDC that's going to collect these data at a more granular level. Are we really going to incentivize the collection of

these at the provider level.

What are the paths forward. What are the ten most central variables we think based on our expertise would be the most crucial adjusters at the community or neighborhood level. And can we come up with some ideas on how to gather those prospectively.

CO-CHAIR PONCE: Thank you. Christie?

DR. BURSTIN: The last item that's listed there, this issue just keeps coming up of how much we're calling social risk may in fact be unmeasured complexity. I just wanted this group to just give us a little bit of thoughts on that.

And most of it just as a safety net doc for years and years and years, they're so intertwined, frailty, poor functional status, many of those issues with some of those social risk factors, this has been an area I would like NQF to focus more attention on as well.

For example, can we get a claims based indicator of frailty to put into some of these risk factors. You know, what is the adequacy of

even being able to use claims data on a, you know, a continuous bases for doing even some of the clinical risk adjustment.

We would just love your perspectives on that as well.

CO-CHAIR PONCE: Ron?

MEMBER COPELAND: Well, I think to pursue that, we're going to have to have partners out in the field who are already in many cases starting to ask patients directly for those type of data so that we have patient level data that's been put into the system.

So whether whoever, you know, the payer systems are regarding risk adjustment and so on as we've heard today, that there's a lot of complexity there. But we should all be aware that a lot of organizations aren't waiting for the Government payers to figure this out.

They're just starting to collect the data from their members directly, putting it into their systems, and creating risk factors based on that to not to adjust payment, but obviously to

adjust interventions, upstream interventions as well as direct patient care in the right environment and so on.

So I think identifying as I think about some type of collaboration or demonstration project, in that space to understand these so-called unmeasured clinical areas because I think structure racism in another one of these areas that fits into that category.

None of this stuff is going to touch that in terms of impact, but it is definitely operating because it informs peoples day to day decisions and it's not going to show up in data based on some measurable social factors.

So there's that stuff and how does that contribute and impact into this whole agenda. So that would be an area to explore. Don't know how many organizations are already doing a lot in this space in terms of collecting data directly from patients and putting it into their systems or not, but that's worth exploring and maybe get some collaboration that can occur

in that space.

DR. BURSTIN: And Sarah presented some data at the meeting you convened, Ignatius, around health plans at least in terms of what they're actually collecting. And it was still pretty darn small for most.

CO-CHAIR PONCE: I do work with AAPCHO, Association of Asian Pacific Community Health Organizations where they're represented there. So they are very interested. I've been talking about social complexity for a long time. I mean, the data's a limitation.

But it might be since you just, you know, you triggered it in my brain when you said since you were a safety net provider, that maybe we should look at these safety net providers to get guidance because they're front liners on dealing with socially complex patients.

Their data may not be as mature as their sensitivity and their thinking about this. But I think they have a sense on the real world problems.

CO-CHAIR PONCE: Marshall?

CO-CHAIR CHIN: I'm trying to think of, like, how to sort of synthesize what we've heard so far. The report is pretty to the point of, like, there was a trial period, here's what we found where 17, the measures were admitted were incorporated.

There's a lot of heterogeneity in what was done, and not a lot of consensus on sort of the ways to move forward given the thorny issues. And so I'm wondering if maybe, well thinking a little bit like, so what are the take homes that we've come to so far.

So for example, it's almost to me, I may have heard, it's like there probably does need to be more standardization, or at a minimum convening of the various different parties with different perspectives, approaches to hammer out some of these, like, advantages that consist of different approaches ranging from what's in the conceptual model, the issue of patient level, community level, availability of data,

statistical approaches.

So we sort of just touched up on this. Maybe it needs to have a subcommittee, but it seems like that there are significant differences between some of the different groups in how I've approached it. Which lead to important differences.

And so that needs to be sort of hashed out also. Let alone then things which are more suited, judgement calls regarding things like what type of significance in a month of change is relevant, whether it's fiscal significance, whether it's the impact.

Or like Bob and Philip are saying, maybe one to three percent of some outcome. But you know, maybe that's enough to, because they use different types of payment, or if you had a 3 percent of groups effective that's important.

Sort of a policy judgement, value judgement type of thing. So I guess my concern is that, like, we're raising a lot of great issues, but we haven't really talked about well,

and so how and presumably would be like a next stage of this work that we don't have two years from now basically the same result of, like, left clarity I guess regarding some of the advancement.

In other words, give us some of these unresolved issues or conflicting approaches sometimes. How do we sort of gain further insight into preferred approaches.

I mean, Sarah's point that she made in somebody, but very important of like there needs to be some flexibility in it all.

So it's this balance between flexibility and learning versus if there are better ways of doing things, then we should know about them and then we should be guiding towards that.

So I'm wondering then, like, on one hand we have basically live it as is and leave it to the wisdom of the higher powers of NQF to make sure that moving ahead this is addressed versus potentially we can probably get a little more

guidance about how do we enhance the likelihood that this continued advancement in this area towards whatever result is going to be the fairest and based upon reality and improving things in terms of, like, the data availability and the statistical approaches and all.

DR. BURSTIN: Just a quick response on that. I think in many ways the issues you've raised are not the ones that we could have simply said do X. There just is not an agreement on doing X.

I do think though it's a way to elucidate with those key questions and go to, you know, subgroups of you guys or something to try to get that specificity. I can't imagine moving forward in the current heterogeneous environment and kind of, you know, what was the Einstein thing, doing the same thing over and over again expecting different results.

No desire to do that again. So I think there is a desire regardless of sort of how he moved forward in whatever way that we need

that clarity.

CO-CHAIR PONCE: Thanks, Helen. Christie?

MEMBER TEIGLAND: Yes, Helen, I just wanted to respond to your question about these additional variables and how important they are. And I have a recent example. And it's public so I can say who it is.

We built some, and I remember that the Impact Act was about post-acute care, right? So we built, Kindred came to us and said can you build us models to show the optimal placement for someone who's leaving the hospital so that we minimize readmissions to the hospital.

And so the model's based on all kinds of chronic conditions that the individual has, you know, what kind of tests and procedures they had in the hospital, why they were in the hospital, you know, how long were they in the hospital, were they in the ICU.

And so ultimately what the model did was shift a lot of people from going to a nursing

home, right, a skilled nursing home to home health, to home health which could save the system, you know, billions of dollars.

But what it came down to was we had to add some additional questions at the end for the person making the placement because can this person go home, you know, can they do activities of daily living, do they have a support, a care giver at home.

And if they don't, guess what, they're going to go be in the nursing home. And so even though I have the same, you know, clinical conditions, and if I went home I would be better off and I would be less likely to go back to the hospital. I'm going to go to a nursing home because I don't have the resources.

So they have really important factors. So when we're thinking about this in the bigger context of saving the health system money and actually having an impact on readmission rates for people with, you know, some and certainly not having social supports at home is a social risk

factor.

You know, ADLs is something else, but these other variables are no less important to get this stuff right. So I absolutely vote for, you know, figuring out how to get that information.

Now once you get to the nursing home, you have all that data, right, on ADLs scores, on ten different activities of daily living. They collect all that data once you're there. But once you're there, it's too late. So yes.

CO-CHAIR PONCE: Thanks, Christie. Emilio?

MEMBER CARRILLO: Yes, on a different topic going back to some of the things that Phil said and also Marshall, the neighborhood based, you don't know if mesh or analysis can help us begin to look at institutional racism.

And how is that? But by retracing the pathway, you have policies and procedures that are driven by government and are driven by certain industries.

Those policies, procedures, regulations impact social determinants which show up in the neighborhood. Now for example housing. You know, there is just so much evidence of how red lining by banks and how certain, you know, even government housing policies result in gettoizing sectors of the population.

And that becomes the seed of a neighborhood so that the policies and regulations that the banks use, the redlining, the government in terms of who gets the loans, in terms of basically dispensations, that can all be traced backwards if you look at the neighborhood and you begin to look at the impact of the housing versus the impact of the transportation, et cetera.

CO-CHAIR PONCE: Thanks. I was also thinking that a lot of the social factors measures are level measures and not, you know, the social stratification measures of residential segregation and income and equality which then aren't amenably to when we start stratifying.

Then you sort of lose that overall

structural factors that create the segregation of services. So thanks. Phil?

MEMBER ALBERTI: Yes, so kind of an existential question maybe for, sorry to do that. For the board to consider on July 20th. And I think it really comes back to this mismatch of a really well specified, evidence based, literature based conceptual model where there's kind of universal scientific agreement that those doctors play a role paired with the complete inability to test it with a national data set.

So I think the question is what does the NQF do in that instance? Do you endorse a measure that you know is invalid because you cannot, I'm just going to be provocative to be provocative, that you know is, or that you think might very well be invalid because you can't do the adjustments and prove via an empirical test how it should be used, or do you scrap the measure.

I mean, those are two really extreme, and I'm doing that on purpose. But you know,

what's the answer when you know that there's a great conceptual basis to do these multi-level adjustments, you can't test it.

Well, we'll either endorse it without it, we know it's not right, or we don't use it and that's a real, now that leaves a hole in the quality measurement. And I don't know what the answer is, I just wanted to put that out there.

DR. BURSTIN: That's basically the scenario. I mean, that's true. I mean, that's exactly the arguments we heard of how do you put it forward if you don't think it's valid versus how do we remove it when we don't have that empiric evidence that it has an effect.

I mean, it's truly the ultimate existential crisis I think we face. I will say that part of what we did do over the past couple of years is for example when measures came forward with a conceptual basis without a clear empiric basis, as part of the annual review of measures that we require all developers to go through, there is now going to be a clear

question for each of them on an annual basis saying so, what's the state of the art lately in terms of data.

Can you look to re-do this. So I think part of our thinking was could we continue to sort of push this rock up the hill a bit. But it's still I think at the end of the day unsatisfying to all, to be very existential.

CO-CHAIR PONCE: Nancy, then David.

MEMBER GARRETT: So to that point, that's what I was suggesting earlier that perhaps there's another category in between those. And so maybe there's an endorse but this is social risk factor sensitive and we're not adequately accounting for that.

And therefore, here's a category where we want to be careful how we use these measures and give some guidance about how they're used. So that would be one option to consider.

And then I just wanted to make the point that in the NAM reports, they identify four categories of how CMS could account for social

risk factors. And risk adjustment's only one of the four.

So there's also direct adjustment of payment which we have in our recommendations restructuring payment incentive design, stratification. So it's all stuff that we're talking about, but I think part of the challenge is that the risk adjustment is not going to address health equity in the way, you know, we're going to have to do other things.

And so addressing this one at a time through the risk adjustment process, it's too much to expect out of that process. And so I think that's a little bit of the challenge that we're facing and maybe something that we can make clear in our recommendations as well is that this is just one thing that we think we need to do, but it's not going to solve the problem.

CO-CHAIR PONCE: It's a good point, Nancy.

MEMBER BERNHEIM: Ninez?

CO-CHAIR PONCE: Yes, Susannah, go

ahead.

MEMBER BERNHEIM: Well, is somebody else in front of me in queue waiting.

CO-CHAIR PONCE: Oh, is that --

MEMBER BERNHEIM: Susannah, yes.

CO-CHAIR PONCE: Yes, okay, go ahead.

MEMBER BERNHEIM: Okay. So Nancy, I appreciated what you just said. And I think responding a little bit to Philip's purposely provocative statement, I think that I would like for a second, race has come up a couple of times now and I would like to talk about race for a second.

One is a clarification because we tested race in our models partly because we thought that that was the guidance and partly because we thought it was important not as a proxy for SES, completely agree that we should not use race as a proxy for SES.

But that the conceptual model for how race affects something like readmission is perhaps in my mind importantly similar to the

ways in which SES can affect readmission and different from the ways clinical factors can.

In general, although it's not this simple, we think about clinical factors as having a pretty direct affect. If you have in addition to the heart attack that you were admitted for you also have end stage renal disease you are at a higher risk because of that renal disease and end up back in the hospital.

If you are a low SES patient like minority patients, the reasons that you have a higher risk of returning to the hospital may be things that are outside of that hospital's control, and that's the argument that people make for risk adjusting.

But they may also have to do with, for both minority patients and low SES patients, the kinds of hospitals that you have access to, and the kinds of treatment that you get within that hospital.

And so when Philip says provocatively when we have sort of a perfectly good conceptual

model for why you would risk adjust, I would argue again that the problem with SES is that the conceptual model suggests reasons to adjust and reasons not to adjust.

And I will go back to what David pointed out about the NAM piece, right? It depends, the different pathways that SES affects the outcome and which of those predominate.

When we did our analyses, we found that the predominant pathways were as much about where you go as who you are. And that's, you know, and when we see that with race we say no way we're going to touch this.

But we don't really like to talk about the ways, though it's low SES patients on the basis of their SES end up with institutional classism if you will.

Right, part of what happens to these patients is that they, not that there aren't many outstanding safety net providers, but they sometimes end up with limited access to high quality care, or with less high quality care

within those institutions. And if we risk adjust for that, we lose important information.

CO-CHAIR PONCE: People are thinking here, Susannah. David?

MEMBER NERENZ: Sure. I was actually going to make the point that Nancy made, her first point. So I'm essentially just agreeing with that, which I think was in response to Phil, so I'm still trying to catch up with the sequence.

But just to put a little smiley face on it, I'm wondering if the NQF endorsement message can come with something like a package insert for prescription medications that, you know, this measure is endorsed but don't use it if this situation occurs or this situation occurs.

And, you know, now back to serious, it basically says we know conceptually, we know on the basis of studies with limited, more regional, or even single institution data sets that there are certain factors that affect this that we

cannot adjust for in the way that we built the model and we're applying it nationally. So, caution.

And so I'm asking a question. Since I don't actually look at the NQF endorsement letter or endorsement document, does it come with caveats or cautions, or is that a reach?

DR. BURSTIN: You know, we don't. I mean, we've done things like that in the past, this is time limited, it's not been tested, this is, you know, things along those lines.

I will tell you one of the biggest challenges here is these measures are the ones most in use in federal payment programs. Let's be honest. So it's kind of the opposite effect, right?

These measures are coming forward in are so controversial because in some ways they are out there being used. So to say use with caution, I'm just not sure it's --

MEMBER NERENZ: And I do understand that. Again, I realize.

DR. BURSTIN: Yes.

MEMBER NERENZ: But even then, I think an example, and I'm not coming up with a good, concrete example, but there was a CMS document that came out a few months ago about proposed measures for use in future programs, I forget exactly what the title was. But at least to my taste it involves some measures that were say developed and validated in one setting, but now were going to be pulled over.

So it was coming from the hospital arena, but now we're going to put it in MIPS and we're going to apply it to individual physicians or something like that.

And in that case I think there is still some avenue, and certainly in our public comment, to that document. We made this point that a measure that's good over here is not necessarily good over there. And this, what I'm now saying is just be kind of a special case of that.

DR. BURSTIN: Right. And actually

interesting, we do put that guidance, and actually the specific example here is the, which Erin did as well, the Medicare Spending for Beneficiary measure which is a hospital level measure is being proposed for a level at the physician level.

And so our committee, and Nancy knows this, explicitly said hey, this measure is endorsed only at the provider level. You know, if you want to use this measure at a different level, additional analyses would be required. But that's always been guidance. It doesn't have quite the same hammer I think of the you're in, you're out kind of endorsement decision.

MEMBER NERENZ: Right. And I certainly, I understand. If we're talking about measures that are already widely in use, than this caution about, you know, they could perhaps be more informative or more fair if adjusted, it doesn't affect much.

DR. BURSTIN: Yes.

MEMBER NERENZ: But maybe still that

message could be put out there just so it's out there.

CO-CHAIR PONCE: So before I call on you, Bob, I just thought about this. Susannah, you know, when you said that there are different mechanisms that lead to what's an observed difference or penalty, not just by race but by socioeconomic status.

So in some ways, doesn't the approach that you and your colleagues took, the decomposition approach, address some of that because again, that approach was, like, classically done on our, the wage gender gap. Is it because of the human capital characteristics of women or is it that employers might be discriminating against women.

So wouldn't that be one way of decomposing it?

MEMBER BERNHEIM: Yes, that's exactly why we did it. And you could, I mean, so you could argue then once you decompose it to include in the model that tiny portion that stays patient

level. It seemed de minimis at that point.

But you certainly could do that, and that might make stakeholders happy. And I know ASSI, I think they ultimately didn't put any of it in the report, but I think that is something that they thought about as well is if you tried to do the decomposition, it creates complicated statistical models.

But you know, one thing this committee could recommend is, you know, developers try to separate the provider level effects from the patient level effects so that if they're adjusting they're primarily looking at the patient level effect.

And of course you could do that for clinical variables. But because the clinical variables are mostly patient level, there's typically less of a need to do that.

CO-CHAIR PONCE: And again, a friendly amendment that I represent I think some of the thinking across the table here is that we make sure that we account for these unmeasured social

complexity and clinical complexity and measured community factors right now.

MEMBER BERNHEIM: Yes.

CO-CHAIR PONCE: Oh, I'm sorry. Go ahead.

MEMBER BERNHEIM: I just, I agree with both of the unmeasured clinical complexity issues and the community factors. We thought a lot about community factors. And it's an important area for continued exploration of these measures.

CO-CHAIR PONCE: I heard a definitely from the NQF voice here. So, Bob? Oh Ron, did you have? Okay, so Bob.

MEMBER RAUNER: Yes, I was just kind of running more with David's analogy about the package inserts, that NQF measures are being used off-label for things they weren't initially intended for. They were for quality improvement, but now they're being used for payment.

And so just like with drugs, we have some post release monitoring for unintended side effects and adverse reactions. We need something

like that for these commonly used NQF measures that are getting put into payment systems because they were studied for this but they're using now for something else.

Probably good, but likely with some unintended consequences just like drugs. So I kind of like that model, actually.

DR. BURSTIN: And actually, you're playing right into our other big strategic area which is getting feedback on measures. So right now if you go to the NQF website and pull up NQF's work, there is now a new button that allows you to click feedback on any measure at any time, 24/7 because that's exactly -- we can't look right now.

(Simultaneous speaking)

DR. BURSTIN: You know, but on the plane, you know what, this measure, and part of it is what we don't actually know is, I mean, we hear a lot about the concerns about the negative unintended consequences. We actually know very little about which measures are actually really

good, which ones in practice move the needle.

I want to use this measure, it really helps me. So I think some of it is we feel like to do our work effectively, we've just got to know that. So much more of that to come.

PARTICIPANT: Thank you for being the plant. All right, I think maybe we've exhausted that.

CO-CHAIR PONCE: No, is there something we haven't touched? Like, I was skirting the data, but we actually have a lot more time to discuss the data.

CO-CHAIR CHIN: It's Marshall. I would just like to hear Susannah's response to Christie's point earlier about this unmeasured community factors and to the degree that your hospital variable could be capturing that.

So in other words, so the community social risk, because we don't have great measures, some of what your models are capturing as a hospital effect are really sort of the unmeasured social complexity of the community.

So how would you respond to Christie's point there?

MEMBER BERNHEIM: Well, it's a little complicated. I think the way the model is set up is pretty specific to the hospital. However, in general, you know, everything, this is going to sound ridiculous but I think it's an important concept. Everything is ultimately nested in other things, right?

So there's probably an effect of, you know, state level policies and there's probably, you know, so we account for the sort of clustering of patients within hospitals as a modeling approach we use, hierarchical modeling which accounts for that.

But in truth, hospitals are in fact if you will kind of clustered within communities. We've talked about some of this in this committee. The things that I think we need to start to sort out to try to think about community factors are what are factors that are community factors that you feel like hospitals don't

influence but that might influence their quality and outcomes.

So first you have to sort of separate factors into ones that are sort of at least partially under the influence of the hospital and those that aren't.

And then you have to think about whether you're thinking about the community that the patients are in or are we more interested in this idea that if patients come from communities with high crime rates, their risk is different, or the community that the hospital is in.

So are we more interested in sort of say social services or policies in that hospital, and then how would you account for that, right, because you often have a cluster of hospitals that looks to be exposed to the same set of community factors if you look at, you know, county level vacancy rates which some people have done, there might be four hospitals in that county who all sort of have that same vacancy rate assigned.

But of course, the way that it influences those four hospitals is going to be different, and that's hard to parse that across. So I didn't completely answer your question except to say there may be a little bit of that, but I think the modeling is mostly hospital focused.

But to some extent, those community factors are affecting not just SES, everything about these models. And the problem with trying to incorporate them in is that there's these layers of questions about which factors you would use and at what level and how you would determine how they differentially affected different hospitals.

We're doing some work on, but it is not simple.

CO-CHAIR PONCE: Thanks, Susannah. I think you're inspiring creative thought here. I think there's, the cards went up and down and up and down. So, I'm going to stick with the order where Ignatius, no? Who? Who goes?

PARTICIPANT: I think Philip was next.

CO-CHAIR PONCE: Philip. Philip then David then Michelle.

MEMBER ALBERTI: I was definitely going up and down, I apologize. You know, so I think we all agree that these variables across the various levels that we're talking about are co-linear, right? They're correlated. It's hard to, really different to tease apart.

So I think that's, I think, I'm looking around, everyone's nodding. So I think that's true.

Getting back to some of the, you know, I would be interested, I don't have your analyses in front of me, Susannah, so I would be really interested in the specific hospital level variables that you used.

You know, I would think that things like connections to social services or an inter-professional care team that's incorporating social work, I would not want to account for those things, that's part of the care process

that is quality care. I would want to be able to kind of isolate those things and not adjust those away.

In terms of community level factors that do not go through and kind of David's mediated model, don't go through, or go directly to outcomes, not through the quality process or quality of care, I mean, I think we could all probably go around for the next hour and just start rattling them off whether it's segregation indices or depravation indices, transportation, food access.

I mean, there's just many, many, many things that I think we would all agree are "beyond the control" of the care process itself that we think would impact things like readmission or the cost of caring for patients.

So those are just some of the thoughts that I had. But I really would like to, I would be interested to just see what kind of hospital factors you were assessing and some of the decomposition analyses.

CO-CHAIR PONCE: Susannah, do you have a quick answer for that?

MEMBER BERNHEIM: Yes, so we don't put fixed factors in. We don't sort of adjust for whether the hospital has CABG capacity. We literally take the patient level SES variable and it gets, and it sort of is separated into the portion that's attributable to the patient and the portion that's attributable to a hospital.

So it's just that same variable decomposed. Again, at this point you've got to get my statisticians on the call. But can I ask a follow up question? So for something like transportation, and maybe this is too in the weeds.

So Helen, I would love to hear from this committee, and maybe we should do it another time. You know, when I think about transportation I go back to all of those questions.

Do I look at the transportation, if I had the variable, acceptable to individual

patients that come to that hospital, or do I look at it regionally and then how do I understand how it affects different hospitals differently within that region?

So there's some interesting questions about what you do with these community factors when you're trying to model hospital quality. It's probably too detailed for this committee, but it would be great for this committee to tackle because I don't think anybody's got good answers and there are a lot of smart people in this room.

MEMBER ALBERTI: You know, this is Philip, I'm just going to jump in real quick. You know, I think we've talked about this before. For something like transportation, I would want to know A, do you have a car. I'm just going to be real.

And B, if not, do you live in a community where there's robust public transportation? I think both of those things would impact something like keeping follow up

appointments and readmission.

So I think that's the importance of really, you know, identifying variables like individual income is important, but so is the immediate income of the community where you're coming from. So I would say both.

DR. BURSTIN: And just quickly to build on I think what Philip said, I think there's been pretty strong agreement in this committee that what we're talking about is community factors for where the patient lives, not where the hospital is.

I think that's been pretty consistent, every head is nodding. So I think that does change that a bit because we're not saying it's about the hospital. It's about where the patient lives and the community affects the kind of things Philip just rattled off for the community, for the patient, sorry.

MEMBER BERNHEIM: But so when we then put things in from the ACS which is something about where the patient lives, nobody thinks

that's a useful thing to look at. So that confuses me.

I mean, I have that. I mean, I can tell you a lot from the ACS about the communities these patients are coming from. But everybody is angry of that approach.

CO-CHAIR PONCE: I hear that no one's angry. But so we can work with you, Susannah. And thank you so much for clarifying for us. I'm going to go to Dave.

MEMBER NERENZ: Well, I think I'm just going to speak in general support of this is a very exciting, encouraging area to look at. I agree absolutely with Susannah, it just becomes more complicated because as you add degrees of nesting, the hierarchical models get more complicated yet.

And at some point nobody can understand them, but that's okay. If they end up good in the end, I'm happy if I don't understand it. I may even try to understand it. But I have thought pretty strongly for a while that we

should, that there are valid and legitimate city level or community level factors that we should explore and see if we can work with them somehow.

At the NAM meeting a couple days ago I was asked, you know, what are some examples. And I had started with the observation that when the readmission penalty started, every single hospital in Detroit get the max penalty.

I said well how, what? They're not owned the same. There's some for profit, not for profit, how can they get the max penalty as a common factor being they're in Detroit. And so what does that mean?

Well then I was challenged. So okay, what are some examples. And I said okay, transportation would be one, that if you live, if you are a low income person or if you live in a low income neighborhood in Detroit, that's not necessarily the same experience as being the same person living in the same income level say in Denver or Seattle, or Boston because there are different services at the city level.

And I know it's hard to deal with that, but I think it would be worth exploring. So I agree with Susannah. A, it's complex, B, there are some ways to do it.

And just maybe as another for thought experiment, I hope I'm corrected if I'm wrong here, but when the hospital global star ratings came out last summer, you know, a lot of people took a look and I did a little, cute little analysis that we published about that.

But imbedded in that was the observation I made, and again tell me if I'm wrong, every single hospital in Brooklyn, New York is a one star, every single one. Now, what does that mean?

Well, but it's kind of interesting to speculate. The first conclusion, and then the discussion ends, is that they're all just bad hospitals. Okay, fine.

But I don't know, is there something then characteristic of Brooklyn, and if so, what might it be? And is it transportation, is it --

(Laughter)

(Off microphone comments)

MEMBER CARRILLO: It's not that simple, it's not that simple. You have, like, Maimonides Hospital, you have New York Methodist Hospital. You have a number of strong hospitals that are three stars, four stars.

MEMBER NERENZ: Okay, so I'm wrong in the observation, I apologize. I just thought as I went through the long list I saw --

MEMBER CARRILLO: I mean, Brooklyn is huge, it's like a city. You know, and so there's a lot of different ZIP codes and nine digit codes that are really very distinct socioeconomically.

CO-CHAIR PONCE: Let's go to Ignatius and then Michelle.

MR. BAU: So back to two additional practical suggestions. I think the risk adjustment trial was a separate thing from the project that CMS did. But I do think there are some congruencies.

So some of the evidence that we

highlight in the first two reports may actually give some conceptual models for folks to think about. And then I think when, so I was actually then looking at the measures that were not recommended for adjustment.

And again, is there similarly a crosswalk back to some of the conditions that were highlighted, the five conditions that we're focused on in terms of the CMS specific task order.

And then I think more importantly, not just the conceptual models but in terms of the data sources, to the extent that we're going to really begin to flesh out what social risk actually means and how it's measured, I think that also will give, you may not need to do it in the committee's reports, but somewhere as you wind up the trial, it may also be good to reference the fact that the committee's actually looking at how to better define social risk and what the data sources might be for social risk to again point people to potential data sources.

CO-CHAIR PONCE: Thanks, Ignatius. Michelle?

MEMBER CABRERA: I think, you know, again just sort of on the editorial kick, we have, and Emilio, you talked about redlining for banks. We have redlining for hospitals, right? I mean, so I think that's an important factor to just remember that what a safety net hospital represents for the community it's serving is last man standing often time.

And so yes, the response that you're getting around the anxiety about the impacts of these things, it's akin to No Child Left Behind policies, right? It's this notion that you can create a test, grade everybody equally, let the science lead the way, and if you don't perform, you get whacked.

And the consequences are the same, you start to divest from institutions that have remained and have persisted despite a lot of challenging care delivery factors. Right?

And so the question is yes, we don't

know, I don't think anybody, I think the one thing we can all agree on is we don't want to give a pass to lower quality. You know, there were some studies of the various CMS Medicare related policies around value based purchasing.

There was one in particular that was published in Health Affairs that found that for California safety net hospitals, they were more likely to be penalized under VBP but their 30 day risk adjusted mortality outcomes were better than their competitors, and cost was virtually the same.

So the conclusion based on VBP alone that they are poor quality hospitals because they didn't perform well on that test does not line up with the outcomes relative to people who were not penalized.

Stuff like this is the kind of stuff that I think we need to keep in the conversation. And again, I'm cautious about drawing the assumption based on whatever measures we have, whatever tests we have so far that because you

didn't perform well, you are a low quality hospital and poor are the folks who have to suffer with that care.

You know, I think the flip side of that is they are the folks there trying every day. And so what can we do to support them? You know, I don't think labeling them poor quality hospitals and giving them the Scarlet Letter is helpful in the end.

So you know, one, I don't know enough about how accurate the scores are, how at the end of the day the data, you know, if the data's so crappy all around, like, are we really accurately lining people up next to each other? Is everything we're measuring all the time the right stuff to figure out if it's actually in service in the populations?

So without knowing that the tests and the measures are great and doing their job great, then I would be hesitant from a purely scientific and data driven standpoint to label folks poor quality.

CO-CHAIR PONCE: Thanks, Michelle. And that could be part of our recommendation, right, for this particular, not just for the trial but that also certainly resonates with our road map and our strategy. So Helen and Erin and Drew, and Tara and Mauricio, have we, and Madison, how are we doing with advising you? Are there any gaps?

DR. BURSTIN: This has been a phenomenally rich discussion that we have to kind of digest it a bit. We'll definitely be back to you because I think you are the group that's going to, you know, depending on how this moves forward, if we are going to continue to do this, and I suspect we will, you know, the degree of specificity you can offer to us that we can then offer and reduce the heterogeneity is our goal collectively.

This has been incredibly useful discussion.

CO-CHAIR PONCE: So I'm going to go ask if we have members on the phone, make some

final comments, and then we'll go to public comment. So Kevin, Susannah, Sarah, if you're still back with us.

MEMBER BERNHEIM: The only thing I'll say is it's been a great discussion. And I apologize for when I get a little animated, but I think this has actually been a very interesting, useful --

(Simultaneous speaking)

CO-CHAIR PONCE: I really value your animation, Susannah. I was trying to impart animation here too to you.

MEMBER BERNHEIM: Excellent. But great discussion.

CO-CHAIR PONCE: Thank you.

MEMBER BERNHEIM: Thank you.

MEMBER FISCELLA: Yes, I agree with Susannah. I really have nothing else to add.

CO-CHAIR PONCE: Thanks, Kevin. Okay, let's, shall we open it up for public comment?

MS. MURPHY: Operator, can you please open the phone lines for public comment?

OPERATOR: Thank you. At this time, if you would like to make a comment, please press star and then the number one on your telephone keypad. We'll pause for just a moment. And there are no public comments at this time.

MS. MURPHY: Thank you. Are there any public comments in the room?

MS. BOSSLEY: Okay, thank you. It would seem a shame not to have someone say something after this conversation. So this is Heidi Bossley on behalf of the Federation of America's Hospitals. Just wanted to say thank you for this conversation.

It's been two years of watching these measures go through the trial period. And as one of the groups commenting, it's nice to see it all come together and have this type of robust discussion. So thank you very much, and we look forward to see where it goes with the CSAC and then the Board.

CO-CHAIR PONCE: All right, thanks, everybody. I think it's time for all to have

safe travels to start, you know, the line of labor and leisure. So leisure is going to start now, and we are adjourning. Thank you so much.

Marshall and I thank you for, can I use robust again, robust discussion, animated, passionate, but also very grounded in advancing the field and moving forward with a clear road map for NQF. So thank you.

CO-CHAIR CHIN: Yes, what Ninez said. It's now the time for, have the image of, like, in the Sound of Music when you have all the kids up on the staircase.

PARTICIPANT: That's a long fair well.

CO-CHAIR CHIN: Yes. I think though that this challenge that Ninez and I and Helen sort of posted at the very beginning about, like, to think boldly and to not be constrained and to think about how can we take advantage of this opportunity to try to advance the field in equity, I think we did it.

I'm very pleased with the discussion and the degree of engagement and the going

through, like, some very tough issues. And so I think again, we're in a good position. There's still a lot of work to do between now and September, but I think we're in good shape in terms of being able to come up with a final report and recommendations that will be impactful. Thank you very much.

DR. BURSTIN: And special thanks to Marshall and Ninez. It was quite the effort to moderate this over the last couple days and the last couple years actually. So thank you, and thanks to the staff as well. We put them through their paces of getting all this work done the last couple of months and --

(Applause)

DR. BURSTIN: Thank you.

CO-CHAIR CHIN: And the staff really is the magic potion here. Okay, so we'll be in contact. Thanks very much.

(Whereupon, the above-entitled matter went off the record at 2:38 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Disparities Standing Committee

Before: NQF

Date: 06-15-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter