

NATIONAL QUALITY FORUM

+ + + + +

DISPARITIES STANDING COMMITTEE

+ + + + +

THURSDAY
JUNE 15, 2017

+ + + + +

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
 LISA COOPER, MD, MPH, FACP, Johns Hopkins
 University School of Medicine *
 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:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ANDREW ANDERSON, PhD, Senior Project Manager
MADISON JUNG, Project Analyst
MAURICIO MENENDEZ, MA, Project Analyst
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

CONTENTS

Welcome.	4
Recap of Day 1	
Discuss recommendations for dissemination of Committee's work.	8
Finalize Implementation Recommendations.	54
Finalize the Roadmap	60
Opportunity for Public Comment	180
Working Lunch - Dissemination Ideas.	182
Review and Evaluate NQF SDS Trial Period	203
Opportunity for Public Comment	333
Adjourn.	335

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

1 can give that will help flesh out the report.

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MEMBER BERNHEIM: Susanna's here.

9 MEMBER COOPER: Lisa's on the phone.

10 CO-CHAIR PONCE: Good morning, Lisa.

11 MEMBER COOPER: Morning.

12 CO-CHAIR CHIN: Good morning.

13 MEMBER SANCHEZ: Eduardo Sanchez is on
14 the phone.

15 CO-CHAIR PONCE: Hello, Eduardo.

16 CO-CHAIR CHIN: Great.

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

19 CO-CHAIR CHIN: Yes, great.

20 CO-CHAIR PONCE: Thanks. Good
21 morning.

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

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

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

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

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

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

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

1 access, quality, and collaboration and
2 partnerships.

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

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

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

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

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

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

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

1 improvement process.

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

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

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

22 So building that out, it's funding

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

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

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

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

22 MR. BAU: So what you have is sort of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 MEMBER HASNAIN-WYNIA: Okay.

19 CO-CHAIR CHIN: Bob?

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

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

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

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

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

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

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

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

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

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

1 to promote these partnerships, to create links.

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

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

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

1 systems that capture linkages.

2 MEMBER CARILLO: It's all there.

3 CO-CHAIR PONCE: Yes.

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

6 CO-CHAIR CHIN: Right.

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

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

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

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

22 Okay, good. So Philip, Michelle,

1 Nancy, then we'll cycle through the phone.

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

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

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

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

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

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

16 MEMBER TEIGLAND: One comment.

17 CO-CHAIR CHIN: Go ahead, Christie.

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

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

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

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

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

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

22 And if the purpose is sort of more

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

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

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

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

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

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

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

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

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

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

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

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

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

5 CO-CHAIR PONCE: Sorry just ---

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

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

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

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

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

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

8 (Simultaneous speaking.)

9 MEMBER GARRETT: Yes.

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

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

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

1 the research, do research research.

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

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

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

22 CO-CHAIR CHIN: So another possibility

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

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

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

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

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

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

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

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

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

10 CO-CHAIR CHIN: Yes.

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

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

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

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

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

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

1 rejoinder and --

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

4 CO-CHAIR PONCE: And Tom.

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

7 (Laughter.)

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

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

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

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

3 MEMBER HASNAIN-WYNIA: Yes.

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

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

10 CO-CHAIR CHIN: Yes.

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

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

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

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

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

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

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

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

19 DR. BURSTIN: No, that's better.

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

1 would work well.

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

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

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

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

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

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

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

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

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

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

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

18 MEMBER BERNHEIM: Thanks.

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

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

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

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

9 MEMBER SCHOLLE: Okay.

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

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

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

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

22 And I would bet, that if we looked at

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

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

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

15 CO-CHAIR CHIN: Thanks, Eduardo.

16 Anyone else on the phone?

17 (No audible response.)

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

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

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

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

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

22 Like you want to know if your patient

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

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

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

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

1 created. It is something they are experiencing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 So in terms of, like, general
17 comments, we'll finish with, like, we have what,
18 Romana, Philip, Emilio, Bob. And then we'll
19 march through, like, the slides starting at slide
20 1 for Strategy 1 for more details. Go ahead,
21 Bob.

22 MEMBER RAUNER: It's actually, it's

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of them?

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

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

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

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

1 attendant thing needs to come through.

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

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

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

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

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

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

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

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

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

22 MEMBER SCHOLLE: Okay. My comment was

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

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

4 (Off the record comments.)

5 CO-CHAIR CHIN: Philip.

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

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

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

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

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

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

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

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

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

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

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

17 MEMBER CABRERA: Yes. You're right.

18 CO-CHAIR CHIN: Yes.

19 MEMBER CABRERA: Yes, okay.

20 CO-CHAIR CHIN: Ninez?

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

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

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

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

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

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

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

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

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

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

1 prescriptive in our recommendations?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 structure?

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

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

18 MEMBER ALBERTI: Yes.

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

22 MR. BAU: I just wanted to underscore

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

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

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

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

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

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

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

15 MEMBER FISCELLA: Okay.

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

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

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

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

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

22 MEMBER COPELAND: Yes. I mean to

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

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

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

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

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

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

6 (Laughter.)

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

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

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

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

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

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

22 MEMBER RAUNER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

1 EHR surveys, et cetera.

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

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

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

1 more of an impact on health.

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

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

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

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

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

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

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

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

1 Ignatius?

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

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

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

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

1 figure out what that middle ground is.

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

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

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

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

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

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

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

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

1 MEMBER SCHOLLE: This is Sarah.

2 CO-CHAIR CHIN: Go ahead.

3 MEMBER SCHOLLE: Yes. This is Sarah.

4 On that point about data collection, one way to
5 strengthen that would be to tack it up to the
6 collection of standardized data, collecting it
7 directly from individuals rather than imputing it
8 or --- so that the information is both collected
9 directly from the individual and updated
10 regularly if it's something that could be
11 updated, like the food insecurity or something
12 you don't just ask once. You ask that over a
13 period of time.

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

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

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

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

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

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

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

1 out, or ---

2 MEMBER NERENZ: Okay. But that's
3 different.

4 CO-CHAIR CHIN: Yes, yes.

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

9 CO-CHAIR CHIN: Yes.

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

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

16 MEMBER NERENZ: Okay.

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

19 MEMBER CARILLO: Yes.

20 CO-CHAIR CHIN: Emilio?

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

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

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

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

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

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

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

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

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

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

1 second slide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Bob then.

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

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

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

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

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

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

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

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

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

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

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

1 talking about this last night.

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

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

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

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

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

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

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

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

15 (Laughter.)

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

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

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

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

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

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

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

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

6 MEMBER NERENZ: I'll give you one in
7 30 seconds.

8 CO-CHAIR CHIN: Okay. Yes, whatever.

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

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

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

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

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

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

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

1 make it explicit.

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

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

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

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

1 to it.

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

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

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

19 MEMBER FISCELLA: Can I have one more
20 comment.

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

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

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

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

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

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

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

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

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

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

3 MEMBER FISCELLA: Will do.

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

6 MEMBER BERNHEIM: This is Susannah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MEMBER COOPER: Yes.

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

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

3 MEMBER COOPER: Okay. I got it.

4 CO-CHAIR CHIN: Michelle?

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

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

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

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

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

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

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

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

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

1 on payments for patients with social risk
2 factors?

3 MEMBER GARRETT: Yes, in the
4 outpatient setting.

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

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

14 CO-CHAIR CHIN: Yes.

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

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

22 MEMBER GARRETT: Yes. I think under

1 the second one.

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

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

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

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

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

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

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

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

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

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

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

15 So let's go to slide 3.

16 MEMBER SCHOLLE: This is Sarah.

17 CO-CHAIR CHIN: Go ahead, Sarah.

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

1 things return in slide 2 and others in 3.

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

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

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

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

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

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

16 Maybe what we can do is we can go
17 through Slide 3 so people understand Slide 3.
18 And then we can revisit your question about does
19 it make sense. All the points you made, Sarah, I
20 think are very important. So let's look at Slide
21 3, march through it, and then revisit Sarah's
22 point about does this really make sense now, or

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

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

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

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

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

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

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

10 CO-CHAIR PONCE: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MEMBER BERNHEIM: And maybe that
17 belongs on Slide 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of disagree with that overall point. But --

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

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

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

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

22 CO-CHAIR CHIN: So, one edit right

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

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

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

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

18 MEMBER COOPER: This is Lisa on the
19 phone.

20 MEMBER HASNAIN-WYNIA: Oops.

21 MEMBER COOPER: When you have time.

22 CO-CHAIR CHIN: Romana, and then Lisa.

1 MEMBER SCHOLLE: Yes. And Sarah too.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MEMBER HASNAIN-WYNIA: You did say in
7 addition to, and reference the bullet on Strategy
8 2.

9 (Off microphone comment)

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

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

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

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

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

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

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

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

22 CO-CHAIR CHIN: What do people think

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

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

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

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

20 (Off microphone comments)

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

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

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

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

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

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

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

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

13 MEMBER SCHOLLE: And Sarah.

14 CO-CHAIR CHIN: Sarah.

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

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

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

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

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

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

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

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

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

20 (Off microphone comment)

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

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

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

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

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

18 CO-CHAIR CHIN: Yes.

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

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

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

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

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

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

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

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

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

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

21 MEMBER GARRETT: To improve
22 comparability within --

1 CO-CHAIR CHIN: To improve
2 comparability --

3 MEMBER GARRETT: Within MVBP --

4 CO-CHAIR CHIN: -- in MVBP programs?

5 MEMBER GARRETT: Something like that.

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

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

14 CO-CHAIR CHIN: Okay.

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

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

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

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

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

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

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

1 net populations.

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

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

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

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

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

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

5 CO-CHAIR CHIN: Thank you, Sarah.

6 MEMBER SCHOLLE: Is it still about
7 risk adjustment payments?

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

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

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

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

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

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

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

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

1 degree of overlap. So, Ninez.

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

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

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

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

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

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

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

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

22 CO-CHAIR CHIN: You cool with keeping

1 it in two and not in one?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 CO-CHAIR PONCE: Oh, okay.

21 DR. BURSTIN: It's good language.

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

1 move to, well, can you hold slide 1?

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

7 CO-CHAIR CHIN: Okay.

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

9 CO-CHAIR CHIN: Yes.

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

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

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

1 research?

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

7 CO-CHAIR PONCE: I am --

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

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

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

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

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

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

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

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

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

1 improvement agenda?

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

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

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

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

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

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

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

16 CO-CHAIR CHIN: Right.

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

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

1 Lisa.

2 MEMBER COOPER: Okay.

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

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

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

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

20 CO-CHAIR CHIN: Oh. Okay.

21 MEMBER NERENZ: The part --

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

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

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

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

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

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

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

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

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

18 (Off microphone comment)

19 CO-CHAIR PONCE: Mic, please, Emilio.

20 (Off microphone comments)

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

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

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

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

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

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

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

11 CO-CHAIR CHIN: So, some type of
12 bullet about developing the evidence, better
13 measures basically, better equity measures. So,
14 Ignatius, and then we'll go to the, improving the
15 --

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

22 And I think we want to be explicit to

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

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

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

21 CO-CHAIR CHIN: Thanks, Ignatius.

22 That's an important comment. So, it's great that

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

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

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

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

22 (Off microphone comments)

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

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

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

17 DR. ANDERSON: Right.

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

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

1 what's the prevalence of disparities in these
2 conditions?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 to think about a refresh.

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

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

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

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

5 DR. BURSTIN: Absolutely.

6 CO-CHAIR CHIN: Okay.

7 DR. BURSTIN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 MEMBER HASNAIN-WYNIA: So, in terms of
10 the social determinants, I think that we need to
11 be very explicit that in some ways, and I think,
12 Helen, you even said, you know, some of the work
13 that we did earlier, so those 2012, business in
14 2012 report, is a bit dated.

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

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

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

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

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

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

22 MEMBER CABRERA: I'm just going to

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

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

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

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

22 In our state Medicaid health plans are

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

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

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

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

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

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

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

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

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

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

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

11 MEMBER COOPER: Okay.

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

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

1 version of what has actually been practical use.

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

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

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

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

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

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

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

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

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

14 (Off microphone comments)

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

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

1 drive toward. And equity is one of those.

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

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

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

14 CO-CHAIR CHIN: Okay.

15 (Off microphone comment)

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

19 (Off microphone comment)

20 CO-CHAIR CHIN: So --

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

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

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

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

1 MEMBER HASNAIN-WYNIA: Sounds good.

2 CO-CHAIR CHIN: Okay. Great.

3 (Whereupon, the above-entitled matter
4 went off the record at 11:52 a.m. and resumed at
5 12:11 p.m.)

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

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

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

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

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

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

19 So maybe I turn to Erin just in terms
20 of, like, the exact wording from Don, that's the
21 editor. And what we're looking for from the
22 group is if you have suggestions on given, like,

1 the editor's response, what do you think then we
2 should do as a committee in terms of what would
3 be a worthwhile paper that would be important,
4 impactful, and that would be in response to what
5 the editor wants? Yes?

6 MEMBER HASNAIN-WYNIA: So this is for
7 Health Affairs? This is the, so you had one
8 paper that was published, and this is for the
9 second round of the equity journal?

10 CO-CHAIR CHIN: Yes, so the paper for
11 June, that was sort of separate from NQF. But
12 this is, like, they have another RFA out there
13 for some time in 2018 it's going to be an issue.

14 MEMBER HASNAIN-WYNIA: Yes, I'm on the
15 committee for Health Affairs.

16 CO-CHAIR CHIN: Excellent.

17 MEMBER HASNAIN-WYNIA: So, I mean, I
18 don't think there's any conflict here, I'm just
19 saying.

20 CO-CHAIR CHIN: Why don't we have Erin
21 first read Don's reply and then your input and
22 why would be very helpful.

1 MS. O'ROURKE: Sure. So just to
2 highlight I think some of the guidance you
3 provided and that we would like the Committee's
4 input on was they seemed to like the premise of
5 our paper, that we could, incentive to reduce
6 disparities can be built into payment policy and
7 performance measurement.

8 But they would like to see the
9 argument developed a bit more than just expert
10 opinion and would like us to support it with some
11 examples and illustrations, arguments and
12 analysis, and empirical evidence rather than just
13 based on the Committee's deliberation.

14 So this language is more along the
15 lines of a standard paper. So we've been
16 brainstorming a little bit about what evidence we
17 can use to support this. I think throughout the
18 meeting the Committee's provided some great,
19 illustrative examples we can look into and build
20 out.

21 As far as empirical analysis, just
22 some quick brainstorms where if there's anything

1 in the trial period data that we've generated
2 that you'll see this afternoon and was in the
3 paper we shared.

4 Perhaps something along the lines of
5 what Susannah talked about with an example from
6 the re-admissions program. Maybe not that one
7 since that's a bit of a flash point, but the idea
8 of, Susannah put it nicely, of once you started
9 measuring and incentivizing something, you reduce
10 something people didn't think could be reduced.

11 So I wanted to open it up for some
12 brainstorming on what might help us support these
13 arguments to get the paper more broadly accepted.

14 CO-CHAIR CHIN: And we'll start with
15 Romana.

16 MEMBER HASNAIN-WYNIA: So the paper
17 that was submitted was submitted as more of a, I
18 don't want to call it empirical because it's not
19 necessarily, it's not an empirical paper. It's
20 more of a commentary thought piece, but they
21 wanted, but it came back with more he wanted more
22 empirical evidence within the commentary.

1 DR. BURSTIN: Evidence. I mean, I
2 think what he was really saying is something
3 along the lines of a standard paper. So don't
4 assume that you can put something forward purely
5 based on the expertise of your committee.

6 MEMBER HASNAIN-WYNIA: Right.

7 DR. BURSTIN: But that there should be
8 some, you know, the incentives to reduce
9 disparities for example. So the Committee's
10 works would better be viewed as a starting point
11 for the paper rather than an end in itself.

12 You can use insight from the
13 Committee's work, of course, but it can't be the
14 sole source of input, and it may only play a
15 minor role in the narrative.

16 MEMBER HASNAIN-WYNIA: Okay.

17 CO-CHAIR CHIN: Bob?

18 MEMBER RAUNER: Yes, I got thinking
19 about this after reading David's article last
20 time is that you could take a hypothetical for a
21 medium sized ACO essentially, and then take what
22 that percentage reduction in quality measures

1 based on what David saw in his article, how that
2 would financially impact an ACO.

3 That you could run, you know, a base
4 case and then run a similar case that if you
5 brought in all safety net clinics and their
6 colorectal cancer treating numbers were all that
7 amount lower using that case, what is the
8 financial impact. And I think that would make a
9 pretty concrete example of how this is
10 potentially messing with FQHCs or safety net
11 clinics.

12 CO-CHAIR CHIN: I guess, I don't know
13 if I mentioned, but we have a time limitation.
14 We're due in September, so there's not a lot of
15 time. And frankly part of it too, I mean, it's
16 because we're NQF that we've probably reached
17 this particular stage.

18 And so even though his email sort of
19 downplays NQF, I don't think we want to sort of,
20 like, throw, I mean, the core probably still has
21 to be like the work this Committee and the things
22 that are going to be embedded in the conceptual

1 model, equity domains and the recommendations in
2 the final report.

3 I mean, that's why we're invited
4 probably. But you hear Erin's comments about,
5 like, so it's a little tricky needle and thread
6 in terms of what we can contribute as NQF and as
7 a committee, and then fitting the material that
8 he puts down. Michelle?

9 MEMBER CABRERA: I just want to
10 promote, if it's relevant, the examples of
11 covered California as well as California's 1115
12 waiver, both of which incentivize both collection
13 of SDS data, or social risk factors, and then
14 pay-for-performance to close gaps or reduce
15 disparities. So is that kind of one of the
16 things you were thinking of as part of the
17 evidence base, or no?

18 CO-CHAIR CHIN: Well I guess part of
19 it can be, like Erin and staff as well have given
20 many examples as possible for the actual report
21 in terms of making things come alive. And then
22 maybe sort of one of the text also that take

1 examples, like what you mentioned or like Bob
2 mentioned today some examples form the ACO world.

3 You can't out do a publication, but I
4 do think, like, some degree of overlap in terms
5 of the report that the staff's writing anyway. I
6 mean, that's what's probably realistic.

7 MEMBER CABRERA: And, well on that, so
8 I had a second question which is I think core to
9 a lot of the work that we're doing here is this
10 concept that if you're trying to improve quality
11 but you're not looking at disparities, you're
12 actually messing up or, you know, missing the
13 ball on something.

14 So I think if there are examples, and
15 I know there have been some but I'm not aware of,
16 like, the best of where a quality improvement
17 effort may have failed because it didn't look at
18 equity or disparities. Would that be an example
19 of the kind of thing that might help?

20 CO-CHAIR CHIN: Your guess is as good
21 as mine. I'm not sure.

22 MEMBER CABRERA: Okay. Well, one

1 suggestion.

2 CO-CHAIR CHIN: Yes. You could
3 consider it though, yes. Emilio and Romana?

4 MEMBER CARRILLO: I think that there
5 would be great interest across the board on the
6 issue of these disparity sensitive measures which
7 is something everybody's, you know, kind of
8 thinking about, and which is something that we're
9 working on and kind of touches a lot of the work
10 that we've done.

11 And going back to some of the
12 foundational stuff like the Weisman paper from
13 '12 or '13 that lays out the characteristics and
14 does a brief analysis of the portfolio of NQF
15 which is thousands of measures. Which of those
16 measures, what type of measures would fall into
17 the category of disparity sensitive?

18 So maybe some just looking at NQF
19 measures and how this particular approach would
20 point out those that are disparity sensitive.

21 CO-CHAIR CHIN: I guess really what
22 you're saying, Emilio, one approach is to really

1 still have it fairly NQF centric where if the
2 overall issue is well, how do you improve equity
3 with a huge lever being equity, well performance
4 measurement and then the use of public reporting
5 and payment.

6 Well, here's a brief history of what
7 NQF has done in the past with disparity sensitive
8 conditions, one of them. Here's the current
9 work, here's the evolving type of questions.
10 Here's some data from the trial period with some
11 risk factors being, like, one important piece of
12 that.

13 So we have some data for that, so it's
14 not just expert opinion. And then the policy
15 regs. I mean, that keeps it in our wheelhouse of
16 what our strength is. I mean, I don't know how
17 much he's really asking for a review paper
18 because, I mean, others can do review papers as
19 well or better than us, so that's not really our
20 strength.

21 I mean, the strength is the work that
22 we're doing, and that's what makes it interesting

1 to, I would presume, the audience. Anyway,
2 Romana?

3 MEMBER HASNAIN-WYNIA: So I'm on the
4 editorial board and I was on both the committees
5 for the special issues or the specific issues on
6 equity. And I think if it's purely focused on
7 the disparity sensitive measures, it won't get a
8 lot of play at health affairs.

9 What I do think is that that could be
10 a component of it, but it has to tell an
11 overarching story, and that story has to be
12 bigger than NQF. But NQF's role in driving, in
13 this case measurement, is important.

14 So in some ways, you know, if we think
15 about even the conversation today, where we were
16 with disparity sensitive measures, where the role
17 of social determinants kind of, you know, where
18 it fell back in 2010, 2011, 2012, I would bring
19 in some of the work with NAM because there's so
20 much crossover, and reference that.

21 So showing some level of cohesion
22 which I think the reports that staff have

1 written, you know, have already started to do
2 showing kind of like this critical mass of work
3 that connects the dots, but then honing in on
4 what NQF is specifically doing around the
5 measurement piece.

6 And you know, so bringing in the
7 disparity sensitive measures, but kind of maybe
8 really emphasizing where that intersection now,
9 the social risk factors and social determinates
10 plays out and how NQF and this Committee has been
11 thinking about that integration.

12 That would be a new contribution in
13 my, at least in my opinion based on the
14 conversations of the Committee that was trying to
15 focus on, you know, what is the ask of authors
16 who would be submitting to this issue.

17 CO-CHAIR CHIN: That makes a lot of
18 sense. Emilio?

19 MEMBER CARRILLO: Just to continue on
20 that train of thought that you proposed, the fact
21 that cultural competence over the years has
22 evolved and now the social determinates coming

1 together in a way that is measurable, I think
2 that that force, those forces that are evolving
3 and how NQF is basically turning those into
4 measures would be, in terms of development of the
5 field, would be an important statement.

6 CO-CHAIR CHIN: Ninez?

7 CO-CHAIR PONCE: Yes, I think both
8 Romana and Emilio have helped us with an outline
9 for the paper. And, but just to get into
10 specifics, in terms of moving the field, I think
11 what I've heard here a lot is the importance of
12 community level factors that have not really come
13 to play in the operationalization of measures.

14 And also, again I always call out
15 Christie's work on emergence of new data sources
16 to get at more granular community level factors.
17 So, and that's all content that happened here.

18 And then Dave presented at NAM again
19 something on community level factors as well. So
20 where it's the place. So some of that I think
21 can help populate the outline that Romana said
22 with the overarching evolution and thinking that

1 Emilio noted. I think we have a paper.

2 CO-CHAIR CHIN: Anyone on the phone,
3 any thoughts about this?

4 MEMBER BERNHEIM: Yes, I think
5 imbedded -- this is Susannah -- in what you all
6 have already said is, or maybe supplementary, is
7 to the extent that we're getting to specific
8 strategies, you know, we don't have complete
9 evidence on what strategies are effective.

10 But among this group we have built
11 some evidence for what strategies at least are
12 feasible. You know, there's lots of examples now
13 that have been sort of scattered through our
14 discussion. And I think it's going to make our
15 report stronger and the paper stronger if we can
16 lean on those.

17 CO-CHAIR CHIN: Thanks, Susannah.
18 Anyone else on the phone, any thoughts? So
19 moving ahead, like, in terms of process, so I
20 guess quickly timelines. So we can talk to the
21 journal about what's possible.

22 But one think we may be able to do is

1 if you have any particular interest in working on
2 this, maybe let Erin know so that we may be able
3 to do something, like, again if the journal
4 allows.

5 But we may be able to do something
6 where there's both a group authorship in terms of
7 the disparity standing committee listed, and then
8 also if there's a subset of people that want to
9 work on it enough to be listed as individual
10 authors also. But we'll have to sort of talk to
11 the Health Affairs about that.

12 But if you have any particular
13 interest in working on it, knowing Susannah wants
14 to work as one person. Any particular interest,
15 maybe just let Erin know and we'll figure things
16 out. Okay.

17 Anything else, Ninez or Helen?

18 DR. BURSTIN: It's great.

19 CO-CHAIR CHIN: Okay, great. Thank
20 you. We have maybe five minutes before the 12:30
21 general item starts. Erin wanted to know, if
22 we're starting to end the work of this contract

1 of CMS and we're talking about dissemination.

2 And so of course it's going to be the
3 final report, this is going to be -- well, we'll
4 see what happens in terms of the Health Affairs
5 paper.

6 Do people have other thoughts
7 regarding dissemination in terms of maximizing
8 the impact of the work of this Committee?

9 MEMBER COPELAND: Is there a planned
10 distribution map already? And you're looking for
11 additions? Or is this starting with a blank
12 sheet of paper?

13 CO-CHAIR CHIN: Great question. So
14 Erin and Helen, what is the default dissemination
15 plan?

16 MS. O'ROURKE: So generally we post it
17 on our website, deliver it to HHS, we notify
18 anyone who's expressed interest in the paper that
19 it's been published. We do put everything out
20 for comment, let all of the members of NQF as
21 well as people who have signed up who are not
22 members to follow the project to please weigh in

1 and share the results.

2 But I think that we're hoping to get
3 some more input from all of you on how we could
4 be more impactful and get more uptake of this
5 than necessarily just putting it on our channels,
6 and would love to know what you think might be
7 useful.

8 MEMBER FERGUSON: There might be an
9 opportunity if you have sort of a template for a
10 press release where we can link it to so that if
11 there's members that are really involved and
12 frequently do send out press releases, and if you
13 have some of the templates, information that can
14 go out then, you know, our organizations can --
15 you might want to get a list and make sure that
16 it's in line. But you know, organizations will
17 be able to disseminate that. You know, I've been
18 giving dates so we'll just have a mass population
19 in terms of a press release, a news release.

20 CO-CHAIR CHIN: That's a great idea.
21 Romana?

22 MEMBER HASNAIN-WYNIA: So, because

1 there is a strategy that focuses on
2 demonstrations, research, evaluation, et cetera.
3 I would recommend that, and I'm going to actually
4 ask Ron to help with this. So I would recommend
5 trying to get a session at the annual meeting
6 which is in DC.

7 And Ron sits on the addressing
8 disparities advisory panel. So this is something
9 Ron can recommend. I know advisory panel members
10 have a lot of weight in terms of their
11 recommendations because it's a committee focused
12 on equity. If it's squarely into their priority
13 for addressing disparities, so that would be an
14 opportunity to present and say, you know, this is
15 NQF saying we need more evidence on X, Y, and Z.
16 So that's just a very specific recommendation.

17 CO-CHAIR CHIN: Great. So maybe Erin
18 and team can follow up with Ron there?

19 MEMBER SANCHEZ: Hey Marshall, this is
20 Eduardo.

21 CO-CHAIR CHIN: Go ahead, Eduardo.

22 MEMBER SANCHEZ: With regards to

1 dissemination, a couple of thoughts. One is that
2 we all, and I've heard mention of this already
3 but I represent a -- I work in a large
4 organization that's got its own communications
5 channel.

6 And so it might be a way to amplify
7 the message. And if I were to know who to work
8 with in advance, we can do both our more
9 traditional communications, but then also we,
10 like many others, have a whole social media
11 presence that we're trying to grow even more.

12 And then I just wonder if there isn't
13 opportunities for blogging and commenting about
14 the importance of not just the notion of equity
15 and disparities, but the importance of
16 measurement and the value of measurement to move
17 us towards the elimination of health disparities
18 and the achievement of health equity.

19 CO-CHAIR CHIN: Thank you, Eduardo. So
20 quick comments from Nancy and Philip, then we'll
21 turn it over to Ninez for the afternoon
22 discussion.

1 MEMBER GARRETT: Well, I wonder if
2 there's some way to team up with the other two
3 efforts that are so related, the NAM report and
4 the ASPE report and show the similarities between
5 them and have some kind of common press release
6 across all three, that would be one idea because
7 it is a little confusing when these things come
8 out singly and then everyone has to try to
9 connect the dots themselves, so that would be one
10 idea.

11 And then I just, I really liked this
12 kind of four page thing that they did for the NAM
13 report. It makes it a lot easier than handing
14 somebody a 50 page report. So something like
15 this I think is helpful in dissemination as well.

16 CO-CHAIR CHIN: Thanks, Nancy. So
17 Philip, and then we'll turn it over to Ninez.

18 MEMBER ALBERTI: Just briefly, you
19 know, AAMC has dozens, many dozens of different
20 kinds of communication channels and venues,
21 meetings, annual meetings, quality focused
22 meetings, distribution lists with tens of

1 thousands of people. So I'm sure there's a way
2 that we can coordinate and amplify the word.

3 CO-CHAIR CHIN: Same thing. So Erin
4 and staff, be in contact with Philip in terms of
5 getting on a panel for AAMC shared by Philip
6 Alberti. Okay, Ninez.

7 CO-CHAIR PONCE: Okay, we're at the
8 point of our meeting where we will discuss the
9 report on the review and evaluation of the NQF
10 on, it still says SDS trial period but I think
11 it's now renamed Social Risk Factors, risk
12 adjustment for social risk factors.

13 I just want to check on the folks on
14 the phone. I know we've gotten an email that
15 Lisa Cooper has left the meeting for a nephew's
16 wedding, very important. Is anybody else on the
17 phone, just to make sure we get your comments.

18 MEMBER BERNHEIM: This is Susannah,
19 I'm still here.

20 CO-CHAIR PONCE: Okay, great. And
21 Sarah dropped off, she was in Alaska.

22 DR. BURSTIN: And Tom thought he would

1 be on by 1:00 p.m., but he'll join us in a little
2 bit.

3 CO-CHAIR PONCE: Okay, great. So I
4 give it to Helen and to Erin.

5 DR. BURSTIN: Perfect. Thank you,
6 everybody. So this has been a long time coming.
7 We're delighted to have the chance to talk with
8 you today about really what our experience has
9 been over the last couple of years, and a lot of
10 this work goes all the way back to the expert
11 panel that Kevin and David chaired for us back in
12 2013, 2014.

13 And at that time, our expert panel
14 really, I think in many ways, started the ball
15 rolling on this issue that has now become so
16 prominent across many different groups which is
17 exciting to see, and really was the idea that for
18 years, NQF had had a prohibition about including
19 race, ethnicity, any of those kinds of factors in
20 risk models, really because of fears that we
21 might be masking disparities.

22 But ultimately, somewhat I think to

1 the surprise of some of us at the start of the
2 panel, ultimately the panel recommended including
3 social risk factors with a pretty high bar as
4 we've now discovered over the last two years of
5 having both a conceptual and an empirical basis
6 for doing so.

7 Given the concerns we were still
8 hearing out in the field, there was a decision
9 that we should move and do a two year trial
10 period and see if we could share the learning
11 over this two year trial period. And during this
12 trial period, allow these social risk factors to
13 be included.

14 And we very much set up this trial
15 period to follow the guidance of the expert
16 panel, and I think probably five or six of you
17 were on that expert panel as well. And the
18 first, and I think much of this very much
19 resonates with I think what we heard just the
20 other day from the National Academy of Medicine
21 as well.

22 So first, we had recommended that each

1 measure really needed to be assessed
2 individually. This was not intended to be a
3 blanket statement that all measures be adjusted.
4 And that in fact there really needed to be a
5 conceptual basis, a logic, a rationale, a theory
6 behind why you would do it as well as empirical
7 evidence that adjusting for it mattered.

8 And I say those words easily.
9 Actually defining those was harder than I think
10 any of us thought, and we'll certainly come back
11 to that. And we gave some examples in the report
12 of what wouldn't be adjusted, for example safety
13 events in hospitals are unlikely to require
14 adjustments for these factors, things that have
15 the longer time periods where patient engagement
16 and their environment were particularly important
17 are the ones that logically have that conceptual
18 basis.

19 We also didn't just limit it to
20 hospitals, although that's where the heat was
21 certainly at the time, and still around
22 readmission measures. It would really be to any

1 level of analysis, health plans facilities,
2 individual clinicians.

3 And that during this trial period, if
4 adjustment was appropriate, we would endorse one
5 measure with specifications also to compute both
6 the adjusted measure as well as the
7 stratification for whatever was significant. And
8 we thought this was important, we felt like it
9 gave us the ability to have our cake and eat it
10 too.

11 Yes, adjust for fairness, but at the
12 same time, provide the transparency that
13 continued to be an issue many had raised concerns
14 about over the years.

15 So what ultimately happened is we took
16 that great guidance from many of you in this
17 expert panel report and we packaged that for all
18 of our standing committees. So all of our
19 standing committees now have the opportunity to
20 look at measures in this way.

21 And specifically had them consider
22 these specific questions, each of them. Is there

1 a conceptual relationship between any of these
2 factors and the measure focus, and some of these
3 just relate to really just good guidance around
4 risk adjustment.

5 Was the factor present at the start of
6 care, is there enough variation in the prevalence
7 of some of these factors across measured
8 entities. Does the empirical evidence show that
9 the factor has a significant and unique effect on
10 the outcome in question. And I think we'll come
11 back to that one as well.

12 And finally, is the information
13 available and generally accessible for the
14 measured patient population, and that is the
15 other one obviously we will come back to as well.
16 I think those were prescient questions when we
17 wrote them two years ago, and they're clearly at
18 the core I think of what we found over the last
19 couple of years.

20 So over the last two years, really
21 just ending April 15th, so pretty recently, any
22 measures submitted for endorsement, whether new,

1 maintenance, any of those measures could be
2 included in the trial period.

3 For the most part though, and I want
4 to emphasize this because the expert panel report
5 did not say focus only on risk adjusted outcome
6 measures. It could be really anything,
7 intermediate outcomes, other issues were
8 certainly raised.

9 I think for the sake of the trial
10 period we were talking about adding factors to an
11 existing model for the sake of simplicity, we
12 mainly focused in on those risk adjusted outcome
13 measures.

14 I will tell you at these tables, many
15 committees raise issues about other measures that
16 did not yet have risk adjustment as part of them
17 at all and said what about social risk. So I
18 think it's something again we've teed up for you
19 to come back to at the end.

20 And you know, the measure developers
21 were required to provide this information on a
22 conceptual relationship. And if they found a

1 conceptual relationship, we then asked them to
2 conduct the empirical analyses between the risk
3 factors and the outcome of interest.

4 And we had each of our standing
5 committees evaluate risk adjustment under the
6 validity criterion where all of that is looked at
7 across all of our committees.

8 So at the start of this, we worked
9 internally with CSAC and actually this group as
10 well to start thinking about what will we even
11 track over the course of these two years. And
12 this is a list of some of the questions that we
13 tracked and drove some of the analysis. You've
14 probably already seen the report, and I'll go
15 over it today.

16 So first, which measures had a
17 conceptual relationship? Something you guys
18 added at your last in-person meeting was the
19 suggestion that we not just look at which
20 measures had it, but how did they come to that
21 point, how did they arrive at that conceptual
22 basis. So for example, was it largely

1 literature, or data driven, how did they come up
2 with that conceptual basis.

3 Which variables and social risk data
4 were available and analyzed? What was the final
5 dispensation for those measures that were
6 submitted with conceptual basis, were they
7 ignored, what was the concerns, what issues were
8 raised?

9 And then finally, if they were
10 included in the risk model, if these social risk
11 factors were endorsed in the model, were we
12 seeing developers following through on the
13 submitting the specifications for stratification.

14 We also went ahead and realized this
15 wouldn't be sufficient, and we also decided we
16 needed to go back and do some qualitative
17 assessments as well. So in fact Drew and Erin
18 and other staff sent a survey to every one of the
19 300-odd committee members who had been part of
20 this process over the last couple of years to get
21 their input as to what they thought about the
22 trial period, what they thought worked well, what

1 information would have been better to have where
2 they felt like they needed more clarity.

3 And in addition, we also looked to see
4 what measure developers perspectives were about
5 being part of this trial period. How onerous was
6 it, how difficult was it to get the data, for
7 example. One of the great limiting steps, as
8 we've discovered.

9 And then we also did a qualitative
10 assessment of all the public comments that came
11 in on those measures to see if there was some
12 similar themes that were emerging around this.

13 All right, so I think we're on to the
14 next one. No, we missed something. Okay, now
15 it's up. Next slide. Oh, I have it. It's been
16 a long few days. It's like three days of sitting
17 and talking about disparities.

18 So this is sort of, this is the slide
19 that really summarizes what we learned over the
20 last two years, just really with numbers more
21 than anything else.

22 So overall, over the last two years,

1 303 measures came in to NQF that could have been
2 considered for the trial period. 126 of those
3 were outcome or intermediate outcome measures.
4 And of those, 93 of those utilized some form of
5 risk adjustment.

6 65 of those, and we included a long
7 table for you at the end that we'll do a little
8 cleanup for the final report, actually had a
9 conceptual basis for adjusting for social risk
10 factors. And then this continues to go down to
11 the narrower part of the cone here.

12 Measures that had the conceptual
13 relationship, 43 of them, so this is 43 out of
14 65, from the number above, were deemed to be,
15 have a significant effect. There was a
16 statistical significance in the model. But the
17 differences were very, very small. Did not have
18 any effect on model performance and did not
19 appear to change the performance of the entities
20 as measured. We'll get into more depth on those.

21 21 were submitted and had social risk
22 factors included. Of those, 17 were actually

1 endorsed. And the five, the four that didn't
2 make it through actually failed on criteria other
3 than validity. It wasn't the issue of social
4 risk that really came forward.

5 So that's kind of how we saw this play
6 out over the last couple of years. And I'll go
7 into each of these in a bit more detail.

8 So the first ones, which measures were
9 adjusted for social risk. So of the 21 of the 65
10 that were submitted with the review, I may have
11 already mentioned this, 17 were endorsed. The
12 CSAC, the group that oversees all of our
13 evaluations didn't overturn any standing
14 committee recommendations around inclusion of
15 these factors.

16 And concerns about the inclusion of
17 risk factors in the measures that were endorsed
18 with them was not a theme in any public comments.
19 I think there was in general some comfort there.

20 These tended to be, as you'll see if
21 you look at the list up there, a number of those
22 are things like patient self report, CAHPS,

1 coordination of care for kids with special
2 healthcare needs which are frequently adjusted
3 for things like parental education or education
4 or language. Not as much about adjustment for
5 things like income or other social factors.

6 We then had this fairly large bucket
7 of measures that had a conceptual relationship to
8 the social factor being examined, but no
9 adjustment was done. And this is, I think, where
10 the heart of the discussion will logically lead
11 us.

12 So of those 93 risk adjusted measures,
13 about 70 percent had a conceptual basis, about 29
14 percent of those there was no conceptual
15 relationship or it wasn't supported. These are
16 the things like the classic safety events where
17 you wouldn't expect there to be a conceptual
18 basis.

19 So from a positive perspective, it was
20 good to see the conceptual bases in fact did not
21 support adjustment for the measures who would not
22 have -- the expert panel would likely not have

1 recommended be adjusted.

2 Of the 43 of the 65 measures though
3 with a conceptual relationship, the developer did
4 note, there were multiple developers here, but
5 many of these, I know Susannah's talked about
6 them, many of these measures were submitted by
7 Yale CORE or other CMS contractors.

8 Was the effect of the social risk
9 variables was significant, but that the addition
10 of the social risk factors did not meaningfully
11 change results or improve the performance of the
12 risk model. Do you have a question, Bob, about
13 that?

14 Or do you want to wait until the end.
15 Okay. I'm sure lots of cards will go up as soon
16 as I stop talking. And this is definitely the
17 place where I think we need to have conversation.
18 There was a lot of comments that did come in
19 about these measures should still be adjusted,
20 there was a significant effect. And I'll go
21 through some of that as well.

22 A little bit about consistency with

1 what the expert panel had told us. So many of
2 you had said social risk factors, only include
3 them if both the conceptual and empirical bar are
4 met. We should use the same guidelines for
5 selecting risk factors, whether they're clinical
6 or social, and we followed that.

7 Generally, measure developers did
8 exactly what was recommended here. They did not
9 include factors that would not have met some of
10 the key selection criteria on this slide.

11 The conceptual basis was interesting.
12 We did try to go back, and thank you to Erin who
13 I think after I asked her to do this, I think
14 this consumed a good portion of her weekend last
15 weekend, so apologies to Addy and her husband, to
16 actually dive back in and figure out exactly what
17 people were using for this conceptual basis
18 because this, even the conceptual bases of some
19 of these measures was quite contentious.

20 So about 65 percent of them used
21 literature to go back and say there was a
22 relationship in the literature. About 19 used

1 prior data. Commenters frequently identified
2 issues with the development of the conceptual
3 model.

4 Some concerns that sometimes the
5 factors that were selected were the factors
6 available as opposed to truly thinking about at a
7 conceptual basis of the large universe of things
8 that could really relate to, for example costs,
9 which factors were you're looking at.

10 So again, I think this was a little
11 bit of a looking for your keys under the lamppost
12 story. But again, it's pretty hard to find any
13 keys in this world, so I think that was part of
14 what happened. And it is definitely we've
15 identified, we would very much like your guidance
16 here as a potential area for greater specificity
17 potentially going forward.

18 The next one was the empirical
19 analyses, and this was the other biggest place
20 where we very much would love your further
21 thoughts. Analyses definitely followed the
22 guidelines for variable selection as we have

1 those risk factor selections we had mentioned.

2 But there was significant variance in
3 the way the approach to inclusion of factors.
4 Some relied on statistical significance. If it
5 was statistically significant and there was a
6 conceptual basis for it, it went into the -- it
7 was in the model and then endorsed by our
8 committees like that.

9 Some made the point the effect size
10 was so small that including it in the model did
11 not make sense. And we're talking of, you know,
12 odds ratios sometimes and the, you know, 1.08,
13 1.04 kinds of odds.

14 And then a third argument was that it
15 didn't improve the performance of the model, the
16 calibration or the discrimination statistics.
17 These statistics didn't move at all, so this
18 isn't truly improving the performance of the
19 model.

20 And then finally Yale in particular,
21 and Susannah could speak to this if there are any
22 questions, specifically looked at if you looked

1 at the social risk factors versus the clinical
2 risk factors, the relative contribution of
3 patient level versus hospital level was very
4 different.

5 And for the social risk factors, they
6 were much more oriented toward hospital effect
7 rather than patient effect. And as you recall in
8 our last discussion when we asked you about some
9 of the unanswered questions we were encountering,
10 there was a fair amount of discomfort about
11 inclusion of provider level factors. So that was
12 another issue that was raised when those measures
13 came forward.

14 But certainly as you'll see, none of
15 these were done with great comfort. This was all
16 a sense of we're learning, we're trying to
17 understand, but this is where we are right now.

18 And the other big finding of this, no
19 surprise given the discussions we've had for some
20 of us the last three days, there was really
21 limited data on social risk factors. We were not
22 prescriptive about saying which data sources had

1 to be used or explored.

2 We specifically expected data was
3 going to be used as a proxy for individual risk
4 factors, but that many of our committees like
5 readmissions and others really made the point
6 that if you're going to use these individual risk
7 factors, they had to be as granular as possible.

8 So initial submissions of income by
9 six digit, income by six digit ZIP code became
10 income by nine digit ZIP code. And you know,
11 efforts to, I mean, we pushed pretty hard.

12 I have some of the developers didn't
13 appreciate it but again, I think we felt like we
14 had an obligation to try to go as far as we could
15 here, get more and more granular data. But even
16 the more granular data, unlike some of the things
17 we saw, you know, from Christie and others over
18 the last couple days, did not show large effects.

19 The focus to date has been patient
20 level factors, that was actually what was in the
21 expert panel report was a focus on patient level
22 factors primarily. Very limited exploration of

1 these more community level factors we spent a lot
2 of time talking about in the last couple days.

3 And overall, the variables that got
4 the most analysis were race, ethnicity, and
5 payer, including Medicaid, uninsurance, and used
6 specifically as part of our discussion. This
7 last time we talked about this this morning we
8 then recommended to the developers not to include
9 race as a proxy for social risk.

10 Some developers included it as a
11 comparator because at times it was more
12 significant than some of the other social risk
13 factors that were examined.

14 Relationship between conceptual basis
15 and empirical bases. This is again I think, I
16 have raised this, this has been I think the most
17 prominent feature of what we found, significant
18 number of measures with a strong conceptual basis
19 that then did not find an empirical relationship,
20 or at least a stronger one.

21 Generally, the conceptual basis was
22 broader than what could be tested empirically.

1 The literature would suggest you could look at
2 all these different factors and there was a
3 relationship, but when they were faced with the
4 actual data in front of them, the data used to do
5 the analysis which was available generally did
6 not show that effect.

7 And again, I think as I've said on the
8 prior slide, developers sometimes differed in
9 their interpretation of the empirical
10 relationship. And I think there was some
11 disagreement on endorsing measures when a measure
12 was analyzed for social risk and ultimately
13 significant but not included. That was
14 definitely a pretty significant point of concern.

15 So a little bit about the qualitative
16 feedback we heard, and we've got, I think Sarah
17 dropped off, we've got Susannah who participated
18 pretty fully in this. Some of the challenges, it
19 was pretty hard to develop the conceptual model
20 if you hadn't already done it.

21 It was difficult to appropriately
22 identify variables that could affect the outcomes

1 without potentially masking disparities. I think
2 that issue was raised a lot by the developers in
3 particular as we were going through this process.

4 And developers had mixed opinions
5 about how hard it was to get data on social risk
6 factors. Some worked really hard, some took a
7 long time to keep trying and trying. But they
8 did all highlight the need for better data on
9 social risk factors to support future analyses.

10 And finally, the majority of
11 developers agreed that examining this question
12 was important. So I think that was an important
13 factor for us.

14 Committee members, again we surveyed,
15 we got about how many of these back, like 70 or
16 so?

17 PARTICIPANT: 69.

18 DR. BURSTIN: 69, I was close. 70 of
19 our committee members, actually 69 came back and
20 actually filled out this pretty extensive survey
21 to give their feedback which was great.

22 And many of them said we needed more

1 consistency across developers in the way this was
2 done. They wanted more, potentially more
3 standardization of the kind of variables tested,
4 the data source to help with their review.

5 They noted significant challenges in
6 evaluating measures, it was just really hard to
7 know what to do with it. I mean, the struggles
8 for example of some of the most high profile
9 committees who sit in this room like readmissions
10 and costs in particular where lots of discomfort.

11 And the information tended to focus on
12 statistical significance as opposed to what would
13 be the real world impact of these measures as
14 used in a particular payment program.

15 And some of this is the schizophrenia
16 of NQF of endorsement being about the measure
17 properties, the measure's application
18 partnership, the MAP being more about the
19 financial impact and understanding the broader
20 implications of programs, of measures selected
21 for programs.

22 But I think, you know, there was a lot

1 of discussion back and forth. Okay, it may be
2 statistical significance, there may be a small
3 affect size, but what affect does this have out
4 there in the world, particularly since we've been
5 talking a fair amount about the safety net for
6 the past couple days on even if it's a small sub-
7 sample of safety net institutions.

8 And there was a lot of concern there.
9 And suggestions were made. Should we have, for
10 example for this particular area, external
11 methodology reviews rather than relying on our
12 usual standing committees. Definitely better
13 data on social risk factors was what they wanted,
14 and we all do.

15 And a closer tie between understanding
16 the conceptual model presented and the empirical
17 analyses then presented to the committee. That
18 disconnect was hard for many of them, and they
19 raised that.

20 And just as an aside, and we put this
21 in the report, Elisa has just led a large kaizen
22 improvement effort we just did across all of our

1 consensus development work. And one of the
2 recommendations you put out for public comment
3 was the idea that we would actually have measure
4 testing reviewed by a separate methods panel just
5 because I think there's a level of expertise
6 there and a look of deer in the headlights when
7 people start talking about split samples and
8 things that, you know, maybe it's time to just
9 move that to a panel more comfortable with that
10 data, with that information.

11 When we did an analysis qualitatively
12 of all the public comment feedback we had gotten,
13 it was a recurring theme in some projects,
14 particularly readmissions and cost and resource
15 use. Public comments highlighted concerns that
16 the measures didn't, you know, generally did not
17 include adjustment, that they thought was
18 adequate for social risk.

19 Public commenters raised concerns that
20 social risk factors were frequently statistically
21 significant, but the developers did not include
22 them. And then finally, commenters expressed

1 concern that the social risk factors empirically
2 tested didn't align as I mentioned earlier with
3 the conceptual models presented.

4 And so then it felt like yes, it's
5 conceptually logically related by the literature
6 and everything else, their prior research, but
7 what you're presenting doesn't meet that because
8 you're giving us a different set of data on
9 social risk factors mainly just due to the
10 availability of social risk factor data.

11 So a couple key challenges and I'll
12 wrap up and I'm sure there will be lots to talk
13 about. Data availability is certainly the
14 biggest one I think we encountered. There is
15 really limited availability of patient level data
16 here.

17 Variables that were examined
18 empirically didn't always align, as I mentioned.
19 And an issue that has come up repeatedly is
20 should we move to this consideration of community
21 level factors and what does that exactly mean.

22 I mean, for example, if Yale used the

1 AHRQ deprivation index which is linked to the
2 American Community Survey at the nine digit ZIP,
3 isn't that essentially a community factor, or are
4 there others that we want to expand beyond that
5 might get a richer set of data.

6 Consideration of race we talked about
7 already so I won't spend much time on this. But,
8 you know, at times there was for example one ESRD
9 measure that was adjusted with race. And some of
10 this does get back to the fact that sometimes
11 there are reasons where race may be appropriate.
12 But it wasn't used as a proxy for social risk.

13 And I took a picture of this, so
14 apologies for the weird placement of the slide,
15 but I really liked this slide at the NAM the
16 other day. And I had Patrick Romano in front of
17 me whose head is right in the middle of my
18 picture.

19 I love him. I've known him forever,
20 but he was right in the middle of my photos. But
21 I thought this was a great, in many ways, summary
22 of I think at least on the data side the

1 struggles we are obviously collectively having
2 between ASPE, NAM, and us of, you know, if you
3 think about worst outcomes for beneficiaries with
4 social risk factors in the center.

5 Quality of care drives that certainly,
6 we know that. That's why we're doing this. But
7 social support and environment matter. And then
8 I like the way they laid it at the top that there
9 is oftentimes higher medical risks that leads to
10 worse outcomes that's measured, but there's also
11 higher medical risk that's unmeasured and this
12 issue of complexity keeps coming up.

13 I always talk about the NAM meeting,
14 and we've talked about it as well. Patient
15 frailty, poor functional status, is that really
16 what we're potentially trying to capture with
17 some of these social risk data, or is it
18 different?

19 And then also -- a picture of my bad
20 picture. And then this question of also that
21 there is higher social risk that could
22 potentially lead to these worse outcomes that's

1 measured. But then that, you know, that light
2 blue-gray box there I think summarizes a lot of
3 the concerns at the end of this two year trial
4 period which is potentially higher social risk
5 that's unmeasured.

6 And I think this is, I thought, just a
7 very nice summative piece, at least for us,
8 around some of our learnings over the last couple
9 years.

10 Couple of other challenges. I think
11 this role on stratification was complex. We did
12 ask developers to provide these instructions for
13 calculating it. We got some inconsistency in the
14 way that instructions would be laid out, and
15 again there weren't that many adjusted variables.
16 But something we would need to be more consistent
17 potentially for in the future.

18 Pretty limited implementation, right?
19 None of the measures that we've now endorsed over
20 the last couple of years that have social risk
21 factors included are out in the field. So we
22 can't really assess the impact of adjustment

1 without implementation.

2 You know, all the concerns raised
3 about what would happen if you put this, you
4 know, mass disparities. We have no way in a two
5 year trial period to really answer that question,
6 and we just want to be honest about the fact that
7 we can't.

8 Now the flip side of that is we do
9 have a fair amount of information from many
10 stakeholders that there may be some negative
11 concerns about measures implemented and its
12 effect on the safety net that don't have
13 adjustment.

14 And so this is really where we are.
15 We would love to discuss with you which issues
16 you feel like we've somewhat resolved, or at
17 least come close to resolving through the last
18 two years. And you'll notice I didn't put any
19 examples under there, although I think there are
20 some.

21 I think we've, you know, in many ways
22 shown this can be done. We could logistically

1 make this work and would certainly love your
2 guidance there. But really I think the main
3 issues we would love to explore with you today,
4 which issues need further consideration. I've
5 highlighted a couple of ones I mention in the
6 slides as well as the report we sent you.

7 And do we need a more consistent
8 approach to conceptual model. How will we
9 consider adjustment versus stratification,
10 statistical significance versus effect size for
11 inclusion is some of them.

12 And what data sources or factors
13 should be potentially used or explored further
14 like community factors or these unmeasured
15 clinical and social complexity.

16 So we're not asking you to make a
17 recommendation to us today around whether we
18 should continue the trial period, stop the trial
19 period, or weave it into our criteria, you know,
20 weave it into our process. That's really a board
21 level decision.

22 We very much want to get input from

1 you, we will also seek input from the CSAC early
2 next month, and then we'll produce an options
3 paper for the board taking all this consideration
4 into hand for the board meeting on July 23rd.

5 You should know that NQF funded this
6 trial period out of its internal dollars which
7 was not funded by CMS. So you know, there are
8 considerations of us moving forward, we just want
9 to be honest about that we need to consider. And
10 I think with that I will see if Erin, Drew, or
11 Alicia have anything else to -- oh, the board
12 meeting is on July 20th. And I think that's all
13 I got. Thank you.

14 CO-CHAIR PONCE: Thank you, Helen.
15 Rob was out first and then Romana, Nancy, David,
16 Emilio, and Christie. And also on the phone,
17 Susannah also if you would like to be in the
18 queue.

19 MEMBER RAUNER: I would like to
20 propose that we move to a phase two that studies
21 not new measures but the currently in use
22 measures for Medicare Shared Savings Program and

1 UDS.

2 David's article already has three of
3 those measures, colorectal cancer screening, A1c
4 poor control, and blood pressures control that
5 showed significant differences on income and
6 unemployment and race in his study.

7 So we know those are in use and
8 already potentially affecting, and so I think we
9 need to confirm from other sources how much those
10 measures are affected by these measures because
11 they are going to affect all these incentive
12 programs.

13 And so I think that's the next phase,
14 not new measures which I think are often very
15 minute little tweaky measures, blood pressure
16 control, those are big ones. And we should move
17 to those.

18 DR. BURSTIN: Those are great points,
19 Bob. And I should point out we did look at both
20 new and maintenance, new and old measures were
21 included. What we didn't do though is we didn't
22 look at some of these measures that are more

1 process measures.

2 And so I guess another question would
3 be if we did continue this, how do we handle
4 looking at measures that don't even have an
5 existing risk model at all to add social risk.
6 So we would very much --

7 (Simultaneous speaking.)

8 MEMBER RAUNER: Although most of his
9 were the outcome measures actually that the
10 process were less affected was the outcome
11 measures, those three.

12 DR. BURSTIN: The A1C, the blood
13 pressure, and the --

14 MEMBER RAUNER: Colorectal acted like
15 an outcome measure and you might want to comment
16 on that.

17 MEMBER NERENZ: Yes, I mean, and we
18 don't want to belabor this but we had a kind of a
19 blend of let's say distal outcome measures most
20 affected by SES, either intermediate outcomes or
21 process things that involved a fair amount of
22 personal investment, time commitment, support

1 like getting a colorectal screening more
2 moderately affected, and then the directly under
3 control provider measures less affected.

4 So it's -- there's a little bit of a
5 spectrum there that I think just reflects the
6 underlying dimension that we talk about all the
7 time of provider scope of control.

8 CO-CHAIR PONCE: Thanks. Romana?

9 MEMBER HASNAIN-WYNIA: Helen, I had a
10 question about you talked briefly about the
11 patient level factors and kind of decomposing the
12 hospital level and the patient level. I was just
13 curious about what the hospital level factors
14 were. And could you just again state what was
15 the issue around the hospital versus patient
16 level decomposition analysis?

17 DR. BURSTIN: Yes, let me take the
18 first part if it and then maybe let us even ask
19 Susannah since it's her analysis to give you a
20 bit more of a flavor of the decomposition
21 analysis.

22 So the first one, hospital factors

1 were things like do you look at percent
2 uninsured, do you look at percent minority
3 patients within your institutions. And I think
4 the concerns that have been raised there is does
5 that necessarily then say those hospitals have a
6 different standard potentially?

7 MEMBER HASNAIN-WYNIA: Were there
8 other measures like nurse staffing ratios and
9 things like that?

10 DR. BURSTIN: No. No.

11 MEMBER HASNAIN-WYNIA: Kind of the --
12 no, okay.

13 DR. BURSTIN: No, this was really
14 around, I should have been more clear, you're
15 right. This is really about hospital factors as
16 they relate to social risk. Right, so very
17 specific there. Susannah, do you want to give a
18 thumbnail on decomposition so I don't butcher it?

19 MEMBER BERNHEIM: Yes, I will try to
20 give a thumbnail and hope that none of my
21 statisticians are listening. I may butcher it
22 but I want to be brief. The concept is that we

1 know that social risk factors also travel,
2 cluster in certain hospitals.

3 And so if you just put a patient level
4 social risk factor into a model and you don't
5 account for that cluster, and this came up in our
6 original report as well, you could be essentially
7 adjusting away part of the hospital quality
8 system.

9 So we use a statistical technique
10 called decomposition that essentially separates
11 out the portion of that seemingly patient level
12 variable that is really about the kind of -- not
13 the kind but the hospitals that have a lot of
14 these patients compared to the patient
15 themselves.

16 And this, and as Helen said, when we
17 do that, we show with some of our measures that
18 the hospital portion of that seemingly patient
19 level signal is much stronger than the patient
20 level so that the risk of putting a patient level
21 variable in is that you essentially lose
22 information about quality which this measure is

1 intended to illuminate.

2 So what we did was we then looked at
3 whether that plays out similarly with clinical
4 variables and show that the SES variables behave
5 very differently, that the clinical variables are
6 primarily, although not entirely, you know,
7 something about the individual whereas often what
8 looks like a patient level variable is carrying
9 more information about the hospital.

10 And so really, and that sort of
11 quality measurement science mind set, it
12 shouldn't be put in without that decomposition.
13 And the one last thing I'll say, I was really
14 glad that Helen mentioned it, is a lot of times
15 our teams' results got framed as there was a
16 conceptual approach.

17 But because the factor didn't make a
18 big difference, we didn't put it in. But it was
19 really more that this decomposition speaks to our
20 conceptual framework which is that SES plays out
21 in two ways.

22 One is things that individuals carry,

1 and the other is the kinds of hospitals that they
2 are at. And that we needed to use an empiric
3 method to try to separate those, and that those
4 empiric results really suggested that it was more
5 problematic to include them than not.

6 I know that is controversial, but it
7 is important to know for this committee that we
8 didn't rest just on it doesn't make a big
9 difference. So that's the concept behind the
10 decomposition. I'm happy to share more if people
11 want.

12 CO-CHAIR PONCE: I think some of us
13 would want to look at that more closely,
14 Susannah. Nancy?

15 MEMBER GARRETT: So I really
16 appreciate the evaluation. Thank you, Helen, for
17 the nice summary. It's a really good report and
18 helpful to kind of understand what's been
19 happening.

20 So as a member of the original risk
21 adjustment committee, one thing for you to be
22 aware of is that we didn't recommend the two year

1 trial period. So that came about I think at the
2 board level.

3 We recommended that the door will be
4 open to risk adjustment, and then when it got to
5 the board, that's when the two year trial period
6 got introduced. So that wasn't in the original
7 recommendation of the committee.

8 And I think that happened because of
9 this fear of masking disparities, et cetera. I
10 think now two years later we have even more of an
11 understanding of the importance of social
12 determinates of health on overall health and
13 also, you know, we're grappling.

14 It's really messy, but I think opening
15 the door is the right thing to do, I think. So I
16 would really strongly recommend that the trial
17 period be ended and that this just become part of
18 what we do is trying to do the best we can with
19 measurements. So that would be my
20 recommendation.

21 In terms of the conceptual basis, one
22 thing I've been thinking about is whether that's

1 really an appropriate task to ask the measure
2 developers to do to figure out the conceptual
3 model.

4 So are there other options? For
5 example, should the endorsing body for that
6 particular measure grapple with that question and
7 whether there's a conceptual relationship that
8 should be investigated further.

9 And it doesn't necessarily have to be
10 a literature review. It doesn't have to be, you
11 know, something that's published to understand.
12 It could be qualitative information based on
13 going and observing a patient population and
14 seeing what factors are important in that kind of
15 care.

16 So that conceptual basis, I think we
17 need to be careful about that it's not just a
18 quick literature review. There's nothing
19 published so there must not be something there
20 because we're so early in the science on this.
21 So I think we should be careful with how we do
22 that, and maybe reframe or redo the process of

1 how that happens.

2 And then the question of what happens
3 if there's a conceptual relationship but there's
4 no empirical evidence? That is a tough one. And
5 so one thing that we talked about in the cost and
6 resource use committee is should we consider
7 having a category.

8 So if, you know, there's either
9 endorsed or not endorsed right now. But is there
10 something like endorsed but social risk plays a
11 role but we can't measure it, and so be careful
12 how you use this measure.

13 Maybe you should just be cautious
14 because you might be inadvertently creating some
15 incentives that you don't want to create because
16 of this. So that's an option as well to have
17 another kind of category of endorsement.

18 CO-CHAIR PONCE: So Nancy, so your
19 recommendation is end but implement, that was
20 your first -- end the trial period but just do
21 it, but with a lot of cautionary notes. Yes.

22 MEMBER GARRETT: And again, you guys

1 don't even need to worry about, I mean,
2 specifically those kind of recommendations are
3 things we're going to have to figure out. I
4 would much rather have you help us with this
5 tougher, muddy, difficult disparity science
6 issues.

7 CO-CHAIR PONCE: David?

8 MEMBER NERENZ: I do have a few
9 points, and a couple things just for background
10 context. You know, I was one of the co-chairs of
11 the panel. And during the course of that work
12 and in the time after I came to take on a very
13 personal strong interest in this work and really
14 felt like I owned it.

15 So as I look at this now, I sort of
16 have a paternalistic feel. It's sort of like
17 when your child goes to school, you want to know
18 how he or she is doing, or is your kid's soccer
19 team winning the soccer game. So whatever I say
20 is kind of filtered through that.

21 But I would have to say first of all
22 the broad thing, I think this is all really good

1 in the sense that now there's an opportunity to
2 learn about the conceptual models, to learn about
3 the data relationships, to learn about what
4 happens with the measures when you try to adjust
5 them.

6 And you know, when we first released
7 the report, we started using, at least I started
8 using the metaphor of opening the door. And I
9 keep coming back to that, that I think the really
10 important thing that the NQF Board did and CSAC
11 in changing the policy was to open the door to
12 this kind of exploration.

13 Before that people, you know, who was
14 going to look because if somebody wanted to go in
15 and really dig in on social factors and the
16 measures, where was it ever going to go? You
17 know, policy said you're not going to do it
18 anyway.

19 So I think this change I'm so happy
20 with, and then it's been reinforced now by the
21 NAM report, it's been reinforced by the ASPE
22 report. So it's good.

1 Now I've been asked occasionally, you
2 know, am I disappointed in some way with the
3 results of what we're seeing here meaning fewer
4 measures with profound changes in risk adjustment
5 or the fact that all of the measures are now not
6 coming through with robust social risk models to
7 them.

8 And my answer is no, I'm not
9 disappointed because that, you know, if we go
10 back to our committee recommendations we said you
11 do adjustment when the conceptual model says yes
12 and the data say yes.

13 And then there's sort of the third
14 thing, as a practical matter can you actually
15 make it happen with the data available. So I
16 think we're learning.

17 Last couple things, I think it's early
18 days in this. So on terms of the first question,
19 issues being resolved, it may take a while before
20 any issues are really resolved other than in
21 general. I think the current, the new/current
22 NQF policy is a good one.

1 I'm thinking for example, at least
2 according to the history I read, how many times
3 did it take Edison to get a light bulb that
4 worked? What, 98 fails before one ever. So, you
5 know, people have to try things. And the first
6 tries aren't necessarily fully successful, so we
7 do it more.

8 Also, for those of you who like video,
9 there are these wonderful examples of late '40s
10 and early '50s tests of rockets where, you know,
11 the rocket would be sitting on the launch pad and
12 they would press the button and the thing would
13 get about ten feet in the air and then it would
14 go down on its side and blow up.

15 And you know, eventually we -- well,
16 yes. But still recently. But you know,
17 eventually we figure out how to put things to
18 wherever we want them to go. So I'm not
19 discouraged by the fact that not everything just
20 clicked and happened. I think we learn this.

21 If there's any, last thing I'll say
22 about, say the consistent approach to conceptual

1 model, you know, I haven't been in and looking at
2 every single one of these that has come through,
3 so I don't have the rich sense that some of you
4 have about how the different approaches have
5 come.

6 But I personally have always liked the
7 idea of the boxes and arrows diagrams that we've
8 seen. You know, we had an example up here a few
9 minutes ago. Alan had one at the meeting
10 yesterday.

11 You know, to my visual taste they run
12 from left to right with it but, you know, you can
13 do it different ways. But it's conceivable to me
14 that we could offer that to measure developers at
15 least as a suggested template and say do
16 something like this.

17 They don't have to. Maybe it doesn't
18 lend itself. But I always find it easy to
19 understand. And if we go all the way back to our
20 panel work, and one of the things where I think
21 we found common ground among us early on in our
22 process was this idea if you take, you know, and

1 I'll sort of draw it up here in the air.

2 If you've got a measure or an outcome
3 over on the right hand side and you say okay,
4 quality of care is one box that feeds that. And
5 then you talk about socioeconomic factors, you
6 can either draw an arrow from socioeconomic to
7 quality and then to the outcome.

8 And you know, everybody said that's
9 the pathway you do not want to adjust away in our
10 adjustment. That's where the socioeconomic
11 factor is influencing quality. You don't want to
12 adjust that away.

13 But then it's the other arrow going
14 straight from socioeconomic to the outcome that
15 does not go through quality. That's what you do
16 want to adjust. So somehow it just seems to
17 create a clarity about, you know, what matters.

18 Now that's just as simple as simple
19 can be. And in the real context of measures you
20 would have more factors and you would have a
21 breakdown of which socioeconomic factors. But as
22 a prototype for how to think about this

1 conceptual model, I think we could do worse.

2 CO-CHAIR PONCE: Thanks, David. And
3 I'm going to turn it to the other dad. I know
4 Kevin is on the phone for that committee. Kevin,
5 are you on mute?

6 MEMBER FISCELLA: Oh yes, I was on
7 mute. I was. Yes, I agree with the comments,
8 with the previous comments from David and Nancy.
9 I think this is a work in progress. Obviously it
10 would be premature to say at this point to
11 abandon the effort.

12 I think this is much too complex an
13 issue with lots of work to be done. So I would
14 agree with the others, with continuing. I mean,
15 I think the results so far suggest I think that
16 likely, a lot of the social factors are being
17 included in many of the hospital risk adjustment
18 measures.

19 So in essence, we are in fact
20 adjusting for social risk via that added
21 morbidity and the ICD-10 codes and the procedures
22 that are included in these risk models.

1 And at the end of the day, that given
2 the crude levels and the crude measures we have
3 for SES, that there isn't that much change when
4 you add that one measure to this fully adjusted
5 model.

6 So it very well could change if we
7 have better measures. But I think it also is
8 important to keep in mind that in fact we are
9 doing probably most of those effects already
10 being adjusted. So the incremental effect in
11 terms of actually changing things is not going to
12 be great.

13 The one thing I do think that needs to
14 be added perhaps during the continuation is the
15 impact on safety net providers and the change in
16 ranking that that has.

17 I think that's an additional point
18 beyond the additional criteria that we have
19 because even if it's only a handful of hospitals
20 or other entities who are affected, they're going
21 to be very, very upset and feel like it's very
22 unfair.

1 And certainly they're caring for large
2 numbers of patients. So I think that should be
3 part of the data that's being collected, and ask
4 developers to look at that.

5 CO-CHAIR PONCE: Thanks, Kevin.

6 Emilio?

7 MEMBER CARRILLO: Thinking outside the
8 hospital environment, again this is not in direct
9 response to the immediate. When we think about
10 the neighborhood, the community, you have a lot
11 of these social risk factors which appear to many
12 of us that are synergistic and you get an
13 enhanced outcome, adverse outcome.

14 So that's just something to put in the
15 parking lot as we, you know, go forward thinking
16 about this, we might want to consider.

17 CO-CHAIR PONCE: Thanks, Emilio.

18 Nancy? Oh, you already did. Okay, sorry.

19 Christie?

20 MEMBER TEIGLAND: Yes, I want to talk
21 a little bit about the data, number one, and the
22 fact that, you know, it really isn't very

1 precise. So it shouldn't be surprising to us
2 that we're not finding some of these effects.

3 Even if you talk about the ACS data at
4 the nine digit ZIP code level, remember what the
5 ACS data is. It is a sample of about two and a
6 half percent of the United States population. So
7 in an area like Washington, DC, you might get one
8 person in a nine digit ZIP code, you might get no
9 people, right.

10 And even if you aggregate that over
11 three years, which then the populations change.
12 There's just so many issues with using that data.
13 Ideally we would have this data at the person
14 level but we don't.

15 So we have found some very different
16 results using some much more precise but more
17 comprehensive covers a lot of the population.
18 You know, 95 percent of the population in the
19 country or something like that.

20 The other thing I want to talk about
21 is these effect sizes and what these models mean
22 because we tend to look at these coefficients

1 separately and we say oh, the odds ratio's only
2 1.04, the odds ratio is -- what you forget is
3 that you add up those effects for people who have
4 a lot of these, you know, risk factors.

5 So if I have five of those risk
6 factors, you got to look at all five of those
7 combined effects to see the effect on my risk for
8 having that outcome. You can't just look at
9 those individually.

10 What those individual odds ratios are
11 telling you is if everything else is equal,
12 right. So if I have cancer and you have cancer,
13 you know, the overriding thing is cancer. That's
14 going to make me more likely to be admitted to
15 the hospital or have some bad outcomes or die or
16 whatever.

17 But if I'm poor and have cancer, and
18 you're rich and have cancer, my risk is higher,
19 right? But what happens is cancer, you know,
20 these clinical chronic conditions are much more
21 prevalent in the disadvantaged population. And
22 so the decomposition analysis that Susannah's

1 talking about, you know, what you see is that a
2 lot of the disparity is actually attributed to
3 the chronic conditions because they're far more
4 prevalent. They're absorbing some of that social
5 risk factor stuff, right?

6 And so if you took those chronic
7 conditions out, those social risk factors would
8 be much more significant.

9 And the other thing I wanted to
10 comment on was just, you know, in terms of the
11 affect size, was looking at the differences in
12 quality, the outcomes, the actual quality gaps
13 that you see.

14 And what people also forget is, you
15 know, what are you comparing, what populations
16 are you comparing. Are you comparing the
17 unadjusted rates to the adjusted rates and
18 there's not a very big difference?

19 The reason for that is because some
20 plans are doing a worse job so they actually come
21 down, right? And some of the plans that serve a
22 lot of disadvantaged people are coming up. So

1 the overall effect, the differences in actual
2 outcome rates for that measure might be zero or
3 very, very small.

4 You need to look at the impacts on the
5 individual plans, some of whom are going to do a
6 hell of a lot worse, some of them who are going
7 to do a heck of a lot better. Those rankings in
8 between are the ones that really count, not those
9 aggregate outcomes.

10 You can't just look and say well
11 there's no difference so we didn't. No, no, no.
12 It's all about those individuals. You know, what
13 CMS and RAND actually did was control for the
14 contracts, the actual MA plans, right?

15 And so what all they were looking at
16 were disparities between duals and non-duals
17 within the same contract. We already talked
18 about the fact that number one, they're skewed
19 really differently. These plans are either lots
20 of duals or very few duals.

21 And so if you were looking at a plan
22 that has only a very few duals, lots of non-

1 duals, you're not going to see a lot of
2 differences in their outcomes. Why? Because
3 that plan has the resources to put to those
4 duals.

5 They're probably going to, they may do
6 better. They may also look a lot more like those
7 non-duals. Right? And also if you look at, you
8 know, those high dual plans and they have a
9 handful of non-duals, you're probably not going
10 to see a lot of difference in their outcomes
11 because the handful of non-duals might be a dual
12 if they were in a Medicaid managed, you know,
13 Medicaid expansion state.

14 They probably look more like those
15 duals. So again, I'm not surprised you don't see
16 a lot of difference within plans. You know, and
17 the statement that the between plan differences
18 represent true differences in quality, I
19 completely disagree with. So those are my
20 comments.

21 CO-CHAIR PONCE: Thanks, Christie. I
22 think you would be a good candidate for this

1 methods subcommittee.

2 DR. BURSTIN: She's on our list.

3 CO-CHAIR PONCE: Okay, good. I also
4 just wanted to clarify one of your points about
5 the decomposition analysis since Susannah's on
6 the phone. So the distribution of the effect,
7 which is what the decomposition does, which
8 attributes the effect to the patient versus the
9 hospital level and then showing that in terms of
10 the social risk factors, the distribution was
11 greater in the hospital, in this particular case,
12 hospital factors versus the patient.

13 Susannah, so my understanding is that
14 includes where you include these clinical
15 factors. And I think Christie's proposition is
16 what would happen if you took away the conditions
17 that are in the clinical, the traditional
18 clinical risk adjustment.

19 And I think that also resonates with
20 ASPE's approach where they started out with the
21 social risk factor adjustment and then they
22 incrementally added clinical factors. So I

1 wondered if you could comment on that, Susannah.

2 MEMBER BERNHEIM: Yes, I've never
3 quite understood, in all honesty, how people --
4 there's some amount of getting concerned about
5 these bordering. I mean, I don't think anybody
6 is proposing that we would risk adjust these
7 models only for SES and ignore the effective
8 clinical factors.

9 So ultimately you're going to have a
10 model that has both and it is true that in
11 general the patients with social risk factors
12 have more clinical comorbidities, particularly by
13 the time they're 65 and in Medicare and they've
14 had sort of a lifetime accumulation often of
15 social risk factors.

16 So if you have one in there and you
17 don't have the other, they may soak up some of
18 the, you know, they may capture some of the
19 signal. So I mean, I don't quite ever know how
20 to respond to that.

21 Yes, it is true that we examine the
22 impact of social risk after the clinical factors

1 are already there. But given that we would never
2 have a model that didn't have the clinical
3 factors, I don't really know why that matters.

4 You could do it the other way and you
5 would see exactly what ASPE saw which is social
6 risk factors look stronger. And when you add the
7 clinical risk factors, they account for a large
8 proportion of what's attributed to the social
9 risk factor when it's just in there alone. So I
10 don't know if that's helpful.

11 CO-CHAIR PONCE: Yes, I think it's
12 just something -- no, that is helpful, thank you.
13 That's something to consider. And also my
14 recollection of the committee that Dave and Kevin
15 chaired is that I thought we suggested that you
16 would show unadjusted, then clinical adjustment,
17 and then adding the social adjustment.

18 MEMBER BERNHEIM: And that is what our
19 team does. But can I make one other quick
20 comment on this which is I think it has been a
21 challenge to be somebody who is more cautious
22 about the fact -- I think the trial has been a

1 good thing. I think David said it really well,
2 that there's been a lot of learning.

3 I think it has generated a lot of
4 exploration in important areas and a call for
5 better data which we all agree upon. So I'm a
6 fan of having the policy of NQF changed to be
7 more open.

8 So, but I've definitely been a voice
9 of being more cautious. And it hasn't been fun
10 because many people see things differently than I
11 do. But there's two things that I've noticed
12 that I want to question with you.

13 One is people who are scientists who I
14 know well seem to be very strongly driven by an
15 underlying belief about this, that sort of no
16 matter what evidence comes forward, the response
17 is there must be something wrong with that
18 evidence.

19 And so I want us as a committee to be
20 careful. I mean, I think that we are learning
21 and we should pay attention both to what our
22 ongoing beliefs are and what the data ends up

1 showing us.

2 And part of the reason I think it is
3 so different than what people anticipate is that
4 we tend to think about for an individual, the
5 risk of social risk factors. But in these
6 measures, patients are aggregated.

7 And David Nerenz has actually said
8 this really well often. And once you account for
9 clinical risk factors and you have an aggregation
10 of patients with relative degrees of these social
11 risk factors, in the end they often don't have as
12 big an impact as we anticipate ahead of time.

13 And we then may think we have the
14 wrong data and other things. And sometimes we
15 probably do have the wrong data, we certainly
16 don't have good enough data. But I think we get
17 confused between the sort of quality signal issue
18 of an aggregated group being seen by a provider
19 and what we believe about individual patient
20 prediction. So that's my one other just piece of
21 caution.

22 CO-CHAIR PONCE: Yes, we really

1 appreciate your cautiousness and also your work
2 on this. I also want to acknowledge that the way
3 David drew out the conceptual framework where you
4 don't want to control for the pathway where it
5 goes through the healthcare provider is in line
6 with the way you conceptualize the decomposition
7 analysis where you're trying to sort that out.

8 MEMBER NERENZ: I just ran out of gas
9 in talking. But Susannah, what I was going to
10 say, what I was describing visually with my hands
11 in the air, I thought it was just a graphic
12 version of what you had said perfectly well about
13 the decomposition. It's the same idea.

14 CO-CHAIR PONCE: Sorry, Susannah, did
15 you have -- go ahead.

16 MEMBER BERNHEIM: No, please. I want
17 to make room for other people. I was just
18 agreeing with David.

19 CO-CHAIR PONCE: She was agreeing with
20 you, David. Philip?

21 MEMBER ALBERTI: I'm trying to
22 organize my thoughts on the fly and not repeat

1 many of the great points that have been made. So
2 in terms of what issues have been resolved, I
3 think it seems like we're all in agreement that
4 we need to continue to explore this.

5 I think the fact that the vast
6 majority of developers were able to develop
7 conceptual models, and that committees during the
8 review said what about these measures that you
9 haven't -- I mean, there's a sense I believe that
10 the resolution is we need to move forward in some
11 way.

12 In terms of conceptual further
13 considerations, when it comes to conceptual model
14 guidance, I think it would be really important
15 for the NQF to kind of delineate explicitly the
16 potential patient, hospital, and community
17 factors that could be incorporated.

18 And I think that if we don't include
19 community factors, we have missed the boat
20 entirely. There are many, many validated, well
21 validated models that show the vast majority of
22 health outcomes are actually due to those

1 variables.

2 And I think that any conceptual model
3 that doesn't include neighborhood level factors
4 as I'll just say potentially incorrect. And I
5 think our last meeting, we had some debate and
6 discussion about when we talked about community
7 or neighborhood.

8 I just want to make it clear that I
9 think we're all talking about the neighborhoods
10 to which we are discharging patients, and not the
11 neighborhoods in which the hospitals are located.
12 I think there was some confusion before at our
13 last meeting, and I think that's a really crucial
14 point that if we're going to include hospital
15 level factors, it's not necessarily the
16 characteristics of the neighborhood the hospital
17 is in.

18 I also want to talk a little bit about
19 the disconnect between the conceptual and the
20 empirical models. You know, there is this huge
21 lack of data. Right? So you specify these
22 beautiful conceptual models that have variables

1 at patient and maybe hospital, but certainly
2 community levels. And then you don't have any of
3 them.

4 So it actually turns up the empirical
5 test, we're using everything in there as a proxy.
6 Right? We're using dual eligibility as a proxy,
7 we're using race as a proxy, we're using
8 everything becomes a proxy because you don't
9 actually have the precision of the variables that
10 we need.

11 And so I think we just need to be
12 aware of that. And so I, like Christie, am just
13 not surprised that we don't see these movements
14 once we adjust because we're not adjusting in the
15 right way for the right things.

16 I also think I really, I read Sarah's
17 email, kind of her plea for flexibility and
18 continued flexibility in terms of how measures
19 are adjusted and what developers propose. And I
20 think in this learning mode, that's really
21 crucial.

22 But I also do think that there needs

1 to be some guidance at kind of high levels on how
2 we input some of these adjuster variables. So
3 you know, we'll see models, empirical tests that
4 adjust for white, not white. It's not great,
5 we're lumping a whole lot of groups together in
6 the not white group, but sometimes that's all the
7 data will allow us to do.

8 I've also seen tests that adjust for
9 black, not black. And I think that's
10 unbelievably problematic because that not black
11 has all kinds of different groups of varying
12 degrees of privilege in.

13 And so I would not be surprised we
14 would not see differences when it comes to black,
15 not black. So I think that we could actually
16 provide some guidance on model development at a
17 very high level.

18 And then the last point has to do with
19 this issue of statistical versus clinical
20 significance. My question is who's the arbiter.
21 Who gets to decide how you translate an odds
22 ratio of 1.04 into the lived experience of a

1 provider on the ground.

2 You know, so if only three percent of
3 payments would shift as a result of doing this
4 SES adjustment, what three percent of hospitals,
5 where are they located, who are they serving, and
6 how much cash does that translate to?

7 I mean, it might not be in the omnibus
8 a hugely meaningful shift, but for those three
9 percent of hospitals, it very well could be. And
10 unless we have some transparency and someone in
11 charge of deciding what a threshold is for a
12 clinically or an on the ground significant, I
13 don't want to leave that up to measure
14 developers. Those are some of my points.

15 CO-CHAIR PONCE: Thanks, Philip. I
16 think you gave some specifics on stronger
17 language on measurement, empirical model
18 inference, and subgroup analysis. Yolanda?

19 MEMBER OGBOLU: I would just like to
20 add that I agree with much of what Philip just
21 said. When I hear the results that you just
22 described of the evaluation, it sounds like

1 although we're talking in the language of social
2 risk factors now, when this trial period started,
3 we were talking social demographic status, and
4 they're not the same thing.

5 And so when you think about social
6 risk factors, we're missing a bunch in this
7 common definition that's going forth now in terms
8 of social risk factors, in terms of cultural
9 contacts, social relationships, community
10 contacts.

11 None of that has been measured by this
12 trial period. So I think switching the language
13 around that is problematic because this really
14 wasn't a trial period of social risk factors. It
15 was a social demographic status.

16 And then it only focused on very
17 limited data points which was race, ethnicity,
18 and payer. And so it really doesn't capture what
19 we need to measure. Some things as a group I
20 think we've already identified that there are
21 some measures about that could be looked at long
22 term, and then some things that we don't have

1 measures for.

2 And then I wanted to piggyback a
3 little bit on what Christie mentioned about the
4 cumulative of those odds ratios. And so thinking
5 about things again, we've talked about this is
6 behind what intersectionality accounted for, and
7 some of the methods that are used in terms of
8 doing these studies.

9 And I hear people talking about why
10 there's something mediates or moderates or if we
11 need to do some kind of path analysis type
12 research as well. And I just don't have enough
13 information.

14 Maybe there's more information
15 available in terms of the methods that were used
16 to do some of, to evaluate whether these risk
17 factors should be accounted for. So those were
18 the additions I had.

19 CO-CHAIR PONCE: Thanks, Yolanda. So
20 you note again that this is, the thinking has
21 evolved. So it's not just a label change to
22 social risk factors, but that thinking is

1 involved and what that means. Bob and then
2 Michelle, I haven't forgotten you.

3 MEMBER RAUNER: I just going to add to
4 what both Phil and Christie were saying that we
5 might add a third category. There's
6 statistically significant, there's clinically
7 significant, and then there's financially
8 significant.

9 And the way the Medicare shared
10 savings program works is that you can achieve
11 savings, but then the Medicare calls back a
12 certain percentage based on your quality score.
13 And most score between 80 and 99 percent, so
14 you're losing between 1 and 20 percent of
15 multiple millions of dollars.

16 And so if you added one or two points
17 down because of colorectal cancer screening, one
18 or two points down for blood pressure control and
19 that starts adding up, that could be the
20 difference between an ACO getting 93 percent of
21 that or 97 percent of it, and that becomes a
22 significant amount because the mean savings was

1 \$5.4 million. That ends up being hundreds of
2 thousands of dollars of potential loss.

3 And then a couple of programs like
4 our, unfortunately our commercial plan, it's all
5 or nothing. So the difference between 49 and 51
6 percent is the entire \$4.7 million.

7 And so those small effect 1.08s, if
8 you add them up, can be a big deal for an ACO.

9 And so I think we need to consider that financial
10 significance too.

11 CO-CHAIR PONCE: Thank you. Michelle?

12 MEMBER CABRERA: So I have a
13 combination of questions and comments. First one
14 is on the, sorry. I had them and now I lost
15 them. Oh, okay.

16 CO-CHAIR PONCE: You were waiting so
17 long.

18 MEMBER CABRERA: That's okay. So on
19 the issue of the sequencing of the adjustment,
20 SDS first versus clinical, I actually do think it
21 matters to do SDS first because a lot of the
22 heated conversations are around things that are

1 happening in Medicare.

2 And you assume that by the time
3 someone is in Medicare, they're likely to be
4 sicker either because they're older or because
5 they have a disability, right?

6 And so that's where, yes, those things
7 come. They kind of converge and they compound.
8 But they're both present. I think if you're
9 looking more broadly across different pairs, then
10 the up-front, you know, social factors followed
11 by the clinical makes a little bit more sense of
12 it.

13 I don't know, just a thought on sort
14 of the Medicare as our kind of anchor on that
15 part of the conversation. I do think that a lot
16 more guidance would be useful, and I think we
17 just have to have an open mind that this is going
18 to be an iterative process and that it's not sort
19 of set in stone forever.

20 But, you know, we should, NQF should
21 give people guidance on a whole number of things.
22 I have a ton of questions which I'm happy to take

1 offline about, you know, what kind of training,
2 what kind of information was rolled out.

3 And one basic question, do we, does
4 NQF require conceptual bases and empirical
5 analyses on non-SDS? No. So there's all kinds
6 of -- maybe? Okay. So yes, okay.

7 So I mean, I guess what I'm trying to
8 figure out is I think that there's a culture
9 shift too within the measure developer community
10 around what it means to do this, and that's
11 really playing out in the readmissions space.

12 And I actually found it helpful to go
13 to, like, some of the comments in that discussion
14 because I don't know this stuff very well. But
15 you know, AHA was commenting on the decomposition
16 issue.

17 And they said, you know, there, it's a
18 mixed effects model which means that they combine
19 hospital level and patient level factors for,
20 they roll that up into a single performance
21 score.

22 So for clinical they mix, but for SDS,

1 we're doing that separating out by pure patient
2 versus hospital. And they've called the
3 question, why. And I call the question about I
4 thought our intent was to inoculate to some
5 degree that hospital which by virtue of their
6 serving, you know, large numbers of uninsured
7 people, was facing low reimbursement rates, or
8 not uninsured but, I'm sorry, uninsured, under
9 insured, you know, again, understanding social
10 risk factors.

11 The people who serve a lot of them
12 might also be facing similar challenges, and that
13 we were trying to mitigate for some of that
14 effect. I think that's why there's sort of
15 concern about how this is playing out. This
16 isn't how it was supposed to go. This isn't what
17 it was supposed to be.

18 And I think there are some legitimate
19 questions in that mix model thing which, you
20 know, makes sense to me at least.

21 But I also want to ask, I mean, I'm
22 not sure it's not appropriate to adjust even if,

1 you know, we're looking at hospital level factors
2 for something because of the impact on the
3 broader community and the fact that again, my
4 understanding was that we were supposed to
5 stratify in order to have the conversation about
6 disparities, not massive disparities, and keep
7 the door open to that ongoing conversation.

8 And it's almost as though when folks
9 are talking about the adjustment piece, they're
10 forgetting that we required the stratification
11 piece and that it was about finances. But all of
12 a sudden now it's about assigning poor quality
13 when again I don't know.

14 You know what I mean? So I just think
15 I would like to register those concerns. I can't
16 remember if I had others.

17 CO-CHAIR PONCE: Ignatius. Thank you,
18 Michelle.

19 MR. BAU: So two very practical
20 suggestions. Again, since the list got narrowed
21 down to 17, there were ultimately endorsed with
22 adjustment at least to do a little more analysis

1 of what the conceptual models were and sort of
2 tease them out more in the lines of technical
3 assistance to say that these were the kinds of
4 literature reviews that were done and here's the
5 kind of evidence that created that conceptual
6 relationship.

7 And then the same thing with the
8 empirical evidence. Given all the challenges and
9 data that again, if respondent education came up
10 as, you know, what was the data source for that
11 and how easy is that so that again, for future
12 measure developers, they at least have something
13 to point to.

14 So I'm sure all that's available if
15 people did their research. But again, since it's
16 only 17, it just might be nice to have a handy
17 little chart just to show either as an appendix
18 or something else for people to see that.

19 CO-CHAIR PONCE: And before I call on
20 you, Michelle, so on the 17 I actually thought
21 wow, 17, that's actually really good. And so
22 this first part seems to be a feasibility test,

1 like can it be done.

2 But what about what happened with
3 these 17? Like, how sort of the impact of
4 changing the, you know, the way that we're risk
5 adjusting, how does it compare? Kind of like one
6 of Christie's charts when she shows when you
7 change it, like, what happens to hospital A and
8 B, where do they fit.

9 So I think that could, that requires
10 more time. You need more of a runway of time to
11 see what happens. But then that would be kind of
12 a, you know, we did, I mean, this first part
13 seems like more of a feasibility. You know, can
14 it be done?

15 Although, of course, it was a mixed
16 bag on how it was done and that's where we're
17 going to give guidance. But then of those that
18 were endorsed. Michelle.

19 MEMBER BERNHEIM: Can I ask for one
20 request?

21 CO-CHAIR PONCE: Sure, sure.

22 MEMBER BERNHEIM: Which is that we are

1 -- Susannah again, sorry. That we're careful
2 again in our language about assuming good and
3 bad. I just heard you say oh 17, that's pretty
4 good. Well maybe 17 is the perfect number.

5 I mean, obviously I don't think it is
6 perfect, but I don't think that this committee
7 should be on record as assuming that a measure
8 being risk adjusted is a better thing.

9 I think the science has to drive that.
10 And it may be that we disagree about the science,
11 but we should be more equal in our assumptions
12 about what is good and bad as the outcome of
13 these measures.

14 CO-CHAIR PONCE: So what I mean by
15 good is it's empirically good. It's good that we
16 have a sample to look at.

17 MEMBER BERNHEIM: And that makes a lot
18 of sense.

19 CO-CHAIR PONCE: Yes. Michelle?

20 MEMBER CABRERA: Yes, I remembered one
21 other point which was I again have this weird
22 question about whether given that we have such

1 limited consistent patient level data sources,
2 should we push out here's what we do have and ask
3 people to look at it in the interest of being
4 data driven for the, you know, anything where
5 we've figured out, like, okay this is now a data
6 set we can play with, asking people to play with
7 it in terms of stratification.

8 And then having that be a component or
9 a driver of a conversation about whether there
10 might be a need or a desire to adjust for that.
11 So again, not knowing as well as folks like
12 Christie and others whether that even exists.

13 But I think that should be one goal or
14 aspiration to compile that and then just say
15 across the board do it so that more people are
16 doing it.

17 CO-CHAIR PONCE: Thanks, Michelle.
18 Christie?

19 MEMBER TEIGLAND: Yes, I just want to
20 draw a parallel between this hospital effect that
21 we're seeing and, you know, maybe it's not
22 appropriate to adjust for the hospital because

1 the hospital is really a reflection of the people
2 it's serving.

3 And in this case we have better data
4 about the hospital because that's an entity and
5 we know exactly what that population, we know a
6 lot more about what that population looks like.

7 Whereas the patient level data is
8 still poor, right, related to the social risk
9 factors. So it's not surprising that the
10 hospital effect --

11 But again, it's just absorbing, just
12 like those clinical chronic conditions are
13 absorbing a lot of the risk factor, you know,
14 income and education factors in some of the risk
15 adjustments estimates we did because it's more
16 powerful because it's way more prevalent in
17 people who have low income, low education. They
18 have more diabetes, they have more heart
19 conditions, they have --

20 So it's pulling away from the effect
21 of the social risk factor, and I think we're
22 seeing that same thing with this hospital effect.

1 So it's really muddying the waters. And so we
2 just have to be really careful about that.

3 CO-CHAIR PONCE: Thanks, Christine.

4 Also I think it speaks to and calls out the
5 unmeasured, its effects of community context.
6 Emilio?

7 MEMBER CARRILLO: Yes, it makes sense.
8 However, recall the VA system had a big study,
9 and the disparities really reduced in the
10 hospital. Again, that might reflect on the VA as
11 opposed to say you know, Harlem hospital.

12 But the hospital does, because of all
13 the standardized guidelines and the way that the
14 care is delivered, they tend to shave down
15 somewhat. Again, the condition is still moved,
16 but it's really reduced, I think.

17 CO-CHAIR PONCE: Mic please, Christie.

18 MEMBER TEIGLAND: That's what we want
19 these models to do is to really which
20 organizations are doing it better. So when we
21 adjust for the organization, we muddy that,
22 right, we mess that up. So that's all I'm

1 saying.

2 CO-CHAIR PONCE: Those on the phone,
3 would you care to comment? If you're talking
4 right now, you're on mute. Okay, go ahead. Was
5 that Susannah?

6 MEMBER FISCELLA: No, this was Kevin.

7 CO-CHAIR PONCE: Oh Kevin, sorry.

8 MEMBER FISCELLA: Yes, I just wanted
9 to respond to an earlier comment that the same
10 standards are applied to clinical risk factors as
11 they are to social risk factors.

12 I mean, I think if you were to take
13 out any single clinical risk factor and then add
14 it back into the model, you would see that it
15 really didn't, you know, probably 95 percent of
16 the cases have any more affect than a single
17 poorly measured social risk factors.

18 So I don't think it's equivalent in
19 that sense. You're taking a well-developed
20 clinical model and adding one risk factor to it.
21 And if you were to do the opposite, I think in
22 most cases you would have a very similar minimal

1 effect.

2 CO-CHAIR PONCE: Okay, thank you. So
3 I think we've given a lot of guidance on the
4 statistical inferences that also include clinical
5 and financial significance. We had a lot of
6 guidance on the conceptual framework, do's and
7 don'ts too on some strong language and what
8 should be a proxy and not a proxy.

9 We offer a template. I think I heard
10 that. We didn't really touch on the specifics of
11 data, but I think we can continue that with
12 recommendations offline.

13 One appeal that Helen had was the
14 measures that were not currently risk adjusted,
15 but the feeling that there should still be under
16 an equity lens of social risk factors. Philip?

17 MEMBER ALBERTI: I actually want to
18 take the data conversation online for a minute.

19 CO-CHAIR PONCE: Okay, take it online.

20 MEMBER ALBERTI: If that's okay.

21 CO-CHAIR PONCE: No, take it online,
22 yes.

1 MEMBER ALBERTI: You know, I think
2 there's just been a general agreement, at least
3 in this room over the last two days and three
4 meetings of the importance of these neighborhood
5 community level factors.

6 And I think that this group with this
7 opportunity that we've pointed out so often these
8 two days, to propose a path forward to collect
9 the data that we need to collect to do this
10 right.

11 And whether that's through
12 demonstration projects in areas like California
13 or New York City where it might be possible in a
14 limited way to do some of those tests, or have,
15 you know, four or five different options. Again,
16 I'm not going to suggest new data collection
17 requirements for hospitals, I would lose my job.

18 But you know, so if, but that's one
19 option right there. Is CMS going to collect
20 these data, is it CDC that's going to collect
21 these data at a more granular level. Are we
22 really going to incentivize the collection of

1 these at the provider level.

2 What are the paths forward. What are
3 the ten most central variables we think based on
4 our expertise would be the most crucial adjusters
5 at the community or neighborhood level. And can
6 we come up with some ideas on how to gather those
7 prospectively.

8 CO-CHAIR PONCE: Thank you. Christie?

9 DR. BURSTIN: The last item that's
10 listed there, this issue just keeps coming up of
11 how much we're calling social risk may in fact be
12 unmeasured complexity. I just wanted this group
13 to just give us a little bit of thoughts on that.

14 And most of it just as a safety net
15 doc for years and years and years, they're so
16 intertwined, frailty, poor functional status,
17 many of those issues with some of those social
18 risk factors, this has been an area I would like
19 NQF to focus more attention on as well.

20 For example, can we get a claims based
21 indicator of frailty to put into some of these
22 risk factors. You know, what is the adequacy of

1 even being able to use claims data on a, you
2 know, a continuous bases for doing even some of
3 the clinical risk adjustment.

4 We would just love your perspectives
5 on that as well.

6 CO-CHAIR PONCE: Ron?

7 MEMBER COPELAND: Well, I think to
8 pursue that, we're going to have to have partners
9 out in the field who are already in many cases
10 starting to ask patients directly for those type
11 of data so that we have patient level data that's
12 been put into the system.

13 So whether whoever, you know, the
14 payer systems are regarding risk adjustment and
15 so on as we've heard today, that there's a lot of
16 complexity there. But we should all be aware
17 that a lot of organizations aren't waiting for
18 the Government payers to figure this out.

19 They're just starting to collect the
20 data from their members directly, putting it into
21 their systems, and creating risk factors based on
22 that to not to adjust payment, but obviously to

1 adjust interventions, upstream interventions as
2 well as direct patient care in the right
3 environment and so on.

4 So I think identifying as I think
5 about some type of collaboration or demonstration
6 project, in that space to understand these so-
7 called unmeasured clinical areas because I think
8 structure racism in another one of these areas
9 that fits into that category.

10 None of this stuff is going to touch
11 that in terms of impact, but it is definitely
12 operating because it informs peoples day to day
13 decisions and it's not going to show up in data
14 based on some measurable social factors.

15 So there's that stuff and how does
16 that contribute and impact into this whole
17 agenda. So that would be an area to explore.
18 Don't know how many organizations are already
19 doing a lot in this space in terms of collecting
20 data directly from patients and putting it into
21 their systems or not, but that's worth exploring
22 and maybe get some collaboration that can occur

1 in that space.

2 DR. BURSTIN: And Sarah presented some
3 data at the meeting you convened, Ignatius,
4 around health plans at least in terms of what
5 they're actually collecting. And it was still
6 pretty darn small for most.

7 CO-CHAIR PONCE: I do work with
8 AAPCHO, Association of Asian Pacific Community
9 Health Organizations where they're represented
10 there. So they are very interested. I've been
11 talking about social complexity for a long time.
12 I mean, the data's a limitation.

13 But it might be since you just, you
14 know, you triggered it in my brain when you said
15 since you were a safety net provider, that maybe
16 we should look at these safety net providers to
17 get guidance because they're front liners on
18 dealing with socially complex patients.

19 Their data may not be as mature as
20 their sensitivity and their thinking about this.
21 But I think they have a sense on the real world
22 problems.

1 CO-CHAIR PONCE: Marshall?

2 CO-CHAIR CHIN: I'm trying to think
3 of, like, how to sort of synthesize what we've
4 heard so far. The report is pretty to the point
5 of, like, there was a trial period, here's what
6 we found where 17, the measures were admitted
7 were incorporated.

8 There's a lot of heterogeneity in what
9 was done, and not a lot of consensus on sort of
10 the ways to move forward given the thorny issues.
11 And so I'm wondering if maybe, well thinking a
12 little bit like, so what are the take homes that
13 we've come to so far.

14 So for example, it's almost to me, I
15 may have heard, it's like there probably does
16 need to be more standardization, or at a minimum
17 convening of the various different parties with
18 different perspectives, approaches to hammer out
19 some of these, like, advantages that consist of
20 different approaches ranging from what's in the
21 conceptual model, the issue of patient level,
22 community level, availability of data,

1 statistical approaches.

2 So we sort of just touched up on this.
3 Maybe it needs to have a subcommittee, but it
4 seems like that there are significant differences
5 between some of the different groups in how I've
6 approached it. Which lead to important
7 differences.

8 And so that needs to be sort of hashed
9 out also. Let alone then things which are more
10 suited, judgement calls regarding things like
11 what type of significance in a month of change is
12 relevant, whether it's fiscal significance,
13 whether it's the impact.

14 Or like Bob and Philip are saying,
15 maybe one to three percent of some outcome. But
16 you know, maybe that's enough to, because they
17 use different types of payment, or if you had a 3
18 percent of groups effective that's important.

19 Sort of a policy judgement, value
20 judgement type of thing. So I guess my concern
21 is that, like, we're raising a lot of great
22 issues, but we haven't really talked about well,

1 and so how and presumably would be like a next
2 stage of this work that we don't have two years
3 from now basically the same result of, like, left
4 clarity I guess regarding some of the
5 advancement.

6 In other words, give us some of these
7 unresolved issues or conflicting approaches
8 sometimes. How do we sort of gain further
9 insight into preferred approaches.

10 I mean, Sarah's point that she made in
11 somebody, but very important of like there needs
12 to be some flexibility in it all.

13 So it's this balance between
14 flexibility and learning versus if there are
15 better ways of doing things, then we should know
16 about them and then we should be guiding towards
17 that.

18 So I'm wondering then, like, on one
19 hand we have basically live it as is and leave it
20 to the wisdom of the higher powers of NQF to make
21 sure that moving ahead this is addressed versus
22 potentially we can probably get a little more

1 guidance about how do we enhance the likelihood
2 that this continued advancement in this area
3 towards whatever result is going to be the
4 fairest and based upon reality and improving
5 things in terms of, like, the data availability
6 and the statistical approaches and all.

7 DR. BURSTIN: Just a quick response on
8 that. I think in many ways the issues you've
9 raised are not the ones that we could have simply
10 said do X. There just is not an agreement on
11 doing X.

12 I do think though it's a way to
13 elucidate with those key questions and go to, you
14 know, subgroups of you guys or something to try
15 to get that specificity. I can't imagine moving
16 forward in the current heterogeneous environment
17 and kind of, you know, what was the Einstein
18 thing, doing the same thing over and over again
19 expecting different results.

20 No desire to do that again. So I
21 think there is a desire regardless of sort of how
22 he moved forward in whatever way that we need

1 that clarity.

2 CO-CHAIR PONCE: Thanks, Helen.

3 Christie?

4 MEMBER TEIGLAND: Yes, Helen, I just
5 wanted to respond to your question about these
6 additional variables and how important they are.
7 And I have a recent example. And it's public so
8 I can say who it is.

9 We built some, and I remember that the
10 Impact Act was about post-acute care, right? So
11 we built, Kindred came to us and said can you
12 build us models to show the optimal placement for
13 someone who's leaving the hospital so that we
14 minimize readmissions to the hospital.

15 And so the model's based on all kinds
16 of chronic conditions that the individual has,
17 you know, what kind of tests and procedures they
18 had in the hospital, why they were in the
19 hospital, you know, how long were they in the
20 hospital, were they in the ICU.

21 And so ultimately what the model did
22 was shift a lot of people from going to a nursing

1 home, right, a skilled nursing home to home
2 health, to home health which could save the
3 system, you know, billions of dollars.

4 But what it came down to was we had to
5 add some additional questions at the end for the
6 person making the placement because can this
7 person go home, you know, can they do activities
8 of daily living, do they have a support, a care
9 giver at home.

10 And if they don't, guess what, they're
11 going to go be in the nursing home. And so even
12 though I have the same, you know, clinical
13 conditions, and if I went home I would be better
14 off and I would be less likely to go back to the
15 hospital. I'm going to go to a nursing home
16 because I don't have the resources.

17 So they have really important factors.
18 So when we're thinking about this in the bigger
19 context of saving the health system money and
20 actually having an impact on readmission rates
21 for people with, you know, some and certainly not
22 having social supports at home is a social risk

1 factor.

2 You know, ADLs is something else, but
3 these other variables are no less important to
4 get this stuff right. So I absolutely vote for,
5 you know, figuring out how to get that
6 information.

7 Now once you get to the nursing home,
8 you have all that data, right, on ADLs scores, on
9 ten different activities of daily living. They
10 collect all that data once you're there. But
11 once you're there, it's too late. So yes.

12 CO-CHAIR PONCE: Thanks, Christie.

13 Emilio?

14 MEMBER CARRILLO: Yes, on a different
15 topic going back to some of the things that Phil
16 said and also Marshall, the neighborhood based,
17 you don't know if mesh or analysis can help us
18 begin to look at institutional racism.

19 And how is that? But by retracing the
20 pathway, you have policies and procedures that
21 are driven by government and are driven by
22 certain industries.

1 Those policies, procedures,
2 regulations impact social determinants which show
3 up in the neighborhood. Now for example housing.
4 You know, there is just so much evidence of how
5 red lining by banks and how certain, you know,
6 even government housing policies result in
7 gettoizing sectors of the population.

8 And that becomes the seed of a
9 neighborhood so that the policies and regulations
10 that the banks use, the redlining, the government
11 in terms of who gets the loans, in terms of
12 basically dispensations, that can all be traced
13 backwards if you look at the neighborhood and you
14 begin to look at the impact of the housing versus
15 the impact of the transportation, et cetera.

16 CO-CHAIR PONCE: Thanks. I was also
17 thinking that a lot of the social factors
18 measures are level measures and not, you know,
19 the social stratification measures of residential
20 segregation and income and equality which then
21 aren't amenable to when we start stratifying.

22 Then you sort of lose that overall

1 structural factors that create the segregation of
2 services. So thanks. Phil?

3 MEMBER ALBERTI: Yes, so kind of an
4 existential question maybe for, sorry to do that.
5 For the board to consider on July 20th. And I
6 think it really comes back to this mismatch of a
7 really well specified, evidence based, literature
8 based conceptual model where there's kind of
9 universal scientific agreement that those doctors
10 play a role paired with the complete inability to
11 test it with a national data set.

12 So I think the question is what does
13 the NQF do in that instance? Do you endorse a
14 measure that you know is invalid because you
15 cannot, I'm just going to be provocative to be
16 provocative, that you know is, or that you think
17 might very well be invalid because you can't do
18 the adjustments and prove via an empirical test
19 how it should be used, or do you scrap the
20 measure.

21 I mean, those are two really extreme,
22 and I'm doing that on purpose. But you know,

1 what's the answer when you know that there's a
2 great conceptual basis to do these multi-level
3 adjustments, you can't test it.

4 Well, we'll either endorse it without
5 it, we know it's not right, or we don't use it
6 and that's a real, now that leaves a hole in the
7 quality measurement. And I don't know what the
8 answer is, I just wanted to put that out there.

9 DR. BURSTIN: That's basically the
10 scenario. I mean, that's true. I mean, that's
11 exactly the arguments we heard of how do you put
12 it forward if you don't think it's valid versus
13 how do we remove it when we don't have that
14 empiric evidence that it has an effect.

15 I mean, it's truly the ultimate
16 existential crisis I think we face. I will say
17 that part of what we did do over the past couple
18 of years is for example when measures came
19 forward with a conceptual basis without a clear
20 empiric basis, as part of the annual review of
21 measures that we require all developers to go
22 through, there is now going to be a clear

1 question for each of them on an annual basis
2 saying so, what's the state of the art lately in
3 terms of data.

4 Can you look to re-do this. So I
5 think part of our thinking was could we continue
6 to sort of push this rock up the hill a bit. But
7 it's still I think at the end of the day
8 unsatisfying to all, to be very existential.

9 CO-CHAIR PONCE: Nancy, then David.

10 MEMBER GARRETT: So to that point,
11 that's what I was suggesting earlier that perhaps
12 there's another category in between those. And
13 so maybe there's an endorse but this is social
14 risk factor sensitive and we're not adequately
15 accounting for that.

16 And therefore, here's a category where
17 we want to be careful how we use these measures
18 and give some guidance about how they're used.
19 So that would be one option to consider.

20 And then I just wanted to make the
21 point that in the NAM reports, they identify four
22 categories of how CMS could account for social

1 risk factors. And risk adjustment's only one of
2 the four.

3 So there's also direct adjustment of
4 payment which we have in our recommendations
5 restructuring payment incentive design,
6 stratification. So it's all stuff that we're
7 talking about, but I think part of the challenge
8 is that the risk adjustment is not going to
9 address health equity in the way, you know, we're
10 going to have to do other things.

11 And so addressing this one at a time
12 through the risk adjustment process, it's too
13 much to expect out of that process. And so I
14 think that's a little bit of the challenge that
15 we're facing and maybe something that we can make
16 clear in our recommendations as well is that this
17 is just one thing that we think we need to do,
18 but it's not going to solve the problem.

19 CO-CHAIR PONCE: It's a good point,
20 Nancy.

21 MEMBER BERNHEIM: Ninez?

22 CO-CHAIR PONCE: Yes, Susannah, go

1 ahead.

2 MEMBER BERNHEIM: Well, is somebody
3 else in front of me in queue waiting.

4 CO-CHAIR PONCE: Oh, is that --

5 MEMBER BERNHEIM: Susannah, yes.

6 CO-CHAIR PONCE: Yes, okay, go ahead.

7 MEMBER BERNHEIM: Okay. So Nancy, I
8 appreciated what you just said. And I think
9 responding a little bit to Philip's purposely
10 provocative statement, I think that I would like
11 for a second, race has come up a couple of times
12 now and I would like to talk about race for a
13 second.

14 One is a clarification because we
15 tested race in our models partly because we
16 thought that that was the guidance and partly
17 because we thought it was important not as a
18 proxy for SES, completely agree that we should
19 not use race as a proxy for SES.

20 But that the conceptual model for how
21 race affects something like readmission is
22 perhaps in my mind importantly similar to the

1 ways in which SES can affect readmission and
2 different from the ways clinical factors can.

3 In general, although it's not this
4 simple, we think about clinical factors as having
5 a pretty direct affect. If you have in addition
6 to the heart attack that you were admitted for
7 you also have end stage renal disease you are at
8 a higher risk because of that renal disease and
9 end up back in the hospital.

10 If you are a low SES patient like
11 minority patients, the reasons that you have a
12 higher risk of returning to the hospital may be
13 things that are outside of that hospital's
14 control, and that's the argument that people make
15 for risk adjusting.

16 But they may also have to do with, for
17 both minority patients and low SES patients, the
18 kinds of hospitals that you have access to, and
19 the kinds of treatment that you get within that
20 hospital.

21 And so when Philip says provocatively
22 when we have sort of a perfectly good conceptual

1 model for why you would risk adjust, I would
2 argue again that the problem with SES is that the
3 conceptual model suggests reasons to adjust and
4 reasons not to adjust.

5 And I will go back to what David
6 pointed out about the NAM piece, right? It
7 depends, the different pathways that SES affects
8 the outcome and which of those predominate.

9 When we did our analyses, we found
10 that the predominant pathways were as much about
11 where you go as who you are. And that's, you
12 know, and when we see that with race we say no
13 way we're going to touch this.

14 But we don't really like to talk about
15 the ways, though it's low SES patients on the
16 basis of their SES end up with institutional
17 classism if you will.

18 Right, part of what happens to these
19 patients is that they, not that there aren't many
20 outstanding safety net providers, but they
21 sometimes end up with limited access to high
22 quality care, or with less high quality care

1 within those institutions. And if we risk adjust
2 for that, we lose important information.

3 CO-CHAIR PONCE: People are thinking
4 here, Susannah. David?

5 MEMBER NERENZ: Sure. I was actually
6 going to make the point that Nancy made, her
7 first point. So I'm essentially just agreeing
8 with that, which I think was in response to Phil,
9 so I'm still trying to catch up with the
10 sequence.

11 But just to put a little smiley face
12 on it, I'm wondering if the NQF endorsement
13 message can come with something like a package
14 insert for prescription medications that, you
15 know, this measure is endorsed but don't use it
16 if this situation occurs or this situation
17 occurs.

18 And, you know, now back to serious, it
19 basically says we know conceptually, we know on
20 the basis of studies with limited, more regional,
21 or even single institution data sets that there
22 are certain factors that affect this that we

1 cannot adjust for in the way that we built the
2 model and we're applying it nationally. So,
3 caution.

4 And so I'm asking a question. Since I
5 don't actually look at the NQF endorsement letter
6 or endorsement document, does it come with
7 caveats or cautions, or is that a reach?

8 DR. BURSTIN: You know, we don't. I
9 mean, we've done things like that in the past,
10 this is time limited, it's not been tested, this
11 is, you know, things along those lines.

12 I will tell you one of the biggest
13 challenges here is these measures are the ones
14 most in use in federal payment programs. Let's
15 be honest. So it's kind of the opposite effect,
16 right?

17 These measures are coming forward in
18 are so controversial because in some ways they
19 are out there being used. So to say use with
20 caution, I'm just not sure it's --

21 MEMBER NERENZ: And I do understand
22 that. Again, I realize.

1 DR. BURSTIN: Yes.

2 MEMBER NERENZ: But even then, I think
3 an example, and I'm not coming up with a good,
4 concrete example, but there was a CMS document
5 that came out a few months ago about proposed
6 measures for use in future programs, I forget
7 exactly what the title was. But at least to my
8 taste it involves some measures that were say
9 developed and validated in one setting, but now
10 were going to be pulled over.

11 So it was coming from the hospital
12 arena, but now we're going to put it in MIPS and
13 we're going to apply it to individual physicians
14 or something like that.

15 And in that case I think there is
16 still some avenue, and certainly in our public
17 comment, to that document. We made this point
18 that a measure that's good over here is not
19 necessarily good over there. And this, what I'm
20 now saying is just be kind of a special case of
21 that.

22 DR. BURSTIN: Right. And actually

1 interesting, we do put that guidance, and
2 actually the specific example here is the, which
3 Erin did as well, the Medicare Spending for
4 Beneficiary measure which is a hospital level
5 measure is being proposed for a level at the
6 physician level.

7 And so our committee, and Nancy knows
8 this, explicitly said hey, this measure is
9 endorsed only at the provider level. You know,
10 if you want to use this measure at a different
11 level, additional analyses would be required.
12 But that's always been guidance. It doesn't have
13 quite the same hammer I think of the you're in,
14 you're out kind of endorsement decision.

15 MEMBER NERENZ: Right. And I
16 certainly, I understand. If we're talking about
17 measures that are already widely in use, than
18 this caution about, you know, they could perhaps
19 be more informative or more fair if adjusted, it
20 doesn't affect much.

21 DR. BURSTIN: Yes.

22 MEMBER NERENZ: But maybe still that

1 message could be put out there just so it's out
2 there.

3 CO-CHAIR PONCE: So before I call on
4 you, Bob, I just thought about this. Susannah,
5 you know, when you said that there are different
6 mechanisms that lead to what's an observed
7 difference or penalty, not just by race but by
8 socioeconomic status.

9 So in some ways, doesn't the approach
10 that you and your colleagues took, the
11 decomposition approach, address some of that
12 because again, that approach was, like,
13 classically done on our, the wage gender gap. Is
14 it because of the human capital characteristics
15 of women or is it that employers might be
16 discriminating against women.

17 So wouldn't that be one way of
18 decomposing it?

19 MEMBER BERNHEIM: Yes, that's exactly
20 why we did it. And you could, I mean, so you
21 could argue then once you decompose it to include
22 in the model that tiny portion that stays patient

1 level. It seemed de minimis at that point.

2 But you certainly could do that, and
3 that might make stakeholders happy. And I know
4 ASSI, I think they ultimately didn't put any of
5 it in the report, but I think that is something
6 that they thought about as well is if you tried
7 to do the decomposition, it creates complicated
8 statistical models.

9 But you know, one thing this committee
10 could recommend is, you know, developers try to
11 separate the provider level effects from the
12 patient level effects so that if they're
13 adjusting they're primarily looking at the
14 patient level effect.

15 And of course you could do that for
16 clinical variables. But because the clinical
17 variables are mostly patient level, there's
18 typically less of a need to do that.

19 CO-CHAIR PONCE: And again, a friendly
20 amendment that I represent I think some of the
21 thinking across the table here is that we make
22 sure that we account for these unmeasured social

1 complexity and clinical complexity and measured
2 community factors right now.

3 MEMBER BERNHEIM: Yes.

4 CO-CHAIR PONCE: Oh, I'm sorry. Go
5 ahead.

6 MEMBER BERNHEIM: I just, I agree with
7 both of the unmeasured clinical complexity issues
8 and the community factors. We thought a lot
9 about community factors. And it's an important
10 area for continued exploration of these measures.

11 CO-CHAIR PONCE: I heard a definitely
12 from the NQF voice here. So, Bob? Oh Ron, did
13 you have? Okay, so Bob.

14 MEMBER RAUNER: Yes, I was just kind
15 of running more with David's analogy about the
16 package inserts, that NQF measures are being used
17 off-label for things they weren't initially
18 intended for. They were for quality improvement,
19 but now they're being used for payment.

20 And so just like with drugs, we have
21 some post release monitoring for unintended side
22 effects and adverse reactions. We need something

1 like that for these commonly used NQF measures
2 that are getting put into payment systems because
3 they were studied for this but they're using now
4 for something else.

5 Probably good, but likely with some
6 unintended consequences just like drugs. So I
7 kind of like that model, actually.

8 DR. BURSTIN: And actually, you're
9 playing right into our other big strategic area
10 which is getting feedback on measures. So right
11 now if you go to the NQF website and pull up
12 NQF's work, there is now a new button that allows
13 you to click feedback on any measure at any time,
14 24/7 because that's exactly -- we can't look
15 right now.

16 (Simultaneous speaking)

17 DR. BURSTIN: You know, but on the
18 plane, you know what, this measure, and part of
19 it is what we don't actually know is, I mean, we
20 hear a lot about the concerns about the negative
21 unintended consequences. We actually know very
22 little about which measures are actually really

1 good, which ones in practice move the needle.

2 I want to use this measure, it really
3 helps me. So I think some of it is we feel like
4 to do our work effectively, we've just got to
5 know that. So much more of that to come.

6 PARTICIPANT: Thank you for being the
7 plant. All right, I think maybe we've exhausted
8 that.

9 CO-CHAIR PONCE: No, is there
10 something we haven't touched? Like, I was
11 skirting the data, but we actually have a lot
12 more time to discuss the data.

13 CO-CHAIR CHIN: It's Marshall. I
14 would just like to hear Susannah's response to
15 Christie's point earlier about this unmeasured
16 community factors and to the degree that your
17 hospital variable could be capturing that.

18 So in other words, so the community
19 social risk, because we don't have great
20 measures, some of what your models are capturing
21 as a hospital effect are really sort of the
22 unmeasured social complexity of the community.

1 So how would you respond to Christie's point
2 there?

3 MEMBER BERNHEIM: Well, it's a little
4 complicated. I think the way the model is set up
5 is pretty specific to the hospital. However, in
6 general, you know, everything, this is going to
7 sound ridiculous but I think it's an important
8 concept. Everything is ultimately nested in
9 other things, right?

10 So there's probably an effect of, you
11 know, state level policies and there's probably,
12 you know, so we account for the sort of
13 clustering of patients within hospitals as a
14 modeling approach we use, hierarchical modeling
15 which accounts for that.

16 But in truth, hospitals are in fact if
17 you will kind of clustered within communities.
18 We've talked about some of this in this
19 committee. The things that I think we need to
20 start to sort out to try to think about community
21 factors are what are factors that are community
22 factors that you feel like hospitals don't

1 influence but that might influence their quality
2 and outcomes.

3 So first you have to sort of separate
4 factors into ones that are sort of at least
5 partially under the influence of the hospital and
6 those that aren't.

7 And then you have to think about
8 whether you're thinking about the community that
9 the patients are in or are we more interested in
10 this idea that if patients come from communities
11 with high crime rates, their risk is different,
12 or the community that the hospital is in.

13 So are we more interested in sort of
14 say social services or policies in that hospital,
15 and then how would you account for that, right,
16 because you often have a cluster of hospitals
17 that looks to be exposed to the same set of
18 community factors if you look at, you know,
19 county level vacancy rates which some people have
20 done, there might be four hospitals in that
21 county who all sort of have that same vacancy
22 rate assigned.

1 But of course, the way that it
2 influences those four hospitals is going to be
3 different, and that's hard to parse that across.
4 So I didn't completely answer your question
5 except to say there may be a little bit of that,
6 but I think the modeling is mostly hospital
7 focused.

8 But to some extent, those community
9 factors are affecting not just SES, everything
10 about these models. And the problem with trying
11 to incorporate them in is that there's these
12 layers of questions about which factors you would
13 use and at what level and how you would determine
14 how they differentially affected different
15 hospitals.

16 We're doing some work on, but it is
17 not simple.

18 CO-CHAIR PONCE: Thanks, Susannah. I
19 think you're inspiring creative thought here. I
20 think there's, the cards went up and down and up
21 and down. So, I'm going to stick with the order
22 where Ignatius, no? Who? Who goes?

1 PARTICIPANT: I think Philip was next.

2 CO-CHAIR PONCE: Philip. Philip then
3 David then Michelle.

4 MEMBER ALBERTI: I was definitely
5 going up and down, I apologize. You know, so I
6 think we all agree that these variables across
7 the various levels that we're talking about are
8 co-linear, right? They're correlated. It's hard
9 to, really different to tease apart.

10 So I think that's, I think, I'm
11 looking around, everyone's nodding. So I think
12 that's true.

13 Getting back to some of the, you know,
14 I would be interested, I don't have your analyses
15 in front of me, Susannah, so I would be really
16 interested in the specific hospital level
17 variables that you used.

18 You know, I would think that things
19 like connections to social services or an inter-
20 professional care team that's incorporating
21 social work, I would not want to account for
22 those things, that's part of the care process

1 that is quality care. I would want to be able to
2 kind of isolate those things and not adjust those
3 away.

4 In terms of community level factors
5 that do not go through and kind of David's
6 mediated model, don't go through, or go directly
7 to outcomes, not through the quality process or
8 quality of care, I mean, I think we could all
9 probably go around for the next hour and just
10 start rattling them off whether it's segregation
11 indices or depravation indices, transportation,
12 food access.

13 I mean, there's just many, many, many
14 things that I think we would all agree are
15 "beyond the control" of the care process itself
16 that we think would impact things like
17 readmission or the cost of caring for patients.

18 So those are just some of the thoughts
19 that I had. But I really would like to, I would
20 be interested to just see what kind of hospital
21 factors you were assessing and some of the
22 decomposition analyses.

1 CO-CHAIR PONCE: Susannah, do you have
2 a quick answer for that?

3 MEMBER BERNHEIM: Yes, so we don't put
4 fixed factors in. We don't sort of adjust for
5 whether the hospital has CABG capacity. We
6 literally take the patient level SES variable and
7 it gets, and it sort of is separated into the
8 portion that's attributable to the patient and
9 the portion that's attributable to a hospital.

10 So it's just that same variable
11 decomposed. Again, at this point you've got to
12 get my statisticians on the call. But can I ask
13 a follow up question? So for something like
14 transportation, and maybe this is too in the
15 weeds.

16 So Helen, I would love to hear from
17 this committee, and maybe we should do it another
18 time. You know, when I think about
19 transportation I go back to all of those
20 questions.

21 Do I look at the transportation, if I
22 had the variable, acceptable to individual

1 patients that come to that hospital, or do I look
2 at it regionally and then how do I understand how
3 it affects different hospitals differently within
4 that region?

5 So there's some interesting questions
6 about what you do with these community factors
7 when you're trying to model hospital quality.
8 It's probably too detailed for this committee,
9 but it would be great for this committee to
10 tackle because I don't think anybody's got good
11 answers and there are a lot of smart people in
12 this room.

13 MEMBER ALBERTI: You know, this is
14 Philip, I'm just going to jump in real quick.
15 You know, I think we've talked about this before.
16 For something like transportation, I would want
17 to know A, do you have a car. I'm just going to
18 be real.

19 And B, if not, do you live in a
20 community where there's robust public
21 transportation? I think both of those things
22 would impact something like keeping follow up

1 appointments and readmission.

2 So I think that's the importance of
3 really, you know, identifying variables like
4 individual income is important, but so is the
5 immediate income of the community where you're
6 coming from. So I would say both.

7 DR. BURSTIN: And just quickly to
8 build on I think what Philip said, I think
9 there's been pretty strong agreement in this
10 committee that what we're talking about is
11 community factors for where the patient lives,
12 not where the hospital is.

13 I think that's been pretty consistent,
14 every head is nodding. So I think that does
15 change that a bit because we're not saying it's
16 about the hospital. It's about where the patient
17 lives and the community affects the kind of
18 things Philip just rattled off for the community,
19 for the patient, sorry.

20 MEMBER BERNHEIM: But so when we then
21 put things in from the ACS which is something
22 about where the patient lives, nobody thinks

1 that's a useful thing to look at. So that
2 confuses me.

3 I mean, I have that. I mean, I can
4 tell you a lot from the ACS about the communities
5 these patients are coming from. But everybody is
6 angry of that approach.

7 CO-CHAIR PONCE: I hear that no one's
8 angry. But so we can work with you, Susannah.
9 And thank you so much for clarifying for us. I'm
10 going to go to Dave.

11 MEMBER NERENZ: Well, I think I'm just
12 going to speak in general support of this is a
13 very exciting, encouraging area to look at. I
14 agree absolutely with Susannah, it just becomes
15 more complicated because as you add degrees of
16 nesting, the hierarchical models get more
17 complicated yet.

18 And at some point nobody can
19 understand them, but that's okay. If they end up
20 good in the end, I'm happy if I don't understand
21 it. I may even try to understand it. But I have
22 thought pretty strongly for a while that we

1 should, that there are valid and legitimate city
2 level or community level factors that we should
3 explore and see if we can work with them somehow.

4 At the NAM meeting a couple days ago I
5 was asked, you know, what are some examples. And
6 I had started with the observation that when the
7 readmission penalty started, every single
8 hospital in Detroit get the max penalty.

9 I said well how, what? They're not
10 owned the same. There's some for profit, not for
11 profit, how can they get the max penalty as a
12 common factor being they're in Detroit. And so
13 what does that mean?

14 Well then I was challenged. So okay,
15 what are some examples. And I said okay,
16 transportation would be one, that if you live, if
17 you are a low income person or if you live in a
18 low income neighborhood in Detroit, that's not
19 necessarily the same experience as being the same
20 person living in the same income level say in
21 Denver or Seattle, or Boston because there are
22 different services at the city level.

1 And I know it's hard to deal with
2 that, but I think it would be worth exploring.
3 So I agree with Susannah. A, it's complex, B,
4 there are some ways to do it.

5 And just maybe as another for thought
6 experiment, I hope I'm corrected if I'm wrong
7 here, but when the hospital global star ratings
8 came out last summer, you know, a lot of people
9 took a look and I did a little, cute little
10 analysis that we published about that.

11 But imbedded in that was the
12 observation I made, and again tell me if I'm
13 wrong, every single hospital in Brooklyn, New
14 York is a one star, every single one. Now, what
15 does that mean?

16 Well, but it's kind of interesting to
17 speculate. The first conclusion, and then the
18 discussion ends, is that they're all just bad
19 hospitals. Okay, fine.

20 But I don't know, is there something
21 then characteristic of Brooklyn, and if so, what
22 might it be? And is it transportation, is it --

1 (Laughter)

2 (Off microphone comments)

3 MEMBER CARRILLO: It's not that
4 simple, it's not that simple. You have, like,
5 Maimonides Hospital, you have New York Methodist
6 Hospital. You have a number of strong hospitals
7 that are three stars, four stars.

8 MEMBER NERENZ: Okay, so I'm wrong in
9 the observation, I apologize. I just thought as
10 I went through the long list I saw --

11 MEMBER CARRILLO: I mean, Brooklyn is
12 huge, it's like a city. You know, and so there's
13 a lot of different ZIP codes and nine digit codes
14 that are really very distinct socioeconomically.

15 CO-CHAIR PONCE: Let's go to Ignatius
16 and then Michelle.

17 MR. BAU: So back to two additional
18 practical suggestions. I think the risk
19 adjustment trial was a separate thing from the
20 project that CMS did. But I do think there are
21 some congruencies.

22 So some of the evidence that we

1 highlight in the first two reports may actually
2 give some conceptual models for folks to think
3 about. And then I think when, so I was actually
4 then looking at the measures that were not
5 recommended for adjustment.

6 And again, is there similarly a
7 crosswalk back to some of the conditions that
8 were highlighted, the five conditions that we're
9 focused on in terms of the CMS specific task
10 order.

11 And then I think more importantly, not
12 just the conceptual models but in terms of the
13 data sources, to the extent that we're going to
14 really begin to flesh out what social risk
15 actually means and how it's measured, I think
16 that also will give, you may not need to do it in
17 the committee's reports, but somewhere as you
18 wind up the trial, it may also be good to
19 reference the fact that the committee's actually
20 looking at how to better define social risk and
21 what the data sources might be for social risk to
22 again point people to potential data sources.

1 CO-CHAIR PONCE: Thanks, Ignatius.

2 Michelle?

3 MEMBER CABRERA: I think, you know,
4 again just sort of on the editorial kick, we
5 have, and Emilio, you talked about redlining for
6 banks. We have redlining for hospitals, right?
7 I mean, so I think that's an important factor to
8 just remember that what a safety net hospital
9 represents for the community it's serving is last
10 man standing often time.

11 And so yes, the response that you're
12 getting around the anxiety about the impacts of
13 these things, it's akin to No Child Left Behind
14 policies, right? It's this notion that you can
15 create a test, grade everybody equally, let the
16 science lead the way, and if you don't perform,
17 you get whacked.

18 And the consequences are the same, you
19 start to divest from institutions that have
20 remained and have persisted despite a lot of
21 challenging care delivery factors. Right?

22 And so the question is yes, we don't

1 know, I don't think anybody, I think the one
2 thing we can all agree on is we don't want to
3 give a pass to lower quality. You know, there
4 were some studies of the various CMS Medicare
5 related policies around value based purchasing.

6 There was one in particular that was
7 published in Health Affairs that found that for
8 California safety net hospitals, they were more
9 likely to be penalized under VBP but their 30 day
10 risk adjusted mortality outcomes were better than
11 their competitors, and cost was virtually the
12 same.

13 So the conclusion based on VBP alone
14 that they are poor quality hospitals because they
15 didn't perform well on that test does not line up
16 with the outcomes relative to people who were not
17 penalized.

18 Stuff like this is the kind of stuff
19 that I think we need to keep in the conversation.
20 And again, I'm cautious about drawing the
21 assumption based on whatever measures we have,
22 whatever tests we have so far that because you

1 didn't perform well, you are a low quality
2 hospital and poor are the folks who have to
3 suffer with that care.

4 You know, I think the flip side of
5 that is they are the folks there trying every
6 day. And so what can we do to support them? You
7 know, I don't think labeling them poor quality
8 hospitals and giving them the Scarlet Letter is
9 helpful in the end.

10 So you know, one, I don't know enough
11 about how accurate the scores are, how at the end
12 of the day the data, you know, if the data's so
13 crappy all around, like, are we really accurately
14 lining people up next to each other? Is
15 everything we're measuring all the time the right
16 stuff to figure out if it's actually in service
17 in the populations?

18 So without knowing that the tests and
19 the measures are great and doing their job great,
20 then I would be hesitant from a purely scientific
21 and data driven standpoint to label folks poor
22 quality.

1 CO-CHAIR PONCE: Thanks, Michelle.
2 And that could be part of our recommendation,
3 right, for this particular, not just for the
4 trial but that also certainly resonates with our
5 road map and our strategy. So Helen and Erin and
6 Drew, and Tara and Mauricio, have we, and
7 Madison, how are we doing with advising you? Are
8 there any gaps?

9 DR. BURSTIN: This has been a
10 phenomenally rich discussion that we have to kind
11 of digest it a bit. We'll definitely be back to
12 you because I think you are the group that's
13 going to, you know, depending on how this moves
14 forward, if we are going to continue to do this,
15 and I suspect we will, you know, the degree of
16 specificity you can offer to us that we can then
17 offer and reduce the heterogeneity is our goal
18 collectively.

19 This has been incredibly useful
20 discussion.

21 CO-CHAIR PONCE: So I'm going to go
22 ask if we have members on the phone, make some

1 final comments, and then we'll go to public
2 comment. So Kevin, Susannah, Sarah, if you're
3 still back with us.

4 MEMBER BERNHEIM: The only thing I'll
5 say is it's been a great discussion. And I
6 apologize for when I get a little animated, but I
7 think this has actually been a very interesting,
8 useful --

9 (Simultaneous speaking)

10 CO-CHAIR PONCE: I really value your
11 animation, Susannah. I was trying to impart
12 animation here too to you.

13 MEMBER BERNHEIM: Excellent. But
14 great discussion.

15 CO-CHAIR PONCE: Thank you.

16 MEMBER BERNHEIM: Thank you.

17 MEMBER FISCELLA: Yes, I agree with
18 Susannah. I really have nothing else to add.

19 CO-CHAIR PONCE: Thanks, Kevin. Okay,
20 let's, shall we open it up for public comment?

21 MS. MURPHY: Operator, can you please
22 open the phone lines for public comment?

1 OPERATOR: Thank you. At this time,
2 if you would like to make a comment, please press
3 star and then the number one on your telephone
4 keypad. We'll pause for just a moment. And
5 there are no public comments at this time.

6 MS. MURPHY: Thank you. Are there any
7 public comments in the room?

8 MS. BOSSLEY: Okay, thank you. It
9 would seem a shame not to have someone say
10 something after this conversation. So this is
11 Heidi Bossley on behalf of the Federation of
12 America's Hospitals. Just wanted to say thank
13 you for this conversation.

14 It's been two years of watching these
15 measures go through the trial period. And as one
16 of the groups commenting, it's nice to see it all
17 come together and have this type of robust
18 discussion. So thank you very much, and we look
19 forward to see where it goes with the CSAC and
20 then the Board.

21 CO-CHAIR PONCE: All right, thanks,
22 everybody. I think it's time for all to have

1 safe travels to start, you know, the line of
2 labor and leisure. So leisure is going to start
3 now, and we are adjourning. Thank you so much.

4 Marshall and I thank you for, can I
5 use robust again, robust discussion, animated,
6 passionate, but also very grounded in advancing
7 the field and moving forward with a clear road
8 map for NQF. So thank you.

9 CO-CHAIR CHIN: Yes, what Ninez said.
10 It's now the time for, have the image of, like,
11 in the Sound of Music when you have all the kids
12 up on the staircase.

13 PARTICIPANT: That's a long fair well.

14 CO-CHAIR CHIN: Yes. I think though
15 that this challenge that Ninez and I and Helen
16 sort of posted at the very beginning about, like,
17 to think boldly and to not be constrained and to
18 think about how can we take advantage of this
19 opportunity to try to advance the field in
20 equity, I think we did it.

21 I'm very pleased with the discussion
22 and the degree of engagement and the going

1 through, like, some very tough issues. And so I
2 think again, we're in a good position. There's
3 still a lot of work to do between now and
4 September, but I think we're in good shape in
5 terms of being able to come up with a final
6 report and recommendations that will be
7 impactful. Thank you very much.

8 DR. BURSTIN: And special thanks to
9 Marshall and Ninez. It was quite the effort to
10 moderate this over the last couple days and the
11 last couple years actually. So thank you, and
12 thanks to the staff as well. We put them through
13 their paces of getting all this work done the
14 last couple of months and --

15 (Applause)

16 DR. BURSTIN: Thank you.

17 CO-CHAIR CHIN: And the staff really
18 is the magic potion here. Okay, so we'll be in
19 contact. Thanks very much.

20 (Whereupon, the above-entitled matter
21 went off the record at 2:38 p.m.)
22

A			
a.m 1:9 4:2 133:5 149:16 182:4	accountable 11:10 63:7 66:2 77:2 149:4 170:4	104:8 116:12 124:2 155:10 161:18 173:15	250:10 251:17 259:18
A1c 70:19,20 235:3 236:12	accounted 271:6,17	252:17,18 295:6	259:21 261:16,17
A1cs 177:22	accounting 123:16 301:15	296:5 309:11 326:17	269:4 273:19 277:9
AAMC 202:19 203:5	accounts 315:15	additions 198:11 271:18	277:22 288:3,14
AAPCHO 290:8	accreditation 10:8 21:18,21 22:2 102:11	address 48:4 49:19 50:12 53:13 59:10	302:3,8,12 326:19
abandon 251:11	113:17	101:21 105:6 142:15	327:5
ability 45:13,13 77:6 101:13 207:9	accumulation 260:14	157:16 166:3 177:7	adjustment's 302:1
able 17:2,15,18 21:7 25:7 34:22 44:3 63:1	accurate 69:19 330:11	302:9 310:11	adjustments 206:14 282:15 299:18 300:3
63:5,10 108:9 109:8	accurately 330:13	addressed 85:6 293:21	ADLs 297:2,8
113:15 150:12 196:22	achieve 68:9 171:2 272:10	addresses 93:9	admitted 255:14 291:6
197:2,5 199:17 265:6	achievement 161:2 201:18	addressing 19:20 20:17 61:22 123:22 127:7	304:6
288:1 319:1 335:5	achieving 11:14 19:19 30:3 73:19 153:3	200:7,13 302:11	advance 130:2 201:8
above-entitled 182:3 335:20	acknowledge 154:16 264:2	adds 40:13	334:19
absence 21:10	ACO 86:9 187:21 188:2 190:2 272:20 273:8	Addy 217:15	advanced 10:5 101:9
absolute 74:16 87:14 87:18,20 88:5,14,17	ACS 22:21 254:3,5 322:21 323:4	adequacy 287:22	advancement 293:5 294:2
102:7 103:16 107:8	act 19:4 167:17 295:10	adequate 227:18	advancing 334:6
107:11,22 108:4,17	acted 236:14	adequately 93:9 301:14	advantage 140:22 334:18
108:20 109:12 112:17 113:8	action 24:9 26:4 77:9 129:21 130:6,14,19	Adjoin 3:18	advantaged 140:11,16
absolutely 125:8,13 146:21 168:5 297:4	130:20 178:13	adjoining 334:3	advantages 291:19
323:14	action-oriented 35:6	adjust 92:4 115:6,9 126:3 139:8 141:15	advantaging 140:22
absorbing 256:4 282:11,13	actionable 24:2 26:21 114:10 179:9	141:16,20 145:8	adverse 253:13 312:22
abstract 161:8 182:20 183:6	actions 129:22	207:11 246:4 250:9	advising 331:7
ACA 104:11	activities 22:2 296:7 297:9	250:12,16 260:6	advisory 200:8,9
Academy 6:2 93:13 169:6 205:20	Acts 117:22	267:14 268:4,8	affairs 181:17 182:9,11
accept 172:19	actual 48:4 189:20 223:4 256:12 257:1	276:22 281:10,22	183:13 184:7,15
acceptable 99:18 320:22	257:14	283:21 288:22 289:1	193:8 197:11 198:4
accepted 183:2 186:13	add 37:18 77:20 95:13 110:2 114:4 147:8	305:1,3,4 306:1 307:1	329:7
access 9:1 14:18 18:3 45:13 56:7,15 60:8	161:4 176:1 236:5	319:2 320:4	affect 164:11,12 223:22
61:3,11 62:5 63:5	252:4 255:3 261:6	adjusted 94:17 206:3 206:12 207:6 209:5	226:3,3 235:11
66:1,8,22 67:2,2,4	269:20 272:3,5 273:8	209:12 214:9 215:2	256:11 284:16 304:1
68:4 105:7,10 304:18	284:13 296:5 323:15 332:18	215:12 216:1,19	304:5 306:22 309:20
305:21 319:12	add- 110:22	229:9 231:15 252:4	affordability 67:11
accessibility 67:11	add-on 109:21 110:7,19	252:10 256:17 267:19	affordable 105:22
accessible 208:13	added 67:14 82:18 101:16 210:18 251:20	280:8 285:14 309:19	afternoon 21:10 22:11
account 239:5 261:7 263:8 301:22 311:22	252:14 259:22 272:16	329:10	22:13 23:13 24:19
315:12 316:15 318:21	adding 61:21 209:10 261:17 272:19 284:20	adjuster 268:2	186:2 201:21
accountability 56:12,19 58:11 59:12,17 60:12	addition 100:14 121:3 127:11 129:7 212:3	adjusters 287:4	age 167:11
60:20 61:6,12 63:22	216:9 304:5	adjusting 9:19 119:5 139:11 206:7 213:9	agencies 18:16,16,22 19:9 50:16,16
65:7 68:4,12 69:7,20	additional 10:10,18 76:12 98:3 100:13	239:7 251:20 267:14	agenda 4:5,11 11:14
146:14,15 148:17		279:5 304:15 311:13	28:5 29:16 34:16,18
149:5 173:2,19 174:9 174:18		adjustment 4:7 22:8 23:18 25:14 73:15	35:3,6 150:2 154:1
		93:16 94:12 98:20	156:17 157:4,10
		121:15 122:19 123:14	182:7 289:17
		124:7 142:1,4,7	aggregate 22:21 84:6 174:1,2,5 254:10
		145:12,15 203:12	257:9
		207:4 208:4 209:16	aggregated 263:6,18
		210:5 213:5 215:4,9	aggregation 263:9
		215:21 227:17 231:22	ago 154:9 175:5 178:8
		232:13 233:9 241:21	208:17 249:9 308:5
		242:4 247:4,11	324:4
			agree 34:20 40:9 66:1
			78:16 83:15 89:19
			93:16 100:9 125:13

126:1 127:20 128:3
 131:22 132:10 142:19
 144:2 154:20 155:4
 176:12 251:7,14
 262:5 269:20 303:18
 312:6 318:6 319:14
 323:14 325:3 329:2
 332:17
agreed 176:4 224:11
agreeing 264:18,19
 306:7
agreement 58:16 87:22
 265:3 286:2 294:10
 299:9 322:9
AHA 275:15
ahead 22:17 46:20 81:2
 81:22 103:21 106:7
 114:17 118:9,10
 136:1,1 147:20
 156:22 196:19 200:21
 211:14 263:12 264:15
 284:4 293:21 303:1,6
 312:5
ahead.' 156:22
Ahh 179:16
AHRQ 34:17 53:8
 157:16 229:1
AHRQ-y 35:7
aid 18:16
aim 89:13
aiming 121:5
air 248:13 250:1 264:11
akin 33:14 328:13
Alan 249:9
Alaska 203:21
Alberti 1:12 21:2 49:4
 55:6 64:14 65:18
 100:9 112:5,16
 129:13 132:4 139:7
 142:17 158:9 202:18
 203:6 264:21 285:17
 285:20 286:1 299:3
 318:4 321:13
Alicia 234:11
align 58:2 71:11 86:15
 228:2,18
aligned 71:10 72:8
 113:19
aligning 9:6 57:22
 65:21 66:20 70:10
 74:8
alignment 64:8 71:12
 72:2 74:6 86:16
aligns 114:2
alive 189:21
all- 61:18
all-necessary 61:19
alleviate 25:7 49:21

50:3
allow 205:12 268:7
allowing 23:17
allows 140:17 197:4
 313:12
alternative 161:13,16
amazing 48:5
amenable 60:20
amenably 298:21
amend 159:1
amended 156:14
amendment 144:22
 149:12 311:20
amendments 52:14
America's 333:12
American 1:12 2:2
 229:2
amount 36:14 91:6
 138:7 188:7 220:10
 226:5 232:9 236:21
 260:4 272:22
amplify 201:6 203:2
analogy 312:15
analyses 210:2 218:19
 218:21 224:9 226:17
 275:5 305:9 309:11
 318:14 319:22
analysis 57:13 185:12
 185:21 191:14 207:1
 210:13 222:4 223:5
 227:11 237:16,19,21
 255:22 259:5 264:7
 269:18 271:11 277:22
 297:17 325:10
Analyst 2:8,9
analyzed 211:4 223:12
anchor 274:14
anchored 174:15
and/or 107:21
ANDERSON 2:8 8:3
 162:18 163:1,17,20
ANDREW 2:8
angles 18:11
angry 323:6,8
animated 332:6 334:5
animation 332:11,12
annual 179:2 200:5
 202:21 300:20 301:1
answer 17:2 60:6 82:11
 143:21 232:5 247:8
 300:1,8 317:4 320:2
answers 29:5 321:11
anticipate 263:3,12
anxiety 328:12
anybody 86:16 106:12
 203:16 260:5 329:1
anybody's 321:10
anymore 103:6

anyway 82:1 179:17
 190:5 193:1 246:18
apart 318:9
apologies 217:15
 229:14
apologize 318:5 326:9
 332:6
appeal 28:3 285:13
appealing 32:3
appear 130:15 213:19
 253:11
appeared 110:20
append 50:18 112:11
appended 49:7
appendix 278:17
Applause 335:15
application 173:19
 174:17 225:17
applications 149:5
 173:3,20
applied 134:6 284:10
applies 84:14 111:8
 115:14 122:20
apply 41:17 42:9
 115:13 116:5,13
 118:8 126:10 135:13
 135:18 140:3 147:19
 183:5 308:13
applying 52:22 104:15
 173:2 307:2
appointments 322:1
appreciate 221:13
 241:16 264:1
appreciated 303:8
appreciation 172:13
approach 32:9 80:14
 117:13 121:3 191:19
 191:22 219:3 233:8
 240:16 248:22 259:20
 310:9,11,12 315:14
 323:6
approached 292:6
approaches 29:14
 117:8 121:5 249:4
 291:18,20 292:1
 293:7,9 294:6
appropriate 37:21 54:7
 60:11 61:12,13 96:8
 101:12 127:15 141:17
 144:7 145:9 207:4
 229:11 243:1 276:22
 281:22
appropriately 44:8
 223:21
approved 104:22
April 208:21
arbiter 268:20
arching 15:5

area 46:15 84:4 154:15
 166:9 218:16 226:10
 254:7 287:18 289:17
 294:2 312:10 313:9
 323:13
areas 59:1 69:18 70:1
 160:1,4 163:19
 167:14 179:22 262:4
 286:12 289:7,8
arena 308:12
argue 119:18 145:14
 305:2 310:21
argues 135:16
argument 76:15 108:7
 149:12 185:9 219:14
 304:14
arguments 91:9 185:11
 186:13 300:11
arrive 210:21
arrow 250:6,13
arrows 249:7
art 301:2
article 170:14,19
 182:10 187:19 188:1
 235:2
ascertain 84:5
Asian 290:8
aside 226:20
asked 97:16 114:7
 174:6 183:15 210:1
 217:13 220:8 247:1
 324:5
asking 71:7 87:7
 192:17 233:16 281:6
 307:4
ASPE 6:1 13:5,11,20
 14:3,10,14 27:17
 43:19 202:4 230:2
 246:21 261:5
ASPE's 259:20
aspect 95:6 154:5
aspects 95:3
aspiration 143:6 281:14
aspirational 97:12,13
 109:7 139:16 142:21
 161:2
assess 63:8,10 155:3
 231:22
assessed 206:1
assessing 12:4 151:12
 152:4 319:21
assessment 42:9 62:10
 63:9 212:10
assessments 211:17
ASSI 311:4
assign 165:8
assigned 316:22
assigning 277:12

assignment 174:3
assistance 278:3
Association 1:12 2:2
 290:8
assume 49:18 74:10
 89:14 102:3 187:4
 274:2
assuming 280:2,7
assumption 44:5
 329:21
assumptions 280:11
Assurance 2:3
assuring 130:9
at- 90:16
at-risk 63:18 104:11
 176:16
attack 304:6
attainable 143:6
attempt 152:13
attendant 53:1
attention 46:15 92:18
 102:22 167:14 262:21
 287:19
attributable 320:8,9
attributed 256:2 261:8
attributes 259:8
attuned 31:21
auctioneer 98:14
audible 40:17
audience 30:9,17,22
 32:4 50:22 51:15 84:9
 114:22 157:15 180:8
 193:1
augmented 90:20
authors 194:15 197:10
authorship 197:6
availability 41:15 69:14
 228:10,13,15 291:22
 294:5
available 17:22 42:15
 69:8 208:13 211:4
 218:6 223:5 247:15
 271:15 278:14
Avalere 2:5
avenue 308:16
average 23:4
avoid 73:16 106:19
avoiding 107:2
aware 86:15 190:15
 241:22 267:12 288:16
Axiom 17:15 22:19
 32:10

B

B 27:18 279:8 321:19
 325:3
back 11:8,17 28:20
 30:18 36:3 40:21

41:18 43:11 54:12
 55:7 57:15 64:12
 65:12 86:16 96:5,15
 98:9 101:7 119:3
 121:8,9,18 126:1
 131:17 132:16 133:7
 133:15 142:10,14
 143:15 160:16 162:9
 165:22 166:17,21
 168:9 170:19 173:1
 176:8 177:4 186:21
 191:11 193:18 204:10
 204:11 206:10 208:11
 208:15 209:19 211:16
 217:12,16,21 224:15
 224:19 226:1 229:10
 246:9 247:10 249:19
 272:11 284:14 296:14
 297:15 299:6 304:9
 305:5 306:18 318:13
 320:19 326:17 327:7
 331:11 332:3
background 162:12
 245:9
backwards 298:13
bad 29:10 38:2 47:5,8
 83:13 183:12,15
 230:19 255:15 280:3
 280:12 325:18
bag 279:16
baked 103:10
baked-in 44:5
balance 107:2 293:13
ball 190:13 204:14
ballpark 178:3
Baltimore 1:22
banks 298:5,10 328:6
bar 205:3 217:3
barrier 45:15 73:6
barriers 104:16 165:1
base 11:18 15:6 33:15
 40:14 105:18 153:13
 153:19 160:9 188:3
 189:17
based 8:5 15:18 24:13
 33:9 37:18 45:18 56:3
 95:3 96:9 97:16 98:4
 166:12 171:18 181:18
 185:13 187:5 188:1
 194:13 243:12 272:12
 287:3,20 288:21
 289:14 294:4 295:15
 297:16 299:7,8 329:5
 329:13,21
bases 215:20 217:18
 222:15 275:4 288:2
basic 275:3
basically 5:6,21 17:15

28:11,13 53:13 65:15
 82:20,21 96:12 98:6
 128:3 131:1 160:2,13
 172:15 176:21 183:6
 195:3 293:3,19
 298:12 300:9 306:19
basis 94:12 154:12
 166:14 173:7 205:5
 206:5,18 210:22
 211:2,6 213:9 215:13
 215:18 217:11,17
 218:7 219:6 222:14
 222:18,21 242:21
 243:16 300:2,19,20
 301:1 305:16 306:20
battle 82:18
BAU 2:13 12:22 65:22
 78:2 133:15 160:16
 277:19 326:17
beat 21:19
beautiful 266:22
beginning 11:20 334:16
beginnings 156:13
behalf 333:11
behave 240:4
behavior 165:4
belabor 236:18
belief 262:15
beliefs 262:22
believe 39:10 96:5
 135:1 263:19 265:9
belong 120:4 121:1,1
belonged 119:1
belongs 119:10 121:17
beneficiaries 13:6
 230:3
beneficiary 105:20
 106:1 309:4
benefit 50:14 75:6 76:8
 135:3 144:17
benefits 91:1
Bernheim 1:13 7:8,17
 14:17 36:8 38:18
 106:6,9 107:6,9
 118:13,21 121:16
 122:4 123:8 125:2
 196:4 203:18 238:19
 260:2 261:18 264:16
 279:19,22 280:17
 302:21 303:2,5,7
 310:19 312:3,6 315:3
 320:3 322:20 332:4
 332:13,16
best 59:19,21 63:18
 102:4,13,14 120:16
 190:16 242:18
bet 39:22
better 17:8 23:20 35:19

37:14 39:20 76:10
 105:19 107:14 113:20
 113:22 119:9 123:15
 123:21 160:12,13
 169:11 176:14 187:10
 192:19 212:1 224:8
 226:12 252:7 257:7
 258:6 262:5 280:8
 282:3 283:20 293:15
 296:13 327:20 329:10
beyond 104:8 229:4
 252:18 319:15
bias 172:16
big 8:10 18:4 26:2
 42:10 87:9 164:5
 166:16 169:1 178:15
 220:18 235:16 240:18
 241:8 256:18 263:12
 273:8 283:8 313:9
bigger 23:5 51:14
 193:12 296:18
biggest 86:21 87:5 96:2
 218:19 228:14 307:12
billing 99:17
billions 154:10 296:3
birth 167:6,7
bit 5:15 19:11 21:20
 28:20 30:20 31:3
 33:17 38:22 40:2 52:8
 54:8 63:2 68:19 75:3
 86:3,17 95:14 104:3
 109:11 114:5 129:5
 137:10 138:13 146:9
 146:19 156:10 158:12
 162:1 163:5 171:14
 171:17 174:20 175:10
 181:16,20 182:9
 185:9,16 186:7 204:2
 214:7 216:22 218:11
 223:15 237:4,20
 253:21 266:18 271:3
 274:11 287:13 291:12
 301:6 302:14 303:9
 317:5 322:15 331:11
black 268:9,9,10,14,15
blank 198:11
blanket 206:3
blend 236:19
block 22:22
blocks 98:21
blogging 201:13
blood 95:17,22 97:2
 169:14 177:18 235:4
 235:15 236:12 272:18
blow 248:14
Blue 86:11
blue-gray 231:2
board 191:5 193:4

233:20 234:3,4,11
 242:2,5 246:10
 281:15 299:5 333:20
boat 265:19
Bob 16:19 21:3 44:6
 46:18,21 49:1 55:3
 60:3 61:15 64:5,6
 65:20 70:10 84:18
 85:22 88:19 94:1
 95:11 98:7 110:13
 162:3 170:11 187:17
 190:1 216:12 235:19
 272:1 292:14 310:4
 312:12,13
Bob's 72:4 82:15
body 31:15 87:1 243:5
boldly 334:17
bolster 78:15 150:9
bolsters 135:12
bonus 64:22 65:14
 140:15
bonuses 10:5
book 134:21 174:10
books 104:21
bordering 260:5
Bossley 333:8,11
Boston 324:21
bottom 16:6,7 81:19
 87:15 88:7 103:2,8
 107:6,19 113:6
boundaries 49:15
box 28:3 231:2 250:4
boxes 249:7
bracket 148:16
brain 23:13 290:14
brainstorm 19:11
 181:19
brainstorming 52:7
 185:16 186:12
brainstorms 185:22
break 57:5 133:5
 181:13
breakdown 250:21
breakout 60:8,21
bridge 169:14 173:12
brief 191:14 192:6
 238:22
briefly 8:11 202:18
 237:10
bring 31:13,16 72:5
 75:18 98:19 101:7
 145:18,20 179:16
 193:18
bringing 24:13 178:8
 178:17 194:6
broad 54:1 97:8 245:22
broaden 158:6
broadened 175:12

broaden 21:22 101:22
 116:13 169:2 222:22
 225:19 277:3
broadly 115:14 186:13
 274:9
Brooklyn 325:13,21
 326:11
brought 75:12 104:9
 172:12 188:5
bucket 8:10 10:1 19:15
 130:8,18,20,20 165:5
 215:6
buckets 13:16 129:15
 129:18 130:15
build 12:15 79:14
 185:19 295:12 322:8
building 10:22 11:22
 98:21 130:10,21
built 42:6 102:8 185:6
 196:10 295:9,11
 307:1
bulb 248:3
bullet 35:21 54:17 56:6
 58:5 65:20 66:20
 73:12,21 74:7,13,17
 77:7 81:20 83:18
 88:21 90:5 91:16,21
 93:11 98:1,8,17 102:3
 106:10 107:6,19
 110:19 111:9 115:5
 118:5,6 121:11,14
 122:15 126:3,15
 127:3,15 128:22
 129:4,5,7 137:9 145:5
 147:15,15,18 150:3
 151:11,16,18 155:7
 155:10,11 157:7,8
 160:12 162:8 168:10
bullets 28:12 59:1
 66:18 68:14 83:22
 84:10 87:16 98:1
 117:5 119:1 120:3,22
 141:7 144:5 146:8
 147:1,14 148:6 156:6
 158:5 159:19
bump 177:5
bunch 270:6
burden 9:10 49:21 50:3
 71:14 72:14 82:16
 86:6
BURSTIN 2:7 24:12
 34:14 35:19 79:13
 80:4 91:12 92:10
 147:21 150:18,21
 163:14,18 165:12
 168:5,7 176:6,12
 177:2 178:21 179:15
 180:21 187:1,7

197:18 203:22 204:5
 224:18 235:18 236:12
 237:17 238:10,13
 259:2 287:9 290:2
 294:7 300:9 307:8
 308:1,22 309:21
 313:8,17 322:7 331:9
 335:8,16
business 134:21
 152:18 160:18 161:19
 171:13 174:10
butcher 238:18,21
button 248:12 313:12
buy 44:17
buy-in 85:1,7 113:20

C

CABG 320:5
CABRERA 1:15 23:11
 43:16 57:4,17,19 72:3
 78:16 88:20 109:5
 146:6 148:15 172:22
 189:9 190:7,22
 273:12,18 280:20
 328:3
CAHPA 174:1
CAHPS 214:22
cake 207:9
calculating 231:13
calibration 219:16
California 1:15 44:13
 44:21 189:11 286:12
 329:8
California's 189:11
call 21:5,12 23:19 50:21
 134:1 158:10 159:12
 167:14 176:13 182:19
 186:18 195:14 262:4
 276:3 278:19 310:3
 320:12
called 239:10 276:2
 289:7
calling 4:10 50:15
 55:22 130:11 287:11
calls 131:7 133:2
 272:11 283:4 292:10
cancer 163:13 188:6
 235:3 255:12,12,13
 255:17,18,19 272:17
candidate 258:22
capable 35:11
capacity 130:10,21
 320:5
capital 310:14
capitated 101:18,21
capture 12:10 20:1 21:7
 21:14 152:13 158:1
 230:16 260:18 270:18

captured 61:2 153:22
 154:18
capturing 147:3 314:17
 314:20
car 321:17
card 148:14
cardiovascular 163:13
cards 216:15 317:20
care 9:17,17 11:11
 42:17 44:2 45:16 76:3
 76:7 78:4,4 82:6
 94:20 103:3 104:2,2,7
 105:8,10,10,22
 106:18 107:3 121:21
 132:18 136:5 164:19
 164:22 165:5 179:9
 208:6 215:1 230:5
 243:15 250:4 283:14
 284:3 289:2 295:10
 296:8 305:22,22
 318:20,22 319:1,8,15
 328:21 330:3
careful 46:11 84:12
 243:17,21 244:11
 262:20 280:1 283:2
 301:17
caregivers 181:2
CARILLO 18:10 20:2,4
 20:7,12 31:8,11 53:4
 83:19,21
caring 11:4 253:1
 319:17
carries 84:6
CARRILLO 1:15 159:1
 191:4 194:19 253:7
 283:7 297:14 326:3
 326:11
carry 69:10 240:22
carrying 240:8
case 74:11 76:11 89:16
 94:18 152:17,18
 153:13,19 160:18
 188:4,4,7 193:13
 259:11 282:3 308:15
 308:20
cases 37:22 284:16,22
 288:9
cash 101:2 269:6
catch 306:9
categories 36:13,17
 163:6 301:22
categorization 169:8
 169:19
category 87:13 191:17
 244:7,17 272:5 289:9
 301:12,16
cause 57:13 164:13
caution 38:5 81:21 82:6

173:8 263:21 307:3
307:20 309:18
cautionary 244:21
cautions 307:7
cautious 37:10 244:13
261:21 262:9 329:20
cautiousness 264:1
caveat 68:12 106:15
caveats 307:7
CDC 286:20
CDPR 159:5,10
center 1:14,20 48:18
230:4
centers 39:19
central 287:3
centric 192:1
certain 11:9 38:11
43:22 97:17 113:11
119:15 120:11 128:13
164:4 171:1 239:2
272:12 297:22 298:5
306:22
certainly 40:3 157:8
206:10,21 209:8
220:14 228:13 230:5
233:1 253:1 263:15
267:1 296:21 308:16
309:16 311:2 331:4
certificate 44:22 45:2
cetera 8:15 18:17 24:15
24:16 30:4 33:22 69:8
75:1 76:14 143:7
166:20 178:6 200:2
242:9 298:15
chaired 204:11 261:15
Chairs 1:9
challenge 40:11 47:9
71:12 85:13 261:21
302:7,14 334:15
challenged 324:14
challenges 223:18
225:5 228:11 231:10
276:12 278:8 307:13
challenging 181:9
328:21
chance 96:15 98:6
101:1 152:11 204:7
change 26:17 28:7
29:11 48:3 155:8
156:19 172:11 213:19
216:11 246:19 252:3
252:6,15 254:11
271:21 279:7 292:11
322:15
changed 92:11 93:11
112:18 262:6
changes 71:18 247:4
changing 99:22 119:21

131:9 246:11 252:11
279:4
channel 201:5
channels 199:5 202:20
characteristic 325:21
characteristics 49:7
50:10,10,11 191:13
266:16 310:14
characterizing 39:15
charge 13:3 269:11
chart 278:17
charts 279:6
check 7:4 203:13
Chief 2:7
child 245:17 328:13
chime 31:8
cholesterol 177:22
chose 164:4
Christie 2:5 17:1,10
21:3 22:17 23:9 34:13
36:3 102:5 221:17
234:16 253:19 258:21
267:12 271:3 272:4
281:12,18 283:17
287:8 295:3 297:12
Christie's 195:15
259:15 279:6 314:15
315:1
Christine 283:3
Christy 121:19 137:17
Christy's 121:19
chronic 255:20 256:3,6
282:12 295:16
circle 6:14 16:6 23:1
36:3
circles 62:18,22
circumstance 37:19
circumstances 119:15
cite 45:1
city 49:10 286:13 324:1
324:22 326:12
claim 135:10
claims 17:6,8,12,16
287:20 288:1
clarification 57:22 74:5
122:14 303:14
clarify 27:15 58:18
70:14 114:22 132:4
136:11 259:4
clarifying 323:9
clarity 52:20 84:13
87:14 88:11 135:22
141:12 212:2 250:17
293:4 295:1
classic 70:18 215:16
classically 310:13
classifying 120:11
classism 305:17

clause 107:7 139:7
clean 9:11 103:11
cleanup 123:2 213:8
clear 25:1 36:22 46:6
51:13 55:17 56:3 64:4
67:21 72:13 87:22
107:14 125:4 143:19
177:15 238:14 266:8
300:19,22 302:16
334:7
clearer 56:22
clearly 208:17
click 313:13
clicked 248:20
clinic 86:12,18
clinical 18:15 155:20
217:5 220:1 233:15
240:3,5 255:20
259:14,17,18,22
260:8,12,22 261:2,7
261:16 263:9 268:19
273:20 274:11 275:22
282:12 284:10,13,20
285:4 288:3 289:7
296:12 304:2,4
311:16,16 312:1,7
clinically 269:12 272:6
clinicians 179:10 207:2
clinics 44:7 70:16,21
86:5 188:5,11
close 35:15 189:14
224:18 232:17
closely 241:13
closer 226:15
closing 130:5
cluster 239:2,5 316:16
clustered 315:17
clustering 315:13
CMS 17:19 59:3 71:6,8
76:21 78:10 102:9
103:3 110:2 114:1
134:4 157:15 198:1
216:7 234:7 257:13
286:19 301:22 308:4
326:20 327:9 329:4
co- 1:9 70:16
co-chairs 245:10
co-linear 318:8
co-payments 104:14
coaching 10:20 144:15
code 17:17 22:21 49:12
221:9,10 254:4,8
coded 76:13,14
codes 23:2 251:21
326:13,13
coefficients 254:22
cohesion 193:21
collaboration 9:1 19:8

20:13 27:21 29:3
289:5,22
collaborations 20:21
50:7
collaborations' 18:13
colleagues 310:10
collect 23:20 41:19
44:8,18 75:8 80:5
85:5,9 286:8,9,19,20
288:19 297:10
collected 23:21 81:8
253:3
collecting 48:15 57:11
72:22 76:21 81:6
85:14 289:19 290:5
collection 8:14 24:5,8
44:15 49:21 54:17
69:13 74:22 76:16
79:19 81:4,6 85:2
189:12 286:16,22
collective 18:13
collectively 230:1
331:18
College 1:16
Colleges 1:13
colorectal 188:6 235:3
236:14 237:1 272:17
column 13:1,4
columns 6:1
combination 87:17
88:13 98:10 108:19
109:2 112:6 113:7
149:20 156:15 273:13
combinations 102:4
103:17 108:18
combine 142:12 275:18
combined 141:8 255:7
come 11:19 32:17
35:11,15 43:10 53:1
58:6 65:11 105:9
131:17 143:18 162:3
189:21 195:12 202:7
206:10 208:10,15
209:19 210:20 211:1
216:18 228:19 232:17
249:2,5 256:20 274:7
287:6 291:13 303:11
306:13 307:6 314:5
316:10 321:1 333:17
335:5
comes 37:22 50:20
66:10 69:5 71:5 119:3
162:5 262:16 265:13
268:14 299:6
comfort 214:19 220:15
comfortable 57:2 83:6
227:9
coming 48:6 54:4 80:9

194:22 204:6 230:12
 246:9 247:6 256:22
 287:10 307:17 308:3
 308:11 322:6 323:5
comment 3:10,16 7:7
 16:21 21:3 22:16
 27:10 36:4 39:15
 43:17 49:4,5 54:19,22
 66:22 79:14 80:6
 91:11 95:13 102:7
 103:20 113:14 114:19
 129:9 133:16 135:20
 137:8 141:6 147:22
 158:18 160:6,17
 161:22 178:8 180:9
 180:11,13,15,19
 198:20 227:2,12
 236:15 256:10 260:1
 261:20 284:3,9
 308:17 332:2,20,22
 333:2
commentary 186:20,22
commenters 27:2
 218:1 227:19,22
commenting 201:13
 275:15 333:16
comments 36:9 46:17
 55:4 63:15 72:1,4
 88:21 95:11 98:8
 131:20 142:9 148:11
 158:20 162:22 179:14
 180:7 189:4 201:20
 203:17 212:10 214:18
 216:18 227:15 251:7
 251:8 258:20 273:13
 275:13 326:2 332:1
 333:5,7
commercial 86:9 93:3
 134:19,19,20 174:7
 273:4
commitment 236:22
committee 1:3,7 2:3
 4:16 8:21 11:19 12:16
 13:22 14:5,9,15 22:6
 24:18 26:5,5 38:1
 70:13 79:8 82:4 93:4
 116:11 124:11 140:7
 142:15 162:21 164:4
 165:14,16 167:22
 169:20 171:20 172:2
 181:7,20 183:8,10
 184:2,15 187:5
 188:21 189:7 194:10
 194:14 197:7 198:8
 200:11 211:19 214:14
 224:14,19 226:17
 241:7,21 242:7 244:6
 247:10 251:4 261:14

262:19 280:6 309:7
 311:9 315:19 320:17
 321:8,9 322:10
committee's 3:4 147:2
 178:18 185:3,13,18
 187:9,13 327:17,19
committees 53:10
 193:4 207:18,19
 209:15 210:5,7 219:8
 221:4 225:9 226:12
 265:7
common 119:3 202:5
 249:21 270:7 324:12
commonly 313:1
commonplace 99:5
communication 164:22
 166:5 172:17 202:20
communications 201:4
 201:9
communities 45:7,8,11
 50:13 77:3 132:19
 133:21 178:6 315:17
 316:10 323:4
community 12:2 23:1
 27:22 41:9 42:5 49:14
 50:11 51:19 54:5
 62:14 84:3 158:11
 159:17 170:7 195:12
 195:16,19 222:1
 228:20 229:2,3
 233:14 253:10 265:16
 265:19 266:6 267:2
 270:9 275:9 277:3
 283:5 286:5 287:5
 290:8 291:22 312:2,8
 312:9 314:16,18,22
 315:20,21 316:8,12
 316:18 317:8 319:4
 321:6,20 322:5,11,17
 322:18 324:2 328:9
community- 21:11 41:1
community-based
 33:21 53:5
community-level 22:7
 22:15 41:11 42:9,14
comorbidities 260:12
comparability 137:12
 138:1,22 139:2,12,19
 143:11,13 145:3
comparatively 138:20
comparator 222:11
compare 6:6 140:12
 279:5
compared 77:18 174:11
 239:14
comparing 10:14
 115:11 117:18 122:16
 122:22 256:15,16,16

comparison 37:17
 118:1 119:14,16,21
 139:8 140:8 144:13
 164:6
comparisons 10:15
 137:9 145:4
compensate 94:22
competence 194:21
competency 40:1 63:9
competitors 44:19
 329:11
compile 281:14
complain 86:7
complement 6:6
complementary 69:4
complete 78:6 115:4
 196:8 299:10
completely 30:7 45:9
 131:22 178:2,3
 258:19 303:18 317:4
complex 231:11 251:12
 290:18 325:3
complexity 99:14
 230:12 233:15 287:12
 288:16 290:11 312:1
 312:1,7 314:22
complicated 109:1
 311:7 315:4 323:15
 323:17
component 193:10
 281:8
components 15:15
 60:15
compound 274:7
comprehensive 67:5
 254:17
compute 207:5
conceivable 249:13
concentrations 90:16
concentric 62:18,22
concept 82:9 107:2
 109:21 110:7 119:11
 138:11 146:13 190:10
 238:22 241:9 315:8
conception 101:16
 175:13
concepts 11:19 110:10
 110:20 128:16
conceptual 6:10 188:22
 205:5 206:5,17 208:1
 209:22 210:1,17,21
 211:2,6 213:9,12
 215:7,13,14,17,20
 216:3 217:3,11,17,18
 218:2,7 219:6 222:14
 222:18,21 223:19
 226:16 228:3 233:8
 240:16,20 242:21

243:2,7,16 244:3
 246:2 247:11 248:22
 251:1 264:3 265:7,12
 265:13 266:2,19,22
 275:4 278:1,5 285:6
 291:21 299:8 300:2
 300:19 303:20 304:22
 305:3 327:2,12
conceptualization
 55:21 58:22 67:9
conceptualize 264:6
conceptually 228:5
 306:19
concern 23:18 24:11
 25:7 124:11,21
 139:22 145:16 157:16
 223:14 226:8 228:1
 276:15 292:20
concerned 119:2 260:4
concerns 156:6 205:7
 207:13 211:7 214:16
 218:4 227:15,19
 231:3 232:2,11 238:4
 277:15 313:20
conclusion 44:3 325:17
 329:13
concrete 4:22 112:8
 188:9 308:4
concur 94:3
condensed 143:17
condition 5:4 149:17
 162:2 175:9 283:15
conditional 121:7
conditions 163:11,11
 163:15 164:2 178:10
 192:8 255:20 256:3,7
 259:16 282:12,19
 295:16 296:13 327:7
 327:8
conduct 210:2
conducting 12:1
cone 213:11
Conference 1:8
confident 35:14
configuration 23:2
confirm 235:9
confirming 23:12
conflate 71:4
conflict 82:2 184:18
conflicting 293:7
confused 263:17
confuses 323:2
confusing 202:7
confusion 146:20
 266:12
congruencies 326:21
connect 24:8 54:3
 202:9

connected 75:22
connections 177:15
 318:19
connects 61:5 194:3
connotation 26:11
 35:18
consensus 31:19 36:21
 38:15 58:14 143:19
 147:7 227:1 291:9
consequences 73:16
 89:21 313:6,21
 328:18
consider 14:13 122:16
 134:11 148:6 191:3
 207:21 233:9 234:9
 244:6 253:16 261:13
 273:9 299:5 301:19
consideration 14:7,11
 38:10 79:10 170:2
 228:20 229:6 233:4
 234:3
considerations 16:3
 134:3 234:8 265:13
considered 69:20 128:7
 213:2
considering 10:14,18
 138:18
consist 291:19
consistency 14:16
 216:22 225:1
consistent 71:5 93:13
 93:17 231:16 233:7
 248:22 281:1 322:13
constant 102:22
constantly 86:14
constrained 334:17
construed 104:4
Consultant 2:13
consumed 217:14
contact 203:4 335:19
contacts 270:9,10
content 195:17
contentious 217:19
CONTENTS 3:1
context 32:17 37:20
 111:16 120:8 146:16
 160:20 161:12 171:21
 181:1 245:10 250:19
 283:5 296:19
contingency 101:11
contingent 64:19,21
continuation 252:14
continue 29:9 73:6
 105:2 194:19 233:18
 236:3 265:4 285:11
 301:5 331:14
continued 207:13
 267:18 294:2 312:10

continues 213:10
continuing 251:14
continuity 17:7
continuous 288:2
contract 103:6 197:22
 257:17
contractors 216:7
contracts 257:14
contradictory 115:3
contribute 189:6
 289:16
contribution 194:12
 220:2
control 10:19 26:13
 30:19 70:19 95:18,22
 96:3 97:3 169:15,17
 170:8 235:4,4,16
 237:3,7 257:13 264:4
 272:18 304:14 319:15
controlling 178:1
controversial 117:15
 145:17 241:6 307:18
controversy 145:18
conundrum 170:11
convened 290:3
convening 291:17
converge 274:7
conversation 11:9
 15:20 21:3 23:16 24:1
 36:20 40:4 43:17 44:6
 45:20 51:18 60:5,18
 60:22 115:19 142:20
 152:15 153:14 161:10
 161:10,15,16,20
 171:19 181:9 193:15
 216:17 274:15 277:5
 277:7 281:9 285:18
 329:19 333:10,13
conversations 11:17
 136:4 147:4 194:14
 273:22
convey 40:12 77:22
cool 128:1 145:22
Cooper 1:16 7:9,11
 27:6 28:19 35:16
 107:16 108:11,21
 109:3 126:18,21
 128:3 151:2,8,10
 152:2,8 154:19
 155:13,17 156:2
 175:17 176:11 203:15
coordinate 203:2
coordinated 78:3,4
coordination 215:1
Copeland 1:17 60:4
 63:4 68:22 94:2
 135:21 136:3,19
 152:12 198:9 288:7

copy 5:20 128:22
core 1:14 18:15 72:19
 82:21 159:4 188:20
 190:8 208:18 216:7
Cornell 1:16
correct 68:1 125:15
corrected 325:6
correcting 5:12
correctly 129:20
correlated 318:8
cost 105:6 153:7,17
 227:14 244:5 319:17
 329:11
costing 153:5
costs 105:20 218:8
 225:10
count 257:8
countries 105:12
country 90:15 105:11
 117:10 254:19
county 1:19 131:18
 316:19,21
county-based 44:13
couple 39:21 49:9 70:4
 82:7 88:20 172:12
 201:1 204:9 208:19
 211:20 214:6 221:18
 222:2 226:6 228:11
 231:8,10,20 233:5
 245:9 247:17 273:3
 300:17 303:11 324:4
 335:10,11,14
course 6:20 49:5 63:22
 179:12 187:13 198:2
 210:11 245:11 279:15
 311:15 317:1
cover 4:13 6:19 36:16
covered 105:19 189:11
covers 254:17
CPE 1:18
crack 7:1 32:1 35:11,14
 54:21 143:20 150:1
crappy 330:13
crazy 47:1 70:16,21
create 19:1 37:8 71:1
 120:18 125:17 244:15
 250:17 299:1 328:15
created 7:3 36:13 43:1
 278:5
creates 311:7
creating 159:15 244:14
 288:21
creative 317:19
crime 316:11
crisis 300:16
criteria 5:4,5,8 68:11
 96:6,10,14 97:17
 99:16,19 133:9

136:14 162:2 163:10
 164:16 165:17 167:10
 168:16 175:5,7,16
 179:3,4 180:22 181:7
 214:2 217:10 233:19
 252:18
criterion 210:6
critical 69:3 194:2
Cross-Blue 86:11
crosses 179:10
crossover 193:20
crosswalk 13:1 100:18
 327:7
crosswalks 14:2,6,10
crucial 21:16 55:17
 266:13 267:21 287:4
crude 252:2,2
CSAC 210:9 214:12
 234:1 246:10 333:19
cultural 40:1 63:8
 194:21 270:8
culture 8:22 56:7,16
 59:15 62:5 64:20 66:3
 68:18 130:2 275:8
culture/structure 101:9
cumulative 271:4
cures 104:13 117:22
curious 237:13
current 6:19 22:9 33:12
 55:20 61:10 67:9
 104:21 111:16 123:18
 148:12 192:8 247:21
 294:16
currently 88:12 100:19
 123:21 151:16 234:21
 285:14
customer 114:1
cut 134:12 166:12
 183:14
cute 325:9
cycle 18:8 21:1

D

D.C 1:8
dad 251:3
daily 296:8 297:9
dancing 146:15
danger 142:20
darn 290:6
data's 290:12 330:12
database 17:16
date 221:19
dated 171:14
dates 199:18
Dave 177:19 195:18
 261:14 323:10
David 1:21 86:3 96:22
 98:13 156:4,11 188:1

204:11 234:15 245:7 251:2,8 262:1 263:7 264:3,18,20 301:9 305:5 306:4 318:3 David's 157:16 187:19 235:2 312:15 319:5 day 3:3 34:22 104:20 167:11 169:5 205:20 229:16 252:1 289:12 289:12 301:7 329:9 330:6,12 days 70:4 99:7 212:16 212:16 220:20 221:18 222:2 226:6 247:18 286:3,8 324:4 335:10 DC 200:6 254:7 de 311:1 deadline 183:4 deal 74:17 273:8 325:1 dealing 90:18 290:18 debate 266:5 decide 268:21 decided 211:15 deciding 269:11 decision 205:8 233:21 309:14 decisions 289:13 decompose 310:21 decomposed 320:11 decomposing 237:11 310:18 decomposition 237:16 237:20 238:18 239:10 240:12,19 241:10 255:22 259:5,7 264:6 264:13 275:15 310:11 311:7 319:22 decreasing 125:9 deductibles 104:14,20 104:22 105:2 deemed 213:14 deepening 38:1 deeper 4:20 20:19 deer 227:6 default 174:3 198:14 define 327:20 defined 94:11 137:5 defining 136:4 168:14 206:9 definitely 111:11 216:16 218:14,21 223:14 226:12 262:8 289:11 312:11 318:4 331:11 definition 137:4 270:7 definitional 36:11 degree 135:17 144:1 164:17 171:7 190:4	276:5 314:16 331:15 334:22 degrees 263:10 268:12 323:15 delete 150:13,16 deliberation 185:13 delighted 204:7 delineate 265:15 deliver 198:17 delivered 283:14 delivering 42:18 44:1 delivery 328:21 demo 28:13 demographic 77:13 270:3,15 demonstrate 12:2 68:17 76:9 94:8 demonstrated 65:16 demonstrating 66:7 demonstration 12:1 26:8 28:11 29:4 30:1 30:2,13 31:3,20 32:7 32:15,20 149:21 151:5 152:3 155:9,14 156:15 286:12 289:5 demonstrations 31:5 200:2 demos 150:7 Denver 1:20 131:19,19 324:21 department 48:2 departments 21:14 49:13 51:7,21 53:12 dependent 168:19 depending 331:13 depends 41:3,3 305:7 depiction 65:3 depravation 319:11 deprivation 229:1 depth 213:20 describe 7:2 62:2 63:2 112:14 168:13 described 269:22 describing 264:10 desegregate 174:10 deserts 41:14 deserve 140:14 design 104:10 105:6 302:5 designation 136:7 designing 66:11 desire 281:10 294:20 294:21 despite 328:20 detail 15:3 22:6 25:21 25:22 36:5 38:16,17 39:8 63:2 112:15 155:22 214:7	detailed 321:8 details 16:2 46:20 determinant 168:19 determinants 19:20 20:18 53:16 84:7 101:22 165:2 166:6 168:16 169:10 170:2 171:10 172:4,7,13 175:11 176:5 177:4,7 177:9 178:9 193:17 298:2 determinates 194:9,22 242:12 determine 317:13 Detroit 324:8,12,18 develop 30:13 35:3 50:12 64:22 223:19 265:6 developed 185:9 308:9 developer 216:3 275:9 developers 78:21 209:20 211:12 212:4 216:4 217:7 221:12 222:8,10 223:8 224:2 224:4,11 225:1 227:21 231:12 243:2 249:14 253:4 265:6 267:19 269:14 278:12 300:21 311:10 developing 11:13,18 33:14 160:12 development 30:2 160:3 195:4 218:2 227:1 268:16 devolve 108:16 devolved 168:3 devote 133:6 diabetes 70:18 97:3 169:12 177:19 282:18 diabetic 173:12,16,17 diagram 6:13 15:22 16:5 diagrams 249:7 dialogue 171:17 die 255:15 differed 223:8 difference 43:21 76:17 240:18 241:9 256:18 257:11 258:10,16 272:20 273:5 310:7 differences 50:13 167:9 213:17 235:5 256:11 257:1 258:2,17,18 268:14 292:4,7 different 5:22 6:9 12:14 18:11,11 19:8 23:6 25:20 28:5 29:14 39:7 42:7,8 48:12 52:15	54:13 55:1 58:22 65:5 70:17 71:13 72:22 79:14 82:3 83:3 84:10 86:6,7 89:11 92:6 93:15 110:10,15,19 112:8 113:3 115:9 118:19 123:4 128:10 128:13 129:3,5 137:10,19 141:19 142:2 149:4,5,12 151:21 152:5 159:22 173:16 178:2,3 202:19 204:16 220:4 223:2 228:8 230:18 238:6 249:4,13 254:15 263:3 268:11 274:9 286:15 291:17 291:18,20 292:5,17 294:19 297:9,14 304:2 305:7 309:10 310:5 316:11 317:3 317:14 318:9 321:3 324:22 326:13 differentially 317:14 differently 23:6 71:8 77:5 169:15 240:5 257:19 262:10 321:3 difficult 19:2 165:21 166:4 176:19 212:6 223:21 245:5 diffuse 30:18 dig 246:15 digest 93:18 149:8 331:11 digit 221:9,9,10 229:2 254:4,8 326:13 digression 70:9 diligent 74:5 dimension 237:6 dimensions 174:13 dinging 173:13 dip 129:17 direct 92:8 121:4,14 253:8 289:2 302:3 304:5 directing 51:16 direction 38:6 directly 9:19 81:7,9 91:14 126:3 141:15 141:20 237:2 288:10 288:20 289:20 319:6 Director 2:11 disability 274:5 disadvantaged 128:9 140:19 255:21 256:22 disaggregated 22:20 disagree 124:6 125:1 140:6 258:19 280:10
---	---	---	---

disagreeing 38:9	204:21 212:17 224:1	135:3 136:13 183:8	331:6
disagreement 223:11	232:4 242:9 257:16	183:17 190:9 192:22	Drew's 162:11
disappointed 247:2,9	277:6,6 283:9	194:4 205:6 230:6	DRG 98:21 99:9
discharge 99:7	disparity 55:22 73:11	245:18 252:9 256:20	drill 16:16 54:8 58:4
discharging 266:10	74:16 88:16 96:10	269:3 271:8 276:1	drilling 16:15
discomfort 220:10	99:4 112:9,9,19 113:1	281:16 283:20 288:2	drive 35:2 71:17 180:1
225:10	159:12 162:9,10	289:19 293:15 294:11	180:3 280:9
disconnect 33:17	164:5,12 168:11	294:18 299:22 317:16	driven 178:4 211:1
226:18 266:19	175:20 176:2,13	330:19 331:7	262:14 281:4 297:21
discouraged 248:19	191:6,17,20 192:7	dollars 112:11 154:10	297:21 330:21
discovered 205:4 212:8	193:7,16 194:7 197:7	234:6 272:15 273:2	driver 155:8 172:21
discretion 164:17	245:5 256:2	296:3	174:2 281:9
discriminating 310:16	disparity-sensitive 5:3	domain 56:2 57:10 65:8	drivers 12:3
discrimination 219:16	5:4 96:6	66:9	drives 70:16,21 230:5
discuss 3:3 21:10 25:4	dispensation 211:5	domains 8:21 38:14	driving 193:12
203:8 232:15 314:12	dispensations 298:12	39:7 56:6 61:18 62:20	drop 35:6 66:14
discussed 15:11 40:8	disproportionality	65:5 67:21 80:19	dropped 203:21 223:17
53:9 56:5 152:14	136:6,20	100:18 159:15,17	drove 210:13
179:2	disproportionally	160:1,8 166:21 189:1	DrPH 2:3
discusses 170:11	137:2	Don 183:20	drug 99:11 104:15
discussing 24:14 90:12	disproportionate	Don's 184:21	drugs 312:20 313:6
discussion 4:7 6:17,20	121:20 136:15	don'ts 285:7	drum 21:19
9:15 22:12,13 24:14	disproportionately	door 124:21 242:3,15	DSH 91:3
25:4 26:7 27:2 39:14	10:12 115:21	246:8,11 277:7	dual 17:21 19:2 137:17
40:22 41:1,19 43:12	disseminate 199:17	dots 194:3 202:9	258:8,11 267:6
46:14 56:11 58:13	dissemination 3:4,12	double 72:3 100:22	duals 137:18 257:16,20
77:10 90:7 92:13	35:17 198:1,7,14	dovetails 80:18	257:20,22 258:1,4,15
108:5 110:12 117:2	201:1 202:15	downplays 188:19	due 188:14 228:9
117:21 131:10 147:2	disservice 38:4	downstream 105:12	265:22
147:8 149:17,18	distal 236:19	dozens 202:19,19	duplicate 128:22
156:13 159:13 175:10	distilled 8:6	DPP 97:5,21	142:13 144:12,14
181:15 196:14 201:22	distinct 326:14	Dr 8:3 24:12 34:14	duplicated 143:18
215:10 220:8 222:6	distinction 45:22 61:1,8	35:19 63:4 79:13 80:4	duplicating 144:19
226:1 266:6 275:13	94:5	91:12 92:10 147:21	147:18 149:14
325:18 331:10,20	distinctive 60:10	150:18,21 162:18	duplication 135:17
332:5,14 333:18	distinguishing 60:19	163:1,14,17,18,20	148:13
334:5,21	distributed 92:17	165:12 168:5,7 176:6	duplicative 91:16
discussions 59:18	131:12	176:12 177:2 178:21	
220:19	distribution 198:10	179:15 180:21 187:1	<hr/> E <hr/>
disease 103:14 163:13	202:22 259:6,10	187:7 197:18 203:22	E&M 99:17
304:7,8	distributors 100:19	204:5 224:18 235:18	earlier 43:18 55:8 73:10
disincentive 108:18	dive 4:20 12:19,21 15:3	236:12 237:17 238:10	120:6 171:13 228:2
disparage 144:16	20:19 217:16	238:13 259:2 287:9	284:9 301:11 314:15
disparities 1:3,7 10:21	divest 328:19	290:2 294:7 300:9	early 39:1 149:18 234:1
12:3,4 24:17 31:17	diving 15:11	307:8 308:1,22	243:20 247:17 248:10
55:11,16 57:13 61:22	do's 285:6	309:21 313:8,17	249:21
72:6 87:19,19 88:3,9	doable 23:7,7	322:7 331:9 335:8,16	ease 146:20
88:14 89:10 90:2 97:9	doc 287:15	draft 4:15 5:19 6:4,19	easier 149:7 202:13
97:18 98:11 107:7,21	doctors 299:9	22:10 35:15 100:3	easily 22:19 59:15
113:9 125:10 133:7	document 12:20 14:18	105:16 148:12	206:8
149:17 153:18 159:3	19:15 21:4 52:11	drafted 183:6	easy 40:11 82:19 117:3
161:1 162:2,13 163:3	55:21 307:6 308:4,17	drafting 14:21	249:18 278:11
163:22 164:1 165:10	documents 5:16 52:3	draw 23:5 44:3 250:1,6	eat 207:9
167:15,18 171:16,21	doing 27:17 38:3 49:14	281:20	echo 145:16
172:8,9,14 175:4	50:21 52:5 63:9 77:4	drawing 329:20	economic 12:4 28:15
183:9 185:6 187:9	94:19 102:11,14	drew 5:10 8:1 13:18,21	151:3,14 152:6,22
189:15 190:11,18	114:2 119:13,20	15:2 165:13 167:20	153:12 155:20
200:8,13 201:15,17	123:15,20,21 134:9	211:17 234:10 264:3	Edison 248:3

edit 61:10 125:22
edited 5:15
editing 5:18 13:9
editor 183:21 184:5
editor's 184:1
editorial 193:4 328:4
Eduardo 2:2 7:13,15
 39:13 40:15 95:17
 200:20,21 201:19
education 10:21 215:3
 215:3 278:9 282:14
 282:17
effect 208:9 213:15,18
 216:8,20 219:9 220:6
 220:7 223:6 232:12
 233:10 252:10 254:21
 255:7 257:1 259:6,8
 273:7 276:14 281:20
 282:10,20,22 285:1
 300:14 307:15 311:14
 314:21 315:10
effective 29:7 104:13
 196:9 260:7 292:18
effectively 314:4
effects 43:4 105:13
 221:18 252:9 254:2
 255:3,7 275:18 283:5
 311:11,12 312:22
efficacies 77:18
effort 18:22 190:17
 226:22 251:11 335:9
efforts 29:6 202:3
 221:11
EHR 17:4 18:3 21:6
 42:20 49:19 75:1
EHR's 17:7
EHRs 18:1
Einstein 294:17
either 6:17 111:7 123:7
 127:10 236:20 244:8
 250:6 257:19 274:4
 278:17 300:4
EI 157:14
electronic 8:15 41:18
element 4:11
elements 27:12 40:7
 62:4
elevating 89:14,15
eligibility 267:6
eligible 61:5
eligibles 19:3
eliminating 153:18
elimination 163:15
 201:17
Elisa 2:9 226:21
else's 86:16
elucidate 294:13
email 14:21 35:12,13,21

67:8,14 79:11 105:15
 106:2 107:15 114:12
 181:6 188:18 203:14
 267:17
emailed 14:19
embedded 64:2 84:11
 85:18 87:10 150:8
 188:22
emergence 195:15
emergency 153:7
emerging 212:12
Emilio 1:15 18:7 19:12
 46:18 49:2,3 50:6
 53:2 83:20 84:16
 156:4 158:8,17,19,21
 172:11 191:3,22
 194:18 195:8 196:1
 234:16 253:6,17
 283:6 297:13 328:5
emphasize 209:4
emphasizing 194:8
empiric 166:12 241:2,4
 300:14,20
empirical 185:12,21
 186:18,19,22 205:5
 206:6 208:8 210:2
 217:3 218:18 222:15
 222:19 223:9 226:16
 244:4 266:20 267:4
 268:3 269:17 275:4
 278:8 299:18
empirically 222:22
 228:1,18 280:15
employers 310:15
enabling 10:9 51:22
encompasses 32:2
encompassing 170:9
encountered 228:14
encountering 220:9
encourage 20:20 29:3
 29:12 109:6
encouraged 183:5
encouraging 29:18
 119:8 323:13
end-stage 103:14
ended 15:9 98:12
 181:10 242:17
endorse 207:4 299:13
 300:4 301:13
endorsed 53:9 211:11
 214:1,11,17 219:7
 231:19 244:9,9,10
 277:21 279:18 306:15
 309:9
endorsement 69:2
 208:22 225:16 244:17
 306:12 307:5,6
 309:14

endorsing 69:21
 223:11 243:5
ends 262:22 273:1
 325:18
engaged 158:11
engagement 27:22
 49:14 159:17 206:15
 334:22
enhance 294:1
enhanced 253:13
ensure 106:16 134:17
 138:19 139:8 143:12
 158:13
ensures 130:17
ensuring 10:15 11:7
 45:20 101:5 132:5,5
entire 273:6
entirely 89:7 240:6
 265:20
entities 132:14 208:8
 213:19 252:20
entity 61:21 63:11
 282:4
environment 42:6
 153:21 206:16 230:7
 253:8 289:3 294:16
environments 17:5
envisioning 41:10
episode 99:1
equal 82:21 137:18
 255:11 280:11
equality 298:20
equally 328:15
equation 66:13 161:3
equities 10:3
equivalent 92:6 284:18
Erin 2:11 5:10 8:1 148:2
 183:6,19 184:20
 189:19 197:2,15,21
 198:14 200:17 203:3
 204:4 211:17 217:12
 234:10 309:3 331:5
Erin's 189:4
especially 86:19 96:21
 133:20 161:12 162:3
ESRD 229:8
essence 166:6 251:19
essential 68:3
essentially 37:8 131:2
 165:18 176:14 179:17
 187:21 229:3 239:6
 239:10,21 306:7
estimates 282:15
et 8:15 18:16 24:15,16
 30:4 33:21 69:8 75:1
 76:14 143:7 166:20
 178:6 200:2 242:9
 298:15

ethnicity 25:5,11 71:3
 78:8 167:8 204:19
 222:4 270:17
evaluate 3:14 94:22
 210:5 271:16
evaluated 31:6
evaluating 61:20,20
 225:6
evaluation 1:14 24:18
 29:20 31:4,20 40:13
 89:8 149:21,22
 156:16 200:2 203:9
 241:16 269:22
evaluations 30:14
 214:13
events 206:13 215:16
eventually 39:6 76:9
 248:15,17
everybody 34:20 53:13
 53:15 75:13 91:1
 112:22 134:7 138:12
 204:6 250:8 323:5
 328:15 333:22
everybody's 191:7
everyone's 77:4 318:11
evidence 11:18,18
 33:15 35:1 40:13
 105:18 160:7,9,12
 185:12,16 186:22
 187:1 189:17 196:9
 196:11 200:15 206:7
 208:8 244:4 262:16
 262:18 278:5,8 298:4
 299:7 300:14 326:22
evidence-based 100:16
evident 61:1
evolution 172:8 195:22
evolved 194:22 271:21
evolving 176:22 192:9
 195:2
exact 183:20
exactly 47:2 64:16
 117:6 217:8,16
 228:21 261:5 282:5
 300:11 308:7 310:19
 313:14
examine 260:21
examined 215:8 222:13
 228:17
examining 224:11
example 11:11 16:4
 19:13 27:21 39:18
 44:21 52:11 58:8 59:7
 59:8,13 65:14 68:15
 78:11 102:12 103:4
 111:12,19 112:15
 114:6,11 115:5
 128:17 144:12 167:6

174:7 186:5 187:9
 188:9 190:18 206:12
 210:22 212:7 218:8
 225:8 226:10 228:22
 229:8 243:5 248:1
 249:8 287:20 291:14
 295:7 298:3 300:18
 308:3,4 309:2
examples 4:22 12:15
 25:10 39:21 59:14
 63:3 79:4,6 82:8 99:6
 113:6,10 114:8,13
 185:11,19 189:10,20
 190:1,2,14 196:12
 206:11 232:19 248:9
 324:5,15
Excellent 150:6 184:16
 332:13
exciting 204:17 323:13
exclusively 132:7
exemplify 70:13
exercise 42:3
exhausted 314:7
exist 154:18 163:22
existential 299:4
 300:16 301:8
existing 9:5 53:20 67:2
 89:9,20 98:5 209:11
 236:5
exists 100:17 281:12
expand 229:4
expanding 134:21
expansion 41:6 258:13
expect 140:11 215:17
 302:13
expectation 69:17
expected 221:2
expecting 294:19
expensive 44:16
experience 18:6 40:3
 51:20 158:15 204:8
 268:22 324:19
experiences 49:9
experiencing 43:1
experiment 325:6
experimental 32:9
expert 185:9 192:14
 204:10,13 205:15,17
 207:17 209:4 215:22
 217:1 221:21
expertise 187:5 227:5
 287:4
explaining 99:11 147:2
explains 146:9
explicit 29:18 47:20
 55:14 102:1 145:6
 160:22 171:11 172:1
explicitly 105:5 160:18

172:7 265:15 309:8
exploration 221:22
 246:12 262:4 312:10
explore 233:3 265:4
 289:17 324:3
explored 38:15 221:1
 233:13
exploring 161:13
 289:21 325:2
exposed 316:17
exposure 41:12
express 38:4
expressed 170:21
 198:18 227:22
expressing 170:15
extensive 224:20
extent 18:19,20 119:6
 140:2 196:7 317:8
 327:13
external 226:10
extra 44:17
extreme 299:21

F

FAAFP 2:1,2
face 300:16 306:11
faced 223:3
facilities 207:1
facility 45:1
facing 276:7,12 302:15
FACP 1:11,16
FACS 1:17
fact 17:3 23:17 47:19
 60:8 90:14 92:21
 109:7 171:3 194:20
 206:4 211:17 215:20
 229:10 232:6 247:5
 248:19 251:19 252:8
 253:22 257:18 261:22
 265:5 277:3 287:11
 315:16 327:19
factor 4:7 8:14 21:15
 23:18 25:14 42:6,22
 43:11 51:12 54:18
 56:1 73:17,22 74:22
 75:7 76:22 85:3 89:2
 123:14 208:5,9 215:8
 219:1 224:13 228:10
 229:3 239:4 240:17
 250:11 256:5 259:21
 261:9 282:13,21
 284:13,20 297:1
 301:14 324:12 328:7
failed 190:17 214:2
fails 248:4
fair 10:16 36:14 37:17
 68:21 123:5 125:7
 137:11 138:3,4,8,14

170:9 220:10 226:5
 232:9 236:21 309:19
 334:13
fairest 294:4
fairly 91:5 182:19 192:1
 215:6
fairness 130:9,11,14,17
 130:20 131:4 132:5,5
 138:1 139:9,15,19
 142:18 143:2,8,13,14
 145:2,2,4,8,8,16
 148:5,9 207:11
fall 191:16
falls 36:12
fan 26:2 262:6
far 56:18 58:15 92:12
 138:3 176:21 181:19
 185:21 221:14 251:15
 256:3 291:4,13
 329:22
fast 26:16
faster 32:18
favor 131:14 137:10
fear 242:9
fears 204:20
feasibility 278:22
 279:13
feasible 196:12
feature 222:17
features 77:13
federal 307:14
federally 39:19
Federation 333:11
fee-for-service 98:22
feedback 15:19 223:16
 224:21 227:12 313:10
 313:13
feeds 250:4
feel 26:7,21 42:14 57:2
 59:21 73:4 75:2 77:7
 80:1 90:11 120:3
 125:7 126:14 138:2
 146:6 232:16 245:16
 252:21 314:3 315:22
feeling 120:13 285:15
feels 26:4 75:3,8
feet 248:13
fell 193:18
felt 207:8 212:2 221:13
 228:4 245:14
FERGUSON 1:18 61:16
 113:13 134:16 199:8
fewer 247:3
field 137:11 195:5,10
 205:8 231:21 288:9
 334:7,19
fields 10:16
fifth 164:21

figure 27:4 46:8 72:12
 78:19 79:1 80:5
 197:15 217:16 243:2
 245:3 248:17 275:8
 288:18 330:16
figured 84:17 281:5
figuring 297:5
file 7:2
files 17:19
filled 224:20
filtered 245:20
final 5:19 14:8 112:6
 181:16 189:2 198:3
 211:4 213:8 332:1
 335:5
Finalize 3:6,8
finally 71:11 134:8
 208:12 211:9 219:20
 224:10 227:22
finance 154:6
finances 277:11
financial 11:3 104:16
 152:22 153:2 188:8
 225:19 273:9 285:5
financially 188:2 272:7
find 19:7 40:1 47:9
 165:21 176:17 218:12
 222:19 249:18
finding 40:12 220:18
 254:2
fine 32:6 107:11,12
 154:15 325:19
finish 46:17 64:11
 133:10 172:11
firmly 174:15
first 6:8,21 7:1,4 8:8,13
 9:16 13:1,17 15:7
 28:18 32:1 35:5,11,14
 38:13,16 54:11,16,21
 58:4 74:21 89:18 90:4
 109:1 111:7 115:5
 117:5,13 119:1 120:5
 122:8 123:4 134:6
 138:17,17 141:7
 144:5 145:1,5 148:6
 148:14 151:15 163:9
 166:7 169:5 175:8
 179:5 180:7 181:8
 184:21 205:18,22
 210:16 214:8 234:15
 237:18,22 244:20
 245:21 246:6 247:18
 248:5 273:13,20,21
 278:22 279:12 306:7
 316:3 325:17 327:1
fiscal 292:12
FISCELLA 1:19 66:21
 67:15 103:19 104:1

106:3 251:6 284:6,8
332:17
fit 13:20 49:11 85:12
87:13 91:18 111:15
279:8
fits 180:4 289:9
fitting 189:7
five 6:9,17 8:20 13:13
15:10,18,21 16:7,8,10
18:4 23:4 36:12 38:14
47:14 49:11 56:6,11
58:9,22 59:10 60:15
60:16,18 61:6,18
67:21,22 68:3 69:2,15
80:19 86:13 102:10
129:11 160:1,8 175:5
175:13 197:20 205:16
214:1 255:5,6 286:15
327:8
five-year 48:8
fix 82:19 109:9 117:4
fixed 4:8,11 320:4
flag 23:14 46:14
flash 186:7
flavor 237:20
flesh 5:1 12:16 118:4
155:22 327:14
flexibility 161:17
267:17,18 293:12,14
flip 232:8 330:4
Floor 1:8
flow 101:5
flows 78:18
fly 264:22
focus 24:5 62:12,14
86:12 94:18 96:1
116:4 131:22 158:3
158:13 163:19 177:17
178:9 183:9,16
194:15 208:2 209:5
221:19,21 225:11
287:19
focused 14:5 22:3
129:22 130:6 171:20
179:6,11 193:6
200:11 202:21 209:12
270:16 317:7 327:9
focuses 115:20 132:3
200:1
focusing 166:7 171:15
fold 181:4
folks 14:13 18:9 36:2
72:16 78:20 89:3,13
94:9 109:6 110:16
149:3 153:20 154:3
182:22 203:13 277:8
281:11 327:2 330:2,5
330:21

follow 124:5 156:7
157:2 198:22 200:18
205:15 320:13 321:22
follow-up 86:3
followed 217:6 218:21
274:10
following 211:12
follows 146:7
food 41:14 75:14,21
76:13 77:15 81:11
319:12
foot 23:15,16
force 195:2
forces 195:2
Ford 1:21 48:18
forever 229:19 274:19
forget 179:12 255:2
256:14 308:6
forgetting 277:10
forgotten 272:2
form 75:7 190:2 213:4
formal 92:14 132:21
formalizing 50:7
format 52:21
formula 161:6
forth 69:4 226:1 270:7
Forum 1:1,8
forward 33:18 35:2
75:12,18 76:22 179:2
181:4 187:4 214:4
218:17 220:13 234:8
253:15 262:16 265:10
286:8 287:2 291:10
294:16,22 300:12,19
307:17 331:14 333:19
334:7
found 208:18 209:22
222:17 249:21 254:15
275:12 291:6 305:9
329:7
foundational 191:12
four 8:6 16:9 39:7 67:10
133:10 150:7,13
179:5 202:12 214:1
286:15 301:21 302:2
316:20 317:2 326:7
fourth 179:12,13,13
180:22
FQHC 47:2 86:19
FQHCs 47:4,8,13,22
48:9,15,19 87:6
188:10
frailty 230:15 287:16,21
frame 15:14 82:6
framed 240:15
framework 13:14 56:9
60:15 94:22 179:20
183:10 240:20 264:3

285:6
framing 38:9
frankly 78:18 188:15
free 170:6
frequently 199:12
215:2 218:1 227:20
friendly 311:19
front 5:20 36:11 52:12
67:22 175:3 223:4
229:16 290:17 303:3
318:15
full 78:11 183:1,15
fully 223:18 248:6
252:4
fun 262:9
functional 77:14 230:15
287:16
fund 19:18 155:9
fundamental 34:7
98:20
funded 234:5,7
funding 11:22 48:1,19
136:9 152:3 161:18
173:11
further 25:18 26:3
79:10 218:20 233:4
233:13 243:8 265:12
293:8
future 33:11 34:9 224:9
231:17 278:11 308:6

G

gain 126:6 153:2 293:8
game 70:1 94:14 100:1
245:19
gamed 59:15
gaming 68:10
gap 130:5 164:3,5
166:1,11 170:18
172:6 175:9,19,21,22
176:2,9,14 178:12
310:13
gaps 63:1 106:17
189:14 256:12 331:8
GARRETT 1:19 25:16
26:1 28:4,9 74:20
90:10 92:15 93:12
109:20 110:18 111:3
111:10,15,22 124:4
131:6 137:7 138:21
139:3,5,10,15 168:15
169:4 202:1 241:15
244:22 301:10
gas 264:8
gather 33:19 287:6
gender 310:13
general 31:19 32:4 36:4
39:5 46:16 48:13

52:19 55:22 56:8
58:13 75:4 79:3 98:17
101:18 110:12 116:12
117:8,13 131:19
165:5 197:21 214:19
247:21 260:11 286:2
304:3 315:6 323:12
generally 13:17,20 14:2
15:5 19:13 20:17
82:15 118:7 147:10
198:16 208:13 217:7
222:21 223:5 227:16
generated 186:1 262:3
generation 35:1 154:17
geocoded 41:13
geocoding 49:17
geographic 84:4
geographic-level 43:5
geographies 50:17
53:17
geography 49:11 53:14
54:1
germane 20:9
getting 27:21 50:6
51:11 72:14 82:18
85:7 91:6 100:20
124:16 150:1 154:22
163:18 196:7 203:5
237:1 260:4 272:20
313:2,10 318:13
328:12 335:13
gettoizing 298:7
give 5:1 46:7 100:6
112:7,12 113:3
120:18 152:11 162:11
167:16 170:6 173:5
204:4 224:21 237:19
238:17,20 274:21
279:17 287:13 293:6
301:18 327:2,16
329:3
given 31:15 43:6 73:22
131:10 183:22 189:19
205:7 220:19 252:1
261:1 278:8 280:22
285:3 291:10
giver 296:9
giving 138:11 199:18
228:8 330:8
glad 177:3 240:14
global 52:13 325:7
goal 31:12 46:4 72:8,15
102:20 148:8 281:13
331:17
goals 56:16,17 57:6
60:9 61:4 67:3 97:12
109:12 164:10 166:18
God 107:9

gold 26:14 72:21 73:1
gotten 94:16 114:1
 203:14 227:12
government 50:16
 52:18 288:18 297:21
 298:6,10
grade 328:15
grant 47:18,18 48:3,8
granular 23:8 195:16
 221:7,15,16 286:21
graphic 264:11
grapple 243:6
grappling 242:13
greater 172:12 218:16
 259:11
greatest 95:15,21
grocery 42:2
ground 79:1 87:4
 146:19 249:21 269:1
 269:12
grounded 334:6
group 57:22 62:13 88:8
 118:4 119:14,16,21
 133:19 144:13 164:6
 164:6 170:20 183:22
 196:10 197:6 210:9
 214:12 263:18 268:6
 270:19 286:6 287:12
 331:12
grouping 119:13
 137:15
groups 36:16 86:14
 118:2 134:7,8 139:8
 139:11 204:16 268:5
 268:11 292:5,18
 333:16
grow 201:11
guarantee 183:1
guess 33:8,16,16 42:7
 42:8 59:20 66:22
 68:13 89:18 93:22
 110:1 115:18 117:22
 144:2 147:15 152:8
 168:8 170:10 171:5,6
 188:12 189:18 190:20
 191:21 196:20 236:2
 275:7 292:20 293:4
 296:10
guidance 37:2 59:6
 173:5 185:2 205:15
 207:16 208:3 218:15
 233:2 265:14 268:1
 268:16 274:16,21
 279:17 285:3,6
 290:17 294:1 301:18
 303:16 309:1,12
guide 157:14
guidelines 217:4

218:22 283:13
guiding 293:16

H

half 99:12 254:6
hammer 291:18 309:13
hand 15:7 58:21 234:4
 250:3 293:19
handful 252:19 258:9
 258:11
handicap 37:12
handing 202:13
handle 236:3
hands 35:10 264:10
handy 278:16
happen 232:3 247:15
 259:16
happened 5:9 33:20
 195:17 207:15 218:14
 242:8 248:20 279:2
happening 4:9 33:19
 241:19 274:1
happens 45:9 48:9
 178:5 198:4 244:1,2
 246:4 255:19 279:7
 279:11 305:18
happy 241:10 246:19
 274:22 311:3 323:20
hard 5:20 87:21 118:14
 218:12 221:11 223:19
 224:5,6 225:6 226:18
 317:3 318:8 325:1
harder 169:14 206:9
hardest 100:20 165:18
 172:18
Harlem 283:11
hashed 292:8
HASNAIN-WYNIA 1:20
 15:8 16:13,18 30:5
 33:8 34:3,8,11 58:17
 96:16 126:16,20
 127:2 129:6 131:21
 132:10 171:9 177:11
 182:1 184:6,14,17
 186:16 187:6,16
 193:3 199:22 237:9
 238:7,11
Haven 1:13
he'll 204:1
head 78:13 229:17
 322:14
header 32:22 131:3,4
 137:2 156:15
header's 149:19
headers 6:18 16:9,12
 131:2
heading 156:7,8
headlights 227:6

heads 61:11
heal 181:17
healthcare 2:4 18:14,15
 37:9 45:6,14 62:1
 63:11 90:15 100:19
 127:5,17 131:11
 152:20 161:14 169:3
 171:16,21 172:9
 175:14 177:21 215:2
 264:5
Healthy 2:1
hear 72:5 92:12 143:4,8
 189:4 269:21 271:9
 313:20 314:14 320:16
 323:7
heard 7:18 67:20 88:2
 144:3 195:11 201:2
 205:19 223:16 280:3
 285:9 288:15 291:4
 291:15 300:11 312:11
hearing 31:7,18 34:19
 78:20 117:4 122:12
 147:9 205:8
heart 2:2 215:10 282:18
 304:6
heat 206:20
heated 273:22
heck 257:7
HEDIS 174:1
Heidi 333:11
Helen 2:7 5:14 34:12
 40:9 74:3,19 79:12
 91:10 144:22 147:20
 157:13 167:19 168:2
 171:12 175:6 176:20
 197:17 198:14 204:4
 234:14 237:9 239:16
 240:14 241:16 285:13
 295:2,4 320:16 331:5
 334:15
hell 257:6
Hello 7:15
help 5:1 25:7 29:20
 39:17 42:20 62:12
 64:1 70:13 137:22
 139:12 146:20 186:12
 190:19 195:21 200:4
 225:4 245:4 297:17
helped 195:8
helpful 12:19 67:14
 78:22 112:13 148:16
 184:22 202:15 241:18
 261:10,12 275:12
 330:9
helping 85:10 146:18
 169:10
helps 48:14 170:17
 314:3

Hennepin 1:19 131:18
Henry 1:21 48:18
hesitant 330:20
hesitate 98:19
heterogeneity 291:8
 331:17
heterogeneous 294:16
hey 200:19 309:8
HHS 48:2 198:17
Hi 14:20
hierarchical 315:14
 323:16
high 45:21 62:6,20 88:7
 90:13,16 92:19 94:17
 98:2,4 105:21 108:8
 132:19 136:6 140:10
 162:8,10 164:14,17
 168:11,14 172:5
 179:21 205:3 225:8
 258:8 268:1,17
 305:21,22 316:11
high-churn 17:5
high-level 15:21
higher 95:2 104:19
 230:9,11,21 231:4
 255:18 293:20 304:8
 304:12
highlight 159:22 185:2
 224:8 327:1
highlighted 65:7
 227:15 233:5 327:8
hill 301:6
hire 78:20
historically 133:20
history 192:6 248:2
hit 100:20 149:16
hoc 161:5
hold 55:1 63:7 66:2
 149:3 151:1
hole 91:18 300:6
home 296:1,1,1,2,7,9
 296:11,13,15,22
 297:7
homelessness 76:14
homes 114:3 291:12
honest 34:21 165:13
 166:14 232:6 234:9
 307:15
honestly 30:6 47:5
honesty 260:3
honing 194:3
hope 32:21 150:16
 162:16 238:20 325:6
hopefully 5:6 71:6
 96:14 98:5
hoping 108:6 199:2
Hopkins 1:16
horizontally 62:9

hospital 41:7,8 42:10
49:16 50:10 108:8
110:8 121:21 220:3,6
237:12,13,15,22
238:15 239:7,18
240:9 251:17 253:8
255:15 259:9,11,12
265:16 266:14,16
267:1 275:19 276:2,5
277:1 279:7 281:20
281:22 282:1,4,10,22
283:10,11,12 295:13
295:14,18,19,20
296:15 304:9,12,20
308:11 309:4 314:17
314:21 315:5 316:5
316:12,14 317:6
318:16 319:20 320:5
320:9 321:1,7 322:12
322:16 324:8 325:7
325:13 326:5,6 328:8
330:2
hospital's 304:13
hospitals 11:12 37:11
37:14,15 38:2,3 40:3
44:13 51:7 118:2
120:15 121:21 123:13
126:11 137:19 143:3
206:13,20 238:5
239:2,13 241:1
252:19 266:11 269:4
269:9 286:17 304:18
315:13,16,22 316:16
316:20 317:2,15
321:3 325:19 326:6
328:6 329:8,14 330:8
333:12
hour 98:7 99:12 319:9
House 104:22
households 23:4
housing 298:3,6,14
HRSA 47:6,7 71:6,8
HUDSON 2:3
huge 192:3 266:20
326:12
hugely 269:8
human 310:14
hundreds 273:1
hurt 136:21 170:16
husband 217:15
hypothetical 187:20

I

ICD-10 251:21
ICU 295:20
idea 38:9 65:2 76:2 85:2
96:17 112:5 118:22
130:1,4 131:1 154:13

166:16 167:3,14
176:8 177:5 186:7
199:20 202:6,10
204:17 227:3 249:7
249:22 264:13 316:10
Ideally 254:13
ideas 3:12 31:20 65:10
72:17 169:6 287:6
identification 50:9
identified 167:4 218:1
218:15 270:20
identify 41:14 179:21
223:22 301:21
identifying 50:17 289:4
322:3
Ignatius 2:13 5:14,21
7:2 8:1 12:20 15:2
33:14 65:21 66:18
78:1,12 133:12
159:11 160:14 161:21
162:21 277:17 290:3
317:22 326:15 328:1
Ignatius' 68:7
Ignatius's 74:14
ignore 153:5 260:7
ignored 211:7
ignoring 129:11 153:17
illness 163:13 164:14
illuminate 240:1
illuminating 123:19
illustrations 185:11
illustrative 185:19
image 334:10
imagine 108:18 294:15
imbedded 196:5 325:11
immediate 159:3,8
253:9 322:5
immunization 39:18
impact 11:3 12:4,6
18:14 43:5 75:9 76:1
89:10 95:16,21 96:2
97:8,19 100:15
124:14 151:3,13,14
152:4,5 154:6 159:2,3
159:4 164:8 166:15
166:16 171:5,6 172:6
175:9 177:16 178:4
178:13 179:21 188:2
188:8 198:8 225:13
225:19 231:22 252:15
260:22 263:12 277:2
279:3 289:11,16
292:13 295:10 296:20
298:2,14,15 319:16
321:22
impactful 184:4 199:4
335:7
impacting 46:1 153:6

impacts 28:15 109:15
158:14 178:4 257:4
328:12
impart 332:11
impetus 24:4 71:20
159:18
implement 8:9 9:5
30:13 54:16 244:19
implementation 3:6
4:22 35:1,17 155:21
231:18 232:1
implementations 114:8
implemented 232:11
implementing 11:14
84:2
implications 51:15
153:1 225:20
implicit 74:11 83:22
172:16
implicitly 133:2
implied 99:2
importance 18:12 25:5
40:12 155:8 166:9
172:3 195:11 201:14
201:15 242:11 286:4
322:2
important 24:7 27:3
29:2 40:6 46:4,13
61:19 62:15 64:1
69:15 73:5 79:16 80:6
80:8,16 84:17 85:11
93:15 103:8 104:7,18
106:14 107:1 109:12
116:20 119:4 130:12
131:7,13 147:13
154:21 155:4 161:22
163:19 181:1 184:3
192:11 193:13 195:5
203:16 206:16 207:8
224:12,12 241:7
243:14 246:10 252:8
262:4 265:14 292:6
292:18 293:11 295:6
296:17 297:3 303:17
306:2 312:9 315:7
322:4 328:7
importantly 43:8
303:22 327:11
impression 168:22
impressions 15:5 36:6
167:21
improvable 179:8
improve 54:20 76:7,17
96:3 108:15,16
120:16 124:17 137:12
137:22 138:21 139:1
143:13,14 145:8
148:5,9 171:8 190:10

192:2 216:11 219:15
improved 78:9 88:17
98:11
improvement 8:19
10:21 11:1,16 25:13
47:4 48:10 56:13,20
57:12 58:12 59:9
61:14 63:20 74:2,7,9
74:16 80:20 85:18
87:17 88:1,13 94:19
95:1,5,6 98:10 102:16
103:16 107:21 108:19
112:22 113:8 121:13
144:16 154:1 190:16
226:22 312:18
improvement-related
22:1
improvements 66:8
108:2
improving 5:7 112:9,10
160:14 219:18 294:4
imputing 81:7
in-person 210:18
inability 299:10
inadvertently 244:14
inappropriate 25:11
incentive 11:8 92:8
100:22 125:17 126:7
150:11 185:5 235:11
302:5
incentives 76:21
120:18,20,22 121:4
125:18,21 134:10
135:14 136:22 141:3
187:8 244:15
incentivize 9:13 79:19
80:3,6 95:7 122:6
123:9 125:9 127:16
129:21 130:14,19
143:7 151:19 153:15
153:20 189:12 286:22
incentivizing 14:1
107:3 127:5 130:6
173:10 186:9
include 8:18,20 16:1
28:14 56:6 67:20
87:20 88:1 89:8 107:8
107:22 113:18,21
155:2 159:10 172:6
217:2,9 222:8 227:17
227:21 241:5 259:14
265:18 266:3,14
285:4 310:21
included 11:7,10
114:13 134:2 149:2
163:11 164:11 205:13
209:2 211:10 213:6
213:22 222:10 223:13

231:21 235:21 251:17
251:22
includes 8:10 9:14 10:3
78:6 89:14 259:14
including 105:7 204:18
205:2 219:10 222:5
inclusion 13:19 214:14
214:16 219:3 220:11
233:11
inclusive 136:12
income 140:10 215:5
221:8,9,10 235:5
282:14,17 298:20
322:4,5 324:17,18,20
inconsistency 231:13
incorporate 6:16
317:11
incorporated 123:7
265:17 291:7
incorporating 318:20
incorrect 266:4
incredibly 331:19
incremental 252:10
incrementally 259:22
independent 43:3
157:5
index 229:1
indicator 287:21
indicators 53:7,11
indices 319:11,11
individual 41:12 42:5
42:15,16 43:3 50:9
62:3,13 81:9 84:3
89:1 197:9 207:2
221:3,6 240:7 255:10
257:5 263:4,19
295:16 308:13 320:22
322:4
individual-level 41:1
individually 206:2
255:9
individuals 9:18,20
10:13 11:4 13:7 49:6
50:18 62:19 81:7 84:6
90:6 97:4 104:2
115:21 120:2 126:4
128:8 135:9 136:6,15
137:3 240:22 257:12
industries 297:22
inequities 100:15
inequity 146:16
inference 269:18
inferences 285:4
influence 316:1,1,5
influences 76:4 317:2
influencing 250:11
inform 29:20 48:14
information 17:19 18:2

33:20 41:20 42:21
69:13 71:7 81:8 149:8
159:16 165:22 167:17
199:13 208:12 209:21
212:1 225:11 227:10
232:9 239:22 240:9
243:12 271:13,14
275:2 297:6 306:2
informative 309:19
informs 289:12
infrastructural 47:16
71:18
infrastructure 19:19
47:21 68:15 96:22
97:20 101:19 104:6
initial 5:12 12:13 15:4
165:16 221:8
initially 312:17
initiative 75:12 153:1
innovative 27:20 32:8
32:13 33:21
inoculate 276:4
inpatients 110:14
input 8:5 184:21 185:4
187:14 199:3 211:21
233:22 234:1 268:2
insecurity 75:15,21
76:13 77:15 81:11
insensitivity 31:21
insert 306:14
inserts 312:16
insight 187:12 293:9
inspiring 317:19
instance 299:13
institution 112:17
306:21
institutional 297:18
305:16
institutions 90:5
117:10 119:7 125:12
226:7 238:3 306:1
328:19
instructions 231:12,14
insurance 105:19
insured 276:9
integral 151:22
integrate 69:1
integration 20:13
194:11
intended 57:15 89:2
206:2 240:1 312:18
intent 20:5,8 116:10,15
127:14,15 178:15
276:4
intention 88:22 89:5
inter- 318:19
interest 45:19 191:5
197:1,13,14 198:18

210:3 245:13 281:3
interested 45:6 290:10
316:9,13 318:14,16
319:20
interesting 77:17 90:11
168:17 192:22 217:11
309:1 321:5 325:16
332:7
intermediate 143:10
209:7 213:3 236:20
internal 234:6
internally 210:9
interpretation 223:9
interpreted 44:10
interpreting 68:2
interrelate 143:16
intersection 72:6 194:8
intersectionality 271:6
intertwined 287:16
intervention 157:5
interventions 12:3
33:21 50:12 100:16
105:7 166:2 171:7
289:1,1
introduced 242:6
invalid 299:14,17
invest 12:9 19:22 54:17
74:21 75:5 79:15
104:1,6 138:9 150:10
invested 138:7 167:3
investigated 243:8
investing 8:13 9:16
85:6 138:5
investment 76:10
124:16 236:22
invited 189:3
involved 18:21 54:1
65:5 199:11 236:21
272:1
involves 308:8
IOM 77:2
isolate 319:2
issue 22:5,6 38:12
48:15 65:21 71:15,15
74:15 75:21 84:9 85:1
85:6 91:11,22 93:1,4
93:10 96:4 99:9,14
104:9,14 105:6 124:8
124:18 125:8,14,20
129:14,16,16 133:8
143:2 176:18 182:12
182:14,14,17 184:13
191:6 192:2 194:16
204:15 207:13 214:3
220:12 224:2 228:19
230:12 237:15 251:13
263:17 268:19 273:19
275:16 287:10 291:21

issues 48:4 137:16
152:20 155:21 170:3
181:10 182:13 193:5
193:5 209:7,15 211:7
218:2 232:15 233:3,4
245:6 247:19,20
254:12 265:2 287:17
291:10 292:22 293:7
294:8 312:7 335:1
it'd 83:22 104:5 110:22
it'll 80:8 87:12
item 4:6,19 5:2 182:7
197:21 287:9
items 4:13
iterative 274:18

J

JD 2:13
Jean 179:15
job 119:9 256:20
286:17 330:19
Johns 1:16
join 204:1
joined 38:22
joining 7:5
journal 182:10 184:9
196:21 197:3
JUAN 1:15
judgement 292:10,19
292:20
Judy 6:21
July 234:4,12 299:5
jump 165:11 321:14
June 1:5 184:11
JUNG 2:8 14:20 39:10

K

Kaiser 1:17
kaizen 226:21
Kara's 160:6
keep 93:17 122:1
129:20 173:1 175:21
224:7 246:9 252:8
277:6 329:19
keeping 144:5 145:22
321:22
keeps 25:2 47:17
102:21 192:15 230:12
287:10
Kevin 1:19 66:21 67:8
103:21,22 105:14
106:1 163:1 204:11
251:4,4 253:5 261:14
284:6,7 332:2,19
Kevin's 105:16,21
key 47:14 217:10
228:11 294:13
keypad 180:12 333:4

keys 218:11,13
kick 328:4
kid's 245:18
kids 215:1 334:11
Kindred 295:11
kinds 50:7,13 65:6
 101:12 119:17 134:3
 155:17 158:10 161:13
 164:15 174:13 202:20
 204:19 219:13 241:1
 268:11 275:5 278:3
 295:15 304:18,19
knee-jerk 30:21
knew 167:8,14
knowing 197:13 281:11
 330:18
knowledge 159:15
known 166:2 229:19
knows 4:8 52:18 309:7

L

label 62:8 136:9 271:21
 330:21
labeling 330:7
labor 334:2
lack 41:15 71:12 100:21
 266:21
lacks 24:6
laid 166:21 230:8
 231:14
lamppost 218:11
language 9:11 24:16
 31:22 32:2 37:11,18
 38:8 46:5 56:3 61:11
 66:10 91:15 98:3
 100:4 105:16 106:2
 107:14 122:1,2 132:2
 133:1 139:19 143:2,8
 143:11,11,14 150:10
 150:21 155:10 158:7
 159:10 165:1 170:10
 185:14 215:4 269:17
 270:1,12 280:2 285:7
language/style 38:12
large 90:7 134:19,20
 164:12 201:3 215:6
 218:7 221:18 226:21
 253:1 261:7 276:6
largely 210:22
larger 10:1 62:13 134:7
 134:8
largest 163:22
lastly 11:6 12:8 166:15
late 39:1 248:9 297:11
lately 301:2
Laughter 33:7 70:6
 98:15 326:1
launch 248:11

layer 100:13
layers 317:12
lays 191:13
lead 38:5 64:12 215:10
 230:22 292:6 310:6
 328:16
leading 164:13
leads 172:20 230:9
lean 196:16
learn 246:2,2,3 248:20
learned 212:19
learning 205:10 220:16
 247:16 262:2,20
 267:20 293:14
learnings 231:8
leave 35:9,10 91:8
 93:17 269:13 293:19
leaves 133:3 300:6
leaving 295:13
led 226:21
left 45:10 203:15
 249:12 293:3 328:13
legal 18:16
legitimate 276:18 324:1
leisure 334:2,2
lend 249:18
lens 285:16
let's 24:1 28:16 37:17
 54:10 67:16 74:15,17
 77:19 87:8 110:17
 111:5 114:15 116:20
 122:1 124:1 141:3
 142:8 149:15 152:11
 168:9 174:11 177:13
 236:19 307:14 326:15
 332:20
letter 307:5 330:8
level 17:17 22:21,22
 23:8 41:2 54:5,6 57:1
 73:5 90:21 91:5 94:7
 96:21 99:17 108:17
 171:2 172:5 193:21
 195:12,16,19 207:1
 220:3,3,11 221:20,21
 222:1 227:5 228:15
 228:21 233:21 237:11
 237:12,12,13,16
 239:3,11,19,20,20
 240:8 242:2 254:4,14
 259:9 266:3,15
 268:17 275:19,19
 277:1 281:1 282:7
 286:5,21 287:1,5
 288:11 291:21,22
 298:18 309:4,5,6,9,11
 311:1,11,12,14,17
 315:11 316:19 317:13
 318:16 319:4 320:6

324:2,2,20,22
levels 92:22 102:18
 252:2 267:2 268:1
 318:7
lever 192:3
life 12:6 171:3
life's 170:22
lifetime 260:14
light 231:1 248:3
liked 202:11 229:15
 249:6
likelihood 65:16 294:1
limit 144:4 177:13,14
 206:19
limitation 188:13
 290:12
limited 13:2,5 100:10
 182:22 220:21 221:22
 228:15 231:18 270:17
 281:1 286:14 305:21
 306:20 307:10
limiting 212:7
Lincoln 2:1
line 32:8 54:11 142:19
 199:16 264:5 329:15
 334:1
liners 290:17
lines 9:21 30:12 97:7
 185:15 186:4 187:3
 278:2 307:11 332:22
lining 298:5 330:14
link 166:19,20 199:10
linkages 12:10 20:1
 49:19
linked 113:16 179:7
 229:1
linking 10:7 166:17
links 19:1
Lisa 1:16 7:10 27:6,9
 28:16,17 30:6 107:16
 108:15 126:18,22
 128:1 151:3,20 156:1
 175:17 203:15
Lisa's 7:9
list 13:8 79:9 147:6,7
 199:15 210:12 214:21
 259:2 277:20 326:10
listed 197:7,9 287:10
listen 74:15
listening 144:22 238:21
lists 202:22
literacy 99:10
literally 320:6
literature 211:1 217:21
 217:22 223:1 228:5
 243:10,18 278:4
 299:7
little 5:15 19:11 21:20

28:20 30:20 31:3
 33:17 38:22 40:2 52:8
 54:8 63:2 68:19 75:3
 77:10 81:21 82:6 86:3
 95:14 109:11 114:4
 129:3,5 137:10 138:2
 138:13 146:7,9,19
 156:10 158:12 161:8
 162:1 163:5 171:17
 175:10 181:16,20
 182:9 185:16 189:5
 202:7 204:1 213:7
 216:22 218:10 223:15
 235:15 237:4 253:21
 266:18 271:3 274:11
 277:22 278:17 287:13
 291:12 293:22 302:14
 303:9 306:11 313:22
 315:3 317:5 325:9,9
 332:6
live 42:1 49:6 169:13
 178:5 293:19 321:19
 324:16,17
lived 158:15 268:22
lives 173:12 322:11,17
 322:22
living 296:8 297:9
 324:20
loans 298:11
located 45:7 266:11
 269:5
logic 116:8 206:5
logically 181:3 206:17
 215:10 228:5
logistically 232:22
long 34:17 48:7 97:10
 102:22 127:15 159:3
 159:8 204:6 212:16
 213:6 224:7 270:21
 273:17 290:11 295:19
 326:10 334:13
longer 82:21 99:7,12
 206:15
look 24:15,21 47:1,7
 54:18 57:12 58:10
 61:2 73:12 74:8 87:15
 88:3,5 107:5 112:20
 115:2 116:20 123:5
 129:2 132:16 153:9
 153:10 155:14 160:16
 163:2 167:5,7 168:18
 173:5 185:19 190:17
 207:20 210:19 214:21
 223:1 227:6 235:19
 235:22 238:1,2
 241:13 245:15 246:14
 253:4 254:22 255:6,8
 257:4,10 258:6,7,14

261:6 280:16 281:3
 290:16 297:18 298:13
 298:14 301:4 307:5
 313:14 316:18 320:21
 321:1 323:1,13 325:9
 333:18
looked 39:22 210:6
 212:3 219:22,22
 240:2 270:21
looking 10:7 12:5 15:10
 19:14 39:4 84:5 89:20
 97:4 114:20,20
 124:22 141:11 142:11
 152:5 155:1,18
 163:12 167:15 174:5
 176:15 177:10 183:21
 190:11 191:18 198:10
 218:9,11 236:4 249:1
 256:11 257:15,21
 274:9 277:1 311:13
 318:11 327:4,20
looks 80:1 240:8 282:6
 316:17
lose 66:5 126:8,11
 131:22 132:2 239:21
 286:17 298:22 306:2
losing 272:14
loss 153:21 273:2
lost 20:8 32:11,22
 36:19 111:13 128:11
 273:14
lot 11:19 14:12 16:22
 21:4 25:4 26:14 36:9
 45:2 46:12 48:17,19
 50:14 53:9 67:5 71:9
 71:17 72:5 78:13,20
 79:4,21 80:11 87:9
 97:12 99:3 124:11
 128:8 137:15 138:5
 146:12 151:12 161:18
 164:18 180:17 188:14
 190:9 191:9 193:8
 194:17 195:11 200:10
 202:13 204:9 216:18
 222:1 224:2 225:22
 226:8 231:2 239:13
 240:14 244:21 251:16
 253:10,15 254:17
 255:4 256:2,22 257:6
 257:7 258:1,6,10,16
 262:2,3 268:5 273:21
 274:15 276:11 280:17
 282:6,13 285:3,5
 288:15,17 289:19
 291:8,9 292:21
 295:22 298:17 312:8
 313:20 314:11 321:11
 323:4 325:8 326:13

328:20 335:3
lots 18:3 37:12,13
 104:4 105:12 173:14
 196:12 216:15 225:10
 228:12 251:13 257:19
 257:22
love 199:6 218:20
 229:19 232:15 233:1
 233:3 288:4 320:16
low 45:18,18 62:6 91:5
 92:21 99:10 167:5,7
 276:7 282:17,17
 304:10,17 305:15
 324:17,18 330:1
low- 43:19
low-income 17:21
 104:17
lower 88:8 102:18
 105:19 188:7 329:3
Luc 179:15
lump 36:21
lumping 268:5
lunch 3:12 181:13,14

M

MA 2:9,10 257:14
MACRA 133:18
Madison 2:8 14:20
 331:7
magic 4:14 335:18
Maimonides 326:5
main 4:13 8:6 16:12
 233:2
maintain 46:4
maintaining 48:16
maintenance 209:1
 235:20
major 16:9 153:1
majority 224:10 265:6
 265:21
makeup 95:3
making 86:21 100:10
 102:19 125:7 135:12
 152:17 160:19 177:20
 189:21 296:6
man 328:10
managed 258:12
Manager 2:8,10
manages 94:9
map 176:19 198:10
 225:18 331:5 334:8
mapped 164:9
mapping 163:10
march 16:10 25:19,21
 36:5 39:6 46:19 54:13
 116:21
market-based 45:1,9
Marshall 1:9,11 58:17

137:8 151:2 179:1
 200:19 291:1 297:16
 314:13 334:4 335:9
Maryland 1:21
masking 204:21 224:1
 242:9
mass 194:2 199:18
 232:4
massage 46:5
massive 277:6
match 17:16
material 189:7
matter 182:3 230:7
 247:14 262:16 335:20
mattered 206:7
matters 45:11 174:3
 250:17 261:3 273:21
mature 69:18 290:19
matures 69:17
maturity 69:13
Mauricio 2:9 331:6
max 324:8,11
maximized 82:22
maximizing 198:7
MBA 1:18
MCO 71:7
MD 1:11,13,15,16,17,18
 1:19 2:1,2,4,7
mean 22:9 36:12 37:1
 41:3 53:19 58:2 59:17
 60:7 68:22 72:4 74:8
 79:18 90:5 91:12,13
 92:2,6,21 97:7 102:9
 104:4 108:1 109:5,16
 112:12 113:2 116:15
 132:6 146:14 149:1
 151:8,11 152:2
 154:20 157:12,20
 159:20 162:10 176:7
 184:17 187:1 188:15
 188:20 189:3 190:6
 192:15,16,18,21
 221:11 225:7 228:21
 228:22 236:17 245:1
 251:14 254:21 260:5
 260:19 262:20 265:9
 269:7 272:22 275:7
 276:21 277:14 279:12
 280:5,14 284:12
 290:12 293:10 299:21
 300:10,10,15 307:9
 310:20 313:19 319:8
 319:13 323:3,3
 324:13 325:15 326:11
 328:7
meaning 177:5 247:3
meaningful 50:17 85:8
 181:2 269:8

meaningfully 216:10
meaningfulness 49:10
means 12:16 26:12
 56:17 57:6,7 58:1
 66:4,12 89:15 272:1
 275:10,18 327:15
meant 107:10 132:5
measurable 94:9 195:1
 289:14
measure 37:19 40:1
 41:4,5 51:10 53:8
 55:9,15,16,22,22
 56:19,20 59:5 69:19
 71:2,19 74:1 78:21
 80:12,12,13,13 82:1
 86:5 95:19 96:11 98:4
 101:13 106:21 107:1
 119:10 133:8 162:10
 162:13 165:8 169:16
 174:16 178:13 179:7
 206:1 207:5,6 208:2
 209:20 212:4 217:7
 223:11 225:16 227:3
 229:9 236:15 239:22
 243:1,6 244:11,12
 249:14 250:2 252:4
 257:2 269:13 270:19
 275:9 278:12 280:7
 299:14,20 306:15
 308:18 309:4,5,8,10
 313:13,18 314:2
measure's 225:17
measured 102:15 208:7
 208:14 213:20 230:10
 231:1 270:11 284:17
 312:1 327:15
measurement 2:10
 6:13 9:10 13:18 51:22
 68:10 80:10,15 82:16
 157:20,21 179:20
 185:7 192:4 193:13
 194:5 201:16,16
 240:11 269:17 300:7
measurements 63:6
 242:19
measuring 42:4 53:17
 186:9 330:15
mechanism 123:19
 125:9,10
mechanisms 310:6
media 201:10
mediate 12:3
mediated 319:6
mediates 271:10
Medicaid 19:3 71:6
 78:3 91:5 92:22
 134:22 135:5 173:22
 174:8,8,10 222:5

258:12,13
medical 1:13,16,19
 76:3 114:3 230:9,11
Medicare 13:2,5 18:20
 19:3 41:5 71:16 86:10
 97:6 99:1 163:10
 234:22 260:13 272:9
 272:11 274:1,3,14
 309:3 329:4
medications 306:14
Medicine 1:17 6:3
 205:20
medium 187:21
meet 68:11 86:8 96:13
 228:7
meeting 5:10 179:3
 185:18 200:5 203:8
 203:15 210:18 230:13
 234:4,12 249:9 266:5
 266:13 290:3 324:4
meetings 202:21,21,22
 286:4
members 140:7 143:1
 198:20,22 199:11
 200:9 211:19 224:14
 224:19 288:20 331:22
membership 115:16
MENENDEZ 2:9
MENTAL 163:13
mention 31:15 110:6
 178:22 201:2 233:5
mentioned 6:8 55:8
 56:14 95:9,17 106:13
 143:16 170:14 175:6
 188:13 190:1,2
 214:11 219:1 228:2
 228:18 240:14 271:3
mentioning 77:15
menu 79:5
merge 65:10
mesh 297:17
mess 283:22
message 115:4 147:17
 201:7 306:13 310:1
messing 188:10 190:12
messy 242:14
met 1:7 167:9 217:4,9
metaphor 246:8
method 241:3
Methodist 326:5
methodology 29:13
 226:11
methods 227:4 259:1
 271:7,15
metric 112:20
metrics 60:20 69:7
 100:11
MHS 1:13

mic 158:19,21 283:17
Michelle 1:15 18:8
 20:22 22:15 23:10
 40:19 43:14 55:2 57:3
 72:2 73:8 78:13 85:16
 88:18,19 90:8,11
 109:4 146:5 172:21
 189:8 272:2 273:11
 277:18 278:20 279:18
 280:19 281:17 318:3
 326:16 328:2 331:1
Michelle's 82:17 121:19
 126:10 147:22
microcosm 62:17
microphone 129:9
 131:20 135:20 158:18
 158:20 162:22 179:14
 180:15,19 326:2
middle 13:4 79:1
 229:17,20
million 273:1,6
millions 272:15
mind 67:9 69:10 82:8
 82:10 94:6 109:11
 132:9 177:11 240:11
 252:8 274:17 303:22
mine 190:21
minimal 17:19 284:22
minimally 112:18
minimis 311:1
minimize 295:14
minimizing 130:5
minimum 77:11 291:16
minor 187:15
minority 31:17 133:20
 238:2 304:11,17
minute 53:16 70:8
 235:15 285:18
minutes 129:12 133:7
 133:11 162:17 178:8
 181:13 197:20 249:9
MIPS 308:12
misinterpreting 157:11
mislabeled 176:7,7,8
mismatch 74:14 299:6
missed 13:9 107:12,18
 115:18 212:14 265:19
missing 57:5 60:7 89:7
 98:18 101:3 152:22
 190:12 270:6
mission 31:12 136:20
misunderstood 125:5
mitigate 276:13
mix 71:19 183:2 275:22
 276:19
mixed 10:4 224:4
 275:18 279:15
mixing 88:10

MMR 17:19
mode 267:20
model 6:11 10:4 49:8
 67:12 95:9 189:1
 209:11 211:10,11
 213:16,18 216:12
 218:3 219:7,10,15,19
 223:19 226:16 233:8
 236:5 239:4 243:3
 247:11 249:1 251:1
 252:5 260:10 261:2
 265:13 266:2 268:16
 269:17 275:18 276:19
 284:14,20 291:21
 295:21 299:8 303:20
 305:1,3 307:2 310:22
 313:7 315:4 319:6
 321:7
model's 295:15
modeling 315:14,14
 317:6
models 10:2 19:17
 100:1 204:20 228:3
 246:2 247:6 251:22
 254:21 260:7 265:7
 265:21 266:20,22
 268:3 278:1 283:19
 295:12 303:15 311:8
 314:20 317:10 323:16
 327:2,12
moderate 335:10
moderately 237:2
moderates 271:10
modifier 134:5
moment 4:18 58:4
 131:18 333:4
monetary 12:7
money 44:17 100:21
 101:11 124:11 296:19
money's 110:14
monitoring 11:2 312:21
month 234:2 292:11
month's 182:14
monthly 17:20,20
months 47:15 308:5
 335:14
moral 154:5
morbidity 164:13
 251:21
morning 4:3,12 7:10,11
 7:12,21 8:3 38:21
 180:18 222:7
mortality 164:13 329:10
motivate 153:20
motivates 76:5
motive 132:11
move 67:17 93:22
 104:19 117:5 122:11

126:2 127:3,12
 128:22 142:12 143:6
 144:8 151:1 201:16
 205:9 219:17 227:9
 228:20 234:20 235:16
 265:10 291:10 314:1
moved 124:12 128:10
 144:6 283:15 294:22
movements 267:13
moves 331:13
moving 61:22 97:5
 109:14 126:2,15
 195:10 196:19 234:8
 293:21 294:15 334:7
MPH 1:11,15,16 2:1,2,3
 2:4,7,9
MPP 1:12
MSSP 95:20
muddy 245:5 283:21
muddying 283:1
multi-level 49:8 300:2
multiple 12:5 216:4
 272:15
MUNTHALI 2:9
MURPHY 2:10 332:21
 333:6
Music 334:11
mute 139:22 251:5,7
 284:4
MVBP 137:13 139:3,4

N

N.W 1:8
NAM 9:21,22 13:1,11
 43:19 63:17 80:22
 91:14 92:7 122:3
 172:2 193:19 195:18
 202:3,12 229:15
 230:2,13 246:21
 301:21 305:6 324:4
Nancy 1:19 18:8 21:1
 23:10 25:15 30:6 74:2
 74:3,18 78:17 79:5,15
 84:21 88:19 92:13
 94:3 109:17,19
 118:20 122:8 124:2,4
 127:20 131:5 133:12
 134:15 135:19 137:6
 142:9 150:8 175:11
 201:20 202:16 234:15
 241:14 244:18 251:8
 253:18 301:9 302:20
 303:7 306:6 309:7
Nancy's 21:19 27:3,10
 30:7 118:18 127:8
 145:16
narrative 187:15
narrow 106:17 157:3

158:4
narrowed 277:20
narrower 213:11
nation 179:22
national 1:1,8 2:3 6:2
 93:13 164:9 166:18
 166:19 169:6 205:20
 299:11
nationally 307:2
nature 59:17
NCQA 63:16 80:21
 113:19 114:2
Nebraska 47:3 87:7
necessarily 27:22
 69:10 83:11 86:4
 89:16 99:13 117:8
 135:3 167:12 186:19
 199:5 238:5 243:9
 248:6 266:15 308:19
 324:19
necessary 50:8 68:9
 92:4 142:1
need 22:12 24:9 25:1
 25:21 26:8,9,19 29:6
 30:8 37:12 38:10 40:5
 44:22 45:3 46:14,15
 47:20 48:20 50:21
 52:5 55:13 59:11
 62:11,14 65:15 68:17
 68:20 71:2 75:2 77:12
 79:10 84:17 85:9,10
 89:8 103:9 105:4
 108:3 116:12 117:1
 124:16 127:9,9
 133:10 135:9 136:11
 138:9,12 139:7 146:7
 160:3,5 171:10
 200:15 216:17 224:8
 231:16 233:4,7 234:9
 235:9 243:17 245:1
 257:4 265:4,10
 267:10,11 270:19
 271:11 273:9 279:10
 281:10 286:9 291:16
 294:22 302:17 311:18
 312:22 315:19 327:16
 329:19
needed 26:4 155:5
 167:17 206:1,4
 211:16 212:2 224:22
 241:2
needle 109:14 189:5
 314:1
needs 21:22 39:17
 52:20 53:1 71:5 80:14
 85:19 93:10 115:17
 116:7 151:5 152:19
 154:17 162:14 215:2

252:13 267:22 292:3
 292:8 293:11
negative 30:21 35:18
 73:16 232:10 313:20
neighborhood 23:3
 42:1 53:6 84:3 253:10
 266:3,7,16 286:4
 287:5 297:16 298:3,9
 298:13 324:18
neighborhood-level
 21:11,14 43:4
neighborhoods 23:5
 49:6 178:5 266:9,11
nephew's 203:15
Nerenz 1:21 81:19 83:2
 83:5,10,16 98:16
 100:6 156:5,18,21
 157:1 236:17 245:8
 263:7 264:8 306:5
 307:21 308:2 309:15
 309:22 323:11 326:8
nervous 26:20
nested 315:8
nesting 323:16
net 10:16,20 11:7,10
 14:5 37:11,14 38:10
 40:2 43:17,20 44:7
 46:9 74:6,9 92:18
 93:8 108:8 115:13
 116:11,15 118:7
 119:7 120:15,17
 122:21 123:10 124:12
 125:6 126:8,11
 127:19,20 128:7
 131:8 132:1,3,6,12,13
 132:14,15,22 133:2
 133:17,22 134:14
 135:8,15 136:5,10
 137:5 138:19 140:1
 141:1,5 142:3 147:12
 147:12,16 188:5,10
 226:5,7 232:12
 252:15 287:14 290:15
 290:16 305:20 328:8
 329:8
nets 127:6
never 133:22 260:2
 261:1
nevertheless 54:2
new 1:13,15 49:10 65:9
 99:11 125:17 159:15
 169:19 194:12 195:15
 208:22 234:21 235:14
 235:20,20 286:13,16
 313:12 325:13 326:5
new/current 247:21
news 183:12,13,14,16
 199:19

nice 72:18 142:19
 166:22 231:7 241:17
 278:16 333:16
nicely 180:4 181:4
 186:8
night 97:1
NIMHD 31:11
nine 221:10 229:2
 254:4,8 326:13
nine-digit 17:17 22:20
 23:2 49:12
Ninez 1:9,12 5:14 7:6
 27:4,10 32:5 35:20
 57:20 65:20 70:7 74:3
 87:12 117:2 118:9,18
 118:20 122:8 123:12
 133:12 137:6 144:1
 144:10,13 150:2,15
 158:17 159:11 195:6
 197:17 201:21 202:17
 203:6 302:21 334:9
 334:15 335:9
Ninez's 33:9 64:12
 124:5 151:16
nobody's 154:2
nodding 28:16 61:10
 318:11 322:14
non 174:8
non- 257:22
non-at-risk 176:16
non-duals 257:16 258:7
 258:9,11
non-safety 74:9
non-SDS 275:5
note 38:4 67:19 74:5
 216:4 271:20
noted 196:1 225:5
notes 5:11 244:21
notice 4:5 232:18
noticed 262:11
notify 198:17
notion 61:6 66:5 89:12
 134:9 201:14 328:14
NPP 164:10
NQF 2:6 3:14 6:4 53:9
 53:10 71:10 98:5
 99:21 124:10 165:20
 175:8 183:8 184:11
 188:16,19 189:6
 191:14,18 192:1,7
 193:12 194:4,10
 195:3 198:20 200:15
 203:9 204:18 213:1
 225:16 234:5 246:10
 247:22 262:6 265:15
 274:20 275:4 287:19
 293:20 299:13 306:12
 307:5 312:12,16

313:1,11 334:8
NQF's 193:12 313:12
nuance 46:13,13 60:14
number 4:9 8:10 53:22
 88:21 91:13 94:5,6,6
 100:11 117:14,16
 127:16 129:4 132:19
 147:14 182:22 213:14
 214:21 222:18 253:21
 257:18 274:21 280:4
 326:6 333:3
numbers 86:8 164:12
 188:6 212:20 253:2
 276:6
nurse 238:8
nursing 1:22 295:22
 296:1,11,15 297:7

O

O'ROURKE 2:11 15:17
 146:21 185:1 198:16
obesity 96:1
obligation 221:14
observation 324:6
 325:12 326:9
observational 26:15
observed 310:6
observing 243:13
obviously 13:2 97:17
 104:5 208:15 230:1
 251:9 280:5 288:22
occasionally 247:1
occur 289:22
occurs 306:16,17
odds 219:12,13 255:1,2
 255:10 268:21 271:4
off-label 312:17
offer 74:21 249:14
 285:9 331:16,17
office 99:10
Officer 2:7
officials 42:11
offline 275:1 285:12
oftentimes 230:9
OGBOLU 1:21 84:20
 269:19
ohhh 179:16
old 16:5 81:17 175:4
 235:20
older 274:4
omnibus 269:7
once 35:13 81:12 186:8
 263:8 267:14 297:7
 297:10,11 310:21
one's 323:7
one-pager 5:18
onerous 212:5
ones 18:4 25:20 58:10

58:11,11 59:15 166:4
 166:8 206:17 214:8
 233:5 235:16 257:8
 294:9 307:13 314:1
 316:4
ongoing 262:22 277:7
online 285:18,19,21
Oops 126:20
open 91:8 109:11 117:2
 122:12 133:3 186:11
 242:4 246:11 262:7
 274:17 277:7 332:20
 332:22
opened 124:21
opening 242:14 246:8
operating 45:8 289:12
operationalization
 195:13
operationalize 165:15
 168:10
operationalized 59:3
 66:19
Operator 180:10 332:21
 333:1
opinion 99:22 185:10
 192:14 194:13
opinions 224:4
opportunities 201:13
opportunity 3:10,16
 75:8 77:8 101:8
 166:22 181:17 182:10
 183:3 199:9 200:14
 207:19 246:1 286:7
 334:19
opposed 16:12 25:13
 95:1 122:5 148:2
 151:22 157:15 218:6
 225:12 283:11
opposite 284:21 307:15
optimal 295:12
option 244:16 286:19
 301:19
options 234:2 243:4
 286:15
order 23:20 75:16,16
 277:5 317:21 327:10
Oregon 78:3
organization 11:11
 59:9 62:3 75:11,14,17
 86:6 88:22 94:7,13
 120:1 128:5 135:14
 136:13,13 145:3
 152:19 170:3 201:4
 283:21
organizational 10:18
organizations 9:20
 10:12,14,15,16,20
 11:4,9 14:6 61:20

62:16 64:1 66:2 78:4
 78:5 85:11 89:3 90:13
 93:9 96:20 115:12,12
 115:14,15,20 116:6
 116:14 117:19,19
 118:8 119:12 120:12
 120:18 122:16,17
 123:1 126:4 127:5
 133:17 134:13,14,18
 134:19,20 135:7
 138:18,19,19 140:3,9
 140:10,18 141:5
 142:3 177:21 199:14
 199:16 283:20 288:17
 289:18 290:9
organize 264:22
orientation 179:17
oriented 220:6
original 6:10 13:13,14
 91:17 124:10 142:11
 142:14 143:15 239:6
 241:20 242:6
originally 16:7 163:12
ourself 146:9
outcome 9:3 43:5
 178:19 179:6,7
 208:10 209:5,12
 210:3 213:3,3 236:9
 236:10,15,19 250:2,7
 250:14 253:13,13
 255:8 257:2 280:12
 292:15 305:8
outcomes 1:14 53:14
 76:10 94:20 155:20
 169:13 179:6,17,21
 209:7 223:22 230:3
 230:10,22 236:20
 255:15 256:12 257:9
 258:2,10 265:22
 316:2 319:7 329:10
 329:16
outline 195:8,21
outpatient 10:9 98:22
 109:22 110:15 111:4
outpatient-enabling
 110:3
outpatients 75:14
 110:12
outside 253:7 304:13
outstanding 305:20
over- 15:4
overall 36:6 60:15
 61:13 68:3,8 85:17
 106:18 112:22 125:1
 129:14 140:4 141:9
 167:16 179:3 192:2
 212:22 222:3 242:12
 257:1 298:22

overarching 36:7
 193:11 195:22
overlap 129:4 144:1
 190:4
overlapping 128:15
overnight 4:13
overriding 255:13
oversees 214:12
overturn 214:13
overview 4:5 8:2 12:20
owned 245:14 324:10

P

P-R-O-C-E-E-D-I-N-G-S
 4:1
p.m 181:15,22 182:5
 204:1 335:21
P4P 101:17
paces 335:13
Pacific 290:8
package 69:22 306:13
 312:16
packaged 207:17
pad 248:11
page 19:16 163:7
 202:12,14
paid 94:16 123:14
 161:14
paired 299:10
pairs 274:9
panel 200:8,9 203:5
 204:11,13 205:2,2,16
 205:17 207:17 209:4
 215:22 217:1 221:21
 227:4,9 245:11
 249:20
paper 182:20 183:1,15
 184:3,8,10 185:5,15
 186:3,13,16,19 187:3
 187:11 191:12 192:17
 195:9 196:1,15 198:5
 198:12,18 234:3
papers 182:19 192:18
par 44:19
parallel 13:10 281:20
parallels 48:5
parent 138:18
parental 215:3
parentheses 61:4
parking 253:15
parse 317:3
part 6:14,15 18:2 34:19
 39:16,17 42:17 60:4
 66:12 68:8 76:3 88:1
 114:14 125:15 129:14
 132:15,21 133:21
 135:2 138:17 140:4
 141:9 152:15 156:8

156:19,21 158:7
 160:19 161:3,5,7,10
 161:15 171:5,15,19
 172:16,17 176:18
 179:17,19,20 188:15
 189:16,18 209:3,16
 211:19 212:5 213:11
 218:13 222:6 237:18
 239:7 242:17 253:3
 263:2 274:15 278:22
 279:12 300:17,20
 301:5 302:7 305:18
 313:18 318:22 331:2
part's 68:19
partially 316:5
PARTICIPANT 224:17
 314:6 318:1 334:13
participate 91:2
participated 223:17
particular 28:17 37:19
 51:16 65:20 90:8
 114:14 162:20 188:17
 191:19 197:1,12,14
 219:20 224:3 225:10
 225:14 226:10 243:6
 259:11 329:6 331:3
particularly 78:21 95:7
 104:19 206:16 226:4
 227:14 260:12
parties 291:17
partly 47:15 48:21
 181:18 303:15,16
partnering 30:15 31:4
partners 2:4 288:8
partnership 2:1 50:5
 225:18
partnerships 9:2 19:1
 20:13,20 21:13 29:12
 29:19 32:16 50:8 56:8
 56:17 62:6 66:4
 101:10 159:18
partnerships' 18:13
parts 12:15 15:20
pass 46:7 92:13 109:18
 170:6 329:3
passed 90:22
passionate 334:6
passive 34:18 35:7
 79:16 172:4
paternalistic 245:16
path 60:12 120:11
 271:11 286:8
paths 287:2
pathway 69:3 250:9
 264:4 297:20
pathways 305:7,10
patient 19:6 34:15
 41:12,17,21,22 42:6

42:22,22 43:4,6,9
 54:5 70:8 99:8,9
 158:10 159:9 174:3
 179:11 206:15 208:14
 214:22 220:3,7
 221:19,21 228:15
 230:14 237:11,12,15
 239:3,11,14,18,19,20
 240:8 243:13 259:8
 259:12 263:19 265:16
 267:1 275:19 276:1
 281:1 282:7 288:11
 289:2 291:21 304:10
 310:22 311:12,14,17
 320:6,8 322:11,16,19
 322:22
patient-centered 114:3
patient-level 21:7 22:7
 22:14
patients 13:7 42:16,18
 51:20 71:16 91:5
 104:16 106:20 111:1
 115:16 119:17 121:22
 124:19 132:20 181:2
 238:3 239:14 253:2
 260:11 263:6,10
 266:10 288:10 289:20
 290:18 304:11,17,17
 305:15,19 315:13
 316:9,10 319:17
 321:1 323:5
Patrick 229:16
pause 333:4
pay 45:13 92:18 106:11
 262:21
pay-for- 10:5
pay-for-performance
 106:16 169:16 189:14
payer 71:19 222:5
 270:18 288:14
payers 9:7 28:22 51:8
 52:17 70:17 72:22
 76:11 288:18
paying 97:6,21 153:12
 153:17
payment 8:18 9:13,14
 9:19 10:2,4,18 11:16
 14:1 18:21 19:5,7,17
 19:18 20:14 47:16,21
 65:14 66:11 68:16
 72:6 74:1 89:9 92:2,4
 92:9 95:9 97:20 99:9
 101:9 105:17 109:9
 110:7,19 115:9
 121:12 123:5 126:3
 141:9,15 148:20,21
 158:4 161:16 185:6
 192:5 225:14 288:22

292:17 302:4,5
 307:14 312:19 313:2
payments 10:5,10
 64:18 76:12 90:20
 91:4 94:13 98:21,22
 98:22 99:1 101:5,18
 101:21 104:15 109:21
 110:3 111:1 130:2
 141:21 142:7 161:13
 269:3
peer 10:14,15 115:12
 118:2 119:13 122:14
 122:16,22 137:9,15
 138:18 139:11 140:8
 145:3 157:14
peers 58:1 64:9 140:12
peg 91:18
penalized 143:4 329:9
 329:17
penalizing 173:7
penalties 100:20
penalty 310:7 324:7,8
 324:11
people 4:9 14:18 15:4
 24:4 29:10,11 31:19
 31:21 46:7 53:22
 54:11,19 56:8,21
 59:21 65:14 71:3 72:7
 75:20 85:20 87:4,11
 87:22 90:13 92:1,20
 95:10 96:11 102:17
 105:9 116:7,17 118:5
 122:7 125:3,7 126:1
 126:14 130:22 131:4
 138:11 140:17 143:20
 146:10,19 147:16
 149:7 153:7 155:3
 162:12 168:12 170:6
 173:11,14 174:4
 175:2,15 178:5
 182:20 186:10 197:8
 198:6,21 203:1
 217:17 227:7 241:10
 246:13 248:5 254:9
 255:3 256:14,22
 260:3 262:10,13
 263:3 264:17 271:9
 274:21 276:7,11
 278:15,18 281:3,6,15
 282:1,17 295:22
 296:21 304:14 306:3
 316:19 321:11 325:8
 327:22 329:16 330:14
people's 38:2,2
peoples 289:12
percent 71:16,18 78:5
 82:11 96:17 105:1
 155:4 166:11 215:13

215:14 217:20 238:1
 238:2 254:6,18 269:2
 269:4,9 272:13,14,20
 272:21 273:6 284:15
 292:15,18
percentage 187:22
 272:12
percentages 90:7
perfect 64:13 204:5
 280:4,6
perfectly 34:21 85:12
 264:12 304:22
perform 37:14 174:11
 328:16 329:15 330:1
performance 8:16 10:6
 25:9 55:15 74:1 95:1
 95:5,6 106:11 115:7
 141:14,17 145:10
 176:15 185:7 192:3
 213:18,19 216:11
 219:15,18 275:20
performing 88:8,8
period 3:14 23:12 72:11
 81:13 181:15 182:8
 186:1 192:10 203:10
 205:10,11,12,15
 207:3 209:2,10
 211:22 212:5 213:2
 231:4 232:5 233:18
 233:19 234:6 242:1,5
 242:17 244:20 270:2
 270:12,14 291:5
 333:15
periods 206:15
Permanente 1:17
persisted 328:20
person 47:12,17 61:17
 165:22 197:14 254:8
 254:13 296:6,7
 324:17,20
personal 236:22 245:13
personally 249:6
perspective 52:15
 159:9 215:19
perspectives 12:5
 212:4 288:4 291:18
pertains 118:6
pharmacies 41:15
phase 234:20 235:13
phased 134:5
phasing 134:10
PhD 1:12,12,19,20,21
 1:21 2:5,8
phenomenally 331:10
Phil 150:4 272:4 297:15
 299:2 306:8
Philip 1:12 18:8 20:22
 22:4 43:14 46:18 49:2

49:3 55:5 64:5,6
 68:14 73:10 88:4
 109:19 112:3 122:8,9
 124:3 128:1 129:10
 129:11,12 139:7
 142:9,10,14 145:1
 150:5 156:4 158:7,16
 201:20 202:17 203:4
 203:5 264:20 269:15
 269:20 285:16 292:14
 304:21 318:1,2,2
 321:14 322:8,18
Philip's 131:1 159:9
 303:9
phone 7:5,7,9,14,18
 14:18 18:9 21:1 23:10
 25:15 27:7 34:13 36:2
 36:4 38:19 39:12
 40:16 54:12 81:15
 103:22 106:5 118:12
 126:19 148:11,14
 175:2,16 180:7 196:2
 196:18 203:14,17
 234:16 251:4 259:6
 284:2 331:22 332:22
photos 229:20
phrase 109:1
phrased 73:18
physician 62:17 309:6
physicians 308:13
pick 41:8 95:18
picking 23:1
picture 229:13,18
 230:19,20
piece 64:22 106:11
 140:5,21 175:19
 176:5 186:20 192:11
 194:5 231:7 263:20
 277:9,11 305:6
pieces 174:18
piggy 133:15
piggyback 84:21 271:2
pipe 66:17
place 37:7 48:18 56:4
 64:20 73:20 96:22
 97:20 99:8 128:11
 134:13 151:21 158:10
 169:20 181:11 195:20
 216:17 218:19
placement 229:14
 295:12 296:6
places 37:16
plain 124:10
plan 42:17 48:13
 104:21 198:15 257:21
 258:3,17 273:4
plane 313:18
planned 198:9

plans 1:18 12:9 19:22 42:10 105:17,19 173:21,22 174:7,12 207:1 256:20,21 257:5,14,19 258:8,16 290:4	259:3 261:11 263:22 264:14,19 269:15 271:19 273:11,16 277:17 278:19 279:21 280:14,19 281:17 283:3,17 284:2,7 285:2,19,21 287:8 288:6 290:7 291:1 295:2 297:12 298:16 301:9 302:19,22 303:4,6 306:3 310:3 311:19 312:4,11 314:9 317:18 318:2 320:1 323:7 326:15 328:1 331:1,21 332:10,15,19 333:21	327:22 potentially 5:7 66:5 76:11 134:3 137:22 144:17,19 148:3 188:10 218:17 224:1 225:2 230:16,22 231:4,17 233:13 235:8 238:6 266:4 293:22 potion 335:18 powerful 172:21 282:16 powers 293:20 PQI 53:17,22 PQIs 53:6 practical 4:21 114:8,11 177:1 247:14 277:19 326:18 practice 62:13 134:5 164:20 168:3 175:7 314:1 practices 63:18 128:6 132:18 133:19 134:2 pre-diabetes 97:4 precede 36:17 precedent 134:4 precise 254:1,16 precision 267:9 preconditions 66:15 prediction 263:20 predicts 41:16 predominant 305:10 predominantly 117:11 predominate 305:8 preferentially 177:6 preferred 293:9 premature 251:10 premise 185:4 preponderance 116:6 Presbyterian 1:16 prescient 208:16 prescription 306:14 prescriptive 60:1 220:22 presence 201:11 present 1:10 2:12,16 200:14 208:5 274:8 presented 63:17 195:18 226:16,17 228:3 290:2 presenting 228:7 President 2:9 presiding 1:9 press 180:11 199:10,12 199:19 202:5 248:12 333:2 pressure 95:18,22 97:2 177:18 235:15 236:13 272:18	pressures 235:4 presumably 293:1 presume 193:1 presumed 157:6 pretty 109:1 120:3 172:1 188:9 205:3 208:21 218:12 221:11 223:14,18,19 224:20 231:18 280:3 290:6 291:4 304:5 315:5 322:9,13 323:22 prevalence 97:18 100:15 163:9,20 164:1 170:17 172:6 175:8 178:12 208:6 prevalent 47:9 97:10 255:21 256:4 282:16 preventative 9:17 preventing 119:9 prevention 53:7,11 preventive 104:2 170:15 previous 101:4 115:8 115:10 251:8 previously 9:8 price 153:12,16 primarily 153:19 171:16 221:22 240:6 311:13 primary 9:17 104:2,6 105:7,10,10 132:18 prime 69:6 principles 128:13 printout 13:12 prior 98:5 113:18 135:13 218:1 223:8 228:6 priorities 18:15 166:18 prioritization 95:15,22 179:1,4 prioritize 9:3 96:9,13,19 162:6 177:9 prioritized 36:16 178:19 prioritizing 13:15 priority 98:2,4 110:15 162:8,10 168:11,14 200:12 private 39:20 privilege 268:12 proactively 8:17 73:18 90:1 probably 34:1 51:9 60:10 86:20 87:5 90:21 95:18,20 103:11 105:12 133:6 138:9 152:12 176:10 188:16,20 189:4 190:6 205:16 210:14
---	--	--	--

252:9 258:5,9,14
 263:15 284:15 291:15
 293:22 313:5 315:10
 315:11 319:9 321:8
problem 29:9 53:10
 107:13 128:12 156:8
 157:1 302:18 305:2
 317:10
problematic 241:5
 268:10 270:13
problems 47:10 99:5
 290:22
procedures 251:21
 295:17 297:20 298:1
process 9:4 11:1 13:9
 44:14 57:12 61:21
 63:19,22 69:16 80:20
 85:19 94:21 136:22
 196:19 211:20 224:3
 233:20 236:1,10,21
 243:22 249:22 274:18
 302:12,13 318:22
 319:7,15
processes 97:19
produce 164:18,19
 234:2
professional 318:20
profile 225:8
profit 324:10,11
profound 167:9 247:4
program 186:6 225:14
 234:22 272:10
programs 8:18 9:6 10:4
 10:8,17 11:8 21:19,21
 30:13,14 71:13 89:20
 92:8 103:14,15
 113:17 137:13 139:4
 169:16 225:20,21
 235:12 273:3 307:14
 308:6
progress 102:19 251:9
prohibit 72:14
prohibition 204:18
project 2:8,8,9,10 11:20
 32:15 47:3,4 78:18
 163:12 198:22 289:6
 326:20
projects 12:1 26:9
 28:13 29:4,21 30:3
 32:7,14,20 151:6
 152:3 155:9,15
 156:16 227:13 286:12
prominent 204:16
 222:17
promote 9:9 19:1,8
 20:12 82:11 83:12
 119:5 130:13 189:10
promoting 18:12 37:7

119:21 129:22 130:7
promulgate 160:8
properties 225:17
proportion 90:13 92:1
 92:19 115:15 261:8
proportions 137:18
propose 133:16 183:7
 234:20 267:19 286:8
proposed 14:14 65:6
 89:9 122:18 126:13
 182:21 194:20 308:5
 309:5
proposing 33:15
 134:17 260:6
proposition 55:7
 259:15
prospectively 11:2
 287:7
protect 120:15
protecting 119:7
 122:21 125:6 131:8
protection 88:15
protective 117:9
protocol 163:2
prototype 250:22
proud 107:5
prove 299:18
proven 104:12 105:7
provide 59:6 90:19
 207:12 209:21 231:12
 268:16
provided 60:6 185:3,18
provider 43:17 85:7
 124:19 173:13 220:11
 237:3,7 263:18 264:5
 269:1 287:1 290:15
 309:9 311:11
provider's 169:17
providers 11:7 12:9
 19:22 43:20 45:10
 52:17 76:5 85:1,10
 92:17,19 122:21
 123:20 124:12,13
 125:6,16 131:13
 133:17 134:14 173:21
 179:10 252:15 290:16
 305:20
provides 96:10
providing 10:20 173:10
 173:14
provisions 116:13
provocative 299:15,16
 303:10
provocatively 304:21
proxy 24:20,22 25:14
 221:3 222:9 229:12
 267:5,6,7,8 285:8,8
 303:18,19

public 3:10,16 4:8
 21:13 42:11 44:13
 49:13,20 50:15 51:6
 51:21 148:18,19
 173:19 180:7,9,11,12
 192:4 212:10 214:18
 227:2,12,15,19 295:7
 308:16 321:20 332:1
 332:20,22 333:5,7
publication 183:1 190:3
published 184:8 198:19
 243:11,19 325:10
 329:7
pull 17:18 172:5 313:11
pulled 169:19 308:10
pulling 17:4,6 78:2
 282:20
punted 122:1
purchasing 10:17 11:3
 44:15 65:6 171:18
 329:5
pure 276:1
purely 58:12 151:22
 187:4 193:6 330:20
purpose 23:21,22 24:6
 25:12,13 31:12 58:13
 153:16 299:22
purposely 303:9
purposes 23:6 61:14
 68:4
pursue 288:8
pursuing 89:13
push 28:20 35:2 42:20
 72:20 281:2 301:6
pushback 72:7
pushbacks 87:6
pushed 221:11
pushes 170:8
put 22:13 25:16 28:10
 62:8 76:22 103:9
 127:13 146:17 151:21
 152:18 154:14,15
 169:20 179:2 180:2
 181:4 186:8 187:4
 198:19 226:20 227:2
 232:3,18 239:3
 240:12,18 248:17
 253:14 258:3 287:21
 288:12 300:8,11
 306:11 308:12 309:1
 310:1 311:4 313:2
 320:3 322:21 335:12
puts 189:8
putting 13:15 23:19
 148:2 199:5 239:20
 288:20 289:20
pyramid 180:3

Q

qualified 39:19
qualify 136:17
qualitative 211:16
 212:9 223:15 243:12
qualitatively 173:16
 227:11
qualities 170:15
quality/equity 56:2
quantified 154:2
quantify 153:11,16
 154:9,12
quasi- 32:8
question 15:9 16:21
 17:1 24:10 33:9 55:6
 58:18,19 69:6 70:9,12
 72:14 73:9 74:12 89:4
 90:11 91:7 116:18
 121:19 126:10 137:8
 139:7 142:11,14,16
 143:15,21 148:4
 159:5 168:9 177:3
 190:8 198:13 208:10
 216:12 224:11 230:20
 232:5 236:2 237:10
 243:6 244:2 247:18
 262:12 268:20 275:3
 276:3,3 280:22 295:5
 299:4,12 301:1 307:4
 317:4 320:13 328:22
questionnaire 77:3
questions 39:5 58:8
 77:2 81:20 192:9
 207:22 208:16 210:12
 219:22 220:9 273:13
 274:22 276:19 294:13
 296:5 317:12 320:20
 321:5
queue 118:15 234:18
 303:3
queued 147:22
quick 36:9 49:4 62:10
 67:18 142:18 162:12
 185:22 201:20 243:18
 261:19 294:7 320:2
 321:14
quickly 31:9 106:9
 196:20 322:7
quite 79:16 86:17
 217:19 260:3,19
 309:13 335:9
quits 159:12

R

race 23:18 25:5,11 71:3
 78:8 88:6 167:8
 204:19 222:4,9 229:6
 229:9,11 235:6 267:7

270:17 303:11,12,15
303:19,21 305:12
310:7
race/ethnicity 24:5,8,16
78:7
racism 24:15 172:14
289:8 297:18
raise 104:22 209:15
raised 5:5 27:14 50:1
55:20 73:10,13 87:12
90:9 207:13 209:8
211:8 220:12 222:16
224:2 226:19 227:19
232:2 238:4 294:9
raising 105:15 292:21
ran 264:8
RAND 257:13
randomized 26:12
30:19
range 170:1
ranges 57:11
ranging 291:20
rank 165:9
ranked 174:1
ranking 252:16
rankings 257:7
rare 86:22
rate 62:3 167:5,16
316:22
rates 39:18 102:13
153:8 256:17,17
257:2 276:7 296:20
316:11,19
ratings 325:7
ratio 255:2 268:22
ratio's 255:1
rationale 206:5
rationalization 161:5
ratios 219:12 238:8
255:10 271:4
rattled 322:18
rattling 319:10
RAUNER 2:1 16:20
46:22 64:7 70:15
71:22 86:2 95:12
170:13 187:18 234:19
236:8,14 272:3
312:14
RCT 27:13
re-admissions 186:6
re-do 301:4
reach 97:8 108:11
307:7
reached 188:16
reaching 108:3
reacting 138:13 168:16
reaction 12:13 26:3
30:21

reactions 312:22
read 97:13 141:20
170:3 184:21 248:2
267:16
readiness 69:19
reading 33:13 187:19
readjust 141:3
readmission 153:8
206:22 296:20 303:21
304:1 319:17 322:1
324:7
readmissions 118:1
221:5 225:9 227:14
275:11 295:14
reads 34:9
ready 69:6
real 24:15 33:11 34:22
43:21 49:13 84:22
85:6 101:1 174:21
225:13 250:19 290:21
300:6 321:14,18
real-time 35:1
realistic 190:6
reality 90:17 294:4
realize 47:1 87:3 307:22
realized 211:14
realizing 85:20
reason 75:18,19 105:2
124:9,10,20 154:3
256:19 263:2
reasonable 68:18
145:15
reasons 24:15 68:10
83:13 229:11 304:11
305:3,4
recall 91:14 220:7
283:8
Recap 3:3
recapping 60:5
recategorization 16:17
receiving 100:21
recognition 92:15
133:18
recognize 172:3
recognized 132:15
133:22
recognizing 95:5
recollection 261:14
recommend 18:20 19:7
169:20 200:3,4,9
241:22 242:16 311:10
recommendation 25:17
26:21 28:21 65:13
79:8 82:3 92:14 93:15
168:10 178:18 200:16
233:17 242:7,20
244:19 331:2
recommendations 3:3

3:6 4:16 5:13 6:1,3,5
6:10,19 8:5,11 9:7,22
10:4 11:21 12:14 13:2
13:4,10,11 25:8 43:13
51:5,16 52:13,16
54:14 60:1 65:4 78:19
93:5 135:8 160:20
162:8 173:6 183:11
189:1 200:11 214:14
227:2 245:2 247:10
285:12 302:4,16
335:6
recommended 205:2
205:22 216:1 217:8
222:8 242:3 327:5
reconfigured 117:1
reconvene 181:22
record 41:18 43:8 55:4
182:4 280:7 335:21
recorded 42:16
records 8:15
recurring 182:13
227:13
red 298:5
redesign 10:2 20:14
92:2,7 94:15 95:9
redesigning 19:16
redlining 298:10 328:5
328:6
redo 243:22
reduce 9:8,10 82:20
88:8 90:2 104:16
185:5 186:9 187:8
189:14 331:17
reduced 186:10 283:9
283:16
reducing 72:6 167:17
reduction 74:17 87:18
87:19 88:4,14,16
98:10 112:19 113:9
144:16 161:1 187:22
reductions 107:7,20
refer 36:9
reference 77:16 78:3
129:7 193:20 327:19
referencing 67:1
referring 39:2
reflect 283:10
reflected 63:16
reflecting 80:21
reflection 282:1
reflects 179:9 237:5
reform 14:2 72:7 109:9
141:9 148:20,21
reforms 9:14 89:9
reframe 243:22
refresh 167:1
regarding 31:22 65:21

94:4 117:17 198:7
288:14 292:10 293:4
regardless 51:11 90:20
294:21
regards 200:22
regimen 99:11
region 321:4
regional 306:20
regionally 321:2
register 277:15
regs 192:15
regularly 81:10 86:5
regulations 298:2,9
regulatory 87:1
reimburse 143:7
reimbursement 92:22
123:18 276:7
reinforced 128:16
246:20,21
reiterating 128:13
rejoinder 33:1
relate 208:3 218:8
238:16
related 10:22 85:1
91:13 101:19 110:10
110:16 119:16 176:1
177:16,18 178:10,13
178:16 202:3 228:5
282:8 329:5
relates 148:19,21
152:18
relationship 208:1
209:22 210:1,17
213:13 215:7,15
216:3 217:22 222:14
222:19 223:3,10
243:7 244:3 278:6
relationships 18:4
246:3 270:9
relative 13:16 220:2
263:10 329:16
release 199:10,19,19
202:5 312:21
released 246:6
releases 199:12
relevant 59:2 60:16
61:7 144:19 189:10
292:12
relied 219:4
relying 226:11
remained 328:20
remedy 93:5
remember 56:10 65:12
110:11,13 144:7
162:20 167:22 254:4
277:16 295:9 328:8
remembered 280:20
remove 300:13

removed 143:17
renal 103:14 304:7,8
rename 130:9
renamed 203:11
rent 45:13
reorganizing 13:8
repeal 104:12
repeat 120:7 264:22
repeatedly 228:19
repeating 145:7
replace 139:18
replaced 16:8 175:20
replacements 16:14
reply 184:21
report 5:1 13:5 16:1
 23:14 24:19 25:11
 47:10 63:18 70:21
 77:6 80:21,22 86:7
 91:14 93:14 98:5
 113:15 114:10,22
 122:3,19 146:22
 147:5 165:4 169:7
 171:14 172:2 189:2
 189:20 190:5 196:15
 198:3 202:3,4,13,14
 203:9 206:11 207:17
 209:4 210:14 213:8
 214:22 221:21 226:21
 233:6 239:6 241:17
 246:7,21,22 291:4
 311:5 335:6
reporting 47:6 57:14
 78:6 148:18,19
 173:19 192:4
reports 17:20,20 43:19
 63:16 85:4 193:22
 301:21 327:1,17
represent 201:3 258:18
 311:20
represented 290:9
represents 328:9
request 87:2 279:20
require 206:13 275:4
 300:21
required 79:22 108:14
 209:21 277:10 309:11
requirements 286:17
requires 174:19 279:9
research 1:14 11:14
 14:10 17:11 25:17,18
 26:3,11,18 27:12 28:5
 28:12,21 29:1,1,1,9
 29:16,17 30:1,3,10,18
 31:16,20 34:16,17
 35:2,3,17 40:5,22,22
 149:22 150:7 151:4
 152:1 153:9,15
 154:12,15,17 156:16

157:4,10,20 158:3,11
 165:22 200:2 228:6
 271:12 278:15
researcher 30:22
researchers 29:3,13,19
 30:15 31:4 32:16
 53:12
residential 298:19
resolution 265:10
resolved 58:6 232:16
 247:19,20 265:2
resolving 232:17
resonated 75:20
resonates 76:18 205:19
 259:19 331:4
resource 153:20 164:14
 227:14 244:6
resourced 132:19
 133:21
resources 45:6,21
 75:22 93:2 140:17
 173:15 258:3 296:16
respector 151:19
respond 96:20 260:20
 284:9 295:5 315:1
respondent 278:9
responding 303:9
response 40:17 183:13
 184:1,4 253:9 262:16
 294:7 306:8 314:14
 328:11
responsible 169:3
 175:14
rest 157:11 180:5 241:8
restart 167:20
restate 70:9
restructuring 302:5
result 5:19 157:6 269:3
 293:3 294:3 298:6
results 172:20 181:1
 199:1 216:11 240:15
 241:4 247:3 251:15
 254:16 269:21 294:19
resumed 182:4
retire 86:4
retracing 297:19
return 115:1
returning 304:12
reveal 123:12
review 3:14 163:7
 192:17,18 203:9
 214:10 225:4 243:10
 243:18 265:8 300:20
reviewed 5:14 227:4
reviews 28:1 226:11
 278:4
revised 8:4 15:12,18
revisit 5:3,7 6:9 22:12

96:15 116:18,21
 162:1
reward 19:22 87:17
 88:13 106:17 108:19
 112:17 113:4,10
rewarding 12:8 74:7
 95:4 130:4
rewards 113:7
reword 77:21 131:1
 150:2,5 151:21
reworked 149:19
RFA 184:12
rich 25:4 38:2 249:3
 255:18 331:10
richer 229:5
rid 83:7,11,12 150:1
ridiculous 315:7
rights 103:7
rigor 40:13
rigorous 29:5,13 30:14
 31:4 149:21
rising 124:11
risks 230:9
road 331:5 334:7
roadmap 3:8 15:10,13
 15:13,16,22 60:16,17
 61:7,13 68:4,8 79:17
 80:1,18 85:17 97:11
Rob 234:15
ROBERT 2:1
robust 69:8 247:6
 321:20 333:17 334:5
 334:5
Rochester 1:19
rock 301:6
rocket 248:11
rockets 248:10
role 49:14,16 50:15
 133:18 178:15 187:15
 193:12,16 231:11
 244:11 299:10
roll 70:4 275:20
rolled 275:2
rolling 204:15
Romana 1:20 15:7
 28:17 30:4 32:22 33:5
 33:6 40:19 43:14
 46:18 49:2 96:15
 100:10 126:15,22
 128:4 142:19 162:4
 162:21,21 167:22
 170:12 171:8 175:11
 176:4 177:3 178:17
 186:15 191:3 193:2
 195:8,21 199:21
 234:15 237:8
Romana's 80:19 135:12
 160:6

Romano 229:16
Ron 60:2 64:15 67:20
 68:2,21 70:4 85:16
 93:22 136:2 152:11
 200:4,7,9,18 288:6
 312:12
Ron's 63:15 160:17
RONALD 1:17
room 1:8 32:13 34:19
 83:7 225:9 264:17
 286:3 321:12 333:7
rooms 153:7
root 57:13 85:13
round 91:18 184:9
run 8:11 71:8 188:3,4
 249:11
running 48:12 312:15
runway 279:10
rural 11:12,12
Rushefsky's 132:17

S

safe 42:2 334:1
safety 10:16,19 11:7,10
 14:5 37:11,14 38:10
 40:2 43:17,20 44:7
 46:8 74:6 92:18 93:8
 108:8 115:13 116:11
 116:15 118:7 119:7
 120:14,17 122:21
 123:10 124:12 125:6
 126:8,11 127:6,19,20
 128:7 131:8 132:1,3,6
 132:12,13,14,15,21
 133:2,17,22 134:14
 135:8,15 136:4,10
 137:5 138:19 140:1
 140:22 141:5 142:3
 147:12,12,16 188:5
 188:10 206:12 215:16
 226:5,7 232:12
 252:15 287:14 290:15
 290:16 305:20 328:8
 329:8
sake 209:9,11
sample 226:7 254:5
 280:16
samples 227:7
Sanchez 2:2 7:13,13
 39:13 95:17 200:19
 200:22
Sarah 2:3 38:22 54:10
 54:21 56:13 63:17
 81:1,3,14 114:16,17
 116:19 117:4 127:1
 128:19 133:13,14
 134:15 135:19 137:6
 139:20,20 142:5

143:16 144:3,13
 203:21 223:16 290:2
 332:2
Sarah's 116:21 143:21
 147:10 267:16 293:10
satisfied 168:1
save 101:1 296:2
saving 296:19
savings 234:22 272:10
 272:11,22
saw 104:20 159:14
 166:13 188:1 214:5
 221:17 261:5 326:10
saying 24:21 25:3 26:3
 37:16 45:5,17 51:3
 55:14 76:20 77:6
 80:12 82:4 84:21 85:5
 96:12 101:20 103:4
 112:10 124:7 125:8
 125:19 128:4 132:12
 137:16 140:9,21
 141:18 142:2 148:7
 184:19 187:2 191:22
 200:15 220:22 272:4
 284:1 292:14 301:2
 308:20 322:15
says 37:18 53:15 69:15
 87:17 115:6 121:2
 134:13 141:13,14,16
 203:10 247:11 304:21
 306:19
scale 169:8
Scarlet 330:8
scattered 196:13
scenario 174:21 300:10
scenarios 112:8,8
 113:3
schema 165:7 179:1
schemes 65:6
schizophrenia 225:15
SCHOLLE 2:3 38:21
 39:9 54:22 81:1,3
 114:16,18 127:1
 128:19 133:13 139:21
 142:6 145:13
school 1:17,22 245:17
science 155:21 171:18
 240:11 243:20 245:5
 280:9,10 328:16
Science's 169:7
Sciences 93:14
scientific 2:7 299:9
 330:20
scientists 262:13
scope 81:22 99:22
 237:7
score 43:22 62:9,19
 115:8 145:10 174:2,6

272:12,13 275:21
scores 8:17 45:19
 55:15 141:17 174:1
 297:8 330:11
scoring 46:1 165:14
 168:17
scrap 299:19
screen 5:17 162:19
 163:4
screening 75:13 235:3
 237:1 272:17
SDOH 101:6
SDS 3:14 50:13 122:18
 189:13 203:10 273:20
 273:21 275:22
Seattle 324:21
second 4:19 5:20 8:16
 9:12 13:3,21 19:16
 20:11 38:8 63:17
 73:12 77:7 84:19 86:1
 89:17 90:5 93:11 95:4
 106:10 111:11,19,21
 112:1,3 118:5,6
 121:11,14 122:15
 137:9 139:6 164:3,8
 179:8,16 184:9 190:8
 303:11,13
secondary 121:3
seconds 100:7
section 114:5
sections 144:6
sector 18:14 39:20
sectors 298:7
seed 298:8
seeing 91:20 172:19
 211:12 243:14 247:3
 281:21 282:22
seek 234:1
seemingly 239:11,18
seen 182:18 210:14
 249:8 263:18 268:8
segregating 140:20
segregation 298:20
 299:1 319:10
SEIU 1:15
seize 77:8
selected 218:5 225:20
selecting 217:5
selection 217:10
 218:22
selections 219:1
self 214:22
send 14:21 199:12
sending 44:9
Senior 2:8,11
sense 26:19 72:18 73:1
 91:1 112:7 116:19,22
 119:16,18,19 123:3

167:7 171:22 172:17
 194:18 219:11 220:16
 246:1 249:3 265:9
 274:11 276:20 280:18
 283:7 284:19 290:21
sensitive 96:11 133:8
 149:17 159:13 162:2
 162:13 164:22 165:1
 165:6,10 169:9 191:6
 191:17,20 192:7
 193:7,16 194:7
 301:14
sensitivity 166:5
 290:20
sent 115:4 170:14,19
 211:18 233:6
sentence 138:17
separate 20:11 70:22
 92:8 98:1 110:16
 111:6,9 115:19
 120:14 125:20 140:5
 140:21 144:11 147:18
 148:12 149:13,13
 155:7 184:11 227:4
 241:3 311:11 316:3
 326:19
separated 69:9 320:7
separately 71:4 255:1
separates 239:10
separating 276:1
September 182:15,16
 188:14 335:4
sequence 57:10 306:10
sequencing 273:19
Sequist 2:4 40:20 43:7
 50:19 82:14
serious 306:18
serve 10:12 115:21
 116:6 117:10 119:17
 128:8 132:19 140:10
 256:21 276:11
served 137:3
serves 89:1 120:2
service 136:15 330:16
services 10:9,10 12:11
 12:11 19:6 45:14
 110:4 164:22 299:2
 316:14 318:19 324:22
serving 9:20 82:21 90:6
 115:15 126:4 140:12
 140:18 158:15 269:5
 276:6 282:2 328:9
SES 53:16 236:20 240:4
 240:20 252:3 260:7
 269:4 303:18,19
 304:1,10,17 305:2,7
 305:15,16 317:9
 320:6

session 200:5
sessions 144:11
set 19:6 33:10 39:15
 65:3 77:1 116:13
 205:14 228:8 229:5
 240:11 274:19 281:6
 299:11 315:4 316:17
sets 28:1 49:20 306:21
setting 109:22 111:4
 308:9
settings 179:10
setup 179:3
seven 47:4,13
severity 164:14
shaded 13:12
shame 333:9
shape 335:4
shaped 136:8
share 121:20 163:4
 199:1 205:10 241:10
shared 178:22 186:3
 203:5 234:22 272:9
sharing 162:19
shave 283:14
sheet 198:12
Shield 86:11
shift 160:20 269:3,8
 275:9 295:22
shifting 102:21
show 13:12 44:18 65:4
 132:17 202:4 208:8
 221:18 223:6 239:17
 240:4 261:16 265:21
 278:17 289:13 295:12
 298:2
showed 235:5
showing 43:3 153:7
 193:21 194:2 259:9
 263:1
shown 5:17 232:22
shows 43:18 279:6
shy 30:9
sicker 274:4
side 76:8 229:22 232:8
 248:14 250:3 312:21
 330:4
sidewalks 41:16
signal 145:6 239:19
 260:19 263:17
signed 198:21
significance 213:16
 219:4 225:12 226:2
 233:10 268:20 273:10
 285:5 292:11,12
significant 72:7 173:20
 207:7 208:9 213:15
 216:9,20 219:2,5
 222:12,17 223:13,14

225:5 227:21 235:5
 256:8 269:12 272:6,7
 272:8,22 292:4
significantly 173:16
similar 13:10 52:12
 188:4 212:12 276:12
 284:22 303:22
similarities 202:4
similarly 119:13 240:3
 327:6
simple 250:18,18 304:4
 317:17 326:4,4
simplicity 209:11
simplified 176:22,22
simply 91:21 167:15
 294:9
simulation 32:9 150:3
simulations 12:2 27:16
 27:18 28:15 35:22
Simultaneous 28:8
 236:7 313:16 332:9
single 249:2 275:20
 284:13,16 306:21
 324:7 325:13,14
singly 202:8
sit 148:1 225:9
sits 125:15 174:16
 200:7
sitting 212:16 248:11
situation 106:19 112:21
 138:5 306:16,16
situations 37:13 135:18
six 47:15 205:16 221:9
 221:9
size 134:5 219:9 226:3
 233:10 256:11
sized 187:21
sizes 254:21
skewed 257:18
skilled 296:1
skirting 314:11
slide 15:3,4 36:5 37:4
 38:17 39:2,10 46:19
 49:3 53:3 54:10,15,19
 54:20 55:1 56:15
 65:12 74:6 79:12
 81:15 84:19 86:1 87:8
 101:4 102:2 103:17
 103:22 113:12 114:15
 114:19,19 115:1,6,10
 116:3,17,17,20 117:2
 119:1 120:21 121:1,9
 121:11,14,17 125:18
 126:1,5,15 129:1,2,2
 134:13 135:13,14
 149:11,13,13,15
 151:1,17,18 175:3,4
 212:15,18 217:10

223:8 229:14,15
slides 39:1 46:19 54:7
 74:15 133:11 135:18
 233:6
slightly 70:17
small 21:17 76:3 80:7
 80:15 91:6 133:19
 213:17 219:10 226:2
 226:6 257:3 273:7
 290:6
smaller 134:2 135:7
smart 321:11
smiley 306:11
so- 289:6
soak 260:17
soccer 245:18,19
socially 168:19 290:18
socio-economically
 128:9
socioeconomic 159:2
 250:5,6,10,14,21
 310:8
socioeconomically
 326:14
sole 187:14
solely 183:16
solo 133:19
solution 84:11
solve 137:15 302:18
somebody 202:14
 246:14 261:21 293:11
 303:2
somewhat 4:19 91:13
 170:5 204:22 232:16
 283:15
soon 216:15
sooner 34:5
sorry 27:5 38:22 67:18
 81:17,19 107:12
 123:11 139:21 144:21
 162:18 180:21 253:18
 264:14 273:14 276:8
 280:1 284:7 299:4
 312:4 322:19
sorted 84:15
sorting 51:18
sound 80:8 315:7
 334:11
sounded 84:22
sounds 34:18 35:7
 77:11 176:21 182:1
 269:22
source 17:8 136:10
 187:14 225:4 278:10
sources 17:13 41:14
 195:15 220:22 233:12
 235:9 281:1 327:13
 327:21,22

space 51:12 135:5
 136:21 153:15 275:11
 289:6,19 290:1
speak 70:11 89:2
 113:21 219:21 323:12
speaking 28:8 84:22
 236:7 313:16 332:9
speaks 50:5 132:13,13
 240:19 283:4
special 38:10 46:15
 59:14 193:5 215:1
 308:20 335:8
specific 21:20 51:2
 54:6 57:1 59:2,22
 69:5 75:3,5,9 76:20
 77:8 78:11,14 79:4,8
 110:2 111:12 114:7
 114:13 147:16 153:16
 154:22 179:4 193:5
 196:7 200:16 207:22
 238:17 309:2 315:5
 318:16 327:9
specifically 20:19
 22:14 73:21 82:10
 83:11 135:15 194:4
 207:21 219:22 221:2
 222:6 245:2
specifications 207:5
 211:13
specificity 57:2 77:20
 218:16 294:15 331:16
specifics 79:21 195:10
 269:16 285:10
specified 299:7
specify 84:1 266:21
spectrum 237:5
speculate 325:17
spelled 20:14
spend 4:17 182:8 229:7
spending 93:1 309:3
spent 222:1
split 166:13 227:7
spoke 118:12,22
spoken 34:21
spurred 160:6
square 91:18
squarely 200:12
staff 2:6 4:14 32:1
 35:11,13,21 47:14
 48:16,18 52:7 67:8,14
 79:11 100:5 105:16
 106:2 107:15 114:7
 114:12 181:6 189:19
 193:22 203:4 211:18
 335:12,17
staff's 149:22 152:13
 190:5
staffing 44:8 238:8

stage 70:1 188:17
 293:2 304:7
staircase 334:12
stakeholders 232:10
 311:3
stand 62:11
standard 26:14 72:21
 73:2 76:16 164:18
 185:15 187:3 238:6
standardization 225:3
 291:16
standardized 81:6
 283:13
standby 77:6
standards 77:1 284:10
standing 1:3,7 82:3
 197:7 207:18,19
 210:4 214:13 226:12
 328:10
standpoint 61:7 330:21
star 102:10 325:7,14
 333:3
stars 326:7,7
start 56:4 72:20 75:12
 87:12 93:5 124:21
 153:13 162:14 169:7
 186:14 205:1 208:5
 210:8,10 227:7
 298:21 315:20 319:10
 328:19 334:1,2
started 4:4 182:7 186:8
 194:1 204:14 246:7,7
 259:20 270:2 324:6,7
starting 46:19 71:11
 94:14 100:4 187:10
 197:22 198:11 288:10
 288:19
starts 153:4 197:21
 272:19
state 41:6 48:2 51:6
 53:12 69:12 77:17
 87:6 173:22 174:6
 237:14 258:13 301:2
 315:11
statement 69:16 98:12
 146:7,18 195:5 206:3
 258:17 303:10
statements 51:2 89:21
 113:18 147:1
states 45:2,4 254:6
statistical 213:16 219:4
 225:12 226:2 233:10
 239:9 268:19 285:4
 292:1 294:6 311:8
statistically 219:5
 227:20 272:6
statistician 87:1
statisticians 238:21

320:12
statistics 219:16,17
status 17:21,22 84:13
 230:15 270:3,15
 287:16 310:8
staying 53:4
stays 310:22
steps 212:7
stick 317:21
stone 274:19
stop 132:1 216:16
 233:18
store 41:19,20 42:21
stores 42:2
story 193:11,11 218:12
straight 250:14
strain 120:17
strange 80:8
strapped 153:21
strategic 313:9
strategically 145:19
strategies 8:7 12:17
 13:13 14:14 15:14,18
 15:22 96:8 113:18
 120:9,10 122:17
 123:4,9,10 128:14
 129:17 130:13 144:9
 148:8,17 170:16
 196:8,9,11
strategize 18:19
strategy 8:8 9:12 10:11
 11:13 13:17,20,21
 14:2,4,6,8,9,10 19:14
 28:13 33:10,13,18
 35:5 46:20 54:15 65:4
 93:8 104:19 115:6,19
 116:3,3,4 117:5,9
 120:4,14 122:5,15
 125:15 127:4,14,16
 127:18 129:7,20
 130:17,19 131:7
 134:11 140:2 141:4,4
 141:8,9,12,14,15
 144:8,8 146:8,13
 147:11 164:10 166:20
 200:1 331:5
stratification 25:12
 73:17,22 78:7 106:22
 141:13 167:13 207:7
 211:13 231:11 233:9
 277:10 281:7 298:19
 302:6
stratified 56:1 78:7
 90:15 167:4
stratify 115:7 141:14,17
 141:20 145:10 277:5
stratifying 8:16 25:9
 55:14 121:12 298:21

Street 1:8
strength 192:16,20,21
strengthen 81:5
striving 73:2
strong 69:2 222:18
 245:13 285:7 322:9
 326:6
stronger 40:2 79:21
 89:21 121:4 140:3
 143:12 145:18 147:17
 196:15,15 222:20
 239:19 261:6 269:16
strongly 120:3 179:7
 242:16 262:14 323:22
structural 172:13,14
 299:1
structure 8:22 9:4 56:7
 56:16 57:10 62:5
 64:20 65:1,9 66:3
 130:3 289:8
structured 48:3
structures 19:5,8
struggle 86:5
struggles 225:7 230:1
struggling 138:2
students 172:15
studied 151:5 313:3
studies 153:11 154:8
 234:20 271:8 306:20
 329:4
study 27:18 235:6
 283:8
stuff 17:6 50:20 77:18
 94:15 109:14 155:22
 174:14 191:12 256:5
 275:14 289:10,15
 297:4 302:6 329:18
 329:18 330:16
sub- 226:6
sub-bullet 87:16 130:16
 150:14 151:17
subbullet 20:16 98:9
 106:10 111:7,11,18
 111:20 112:3,6 113:7
subbullets 20:19 95:10
subcommittee 259:1
 292:3
subdomains 6:18
subgroup 269:18
subgroups 294:14
subheaders 16:12
submissions 221:8
submit 182:20,22
 183:15
submitted 186:17,17
 208:22 211:6 213:21
 214:10 216:6
submitting 194:16

211:13
subpoints 98:18
subset 58:10 197:8
subsidy 17:22
substantial 154:11
substitute 28:11
substrategies 16:2
subsumed 147:11
subtle 98:14
succeed 65:16
successful 248:6
suck 44:11
sudden 71:20 277:12
suffer 330:3
sufficient 116:14
 211:15
sugar 169:14
suggest 157:2 223:1
 251:15 286:16
suggested 27:16
 108:15 122:11 241:4
 249:15 261:15
suggesting 96:7 125:14
 144:13 301:11
suggestion 77:19 126:2
 191:1 210:19
suggestions 4:21 56:21
 78:14 95:10 114:9
 183:22 226:9 277:20
 326:18
suggests 37:11 305:3
suitable 61:5 68:5
suited 292:10
summarizes 212:19
 231:2
summary 229:21
 241:17
summative 231:7
summer 325:8
supplementary 196:6
support 10:2 11:21
 19:17 46:8 47:17
 75:17 79:19 80:2,4
 92:2 96:16 101:12,15
 116:12 120:19 121:4
 122:5 123:10 125:11
 125:16,21 126:7
 127:19 131:9 140:1
 141:10 150:11 151:19
 185:10,17 186:12
 215:21 224:9 230:7
 236:22 296:8 323:12
 330:6
supported 215:15
supporting 10:9,11
 119:11 120:1 125:11
 135:6 153:1
supports 116:5 296:22

supposed 110:1 133:5
 276:16,17 277:4
surprise 205:1 220:19
surprised 258:15
 267:13 268:13
surprising 254:1 282:9
surrogate 60:9
survey 63:9 211:18
 224:20 229:2
surveyed 224:14
surveys 8:15 21:6
 59:16 75:1
Susanna's 7:8
Susannah 1:13 36:8
 38:20 55:8,19 73:13
 88:2 106:6,8 107:4
 118:13,20 122:10
 124:6 129:19 183:4
 186:5,8 196:5,17
 197:13 203:18 219:21
 223:17 234:17 237:19
 238:17 241:14 259:13
 260:1 264:9,14 280:1
 284:5 302:22 303:5
 306:4 310:4 317:18
 318:15 320:1 323:8
 323:14 325:3 332:2
 332:11,18
Susannah's 7:17
 117:20 126:2 216:5
 255:22 259:5 314:14
susceptibility 170:1
suspect 331:15
switch 126:13
switching 94:19 270:12
synergistic 253:12
synergy 14:12
synthesize 291:3
system 1:14,21 2:4
 37:9 39:16,16,17 44:8
 44:17 45:9 49:17,22
 66:11 113:4 123:5
 127:17 141:4 169:3
 169:19 171:22 172:19
 239:8 283:8 288:12
 296:3,19
system's 175:14
systematic 28:1
systems 12:10 20:1
 24:6 28:22 29:11
 42:11 44:15,16
 288:14,21 289:21
 313:2

T

table 5:22 74:14 163:8
 213:7 311:21
tables 209:14

tack 81:5	technically 128:7	testing 29:13 227:4	303:17 310:4 311:6
tackle 321:10	technique 137:21 239:9	tests 26:16 28:7 248:10	312:8 317:19 323:22
tailor 31:3	teed 209:18	268:3,8 286:14	325:5 326:9
taken 156:17	teeth 77:21 160:10	295:17 329:22 330:18	thoughts 36:7 69:1
takers 74:5	TEIGLAND 2:5 17:14	text 52:21 55:19 64:3	74:21 102:2 122:9
takes 99:7,11 103:3	22:16,18 102:6	66:22 77:12,19 79:5	124:2 175:15 176:3
121:21	253:20 281:19 283:18	90:3 111:19 114:14	196:3,18 198:6 201:1
talk 4:17 6:22 21:4,9	295:4	137:4 155:11 168:13	218:21 264:22 287:13
37:3,4 38:17 40:7	teleconference 2:16	189:22	319:18
63:19 64:7 73:21 74:7	telephone 180:11 333:3	texture 112:12	thousands 191:15
93:19 118:3 125:3	tell 140:15 193:10	thank 24:12 26:1 63:14	203:1 273:2
143:1 181:16 196:20	209:14 307:12 323:4	70:3 129:13 142:5	thread 189:5
197:10 204:7 228:12	325:12	197:19 201:19 204:5	three 4:12 5:22 60:13
230:13 237:6 250:5	telling 255:11	217:12 234:13,14	61:13 66:12 67:10
253:20 254:3,20	template 199:9 249:15	241:16 261:12 273:11	68:6 83:13 87:16
266:18 303:12 305:14	285:9	277:17 285:2 287:8	96:19 112:7 113:3
talked 12:5 18:12 22:5	templates 199:13	314:6 323:9 332:15	126:12 131:3 142:11
36:14 60:14 64:16	ten 134:8 162:16	332:16 333:1,6,8,12	143:22 147:19 148:13
87:13 95:14 117:17	248:13 287:3 297:9	333:18 334:3,4,8	166:7 168:4 175:8,18
117:21 137:14 150:19	tend 49:15 254:22	335:7,11,16	175:18 177:13 202:6
158:11 169:5 183:6	263:4 283:14	thanks 7:20 15:2 22:4	212:16 220:20 235:2
186:5 216:5 222:7	tended 214:20 225:11	23:9 38:18 40:14,15	236:11 254:11 269:2
229:6 230:14 237:10	tens 202:22	49:1 73:8 78:12 81:14	269:4,8 286:3 292:15
244:5 257:17 266:6	term 29:16 34:16 48:7	105:14 158:16 161:21	326:7
271:5 292:22 315:18	145:17 159:4,8	165:12 167:19 176:20	threshold 74:16 87:18
321:15 328:5	270:22	180:16 181:8 196:17	88:6,14 90:21 98:10
talking 21:18 23:12	terms 4:4,20,21 5:7,19	202:16 237:8 251:2	102:15 103:3 108:3,4
26:8 29:10 41:10	6:22 8:2 19:4 20:4,7	253:5,17 258:21	108:17,20 109:12
43:19 51:1,6,7,8,20	33:17 43:12,13 46:16	269:15 271:19 281:17	112:9,10,18 113:8
51:21 52:4 60:19	49:6 50:1,6 53:14,18	283:3 295:2 297:12	269:11
73:14 84:1 94:7,15	53:20 54:8 55:17	298:16 299:2 317:18	thresholds 87:20 88:17
97:1 99:20,22 111:17	56:18 58:15 59:3,15	328:1 331:1 332:19	102:8 107:8,11 108:1
113:9 121:20 136:11	62:5 63:2,11 64:17	333:21 335:8,12,19	threw 72:17
154:22 157:3 167:12	68:21 69:18 85:1,6	that'd 67:7,14 79:11	throw 59:20 188:20
182:9 183:7 198:1	92:14 98:14 100:20	106:1	throwing 24:10
209:10 212:17 216:16	101:20 102:4 105:5	theme 119:3 182:12,13	thumbnail 238:18,20
219:11 222:2 226:5	118:7 132:1 133:8	182:14 214:18 227:13	THURSDAY 1:5
227:7 256:1 264:9	151:13 153:6 165:9	themes 212:12	ticket 166:7
266:9 270:1,3 271:9	171:5,9 172:1 175:12	theory 147:10 206:5	tie 53:21 101:8 161:19
277:9 284:3 290:11	183:2,14,19 184:2	there/available 45:21	226:15
302:7 309:16 318:7	189:6,21 190:4 195:4	they'd 63:10	tied 165:3
322:10	195:10 196:19 197:6	thinks 322:22	tiered 37:8
talks 19:16,18 155:11	198:4,7 199:19	third 5:2 6:4 8:20 10:1	timelines 196:20
170:17	200:10 203:4 242:21	10:11 14:4 56:5 58:5	times 18:11 38:11
tandem 114:20	247:18 252:11 256:10	73:21 91:21 93:8	172:12 222:11 229:8
tangible 82:8 99:15	259:9 265:2,12	98:17 106:10 107:5	240:14 248:2 303:11
Tara 2:10 5:11 6:21	267:18 270:7,8 271:7	107:19 113:6,12	timing 69:22 133:5
15:2 331:6	271:15 281:7 289:11	179:9 219:14 247:13	tiny 23:3 310:22
target 32:4 84:9	289:19 290:4 294:5	272:5	title 28:6 30:2 308:7
targeting 100:12	298:11,11 301:3	THOMAS 2:4	today 153:10 154:18
task 243:1 327:9	319:4 327:9,12 335:5	thorny 291:10	190:2 193:15 204:8
taste 249:11 308:8	terribly 106:20	thought 58:15 59:7	210:15 233:3,17
teach 172:15	test 43:22 177:21 267:5	81:17 116:11 186:20	288:15
team 200:18 202:2	278:22 299:11,18	194:20 203:22 206:10	told 217:1
245:19 261:19 318:20	300:3 328:15 329:15	207:8 211:21,22	Tom 33:3,4,5,6 34:13
teams' 240:15	tested 70:19 222:22	227:17 229:21 231:6	36:3 39:12 40:18
tease 278:2 318:9	225:3 228:2 303:15	261:15 264:11 274:13	50:19 52:7 82:13
technical 278:2	307:10	276:4 278:20 303:16	83:14 203:22

Tom's 49:5
ton 274:22
tool 109:9
tools 77:17 79:6
top 6:14 16:6 32:8,22
 102:15,20,21,21
 148:3 163:10 168:4
 175:18 177:5 179:21
 179:21 180:3 230:8
topic 28:17 33:6 46:10
 53:5 60:6 77:11
 118:19 119:22 297:15
topics 15:10,12
topped 82:22
total 38:15
totally 51:4
touch 14:15 285:10
 289:10 305:13
touched 292:2 314:10
touches 191:9
tough 181:10 244:4
 335:1
tougher 245:5
traced 298:12
Traci 1:18 60:3 61:14
 63:14,15 64:15
 109:19 112:4 113:11
Traci's 65:2
track 15:6 210:11
tracked 210:13
Tracy 133:12 134:15
traditional 26:19 201:9
 259:17
train 194:20
training 275:1
translate 268:21 269:6
translates 43:12
transparency 57:7,14
 207:12 269:10
transportation 298:15
 319:11 320:14,19,21
 321:16,21 324:16
 325:22
travel 239:1
travels 334:1
treating 188:6
treatment 304:19
trial 3:14 23:12 27:13
 72:10 181:15 182:8
 186:1 192:10 203:10
 205:9,11,12,14 207:3
 209:2,9 211:22 212:5
 213:2 231:3 232:5
 233:18,18 234:6
 242:1,5,16 244:20
 261:22 270:2,12,14
 291:5 326:19 327:18
 331:4 333:15

trials 26:13 30:19
tricky 68:7 145:12
 189:5
tried 13:8 15:19 27:13
 79:9 154:9 165:14,19
 311:6
tries 248:6
triggered 290:14
trillions 154:10
triple 89:13
tripping 34:15
trouble 145:21 146:3
true 20:9 31:1 44:12
 75:4 154:7 258:18
 260:10,21 300:10
 318:12
truly 59:10 135:7
 166:11 218:6 219:18
 300:15
truth 315:16
try 18:22 26:9 31:13
 54:8 72:10 114:21
 149:16 153:11 154:12
 202:8 217:12 221:14
 238:19 241:3 246:4
 248:5 294:14 311:10
 315:20 323:21 334:19
trying 15:14 19:3 20:12
 20:19 26:16 31:16
 33:10,11,19 44:14
 47:2 70:21 73:15 76:5
 76:6 90:1 91:17,22
 102:17 106:19 109:6
 116:7 125:20 140:22
 141:2 143:21 149:1,3
 149:6 154:16 161:8
 162:19 168:18 169:22
 190:10 194:14 200:5
 201:11 220:16 224:7
 224:7 230:16 242:18
 264:7,21 275:7
 276:13 291:2 306:9
 317:10 321:7 330:5
 332:11
turn 7:2,22 59:13 98:8
 175:1 183:19 201:21
 202:17 251:3
turning 47:17 195:3
turnover 47:14,15
turns 267:4
tweak 156:9
tweaked 99:17
tweaking 26:16
tweaky 235:15
two 4:12 5:16 31:13
 36:9 55:17 65:10
 67:11 69:9 71:4 81:20
 86:12 95:2 96:18 99:7

110:10,16 112:7
 113:3 117:5,7,13,17
 119:1 120:3,22
 122:11 123:4 131:2,2
 137:18,18 141:7
 142:11 143:22 144:5
 144:11,14,18,20
 145:1 146:1 147:18
 148:6,12 177:13
 202:2 205:4,9,11
 208:17,20 210:11
 212:20,22 231:3
 232:4,18 234:20
 240:21 241:22 242:5
 242:10 254:5 262:11
 272:16,18 277:19
 286:3,8 293:2 299:21
 326:17 327:1 333:14
tying 53:18 130:1
type 79:11 96:14
 111:20 160:11 170:10
 191:16 192:9 271:11
 288:10 289:5 292:11
 292:20 333:17
types 19:9 154:22
 292:17
typically 311:18

U

U.S 167:6
UDS 71:9 95:19 235:1
ultimate 300:15
ultimately 204:22 205:2
 207:15 223:12 260:9
 277:21 295:21 311:4
 315:8
umbrella 32:15
unadjusted 256:17
 261:16
unanswered 220:9
unbelievably 268:10
unchanged 112:18
unclear 129:15
underlying 146:16
 237:6 262:15
underneath 137:20
 148:2
underscore 39:14
 65:22
underscoring 46:6
understaffed 86:19
understand 15:15 30:7
 32:17 49:15 75:20
 76:3 85:7,11 107:10
 109:13 114:21 116:8
 116:17 129:19 137:1
 139:22 149:8 169:9
 169:11 177:8 220:17
 241:18 243:11 249:19
 289:6 307:21 309:16
 321:2 323:19,20,21
understanding 53:21
 153:4 158:14 168:20
 225:19 226:15 242:11
 259:13 276:9 277:4
understood 260:3
unemployment 235:6
unequally 131:12
unevenly 92:17
unfair 119:10 252:22
unfairly 123:17 143:3
unfairness 132:8
unfortunately 273:4
unified 66:16
uninsurance 222:5
uninsured 17:5 238:2
 276:6,8,8
unintended 73:16
 312:21 313:6,21
unique 208:9
United 254:6
units 12:7
universal 299:9
universally 75:13
universe 218:7
University 1:17,19,21
unmeasured 230:11
 231:5 233:14 283:5
 287:12 289:7 311:22
 312:7 314:15,22
Unrelated 131:16
unresolved 293:7
unsatisfying 301:8
up-front 274:10
update 44:14 98:6
updated 81:9,11 162:15
updates 169:1
updating 133:8 175:16
upfront 19:18 47:20
 64:17 68:15 101:18
 101:21
uphill 82:18
upset 252:21
upstream 289:1
uptake 113:22 199:4
URAC 102:11 113:19
urge 21:12
use 9:8 11:15 13:6
 17:13 24:21 28:6 32:9
 37:2 40:6 41:4 42:5
 42:10,11,12 56:11,12
 58:9,11,12 59:4 61:17
 79:19 82:20 85:7
 87:19 88:16 94:22
 98:2 105:5 107:7,20
 107:21 108:3 120:9

133:16 137:5 145:19
 145:19 157:4 158:3
 164:14 166:4 168:11
 169:15 177:1 185:17
 187:12 192:4 217:4
 221:6 227:15 234:21
 235:7 239:9 241:2
 244:6,12 288:1
 292:17 298:10 300:5
 301:17 303:19 306:15
 307:14,19 308:6
 309:10,17 314:2
 315:14 317:13 334:5
useful 41:5,7 199:7
 274:16 323:1 331:19
 332:8
usual 226:12
utilize 62:2
utilized 213:4

V

VA 283:8,10
vacancy 316:19,21
vaccinations 96:1
vague 68:20 88:12
 104:3 109:2 150:10
vagueness 126:9
valid 300:12 324:1
validated 265:20,21
 308:9
validity 210:6 214:3
value 43:2 66:6 82:22
 160:21 161:3,11,19
 171:18 201:16 292:19
 329:5 332:10
value-based 10:17 11:3
 65:6 66:11 104:10
 105:6,17 134:4
valuing 123:18
variable 157:5 218:22
 239:12,21 240:8
 314:17 320:6,10,22
variables 211:3 216:9
 222:3 223:22 225:3
 228:17 231:15 240:4
 240:4,5 266:1,22
 267:9 268:2 287:3
 295:6 297:3 311:16
 311:17 318:6,17
 322:3
variance 219:2
variation 164:19 208:6
variety 152:4 155:19
various 68:10 83:22
 155:20 291:17 318:7
 329:4
varying 268:11
vast 265:5,21

VBP 329:9,13
veering 120:10
vendors 42:20
venues 42:2 202:20
verb 79:16
verbal 69:2
verbs 80:5
version 15:12 177:1
 264:12
versions 52:16 101:4
versus 22:7 24:2 59:5
 60:20 97:14 125:21
 150:7 176:16 220:1,3
 233:9,10 237:15
 259:8,12 268:19
 273:20 276:2 293:14
 293:21 298:14 300:12
vertically 62:8
Vice 2:9
video 248:8
view 70:2 73:15 179:11
viewed 187:10
viewing 68:13
virtually 329:11
virtue 276:5
vision 15:21
visit 99:13,17
visual 61:17 249:11
visually 264:10
voice 262:8 312:12
volume 89:3
vote 297:4
vulnerable 45:8 117:11
 124:15 138:6

W

waffle 22:10
wage 310:13
wait 53:15 118:14
 131:16 216:14
waiting 165:7 273:16
 288:17 303:3
waiver 189:12
walk 8:4 12:13,14
 146:10
walkable 41:15
walked 13:18,22 177:4
walking 75:10
wanted 12:12 22:18
 23:1 40:20 65:22
 70:10 84:20 87:22
 107:17 114:18,21
 122:13 124:5 126:9
 131:15 133:15 134:16
 137:7 150:9 160:16
 163:2 186:11,21,21
 197:21 225:2 226:13
 246:14 256:9 259:4

271:2 284:8 287:12
 295:5 300:8 301:20
 333:12
wanting 86:10,11
wants 86:6 160:7 184:5
 197:13
warranted 144:12
 148:13 149:14
Washington 1:8 254:7
wasn't 38:14 87:14
 168:1 214:3 215:15
 229:12 242:6 270:14
watching 333:14
waters 283:1
way 14:15 19:7 29:5
 32:3 46:8 48:3 49:8
 50:9 52:9 56:14 59:8
 65:10 66:18 67:5 69:3
 70:5 72:13 81:4 85:8
 88:9 92:16 97:10
 102:21 104:16 108:9
 117:1 120:16 136:8
 143:6 151:21 156:8
 158:1 159:15 161:9
 161:19 169:10 172:19
 176:8 195:1 201:6
 202:2 203:1 204:10
 207:20 219:3 225:1
 230:8 231:14 232:4
 247:2 249:19 261:4
 264:2,6 265:11
 267:15 272:9 279:4
 282:16 283:13 286:14
 294:12,22 302:9
 305:13 307:1 310:17
 315:4 317:1 328:16
ways 27:20 54:20 56:15
 56:22 73:11 78:14
 81:21 85:17 91:15
 104:4 109:5 115:2
 117:15 142:12 148:7
 149:7 152:5 161:14
 167:20 168:22 171:11
 193:14 204:14 229:21
 232:21 240:21 249:13
 291:10 293:15 294:8
 304:1,2 305:15
 307:18 310:9 325:4
weaknesses 162:15
weave 233:19,20
website 47:7 198:17
 313:11
wedding 203:16
weeds 320:15
weekend 217:14,15
weigh 198:22
weight 69:11 167:6,7
 200:10

Weill 1:16
weird 229:14 280:21
Weisman 191:12
Welcome 3:2
well-developed 284:19
WellCare 1:18
went 163:5 182:4
 211:14 219:6 296:13
 317:20 326:10 335:21
weren't 156:12 231:15
 312:17
whacked 328:17
whatnot 15:6 28:15
 52:21 54:21 56:13
 68:11 157:15
wheelhouse 192:15
whichever 176:13
white 268:4,4,6
wide 113:2
widely 53:12 309:17
wider 85:16
width 164:4
wind 327:18
winning 245:19
wisdom 293:20
withhold 78:5
withholding 173:7
women 310:15,16
wonder 12:18 28:4
 82:19 91:17 101:7
 115:18 116:1 150:7
 169:18 201:12 202:1
wondered 154:21 260:1
wonderful 248:9
wondering 30:11 31:2
 76:19 82:7 88:21
 151:10 291:11 293:18
 306:12
word 13:6 28:5 29:10
 35:6 67:22 138:3,14
 138:15 142:18 150:1
 156:16 176:14 203:2
worded 56:14 156:9
wording 5:12 19:12
 35:22 46:12 79:3
 93:10 137:10 159:2
 183:20
words 40:5,12 66:14
 157:12 206:8 293:6
 314:18
wordsmith 32:1
wordsmithing 35:13
work 3:4 4:14 15:19
 18:16,17 26:14 27:17
 36:1 37:6 50:2,8 64:2
 64:21 67:1,6 73:5
 77:17 85:10 87:4 98:7
 100:22 123:18 128:6

129:1 132:17 134:10
 136:14 138:15,16
 140:4 145:17 158:14
 162:13 165:15 171:12
 172:1,8 174:20
 181:18 183:7,9
 187:13 188:21 190:9
 191:9 192:9,21
 193:19 194:2 195:15
 197:9,14,22 198:8
 201:3,7 204:10 227:1
 233:1 245:11,13
 249:20 251:9,13
 264:1 290:7 293:2
 313:12 314:4 317:16
 318:21 323:8 324:3
 335:3,13
worked 84:12 210:8
 211:22 224:6 248:4
working 3:12 21:13
 47:13 48:2 62:18
 67:12 162:19 181:14
 191:9 197:1,13
works 26:10 28:2 45:3
 107:12 187:10 272:10
world 26:12 174:21
 190:2 218:13 225:13
 226:4 290:21
worlds 31:13
worry 37:6 97:11 245:1
worrying 88:12
worse 230:10,22 251:1
 256:20 257:6
worst 102:13 230:3
worth 174:20 289:21
 325:2
worthwhile 184:3
wouldn't 206:12 211:15
 215:17 310:17
wound 166:6
woven 24:18 80:15
wow 44:10 278:21
wrap 228:12
write 114:9
writers 67:19
writing 47:20 190:5
written 19:14 194:1
wrong 68:2 89:8 262:17
 263:14,15 325:6,13
 326:8
wrote 33:14 208:17

X

X 82:1,4 200:15 294:10
 294:11

Y

Y 82:1,4 200:15

Yale 1:13 216:7 219:20
 228:22
year 48:10,11,11 75:12
 170:14 205:9,11
 231:3 232:5 241:22
 242:5
years 85:4 154:8
 170:22 175:5,13
 194:21 204:9,18
 205:4 207:14 208:17
 208:19,20 210:11
 211:20 212:20,22
 214:6 231:9,20
 232:18 242:10 254:11
 287:15,15,15 293:2
 300:18 333:14 335:11
yesterday 5:5,10 6:7
 8:5 9:15 14:1 15:9
 18:10 24:14 25:4 26:7
 27:14 36:14 50:1 52:8
 55:20 56:10 61:8
 63:17 64:17 72:16
 90:12 95:14 104:9
 106:13 110:11 137:14
 152:14 158:12 163:4
 177:20 178:18 249:10
yesterday's 60:5
Yolanda 1:21 84:18
 269:18 271:19
York 49:10 286:13
 325:14 326:5
York- 1:15

Z

Z 82:2,4 200:15
zero 44:22 257:2
ZIP 17:17 22:20 23:2
 49:12 221:9,10 229:2
 254:4,8 326:13

0**1**

1.04 219:13 255:2
 268:22
1.08 219:12
1.08s 273:7
1:00 204:1
100 96:17 134:7 155:4
1030 1:8
11:30 149:16
11:45 133:5
11:52 182:4
1115 189:11
12 48:12 191:13
12:10 181:22
12:11 182:5
12:30 4:5,9 181:15

182:7 197:20
126 213:2
13 166:11 191:13
15 1:5 70:8 133:6
 181:13
15th 1:8 208:21
17 213:22 214:11
 277:21 278:16,20,21
 279:3 280:3,4 291:6

180 3:10

182 3:12

19 217:22

2

2 14:7 65:4 81:15 87:8
 88:21 91:13 94:4,5,6
 102:2 103:22 114:19
 115:1 116:3 117:5
 119:1 121:9,9 123:7
 125:18 126:1,3,15
 127:3,4,16,16 128:22
 129:8,20 130:20
 141:8,14 144:8
 147:11 149:13

2:38 335:21

20 71:15 133:11 163:10
 272:14

2010 193:18

2011 193:18

2012 171:13,14 193:18

2013 204:12

2014 204:12

2017 1:5

2018 182:16 184:13

203 3:14

20th 234:12 299:5

21 213:21 214:9

23rd 234:4

24/7 313:14

29 215:13

3

3 14:2,6,10,11 58:21
 91:16 94:6 98:8
 103:17 114:15,19
 115:1,6 116:3,4,17,17
 116:21 117:2,9
 121:17 122:5,15
 126:5,15 127:18
 129:1,2,2,5 130:8,20
 141:15 146:13 147:15
 149:13 157:7 292:17
30 100:7 329:9
300 165:20
300-odd 211:19
303 213:1
333 3:16
335 3:18

4

4 3:2 14:9 149:11,15
 151:16,17 157:8
4.7 273:6
400 165:20
40s 248:9
43 213:13,13 216:2
49 273:5

5

5 99:17
5.4 273:1
50 202:14
50s 248:10
51 104:22 273:5
54 3:6

6

6 98:1 147:15
60 3:8
65 213:6,14 214:9 216:2
 217:20 260:13
67 39:2
69 39:10 224:17,18,19

7

7 163:7
70 215:13 224:15,18

8

8 3:4 70:20
80 71:18 82:11 272:13

9

9 70:20
9:00 1:9
9:03 4:2
93 213:4 215:12 272:20
95 254:18 284:15
97 272:21
98 248:4
99 272:13
9th 1:8

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.



Court Reporter

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com