

NATIONAL QUALITY FORUM
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RISK ADJUSTMENT AND SOCIOECONOMIC STATUS OR
SOCIODEMOGRAPHIC FACTORS EXPERT PANEL
MEETING
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WEDNESDAY
JANUARY 15, 2014

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The Expert Panel met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Kevin Fiscella and David Nerenz, Co-Chairs, presiding.

PRESENT:

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ANN HAMMERSMITH

KAREN PACE

SUZANNE THEBERGE

* present by teleconference

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

8:31 a.m.

MS. THEBERGE: Good morning,
everyone. We're going to get started.

Operator, can you open the phone
lines?

THE OPERATOR: Okay. One moment.

Okay. I am going to go ahead and
read the introduction. One moment, please.

MS. THEBERGE: Okay. Thank you.

THE OPERATOR: Welcome to the Risk
Adjustment and Socioeconomic Status meeting.
Please note today's call is being recorded and
all public lines will be muted during this
broadcast.

Committee Members, please note
your lines will be open for the duration of
today's call. Please be sure to use your mute
button when not speaking or presenting, and
please do not place the call on hold.

If you need any assistance at
anytime today, please press *, then zero. An

1 operator will assist you.

2 For technical support for today's
3 program, you may send an email to
4 nqf@commpartners.com.

5 Today's meeting will include
6 specific questions and comments period.
7 However, you can submit a question at anytime
8 during today's presentation using the web
9 conference window. To do so, simply type your
10 question to the text chat box area at the
11 lower left corner of the window. Be sure to
12 click Send to send your question directly to
13 our presenter.

14 During the designated public
15 comment period, you will also have the
16 opportunity to ask live questions over the
17 phone by simply pressing *1. These
18 instructions will be repeated later in the
19 program.

20 And now, it is my pleasure to
21 welcome you to the program. Let's get
22 started.

1 MS. THEBERGE: Good morning,
2 everyone, and welcome to the National Quality
3 Forum's Risk Adjustment and Socioeconomic
4 Status or Other Sociodemographic Factors
5 Expert Panel Meeting.

6 Before we begin, I just want to
7 make a quick technical announcement. The
8 webinar number for day one that's on the
9 agenda, there's a typo. The correct webinar
10 number is 400441. That's 400441 for anyone
11 who is on the line and having trouble seeing
12 our slides.

13 So, with that, I am going to go
14 ahead and get started, just do a quick
15 overview of the purpose and scope of the
16 project.

17 My name is Suzanne Theberge. I'm
18 the Project Manager here for this project at
19 NQF.

20 The purpose of this project is to
21 identify and examine the issues related to
22 risk adjustment outcome and resource use

1 performance measures for SES and other
2 sociodemographic factors. And we're looking
3 to this panel to make recommendations
4 regarding if, when, for what, and how outcome
5 and resource use performance measures should
6 be adjusted. And we are focusing on outcome
7 performance measures, outcome performance
8 measures for accountability applications and
9 consideration of SES or other sociodemographic
10 variables as factors for risk adjustment.

11 But we are not going to be looking
12 at specific performance measures, although we
13 do have a panel this morning that will use a
14 couple of specific measures for illustration
15 purposes. We are also not going to focus on
16 adjustments for determining payment for
17 services such as capitated payments, and we
18 are not going to be selecting a particular
19 risk model or approach today.

20 Before we dive into the project, I
21 just wanted to go over the project schedule
22 very quickly.

1 Today is the panel's in-person
2 meeting. We will have two followup conference
3 calls in the next month, one on February 10th
4 and one on February 18th. We will bring the
5 panel back together continue the discussion,
6 to review the draft report that the project
7 team will be working, and to just really
8 continue the discussion.

9 Once we have completed those two
10 calls and written up the draft report, we will
11 go to the NQF member/public comment period,
12 which is a 30-day period from late February
13 through late March. We'll take comments.

14 Following the close of that, we
15 will send all those comments out to the
16 Committee and bring you back together on
17 another conference call in April to discuss
18 the comments, make changes to the report,
19 changes to your recommendations as necessary.

20 NQF's Consensus Standards Approval
21 Committee will review the project on May 13th
22 during a conference call. And then, the NQF

1 Board will review the recommendations in June
2 and put the stamp on approval on those. And
3 we expect to finish this with a final report
4 by June 30th of 2014.

5 All right. Now I am going to turn
6 it over to Karen.

7 MS. PACE: Good morning, everyone.

8 Just before we get into our
9 setting the stage -- and we will -- after our
10 Co-Chairs speak to us, we are going to do
11 introductions of everyone, but we wanted to
12 kind of set the stage before we got into the
13 individual introductions.

14 So, I just want to introduce who
15 is up here. We have Kevin Fiscella and David
16 Nerenz, our Co-Chairs, that we are delighted
17 to have working with us.

18 Next to them is Helen Burstin, our
19 Senior Vice President for Performance
20 Measurement, and Ann Hammersmith, our General
21 Counsel, who also will say a few words when we
22 get into introductions.

1 But I will just ask, before we
2 turn it over to our Co-Chairs, Helen, if you
3 want to make any opening remarks.

4 DR. BURSTIN: Just to say good
5 morning. We will have a chance to discuss
6 this further later, but certainly we recognize
7 how high-profile and how important this work
8 is, and we really thank you for taking the
9 time to review the scads of remarkable
10 materials that all of you suggested. And we
11 really hope to have something that comes out
12 of this that really helps push the issue
13 forward. In a way, it feels like it has been
14 sort of stuck for a while. So, really, thanks
15 to everybody.

16 MS. PACE: And as you have seen
17 from the agenda, we have a very packed agenda.
18 We think we have set the times to allow for
19 lots of discussion and interaction with our
20 expert panel members. But we will try to stay
21 on time and appreciate everyone helping us
22 with that.

1 So, with that, I am going to turn
2 it over to David to start us out. And then,
3 we will go to Kevin after that.

4 CO-CHAIR NERENZ: Well, thanks and
5 good morning.

6 I will make one observation. We
7 are already ahead of schedule. This may be
8 the only time. So, enjoy it for the moment
9 while it lasts.

10 (Laughter.)

11 Thank you for being here. I think
12 we are addressing a very significant issue.
13 You have all taken time from very busy
14 scheduled to be here and we do appreciate it.

15 All of us are here because we have
16 some important perspective on the issue in
17 front of us, some domain of expertise that NQF
18 wanted to include in the discussion. So,
19 you're here because you're special, and we
20 appreciate that.

21 Just a few things about how we
22 think about today's work in the larger

1 context.

2 The overall task in front of us
3 has already been described. I think, as we go
4 along, we will probably develop a little
5 clearer sense of exactly what is within the
6 target of our discussion, what might be
7 outside, and I suspect once in a while we will
8 probably deviate a little bit out to make a
9 point or two, and then, come back in. Our job
10 is to try to keep those deviations at least
11 generally on point. We will try to do that.

12 But a little more specifically,
13 our main task is to develop a set of
14 recommendations. The recommendations are
15 important. They, presumably, will influence
16 NQF policy in this domain. NQF, in turn, I
17 think as you all know, has a very important
18 role, particularly with regard to CMS and what
19 CMS does in its various performance
20 measurement programs.

21 Much of this is set in law in the
22 Affordable Care Act. But, even if it wasn't,

1 still, the policies and positions of NQF and
2 the technical specs of the endorsed measures
3 have great influence throughout CMS and
4 elsewhere. So, we are taking up an issue that
5 is part of that process.

6 Our task in front of us is to
7 examine, first of all, associations between
8 various SES variables and performance
9 measures, either as individual examples or as
10 a class, and then, to develop recommendations
11 about, first of all, whether some set of SES
12 variables should be included in adjustment
13 models. And then, if the general answer to
14 that would be yes, then there are all the
15 detailed questions of how, when, which
16 measures, which variables, which models.

17 In two days, we cannot possibly
18 work through all the details. As Suzanne
19 said, our task is not to go measure by
20 measure, detailed model choice by detailed
21 model choice. We really are being asked to
22 work at the level of general principles, so

1 that details can follow, either after this in-
2 person meeting to some extent or even after
3 that, in the hands of the measure developers
4 and the other NQF panels who look at
5 individual measures and their parameters.

6 So, in our two days here together
7 in person, much of the agenda today is on some
8 expert presentations, where we will get some
9 information. Much of it will be new to many
10 of us or at least it will be designed to
11 illustrate certain points, either about the
12 relationship between SES variables and some
13 set of performance measures or, then, about
14 some of the technical details; for example,
15 about where these data might come from or
16 about how they might be included in an
17 adjustment model.

18 The object here is not to
19 immediately point to something and say, "Yes,
20 this is right. This is the answer," but to
21 say, "Here are a range of things that we think
22 are important and that we should consider."

1 So, I think our task through much of the first
2 day is to listen, to ask clarifying questions,
3 perhaps to challenge a bit about
4 interpretation. But, as we go through much of
5 today's agenda, we are not seeking to decide
6 or specifically endorse something that a
7 person is presenting.

8 Okay. I guess we move to the next
9 slide.

10 So, rules of the game. I think
11 just about everyone here has been in many
12 groups of this types. Although some of us
13 know each other, we are barely acquainted and
14 some of us are just, frankly, strangers to
15 each other. We don't have a lot of time to
16 get to know each other.

17 For those of you who have been on
18 IOM committees that meet five or six times
19 over a year and a half, you can appreciate
20 that that pace is quite a bit of different.
21 Often, in that time you spend the first
22 meeting just basically getting to know each

1 other. You develop some trust. You develop
2 a sense of where people are coming from. We
3 don't have a lot of luxury for that. We are
4 going to have to just move right through into
5 the more substantive agenda.

6 So, a few requests I think are
7 straightforward. First of all, listen with an
8 open mind. Understand that those people who
9 are here are here because they are experts of
10 one type of another. When we may disagree,
11 let's disagree in a polite, professional
12 fashion. I don't know that we can get the
13 police up here rapidly to break up fist
14 fights. I hope none occur.

15 (Laughter.)

16 So, we are not really set up for
17 that.

18 I think, again, we are here as a
19 group of colleagues. I think what we seek to
20 do is to identify the common ground that can
21 serve, then, as the basis for a set of
22 recommendations that, presumably, all of us,

1 then, at the end feel like we can endorse.
2 Again, there may be details in how this all
3 rolls out where we still have some differences
4 of opinion, but I think our task, at least
5 from the front of the room here, is to try to
6 find those areas of common ground, try to help
7 work through some areas of disagreement, if we
8 think we can, and then have that be the core
9 of what we report out.

10 Okay. Is this our --

11 MS. PACE: We just wanted to
12 remind people about some of the definitions
13 that we are using in the project. We talked
14 about these on the conference call, and they
15 are in your materials. So, we don't have to,
16 obviously, read through these, but just wanted
17 to kind of keep us grounded on some of our
18 definitions. So, I think we can quickly move
19 through those.

20 The next one.

21 CO-CHAIR NERENZ: Okay. Well,
22 yes, clearly, again, the task here is not to

1 read these slides. That's a horrible abuse --

2 MS. PACE: Right.

3 CO-CHAIR NERENZ: -- of people in
4 a room to read what's --

5 MS. PACE: Right.

6 CO-CHAIR NERENZ: -- on a
7 PowerPoint slide.

8 But if we could just actually back
9 up to the previous slide, I think a point to
10 make about that, our charge is not
11 specifically about disparities. It is really
12 about measurement and, a little beyond that,
13 it is about the accuracy, I'll call it
14 accuracy and informative nature of the
15 measures, and how SES plays into that.

16 The current NQF position really
17 does speak, though, to disparities. It says
18 that adjustment for SES can have the effect of
19 masking disparities and, therefore, that is a
20 concern. So, I think we just need to keep
21 that in the back of our mind as we go through
22 the discussion, recognizing that there are

1 both health and healthcare disparities that
2 are somewhat different in nature, and that the
3 context that we enter into about SES
4 adjustment includes concern about the effect
5 of adjustment on disparities or, presumably,
6 the effect of lack of adjustment on
7 disparities. And we will certainly discuss
8 that. Okay?

9 MS. PACE: Next slide.

10 CO-CHAIR NERENZ: Now the word
11 "outcome" was in Suzanne's discussion. I
12 think that's worth a little special emphasis.
13 There can be some fuzziness around the edge of
14 what's outcome; why do we even talk about
15 outcome?

16 In general, my sense in the domain
17 of performance measures is that we tend to
18 think about adjustment, including potentially
19 SES adjustment, a little more in the domain of
20 outcomes than we do in some of the healthcare
21 process measures. That is not universally
22 true. It is not strictly true. But it tends,

1 all else equal, to be true.

2 And that is because there are some
3 process measures where the thing being
4 measured is so mechanical that the right thing
5 can be done virtually all the time for
6 essentially any patient. And so, you just
7 don't think a lot about adjustment. Or
8 whatever is necessary for adjustment is just
9 defined by how you define the denominator
10 population.

11 But, more frequently in the domain
12 of outcomes, other factors, other causal
13 pathways play into the eventual measure
14 performance. And some of them have to do with
15 comorbidity and clinical severities, but some
16 of them may have to do with these SES
17 variables that we are talking about.

18 So, that is the reason why the
19 word "outcome" is put in the framing. I
20 suspect that we may in our discussions bring
21 up examples of performance measures that may
22 not be strictly outcomes, at least in the

1 Donabedian sense, but we will at least try to
2 remember that this is the domain in which what
3 we talk about probably matters most.

4 Just at the bottom of this slide,
5 we point out that there are some outcome
6 measures that may be expressed as cost. And
7 this something where people can debate the
8 semantics, but at least we make the point here
9 that there are some performance measures that
10 get expressed in dollar terms that at least
11 are in the scope of what we are talking about.

12 I don't think we need a lot of
13 definition here, except maybe to point out
14 that, even though the general concept of risk
15 adjustment can have different meanings, there
16 are different statistical methods, there are,
17 say, stratified reporting approaches that some
18 people may quibble and say, well, that is not
19 really adjustment at all; I mean, you haven't
20 really done any mathematical manipulation of
21 anything. You've just taken a measure and
22 sort of broken it out.

1 But, essentially, we are talking
2 about a conceptual issue here of accounting
3 for or working with variants that may
4 otherwise create some distortion or some
5 inaccuracy of interpretation of a performance
6 measure.

7 And I don't know; again, you can
8 read faster than I can talk, and these were
9 all discussed in our conference call, anyway.
10 So, I guess we would just say, if there are
11 any points of lack of clarity or questions,
12 this might be the time. But I think that we
13 covered this already in the first phone call.

14 MS. PACE: All right? Okay, we
15 will move on to Kevin.

16 CO-CHAIR FISCELLA: For me, this
17 question has had my head spinning. I mean, it
18 really is a daunting task.

19 And so, to try to clear up some of
20 the fuzziness, I began mapping out the two
21 different pathways in my head. And I thought
22 I would share it with the group.

1 So, the task before us is the
2 question placed very simplistically: adjust
3 the quality metrics for SES or not? So, if we
4 go yes -- yes, these are going to be very fast
5 slides -- we worry about a two-tier system,
6 which, in turn -- next slide, please -- brings
7 up some of the concerns that David mentioned:
8 masking disparities, setting a lower bar for
9 those with lower SES, and either masking or
10 even fostering institution or individual bias.

11 This, in turn, could cause
12 healthcare disparities to drop off the public
13 agenda, after they have been on there for more
14 than a decade now, and create lower
15 expectations of care, ultimately, resulting in
16 worse care and, in turn, either healthcare
17 disparities persist or worsen.

18 So, I think the pathway at the
19 top, and I think later on, if folks have
20 additional concerns, I think these should be
21 added to the top pathway. The bottom pathway,
22 the no pathway, is a bit more complex. You

1 know, at a very basic level, there is the
2 potential that the quality measures could be
3 perceived as invalid, which, in turn, could
4 undermine -- next slide, please -- undermine
5 confidence in the metric itself.

6 But a bigger concern really is
7 that providers and organizations serving large
8 low SES populations might, on average -- and,
9 obviously, we can all think of exceptions --
10 have worse performance metrics. Well, why
11 might this happen?

12 Two reasons. One is greater
13 population need, and the second is fewer
14 organizational resources. In organizational
15 resources, we mean things like resources to
16 fund quality improvement or Lean Six Sigma,
17 funding for patient enablement services and
18 language translation, low health literacy, et
19 cetera. Training needs, level of IT, and
20 electronic health information technology, and
21 time needed to train and transform systems.

22 So, if we think about population

1 need and we think about resources, the risk is
2 that in providers of the disadvantaged that
3 there is a potential mismatch between need and
4 resources. And so, that residual, that
5 difference, when you don't have the resources
6 to address a need, some type of healthcare
7 disparity may often show up and some of it
8 will be captured through metrics.

9 Next slide, please.

10 So, some of the unintended
11 consequences -- I think a lot of us have
12 thought about this, and it was raised in the
13 first call, of course -- is worse payment with
14 P4P, pay for performance, which, in turn, can
15 undermine -- next slide, please -- fewer
16 organizational resources, which, in turn, can
17 affect quality of metrics.

18 So, one has a cycle, a feedback
19 cycle, that actually can worsen. A similar
20 feedback cycle would be contractors and
21 patients. If they see that the performance is
22 worse for safety-net providers, they may avoid

1 contracting or avoid obtaining care there,
2 which, in turn, could lead to fewer
3 organizational resources, which could set up
4 a cycle back with patients and contractors
5 avoiding it because the resources are fewer,
6 as well as affecting the quality metrics
7 itself.

8 Next slide, please.

9 And a third potential consequence
10 would be -- next slide -- would be that the
11 providers avoid lower SES patients and
12 populations, which, again, could result in
13 fewer organizational resources. If you have,
14 for example, disciplines from a certain
15 provider who are avoiding an organization
16 because they don't have the equipment and
17 resources needed to do that, now you have a
18 resource problem and a difficulty in
19 addressing that need.

20 Okay. And again, we have got the
21 same concern here. Healthcare disparities
22 persist or worsen with this pathway.

1 So, let's briefly decompose need
2 and resources. Next slide, please.

3 So, what do we mean by need? One
4 is -- and I think this came up on the first
5 conference and we will have some talks that
6 will address this -- worse health among
7 patients with lower SES. Why worse health?
8 Worse health based on a number of different
9 factors.

10 Next slide, please.

11 These include early life factors,
12 actually, beginning oftentimes even before
13 birth; epigenetic factors many of you are
14 quite familiar with, the cumulative lifelong
15 effects of stress, material deprivation,
16 psychological and behavioral factors.

17 Next slide, please.

18 Another key pathway, in addition
19 to the health pathway, is what I have labeled
20 here as access and adherence factors.

21 Next slide, please.

22 And these are factors that we are

1 all familiar with among low SES populations:
2 the ability to afford care, levels of patient
3 activation, health literacy and numeracy,
4 limited English proficiency, differences in
5 culture, lack of social support either within
6 the family or in the community, homelessness,
7 and even the stress and skepticism of
8 providers in medical institutions.

9 And these factors are compounded
10 because, by definition, safety-net providers
11 serve and have a concentration of low SES
12 patients within these providers, basically,
13 for two reasons.

14 Next slide, please.

15 One is a concentration
16 geographically to the socioeconomic
17 residential segregation. And the other is
18 organizational mission itself to serve the
19 underserved.

20 Next slide, please.

21 In terms of organizational
22 resources, we are all familiar with it. More

1 uninsured and, also -- next slide, please --
2 the payment distribution, lower payments
3 through Medicaid and Medicare relative to
4 private payers.

5 Next slide, please.

6 Some additional issues include
7 systematic measurement area. This gets -- and
8 I think some of the talks will address this --
9 unaccounted disease severity through
10 traditional case mix adjustment, which often
11 doesn't directly measure severity, but rather
12 diagnoses.

13 And the ICD and CPT coding bias,
14 meaning that oftentimes the underserved have
15 fewer visits and, as a result, may have fewer
16 codes for that visit. They may utilize
17 healthcare less, undergo fewer procedures,
18 which can introduce, if you use ICD-9 and CPT
19 coding, you may underestimate either the
20 disease severity or even comorbidity.

21 Next slide, please.

22 So, very briefly, mapping this

1 out, one can begin to see -- and I am not
2 necessarily proposing all of these, but these
3 are just examples of opportunities to begin
4 thinking about "both/and" rather than an
5 "either/or" to the basic question. One is
6 organizational stratification; another is --
7 next slide, please -- individual-level patient
8 stratification. I think David alluded to some
9 of these.

10 Next slide, please.

11 The issue of whether the
12 methodology should be different or the same,
13 depending on the purpose; whether for payment
14 should be the same; for reporting, whether it
15 should or should not be.

16 Next slide, please.

17 Whether the type of payment should
18 be different; for example, pay for improvement
19 rather than pay for performance.

20 Next slide, please.

21 Minimize concentration of
22 disadvantaged.

1 Next slide, please.

2 Improve adjustment for disease
3 severity, which accounts for some of the
4 variance in SES.

5 Next slide, please.

6 And beginning to develop
7 intermediate measures for access and adherence
8 barriers.

9 Next slide, please.

10 And ultimately, at the back-end --
11 and we are not going to focus on this
12 explicitly -- is improve equity in payment.
13 That is actually leveling the playing field.

14 Next slide.

15 So, I thought I would put this out
16 there, just as background for people to think
17 about some of the potential pathways, and
18 perhaps, as we move on, later on people can
19 add or subtract to some of these pathways.
20 But, hopefully, there is a common language in
21 the potential consequences of going down each
22 path and at least some preliminary thoughts on

1 them, on where one might seek a "both/and".

2 MS. PACE: Okay. Thank you very
3 much.

4 Sorry about the technical glitch
5 there.

6 What we wanted to do next was to
7 really go through and have all of the expert
8 panel introduce themselves. And as part of
9 that, we will be asking you a couple of
10 things.

11 One is who you are; you are a
12 physician, an organization. We will be asking
13 you tell us about your disclosure of
14 information that you submitted when you were
15 in the nomination process. And Ann
16 Hammersmith will tell us a little bit more
17 about that.

18 But, then, we really want you to
19 also -- we have enough time here that we want
20 you to tell us what your perspective is on
21 this issue, not in great detail, but kind of
22 if you have a current thought or position, we

1 really want to get those out on the table.

2 But, as David said earlier, we know everybody
3 came with thoughts about this, so we might as
4 well share those and be aware of those.

5 But to ask people, also, to kind
6 of suspend final judgment until we
7 collectively examine the issues and think
8 about potential solutions.

9 So, before we start, I am going to
10 ask Ann to go through our usual disclosure
11 information.

12 So, Ann?

13 MS. HAMMERSMITH: Good morning,
14 everyone.

15 As Karen said, those of you have
16 been on our committees before are probably
17 familiar with this process, but it is very
18 important. So, we go over it every time,
19 remind you of a few things, and give you some
20 guidelines for the disclosures that we look
21 for you to make this morning.

22 If you recall, you all filled out

1 probably the electronic version of our new
2 disclosure-of-interest form, where we ask even
3 more detailed questions. And we thank you for
4 doing that.

5 We do not expect you this morning
6 to recount your resumes. In fact, we wish you
7 wouldn't because we will be here all day. So,
8 we are only looking for you to disclose things
9 that are relevant to the work of the
10 Committee. So, if you have engaged in
11 research, consulting activities, speaking
12 engagements, if you have received grants, if
13 you have done any advocacy or lobbying work
14 that is connected to the topic before the
15 Committee today and tomorrow, we would look
16 for you to disclose that.

17 The other thing I want to remind
18 you of is, just because you disclose, it does
19 mean you have a conflict of interest. Part of
20 the point of this process is to get things out
21 on the table, so everybody understands your
22 background, where you are coming from, and

1 that we are completely open and transparent in
2 our process.

3 Many times people will say, "I
4 have no conflicts," which is great. You may
5 not, but, then, they seem to think they don't
6 have to disclose anything. And you may not
7 need to disclose anything, but what we don't
8 want you to do is look at your disclosure
9 narrowly as only I have a conflict; I don't
10 have a conflict. We are looking for you to
11 disclose openly.

12 The other thing I want to remind
13 you of is that you sit as individuals.
14 Sometimes people, entirely well-meaning, will
15 say, "I'm Susie Smith and I represent the
16 American Society of" fill in the blank. And
17 actually, you don't, not on a Committee like
18 this. You sit as individuals. You're here
19 because you're expert. So, you don't
20 represent the interest of your employer. You
21 don't represent the interest of anyone who may
22 have nominated you to serve on the Committee.

1 And then, finally, we're not just
2 interested in things that you do where money
3 has changed hands. People will often say,
4 entirely in good faith, "I have no financial
5 disclosures" or "I have no financial
6 conflicts," which is great. But because of
7 the nature of the work we do, we are also
8 interested in your disclosure, if applicable,
9 of things that you did where no money may have
10 changed hands. You may have done it as a
11 volunteer. You may have sat on a committee.
12 And all those types of things are relevant to
13 the work that you will do on the Committee.

14 So, that is my two-minute summary
15 of the conflict-of-interest process. Again,
16 I want to remind you that you only need to
17 disclose things that are relevant to the work
18 that the Committee will be doing.

19 And, Dr. Nerentz, did you want to
20 add anything before we go around? Okay.

21 CO-CHAIR NERENZ: Well, again,
22 good morning.

1 I'm David Nerenz. I'm from the
2 Henry Ford Health System in Detroit. I have
3 a couple of job titles there, but the one
4 relevant is I'm Director of our Center for
5 Health Policy and Health Services Research.

6 I have spent much time in the last
7 20 years working on issues of healthcare
8 disparities, particularly racial and ethnic
9 disparities, in the context of managed care
10 plans, basically, seeking to reduce and
11 eliminate disparities in HEDIS measures. I
12 think I've got a strong record, concern about
13 disparities and advocacy for work against
14 them.

15 And from that platform, I am very
16 concerned about the possible effects of risk
17 adjustment, of SES adjustment, on disparities.
18 But I am concerned about the effect of the
19 absence of adjustment on disparities. So,
20 both of them are present in my mind through
21 the past that Kevin described.

22 Our organization has hospital,

1 medical group, health plan, home health, other
2 components. There is probably not a
3 performance measure on earth that does not
4 affect that organization in some way. And so,
5 I at least have exposure to a lot of the
6 domain.

7 I am also a MedPAC Commissioner
8 and was part of the approval process for the
9 MedPAC recommendation about stratification of
10 the hospital readmission measure that is part
11 of our background reading material. So, at
12 least in that sense, I am formally on record
13 in favor of that particular approach in that
14 particular measure.

15 CO-CHAIR FISCELLA: Good morning.

16 I'm Kevin Fiscella. I'm a family
17 physician/researcher at the University of
18 Rochester. Actually, all my clinical work has
19 been in federally-qualified health centers.
20 My research has largely focused on healthcare
21 disparities and strategies to mitigate them.

22 In terms of conflict of interest,

1 I mentioned, possibly related, I am on the
2 National Commission for Correctional
3 Healthcare -- I'm on the Board of Directors --
4 because they do certify the healthcare quality
5 in jails and prisons.

6 I can't think of any other
7 conflicts of interest.

8 Oh, yes, as you can tell from the
9 slide, I am very torn. Like David, I am
10 concerned about both potential pathways.

11 I am really excited that we have
12 really such an esteemed panel and really
13 smart, creative people here to come to help
14 resolve this dilemma.

15 MS. PACE: Before we move on to
16 the panel here, I just want to check in. We
17 have two people that are on the line, to make
18 sure they are there.

19 Marshall Chin, are you on the
20 line?

21 MEMBER CHIN: Yes, thank you.

22 MS. PACE: And why don't you go

1 ahead and introduce yourself? And then, we
2 will go to Mary Beth.

3 MEMBER CHIN: My name is Marshall
4 Chin. I'm a general internist at the
5 University of Chicago, a health services
6 researcher. I do mostly disparities research
7 in the safety net.

8 One of our grants that just ended
9 came from the Merck Foundation, which is a
10 philanthropic foundation funded by the Merck
11 company on business disparities. As part of
12 that, we made some Hill visits to
13 congressional staff and Members, educating
14 multi-business disparities.

15 Some of my collaborative work
16 involves groups that will be affected by,
17 essentially, risk adjustment, including the
18 National Association of Community Health
19 Centers and America's Essential Hospitals. At
20 the University of Chicago, about our third of
21 our patients are Medicaid patients.

22 Sorry I can't be there. The D.C.

1 airport is closed because of fog last night.
2 So, we were rerouted back to Chicago. But I
3 am looking forward to participating.

4 MS. PACE: And do you want to
5 share anything about your current perspective
6 about adjusting for sociodemographic factors?

7 MEMBER CHIN: Yes. Thank you for
8 that.

9 First, I thought Kevin's summary
10 was brilliant. It will cover, I think, the
11 vast majority of issues we are going to
12 discuss over the next couple of days.

13 One thing is that I'm the
14 disparities representative on the NQF Measures
15 Applications Partnership Coordinating
16 Committee, which is one of the umbrella
17 organizations within NQF. One of my concerns
18 throughout has been that, especially for
19 disparities, the issues that are importantly
20 potentially go beyond -- I know David and
21 Kevin mentioned what is the scope of NQF. So,
22 in particular, many of the issues I think that

1 Kevin put on the slide really start getting at
2 the implementation end of things, as opposed
3 to purely measure selection or risk adjustment
4 per se.

5 And so, I guess one of my concerns
6 going into the meeting is that we truly
7 address the important issues, because I think
8 that some of them will start getting into this
9 gray zone about what/where within our scope.
10 But, unless we do address them in some way,
11 the Committee's work really won't be fruitful.
12 And so, I do think we need to explicitly think
13 about how can we make sure that we do address
14 the issues that are important within the
15 constraints that we have.

16 MS. PACE: Okay. Thank you.

17 And, Mary Beth Callahan, are you
18 on?

19 MEMBER CALLAHAN: Yes, I am. Can
20 you hear me?

21 MS. PACE: Yes.

22 MEMBER CALLAHAN: Good, good.

1 I am a nephrology social worker
2 and have worked in dialysis and transplant for
3 about 30 years. I guess in terms of
4 disclosure, nothing financial, but I have
5 worked with the National Kidney Foundation and
6 Counsel of Nephrology Social Workers in terms
7 of their KDOQI guidelines, two of them, in
8 particular.

9 I sat on the panel for preemptive
10 transplant. And in that regard, there are
11 certainly some considered financial
12 disparities in who can get on a transplant
13 waiting list because, within insurance, of
14 course, a person can't get on a transplant
15 waiting list. And the other KDOQI guideline
16 would be hypertensive and anti-hypertensive
17 agents in chronic kidney disease.

18 And then, also, I worked with a
19 task force of the Texas Medical Foundation on
20 a Dallas Advisory Group to improve kidney
21 testing among African-Americans with diabetes.
22 And the idea there was to improve

1 microalbuminuria testing for patients
2 identified in certain zip codes that were
3 thought to not be able to get testing who had
4 diabetes.

5 Additionally, I work with the
6 Society for Transplant Social Workers and
7 Public Policy, and have worked with public
8 policy with the National Kidney Foundation, so
9 that as a disclosure.

10 From a social work perspective, I
11 think a couple of things. Of course, we all
12 probably know that, when insurance is limited,
13 whether that be because of lack of insurance
14 or because premiums are too high or because
15 deductibles are too high -- last year I had
16 someone with a \$15,000 deductible -- decisions
17 are going to be made between healthcare and
18 food or medicines. And so, that is just out
19 there.

20 Sometimes it has been my
21 experience that somebody who has Medicare and
22 Medicaid, whether that is Medicaid Q and B or

1 regular Medicaid, has better access to
2 healthcare than someone with an employer group
3 health plan, because with Medicare Q and B
4 everything is paid for. Now there could be
5 issues with access in terms of who will accept
6 that, but I just wanted to get that out there
7 in terms of my thinking.

8 And then, the last thing is that I
9 think that, when there are multiple
10 socioeconomic risk factors, cognitive capacity
11 becomes a more significant issue in managing
12 the whole situation.

13 There is one more disclosure. I
14 wrote a chapter in a book titled, Kidney
15 Transplantation: A Guide to the Care of the
16 Kidney Transplant Risk Event, and the chapter
17 title was "Socioeconomic Issues and the
18 Transplant Recipient". And I wrote that with
19 Dr. Connie Davis.

20 So, thank you.

21 MS. PACE: Okay. Thank you.

22 So, now we can go around the room,

1 and maybe, Nancy?

2 MEMBER GARRETT: Good morning,
3 everybody.

4 I'm Nancy Garrett. I'm the Chief
5 Analytics Officer at Hennepin County Medical
6 Center, which is a safety-net care provider in
7 Minnesota. So, Hennepin County that
8 Minneapolis is located in. And so, I lead
9 analytics and information technology at
10 Hennepin County Medical Center.

11 I don't have any disclosures.

12 And in terms of my thinking on th
13 is, it has kind of evolved over my care, I
14 would say. So, a lot of my career has been at
15 health plans. I'm a sociologist and
16 demographer by training. And so, like David,
17 I have worked on issues of disparities for a
18 lot of my career. I helped create a system
19 for collecting race and ethnicity data at
20 HealthPartners, which is a provider and a
21 health plan, and also worked at a health plan
22 to try to start collecting that data as a

1 first step toward starting to address
2 disparities.

3 And I served on the Board of
4 Minnesota Community Measurement, where we also
5 set up systems for developing quality and cost
6 measures in the State. And I was really
7 concerned at that point of masking
8 disparities, as Kevin so nicely outlined those
9 risks.

10 And now, with this new perspective
11 of working with a safety-net population, I am
12 really concerned if we don't start to address
13 it. And one of the reasons is because of the
14 fact that payments are increasingly being tied
15 to performance. And I feel that if we don't
16 address it, we are really missing an
17 opportunity.

18 And just having interacted with
19 our patient population and really seeing
20 examples of a patient, for example, who was in
21 our hospital recently with community-acquired
22 pneumonia and was medically stable, ready to

1 be discharged, but we were going to be
2 discharging him to a homeless shelter and it
3 was January, and they kick them out in the
4 middle of the day. And so, he would be
5 wandering around and it's 10 below. Is that
6 a good medical decision?

7 And so, how do we get the
8 resources to be able to manage those social
9 conditions that are so interrelated? So, I am
10 concerned that, if we don't address this
11 issue, we are not going to be able to take
12 care of the populations adequately.

13 I think the one additional thought
14 I will throw in about the way we have
15 structured the day is, you know, specifically,
16 we said our scope is not to talk about
17 payments and capitation. But the thing is
18 that the cost and resource use measures are so
19 related to that.

20 So, in Minnesota the cost and
21 resource use measures that NQF endorses are
22 actually used in shared savings programs, and

1 they are directly connected. So, it is neat
2 to kind of sort of divide that, but I don't
3 know if we really can because that is all part
4 of what we are doing here.

5 So, thank you.

6 MEMBER SUGG: Hi. I'm Nancy Sugg.
7 I am an Associate Professor of Medicine at the
8 University of Washington and I am a primary
9 care internist working at Harborview Medical
10 Center. I am the Medical Director for the
11 homeless programs there.

12 So, the first disclosure is I work
13 for a State university. And then, I also sat
14 on the Seattle Council to look at outcomes for
15 grants done by Seattle specifically to the
16 safety-net population.

17 So, a few thoughts. One is, when
18 I look at disparities, I definitely like to
19 look at non-adjusted data because I think it
20 does shine light on important things. But
21 when I look at quality measures, I really want
22 to have socioeconomic adjustments made to

1 that.

2 I think it is really difficult to
3 look at quality and not really be able to
4 compare apples to apples. When I think about
5 looking at quality, though, I want to make
6 sure that we know the measures are not going
7 to be perfect, but I think they can be
8 somewhat accurate. But I think it is very
9 important to be able to say why they will or
10 will not be accurate.

11 So, I think of it much like why I
12 order a lab test. I know that there are
13 certain things that will make it a false-
14 positive and there are certain things that
15 will make it a false-negative. And so, I
16 would like downstream of this process to be
17 able to make sure that, when we come up with
18 measures, that we are able to clearly say
19 these are things that you can use these
20 measures for and these are things that you
21 cannot use these measures for, and these are
22 the limitations and this is why.

1 And that will make me feel better
2 that downstream, when these things are looked
3 at for things like pay for performance or
4 physician quality program records, where they
5 actually put you on the web and say this is
6 your quality performance, that we can really
7 say, no, that it is not a legitimate use of
8 this measure or, yes, this is a legitimate use
9 of this measure.

10 Thank you.

11 MEMBER BHAREL: Hi. Good morning,
12 everyone.

13 My name is Monica Bharel. I'm the
14 Chief Medical Officer at Boston Healthcare for
15 the Homeless Program in Boston, Mass, and
16 Nancy and I don't know each other, but I think
17 our souls must be connected because I happened
18 to sit right next to her.

19 (Laughter.)

20 So, disclosures, so that I don't
21 forget them. I serve on a couple of
22 subcommittees that might be relevant,

1 including the National Healthcare for the
2 Homeless Council of Policy and Clinical
3 Committee on the Mass League of Community
4 Health Centers Policy and Clinical Committee.

5 And I also, through my
6 organization, do lobbying work at the
7 Massachusetts Medicaid level on risk
8 adjustment for homeless as a risk indicator.

9 In terms of my association, so I
10 am at Boston Healthcare for the Homeless. My
11 academic associations are at Mass General
12 Hospital, HMS, HSPH, and Boston Medical
13 Center. I am a primary care generalist by
14 training and have worked extensively in
15 different safety-net groups.

16 As for the question at hand, I do
17 believe we should adjust quality metrics for
18 SES. And additionally, I believe that we
19 should look outside of traditional realms of
20 how SES is defined, at indicators such as
21 homeless status. However, I do believe that
22 I think we could spend the entire time looking

1 at Kevin's slide, which really got to the meat
2 of the information. I do believe it's the
3 devil is in the details of how including
4 things like organizational stratification and
5 pay for improvement are critical.

6 Thank you.

7 MEMBER GROVER: Good morning,
8 everyone.

9 I am Atul Grover. I am the Chief
10 Public Policy Officer at the Association of
11 American Medical Colleges and, quite frankly,
12 familiar with most of the people and
13 institutions that have already spoken because
14 they're all our members, whether it is Henry
15 Ford or University of Washington or Boston
16 Medical Center. And so, these are the issues
17 we hear about all the time.

18 I am, by background, a general
19 internist and health services researcher. And
20 certainly, from my own clinical experience, I
21 know how frustrating it is, inpatient or
22 outpatient, to have to deal with factors that

1 largely are beyond your control.

2 And I think, you know, my own sort
3 of personal perspective, having lobbied on the
4 ACA on behalf of med schools and teaching
5 hospitals, who, by the way, do take a
6 disproportionate share of the care of the
7 underserved, both the charity care as well as
8 Medicaid patients and medically-complex, is
9 that it was really remarkable that we spent so
10 much time thinking about how to push all the
11 levers on the hospital to improve care and
12 adjust for quality and outcomes, when so much
13 of the care that we are looking to really
14 improve and that is actually delivered in the
15 community is outside those four walls.

16 And so, how do we come up with
17 measures and metrics that adjust for what
18 happens when that patient leaves, whether they
19 are going to a homeless shelter or whether
20 they have a dual diagnosis or other factors?

21 And we also spend a lot of time
22 thinking about how we improve disparities,

1 certainly have a long history in many of our
2 institutions of distrust by the communities
3 that they serve. And how do we improve those
4 relationships and improve outcomes for those
5 communities?

6 But, again, I just sort of
7 generally feel at my core that we need to find
8 ways to at least adjust in some way without
9 entrenching those disparities. And I think
10 everyone has really reinforced what Kevin laid
11 out for us; find ways to level the playing
12 field while at the same time not keeping our
13 eye off the ball of saying, you know, we don't
14 want to really relegate anyone to the dust bin
15 of the second or third tier of healthcare.
16 And I don't come in with any answers of how to
17 do that, but I do think it is very important
18 we try to do our best to find a way.

19 MEMBER LIPSTEIN: Good morning.

20 My name is Steve Lipstein. I'm
21 the President and Chief Executive of BJC
22 HealthCare in St. Louis.

1 I'm a little bit intimidated in
2 this audience because I'm not a doctor, I'm
3 not a researcher, and I don't have any
4 academic rank.

5 (Laughter.)

6 So, I'm sitting here, as we
7 started the introductions, thinking, why am I
8 here? And so, my disclosures are that I do
9 serve on the Boards of Trustees at Emory
10 University and Washington University. I serve
11 on the Board of Governors of the Patient-
12 Centered Outcomes Research Institute, and I
13 think there's a PCORI-funded investigator
14 somewhere in the room.

15 And I'm a previous Director of the
16 St. Louis Federal Reserve Bank, which probably
17 has some influence on why I am here because
18 what interlaces with this whole issue of
19 socioeconomic status risk adjustment is human
20 behavioral economics and how people are going
21 to respond to the presence or absence of risk
22 that is or is not adjusted for.

1 So, those are my disclosures.

2 I think what gives me keen topical
3 interest, as the head of a health system, is
4 that with BJC HealthCare we have 12 hospitals,
5 and two of those hospitals are located in
6 rural communities, one of which is a critical
7 access hospital. Four of those hospitals are
8 located in suburbia. Three of those hospitals
9 are large community medical centers, one in a
10 very affluent section of St. Louis and one in
11 a very -- I don't know if this is the right
12 word, David -- unaffluent, inaffluent --

13 CO-CHAIR NERENZ: We get the
14 point.

15 (Laughter.)

16 MEMBER LIPSTEIN: You get the
17 point. And then, two of these hospitals are
18 big teaching hospitals, and the rest are non-
19 teaching hospitals. So, think large and
20 small, teaching and non-teaching, urban and
21 rural, pediatric and adult.

22 And as I was looking at Kevin's

1 diagram, the socioeconomic status, risk
2 adjustment, yes or no, the yes pathway is a
3 hypothetical; the no is what I'm living.
4 Okay?

5 And since the no is what I'm
6 living, and we study outcomes across all 12 of
7 our hospitals in great detail, using health
8 information management databases, which we
9 used to call medical records, as opposed to
10 claims datasets or the Medicare professional
11 analysis review MEDPAR, we have come to learn
12 that what you know through studying patients
13 in MEDPAR doesn't give you a complete picture
14 of the patient. You are working with
15 incomplete data.

16 And when you work with incomplete
17 data, you don't get an incomplete answer. In
18 our view, you get the wrong answer. So, if
19 you take three plus five plus "X" and you say,
20 well, the answer is eight and what we don't
21 know -- we know the answer is not eight. And
22 so, trying to work with more complete data to

1 understand outcomes has become kind of a
2 passion of ours.

3 And so, I will share with you and
4 disclose that two of our twelve hospitals pay
5 pretty significant penalties for high
6 readmission rates and ten do not. And we
7 spend a lot more money on trying to prevent
8 avoidable readmissions at those two than we do
9 at the other ten.

10 So, as you know, many hospitals
11 are out there hovering for 30 days post-
12 discharge over patients, and we are trying to
13 understand. And so, one of the things that is
14 interesting to us a little bit is that, if we
15 don't know what happened to the patient,
16 meaning they weren't readmitted within 30
17 days, if we don't know what happened to the
18 patient, we think that is a good outcome. But
19 if we do know what happened, they were
20 readmitted, or we do know other things about
21 them, we are not sure that is a good outcome.

22 And so, just to kind of finish

1 this up, since I know you don't want me to go
2 on too long, one of the things we know about
3 our 12 hospitals is that they are located in
4 very geography, as described in empirical data
5 by Census-tracked information.

6 And so, what we have learned is
7 that the individual income of the patient
8 isn't determinative of many outcomes, but
9 where they live has great influence. And so,
10 if you live in a community that doesn't have
11 grocery stores or doesn't have drug stores or
12 doesn't have laundromats or doesn't have
13 taxicab stands or public transportation, that
14 that plays a significant role in the outcome
15 that happens after a patient is discharged
16 from the hospital.

17 And so, we serve all those
18 different kinds of communities, and we can
19 compare with BJC what happens from an outcomes
20 perspective. And then, what we try to figure
21 out is, okay, once we know what happens from
22 an outcomes perspective within BJC, what

1 happens across our State, what happens across
2 our country.

3 But one of my aha experiences in
4 all this was when I joined the Patient-
5 Centered Outcomes Research Institute Board, at
6 my first dinner I sat next to Harlan Krumholz,
7 who is also on that Board, who actually knows
8 a little bit about readmission rates and a
9 little bit about socioeconomic adjustment, and
10 kind of has helped me to understand that this
11 is a much more complicated topic than just
12 where your hospital is located and the
13 patients that it takes care of.

14 But suffice to say that the
15 perspective I hope I bring to this is that we
16 know that where those hospitals are located
17 and the resources that they have available to
18 manage patients who have difficult life
19 circumstances is highly influential on the
20 patient's outcome.

21 And when you write public policy
22 at the national level and you think East St.

1 Louis is the same as Chesterfield, or you
2 think Detroit is the same as Scottsdale,
3 Arizona, the public policy implications are
4 pretty significant. And because we have
5 linked that to pay for performance, there is
6 now federal funds flow, in my view, leaving
7 Detroit and going to Scottsdale because of
8 absence of socioeconomic risk adjustment.

9 MEMBER SAWHNEY: It's hard to
10 follow up on that.

11 (Laughter.)

12 I'm Tia Sawhney. I am the
13 Director of Data Analytics and Research for
14 the Illinois Department of Healthcare and
15 Family Services, which is a long way of saying
16 the Illinois Medicaid plan.

17 I'm a qualified health insurance
18 actuary, a Fellow of the Society of Actuaries,
19 and a member of the American Academy of
20 Actuaries. I am active in both organizations.
21 And those are long-term credentials.

22 In the more recent-term, I got a

1 doctorate degree in public health, and my
2 dissertation was at the divergence of
3 insurance and public health, specifically,
4 risk selection by both insurers and providers
5 and risk adjustment under the ACA. So, I
6 spend a lot of time thinking through the
7 issues, but more from a commercial insurer
8 perspective.

9 I am a data person. So, what I
10 will probably do from time to time in this
11 conversation is ask things like, "Yes, but how
12 do we do it, and how do we do it reliably, and
13 how do we make the math work?" And some of
14 you may want to throw your shoe at me, and
15 that's okay. And it is not that I'm not
16 sympathetic to the larger social goals,
17 because I'm all for them, but how do you make
18 it happen?

19 MEMBER COHEN: I'm Mark Cohen. I
20 am a statistician. I manage the Cisco group
21 for ACS NSQIP, which is the American College
22 of Surgeons and their Surgical Quality

1 Improvement Program.

2 Until I joined this Committee and
3 read the materials, I didn't know how easy I
4 had it.

5 We not only are involved,
6 essentially, in reporting, but it is private
7 reporting. So, the consequences, there's no
8 pay-for-performance compensation, no
9 consequences for being held up to public
10 scrutiny.

11 Our models are really pretty
12 successful. We have maybe a hundred few
13 models. We have 40 predictors usually
14 available for selection, a lot of overlap. We
15 include race and ethnicity, but because our
16 variables are very correlated, they rarely are
17 very powerful.

18 But after hearing this discussion
19 of when you move from the position of private
20 reporting to the position of pay for
21 performance and public reporting, my
22 sympathies are towards making the adjustment

1 as being essential.

2 But I am also a data person, and
3 looking at that graph, there are a lot of
4 questions about how you implement this and how
5 you make the distinction.

6 I was also struck by the fact --
7 one thing clear in reading the documents was
8 the issue about that NQF measures have to be
9 used for both quality and accountability,
10 which seems to say that they can only be used
11 for accountability.

12 We are very successful in quality
13 improvement, even though we may not attend to
14 income disparities. For our purposes, it
15 serves very well.

16 So, I just wanted some
17 clarification about, is that really essential,
18 that you can't get NQF endorsement unless the
19 measure is intended for both purposes? Okay.

20 Thank you.

21 MS. HAMMERSMITH: Do you have any
22 disclosures that you would like to make? You

1 don't have to if you don't have any.

2 MEMBER COHEN: I don't believe I
3 have any disclosures to make.

4 MEMBER CASALINO: Larry Casalino.
5 I'm the Chief of the Division of Healthcare
6 Policy and Economics at Weill Cornell Medical
7 College. Before that, I was at the University
8 of Chicago. And before that, I worked for 20
9 years as a family physician in a small private
10 practice in Half Moon Bay, California. So, it
11 is on the coast just south of San Francisco.

12 Disclosures: let's see, these are
13 all unpaid. I'm on the Board of Directors of
14 the American Medical Group Association
15 Foundation, of the American Hospital
16 Association. I'm a member of the American
17 Hospital Association Committee on Research,
18 and I'm a member of the Board of Healthcare
19 Research and Education Trust, which is closely
20 aligned to the AHA.

21 I have also done a fair amount of
22 research and some speaking related to the

1 STARS, some of that research actually with
2 Alyna and Marshall, who are both members of
3 the Committee.

4 First of all, fantastic materials
5 for the meeting. Really, for David and Kevin
6 and the NQF staff, I don't think I have ever
7 been to a meeting that the materials were
8 better for it, and not just that they were a
9 very complete references in the articles
10 handed to us, but also just the
11 thoughtfulness. I mean, each sentence in the
12 prep materials is very carefully crafted and
13 really addresses the issues, and it lays them
14 out in a thoughtful way.

15 In terms of my perspective, one
16 quick point. I think somewhere in the
17 materials it does mention that the usual view
18 of process measures is that they don't have to
19 be adjusted for anything really. And that I
20 believe is true for inpatient measures, such
21 as preventing central line infections. Or I
22 guess that's not really a process measure.

1 Better would be counseling before people are
2 discharged.

3 But in my mind that is just a
4 silly statement, and I can't believe that it
5 still is the norm in relation to outpatient
6 measures. In our practice in Half Moon Bay,
7 because of our location and the fact that we
8 were the only game in town, we had Silicon
9 Valley executives and we have farm workers and
10 everybody in between. And believe me, it's
11 easier to get a high mammography rate for
12 Silicon Valley executives than it is for farm
13 workers, right, who have almost no -- many
14 reasons; I don't need to go into the details.

15 The other perspective I'll
16 mention, just to summarize that process
17 measure, I think if the process measure
18 depends on the patient doing something, which
19 the inpatient measures don't, then you have to
20 think about whether it has to be adjusted. I
21 think that should be the maximum.

22 In terms of the overall issue,

1 though, I think that both points of view, the
2 concerns for and against doing some kind of
3 adjustment for SES are valid, right? So, we
4 are not going to find some pure principle that
5 requires no compromise that we can just move
6 forward on.

7 You know, the philosopher Isaiah
8 Berlin, his whole life really was spent saying
9 you cannot create a Utopian society. There
10 will be conflicts among equally-valid
11 principles and people of equal goodwill, and
12 you need to have a system that can accommodate
13 that. So, he is very anti-Utopian ideologies.
14 And I think we will need compromise as well.

15 So, in this context I think it is
16 important -- and I won't go on much longer --
17 I think it is important to differentiate among
18 accountability applications. So, one might
19 want to do things differently, for example,
20 for pay for performance and for public
21 reporting.

22 So, for public reporting, my view

1 at this point -- and I am, I think, quite open
2 to change, based on what happens these two
3 days -- is it is complicated, but I would
4 report both unadjusted and probably stratified
5 results. I would report them both. There's
6 no particular reason that that can't be done.
7 But I would report both by type of
8 organization. So, X kind of organization
9 compared to other X kind of organizations, but
10 also for all organizations how they do for
11 different types of patients. So, that is what
12 I would do for public reporting.

13 For pay for performance, you know,
14 we can't report it both ways. So, there I do
15 think -- and I'm sure others agree with some
16 version of this -- that we need some kind of
17 blended measures. My thinking now is I
18 probably would pay based on a blend of
19 unadjusted and stratified performance and,
20 also, pay on a blend of ABSTA scores and
21 improvement in scores. And that would go far
22 to deal with the issues that we are talking

1 about.

2 The problem is, I think it is two
3 problems. One quick one, and then, I am done,
4 is that the stratification is nice to talk
5 about, but in many cases, except for the very
6 largest organizations, the "N" may be too
7 small for some of the cells, for critical
8 cells. I would be interested to hear people's
9 ideas about what to do about that.

10 And the other point is I think --
11 and Marshall alluded to this, I believe -- it
12 is one thing to identify an SES measure and
13 say we think it ought to be used. It is
14 another thing to talk about how it ought to be
15 used.

16 I do think that the comments so
17 far and in the materials, and I think in a lot
18 of the rest of the meeting, are really
19 necessarily about how the measure ought to be
20 used. The reasons why are obvious, I think.

21 So, I'm not sure if I am correct
22 about this, but I seem to remember from the

1 conference call and from some comments in our
2 packet that this goes beyond what NQF usually
3 does, is to talk about how things ought to be
4 done. And so, this is a problem I think we
5 may come up against again and again.

6 MEMBER ADAMS: Hi. Alyce Adams.
7 I am a research scientist as well as Chief of
8 Healthcare Delivery and Policy at Kaiser
9 Permanente's Division of Research in Oakland,
10 California.

11 In terms of disclosures, I'm also
12 on the Kaiser Permanente Work Group on
13 Healthcare Disparities. It is not a
14 decisionmaking group, but we are grappling
15 with these issues every day, about reporting,
16 what do we report, how much do we trust the
17 data.

18 And so, I am particularly
19 interested in this issue of data quality
20 because it is a big problem. We've just
21 gotten to the place where we feel like we
22 trust our race/ethnicity data. So, SES data

1 is another realm for us, and I am sure other
2 sort of healthcare organizations, as we try to
3 assess whether or not to adjust.

4 We have talked a lot about
5 adjusting in terms of the process measures as
6 well as outcome measures and what that might
7 mean. And I concur with what has been said so
8 far, both in terms of the materials that we
9 were given and the conceptualization we got
10 this morning are really spot-on. I don't know
11 the answer. I don't feel like I have a
12 specific preference to go in either direction.
13 But a lot of our work does deal in unintended
14 consequences.

15 And I think it is incredibly
16 important to look at it through that lens
17 because anything we do is not going to be
18 perfect, but as long as we can talk about the
19 consequences of each of our choices and the
20 reasoning behind that, I think that is going
21 to go a long way in terms of helping us take
22 that next big leap to this question of

1 adjustment.

2 MEMBER BARGER: Hi. I'm Mary
3 Barger. I am an Associate Professor at the
4 University of San Diego. I am a certified
5 nurse midwife and perinatal epidemiologist.

6 My disclosures are I do research
7 on racial disparities related to perinatal
8 outcomes. I have had grants related to that.
9 I was one of the representatives for the
10 American College of Nurse Midwives to the
11 first Healthy People Work Group, where we
12 published target measures by race. And then,
13 we felt, oh, that was a big mistake. And
14 then, we said, no, there should just be one
15 target measure.

16 So, having taught in a school of
17 public health, where I think -- you know, I
18 pointed out to my students that racial
19 disparities are important; if we don't collect
20 data on it, it will be put under the table.

21 I have feelings on both sides of
22 the coin, having worked in community health

1 clinics as a nurse midwife, realizing that a
2 lot of the things we do are completely outside
3 our realm as healthcare providers, especially
4 if we look at the life course perspective.
5 You know, we can't go back to things that
6 happened at birth to people and change that.

7 And so, that's a concern. I think
8 I am leaning towards that, yes, we should have
9 some adjustment for quality measures because
10 of that. However, as an epidemiologist, I
11 worry about these are really, really rough
12 measures for whatever proxy we think it means.
13 And so, when you adjust, are you just putting
14 in more confusion. Instead of getting closer
15 to the truth, are you get farther away from
16 the truth? And there are certainly
17 theoretical models in epi that show that, if
18 you do that, you get further from truth than
19 closer to the truth when you use a rough proxy
20 measure.

21 So, I have a concern about that,
22 in that large variability is a way for us to

1 highlight opportunities to improve care. So,
2 that is sort of where I am at the moment.

3 CO-CHAIR NERENZ: Karen, if I can
4 just make one pace observation --

5 MS. PACE: Yes.

6 CO-CHAIR NERENZ: -- as we switch
7 to the other side of the table?

8 In principle, on a minutes-per-
9 person, we are running a little behind, except
10 I think people have done a wonderful,
11 wonderful job of speaking clearly and
12 concisely. And I think this has been really
13 good so far.

14 Am I correct we do not have a CMS
15 presentation this morning?

16 MS. PACE: Right.

17 CO-CHAIR NERENZ: So, we can let
18 this run a bit longer than the agenda says?

19 MS. PACE: We have until 10:20.

20 CO-CHAIR NERENZ: Fine. Good.

21 MS. PACE: So, we have plenty of
22 time.

1 And I should have mentioned that
2 Kate Goodrich from CMS is planning to join us
3 this afternoon.

4 But we have until 10:20. So,
5 we're good.

6 CO-CHAIR NERENZ: We're doing
7 fine? Okay. Good.

8 MS. PACE: We're good.

9 MEMBER ACCIUS: Jean Accius. I
10 work with AARP. I am the Director of Health
11 and Long-Term Service and Supports. In that
12 capacity, I work with our National Policy
13 Council, which is a group that advises the
14 Board of Directors on health and economic and
15 consumer issues.

16 I am extremely interested in this
17 topic. In fact, I have done work looking at
18 racial disparities, particularly in access to
19 care among Medicare beneficiaries, as well as
20 doing some work around the implications and
21 the variation across racial groups as it
22 relates to retirement decisions within the

1 context of Social Security and potential
2 reforms to the program.

3 So, I come to this from the
4 perspective of, how do we, as Steven
5 articulated earlier, look at policy
6 implications, both at the national level, but
7 also at the local level, to fully understand
8 how can we incentivize behaviors regardless of
9 what the unit of analysis is.

10 From the perspective of AARP,
11 clearly, there is a great deal of interest
12 from the perspective of a life course
13 perspective, that the disparities that we see
14 in old age just did not trigger at the age of
15 50 or 65 or 62, whatever marker you define as
16 old, but that it had pretty much life course
17 implications over time.

18 So, that being said, my goal here
19 is to really kind of raise some of the
20 questions around what are the policy
21 implications and how do we really incentivize
22 behavior in a meaningful way, to really try to

1 reduce the disparities that we see across a
2 lifespan.

3 MEMBER O'BRIEN: Good morning,
4 everyone.

5 I'm Sean O'Brien. I'm a
6 statistician at Duke University. Part of the
7 work I do there involves development and
8 evaluation of performance measures, in
9 particular, working with cardiovascular
10 registries, national clinical registries.

11 So, in terms of conflicts of
12 interest, I have been involved with several
13 NQF measure submissions, some that are
14 currently in the pipeline, especially with the
15 Society of Thoracic Surgeons. They have three
16 databases that I'll submit measures to NQF.

17 I was recently involved in
18 development of a 30-day readmission measure
19 that was contracted by CMS that was for
20 patients undergoing bypass surgery, and a
21 couple of other miscellaneous measurement
22 projects.

1 So, the issues of how to address
2 socioeconomic factors and case mix adjustment
3 have come up in basically every project I have
4 been involved with that involved NQF measure
5 submissions, and I was also in other projects
6 where I have served on NQF panels.

7 So, in terms of my perspective, as
8 a statistician, I think I usually let other
9 people do more of the setting the agenda and
10 saying what questions should we be attempting
11 to answer, and ask and answer with data. I
12 usually limit myself somewhat to basically,
13 given some particular set of objectives,
14 what's methodologically the appropriate way to
15 address those. And I am willing to make a
16 statement about what we should or shouldn't
17 do, you know, a blanket statement. But I am
18 more a stickler about, given this particular
19 set of objectives, how should that be done?

20 So, currently, when I think about
21 performance measures, the things you showed us
22 distinguished a couple of different

1 perspectives. And one is they are used to
2 incentivize, I think, behavior and effecting
3 behavior change. And the other is basically,
4 when you are reporting data, you're trying to
5 answer questions with the data. You're trying
6 to answer maybe a "What if?" question. What
7 would outcomes look like if case mix was
8 different? Or what inferences can we draw
9 about the processes and underlying quality of
10 the providers?

11 And when you're trying to report
12 measures that have a particular
13 interpretation, and you are also trying to
14 incentivize a certain behavior, you are trying
15 to do two objectives at once. And in my
16 experience, unfortunately, sometimes when you
17 have multiple objectives, it is hard to do
18 either one really, really well.

19 And when it comes to incentivizing
20 behavior change, I don't think it is a
21 requirement that measures need to be valid or
22 have any particular interpretation for them to

1 be successful at incentivizing behavior.

2 So, in a P4P context, you could
3 reward units that have good outcomes, even
4 very small numbers of patients, and maybe too
5 small to get reliable estimates of some
6 underlying performance. So, it may be driven
7 by chance, but that still can potentially
8 drive people to improve. And in sports
9 competitions there's a lot of random
10 variability and people get very motivated in
11 those contexts.

12 So, I don't think validity is
13 necessarily a requirement, but what I am kind
14 of stickler for is that, if people are
15 interpreting measures in a certain way and
16 they are going to draw inferences, I think the
17 methods need to support those inferences. And
18 so, when you don't adjust for certain
19 variables, I think it is relatively hard to
20 say what the correct interpretation is. And
21 that is a problem for me.

22 I have heard a few things repeated

1 that I have never been able to quite wrap my
2 mind around as a statistician. And one is
3 that we shouldn't risk-adjust for associated
4 factors; instead, stratify. But, in my mind,
5 stratification really is a form of risk
6 adjustment, and they can have some of the same
7 problems in terms of reducing incentives to
8 improve or masking disparities.

9 So, I think, well, what do you
10 mean by stratifying? Typically, we're
11 starting with a performance measure that is
12 trying to measure and compare the performance
13 of different units, such as hospitals or
14 physicians. When we say, "Well, we're going
15 to stratify now," what are we talking about?
16 Are we talking about, within different
17 subgroups of patients, compare outcomes of
18 different units within these subgroups of
19 patients?

20 So, for example, it may be useful
21 to compare how hospitals do among lower
22 socioeconomic status patients. Well, having

1 adjustment in your risk models doesn't prevent
2 you from doing that type of comparison.
3 There's actually no problem with that.

4 If you are interested at a
5 population level being able to look to see,
6 well, which groups of patients have better
7 outcomes/worst outcomes, you get that exact
8 type of inference from having those factors in
9 the risk model. So, at the point in time when
10 the risk model is developed at a population
11 level, you can actually get a good insight in
12 terms of disparities by putting these
13 variables in models and seeing what their
14 effect is after adjusting for other models.

15 And if you are interested in kind
16 of comparing how disparities change over time,
17 not at the point the risk model is developed,
18 there are approaches you can use and still use
19 these risk models that include adjustment for
20 socioeconomic factors and still make the types
21 of comparisons you're interested in.

22 For example, when you comparing

1 across groups of patients, if your model
2 adjusts for that factor that you're interested
3 in comparing, you are adding something to the
4 model in the denominator of your observed
5 expected ratio at the same time you are trying
6 to compare differences across observed, and
7 you subtract out the effect of interest.

8 What we can do is you can evaluate
9 your risk model algorithm as if all patients
10 in your population you're interested in
11 studying, as if they all have the same
12 socioeconomic factors, and just arbitrarily
13 treat all patients as if they were the most
14 common race or the most common socioeconomic
15 status. And then, you can still apply that
16 model. So, a lot of the recommendations I
17 hear, when I think about them, they are not
18 very necessary.

19 And finally, in terms of the
20 concern about taking away the incentive to
21 perform, I just think the incentives need to
22 be designed and addressed explicitly. And

1 right now, the measures people pay attention
2 to these overall global summaries of
3 performance where basically you're measuring
4 a hospital or a unit's performance.
5 Implicitly, it is weighting their outcomes
6 across all the different subgroups of patients
7 in proportion to their prevalence of those
8 populations in the population.

9 And instead, you could provide
10 measures that upweight different groups of
11 patients or you could report outcomes
12 separately for different groups of patients,
13 which is stratification, and explicitly build
14 those incentives into the measurement process.

15 So, those are some of my
16 perspectives.

17 MEMBER JIMENEZ: Hi. I'm Dionne
18 Jimenez. And I guess my disclosure is I'm
19 employed by the Service Employees
20 International Union. So, we're the largest
21 union of healthcare workers, representing over
22 a million healthcare workers.

1 I mean, it is great to be part of
2 such a wonderful group with so many areas of
3 expertise. Just hearing Sean speak, I'm like,
4 "Wow." I should have paid more attention in
5 my statistics classes.

6 One thing I wanted to say from my
7 own personal -- so, I am a Research and Policy
8 Coordinator for the Union. And so, in that
9 role, basically, I help inform our leaders in
10 terms of what positions we should advocate
11 with both the state and the federal levels
12 regarding various healthcare policy issues.

13 So, from my personal perspective,
14 I think that it is very important to address
15 healthcare disparities. But, as we are seeing
16 the results of the first few years of the
17 accountability applications, especially in the
18 Hospital Value-Based Purchasing Program, which
19 I spend a lot of time looking at, and the
20 Hospital Readmissions Reduction Program, you
21 know, I think there is definitely a pressing
22 need to address for SES, because we are not

1 necessarily eliminating disparities. It is
2 actually exacerbating them, especially for
3 seeking the institutions.

4 And I think when we are looking at
5 real-world consequences, you know, you could
6 see the provider perspective, but we also have
7 to think about the people who are working in
8 the hospitals and the institutions. I mean,
9 anecdotally, we are seeing our represented
10 providers starting to come to us in
11 negotiations, thinking about, well, where are
12 we going to have start making cuts, when the
13 purpose of these programs is actually to
14 improve quality.

15 And you have to remember that a
16 lot of these workers are actually in lower SES
17 categories, too. So, I want to keep in mind.

18 But I think from the research
19 perspective, I think I agree, though, it is
20 very important that there needs to be both the
21 raw and the unadjusted as well as the adjusted
22 data. So, all of our work could be used. But

1 when it comes to the implementation programs,
2 adjustment is very important.

3 So, that's it.

4 MEMBER PONCE: Good morning.

5 I'm Ninez Ponce. I'm a Professor
6 in the Department of Health Policy and
7 Management at the UCLA Fielding School of
8 Public Health.

9 My disclosures are I'm a health
10 services researcher with economics training,
11 and I am a disparities researcher. I am also
12 on the Board of the National Health Law
13 Program, which champions the rights for the
14 low-income population, particularly those on
15 Medicaid.

16 I was nominated here by the
17 California Pan-Ethnic Health Network, which is
18 an organization of several racial/ethnic
19 disparities organizations.

20 I guess my research disclosure is
21 I lead the California Health Interview Survey,
22 which is a population-based survey. So, I

1 definitely have a bias towards population-
2 based measures and social determinants. I
3 recently a chapter on multi-level social
4 determinants of health.

5 So, my perspective on adjustment
6 -- I also teach econometrics, and I have a
7 fear of meta-variables. So, not having social
8 determinants of health as structural
9 indicators of the complexity of the patient is
10 really important.

11 And some of the articles that I
12 read said disease severity helped, but there
13 was one article that swamped out income which
14 was really disconcerting for me. So, I think
15 if we are going to use social determinants of
16 health or SES as a way to adjust, then it
17 really is trying to get at incentives and
18 rewards for providers. So, not to identify
19 those who avoid sick patients, but to reward
20 those who seek sick patients and complexity
21 and the structural determinants. So, that is
22 my perspective.

1 I also work very closely with
2 Thu. I think that has to be disclosed. We
3 have worked on a project on social
4 determinants of health and risk adjustment
5 using her clinical data. I have worked with
6 her also in a HRSA-funded project called --
7 and Kevin is on it, too -- on Community Health
8 Centers. And I have just agreed to be on a
9 panel for the National Association of
10 Community Health Centers -- and Michelle is
11 here -- on social determinants of health and
12 risk adjustment.

13 MEMBER QUACH: Hi. I'm Thu Quach.
14 I am the Research Director for Asian Health
15 Services, which is a Community Health Center
16 in Oakland Chinatown, California. We serve
17 about 24,000 patients. Most of them are
18 Asian-Americans and Pacific Islanders. The
19 majority are immigrants. And so, we are
20 really big on the issue of language and
21 culturally-competent services.

22 And so, my disclosure is that I'm

1 also a research scientist with the Cancer
2 Prevention Institute of California, where I am
3 funded to do a lot of different environmental
4 health research. I'm an environmental
5 epidemiologist. A lot of my research is
6 focused on Vietnamese nail salon workers and
7 their disproportionate exposures in the
8 workplace.

9 My big disclosure is that I do a
10 lot of work around environmental justice, both
11 in my professional and personal affiliations.
12 I am involved with a lot of advocacy
13 organizations that promote health and equality
14 for Asian-Americans and Pacific Islanders.
15 I'm really big on immigrant experience and how
16 to get at that, and sort of the complexity of
17 patients who are immigrants and sort of some
18 of the social barriers and the cultural stress
19 that they face when resettling here. I think
20 Ninez mentioned some of my other disclosures.

21 In terms of my perspective, as an
22 epidemiologist, I do believe that you have to

1 adjust. I think the big issue is how well the
2 data captures the complexity of the patients
3 and the communities that we served.

4 In a lot of my work, I do a lot of
5 community-based participatory research. And
6 so, it is hard to say that you don't do
7 advocacy because a lot of your research should
8 inform social change. So, I really believe
9 that a lot of the data that I am collecting,
10 oftentimes with the community, really is
11 informing, should inform more of the health
12 policies. And so, risk adjustment in this
13 work, while I am really new to the healthcare
14 field, I do believe that -- someone said it
15 best -- the devil is in the details in terms
16 of how you capture some of these complexities
17 for communities.

18 MEMBER NUCCIO: Good morning.

19 Gene Nuccio, University of
20 Colorado Anschutz Medical Campus, I'm a
21 faculty member there.

22 In terms of disclosure, I work in

1 doing home health risk adjustment. That is,
2 the OASIS instrument is the instrument that my
3 Division promulgated and has revised twice.
4 I am personally in charge of doing all the
5 risk models to risk-adjust about 41 healthcare
6 outcomes and about 10 adverse event outcomes
7 for the home health world. These outcomes are
8 recorded both privately by CASPER Reports and
9 on the Home Health Compare site that we also
10 helped design back in 2003.

11 My work is primarily funded out of
12 CMS and MedPAC. With MedPAC, I helped design
13 some alternative outcome measures and looked
14 at a 30-day both hospitalization and a 30-day
15 rehospitalization measure based on claims data
16 and risk-adjusted through the OASIS
17 instrument.

18 The OASIS instrument is one that
19 home health agencies use to assess a patient
20 at the beginning of care and at every 60 days,
21 should they be on care that long, and at the
22 end of care, whether that care goes back to

1 the hospital or if they are discharged to the
2 community.

3 As such, I'm very much interested
4 in the whole concept of risk adjustment and
5 distinguishing between creating the prediction
6 model that is used to risk-adjust or to
7 predict the outcome and whether or not we
8 include or don't include some measure of
9 sociodemographics in that model, but also how
10 you end up applying that information to
11 adjust.

12 That is, currently, many of our
13 adjustments are based on the idea of using a
14 national reference to adjust the value. That
15 is, everybody is held to a national standard.
16 And my belief is, why? As many of you have
17 pointed out, there are huge differences
18 between Arizona and Minnesota or South Dakota
19 and Boston. Why don't we use something else,
20 like maybe a CMS regional value or a state
21 value, as our reference point in terms of
22 adjusting?

1 With regard to, if we decide that
2 it is appropriate in some instances to use SES
3 to adjust an outcome based on accountability
4 issues and quality issues or other
5 perspectives, do we represent that information
6 using a patient-level value, that is, the
7 individual's racial SES, and so on and so
8 forth, or do we use some sort of geo-value, a
9 Census value, for the various population areas
10 that that healthcare provider looks at or
11 typically serves?

12 So, I mean, you know, all
13 healthcare is local. I mean, you might need
14 to go to Mayo in Minnesota, but, more likely,
15 you're going to go to the hospital that is
16 down the road.

17 So, those are my particular
18 issues. So, I guess right now my perspective
19 is perhaps not yes or no, but sometimes. And
20 then, the criteria or the important variables
21 is how are we going to use the information
22 and, then, how should we adequately represent

1 the information.

2 MEMBER CHIEN: Hi. My name is
3 Alyna Chien. I am an Assistant Professor at
4 Boston Children's Hospital and Harvard Medical
5 School.

6 The way I usually describe what I
7 do is I work on how we pay doctors, but I
8 think about incentives broadly. There are
9 payment incentives, reputational ones, what
10 your organization is doing to help you.

11 Clinically, I'm a general
12 pediatrician, and I recognize all of the
13 issues that all of the providers have spoken
14 about. I share all of the concerns that have
15 been raised about data quality and being torn.

16 I guess where I fall is mainly
17 that, even though we want to stay focused so
18 that we can have a productive conversation,
19 I'm worried about oversimplifying the
20 situation, and that we do need to recognize
21 that how quality measures are used is very
22 complex. And I think that we should use all

1 the tools that we normally use to understand
2 the situation, as researchers and healthcare
3 providers in the broader quality realm.

4 MS. HAMMERSMITH: Do you have any
5 disclosures that you would like to make?

6 MEMBER CHIEN: I mean, just that I
7 make a living doing this.

8 MS. HAMMERSMITH: Okay. That's
9 good.

10 (Laughter.)

11 MEMBER CHIEN: But I honestly
12 wouldn't have gone to medical school or chosen
13 a research path if I wasn't passionately
14 interested in vulnerable populations. So,
15 take that for what it's worth.

16 MEMBER WERNER: I'm Rachel Werner.
17 I am an Associate Professor of Medicine at the
18 University of Pennsylvania, where I am a
19 health economist and I do research related to
20 the use of quality improvement incentives,
21 specifically financial incentives on
22 healthcare delivery and quality of care. I'm

1 also a general internist and I have a joint
2 appointment at the Philadelphia VA, where I
3 practice.

4 For disclosures, you know, I
5 receive grant funding to study these issues
6 and I speak nationally about these issues.
7 But, beyond that, I don't have any other
8 disclosures.

9 In terms of my perspective, I also
10 am sort of torn. I think that David and Kevin
11 laid out very nicely that there's two
12 potential outcomes from risk-adjusting,
13 however you go about risk-adjusting. I think
14 they are both important.

15 I think it is, from my
16 perspective, very clear that, when financial
17 incentives are being tied to quality of care,
18 we need to do something to level the playing
19 field, so that providers who
20 disproportionately care for uninsured or low-
21 SES patients are not penalized for that.

22 But I think that in terms of

1 measuring quality, it is not so clear to me
2 what to do.

3 And I want to just sort of lay one
4 thing on the table, which is, as an economist,
5 I'm also scared of metavariabes, and I worry
6 a little bit about what we are measuring when
7 we measure socioeconomic status. In Kevin's
8 diagram, he laid out a number of things that
9 lead to low or poor health among low-SES
10 patients or socially-disadvantaged patients.
11 And those are things like early-life factors,
12 epigenetics. There's also things related to
13 access and adherence, language, patient
14 activation.

15 So, I worry that, by simply
16 adjusting for socioeconomic status, we are
17 really trying to capture all of that
18 information which we don't have data on, and
19 that it may sort of dampen the enthusiasm for
20 directly addressing those things which may
21 improve equity in care. And so, I don't say
22 this to let the perfect be the enemy of the

1 good, but just to be aware of sort of some of
2 the downsides of trying to adjust for these
3 things.

4 MEMBER OWENS: Hello. My name is
5 Pam Owens. I am the Scientific Director of
6 the AHRQ Quality Indicators. That's a project
7 that has 92 indicators for the patient safety
8 indicators, the patient quality indicators,
9 prevention quality indicators, and pediatric
10 quality indicators.

11 The other hat -- I have been at
12 AHRQ for 12 years -- the other hat that I wear
13 at AHRQ is that I am the Coordination of
14 Outpatient Data on the Healthcare Costs and
15 Utilization Project. We have 44 states
16 participating with their discharge data for
17 both the hospital side, inpatient hospital,
18 and then, 33 states participating on the
19 outpatient side.

20 So, I am saying this in the
21 context I'm a data person, and I have the
22 policy piece as well as the technical

1 specifications on the quality indicators,
2 which, as you know, many of the quality
3 indicators are being used in CMS programs.
4 And I work closely with CMS as those get
5 translated.

6 The other things you should know,
7 I do sit on the NQF MAP Hospital Workgroup.
8 I also am going to be sitting on the NQF
9 Population Health Workgroup. I sit on the
10 Interagency Committee from the Department of
11 Health and Human Services on Measurement and
12 Measurement Policy. So, there's a couple of
13 different influences that you may hear that
14 might have subliminally got into me.

15 From an analytic standpoint, one
16 of the projects that I am a Task Order Officer
17 on is improving the AHRQ Quality Indicators.
18 And we are explicitly looking to see if
19 hospital characteristics should be risk-
20 adjusted for the Quality Indicators to improve
21 their performance. And what I mean by that is
22 we are looking at things like safety net.

1 And so, the analysis is not there
2 enough, or I'm not confident that we have
3 taken into account the clinical aspects of
4 that analysis enough to bring it to this
5 table, but it is really relevant because we do
6 see differences.

7 The other piece is I actually
8 started four years ago -- well, for four
9 years, I took a break from AHRQ and I worked
10 at Washington University and with Steve
11 Lipstein at BJC. And we started the
12 discussion around SES and readmissions. Or
13 maybe my views are influenced by you, so
14 there. But, at any rate, so that you have
15 some context of where I am coming from.

16 In terms of what I'm coming to the
17 table with right now, and it is very
18 important, Ann, to reflect this is my view;
19 this is not AHRQ's view. And you will see all
20 that, all those caveats on all manuscripts,
21 "This is an individual view; it's not the AHRQ
22 view," because I have not vetted it with AHRQ.

1 So, I do think SES is a complex
2 concept, and it is actually one I started my
3 dissertation on many, many years ago,
4 examining how SES relates to recurrent
5 strokes. And the first part of that
6 dissertation is let's delve into what do we
7 mean by SES.

8 Now it's interesting because
9 around the table I have heard many people
10 reflect different statements of what SES is to
11 them and what it is reflecting. And I think
12 that's important, that we think about as we
13 move forward, because it is both the concept
14 of what we are trying to reflect as well as to
15 operationalize it.

16 The other piece that has come up a
17 number of times, and which I agree with, it
18 does depend on its purpose. And I think we
19 need to think both in its purpose from a
20 research perspective and improving the measure
21 and the specificity and sensitivity of the
22 measure, but also from the implementation

1 perspective.

2 And these things have legs that
3 you don't realize. So, whatever we recommend,
4 things happen to them, and you should just be
5 aware of that.

6 In terms of what I am currently
7 sitting with respect to adjustment, I do see
8 a need for unadjusted measures and I see a
9 need for stratified measures. I am less clear
10 how to do risk adjustment in which it is just
11 an indicator, a variable in a model, and
12 everybody is mooshed together.

13 I feel like we are masking some of
14 those disparities. And as you know, AHRQ does
15 a lot of work on the NHDR, examining those
16 disparities, using the Quality Indicators, and
17 we do use risk-adjusted indicators in them,
18 but we haven't put SES in them. So, there is
19 a lot at stake.

20 MEMBER BERNHEIM: Hi. I'm
21 Susannah Bernheim. My main job is that I am
22 the Director for Quality Measure Programs at

1 Yale Center for Outcomes Research and
2 Evaluation. And in that role, I oversee two
3 contracts with CMS where we develop outcome
4 measures. So, we are the developer of the
5 publicly-reported readmission measures and
6 mortality measures that people are aware of.
7 So, we spend a lot of time talking about this,
8 from meetings in-house to dinner table
9 conversations, to everything else.

10 I am also a family physician. I
11 do my clinical work at a federally-qualified
12 health center. I have always done my clinical
13 work in underserved populations; trained at
14 San Francisco General Hospital.

15 And I have the research background
16 and the research training, and my research has
17 always focused on the intersection of quality
18 and socioeconomic status. So, I come at this
19 from many perspectives.

20 And I am going to talk a little
21 bit later just specifically about how we think
22 about it as a measure developer to give that

1 perspective. But, as other people have said,
2 I do not sit at this table as CMS's
3 representative or Harlan's representative or
4 anyone else's representative. I really do
5 think about this from a lot of different
6 angles, and I agree with everyone that it is
7 complex.

8 I don't think I have any other
9 conflicts to disclose. But I will say, just
10 in terms of my perspective, I am going to show
11 you some of the analyses we have done and how
12 we have thought about them. I am comfortable
13 with the decisions we have made in the current
14 readmissions measures. They were done in
15 accordance with NQF guidance. But I do not
16 think that this is a one-size-fits-all
17 situation. I think that, as I have thought
18 about how we came to those decisions, I have
19 tried to think a lot about sort of what are
20 the criteria where, given that you are not
21 going to get this right, right -- there's a
22 mix of things going on -- I'm really coming to

1 this trying to think about how can we, as a
2 group, articulate as clearly as possible what
3 are the circumstances under which the
4 risk/benefit of this kind of risk adjustment
5 goes in one way versus the other.

6 So, I think that is really our
7 job, to say, you know, what purposes of
8 measures, what kinds of data analyses, what
9 kinds of SES variables that are available that
10 seem like the right ones. When do we have a
11 setup where it is clear that we should do one
12 thing versus the other? And I don't think
13 that is an easy task, but I come to this with
14 a perspective that that is kind of the job we
15 have at hand.

16 The one other thing I will say --
17 and it has been echoed by Larry and Rachel and
18 some other people -- is I know that it is hard
19 to differentiate the implementation of a
20 measure from the measure itself, but one thing
21 I will say is that I start, because it is
22 where I started, by thinking about first these

1 measures as how do we best reveal quality,
2 knowing that this is going to play out in
3 different ways.

4 And then, what if those measures
5 get used in ways that are going to hurt the
6 safety net? Maybe that gets dealt with in a
7 different place. So, that is a little bit of
8 a bias that I come to, that we should separate
9 how we think about quality measures and
10 implementation, and I know that's not simple.
11 And I think it is a conversation we are going
12 to have lots of times.

13 But what I have generally argued
14 for is that the policy of how these measures
15 are used should be changed, but not that the
16 measures themselves should change. So, that
17 is probably my predisposition, but I am very
18 open to us talking about sort of criteria and
19 specific measures where we would do things
20 differently.

21 MEMBER GOLDFIELD: Again, I'm glad
22 that I'm the last one, I guess.

1 (Laughter.)

2 Or maybe not. There's more. Or
3 we could start all over again, I guess.

4 (Laughter.)

5 My name is Norbert Goldfield, and
6 I'm the Medical Director of the Research Group
7 at 3M Health Information Systems and a
8 clinical internist.

9 I guess from my perspective, while
10 everybody has emphasized these issues are
11 complex, decisions are continuously made
12 regarding SES payment and quality. So, we
13 just need to acknowledge that upfront, that I
14 think it is real important.

15 The main reason I'm interested in
16 this is that I am hoping that we can push the
17 process forward. And by that, I mean the
18 pushing the process forward, as Medical
19 Director of the Research Group at 3M Health
20 Information Systems, we do a lot of work with
21 CMS, AHRQ, and MedPAC in approximately 35
22 states and private insurers.

1 And by that, I mean specifically
2 create case mix measures. I'm the lead
3 clinical developer of the case mix measures
4 that link payment and outcomes quality for
5 each of the four types of healthcare
6 encounters. And for me, they are ambulatory
7 care; hospital care; year-long, person-based
8 episodes, and long-term care.

9 As a clinical internist, I see
10 patients two days a week at a health center.
11 I'm particularly interested in programmatic
12 innovation. We were the first site of
13 implementation of a dual-eligible program in
14 Massachusetts, where I live.

15 Just a couple of observations. I
16 think it is important to distinguish between
17 using SES as an independent variable versus a
18 dependent variable. I think it is important
19 to understand are we talking about
20 confidential disclosure versus public
21 disclosure or used as payment. I consider
22 public disclosure tantamount to payment, for

1 any number of reasons.

2 As a consequence, my personal
3 perspective is that -- and I do speak for our
4 Research Group -- is that it is really
5 necessary to have clinically-robust, detailed,
6 severity-adjusted measures. And frankly, most
7 are not.

8 The devil is certainly into
9 detail. Implementation is key. You can have
10 a great tool, and I would say there's still an
11 80-percent chance of poor implementation,
12 which creates its own set of issues. That is
13 not really part so much of this group.

14 I would say that, from a
15 disclosure point of view, that, in essence,
16 when CMS uses our work, it is public domain.
17 When it is not, I have, frankly, the
18 intellectual luxury -- and it is a luxury --
19 to develop tools that are proprietary that
20 are, then, used in states and overseas by
21 private insurers.

22 A good example might be New York

1 and Texas. New York and Texas, as far as I
2 know, are run by different political parties,
3 but have focused on paying for better
4 outcomes.

5 And in that spirit, I want to say
6 -- and David and Kevin and Suzanne and Karen
7 know -- that I believe that there is a
8 significant error in the charge for this
9 group, which is to say that payment and
10 quality have been separated. And, in fact,
11 everybody, starting with yourself, has
12 outlined, in fact, how the two are not
13 separate. And I think we are being
14 disingenuous when we make that separation.

15 And certainly, any number of
16 states, and to a certain extent CMS, but many
17 states -- and that's why I used New York and
18 Texas, and there are almost 100 million people
19 there -- are really focusing on paying for
20 better outcomes.

21 And the intermix, the necessity
22 for linking the question of SES is addressed,

1 had to be addressed in both of those. So,
2 clearly, I hope that the charge can be
3 changed. But, if not, whatever happens, I'm
4 hoping that there be a clear set of
5 suggestions on a timeline and an approach for
6 including SES measures that are the least
7 gamable. It is not a small issue in terms of
8 its gamability.

9 I'm particularly interested in
10 dependent variables. A clear example of what
11 I am speaking about is the work that I am
12 doing with several states to try to have a
13 statewide consistent collection of the term
14 "homelessness". And so, as a consequence, it
15 is obvious -- I mean, for myself, I saw
16 patients all day yesterday until nine o'clock
17 last night -- that anybody who is homeless is
18 a clear risk. At the end of the day,
19 obviously, there is a lot of discrepancy over
20 that definition. But if you can have a
21 consistent, clear, statewide, probably HUD-
22 reliant definition, I think that should be

1 absolutely useful for linking payment and
2 outcomes quality.

3 So, to put it differently, the
4 perspective I bring recognizes that at the end
5 of the day healthcare is fundamentally an
6 economic activity. And obviously, it doesn't
7 requiring, from knowing what different people
8 do here, it is clearly the poorest who are
9 discriminated the most, whether it is in this
10 country or the country I was born in, in
11 Italy, where they have a much better
12 healthcare system than the United States.

13 But the best way to devoid
14 politicization from my perspective, because
15 then it becomes whoever has the most power who
16 is a safety-net institution, is to have
17 clinically-robust models.

18 But we also need to acknowledge --
19 and I have been impressed by that big time by
20 Karen, and so I want to acknowledge Karen's
21 absolute correctness in stating that clinical
22 models, we are dealing with human beings.

1 Let's get real folks, right? Which is why it
2 is an honor to be a physician.

3 We will never explain 100 percent
4 of the variance. And thus, we need to suggest
5 a path forward and to maximize the probability
6 of acceptance of use. So, that's important.
7 And we need to understand that funding
8 typically is a zero-sum game. If a safety net
9 gets more, that means a wealthy hospital gets
10 less. So, we need to be very robust in
11 understanding, making the argument that a
12 safety-net institution should get more.

13 And that I think can be very well-
14 described, and I will try to show that, that
15 if we have clinically-valid descriptions of
16 human beings, that can be fostered. So, for
17 me, it is not "whether," but "how" and "what
18 timeline".

19 So, I am pleased to be here, and
20 thanks.

21 MS. HAMMERSMITH: Okay. Thank you
22 for your thorough disclosures and thoughtful

1 comments.

2 Do any of you have any questions
3 of each other or of me, based upon the
4 disclosures that you made this morning?

5 Okay, you do?

6 MEMBER LIPSTEIN: I have just one
7 question.

8 MS. HAMMERSMITH: Would you turn
9 on your microphone, please?

10 MEMBER LIPSTEIN: Okay. My
11 question is, especially since I'm new to NQF
12 and some people are not, there's an issue of
13 whether we risk-adjust with the purpose of
14 improving quality and outcomes or there's an
15 issue of NQF taking the position that one of
16 its measures, if not risk-adjusted, might not
17 be fair to use in payment methodology. Is
18 that on the table or is that off the table?

19 In other word, as part of our
20 charge, is NQF willing to do something that
21 I'm told, I guess, by people in the room that
22 it hasn't done before, which is to tell CMS

1 what it should and should not do with the
2 outcome measures that it endorses?

3 MS. HAMMERSMITH: I think that
4 that is part of the substantive work of the
5 Committee. So, I will let them address that
6 after I am out of here.

7 (Laughter.)

8 You are all delightful, but I
9 would like to leave.

10 (Laughter.)

11 Any other questions about
12 disclosures that people made?

13 (No response.)

14 Okay. Thank you and good luck.

15 MS. PACE: And actually, we're
16 moving into that right now in terms of NQF.
17 So, we will do a little presentation and can
18 have some further dialog about that.

19 So, we have one more set of
20 presentations. Helen and I will present. And
21 then, we are going to take a break. And then,
22 we will come back after the break and continue

1 our agenda.

2 So, Suzanne, do you want to move
3 on?

4 DR. BURSTIN: Great. Since you
5 have all been asking for context, here it is.

6 (Laughter.)

7 So, appropriately named "Context"
8 by Karen.

9 So, thank you for those
10 incredibly-thoughtful introductions and
11 perspectives. There's actually more
12 commonality than I thought, walking in the
13 room. I think as Kevin said earlier, the
14 devil is in the details of how we sort of make
15 this work, but more there.

16 So, I want to talk a little bit
17 about endorsement, but also about what is
18 truly potentially a significant change afoot.
19 Some of you know Chris Cassel joined us as our
20 CEO, President and CEO, about six months ago.

21 We are very much in a state of
22 looking at what we do very differently, very

1 critically. And, in fact, a lot of work with
2 our Board on strategic planning is, in fact,
3 looking very closely at exactly the questions
4 that all of you have raised today about our
5 role. So, I can't give you definitive
6 answers, but I will at least give you some
7 context.

8 So, first, specifically about
9 endorsement, and then, I will return to the
10 questions several of you asked about how this
11 relates to payment and selection of measures.

12 So, first of all, the current
13 state is, in fact, that at least our current
14 process is that there's an expectation that,
15 if an NQF measure is endorsed, the Committee
16 has decided that that measure is suitable for
17 both performance improvement and
18 accountability applications. We have not to
19 date made a distinction between saying this
20 measure is okay for quality improvement.

21 Oh, look, I say "Dr. Cassel," and
22 she walked in the room.

1 Welcome to Chris Cassel, our CEO.

2 So, we have to date not
3 distinguished endorsement for measures for
4 different purposes. So, currently, there is
5 an expectation that you would use performance
6 results for a wide range of potential
7 purposes, and they are listed out here. And
8 to date, when we have talked about
9 accountability, we are specifically referring
10 to this wide breadth of public reporting,
11 accreditation, licensure, certification,
12 incentives, performance-based payment, network
13 inclusion/exclusion, et cetera.

14 But we recognize the world has
15 significantly changed from these early days
16 when one-size-fits-all. And I think there is,
17 clearly heard from our Board, as well as from
18 the MAP discussions last week, a great deal of
19 interest in potentially moving towards
20 endorsement more fit for purpose.

21 So, I think part of what we will
22 get a very good sense of over the next couple

1 of days is really beginning to understand --
2 and many of you brought this up -- what, in
3 fact, differentiates measures for different
4 purposes. When is a measure potentially
5 appropriate, as somebody said, for private
6 benchmarking or quality improvement? When is
7 a measure appropriate for public reporting?
8 When is a measure appropriate for patient-
9 level selection/payment purposes?

10 Interestingly, some of you, you
11 know, talking about payment is potentially the
12 top of that hierarchy. And I will tell you
13 that it is very interesting at NQF, where
14 there are so many perspectives at the table,
15 that we frequently hear, for example, from
16 consumers and purchasers that their ability to
17 select the right provider for what they need
18 is equally high stakes for them, as the
19 financial issues might be high stakes from the
20 provider perspective. So, we are careful
21 about language in terms of some of that.

22 But we do fully recognize that we

1 are at the point of needing to undertake this
2 exercise of considering whether to endorse
3 measures for different purposes, in addition
4 to the fact that we have not to date dived
5 deeply, at least on the endorsement side, into
6 how a measure is implemented or how a measure
7 is reported.

8 We have had some forays into this
9 work. And, in fact, as part of our
10 readmission project, that probably was the
11 major impetus for this work a year or two ago
12 now, the Committee did specifically recommend,
13 as part of the use of the all-cause
14 readmission measure that was submitted by Yale
15 and CMS, that like hospitals be compared with
16 like hospitals. So, it was the beginning of
17 that thinking of how do you begin looking at
18 least the reporting and the implementation of
19 those measures.

20 The last thing is there is a part
21 of NQF, the Measures Application Partnership
22 that Marshall mentioned at the outset, which

1 has specifically been charged with helping to
2 assist CMS and other agencies, CMS and others,
3 in the selection of measures for different
4 programs. And that's where the fit-for-
5 purpose sort of thoughts have really been
6 mostly concentrated to date, as opposed to the
7 endorsement side.

8 And I think what we have
9 increasingly seen is that the MAP is very
10 dependent in some ways around a scientific
11 review of the measures. And so, increasingly,
12 we are considering better ways to begin
13 integrating at least our internal work to
14 potentially allow the endorsement function and
15 the review of measures to provide a more
16 granular assessment of the potential uses for
17 which the scientific properties of the
18 measures lend themselves.

19 So, naturally, it would be
20 stepping into areas like this. So, we are
21 very much at a cusp of thinking about how
22 potentially to integrate or at least better

1 relate the work we do on the scientific review
2 of the measurement properties, evidence,
3 scientific validity, reliability, usability,
4 and how that, then, relates to the selection
5 of a measure for a particular program for a
6 particular purpose. So, that is our current
7 state.

8 Chris, I don't know if you want to
9 add anything there?

10 DR. CASSEL: No. Well, just let
11 me welcome everyone, and I'm sorry I can't
12 actually be with you for the entire meeting
13 because this is such an important issue for
14 the nation, actually. And so, we really
15 appreciate your contribution to helping us
16 take this issue to the next step.

17 I mean, Helen has, I think,
18 described very well what NQF Board and staff,
19 I think, really think we are at the cusp of
20 having to look at the endorsement process very
21 differently, given how innovation, and some
22 people would say chaos, but it is probably a

1 combination of the two, are helping in the
2 healthcare world, much of it around
3 measurement, measurement systems, ways of
4 using data in this extremely data-rich
5 environment that we now find ourselves in.

6 And the NQF process and single set
7 of criteria for endorsement just isn't
8 adequate for that, for all of that purpose.
9 So, this may have seemed, when we put out the
10 call for nominations, this may have seemed
11 like a relatively-academic sort of
12 methodological discussion, and I'm sure you'll
13 have plenty of that, but it also is very
14 consequential, I think, in helping us think
15 about should we have multiple different
16 approaches to measures that mean different
17 things for different audiences, for different
18 purposes, et cetera.

19 So, thank you again for your
20 participation, and I just look forward to a
21 real interesting process and report.

22 DR. BURSTIN: Thanks.

1 So, next slide.

2 So, I think on this slide we just
3 give you a couple of examples of the current
4 uses of endorsed performance measures, both
5 public reporting -- for example, the measures
6 on Hospital Compare, Nursing Home Compare,
7 fill-in-the-blank "Compare" programs, as well
8 as the way some of the measures have been used
9 quite extensively, particularly on the
10 hospital side, around the Readmission
11 Reduction Program, Value-Based Purchasing, and
12 the Shared Savings Program, again, just as an
13 example.

14 So, we do have a very close
15 working relationship with HHS and CMS, and
16 that was brought up in some of the questions
17 early on. And again, this is independent
18 work. It is funded by HHS. You will have an
19 opportunity to hear from Pam at the table.
20 You will have an opportunity to talk to Kate
21 later as well.

22 But, again, I think it is just

1 really important to emphasize this is very
2 much an independent endeavor. There is no
3 sense that we have at the start of this work
4 how it will turn out, and that is really our
5 intent.

6 And you probably have already
7 heard that you come from such an incredible
8 variety of perspectives and expertise, that I
9 have no doubt this will be a great effort
10 going forward.

11 Karen will go into a deeper dive
12 to follow on our criteria.

13 And somebody had raised the issue
14 earlier of how CMS -- oh, I guess it was
15 Susannah -- how CMS, basically, and Yale
16 followed NQF's guidance. So, it is, in fact,
17 true that NQF's guidance to date has been not
18 to risk-adjust for these variables for which
19 there is potential for obscuring disparities
20 and really having a preference for
21 stratification.

22 So, in fact, this Committee's

1 findings may have a very significant impact on
2 our criteria for measures, which will, then,
3 obviously, have a pretty significant effect on
4 measure development and potentially changes to
5 measures going forward. So, I just wanted to
6 put that out there.

7 Karen?

8 MS. PACE: Okay. So, next slide.

9 And we won't get into our criteria
10 in great detail, but, basically, we have a
11 section of our criteria about scientific
12 acceptability measure properties, primarily
13 reliability and validity. And when we look at
14 validity, we also in terms of what we ask the
15 measure submitters to do is to do some
16 traditional validity testing, but we include
17 under our validity criterion looking at things
18 that could be threats to validity.

19 And generally, when you are
20 looking at outcome or resource use performance
21 measurement, if you don't risk-adjust, you're
22 at risk of incorrect inferences or conclusions

1 about quality. And that is why we kind of put
2 it with our thoughts about validity.

3 Next slide.

4 And as Helen mentioned, I mean,
5 our criteria says we're looking for an
6 evidence-based risk-adjustment strategy. It
7 should be based on patient factors that
8 influence the measured outcome, but not
9 factors related to disparities in care or the
10 quality of care and are present at the start
11 of care, have demonstrated adequate
12 discrimination and calibration.

13 And one of our notes is
14 specifically risk models should not obscure
15 disparities in care for populations by
16 including factors that are associated with
17 differences or inequalities in care.

18 And I should point out -- and I
19 think Sean's and another people's comments
20 earlier on -- that stratification is one way
21 of adjusting. And we should clarify that this
22 was really specifically talking about them in

1 a statistical risk model versus doing
2 something with stratification. And the
3 preference was, in the light of interest in
4 identifying and reducing disparities, of not
5 obscuring those.

6 So, any of you who have been
7 working with NQF over the years, you know that
8 we evolve as the field evolves. We are
9 definitely open to revisiting this issue and
10 really thinking through it with all of you as
11 experts, and seeing where we come out.

12 As Helen said, the recommendations
13 that you come out with will definitely impact
14 how we state our criteria and how we implement
15 that, which will have implications for
16 endorsement.

17 Okay. Is that the last one?

18 Oh, so the other thing that I
19 wanted to just talk a little bit about -- it
20 has come up several times -- about adjustment
21 for performance measurement versus adjustments
22 that are done in terms of determining payment

1 for providing services, not the pay for
2 performance that is based on quality
3 performance. But, obviously, those
4 adjustments are also made.

5 And some examples of those that
6 are already in place are there some hospital
7 payment adjustment for disproportionate share
8 of certain low-income patients. We have just
9 posted some of these things on our SharePoint
10 page for you all. That is in a fact sheet
11 about Medicare hospital payment.

12 And certainly one example would be
13 in the inclusion of Medicaid status and case
14 mix adjustment for Medicare Advantage plans.
15 Sometimes Medicaid status, obviously, is tied
16 to income and sometimes that is used as a
17 proxy.

18 So, these things are happening,
19 maybe not as systematically or to the degree
20 that we want. And I think there's obviously
21 a couple of things in regards to our work
22 here. Our specific charge is about outcome

1 performance measurements, which is what NQF
2 endorses, but we totally recognize that there
3 is a linkage and overlap. There's not a
4 bright line between these things because, as
5 Kevin pointed out, the payment affects the
6 resources of the provider, which, in turn,
7 affects the kinds of care that they are able
8 to provide. So, they are definitely linked,
9 and we're not saying that we can't discuss
10 those, but, ultimately, our charge is: what
11 are we going to do about outcome performance
12 measurement?

13 We certainly can include
14 recommendations. It is not going to have the
15 same kind of effect because NQF doesn't do
16 anything in the adjusting for payments, that
17 realm. But certainly we don't mean to cut off
18 that kind of discussion or how they interact
19 and questions about, well, what if the payment
20 really did adequately adjust, so that
21 providers were given adequate resources to
22 care for these patients? Does that have any

1 implications for what we would do or wouldn't
2 do on the outcome performance side?

3 So, I think we definitely will
4 need to have those conversations, just in
5 terms of kind of our realm of working in
6 performance measurement in general.

7 Okay. I think that was the
8 last -- okay, so this is just exactly what I
9 was just saying. You know, similar issues;
10 it's related, but in terms of being out of
11 scope, as I said, it is really in terms of
12 what we really can implement and some of the
13 things that we have already talked about.

14 You know, certainly, these
15 patients have greater needs. And does payment
16 actually reflect the cost of caring for these
17 patients? And then, if it does, does that
18 have any implications for how we think about
19 outcome performance measurement?

20 So, we have a few minutes. We can
21 have some clarifying questions or some
22 comments about this or anything we have talked

1 about this morning before we go to break, and
2 just want to open that up.

3 MEMBER GARRETT: So, you gave a
4 couple of examples, Helen, of some ways that
5 NQF measures are used in national reporting
6 programs and pay-for-performance programs.
7 But, I mean, NQF measures are used a lot at
8 the local level, too. So, I think the impact
9 can't be understated here, the work.

10 DR. BURSTIN: You're absolutely
11 right, and we have really just begun to sort
12 of dive deeper into particularly some of the
13 state-based issues, which I know you are very
14 familiar with, Nancy. But, again, I think
15 these have broader implications than just
16 federal. But since there is such a strong
17 focus around some of the federal measures
18 we've been talking about, we thought it would
19 be appropriate to just give those as examples.

20 MS. PACE: I misspoke. Actually,
21 we have David presenting on the MedPAC
22 recommendations. David, you may have been

1 ready to make a comment first, but I just
2 wanted to --

3 CO-CHAIR NERENZ: No, actually, I
4 was just going to do a very mechanical
5 process. As we get to the point where it's a
6 more open flow of discussion, we just need a
7 rule for how do people indicate that they have
8 something to say. My suggestion is that they
9 do this (indicating). Because the trouble is
10 this is such a big room, that a gentle and
11 polite, this sort of gesture, we can't even
12 see at the far end. And we'll try to keep
13 track of whose things have gone into the
14 vertical mode first. Okay. And I see this
15 starting up. That's all.

16 MS. PACE: All right. David, we
17 were going to have you talk a little bit about
18 the MedPAC recommendations.

19 CO-CHAIR NERENZ: Can we have a
20 couple of comments, though, on this?

21 MS. PACE: Yes, sure. Sure.

22 MEMBER LIPSTEIN: I wanted to see

1 if we could add a third bullet to your
2 implications that derives from the evidence
3 around the human behavioral economics. And
4 you just took the slide away, which was
5 important.

6 Because the two implications have
7 to do with the cost of providing care. And
8 what's obvious now, from what Dr. Cassel
9 described and what Helen described, was that,
10 when risk exists, okay -- I'm going to take
11 this to a real high level -- in the world of
12 behavioral economics, when risk exists, people
13 will take on that risk if the rewards are
14 greater than the risk. People will try to
15 reduce the risk, and people will try to
16 eliminate the risk. But, if they can't, they
17 will avoid the risk.

18 And so, risk avoidance becomes a
19 reality when payment methodologies are
20 introduced when you introduce financial into
21 either offsetting or not offsetting risk. And
22 one of the reasons I sent in papers related to

1 a non-healthcare application, which was
2 teachers, was because in the world of trying
3 to improve public education and public test
4 scores for fifth-graders, third-graders, and
5 eighth-graders, what we have learned is that,
6 if you don't risk-adjust test scores, and
7 teachers, then, perceive themselves to be on
8 an unlevel playing field, do they avoid the
9 risk of working in high-vulnerable innercity
10 public schools? And so, there is a lot of
11 literature out there now about whether Race to
12 the Top actually became Race to the Suburbs.

13 And so, I wanted to introduce the
14 concept of behavioral economics in this
15 because it is highly relevant.

16 MEMBER GROVER: Just a question,
17 since I'm not as familiar with the NQF
18 process. And you had mentioned the role of
19 the MAP. Typically, does the MAP just say,
20 "Use this measure" or does it ever say, "Use
21 this measure, but adjust it in this way" or
22 "Use it in this circumstance or not this

1 circumstance."?

2 DR. BURSTIN: Yes, so the MAP does
3 provide some conditional support with some
4 conditions put forward. Again, I think they
5 often look towards the scientific review of
6 the measure for that input, and I think that
7 is where the issue has been, to make sure that
8 we have got the appropriate input for them as
9 they are making that. Do they have the right
10 information to make those recommendations?

11 But it's an excellent question.

12 MEMBER CASALINO: Yes, I'm just
13 delighted to hear that NQF is open to
14 discussing at least the possibility of
15 recommendations for how these measures could
16 be used.

17 But I just want to highlight, once
18 again, I think it seems to me that this is
19 different than the average thing that NQF has
20 had to consider in the past, right? So, it is
21 one thing to think about what's a good measure
22 of cardiovascular care, right? And that's not

1 easy to do, but one can use certain criteria
2 to decide what is a good measure and, then,
3 put it out there, and that's it, right?

4 Well, so we really have two tasks,
5 as I see it. One is that, right? What is a
6 good measure or measures of SES, for example,
7 right?

8 But a lot of the energy in the
9 room, however, appears to be about the other
10 task, which is a less traditional task for
11 NQF, as I understand it, which is how should
12 the measure be used. And that's important for
13 SES measures in a way that is not true for
14 just measuring cardiovascular care, you know,
15 what you could measure of cardiovascular care.

16 Because, I mean, if you asked me,
17 I think, or probably, it sounds like, most of
18 the people in the room, "Would you endorse X
19 measure of SES?", you know, my answer right
20 now would be, "Well, yes, that's a good
21 measure, but depending on how it's used, it
22 could make things much worse. It could make

1 disparities much worse or it could make them
2 better."

3 So, I can't endorse that measure
4 without also give me statement about the ways
5 that the measure I think could be accurately
6 use. Because, if it is just endorse, yes or
7 no, we're put on the horns of the dilemma
8 which we're all aware of.

9 So, I do think that most of the
10 energy in the room that we have heard so far
11 is about the second task, which is how it
12 should be used, how measures should be used,
13 the SES measures. But, you know, the first
14 task is also a difficult one. And
15 fortunately, there are some experts in the
16 room, not including me, to help us decide,
17 well, leave aside for the moment how should
18 they be used; what actually are good measures
19 of SES for our purposes?

20 MEMBER SUGG: To kind of segue on
21 what you are saying, I think when we talk
22 about socioeconomic status, the issue is, if

1 we try to get very granular, so we can really
2 compare quality to quality, it takes a lot of
3 money to do that. And I think, when we talk
4 about cost, that is one of the things that I
5 want to make sure is really out there: what
6 is the burden if we want to collect a whole
7 lot of socioeconomic things, so we have a
8 really good quality measure? Great. But if
9 we have overburdened organizations and
10 actually taken away money from patient care to
11 do this, then we also increase the
12 disparities.

13 So, it would be great if we could
14 put all these amazing things into our
15 socioeconomic status, but I am very sensitive
16 to how much is this going to cost medical care
17 to do this.

18 CO-CHAIR NERENZ: Let me just make
19 one quick response to Larry's point, and I'm
20 going to look very much sideways for
21 clarification because I am going to say
22 something that I may not be the right person

1 to say.

2 But it had not occurred to me
3 until you said it that our task or NQF's task
4 was to endorse SES measures. It just hadn't
5 occurred to me, with that phrase in it, that's
6 what we were about here, at least in the sense
7 that NQF endorses quality or performance
8 measures.

9 I had understood our task to be
10 that we were talking about the inclusion of
11 one or more sociodemographic factors in the
12 adjustment of quality or performance measures.
13 I'm seeing some nods around the table.

14 So, I am checking here, too,
15 because I worry we could be distracted if we
16 somehow begin to think that NQF is in the
17 business of literally endorsing SES measures.

18 MS. PACE: You are absolutely
19 right. We are talking about use of these
20 factors in adjustment of outcome performance
21 measures.

22 Now, obviously, part of that

1 discussion is what sociodemographic factors
2 and how that can be measured and the data
3 burden, et cetera. But you're right on in
4 terms of our mission.

5 DR. BURSTIN: And just to build on
6 that a bit, we have been doing a fair amount
7 of work in the population health space. We
8 have, in fact, been looking at the question
9 of, should we be endorsing measures, for
10 example, of social determinants of health and
11 this question of, is it at what level? Is it
12 a community? Is it a state? So, these issues
13 are on the table, but I think they are
14 directly on the table for this particular
15 discussion.

16 CO-CHAIR NERENZ: And then, having
17 going that step out on a limb, I'll go yet
18 again. In response to a comment Norbert made,
19 it had also not occurred to me that we would
20 be talking about situations in which SES or a
21 sociodemographic variable was a dependent
22 variable with, presumably, some healthcare

1 thing as the independent variable. It had
2 occurred to me, I had assumed it was always in
3 our discussion the other way around, that the
4 SES or sociodemographic variable is an
5 independent variable; a healthcare performance
6 or quality measure is the dependent variable.
7 And I am seeing a few nods about that as well.

8 MEMBER GOLDFIELD: I don't know
9 who added that, because I think, Kevin, in
10 your email, you know, actually brought that
11 issue up. I mean, I will discuss that in one
12 of the slides that I will show.

13 CO-CHAIR NERENZ: All right. I'll
14 do this very quickly because I know we are up
15 against our break time.

16 And first of all, a little context
17 explanation. In the previous version of the
18 meeting agenda, this made much more sense than
19 it does now, just the sequence.

20 (Laughter.)

21 There was going to be a CMS
22 presentation about their general policies and

1 principles about SES adjustment, which
2 generally are of the nature not to do it. And
3 then, in that context, it made sense to say,
4 well, why did MedPAC do something different?
5 And then, I was going to talk a bit about
6 that.

7 We don't have the previous
8 context, but here we are. So, what I will try
9 to do just very quickly is to talk about the
10 recommendation MedPAC made in the June 2013
11 report about the hospital readmission measure,
12 which, in fact, we did perceive as being
13 somewhat running against the grain of the
14 typical CMS and NQF policy.

15 I tried to be just literal in the
16 selection of tables from the report. They end
17 up being a little busy. I hope people are
18 close enough to one screen or another that
19 they can see it.

20 The real technical trick here,
21 though, is I have, will have shortly, a laser
22 pointer that can only shoot at one screen at

1 a time.

2 (Laughter.)

3 I haven't learned how to do this.

4 I can't even get to the -- oh, there we go.

5 Okay. As long as I don't hit something.

6 All right. The issue in front of
7 us at MedPAC back a year or so ago was what we
8 started with, an observed empirical
9 relationship between a particular measure of
10 low income and the readmission measure.

11 So, what we start with here is a
12 table in which hospitals are grouped into 10
13 deciles on the basis of the proportion of
14 their Medicare patients who are eligible for
15 supplemental security income. So, I will
16 point out right here this is just one
17 variable. There could have been others. This
18 has at least some advantage of being
19 objectively measured. It's hard to game.
20 It's in administrative datasets.

21 And we clearly could, staff
22 actually, since Commissioners didn't do this,

1 could have done quintiles, could have done
2 quartiles. It just happens to be deciles
3 here.

4 So, the deciles are defined by the
5 percent of patients in the overall Medicare
6 mix who are on SSI from low to high. So,
7 relatively affluent patients, relatively poor
8 patients.

9 The key point is that, if you look
10 at the average readmission penalty -- and this
11 is now a percent of hospital revenues -- it is
12 relatively small here; it is relatively large
13 here. If we, then, look at the percent of
14 hospitals who got the max penalty, relatively
15 small here; relatively large here, a factor of
16 four difference.

17 And then, it is just the inverse
18 or converse. Those percent with no penalty,
19 relatively high here; relatively low here.
20 Okay? So, that's the starting point.

21 And as a group, we felt this was
22 wrong. And I guess I may as well just say

1 that explicitly.

2 Okay. Next slide.

3 So, there was an alternative
4 method derived that would apply the penalty
5 within strata. So, if you were relatively
6 high in your readmissions, within your decile
7 there would be a penalty. There are some
8 technical details we don't have time to get
9 into here.

10 But, basically, these are sort of
11 the current state penalties as a percent of
12 hospital revenues. It repeats what we saw in
13 the previous slide. In a peer group
14 comparison where you're compared to those in
15 your decile, these are relatively even.

16 Now you see these are all
17 relatively high, actually. That's because
18 there was an arbitrary target set. That could
19 be modified up/down. So, you could make these
20 as big or small as you wanted. The point
21 though, is that they are relatively equal
22 across the deciles.

1 Okay. Next slide.

2 Now we recognize, of course, that
3 this is not a static thing, that every year
4 hospitals do work on this. We have evidence
5 of national improvement. We have evidence of
6 local improvement.

7 So, there was a question, so what
8 happened if all the hospitals got 10 percent
9 better? I won't walk through every slide,
10 except just to point out that, under the
11 current penalty, again, there's a relatively-
12 light hit here, a relatively-heavy hit here.

13 And if you apply the adjustment
14 model -- and here's where this table gets a
15 little difficult to follow -- it becomes more
16 even, but, again, it is a little hard to
17 intuit this when it is expressed as a percent
18 of revenue penalty. The only thing I can say
19 is that it is relatively more even, which I
20 think is the point of the adjustment.

21 Okay. Next slide.

22 So, again, this is just to

1 represent an illustration. The first thing is
2 the stratification here involves a
3 stratification of hospitals into deciles that
4 are defined by this percent SSI. There are
5 all sorts of other ways to do stratification.
6 This is a way.

7 We did not talk about, nor
8 recommend, the stratified reporting of
9 readmission rates within each hospital for
10 individuals either with or without SSI or some
11 other variable. We didn't say anything
12 against it. We just didn't speak to it. So,
13 just to point out, that could be also part of
14 this picture.

15 Percent SSI is an option, one
16 option among many; could have done something
17 else. The fact that it is a MedPAC
18 recommendation does certainly not mean that it
19 is law or that it is CMS policy. We advise.
20 People either take the advice or they don't.
21 So, it has that standing, but has not yet been
22 implemented, to my knowledge, as actual

1 policy.

2 And then, we have this question
3 that kind of gets into this interface between
4 what's performance measurement and what's
5 payment. We recognize this could be a
6 question, well, do you need to do that if
7 these high SSI hospitals are already receiving
8 DSH payments? I mean, hasn't the problem
9 essentially already been solved? And we just
10 observe -- and this is just a verbatim cut-
11 and-paste from the report -- that, in
12 principle, the DSH payments go for the higher
13 cost of treating patients while in hospital.
14 They are not designed to cover any excess cost
15 related to readmission or to offset a
16 readmission penalty. And I see some nods
17 around the table.

18 Okay. So, that's it. It's just
19 to indicate that there is this recommendation
20 out there. It would have made a little more
21 sense this morning if we could have set that
22 a little more clearly, sort of against where

1 CMS has been on this. But it is an
2 illustration and it is a formal MedPAC
3 recommendation.

4 I am not personally aware of any
5 response. They would not come to me. Again,
6 those tend to come to Mark Miller or to Glenn
7 Hackbarth, not to me. I'm only one of the
8 Commissioners.

9 Others actually may be able to
10 speak to that.

11 MEMBER GROVER: I can tell you
12 that, during both discussions with Senate
13 Finance originally in thinking about this, the
14 original legislative language had more
15 explicit direction to HHS to account for
16 factors such as SES. That was stripped in the
17 end, but it was still an option with the
18 Secretary.

19 And so, when this data and similar
20 data that we ran and did by DSH percentile
21 showed similar findings, I think the two
22 responses we really got were, one, that means

1 somebody who is not losing as much money now
2 is going to lose more money, and we're worried
3 about doing that. Otherwise, we will get less
4 money out of the hospitals as a group, and we
5 don't want to give it up.

6 And third, they ultimately came
7 back to, well, if Denver Health can do this,
8 and they have a decent outcome, why can't the
9 rest of you, right? So, if I can find you one
10 example of a place that it works, then Henry
11 Ford and BJC and everybody else should do it.
12 That was their response.

13 MEMBER LIPSTEIN: So, you have
14 introduced the subject of stratification,
15 which I think is an important topic for our
16 panel to think about and talk about. But it
17 reminded me of something Gene said. Because
18 there is literature that suggests that within
19 strata you can still make improvements in
20 readmission rates. And not everybody who is
21 a high SSI decile necessarily has a poor
22 readmission outcome.

1 So, we went in search of what else
2 is going on. And having lived in Baltimore,
3 East Baltimore, at the time they closed
4 Baltimore City Hospital, and then, lived in
5 Chicago where they have Cook County Hospital,
6 and worked in Atlanta, where they have Grady
7 Memorial, what we found -- and this is really
8 important -- is that each part of the United
9 States has a different tax base.

10 And so, in the case of Denver or
11 Cook County or Atlanta, there's a local tax
12 base that supports the regional safety net.
13 And if you don't have a local tax base that
14 supports the regional safety net, even if you
15 have a high percentage of SSI or a high
16 percentage of DSH payments, there are local
17 circumstances that really drive outcome.

18 And so, what I am worried about
19 here isn't BJC. In rural communities, they
20 just can't increase taxes to support their
21 safety net. In Denver, they do increase taxes
22 or do have taxes. In Kansas City at Truman

1 Medical Center, it pays for a whole primary
2 care apparatus when you discharge patients
3 from a hospital into the community, if there
4 is a safety net there that is funded by the
5 local community.

6 What is happening in America right
7 now is federal funding of the local safety
8 nets is changing through reduction of DSH
9 payments or through these penalties. And so,
10 it comes back to, if you write policy at the
11 federal level, MedPAC, without recognizing
12 that there's real variability in local tax
13 bases supporting safety nets, you get very
14 variable outcomes.

15 And one of the purposes of NQF
16 policy is to eliminate variation or eliminate
17 disparities. But if you don't address those
18 local tax base issues, you are going to again
19 get to the wrong answer.

20 MS. PACE: Okay. One more
21 comment, and then, we need to break and get
22 back.

1 MEMBER SAWHNEY: We need to keep
2 some different perspectives in mind. One is
3 we all come from a public health background,
4 but one of the major players is the commercial
5 insurance players. And we're all very
6 comfortable talking about race and racial
7 disparities.

8 Commercial insurance companies
9 have a history that goes back long before I
10 was in the industry of acting very badly with
11 respect to race and getting their butt sued.
12 And after that, they officially became race-
13 blind. Now it is not to say they really are,
14 but they try very hard to keep up that
15 pretense and to openly talk about race and
16 race disparities in commercial context. This
17 is very difficult for them.

18 And I'm just putting that on the
19 table. They will talk about income much more
20 readily, and they are players in this.

21 The other thing, they are also
22 players -- I mean, Medicare and Medicaid have

1 clear social good objectives. So, when we
2 talk about adjustment payments and talk about
3 adjusting Medicare and Medicaid payments,
4 that's one thing. But, then, when the same
5 providers want the commercial world to adjust,
6 that's going to be a different issue. And
7 then, the commercial world is going to say,
8 well, if we have to adjust our payments to
9 providers, who is going to pay us for that?
10 So, things to think about.

11 MS. PACE: Okay. So, we are
12 actually now behind a little bit.

13 (Laughter.)

14 But great discussion.

15 And why don't we take a 10-minute
16 break and be back here at 11:10 and we'll
17 reconvene?

18 (Whereupon, the foregoing matter
19 went off the record at 10:58 a.m. and went
20 back on the record at 11:12 a.m.)

21 CO-CHAIR NERENZ: One thing I
22 think most of us learned very early on in this

1 kind of context, there is no such thing as a
2 10-minute break. It's just not possible. You
3 can say 10; you can try 10. Twelve is not
4 bad. Twelve is pretty good. So, I think that
5 is about as good as we can do.

6 We have a couple of presentations
7 here. In terms of trying to catch up a little
8 bit, I'll watch the time allocations pretty
9 quickly and I'll start waving or flashing a
10 light or something if we are getting close.

11 There is a time block for question
12 and discussion. We don't want to cut that off
13 entirely, but let's try to have the questions
14 be clarification questions rather than broader
15 discussion, because for the rest of the two
16 days there will be much chance for some of the
17 broader discussion. And I think, by doing
18 that, then we can get this bit and, then, to
19 the next panel, and eventually to lunch, which
20 people will start thinking about.

21 All right. Susannah?

22 Let's do this: since there are

1 two in this section, if there is an
2 absolutely-direct clarifying question for
3 Susannah, let's do that before we move to the
4 next, just because, otherwise, we'll lose
5 track of it. But let's try, again, to keep it
6 very much focused on what does this number
7 mean; what did you mean when you said this,
8 that kind of thing. Okay?

9 MEMBER BERNHEIM: You'll just
10 advance slides for me? Okay, great.

11 Okay. So, I'm Susannah Bernheim
12 again, and I, as I said, come with many hats.
13 I am right now putting on my measure developer
14 hat. My goal is to talk through how we have
15 thought about this issue, particularly with
16 reference to the readmission measures.

17 I am going to show a couple of
18 slides that are pretty basic about sort of how
19 we think about risk adjustment. People are
20 coming from very different backgrounds.
21 Forgive me if this is oversimplified, but I
22 think it is an important baseline for sort of

1 how measure developers kind of approach this
2 problem.

3 I am going to show a couple of
4 slides that show analyses and try to say both,
5 per Karen's request, whether we have done this
6 in other measures, so people have a sense of
7 how universal these findings are, and how we,
8 as measure developers sort of think about
9 these findings. And then, I have a couple of
10 conclusions. And I am going to try very hard
11 to go slow enough that you can understand me
12 and quick enough that we are within 10
13 minutes.

14 So, when we are building risk-
15 adjustment models for the purpose of measuring
16 quality, this first one is a very important
17 point, and it is often confused. We are not
18 aiming to maximize patient-level prediction.
19 I am not putting everything I can in the model
20 to predict whether or not a patient is going
21 to be readmitted. And there's a number of
22 reasons for that.

1 But the most obvious is that I am
2 trying to illuminate quality. So,
3 conceptually and very simplistically, as a
4 measure developer, we think about a patient
5 outcome as being the result of the baseline
6 status that they come in with, the quality of
7 what -- this especially applies to
8 hospitalized patients -- the quality of what
9 we do, and some random variation producing the
10 outcomes.

11 So, what I am trying to do is
12 level the playing field for those baseline
13 factors and not adjust for anything that is
14 largely mediated by the quality of the care
15 that is provided, because I am trying to
16 illuminate those differences.

17 So, to make this really concrete,
18 if I wanted to predict mortality, and I knew
19 whether a patient had had a complication that
20 led to them going to the ICU, I would
21 certainly build that into my prediction model
22 because those patients are more likely to die

1 in the next 30 days.

2 If I want to look at quality, a
3 hospital that, once you have risk-adjusted for
4 how sick the patients are when they come in,
5 that has more patients having complications
6 that lead to ICU stays should probably look
7 worse on a quality measure, right? So, this
8 is, again, oversimplified, but that's what is
9 in the measure developer's head: what is
10 baseline and somewhat
11 unmediateable/mediateable health status? And
12 what is potentially quality of care? And it
13 is not always a simple decision, but that is
14 sort of how we think about measures.

15 Can I have the next slide?

16 The other thing you need to
17 understand -- and this applies to the
18 readmission and mortality measures; some
19 measure developers do this differently -- the
20 measures are designed to be relative measures.
21 We are comparing a hospital, actually, really
22 not to the hospital down the street, but,

1 actually, to what the model says would be
2 expected for an average caring for the same
3 patients.

4 We use hierarchical modeling,
5 which allows us to account for the clustering
6 of patients within hospitals. It produces a
7 ratio, which we call a predicted-to-expected.
8 The predicted is complicated, and I spend a
9 lot of my days trying to stand between
10 hospitals and statisticians and somehow make
11 these things make sense. But you can think
12 about it in this context as being analogous to
13 an observed-to-expected. We are creating a
14 ratio that says, how does this hospital do
15 compare to what a hospital with a similar case
16 mix would do, an average hospital with a
17 similar case mix would do?

18 And so, quite literally, when we
19 are talking about risk adjustment, we are
20 talking about the setting the expected for a
21 hospital. We are talking about setting the
22 standard. And people really don't like us

1 using the word "standard," but I think, quite
2 honestly, that's true, that when you put
3 something into the risk-adjustment model, you
4 are setting what is expected for that
5 hospital. You are saying, what is the case
6 mix of this hospital that we are comparing it
7 to? So, that is how we think about risk
8 adjustments.

9 I'm just going to make sure I
10 haven't forgotten anything crucial, but I
11 don't think I have. Okay.

12 So, the next slide.

13 There are a few basic standards
14 about risk adjustment. These are both
15 consistent with NQF and with published
16 standards about how you develop outcomes
17 measures.

18 One is that you want to adjust for
19 factors that are present at the start of your
20 measurement period. That is also consistent
21 with what I said about complications.

22 And again -- I sort of said this

1 earlier -- you don't want to have the factors
2 that are clearly affected or mediated by
3 quality, like complications.

4 SES is really hard. So, as a
5 measure developer, how do I think about SES?
6 I know that SES affects baseline health
7 status, and our models reflect that.

8 So, I will tell you that, when we
9 look at Medicaid versus non-Medicaid patients
10 in our models, the expected readmission rates
11 for the Medicaid patients are higher. They
12 are sicker, and the model counts them as
13 sicker. So, we are accounting to some extent
14 for the fact that these patients are coming
15 in. Part of the way SES plays out is that
16 patients come in sicker, and the models
17 accounts for that.

18 There are many ways in which
19 quality of care can intercept with SES. We
20 know from some of the literature on race, in
21 particular, that Black patients are more
22 concentrated in poor-performing hospitals.

1 They are literally going to hospitals that do
2 less well. We know that there may be within
3 hospitals differential treatment, and we know
4 that hospitals may, in the context that we
5 have been talking about before around
6 resources, not be able because of resource
7 constraints to give the same or I guess to
8 give the quality of care we would aspire to,
9 that some patients may require more resources,
10 and hospitals may or may not be able to
11 provide that. And that is a very complicated
12 one.

13 And last, there may be pathways
14 that don't fit into either of my nice boxes,
15 which is sort of what happens on the back-end
16 and how much can a hospital or a health system
17 affect adherence or access. So, there's lots
18 of ways that SES can play out. So, it doesn't
19 fit into one of the boxes. And so, we're
20 stuck sort of thinking about what is the
21 risk/benefit of where to put it in our models.

22 The one thing I will say is this

1 concept of sort of the hospital's
2 responsibility has been -- actually, let me
3 show you some data, and then I will come back
4 to that.

5 So, the first thing we do -- and I
6 don't want to actually go to the next slide
7 yet because I want to set the stage for it --
8 is we just look at the hospital level, at how
9 hospitals that are caring for a large
10 proportion of low SES patients compare on the
11 measures to hospitals that have fewer low SES
12 patients.

13 And I will tell you we have done
14 this using many measures of SES. The easiest
15 thing for us to do is to look at the
16 proportion of patients that are of Medicaid
17 status. And we can do that either at the
18 hospital level or the proportion of patients
19 within the measure that have Medicaid. We
20 have linked patients' zip codes to the Census
21 tract and looked at the median income or the
22 poverty level from their Census tract. We

1 have identified hospitals based on whether
2 they are considered safety-net hospitals,
3 comparing them to the average Medicaid
4 caseload in their state, because Medicaid is
5 different by states, and whether they are
6 public hospitals. We have looked at this
7 percentage.

8 We have grabbed what variables we
9 can and done these analyses many different
10 ways. And the two key things to know are you
11 identify different hospitals, right? And this
12 Committee knows this, but when I said who are
13 the 20 percent of hospitals caring for the
14 greatest burden of low SES patients based on
15 Medicaid status, they are not the same, if I
16 say who are the 20 percent of hospitals caring
17 for the greatest proportion of low SES
18 patients based on the zip code median income.
19 And I don't know what the right one is.

20 So, what I have chosen to show you
21 today is actually the most extreme version of
22 this because I don't want to oversimplify

1 this. So, what we have done in the next slide
2 is we have taken hospitals and the heart
3 failure readmission measure, and we have used
4 Medicaid status, because that's where we get
5 the most extreme differences, and we have
6 taken the 20 percent of hospitals that have
7 the fewest Medicaid patients and we have taken
8 the 20 percent of hospitals that have the
9 greatest percentage of Medicaid patients, and
10 we have just lined up the distribution of
11 their performance.

12 And now to the next slide.

13 So, what you see here -- oh, the
14 slide doesn't work perfectly; I seem to have
15 repeated my figure.

16 So, what you see here is what we
17 call the Q1, which is not actually quartile.
18 It is quintile 1. These are hospitals that on
19 average have only 7.1 percent of their heart
20 failure patients with Medicaid, and the Q5
21 hospitals are hospitals that on average have
22 55 percent of their patients on Medicaid. So,

1 a pretty big difference in the case mix I'm
2 looking at.

3 And you see that the white and
4 gray is those Q5 hospitals. These are the
5 readmission rates, the distribution of
6 readmission rates for hospitals caring for a
7 greater proportion of Medicaid patients, and
8 the Q1 is the distribution of hospitals'
9 performance on the readmission measure for
10 those caring for the lowest percentage. And
11 they overlap a lot, and they don't overlap
12 completely, right?

13 So, again, what I have given you
14 -- and we have done this now looking at
15 certainly all of the publicly-reported
16 measures and a number of the measures in
17 development, and generally, these curves
18 actually overlap more. What you see is that
19 there is a difference between those two curves
20 and that they are largely overlapping.

21 And Steve loves it when CMS says
22 this, but I will say it again: you see in

1 those white bars many hospitals with very
2 large Medicaid proportions achieving low
3 readmission rates.

4 MEMBER OWENS: Just a quick
5 clarifying question. When you say "percentage
6 of Medicaid patients," is that percentage of
7 Medicaid patients who are also Medicare, or
8 are you looking at a hospital characteristic
9 overall in your definition, whatever
10 definition, you are actually all patients --

11 MEMBER BERNHEIM: Right.

12 MEMBER OWENS: -- because you have
13 focused mostly on --

14 MEMBER BERNHEIM: So, we have done
15 it both ways without a huge difference in our
16 findings. In this case, this is the heart
17 failure readmission measure, and we are
18 looking at the proportion of the patients who
19 are all fee-for-service Medicare patients in
20 the measures who are dually eligible for
21 Medicaid. So, I should have been more clear
22 about it.

1 But, again, we have done it by
2 just looking at the hospital's percentage
3 among all their patients as well.

4 So, what do we do with this? As a
5 measure developer, we say these are a little
6 bit different, and we see that there is a lot
7 of burdened by low SES hospitals performing
8 well on the measure. And it doesn't fully
9 answer the question, but it is important.

10 I am just making sure I'm keeping
11 up with my own notes here.

12 And we don't know how to interpret
13 the slight difference that remains, again,
14 whether this has to do with inherent patient
15 factors or differences among what hospitals
16 are capable of. But we do think that it is
17 important that these hospitals are capable of
18 performing well on this measure.

19 The next thing I am going to show
20 you is what if we took this exact same measure
21 with the Medicaid status as an indicator of
22 risk and in the patient model risk-adjusted

1 for it. And we are often reticent to show
2 this figure because I don't think conceptually
3 whether risk adjustment makes a difference or
4 not is the right rationale for putting it in
5 the model. I think it is more of a conceptual
6 thing. But people are really interested to
7 see this.

8 So, if you'll go to the next
9 slide?

10 Here I have on the X-axis the risk
11 standardized readmission rates for all of the
12 hospitals with the current measure that is in
13 public reporting. I have now pulled into the
14 model on the Y-axis adjusted for the same
15 patient-level measure that I used in the
16 previous one to define the hospital groups.
17 And we have color-coded, and I know this is
18 hard to see, but that is part of the point.

19 So, the Q1 hospitals are the ones
20 who had the least low SES patients. They are
21 in blue. You can see that they rise a tiny
22 bit off the line, if you look really

1 carefully. We have lumped all the Q2 through
2 4 hospitals together. I think that is
3 mislabeled as Q5. It is Q2 through Q4. They
4 are the yellow hospitals. And then, you can
5 see the red hospitals are the ones that have
6 the greatest proportion of Medicaid patients.

7 And you see that, in fact, despite
8 the slight differences we saw in the two
9 distributions, when we add SES to the risk-
10 adjustment model, it makes very little
11 difference. And I'll give you some numbers to
12 go with this, just so you have a sense.

13 Of the Q5 hospitals, those with 55
14 percent on average Medicaid patients, their
15 RSRs change on -- the median hospitals' RSR
16 among that group changes by 0.17 percent. And
17 the ones that change the most, 5 percent of
18 the Q5 hospitals by 0.5 percent. And you're
19 now down to 20 percent of hospitals, and 5
20 percent of those changing by half a percent.

21 So, in this measure we don't see a
22 big difference. And again, we have done this

1 with the income as well to see if it looks
2 different.

3 MEMBER LIPSTEIN: Susannah, just
4 because I don't know how the statistics work,
5 the variability of eligibility from state to
6 state, does that all just get mooshed in here
7 or does this somehow take into consideration
8 that some states are eligible up to 138
9 percent of federal poverty and some aren't
10 eligible at all?

11 MEMBER BERNHEIM: Right. So, this
12 doesn't, which is why we have done it other
13 ways, because there is inherent problems with
14 all these variables. So, then, we have linked
15 to income; it looks the same.

16 What we can't do is -- well,
17 what's too complicated to do in this room is
18 to try to account for those things
19 simultaneously. Maybe somebody could. I
20 don't know if it would make a huge difference.

21 Do people have other questions on
22 this?

1 CO-CHAIR NERENZ: I know it's a
2 little tough. We're already a little past 10
3 minutes.

4 MEMBER BERNHEIM: Oh, are we?
5 Okay, I can be real fast. I've got two more
6 slides and that's all.

7 Okay. Next slide.

8 Okay. So, conceptually, now we
9 are still stuck with this problem of sort of
10 patient-versus-hospital influence. So, we did
11 one other analysis. This we did in the
12 hospital-wide measure.

13 And here's what we did: we took
14 the hospitals and stratified them based on
15 Medicaid patients, but, then, we ran the model
16 only on their Medicare patients. So, they are
17 now not being judged on the outcomes of the
18 Medicaid patients; they are only being judged
19 on the outcomes of their Medicare patients,
20 but we know what group they are in.

21 What you see is that the high
22 Medicaid hospitals still have slightly higher

1 readmission rates among their Medicare
2 patients, which are used at least for some
3 influence of the hospital.

4 I am going to do one last slide.

5 And we can talk about this later,
6 but it is really important to understand with
7 these measures that stratification is not
8 simple. So, I am not going to talk about
9 patient-level stratification because it hasn't
10 been mentioned a lot.

11 But there's two ways to think
12 about stratification at the hospital level.
13 What we have to remember is that these
14 measures are observed-to-expected-ish. So,
15 you come up with a ratio, and then, you
16 multiply it by a national rate.

17 So, if you separate hospitals into
18 two groups before you run the model, you then
19 have different rates. And so, it is going to
20 be very confusing because Hospital A from
21 strata 1 and Hospital B from strata 2 might
22 both be 24 percent, but for one of them that

1 was against a 23.7 national rate. So, they
2 are actually doing a little worse than
3 expected. And the other one, it was 24.5, and
4 they look the same, right? Big mess.

5 What you can do is run the model
6 on everybody -- and this is what I believe
7 MedPAC's recommendation is -- and then,
8 stratify the hospitals and set a cutpoint that
9 is different for the two strata, right? And
10 that's my understanding of MedPAC's
11 recommendation. That's not really stratifying
12 the measure. It is stratifying the hospitals
13 after you have applied the measure.

14 My last one is just a conclusion.
15 It just says what we found. We don't find it
16 determinative of hospital performance. There
17 is a wide range: how SES defined changes,
18 what hospitals are identified as low SES.
19 Risk adjustment does not change hospital
20 performance substantially, and we find that
21 there's both a hospital influence as well as
22 a patient influence on the outcomes.

1 CO-CHAIR NERENZ: Thank you.

2 Any other immediate clarifying
3 questions?

4 Yes, Nancy?

5 MEMBER SUGG: I just had a
6 question. When you said that you ran it also
7 by income --

8 MEMBER BERNHEIM: Uh-hum.

9 MEMBER SUGG: -- was that zip code
10 income? Okay.

11 MEMBER BERNHEIM: Yes, it is zip
12 code income, which I think at a patient level
13 may not be ideal, but at a hospital level, if
14 you are trying to understand whether they've
15 got a lot of poor patients, if you know all
16 the neighborhoods they're coming from, it
17 probably helps you understand the kind of
18 patients. And then, we see hospitals with
19 over 90 percent coming from low-income areas
20 and other hospitals with 1 percent.

21 CO-CHAIR NERENZ: Thank you. Very
22 helpful.

1 Our next person is actually on the
2 phone, I understand.

3 MS. PACE: Yes.

4 CO-CHAIR NERENZ: Okay. So, I was
5 looking around the room to find that person
6 and said, wait a minute, I'm lost.

7 (Laughter.)

8 MS. PACE: Sajid?

9 MR. ZAIDI: Yes, I'm here. Can
10 everybody hear me?

11 MS. PACE: Yes. Do you want to
12 just introduce yourself quickly? And then, we
13 will get into your presentation.

14 MR. ZAIDI: Yes. So, I am Sajid
15 Zaidi. I'm a measure developer here at
16 Acumen, and we are the measure developer for
17 the Medicare spending-per-beneficiary measure
18 contracted with CMS.

19 Yes, and so, we just went through
20 the NQF endorsement process, actually, this
21 fall. So, yes, we have been looking at these
22 issues quite a bit.

1 So, should I just get started
2 then?

3 CO-CHAIR NERENZ: Yes, please.

4 MR. ZAIDI: Okay, great.

5 Could we go to the second slide,
6 please?

7 CO-CHAIR NERENZ: We're there.

8 MR. ZAIDI: Great.

9 So, I would just like to provide a
10 brief overview of the Medicare spending-per-
11 beneficiary measure for those who may not be
12 familiar with it. The MSPB measure measures
13 total Medicare-allowed cost for
14 hospitalization episodes. So, it is a cost
15 measure for hospitals where cost is defined as
16 spending by Medicare. An MSPB episode
17 includes all Medicare Part A and B claims, but
18 not Part D, between three days prior to the
19 index admission date up to 30 days after the
20 hospital discharge date.

21 This measure includes all
22 conditions. So, it is all discharges. It

1 applies to Medicare fee-for-service
2 beneficiaries discharged during the period of
3 performance, which is usually a one-year
4 period, for hospitals paid under the inpatient
5 prospective payment system which are located
6 in the 50 states or D.C.

7 The measure is payment
8 standardized and risk adjusted to allow for a
9 comparison across all hospitals in the
10 country. So, we remove things like IME and
11 DSH and the effects of the wage index.

12 The MSPB amount is the average
13 payment standardized risk-adjustment spending
14 across all of the hospital's eligible MSPB
15 episodes. And then, in order for an episode
16 to be eligible, you know, the patient has to
17 be enrolled in Medicare fee for service
18 through the whole episode time window, and
19 they can't have a primary payer other than
20 Medicare.

21 And finally, the final MSPB
22 measure is the ratio of the MSPB amount for

1 that hospital divided by the median MSPB
2 amount across hospitals. So, this is just for
3 ease of interpretation. So, a measure of 1
4 means that the hospital is performing, is at
5 the median across all hospitals.

6 Next slide, please.

7 So, I would like to briefly
8 describe the MSPB risk-adjustment model, and
9 I would like to reiterate what Susannah said.
10 Basically, we are trying to control for
11 everything that we think is outside the
12 provider's control at the start of the MSPB
13 episode. So, we are using all the information
14 we have which is present at admission to the
15 index admission for the MSPB episode.

16 So, the risk adjustment uses an
17 augmented ACC model and includes the following
18 variables: age, the HPC variables and their
19 interactions, ESRD status, disability status
20 which is defined as whether they are eligible
21 for Medicare under the disability provisions.
22 We control for the MS-DRG of the index

1 admission, and we also control for whether the
2 patient is institutionalized in the long-term
3 care facility.

4 We don't control for gender or
5 Medicaid status, and we did this to be
6 consistent with NQF policy at the time that we
7 were formulating our measure. But, for the
8 purpose of NQF endorsement, we did test the
9 effects of including Medicaid status as a risk
10 adjuster. And those are the results I'll
11 describe here today.

12 Oh, and one final note. We used
13 linear regression because cost is a continuous
14 variable.

15 Next slide, please.

16 So, these tables describe the
17 episode level differences in spending between
18 Medicaid beneficiaries and non-Medicaid
19 beneficiaries. And, of course, this is just
20 restricting to the Medicare population. So,
21 we are looking at Medicare beneficiaries who
22 are also eligible for Medicaid versus those

1 who are not.

2 So, in the first table you can see
3 that, just looking at observed costs without
4 doing any risk adjustments, Medicaid
5 beneficiaries are more expensive on average
6 than non-Medicaid beneficiaries, but the
7 difference in the magnitude is not as great as
8 one would think. It is a difference of about
9 2 percent.

10 After risk adjustments -- so, that
11 is the second line -- you can see that the
12 difference is still there, and it is around
13 the same magnitude of about 3.1 percent. I
14 wouldn't interpret the difference between the
15 2 percent and the 3.1 percent, I wouldn't
16 interpret that as being significant. The
17 magnitude is very similar.

18 The next table shows the
19 coefficient if you include a variable for
20 Medicaid status in the regression. And the
21 magnitude of the coefficient is around \$1,000,
22 which if you express that as a percentage of

1 the average episode cost, that's around 5
2 percent of cost. You know, the p-value is
3 zero. So, it is highly statistically-
4 significant. So, Medicaid does, we can
5 conclude that Medicaid status does have an
6 impact on predictive cost.

7 Next slide, please.

8 So, this slide shows the actual
9 impact on hospital rankings if you include a
10 Medicaid status indicator in the regression.
11 So, for the Value-Based Purchasing Program,
12 the actual achievement and improvement points
13 that a hospital received are based on the
14 decile that the hospital falls in compared to
15 all hospitals in the country.

16 And so, this first table shows the
17 distribution of decile changes. So, if a
18 hospital doesn't change the decile they're in,
19 when you include Medicaid in the risk
20 adjustment versus not including it, they would
21 show up in the no-change row.

22 So, what you can see is 84 percent

1 of hospitals do not change the decile that
2 they are in in the distribution, and over 99
3 percent have a change of one decile or no
4 change. So, including Medicaid status doesn't
5 actually have that much of an effect on the
6 final distribution of MSPB measures across
7 hospitals.

8 And the second table on this slide
9 shows the improvement in the r-squared of the
10 regression. You can see it is a very
11 negligible improvement in the r-squared when
12 you include Medicaid status.

13 So, I think the takeaway here is
14 that Medicaid status does have an impact. It
15 is a statistically-significant coefficient.
16 But, in terms of explaining overall variation,
17 it is very negligible, of course, with the
18 major caveat being that is after controlling
19 for all the other health factors that we have
20 in the model.

21 So, once you control for the ACCs
22 and DRGs and AH and all those other factors,

1 it seems that Medicaid doesn't contribute that
2 much extra in terms of explaining overall
3 variability.

4 Next slide, please.

5 So, yes, this just repeats what I
6 just said. Our conclusion is that including
7 Medicaid status in the risk model has a
8 statistically-significant effect on spending,
9 about 5 percent of average episode cost, but
10 the change in r-squared is negligible.

11 In terms of final results,
12 including Medicaid status has very little
13 effect on final hospital ranking. And the
14 final note that I would make is that Medicaid
15 status may have a more limited effect for the
16 MSPB measure than for other cost measures,
17 such as total per-capita cost, because MSPB is
18 conditional on being hospitalized. And we
19 know that a big part of the extra cost for
20 Medicaid beneficiaries is their rates of
21 hospitalization in the first place.

22 And the MSPB measure also controls

1 for the initial DRG. And again, that is
2 another margin of variation that Medicaid
3 status could be having an impact on.

4 So, yes, that's the end of the
5 presentation, and I would be happy to take any
6 questions that people might have. Thank you.

7 CO-CHAIR NERENZ: Okay. Thank
8 you. That was great.

9 We'll moderate questions, but
10 because you can't see, I don't think, who is
11 asking, I'll just ask people to start with
12 their names, just so you know who is asking
13 you the question.

14 Yes, go ahead.

15 MEMBER GROVER: This is Atul
16 Grover.

17 Thanks for your presentation.

18 Two questions. One, in that shift
19 of 263 or so hospitals that went down by one
20 decile, I mean, these are fairly narrow
21 differences in terms of the spend. Any
22 characteristics that you could pull out from

1 looking at those hospitals in terms of region,
2 size, public, private, teaching, that might
3 help us get a sense of whether there is a
4 cohort that is moving here?

5 And similarly, you know, when we
6 look at Medicare spend, and if you look at how
7 this is done with HRRs in general, you get
8 very different maps of the U.S. once you
9 adjust for wage indices and policy payments.
10 But, then, if you look at Medicare total
11 spend, which would include the Part D and out
12 of pocket, all of a sudden, when you go from
13 having the coasts light up as high-spend
14 areas, you end with the middle of the country
15 bottom-to-top as high-spend areas. So, was
16 any work done to look at total spend on these
17 Medicare beneficiaries?

18 MR. ZAIDI: Yes, that's a great
19 point. So, we do include out-of-pocket costs.
20 This is total Medicare-allowed cost, which
21 includes out-of-pocket costs, but we don't
22 include Part D, as you said.

1 And we did see that same pattern
2 that you referred to. Once you controlled for
3 geographic payment differences, the coasts
4 become far less prominent in terms of overall
5 spending.

6 But I didn't include that
7 information here because it wasn't directly
8 relevant to the question of Medicaid status,
9 I think, unless I missed part of the question.

10 The first part of the question
11 about the cohort of hospitals that moved down
12 one decile, I didn't include a graph we did,
13 but we did look at the correlation of these
14 hospitals versus other factors, such as
15 teaching status, number of beds, and whether
16 they are urban or rural.

17 And what we saw is that, depending
18 on what variables you are looking at, once you
19 control for those other variables, it can have
20 a large effect on these results. So, I guess
21 the overall point is that, including Medicaid
22 status in the regression, the results could be

1 very different if you also control for other
2 hospital factors, such as teaching status or
3 the number of beds or urban/rural status. So,
4 there are a lot of interacting variables here.
5 And, yes, they are highly correlated.

6 CO-CHAIR NERENZ: Okay. Thank
7 you.

8 Mark?

9 MEMBER COHEN: I have a question
10 for the previous presentation, if that's okay.

11 CO-CHAIR NERENZ: Larry, is yours
12 on the second presentation?

13 MEMBER CASALINO: I just had one
14 point about each.

15 CO-CHAIR NERENZ: Okay. Let's
16 sort of, if you can flip order, because, then,
17 we can switch back to Susannah, but at least
18 let's stay focused on this one as long as we
19 have the slides in front of us.

20 MEMBER CASALINO: Oh, sure, yes.
21 I actually have a question, yes, about this
22 one, just a simple point. I mean, 263

1 hospitals plus the smaller number that went
2 down more than one decile, it doesn't sound
3 like a lot, but just to kind of reiterate
4 Atul's question, which wasn't entirely
5 accurate, I think.

6 If those 263-plus, it doesn't
7 sound like a lot, but if those are all
8 hospitals that have high Medicaid proportions,
9 then that's exactly the hospitals we wouldn't
10 want to hurt. And if there is 300 of them, I
11 think that is a lot, actually.

12 CO-CHAIR NERENZ: Okay. Just
13 before we move back to Susannah, any other
14 questions for Sajid?

15 I'm sorry, Nancy?

16 Okay, I'm sorry, I didn't pick up
17 the question (referring to Mr. Casalino's
18 question).

19 Sajid, is there an answer to that?

20 MR. ZAIDI: I'm sorry, I couldn't
21 hear that question.

22 MEMBER CASALINO: I'm sorry, I

1 didn't phrase it very it very clearly the
2 first time.

3 Those 263 plus some more that went
4 down more than one decile hospitals,
5 presumably, they were hospitals that had very
6 high percentages of Medicaid patients, is that
7 correct?

8 MR. ZAIDI: I didn't look at that
9 hospital-level correlation specifically, but,
10 yes, I would assume so.

11 But, again, I would emphasize that
12 a one-decile change is a relatively small
13 magnitude. We're not seeing any hospitals
14 with -- we are seeing only two hospitals with
15 more than one-decile change. And so, it's not
16 like there are hospitals moving four or five
17 deciles.

18 But, yes, I would agree with that
19 point, that the hospitals that move down one
20 decile probably have higher Medicaid
21 percentage. But there are an equal number of
22 hospitals which moved up one decile.

1 CO-CHAIR NERENZ: Okay. Nancy,
2 why don't let's go with you, if you have one
3 for both? And then, we'll come back and pick
4 up Mark.

5 MEMBER GARRETT: So, this may be
6 something that is going to be covered later,
7 but I just would like a little more
8 clarification about using Medicaid as a proxy
9 for socioeconomic status and what evidence we
10 have that you can actually do that.

11 My concern is hospitals that do a
12 lot of unfunded care or undocumented care.
13 And I'm also worried about rural hospitals in
14 states that do not have expanded Medicaid, and
15 that they're going to look worse and it is not
16 because it is worse quality. It is, again,
17 back to kind of local taxing, economics,
18 politics. So, just in general comments about
19 it.

20 MEMBER BERNHEIM: I am happy to
21 respond to it, but, like everyone here, this
22 is part of the challenge, right? You know, if

1 I think it is really about adherence, I don't
2 have a measure for that.

3 Medicaid status, when you're on
4 Medicare, is at least partially related to
5 income status, but it changes by state, and it
6 is about to change a lot. And so, I think we
7 have to really think about that, right,
8 because different states are doing different
9 things with Medicaid expansion. So, it is
10 going to differ across states even more.

11 Again, I chose that one. It is
12 not actually my favorite, but it is very
13 accessible data, and I was actually trying to
14 show the place where we were seeing the
15 biggest differences.

16 So, our group's approach has been
17 to say, even if there is not a clear right
18 variable, let's look at kind of everything we
19 can get our hands on, to see if there is a
20 different pattern. And there's different
21 hospitals, but not a different pattern in
22 terms of the relationship.

1 MEMBER COHEN: I just have a
2 technical question. When you were doing this
3 30-day readmission, right, was there control
4 for the length of the hospitalization?

5 MEMBER BERNHEIM: We don't control
6 for the length of the hospitalization, again,
7 in the spirit of sort of establishing the time
8 zero for these measures in terms of risk
9 adjustment at the entrance to the hospital,
10 because after that, theoretically, the
11 hospital is in control.

12 MEMBER COHEN: Right.

13 MEMBER BERNHEIM: But we do -- and
14 I think it is important -- have a standard
15 assessment period. So, some measures run into
16 trouble when you're being watched for seven
17 days versus 14 days, where the length of stay
18 changes how long you're actually tracking a
19 patient.

20 MEMBER COHEN: It does.

21 MEMBER BERNHEIM: So, these are
22 all standardly from the time of discharge to

1 a non-acute setting --

2 MEMBER COHEN: Right.

3 MEMBER BERNHEIM: -- for the
4 following 40 days.

5 MEMBER COHEN: But if one group is
6 sicker, can they stay longer? That might be
7 protective readmission.

8 MEMBER BERNHEIM: Right. So, you
9 don't know, when people stay longer, whether
10 it is differences in hospitals' approach,
11 complication rates, sicker. I mean, we hope
12 and believe that we're catching some amount of
13 the sicker at the time of admission. And
14 these measures have all been held up against
15 chart measures, where you have medical record
16 data to understand how sick they were and the
17 profiling of the hospital.

18 MEMBER COHEN: You know, it could
19 be correlated with the SES variable. They
20 might be sicker going in, but in longer and,
21 then, they are protected for readmission.

22 MEMBER BERNHEIM: Right. Right.

1 I mean, again, the models account, as best
2 they can, for the severity when you enter, but
3 they don't account for length of stay.

4 CO-CHAIR NERENZ: Larry again.

5 MEMBER CASALINO: It seemed to me
6 that there was a contradiction between the
7 MedPAC results and Susannah's results, and to
8 some extent Sajid's.

9 So, first of all, is that
10 perception correct? Is there a contradiction?
11 And secondly, what's the explanation?

12 CO-CHAIR NERENZ: I guess you have
13 to say more. What contradiction?

14 MEMBER BERNHEIM: So, I didn't
15 want to bring this up earlier, but I think it
16 is important. The measure is a risk-
17 standardized readmission rate and has an
18 interval estimate and hospitals have a point
19 estimate, but also in terms of being
20 identified as whether they are high- or low-
21 performers, it matters whether their interval
22 estimate crosses the national rate.

1 The way that ACA was written, it
2 uses that ratio without accounting for the
3 interval estimate. And hospitals that are on
4 one side or the other of one for their ratio,
5 that determines their penalty, and how far
6 away they are determines how big the penalty
7 is.

8 And there's three measures that
9 you can be on one side or the other for one.
10 So, many more hospitals get penalized because
11 all you have to do is be on one side or the
12 other of one. And so, part of what may be
13 accounting for that is whether the
14 accumulation of those three measures is
15 differentially adding up on those.

16 Does that make sense? I'm trying
17 to talk fast. But it is an issue of both the
18 three measures and the fact that they don't
19 take any account of the interval estimate
20 around the measure when they assign the
21 penalties.

22 MEMBER WERNER: I don't know if

1 this is what Larry was asking, but I am not
2 sure how that explains why the MedPAC report
3 seemed to find that, when you adjust or when
4 you stratify by SSI category, it seemed to
5 make a very big difference in penalties;
6 whereas --

7 CO-CHAIR NERENZ: No. I can speak
8 to that; actually, our expert staff person.

9 Essentially, that is by design,
10 meaning that if you create a model that, then,
11 applies the penalty based on a certain
12 cutpoint within each decile, you have almost
13 guaranteed that the number of hospitals or
14 percent penalized within each decile is going
15 to be the same. I mean, it is not an
16 empirical finding in the same way that some of
17 your analyses are.

18 So, in that sense, I didn't see a
19 contradiction, actually, between the two. In
20 your situations, and I think in this one, the
21 analyses do not make any intentional change in
22 the application of the penalty or a

1 calculation of, say, a per-capita cost decile.
2 Those are just left as they are, and you say,
3 how does the movement of hospitals across
4 those deciles change if you add or don't add
5 the variable?

6 But that is not what the MedPAC
7 analysis did. The MedPAC analysis actually
8 said, first of all, let's group hospitals
9 according to this particular measure. Now,
10 just intentionally and by design, let's apply
11 the penalty in a different way. Let's apply
12 it within decile rather than as we currently
13 do it.

14 And you have essentially
15 guaranteed, then, as an illustration, that the
16 number of hospitals penalized, the percent
17 hospitals where the impact as a percent
18 revenue within each decile is now the same, or
19 close to the same, not different.

20 So, again, I actually saw no
21 contradiction among these.

22 MEMBER CASALINO: Well, I am still

1 not sure I entirely grasp. I'm closer to
2 grasping the technical side. But, the
3 contradiction conceptually, you know, in my
4 mind, is based on what Susannah showed and to
5 some extent Sajid. One wouldn't think that
6 MedPAC should recommend what MedPAC
7 recommended, and yet, you did. And so, why?

8 CO-CHAIR NERENZ: Well, I mean,
9 part of it is that we were based on a certain
10 set of findings and analyses, but I think it
11 still stands as valid that in the current
12 application penalty -- and particularly as
13 Susannah just said -- it is not just the heart
14 failure component; it is actually the way the
15 measure is actually constructed with the three
16 different clinical groups. It simply is a
17 matter of fact, I think, unless there is some
18 technical error, that hospitals in the highest
19 decile, meaning the highest percentage of SSI,
20 were four times as likely to get the maximum
21 penalty as CMS currently applies as it as
22 those in the lowest decile. It is just what

1 the data show.

2 And again, I don't think that
3 essentially contradicts anything in your
4 dataset. It is just a way of manipulating the
5 numbers. But, as far as I know, the numbers
6 are correct.

7 MEMBER BERNHEIM: So, was the
8 confusion around, once there was risk
9 adjustment, why it was -- once they were
10 stratified, why it was equal, or more the
11 preliminary findings where I am showing that,
12 when you assess by quintiles, there is not a
13 huge difference between two groups? And when
14 they are dividing by deciles, they are seeing
15 bigger differences among the groups? Which of
16 those two things were the confusion?

17 MEMBER CASALINO: The latter.

18 MEMBER BERNHEIM: Okay. That's
19 what I thought. So, it is not so much about
20 why the stratification works.

21 So, I think if you take the two
22 overlapping histograms, the way the penalty is

1 set up is that it essentially takes half the
2 hospitals because the model is made in a way
3 that about half the hospitals are going to
4 have a ratio that is greater than one, and
5 about half the hospitals are going to have a
6 ratio that is less than one.

7 When you, then, look at high-SSI
8 hospitals, which we didn't do exactly, on any
9 given measure, those hospitals have a slightly
10 higher than 50-percent rate. And I can tell
11 you on the heart failure measure I think it is
12 57 percent, but I can go back and look. I
13 have it.

14 But, then, there are three
15 measures that are put into the formula. So,
16 I suspect -- I haven't done this math -- but
17 I suspect the reason they are getting numbers
18 that are even higher than the 50-some percent
19 is that, if you also have 50 percent of those
20 hospitals getting penalized for the pneumonia
21 measures, and those aren't the same ones, you
22 start to build these differentials where I

1 think that it kind of adds up. And I think
2 that that is why in that top decile you're
3 seeing higher percentages in the original
4 stratification than you would expect from my
5 histograms, because I was looking at a single
6 measure. Does that make sense? I mean, I
7 don't know that, but that is my best guess
8 about why those are different.

9 CO-CHAIR NERENZ: The geeks among
10 us could enjoy a long discussion about this.
11 We may have to take this offline and see if
12 there is something that we can come up with
13 that is relevant to the group. We can bring
14 it back sometime in the next couple of days.
15 But we probably should move on to our next
16 panel and make sure that we don't delay lunch
17 to the point that people faint and have other
18 problems.

19 MS. PACE: Okay. So, we are going
20 to move on to our panel. We are going to just
21 ask you to present from your places there.
22 You each have a microphone. Suzanne will

1 advance the slides.

2 And we really do need to ask you
3 to stick to your five minutes. I know we said
4 five to six, but we want you to try to do it
5 in five.

6 Again, we wanted these
7 presentations, again, to offer some
8 information for us to be kind of thinking
9 about. We are not really going to discuss
10 each of the presentations. You know, this
11 will carry us over into this afternoon's
12 discussions, because some of these will be
13 illustrations that we want to think about as
14 we start really delving into the issues.

15 So, with that, I think we will go
16 ahead and start with Monica.

17 MEMBER BHAREL: Great. Thank you.

18 So, in my four minutes, I'm going
19 to try and express a lot of information, but
20 there's tons of data behind this. I cheated;
21 I put two slides in one. So, I am going to
22 talk fast and go through a lot of information.

1 I am going to have to skip over clinical
2 models, which are important to understand the
3 context of this, and I'm going to have to skip
4 over a lot of the ways Massachusetts is
5 different than the rest of the country. But
6 I can get back to that offline or in this
7 presentation, or you may already know that in
8 all ways.

9 So, one of the points of focusing
10 on homeless is, one, to see if it, indeed,
11 should be looked at independently of these
12 other more traditional socioeconomic risk
13 factors, but also because it is an extreme
14 case, and extreme cases can teach us a lot.

15 So, with that, let me just go to
16 the next slide, please.

17 So, abject poverty covers a lot of
18 these SES measures that we are talking about.
19 We are talking about the extremes of poverty
20 in this case.

21 If you look at the left side of
22 the slide, you will see that, in addition to

1 the standard SES measures that we are used to
2 thinking about, we are also talking about, in
3 addition to that, compounding that, the nexus
4 of lack of consistent shelter, violence and
5 trauma that is disproportionate to any other
6 population. As an example, 96 percent of
7 homeless women have had some kind of violence
8 or trauma experience. And then, even more
9 disproportionate absence of healthy food.
10 Thinking about this in terms of health and
11 healthcare, you move to the right side of the
12 slide. All of those points that I list there
13 have data behind them in terms of where this
14 is specifically an issue for homeless
15 individuals and, also, they fit into all the
16 different categories that we are thinking
17 about not just healthcare, but environment as
18 well as behaviors, et cetera.

19 So, keeping that in mind, if you
20 can go to the next slide, please?

21 So, let's talk for a second about
22 the higher morbidity among homeless

1 individuals, in an attempt to look at
2 pathways. So, if you look at the left slide,
3 this is Medicaid data, Massachusetts Medicaid
4 data, and this is looking at disease
5 prevalence in 2010 of 6500 individuals who we
6 care for at Boston Healthcare for the
7 Homeless.

8 So, you will see profound burden
9 of disease. Just to point out a couple,
10 hepatitis C at 23 percent; the national
11 average is 1.8; mental illness at 68 percent;
12 substance use, 60 percent of the entire
13 population. And even common diseases, such as
14 diabetes, is 18 percent compared to a level of
15 8 percent in the general population.

16 So, when you look at that, I want
17 to point out one thing that has come up this
18 morning, and that is about data and where to
19 get data. The reason we fed into the system
20 our Healthcare for the Homeless patients was
21 because it is not well-collected, this issue
22 of how -- and this has come up -- who is

1 homeless. But I must say that it is possible
2 to collect.

3 The second thing is we talked in
4 some of the previous discussions about ICD-10
5 and coding. So, the hepatitis C rate, which
6 is 23, so that is a quarter of our population,
7 when we do more extensive chart reviews -- we
8 took a sample of a thousand random charts --
9 their percentage was actually 40 percent. So,
10 even this percentage I believe is an
11 underrepresentation of what is actually
12 happening in many of these categories.

13 If you move to the right side of
14 the chart, this is to give you some comparison
15 data. The statewide number is for patients in
16 our Massachusetts Medicaid PCC program. That
17 is basically non-managed care, full Medicaid.
18 And that's compared to a cohort of our
19 patients from that larger sample, about 4,000,
20 who are in our primary care panel.

21 And what I want to focus your
22 attention on here is the DxCG score in

1 relation to thinking about risk and risk
2 adjustment. So, a DxCG score in Massachusetts
3 is used by Medicaid for some risk adjustment.
4 And you'll see that the statewide group has a
5 DxCG score of 1.5, and this is averaged out in
6 2010 to about 1 for general Medicaid patients.
7 In the homeless individuals it is 3.4. So,
8 some, but not all, of the risk is captured in
9 this DxCG score, saying there's 3.4 times as
10 much disease burden for the diseases that we
11 measure.

12 Next slide, please.

13 Let's look at mortality for a
14 second. I don't need to draw on the fact that
15 there's premature mortality. In our most
16 recent, Travis Baggett from our group, looking
17 at death data, found the premature mortality
18 average age to be 51. I draw your attention
19 to drug overdose in the youngest group, which
20 is nine times higher than the general
21 population.

22 Next slide, please.

1 If you look at the left side of
2 this first, please, so if you look at etiology
3 of premature mortality, some of the
4 generalizations about homeless individuals and
5 mortality are related to substance use, as our
6 last slide showed.

7 If you look at this -- and this I
8 ask you not to share; it is a manuscript in
9 preparation -- using some techniques of
10 population attributable fractions that I can
11 go into later, if you would like, the etiology
12 of these premature mortalities was 52 percent
13 substance use. But, then, what is in this
14 unexplained mortality gap of 48 percent and
15 what is the risk associated with that, and
16 where is that? It is not known, but there is
17 something there in that 48 percent. So, about
18 half of them not explained by some of the
19 common beliefs of risk of death.

20 If you look on the right side, you
21 know, is homeless independently associated
22 with death, the real truthful answer is we

1 don't know. These are all assumptions that we
2 are making. But here is a little bit of data
3 from Steve Hwang, who is now in Toronto, from
4 our group at the time, looking at a hazard
5 ratio of almost two times for staying in a
6 shelter. And that is when you attribute --
7 everything else is matched. So, that is just
8 by staying in the shelter, about two times
9 more hazard ratio.

10 Next slide, please.

11 Just looking at the first bullet
12 point for a second, so, you know, we are
13 talking about how to tease out the issue of
14 homelessness. So, if we look for a second at
15 resource use as a proxy for disease burden,
16 then this is the cost data from that same
17 Medicaid data. And in this part of the
18 analysis, we matched DxCG scores.

19 So, for example, we are looking at
20 an individual who has, say, schizophrenia and
21 diabetes who is housed and has Medicaid versus
22 schizophrenia and diabetes who is homeless.

1 And to care for those individuals with the
2 same matched DxCG scores, so standard ways of
3 looking at risk as we now have it in the
4 system, there was a cost differential of \$210
5 more monthly to take care of the homeless
6 individuals.

7 Does that get at an independent
8 variable? Not quite, but it is a roundabout
9 way to get at it.

10 So, what I am showing you here is
11 that the morbidity and mortality data is
12 suggestive. The clinical experience is more
13 than suggestive that, when you take
14 homelessness on top of the other factors that
15 we are speaking about, that there is something
16 that happens when you put those all together
17 that the homeless compounds that is not being
18 picked up in the current system.

19 And, you know, truthfully, to get
20 direct causal data will be challenging, and
21 the methodology for that is not available.
22 But I ask us to look at, in this context that

1 we are talking now, homeless in two ways.
2 One, to think about it as a group of
3 individuals who we know are greatly affected
4 by all of these issues that we're talking
5 about, but that there is something above and
6 beyond that can be measured. That should be
7 something we should consider.

8 Thank you.

9 CO-CHAIR FISCELLA: Thank you,
10 Monica.

11 I think we are going to defer all
12 the questions until the end because we have
13 six presenters and we are about 30 minutes
14 behind. And that will also help for those of
15 you who have multiple questions to multiple
16 presenters.

17 So, let's go on to Thu.

18 MEMBER QUACH: Okay. Again, I am
19 from Asian Health Services, and we are a
20 Community Health Center that serves mostly
21 Asian immigrants. A lot of them are limited
22 English proficient patients. And so, we want

1 to consider LEP in the risk adjustment.

2 And I want to note that I am
3 presenting also on behalf of Ninez. So, she
4 will also help with some of the questions.

5 Next slide.

6 So, in terms of the question that
7 we want to pose, we want to ask whether LEP,
8 when it is added to the conventional risk
9 adjusters, does it provide a better risk
10 prediction tool? And in this conceptual
11 model, we show several pathways in which LEP
12 can affect the outcomes. So, you know, it can
13 affect it through some of the underlying
14 health, which would be captured in some of the
15 comorbidities, the diagnosis data.

16 But it also really affects the
17 process of care, the appropriate care that
18 people get. And so, with that, it can limit
19 access to care, affect patient/provider
20 communication, which, then, can affect the
21 outcomes.

22 But one thing I really want to

1 note is the enabling services that are
2 provided. These are non-clinical services,
3 like language interpretation, that really
4 address some of these barriers. And so, when
5 we are considering the data, we really want to
6 consider enabling services down the line.

7 Next slide.

8 So, in terms of whether LEP data
9 does exist, at least for the Community Health
10 Centers, we are funded by HRA, and we report
11 annually to UDS, the Uniform Data System. And
12 among the variables that we report, one of the
13 variables is patients best served in a
14 language other than English. So, at the
15 Community Health Center we have this data at
16 the patient level and, thus, at the Community
17 Health Center level.

18 Next slide.

19 So, what we did, we were modestly
20 funded by the California Endowment to really
21 do an exploratory study, more of a proof-in-
22 concept study, and it is still in progress.

1 But what we did is we wanted to see whether we
2 can take our patient data and use LEP, as well
3 as poverty, but we focused more on LEP in this
4 presentation, use our LEP status information
5 and put it in the risk adjustment.

6 So, we actually got only a subset
7 of our patients due to limited access to some
8 of the data with the health plans. We got
9 about 50 percent of our entire population, and
10 this mostly focused on the Medicaid managed
11 care group, the Healthy Families group.

12 But it is about almost 17,000
13 members, and we looked at the years of 2011 to
14 2012. I want to note that 89 percent of the
15 ones included in there are of LEP status. So,
16 it is really a high proportion of LEP.

17 In the analysis, we actually
18 worked with Dr. Todd Gilmer from UC-San Diego,
19 who is one of the co-developers of Chronic
20 Illness and Disability Payment System, the
21 CDPS, which it is very similar to an HCC
22 model, and I think most of you are familiar

1 with it.

2 In terms of our data, we mostly
3 looked at demographics, enrollment, diagnosis,
4 and pharmacy data. And the scores, the CDPS
5 scores, what it does is it accounts for age,
6 gender, and diagnoses. And what we did is we
7 added on the LEP status.

8 Next slide, please.

9 So, in terms of our results, here
10 you see, on top, we looked at LEP stratified.
11 So, you know, on the middle column, you have
12 the LEP. And then, on the righthand side, you
13 have the non-LEP risk scores. And it is
14 broken up by the four aid categories: adult,
15 children, disabled, and elderly.

16 And you can see that for LEP we
17 are seeing lower risk scores when compared to
18 a national benchmark. That national benchmark
19 is mostly Medicaid, based on a Medicaid
20 dataset relative to the non-LEP.

21 On the bottom, we added in LEP
22 status as a risk adjuster, so in the model,

1 and it shows you for each of those aid
2 categories as well as combined. And again,
3 LEP compared to non-LEP, in our patient
4 population you see that the LEP has a lower
5 risk. I do want to note that the model that
6 included LEP, the r-squared for it was
7 slightly higher than the model without it.

8 One thing I do want to note here
9 are the weights. So, a lot of the weights
10 here, you know, the CDPS program weighted it,
11 the diagnoses, to age and to sex. But,
12 because it lacked information on language, it
13 was not weighted on language. So, that is one
14 of the big limitations to our results.

15 Next slide and final slide.

16 So, you know, again noting the
17 fact that the data is not weighted by the LEP
18 status. We couldn't do it for our data
19 because it was quite small. Also, that we
20 compared to a national benchmark rather than
21 to California, because California really
22 differs. So, we want to note that.

1 In terms of outcomes, you know, a
2 lot of the risk adjustment is so based on
3 diagnoses data, and we know that with a lot of
4 these populations, as well as other
5 disadvantaged populations, they face a lot of
6 barriers. So, this issue on underutilization
7 and underdiagnosis is major, and we really
8 want to underscore that point.

9 When it comes to our risk
10 adjuster, LEP as a risk adjuster, we want to
11 note about the selection bias. We did an
12 internal comparison in that analysis, and we
13 are comparing it to non-LEP within our patient
14 population. Well, who are these non-LEP
15 coming to a health center that mostly provides
16 language services needs to be considered,
17 right?

18 Data limitations for us, we
19 couldn't get all of our patient data. So, it
20 is subsetted.

21 And then, the issue is that we
22 didn't have hospital and mental health data.

1 For the stratified, we compared to the
2 national benchmark, which did have that. So,
3 that needs to be accounted for as well.

4 The issue of stratification versus
5 risk adjuster, I think we will continue to
6 have that discussion. But a major point I
7 want to make here is in our model and in our
8 analysis, at Asian Health Services we provide
9 language services and a whole bunch of other
10 enabling services universally to our patients.
11 So, if you are looking at that and you are not
12 considering the enabling services in the
13 model, then you really are going to downward-
14 bias your analysis.

15 So, it is something that, you
16 know, it is not just LEP, but, as we consider
17 other social factors like homelessness, we
18 really do need to consider what the providers,
19 what these primary care providers are
20 providing in terms of enabling services,
21 because it is already addressing that pathway.
22 And by not adjusting for that, by not

1 controlling for that, you may have not the
2 best accurate results when you are looking at
3 these things.

4 CO-CHAIR FISCELLA: Thank you,
5 Thu. Very succinct.

6 Tia?

7 MEMBER SAWHNEY: Okay, next slide.

8 Okay. This is kind of like field
9 notes from someone who plays with data. So,
10 when we talk about, and it is noted in some of
11 the reading, there is difference between
12 health and healthcare. Within health and
13 healthcare, there is a difference between
14 incidence and prognosis. And this came up in
15 the presentation regarding hospital care.
16 Once the health event begins, that is one part
17 of the path, but, then, who is at risk for the
18 health event to begin? And I think we always
19 need to be thinking along those lines because
20 it has a big impact on the models that you
21 build.

22 A classic case in an SES

1 adjustment. People with no diagnostic
2 history, two young men 23 years old, one is on
3 the streets in the south side of Chicago and
4 one is a student of U of C. Which one has a
5 different risk -- you know, is there a
6 different risk profile? Yes, you'd better
7 believe it.

8 And, in fact, the one who at U of
9 C and going to student health may actually
10 have a diagnostic history that the kid on the
11 streets of Chicago doesn't have. But I know
12 which one, coming from an insurance
13 background, I would rather be insuring.

14 Traditional risk adjustment looks
15 at age, sex, and diagnostic history, and
16 pharmaceutical history, which is really a
17 proxy for diagnostic history. So, it is
18 really limited for those who don't have a
19 diagnostic history. The takeaway is you
20 really need to think of what we are adjusting
21 for and what the risks are that we are
22 adjusting for.

1 Next slide.

2 It is usually not just diagnostic
3 history. It is usually one year of diagnostic
4 history, which I think is also reflective of
5 regular contact with the healthcare system.
6 And that is another thing we all need to be
7 thinking about.

8 So, some research that I did, and
9 I'm not going to spend a lot of time on it
10 because it is not necessarily as applicable in
11 this forum because it is total healthcare
12 cost, and it is risk-adjusted for SES in that
13 context.

14 But I did look at income as a
15 marginal variable after traditional risk
16 adjustment in order to predict total
17 healthcare cost. And I did find that there is
18 a relationship after adjusted for age, sex,
19 and diagnosis between SES and total cost.

20 And now, it levels off. It is the
21 difference between what MEPS would define as
22 poor, near poor, middle class, and high not

1 class but income, high income. Now their
2 definition of high income is not all that
3 high. It is 400 percent of the federal
4 poverty level.

5 But, actually, even the middle
6 income and the high were relatively flat to
7 each other. The gradient really seems to be
8 between poor, near poor, and middle.

9 And then, my theory, unproven, is
10 that there isn't as much of a gradient between
11 middle and high, and that's because, whereas
12 health clearly continues to improve as you go
13 up the spectrum, so does the sophistication of
14 the demands that people make on the healthcare
15 system. So, health improves, but costs go up
16 because -- well, we all go to the doctor; we
17 are pretty demanding customers, right?

18 (Laughter.)

19 Okay. There's a lot of problem in
20 trying to look at SES because, historically,
21 it just hasn't been systematically captured
22 and connected to the healthcare experience and

1 the cost, to the healthcare data and the
2 health cost data. And every dataset is
3 imperfect, including the one I used.

4 Next slide.

5 Another point I really want to
6 make -- and it may cause some of your eyes to
7 glaze over, and I'll make it very fast -- is
8 that, when looking at models, focus on
9 r-squared in the context of SES adjustment
10 just doesn't work, especially when we are
11 talking individual -- not necessarily
12 hospital data, which we saw earlier, which has
13 that nice bell-shaped curve. Individual-level
14 data, it doesn't matter whether it is cost or
15 whether it is prescriptions or number of
16 doctor visits, or whatever. It is
17 statistically ugly data. It has its huge
18 density at zero. It has extreme outliers. It
19 is skewed heteroscedastic, which I love that
20 word; it is just so fun to say.

21 (Laughter.)

22 And until you can take a

1 population -- and the fact is it is a spread-
2 out mess. That is a scientific term, a
3 spread-out mess. And until you can start to
4 differentiate one mess from the other, then
5 the r-squareds don't come out, even if there
6 are cost differences.

7 And I'm like, wait, how can there
8 be a 20-percent cost difference between
9 populations? And I was working with real
10 data, and I was finding 20-percent cost
11 differences between two populations, but there
12 was no difference in r-squared. I mean, it
13 was out in the nth decimal place.

14 And so, I started modeling it. I
15 started with a population and, then, I modeled
16 the different ways I could drive, artificially
17 drive, a 20-percent difference. And I
18 realized the fundamental problem was, until
19 you can start creating two mountains instead
20 of marginal changes to the first mountain, you
21 just don't get the r-squared. So, we can't
22 focus on r-squareds.

1 Go on.

2 The other word is a word from --
3 the last one is a word from the actuaries.
4 This goes back, and I don't know that they
5 were the first ones, either, but this is for
6 1996. Practical considerations for risk
7 adjustment variables, I mean, you have to have
8 the data for most patients. It has to be
9 reliable. It can't be susceptible to gaming,
10 and it has to be stable over time.

11 And that's just like so important,
12 and that is one of the problems with
13 homelessness because, yes, the man living
14 under the bridge is clearly homeless, but
15 there are a whole lot of gradients beyond
16 that. And it is not necessarily stable over
17 time.

18 Next. Done. Okay, cool.

19 (Laughter.)

20 MEMBER GARRETT: So, I am going to
21 talk just briefly about some work that one of
22 our physicians, Scott Davies, has been doing

1 at the Hennepin County Medical Center. And it
2 really speaks to, if we decide that we are
3 going to recommend that there should be some
4 kind of adjustment for SES and
5 sociodemographics. And this kind of gets into
6 a bit of the questions we are going to have to
7 answer with the "how," and part of that "how"
8 is going to be, well, what's the definition of
9 sociodemographics and SES.

10 And so, Dr. Davies has been
11 challenging us to take a look at this -- and
12 if you could do the next slide? -- and start
13 to think about tobacco use. And is tobacco
14 use really an outcome variable or is it
15 actually more of a sociodemographic variable?

16 And so, just to tee this up, we
17 use a measure in Minnesota called the D5.
18 There are five components of this diabetes
19 measure. It was NQF endorsed in 2010. And
20 so, it is probably used in other places as
21 well.

22 And one of those five components

1 is self-reported that you are tobacco-free.
2 So, that is an outcome variable. And that
3 makes a lot intuitive sense because, as we all
4 know, which a huge impact smoking status has
5 on our health.

6 And there certainly are things
7 that we can do, as the healthcare system, to
8 help people quit. And so, we are hoping that
9 we are giving an incentive to use as providers
10 to actually intervene, get people into the
11 right cessation programs, and try and address
12 tobacco use.

13 And so, go to the next slide.

14 So, the premise of having this in
15 the D5 as one of the measures is, if you look
16 on the left, if you go from an excellent
17 clinic to a worse clinic, then your overall D5
18 score is going to go from high to low. And
19 so, the idea is that those five components are
20 going to measure provider performance.

21 Now, just as an illustration, if
22 you look at the tobacco-free rates by four

1 actual real-live clinics within our system,
2 the tobacco-free rate also kind of follows
3 that curve. There is a lot of variation in
4 that rate. And because it is an all-or-
5 nothing, you have to hit each of those five
6 measures in order to get a 1 in the numerator.
7 If you have a clinic -- like we actually have
8 a real clinic where the smoking rate is 70
9 percent, and we think that might be one of the
10 highest rates within a clinic in the country.
11 And so, our theoretical maximum for being able
12 to achieve on that measure is very low.

13 And so, then, the question is,
14 well, how amenable to change are smoking
15 rates. And Dr. Davies, who is a
16 pulmonologist, has done a lot of research on
17 this. The very best, most expensive
18 interventions maybe at a population you can
19 see 3-percent decline a year. So, how
20 amenable is that measure really to clinician
21 intervention, is one of the questions that he
22 is asking us to think about.

1 And then, another thing about
2 smoking is that the most successful
3 interventions have really been kind of at the
4 community and public health level. And so,
5 how do you factor that in, when you're trying
6 to incent performance is another thing we have
7 been thinking about.

8 Next slide, please.

9 And so, kind of as I have been
10 saying, a lot of the future improvement will
11 come from environmental efforts. And how much
12 can you really do with individuals? And once
13 you get into people who are smokers and have
14 been for their whole lives, and have a lot of
15 others who are going on, how much opportunity
16 is there really to change?

17 Next slide, please.

18 So, you are all very familiar with
19 this, but there is high correlation between
20 smoking rates and other dissociative
21 demographics. So, these are a couple of
22 results from some surveys within Hennepin

1 County about associations with race and
2 ethnicity and education. And there's just
3 lots and lots of correlation here. So, again,
4 it kind of raises the question, is this an
5 outcome variable or more of a sociodemographic
6 variable that we want to consider controlling
7 for?

8 Next slide, please.

9 And we have done some multivariant
10 analysis to understand what impacts are
11 diabetes scores, and some of those results are
12 here. We see things that improve the score
13 are age, diagnosis of CAD, primary language
14 other than English. Things that make it
15 worse: younger age, race/ethnicity, some
16 factors there, substance abuse and psychiatric
17 illness, which are really huge in our
18 population. So, it just really kind of has
19 gotten us thinking about this question about
20 variable versus control.

21 And then, the last slide is a bit
22 of a different view of this. But we have been

1 collecting data on one of our Medicaid
2 expansion populations with a tool we're
3 calling the Life Cell Overview Survey. And
4 these are the different types of factors that
5 we are collecting in that. Tobacco use we are
6 collecting in that as well because we are very
7 much thinking about it as a key thing that we
8 need to be working on.

9 And I know Steve had put an
10 article in our packet about this Life
11 Circumstances Index that he has proposed,
12 which I think is a really interesting idea.
13 It is kind of related to this idea of the
14 lifestyle overview, that we are trying to
15 understand all these different factors that
16 impact health.

17 And one of the things that is at
18 the very top of our list in terms of
19 prevalence is social support. So, we have a
20 couple of questions, including: how many
21 people can you count on in times of need? Do
22 you have a spouse or a partner? Are there any

1 adults, including spouse or partner, with whom
2 you have regular talks?

3 And so, I also just want to throw
4 out I think that that social support is
5 something also that we believe is very highly
6 correlated to ability to change health. And
7 I think we should consider that as well, as we
8 are thinking about definitions of
9 sociodemographics.

10 Thank you.

11 CO-CHAIR FISCELLA: Norbert?

12 MEMBER GOLDFIELD: What I have
13 been impressed by the conversation is that
14 there are sort of two kinds of conversations
15 that are going on. No. 1 is whether or not to
16 incorporate SES data elements, and some
17 presentations seem to present that we
18 shouldn't. And then, others talk about
19 different data elements that we should
20 consider.

21 As already indicated in my initial
22 remarks, I think low-income populations are so

1 discriminated against in this country, it is
2 not a question of whether, but how.

3 And just as a way to kind of
4 contrast our approach to the world, which is
5 I have been only with the research group that
6 developed the DRGs for 30 years, but Rich has
7 been working with it since the beginning with
8 Bob Fetter and John Thompson. And arguably,
9 it is certainly the methodology that has had
10 the greatest impact on healthcare policy, both
11 in the United States and beyond.

12 I would just say that the way we
13 look at the world is try to have these kinds
14 of conversations and look at new data elements
15 that we should be collecting. And so,
16 typically, that might be I-9 or I-10 or
17 additional data elements, such as homelessness
18 and make as rigorous a definition as possible,
19 and then, test it out in a large state. So,
20 we are much more interested as much a possible
21 in working with states to get at that.

22 And so, the point that I want to

1 say, building off this slide here, is, again
2 -- I have said it already, and everybody seems
3 to say it, but, then, we just say, well, poor
4 people can be discriminated against and that's
5 okay. You know, that these classification
6 systems are going to be used for payment, and
7 we have just got to hammer that home over and
8 over again.

9 I also say that it is really
10 important to try to use clinical data in
11 extreme detail in ways that DRGs have
12 pioneered and continue to pioneer. And I will
13 give you an example of that in just a second.

14 I want to highlight, as a
15 consequence, I tend to be very practical, you
16 know, which is to say I like to specify the
17 healthcare encounter question. Obviously,
18 readmissions are different from complications.

19 In a positive way, Susannah and I
20 look at the work of readmissions very
21 differently. That is to say, we would look at
22 readmissions the way the hospital thinks about

1 it, that is to say, at the point of discharge.
2 And we would look at all the conditions at the
3 point of discharge. And at least initially,
4 unless we can specify which ones are
5 complications, which is a separate one, we
6 should include them.

7 So, we want to have as detailed
8 and rich model as possible, understanding that
9 we also want to look at it the way the
10 hospital looks at, which is to say the
11 hospital looks at readmissions as the point of
12 discharge.

13 And then, of course, I have
14 already said the issue of -- I think it is
15 important, and that is certainly the reason
16 that I'm here -- is the whole issue of a
17 national/state strategy that, hopefully, can
18 come out from NQF, in particular, with respect
19 to homelessness.

20 The next slide.

21 The only thing that I want to say
22 on this slide is that it is very important to

1 identify those individuals, as I will show on
2 those slides, who are often with a lower
3 socioeconomic status who have higher severity
4 of illness. It sounds like an obvious thing,
5 but I'm going to show an example why most of
6 the models do not get into that.

7 Then, obviously, higher payment
8 will minimize adverse selection. And that is
9 constantly an issue that we face, that
10 everybody has highlighted.

11 I want to just point out with
12 respect to what kind of items to include, DRGs
13 are a categorical risk model. As I was joking
14 with Pam Owens, that people have access to the
15 APR DRG Manual which is used in some of the
16 AHRQ QI Indicators and this 5,000 pages of
17 detailed model that people can look at. And
18 I think, from an item point of view, it is
19 important to try to identify those clinical
20 variables that have the least gamability.

21 Lastly, on timing, partly because
22 Karen asked me to comment on that, it really

1 should not impact the classification from our
2 perspective. The results will be different,
3 obviously, for readmission at two versus four
4 weeks, but the classification should be the
5 same.

6 Next slide.

7 So, I want to give an example
8 here. So, a patient with cerebral palsy needs
9 to be stratified by severity of illness. Of
10 course, most models don't even have cerebral
11 palsy identified. So, putting that aside, we
12 have different categories not only for that,
13 but categories for patients when we are
14 looking at a year's period of time in terms of
15 that dependent variable; those patients who
16 are in foster care. And that is an
17 interesting question, as to whether or not to
18 use a use variable such as foster care as an
19 SES variable. That is, yes, just to raise the
20 issue. And I met with foster care providers
21 for over two years on that very issue.

22 But, without this detail, the

1 approach to risk categorization, it is
2 inevitable, and we know it -- we talk about
3 it, but, then, we ignore it -- that poor
4 people will just be ignored. And that managed
5 organizations will assiduously create any kind
6 of risk incentive to avoid these patients.

7 Next slide.

8 So, here's a bottom line. And so,
9 Nancy brought up -- I think it was Nancy who
10 brought up -- the issue of the patient with
11 diabetes and schizophrenia. So, you could
12 replace this issue of diabetes and
13 schizophrenia, of CHF. And so, what you have
14 here on this slide is patients on the top
15 slide who only have diabetes as a chronic
16 illness. And these are four levels of
17 severity. So, that is their only major
18 chronic illness. And on the bottom, rather,
19 row is patients who have diabetes, COPD, and
20 CHF, and those are levels of severity. That
21 could be replaced by schizophrenia, also,
22 instead of COPD.

1 So, I think it is that kind of
2 detail that, for example, New York State and
3 Texas have gotten into with respect to looking
4 at paying for better outcomes. Because, in
5 fact, if you want to recognize certain aspects
6 of socioeconomic status, at a minimum, we know
7 that diabetes who are schizophrenics, you
8 know, those are very different patients. And
9 we really need to look and stratify by
10 severity.

11 Now, again, we know that that will
12 not be 100 percent of the variation, but I am
13 already accepting and wanting to test out, for
14 example, homelessness.

15 So, on the next slide -- and that
16 will be my last slide, actually, because we
17 are really not supposed to talk about payment
18 -- there are three different types of clinical
19 data that can be incorporated into risk
20 adjustment, data that is available today. So,
21 actually, bottomless index is actually not a
22 terrible piece of information and foster care

1 is actually also available.

2 We are the developer of the I-10
3 procedure classification system. That will
4 actually make some significant impact on the
5 types of information that we can have
6 available starting next year.

7 There's data that is available for
8 some individuals, but not reliably collected.
9 And I have raised that homelessness, and I am
10 not going to get into it.

11 Data that is not generally
12 available, but should be available in the next
13 three to five years that I am hoping that the
14 panel will get into that. So, for example,
15 patient-derived health status, that is already
16 available for certain PPSes such as the home
17 health. Incarceration, there are some linked
18 databases in New York State and other states
19 that we can do.

20 I am particularly a fan myself --
21 and I'll put out my point here -- it is that
22 I think that patient activation or

1 empowerment, I am a much bigger fan of that as
2 opposed to something like English language
3 proficiency.

4 My last comment is that I think we
5 need to have humility, folks. I mean, I think
6 it is in short supply. And so, we talk about
7 CHF, and I obsess about CHF. And we at the
8 same time forget that there's maybe an
9 increasing body of literature that looks at
10 the relationship between readmissions and
11 mortality.

12 So, I think that there is a lot
13 that we need to learn while we try to put in
14 this issue of SES. And I am hoping that this
15 panel will have a clear, or as clear as
16 possible, strategy as to how we can
17 incorporate SES, not whether.

18 CO-CHAIR FISCELLA: Thank you,
19 Norbert.

20 We are going to take public
21 comments first. And then, we can make a
22 decision as to whether to do comments before

1 lunch or after lunch.

2 MS. PACE: We will see, first of
3 all, if there is anyone here present in the
4 room that wants to do public comment. If you
5 would come up to the microphone?

6 And then, we will go to the phone.

7 MR. SHAW: Hi. I'm John Shaw from
8 Next Wave in Albany, New York, and we're a
9 health services researcher and interested in
10 this issue for quite a while.

11 One of the things that helps
12 inform the discussion is what happened last
13 week. There was a discussion of the
14 population health framework down here. And
15 they suggested one thing that would be helpful
16 in discussing these new, complicated topics is
17 to make the implicit assumptions explicit.

18 And two things come to mind
19 relative to this. One is the big
20 controversial measures are either all after
21 discharge for readmissions or for the cost
22 measure 80 percent of the variation was after

1 discharge.

2 So, what we are really doing is
3 assuming that the patient, their informal
4 caregivers, and their local community are
5 capable to understand what to do and have the
6 resources to be able to do it.

7 We have had a few examples where
8 someone that is homeless versus someone who is
9 a Wall Street executive might have differences
10 there. The current system assumes that they
11 are both the same. The current system also
12 assumes that the measures that we are looking
13 at that are constrained by the data we have
14 for Medicare is all of the data that there is.

15 And we don't collect much of the
16 data after discharge on what's really going
17 on. We're starting to. The patient
18 activation, the social supports at home are
19 critical factors, as well as some of the
20 population data where the provider may be
21 situated.

22 And so, what may be useful in

1 having a complex situation a little bit
2 simpler to see is make sure that, if we are
3 making assumptions, we have them listed
4 explicitly on the table, not just assumed to
5 be the same.

6 Thank you.

7 MS. PACE: Is there anyone else on
8 the conference call line that would like to
9 make a comment?

10 MEMBER CALLAHAN: This is Mary
11 Beth Callahan.

12 MS. PACE: Oh, thank you, Mary
13 Beth.

14 And, Marshall, also feel free.

15 MEMBER CALLAHAN: I just wanted to
16 kind of make a connection between something
17 Dr. Goldfield said and something Nancy Garrett
18 said, and futuristically thinking, I think Dr.
19 Goldfield said there could be data to be
20 collected in two to three years. I think he
21 was maybe referring to patient-perceived
22 quality-of-life data in terms of empowerment

1 and such. And I don't want to put words into
2 his mouth.

3 But, then, Nancy Garrett, I
4 believe, related that -- and I believe also
5 that -- social support is very important in
6 how illness is going to play out and can
7 mediate factors of socioeconomic determinants
8 in ways that I don't fully understand.

9 And so, I just think that is an
10 interesting concept, and I don't really know
11 how to put it forward, but I just wanted to
12 connect those two thoughts.

13 Thank you.

14 MS. PACE: Okay. Thank you.

15 And anyone else in the audience
16 here?

17 (No response.)

18 Yes, Operator, would you open the
19 lines? Maybe that is part of the problem.

20 THE OPERATOR: At this time, in
21 order to ask a question, press *, then the
22 number 1 on your telephone keypad. That's *,

1 then the number 1 on your telephone keypad.

2 MS. PACE: Would you turn off your
3 microphones?

4 THE OPERATOR: At this time there
5 are no questions.

6 CO-CHAIR FISCELLA: We can do
7 clarifying questions now before lunch or come
8 back and do it after lunch.

9 MS. PACE: We can do five minutes
10 of clarifying questions and, then, we can go
11 for lunch.

12 CO-CHAIR FISCELLA: Okay, we'll do
13 it.

14 Questions?

15 MEMBER NUCCIO: Yes. I have a
16 question. I'm sorry. I had a question for
17 Nancy.

18 Nancy, I noticed on one of your
19 charts there was a curvilinear relationship
20 between some of your variables and your
21 outcome, and there was linear in the other
22 cases. Could you talk a little bit about

1 that, especially where smoking appeared to be
2 curvilinear? That is, it went down and came
3 back up.

4 MEMBER GARRETT: So, the first
5 example was really more theoretical, showing
6 differences across four different types of
7 clinics. Either you could consider them good
8 to bad or, then, I was kind of putting that
9 next to here's how smoking status actually
10 looks in our clinic. So, that was more
11 theoretical. And then, the other one was a
12 regression analysis, which was a linear look
13 at things. So, does that help?

14 MEMBER PONCE: For Norbert
15 Goldfield, please help me understand the
16 rationale why patient activation over LEP is
17 preferred.

18 MEMBER GOLDFIELD: That is a great
19 question. And at the end of the day, there
20 are going to be patients with limited English
21 proficiency -- I, myself, speak Spanish with
22 an Italian accent -- who are very activated.

1 In fact, I am not sure if in one of these --
2 oh, it was a different document.

3 I think it was a document that was
4 posted in one of my blogs where I spoke about
5 a patient who has no English language
6 proficiency and has significant intellectual
7 disability, but over a period of time became
8 extremely activated and empowered, and her
9 diabetes is very well-controlled. That
10 doesn't mean she doesn't have other issues,
11 you know, but I am just talking about the
12 outcome of diabetes.

13 So, I guess just from my own
14 clinical background, and just from reading the
15 literature that has been pioneered by Judy
16 Hibbard, Kate Lorig, and John Watson, I
17 believe that these items can transcend, shall
18 we say, limited English language proficiency.
19 So, that is how I look at it.

20 Then, I was just going to comment
21 on the question that was posed on the phone,
22 if that would be okay?

1 So, I just want to say that, with
2 respect to social situation, I consider that
3 just as important as activation. In fact, a
4 study that we are doing right now for a
5 federal agency, in OASIS they do collect
6 living alone, right? And so, I think a
7 schizophrenic who is living alone as opposed
8 to a schizophrenic who is living with his or
9 her family, again, I'm not talking rocket
10 science, folks. And we have a linked database
11 that looks at that. That should be something
12 that should be tested and moved.

13 So, I definitely accept, and, in
14 fact, I am very excited about, this project
15 that we are doing for a federal agency that
16 looks at that specifically for the severely
17 mentally-disabled.

18 MEMBER GARRETT: So, a question
19 for you, Norbert. You talked about that the
20 current risk-adjustment tools, clinical risk-
21 adjustment tools, don't do a good job with
22 severity. So, can you tell us a bit more with

1 the existing data that we have, with existing
2 diagnosis code systems and procedure code
3 systems, do we have the ability to improve
4 that or does that really require moving on to
5 new types of data?

6 MEMBER GOLDFIELD: The short
7 version is both, which is to say, for example,
8 what New York State uses for looking at
9 outcomes and payment for year-long patient-
10 based episodes has a thousand categories and
11 has very detailed categories specifically for
12 children.

13 That said, I spent literally maybe
14 50 hours with foster care providers, and they
15 finally positively beat me over the head that
16 we need a separate category for foster care.
17 And I highlight that because it is actually
18 interesting from an intellectual perspective.

19 So, I believe that you have to
20 start somewhere. That is the whole premise of
21 DRGs; you have to start somewhere. But there
22 is a lot more detail that can be captured, and

1 I just tried to give one example.

2 At the same time, we should
3 absolutely -- and I think all of us here, this
4 is just an incredible experience from
5 everybody that is here -- that we could really
6 lead the way in terms of setting out an agenda
7 as to what kind of data elements should be
8 collected for extremely discriminated-against
9 individuals.

10 MS. PACE: All right. Lunch
11 should be ready. So, feel free to get up and
12 take a break and grab your lunch. I think we
13 will be able to make up some time. So, let's
14 just plan to reconvene at 1:15. Maybe try to
15 get back to your seats at 1:10 and we'll
16 proceed from there.

17 Basically, you will have to bring
18 your food back to your place. There are a few
19 empty seats in the other area. The buffet is
20 in the back.

21 (Whereupon, the foregoing matter
22 went off the record at 12:41 p.m. and went

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back on the record at 1:15 p.m.)

1 opportunity to tie in, to basically leverage
2 NQF's convening function to address some of
3 these issues that we are discussing today.

4 So, as you all know, CMS has not
5 traditionally adjusted for race or
6 socioeconomic factors or other types of
7 related factors. And we also don't in most of
8 our programs have the authority to be able to
9 address those factors through stratification
10 of payment or anything like that.

11 So, as we started to implement
12 these outcome-based measures, thinking the
13 mortality, readmission, and even our cost
14 measures in our pay-for-reporting and, then,
15 ultimately, pay-for-performance or pay-for-
16 value-type programs, like Hospital Value-Based
17 Purchasing, like the Hospital Readmissions
18 Reduction Program, there has been a lot more
19 attention given, obviously, to the measures
20 and how they're constructed, but around this
21 particular issue that we are discussing today,
22 and the fact that within the measure we have

1 not traditionally accounted for these factors.

2 And I think over the last few
3 years a lot has been written, a lot has been
4 said about how CMS and, presumably, other
5 payers should account for these factors or how
6 we should handle this within the measures or
7 within our payment systems. And so, we really
8 saw this as an opportunity to use the NQF
9 convening function to address this head-on in
10 really an evidence-based, data-driven kind of
11 way, where we have evidence and data.

12 Because, again, I do think a lot
13 has been said. There has been a lot of real
14 concerns and perceived concerns. So, we felt
15 that it made a lot of sense to just get it all
16 out on the table, but, again, in as much as
17 possible, data-driven, and evidence-based way.
18 So that we can have a really smart discussion,
19 hear all the viewpoints.

20 And I think what would be helpful
21 for us at the end of the day is going to be
22 some, essentially, principles around this

1 issue. I don't think we necessarily are
2 looking for or think we can get out of two
3 days specific direction, but just having those
4 principles that are agreed upon by a Committee
5 such as this, and this is a phenomenal
6 Committee, I think would really, really help,
7 not only us because my group, we oversee the
8 Medicare Fee-for-Service programs. I think it
9 would help other components within CMS. And
10 certainly, it would help the private sector as
11 well.

12 So, I am very thrilled to be here.
13 I wish I could be here all two days, but I
14 will be here this afternoon. So, I'm looking
15 forward to it.

16 Thank you.

17 MS. PACE: Thank you.

18 CO-CHAIR NERENZ: Okay. I think
19 our next session, essentially, continues a
20 couple of the main themes we had before lunch.
21 We are talking about examples of inclusion of
22 one or more SES variables in an adjustment

1 model and what effect that has. We have a few
2 examples.

3 As we did before, we will try to
4 work through very quickly, five minutes at a
5 time. I'll try to be the enforcer on that,
6 but people have been pretty good. So, I
7 haven't had to be too strict.

8 I don't think I need to say
9 anything more by way of overview. We will do
10 some questions after.

11 Atul, it's all yours.

12 MEMBER GROVER: You can go ahead
13 and advance it one slide.

14 Actually, this paper just came out
15 online on Monday in HSR, and we have made the
16 language available. I am happy to share it,
17 if you ask me any questions. I am going to
18 look at the paper because I didn't actually
19 write it. My colleagues at AAMC and AHA did
20 it with Hugh and Kaynig.

21 Next slide, please.

22 You know, interestingly, even

1 during the whole readmissions discussion where
2 CMS did have the ability to stratify but chose
3 not to, it was interesting to watch the
4 presentations from their data shop and Brennan
5 presenting how readmissions vary across HRRs,
6 and really sort of laying out the striking
7 difference between the place with lowest
8 readmissions in the country -- anybody care to
9 guess? -- Idaho Falls, Idaho, and then, the
10 place with the highest readmissions in the
11 country -- care to guess? -- Chicago, and
12 saying, "Gee, you would think people would
13 understand Chicago by now."

14 And what CMS's data shop showed
15 was essentially the biggest correlations there
16 were that in Chicago you had 33-percent dual-
17 eligibles. That was about 16 percent in Idaho
18 Falls. Idaho Falls is also 95-percent White
19 non-Hispanic. So, if you didn't know there
20 were places like that that still existed,
21 there are. And Chicago is, of course, a
22 majority/minority city at 60-some percent

1 minority.

2 So, what we did was, looking at
3 proxies for SES and really focusing on dual
4 status with the Medicare Program, looking to
5 see if we could find differences, as has been
6 pointed out. And I know that those
7 differences seem small in many of the analyses
8 that have been presented here, but they do
9 make a difference in terms of payment policy.
10 And I think that is one of the things we
11 wanted to highlight.

12 And what my colleagues found was
13 that duals were certainly more likely to be
14 readmitted to a hospital within 30 days after
15 discharge, even after adjusting for age, sex,
16 and comorbidities.

17 What was also interesting is that
18 the share of patients discharged by a hospital
19 that were duals also seemed to have an effect
20 and appeared to work as a proxy beyond just
21 looking at those individual patients. And
22 again, I think some of that has been discussed

1 today, as, you know, does that reflect other
2 conditions in the catchment area of a
3 hospital?

4 I will also note that what my
5 colleagues found was that in those areas,
6 those hospitals that served high-percentage
7 dual populations, they also had more
8 admissions that were tied to ambulatory-care-
9 sensitive conditions. So, clearly, there is
10 something going on in the ecosystem of that
11 neighborhood that may not be fully adjusted
12 for if you just look at the status of that one
13 dual patient.

14 And we know that hospitals with
15 higher shares of duals are, then,
16 disproportionately penalized under the
17 readmissions program. And interestingly, of
18 the hospitals with the highest quartile dual
19 shares, over half had negative total profit
20 margins in 2008 and 2009 compared with only 20
21 percent of the lowest quartile. So, again,
22 are we at risk of entrenching disparities

1 because of removing resources from those that
2 serve the most vulnerable?

3 Next slide, please.

4 And again, you know, looking at
5 the absolute change in readmission rates is
6 one thing, but if you look at what this means
7 from a payment policy perspective, we know
8 that comparing hospitals that have the lowest
9 share of duals in their discharges and those
10 in the highest quartile and those that have no
11 reduction from the readmissions program, 23
12 percent in the lowest quartile, 10 percent in
13 the highest quartile.

14 If you look at the maximum penalty
15 of 2 to 3 percent, we project using the three
16 existing conditions, and then adding in COPD,
17 CABG, PTCA, and other vascular conditions,
18 that, again, in the highest quartile 10.5
19 percent of the hospitals will have the highest
20 penalty; whereas, that is only less than 6
21 percent in the lowest quartile.

22 So, the next and final slide,

1 please.

2 So, what my colleagues did was,
3 then, within the regression, hierarchical
4 regression, try and adjust for nothing. So,
5 looking at comparing, say, heart failure,
6 which is circled here, in terms of the gap
7 between those with excessive readmission
8 rates, in the highest quartile it was about 61
9 percent and 41 percent in the lowest quartile.
10 When you adjusted for the individual dual
11 status, you equalized that a little bit at 43
12 and 57. But when you adjust for both
13 individual-level characteristics as well as
14 the hospital characteristics of having a
15 larger share of duals, that equalized almost
16 completely, 49 percent and 50 percent.

17 So, again, I can't tell you
18 exactly what it is we're measuring. I think
19 we have seen some examples here. But maybe
20 looking at a way to stratify based upon that
21 population is the right way to go.

22 I'll stop there, and I think

1 people will have similar presentations.

2 CO-CHAIR NERENZ: Are there some
3 very quick clarifying questions before we move
4 off? Because we will cycle back. We have got
5 a lot of discussion block coming.

6 MEMBER BERNHEIM: I'm just curious
7 what the readmission measures they were using
8 were. I mean, I know the conditions, but were
9 they using the CMS --

10 MEMBER GROVER: They were using
11 the CMS.

12 MEMBER BERNHEIM: Okay. Because
13 for some of those conditions, they are not out
14 there yet. Maybe I can just look at the paper
15 now that it is out and try to understand.

16 MEMBER LIPSTEIN: That's his
17 slide.

18 MEMBER GROVER: That's my slide.

19 MEMBER LIPSTEIN: Oh, did you want
20 me to start my presentation. Oh, okay. Okay.

21 (Laughter.)

22 So, if there's anything that you

1 take away from these slides, what I guess I
2 would hope you would write down, especially
3 since I think Kate just mentioned empirical
4 data, is I hope you would think Census tracts
5 with high housing vacancy rates. That is the
6 first thing to remember. The second thing is
7 patient discharged to nursing homes. And the
8 third thing is, yes or no, is the hospital
9 located in a local taxing district for a
10 regional safety net, yes or no?

11 And so, I am going to talk about
12 each of those three variables. I picked those
13 three because there's not a lot in the
14 literature that was sent out to all of us, No.
15 1. And No. 2 is that data is available at a
16 national level. And so, those become really
17 kind of important indicators.

18 I want to start, before I just
19 jump into the slides, because my slides go
20 really quickly, to kind of give a framework
21 for this. And I am going to use a non-
22 readmission example real quickly.

1 In St. Louis, Barnes-Jewish
2 Hospital is the only hospital in the city
3 limits that still delivers babies. And we
4 used to think that a good outcome was when we
5 would discharge a healthy baby into the
6 community.

7 We have now broadened the
8 definition of outcome. And we now know that,
9 in addition to discharging a healthy baby, we
10 want to help that healthy baby get to third
11 grade. And we want them to get to third grade
12 fully immunized with complete eye and dental
13 care and with a Body Mass Index appropriate to
14 their age and height, and here's the kicker,
15 reading on grade level.

16 And the reason we want to do that
17 by third grade is we know that, if you get to
18 third grade with those health indicators and
19 reading on grade level, there's a much higher
20 likelihood that you're going to graduate from
21 high school. And if you do graduate from high
22 school, we know that that affects life

1 expectancy and mortality rates long-term.

2 And so, if we want a good outcome
3 for this healthy baby born at Barnes-Jewish
4 Hospital, the definition of the outcome has to
5 go beyond what happened at discharge. Okay?
6 And so, one of the things I like about
7 readmission rate is it really has focused our
8 nation and our community on what happens to
9 the patient after they leave the hospital.
10 And that's a good thing.

11 Now fast forward. I shared with
12 you earlier that I serve on the Board of the
13 Patient-Centered Outcomes Research Institute.
14 And at my very first dinner meeting I sat next
15 to Harlan, Dr. Krumholz, from the Center for
16 Outcomes Research and Effectiveness. He was
17 having a glass of wine; I was probably having
18 a Budweiser since I'm from St. Louis.

19 (Laughter.)

20 And that was when Harlan first
21 told me the conclusion that Susannah shared
22 with us earlier, that socioeconomic status

1 isn't determinative of hospital outcomes,
2 hospital performance with regard to
3 readmissions. Did I say that about right?

4 And so, I looked at him and I
5 thought, what is he drinking?

6 (Laughter.)

7 Because at BJC we have 12
8 hospitals, and our two biggest
9 disproportionate share hospitals have always
10 had the biggest challenge on readmission
11 rates. And so, I was trying to figure out,
12 going back, then, and really looking and
13 beginning to read the literature that was
14 stimulated by my discussion with Dr. Krumholz,
15 what do the national people who study this,
16 the researchers in this room, what don't they
17 know about St. Louis? Okay? Or what don't
18 they know about BJC patients? Or what don't
19 they know about patient-reported outcomes?

20 And that's when I began to
21 separate in my mind socioeconomic status from
22 difficult life circumstances. And that's why

1 -- I'm glad, Nancy, you're probably the only
2 person, other than me, who has read that paper
3 -- why I wrote a paper on life circumstances,
4 and a Life Circumstances Index is probably
5 just as important as a case mix index in
6 determining patient outcomes.

7 So, setting about this journey on
8 how to figure out what is it that really
9 happens in St. Louis that people at the
10 national level don't know about that makes the
11 readmission rate challenge so much greater at
12 Barnes-Jewish Hospital and Christian Hospital,
13 our two big safety-net providers, compared to
14 the other 10 BJC hospitals.

15 And so, here's what we learned.
16 If you go to the next slide, what we learned
17 is that, if you would just remove -- within
18 BJC, so this is not kind of a national
19 scientific study, just within BJC -- if we
20 took the patients out of the data that were
21 either discharged to Census tracts with high
22 unit vacancy rates or we took out the patients

1 that were discharged to nursing homes, and I
2 am making a real big presumption here. They
3 were discharged to nursing homes either
4 because they weren't well enough to go home or
5 because they couldn't go home because there
6 wasn't really a home to go to. If you those
7 two out of the database, Barnes-Jewish and
8 Christian had readmission rates that were
9 about the same as everybody else within BJC.

10 So, I said, okay, nobody's going
11 to look at just data that is only applicable
12 to BJC. So, how do we begin to find out what
13 really happened?

14 And so, what we did is an analysis
15 for the whole State of Missouri. And what I
16 like about this analysis at the State level is
17 it is the same Medicaid program throughout the
18 State.

19 So, for example, when Susannah was
20 talking about Medicaid programs, as you know,
21 eligibility for Medicaid is differential
22 across the entire United States, and Medicaid

1 programs pay providers differently across the
2 United States. So, Medicaid eligibility or
3 not, it is not a great determinant of
4 individual ability to manage outside the
5 hospital environment.

6 And, David, when you brought up
7 SSI indicators earlier, what we have also
8 learned is that a poor person in Chapel Hill,
9 North Carolina, is not the same as a poor
10 person in East St. Louis, even if they have
11 the same incomes. Because the person in
12 Chapel Hill has access to a high-density
13 environment where there are social support
14 mechanisms. There are restaurants. There are
15 grocery stores. There are drugstores. There
16 are laundromats. There are taxicabs. There
17 is a bus service. In East St. Louis, if you
18 just come with me, I think you will see the
19 difference.

20 And so, what we did is -- if you
21 go to the next slide? -- what you will see is
22 we took that data that is readily available to

1 hospitals and contains some factors that are
2 not typically in administrative or claims
3 data. And we recognize the limitations, that
4 when you look at Census tract data, it could
5 reflect either individual or neighborhood
6 effects. And it doesn't capture all the
7 social factors that we have talked about
8 today.

9 But, when we ran the analysis
10 -- next slide -- we compared the replicated
11 CMS models alone to the models using the
12 Census tract variables. And the one that we
13 really haven't talked a lot about today is
14 this high-vacancy housing unit variable. And
15 the data came from all over the Missouri
16 hospitals, and the Census tract variables from
17 the analytics.

18 Next slide.

19 And you will see, for the three
20 conditions, that what really shows is
21 variability gets condensed.

22 Go to the next one.

1 And this is myocardial infarction.

2 And the next one.

3 And so, this data is online. But
4 you will see that what CMS is trying to do is
5 reduce variation in readmission rates. And
6 so, housing unit vacancy and Census tract
7 variables, not Medicaid, not income, not
8 taking anything away from dual-eligibles, can
9 do this at a statewide level, and the data is
10 available nationally.

11 And so, one of the things that,
12 when you go outside the State of Missouri --
13 and this is really the last important point
14 I'll make -- St. Louis City -- I was in
15 Baltimore when Baltimore closed Baltimore City
16 Hospital. And then, I went to Chicago, where
17 we had Cook County. And then, in St. Louis,
18 St. Louis Regional Hospital closed in 1997.
19 So, we don't have a publicly-funded safety-net
20 environment at the local level. They do in
21 Kansas City with the Truman Medical Center.
22 They do in a number of geographic areas.

1 But especially in the rural
2 communities of our State, there are not local
3 taxing districts to support a safety net. And
4 it makes a big difference in what happens to
5 a patient when they leave the hospital.

6 What I guess I am hoping is, if
7 you were to look at readmission rate or Value-
8 Based Purchasing data, and you were to look at
9 patients discharged to high-vacancy, high-
10 housing-vacancy residential neighborhoods,
11 patients discharged to nursing homes because
12 they either can't go home or they are not well
13 enough to go home, or patients discharged into
14 a community that has local tax-based support
15 for a safety net, it has a pretty big
16 influence on outcomes.

17 And so, I guess I will just leave
18 you with this final thought, because I always
19 think it all the time. If you take the Henry
20 Ford Medical Group and you move them to
21 Scottsdale, Arizona, would they still pay one
22 of the highest readmission penalties in the

1 United States? And if you took the Mayo
2 Clinic folks, arguably, among the best doctors
3 in the world, out of Scottsdale and you moved
4 them to Detroit, would they still pay no
5 penalty?

6 And so, at the provider level
7 there is a credibility issue here when we
8 think about rewards and lack of rewards or
9 punishments or lack of punishments for
10 outcomes that are not adjusted for
11 socioeconomic status.

12 My biggest concern is that, by not
13 adjusting for socioeconomic status, not only
14 are you entrenching disparities, but you will
15 make them permanent. Because what will happen
16 is, it isn't the providers will avoid the poor
17 and the uninsured; it is just that they will
18 invest their capital in places where they can
19 be successful. And if they know that there is
20 going to be a higher degree of difficulty and
21 a financial penalty associated with investing
22 their capital in neighborhoods, Census tracts

1 with high-housing-vacancy rates, they just
2 won't invest their services there. They won't
3 grow their services there.

4 The readmission rate for hospitals
5 in East St. Louis is now zero, as is the
6 admission rate, because Kenneth Hall Hospital
7 has closed. It isn't just because of the lack
8 of socioeconomic adjustment, but is reflective
9 of an environment where the federally-funded
10 safety nets, as opposed to the locally-funded
11 safety nets, the federally-funded safety nets
12 are facing challenges on the Medicare front,
13 challenges on the Medicaid front, especially
14 in those states that are not taking the
15 expansion. They are facing financial
16 penalties on readmissions and Value-Based
17 Purchasing, and they weren't financially
18 strong to begin with.

19 And so, one of the things we
20 learned about getting that newborn baby to
21 third grade, reading on grade level, is that
22 it involves interventions that are expensive:

1 a parent educator from birth through third
2 grade, nurses for newborns. And those
3 resources have to be provided by society
4 because they are not available within the
5 family or within the local school district.

6 And so, if we are going to take
7 resources from Detroit and send them to
8 Scottsdale, it does have real serious
9 ramifications for patient outcomes.

10 CO-CHAIR NERENZ: Thank you.

11 Quick clarifying questions, any?

12 Yes, Nancy? And then, we will
13 probably move on from there, but we can always
14 come back to these. Yes?

15 MEMBER GARRETT: Yes, thanks,
16 Steve.

17 So, I'm curious, among the SES
18 variables you tested, did they all end up
19 being significant in your final models?

20 MEMBER LIPSTEIN: Pardon?

21 MEMBER GARRETT: Did all of the
22 variables, SES variables, you tested end up

1 being significant in your final models or did
2 some of them fall away, because they are very
3 highly --

4 MEMBER LIPSTEIN: Well, if you go
5 back to the models that were in the -- can we
6 go back a couple of slides? One more. Yes,
7 right there.

8 So, you know, we looked at whether
9 income alone was determinative. And it turns
10 out that, if you just look at income -- and
11 there's some problems with patient-reported
12 income, as you know -- but what we started to
13 do was we started to collect data on every
14 single patient for all their difficult life
15 circumstances, income, education level,
16 whether they were above or below the federal
17 poverty. We looked at obesity. We looked at
18 substance abuse. We looked at disability,
19 physical, emotional, or behavioral disability.
20 We looked at smoking status.

21 And what was really kind of eye-
22 opening for us was the housing unit vacancy

1 rate. Okay? That was the one that -- and you
2 have to go to the Census tract level because,
3 even within zip codes, the neighborhoods are
4 very, very different.

5 And so, there's a video that is on
6 the internet about St. Louis and the
7 communities north of Delmar. But what you
8 will find is that you needed to go to the
9 Census tract level. The zip code or
10 geomapping of the zip code level didn't expose
11 this.

12 CO-CHAIR NERENZ: Then, to Gene.
13 And again, we're borrowing a little time here
14 from the next time block that is much more
15 open discussion, just because I think we are
16 getting some important material out here. So,
17 if there are other questions more substantive,
18 more thoughtful, about where this is all
19 going, we are just about to enter that time
20 block anyway.

21 So, Gene?

22 MEMBER NUCCIO: Hi. There's the

1 title slide with my colleagues listed down
2 there. I apologize for the size of the font.

3 The work that I am going to be
4 reporting on was partially funded by Kate and
5 her group with the Home Health folks and with
6 MedPAC folks.

7 Next slide.

8 Just a quick history. Nursing
9 Home Compare happened in 2002, Home Health
10 Compare in 2003, and Hospital Compare is a
11 sort of Johnny-come-lately in 2005.

12 The risk adjustment in home health
13 is based on a 12-month rolling average of the
14 observation period. Risk adjustment, as I
15 mentioned, is a two-part process. For us,
16 there is a prediction model, and then, there
17 is the application of the model's result.

18 For Home Health Compare, we take
19 the observed value and we add the national
20 predicted value and subtract the agency's
21 predicted value from that to adjust that value
22 down.

1 I am not going to speak to the
2 issue of whether that is right or wrong, or
3 how it can be improved. As I mentioned to
4 Sean, if you want to see the results of that,
5 you have to Academy Health.

6 The prediction model that we are
7 going to be talking about here, basically, is
8 based on OASIS data, the OASIS assessment
9 instrument. I took this model from a million
10 quality episodes of care. And it was
11 validated against another million episodes of
12 care. So, it is reasonably well-based.

13 There's about 12,000 home health
14 agencies in the country. And obviously, this
15 is a post-hospital thing. So, if you are
16 wondering what happens to your patient in that
17 30-day window, they come to us. And then,
18 hopefully, we can help out. There's about 5
19 million episodes of care in the last 12-months
20 period.

21 The results that I'm going to be
22 describing here in the next couple of slides

1 are a claims-based, OASIS-adjusted, acute-care
2 hospitalization measure within 30 days of the
3 end of care. Now that's different from -- the
4 end of our care. Okay, the end of the home
5 health agency care.

6 And I want to note that this is
7 different than the claims-based measure that
8 is currently being reported on the Home Health
9 Compare, which measures a 30-day window from
10 the start of care.

11 Now we obviously overlap because,
12 if a patient comes into care and, then, leaves
13 care within the first 30 days, they would be,
14 obviously, in the hospital within 30 days of
15 the end of the care.

16 Next slide, please. Actually,
17 could you flip to the next slide? Okay.

18 The short model for this -- and
19 this might seem long, but the larger models
20 have more than 100 variables, and there is a
21 reason for that. But the short model starts;
22 the most important variable has to do with

1 whether or not the patient has had multiple
2 hospitalizations, multiple prior
3 hospitalizations, obviously, a very strong
4 odds ratio.

5 Notice that the relationship for
6 the variable care for joint replacement --
7 basically, if they had a hip or knee -- is
8 negative. That is, we're very likely not to
9 have a rehospitalization if the patient comes
10 in with those sorts of things.

11 So, now if you could flip back?

12 And all those are P to the three
13 zeroes and a 1. So, wildly significant.

14 The full models that we create for
15 risk-adjusting the outcome, this particular
16 outcome or the outcome similar to this for
17 Home Health Compare for the home health, we
18 purposely use many, many risk factors. And
19 the reason for that is because people call up
20 and say, "Hey, what should I put on this
21 particular -- how should I answer this
22 question, so that I get the most points?"

1 And I just tell them, I said, "You
2 should put on there what the patient is
3 presenting as." Okay. So, if the patient is
4 a five on this scale, then put a five. And if
5 they're a four, it's a four. "Don't worry
6 about it because you can't beat the model."
7 When you have 100-plus variables in the model,
8 it can't be beaten.

9 I give you some of the statistics
10 there that you might be interested in. So,
11 for the full model, the C statistic is .7,
12 which is a pretty strong model. And if you
13 look down at the mini-model, which was the one
14 that you just saw, you will see that the C
15 statistic is .69.

16 So, when we drop from 113
17 variables down to 22, we capture virtually
18 everything. So, it is just a way of
19 preventing cheating, if you will.

20 If you look at what we did
21 following this, we said, starting with this
22 model -- and if you would focus on Table 2 --

1 if you, then, add in the characteristics of
2 race, how does that change the C statistic in
3 the model? We improve it 1/1000th. If you
4 look at dual-eligible, what happened? Well,
5 we improved it by 2/1000th.

6 If you look at length of
7 stay -- and now, let me just point out we had
8 a question about did you consider length of
9 stay as a patient variable. This is a length
10 of stay based on the agency. So, all these
11 variables, race, dual-eligibility, and mean
12 length of stay, are agency or organizational
13 variables.

14 What we find is that agencies in
15 Region 6, okay, which is Louisiana, Texas,
16 Arkansas, all the way over to New Mexico and
17 Oklahoma, those agencies in those states tend
18 to have double the average length of stay for
19 other agencies in the country.

20 So, it is not necessarily a
21 patient perspective, but it is an
22 organizational perspective. And so, what I am

1 arguing here is that, if we are going to be
2 looking at SES kinds or sociodemographic
3 variables, if we consider them as an
4 organizational characteristic or a context-of-
5 care characteristic, that's one way of dealing
6 with this.

7 Another issue is that, for home
8 health agencies -- we have 12,000 of them, and
9 someone was asking about, well, if we stratify
10 the results, can't you report the information?
11 The problem is that we have about 25 percent
12 of the home health agencies nationally that
13 don't have scores reported for one or more
14 outcome measures because they are too small.

15 And so, if you are reporting at a
16 provider level, and you are, then, basing your
17 analysis in terms of your incentive, pay for
18 performance or whatever, on that, you're
19 automatically disqualifying a quarter of the
20 agencies because they are too small to have
21 reliable data. As Sean said, there was too
22 much variation.

1 Next slide.

2 Before you stratify.

3 Next one.

4 So, just some final thoughts.

5 Adding the provider level, even demographics
6 don't seem to add a lot of predicted power
7 between the models. The provider levels, when
8 you look at length of stay, actually, does the
9 best, and that one was one I showed.

10 We did another analysis that I did
11 not show that talked about dual-eligibles.
12 And what we found was that the relationship
13 between performance and percentage of dual-
14 eligibles was not linear, but curvilinear.
15 That is, agencies that had very low rates of
16 Medicaid patients and agencies that had very
17 high rates actually did better than agencies
18 that had sort of the middle level of patients.
19 So, we have to be careful about imposing
20 linearity on all of our variables.

21 Parsimonious was better than
22 others. And then, the issue of how you are

1 going to apply it, whether you are going to
2 use regional or state predicted values rather
3 than national, and whether or not you should
4 use a difference model or a multiplicative
5 model or some sort of ratio model or some sort
6 of index model, all is to Steve's point. You
7 know, how can we drive down the variability,
8 so that when we find an extreme value, either
9 extremely high or extremely low, we are not
10 getting false-positives or false-negatives in
11 those extreme positions.

12 I think I made it.

13 CO-CHAIR NERENZ: Thank you.

14 We had a couple of clarifying
15 questions. Are there others, again, directly
16 and pure clarifying?

17 Nancy?

18 MEMBER GARRETT: So, are you
19 making a recommendation, Gene, in terms of
20 whether the right approach to doing risk
21 adjustment is at the provider level or at the
22 patient level?

1 MEMBER NUCCIO: I'll defer that
2 until tomorrow. Okay?

3 (Laughter.)

4 MEMBER GARRETT: I'm going to be
5 in suspense. Okay.

6 (Laughter.)

7 MEMBER NUCCIO: I think it is
8 something we should consider. If you are
9 going to be representing the characteristic --
10 okay, are we representing the characteristic
11 as a patient characteristic, like we're doing
12 with their medical condition, or are we going
13 to be looking at or should we think about
14 representing demographics as an organizational
15 or a care context variable?

16 And in that sense, then, it would
17 be more appropriate to look at the context of
18 care. The context, whether it is rurality --
19 and, clearly, Colorado has lots of rural
20 outcome kinds of things -- or if we are going
21 to be looking at it at the patient level.

22 CO-CHAIR NERENZ: Last but not

1 least, Alyna.

2 MEMBER CHIEN: Okay. I heard five
3 minutes, and I said there's no way I'm going
4 to put any data on any slides. So, if you
5 feel like you need a visual, the paper I am
6 going to talk about is in the set of papers
7 that were put on the SharePoint. It's the
8 Geocoded SES Factors Change of P4P Program in
9 a Primary Care Setting.

10 But what I thought I would talk
11 about is this sort of total question mark
12 about what we think we are capturing when we
13 are using geocoded information. And I have
14 worked on the project with Larry in the P4P
15 primary care setting, and then, also, I have
16 a grant from NICHD looking at the same
17 information geocoded almost exactly the same
18 way and the same set of variables, but I'm
19 saying that it represents the neighborhood
20 health risk of a child in a spending model.

21 So, if you want the variables that
22 I use -- well, first of all, let me say why we

1 were attracted to Census information. It goes
2 back to something that Tia said, which is,
3 aside from being stable over time, unless your
4 address is changing is a lot, Census data is
5 very readily available. It's free. It's
6 reliable. It's very well-collected. It's
7 very well-studied, also, in terms of how it
8 might map onto social determinants.

9 So, in the United States there
10 haws been a lot of work by a lot of people,
11 but we relied on Nancy Krieger's work that
12 assembled about 10 different SES variables
13 from the Census. So, their median household
14 income, which we think represents wealth. It
15 is percent education level within whatever
16 area you're talking about. And we could be
17 talking about something as small as a block,
18 a block group, which is a little bit bigger,
19 maybe 200-300 people, or a Census tract, which
20 can go up to 500 people, as opposed to a zip
21 code, which is very heterogeneous and perhaps
22 explains why it doesn't pick up some of the

1 things when we are looking at putting zip-
2 code-level poverty levels into models.

3 So, it assembles all of those 10
4 factors. You average them out. So that, if
5 you're average, it's a zero. And then, if you
6 are at one of the two ends of the tails, you
7 get plus-2 or minus-2 in terms of standard
8 deviations, and you add it up.

9 So, the poorest person, the
10 poorest Census tract ends up as a negative,
11 like 24 or 26, and the most wealthy Census
12 tract ends up being a positive 26. And it's
13 nice because there is a pretty long gradient.

14 So, in the study that Larry and I
15 did, we looked at IHAs, pay-for-performance
16 program in California. So, we had pretty much
17 200 physician organizations, which was 10,000
18 practices, delivery care sites across the
19 entire State.

20 And we thought that this Census
21 tract information, if we mapped it to
22 practices, it could represent practice-level

1 resources or the patients that are going
2 there. We weren't really sure. But we
3 thought, either way, it might matter in terms
4 of your ability to deliver care that is high
5 quality.

6 So, what we found -- and it's in
7 the paper -- is that the folks who had more of
8 their practices in low SE Census tracts had
9 almost a 1.5 -- the ones who were wealthier
10 had 1.5 greater odds of getting the P4P bonus,
11 taking percent Medicaid into account.

12 So, it is an application of
13 quality measurement in a setting that we are
14 kind of being guided towards not talking
15 about, but it is just another representation
16 in a more primary care setting of how
17 socioeconomic information might matter and
18 widen disparities.

19 So, then, my next slide. So, I'm
20 on slide -- I only have like basically two
21 slides.

22 So, in the spending models for

1 pediatrics, it is the same geocoded
2 information. We are playing around with
3 Census tract versus block group. But, again,
4 it is unclear what information we think we are
5 picking up on.

6 There's lots of Census tract area
7 information that suggests that, if you live in
8 a lower SE tract, you are more exposed to
9 violence. You have greater risk for
10 infectious diseases like bacterial vaginosis,
11 strep pneumo. There's lots of reasons to
12 articulate that there might be, if you are
13 living in that tract, you might actually have
14 more health risks.

15 So, in this case we are
16 attributing almost individual-level exposures
17 based on the same Census tract information.
18 None of these models have any multi-level
19 components to them. They also don't take into
20 account how the size of the area that you are
21 using might impact things differently.

22 For example, block groups really

1 matter for exposure to violence and perhaps
2 injury, but very wide swatches and sprawl
3 indices suggest your risk for obesity. That's
4 all being mooshed in here.

5 So, those are the two things I am
6 working on. That is how we are thinking about
7 what we think geocoded information might
8 actually bring. It is very easy to work with.
9 It is easy to get. It is difficult to game
10 because it is hard to change somebody's
11 address, unlike ICD-9 codes where we know that
12 providers just will upcode to make their
13 patients look more complex.

14 So, if you want to see the Census
15 tract information that is in what we are
16 using, it is the next slide. The next slide.
17 Oh, it's that one.

18 And then, I thought I had to
19 weigh-in -- so, can you go back one slide? --
20 had to weigh-in on what I thought whether to
21 adjust or not to adjust. I just made it
22 binary like this, even though I don't think of

1 this as black and white.

2 So, for spending, definitely, I
3 think you need to take these factors into
4 account or you will mismatch resources with
5 the complexity of the patient.

6 For payment that is based on
7 quality, I think it really just depends on the
8 program design.

9 And risk adjustment is not our
10 only tool at getting at disparities problems.
11 The pay-for-performance programs are currently
12 much more achievement-oriented, but we can
13 design them to be improvement-oriented, so
14 that maybe some of these factors don't get so
15 widened-out the way they are. So, we could do
16 a piece-rate pay for performance instead of
17 the achievement point.

18 And I just don't want people to
19 forget that we can advocate for different
20 program designs.

21 That's it.

22 CO-CHAIR NERENZ: Thank you.

1 We said we are going to try to
2 make a seamless transition into this upcoming
3 block of time, but let me talk a little bit
4 about how we might do that.

5 We still should take some time for
6 questions to the speakers collectively, those
7 who just went. But I wanted to just at least
8 look around the corner to what is coming to
9 help frame questions.

10 If we think of the charge in front
11 of us, there are really two big meta-
12 questions. The one is whether or not to take
13 into account SES or sociodemographic
14 variables, which effectively is a yes/no
15 question in principle. And then, there is the
16 how, when, whether, which, and all the
17 details.

18 At least as the agenda is printed,
19 the next hour or so in front of us is to talk
20 just free-flowing as a group about the first
21 of those two, the "whether".

22 So now, as you think of questions

1 to the people who have just spoken, if your
2 question can transition us into this larger
3 "whether" discussion, that would be good. You
4 don't have to do that. But I would say, if
5 you want to ask someone about a very picky
6 methodological question that's more the "how,"
7 perhaps that could be held for later.

8 But, again, just a general
9 suggestion, because now, from the perspective
10 of the front of the table, this is when we
11 enter the herding-cats part of the discussion.

12 (Laughter.)

13 It will be very hard to keep this
14 all linear and flowing. So, first, a token
15 attempt.

16 So, Nancy, you had your tag up.

17 MEMBER GARRETT: I just had a
18 quick followup. I'm just a little confused as
19 to whether you are using Census data to assign
20 characteristics of where a provider is located
21 to the care that is delivered there or patient
22 care choices where they live, or both.

1 MEMBER CHIEN: So, both projects
2 we are using Census tract. So, that is the
3 area. But in the P4P program evaluation, we
4 were ascribing that to the practice. In the
5 one for the spending models for the children,
6 we are ascribing that to the individual's
7 neighborhood, for a lack of a better term.

8 MEMBER GROVER: I also have kind
9 of a methodological question, but it is also,
10 I think, a bit of a philosophical question.
11 And that is sparked originally by Steve's
12 comment about looking at the variation in
13 Medicaid eligibility and how that differs.
14 How do you sort of normalize for that.

15 But, even, then, with the Census
16 information, if you are looking at household
17 income, and you realize that poverty is very
18 different if you are living in New York City
19 or San Francisco versus living in St. Louis,
20 how much adjustment do we do at a local area
21 level for how much your home is worth or how
22 much money you make?

1 MEMBER CHIEN: That's directed at
2 me? Okay.

3 (Laughter.)

4 Because I am sure others can
5 answer this question.

6 For the way we constructed it, it
7 is a relative measure. So, it goes after that
8 idea that it is that social ladder and your
9 distance between the highest person and the
10 lowest person. That is what matters here, not
11 what the actual value is.

12 CO-CHAIR NERENZ: Okay. I should
13 also just make sure we don't forget the folks
14 on the phone. Questions for any of the folks
15 who have presented in this last group?

16 MEMBER CALLAHAN: This is Mary
17 Beth. I don't have anything. Thank you.

18 MEMBER CHIN: Thanks for the great
19 presentations.

20 CO-CHAIR NERENZ: That's good.
21 It's always tough, though. We just forget
22 that there are folks up in the ceiling here.

1 We can't see them.

2 (Laughter.)

3 Okay, Susannah?

4 MEMBER BERNHEIM: I have a
5 question for Atul and anyone else who wants to
6 weigh-in on it.

7 I have tried to pull the paper up,
8 but I think what you showed is that, when you
9 risk-adjust for patient SES, there is a small
10 difference, and when you risk-adjust for this
11 sort of hospital SES, there is a bigger
12 difference. And I just wanted you to talk a
13 little bit more about your interpretation
14 because I think there's lots of ways you could
15 interpret that, and I wanted to hear a little
16 bit more about what you thought.

17 MEMBER GROVER: I think one
18 interpretation could be that -- and this is
19 looking at adjustment with both individual-
20 and hospital-level characteristics -- one way
21 to interpret it is I think there is something
22 going on in that community that affects

1 patients more broadly, and particularly as it
2 relates to the ambulatory-sensitive
3 hospitalizations. Is there just low quality
4 or lots of barriers to good quality access to
5 care in the community, which at least for the
6 case of readmissions, then, would make sense.
7 You are going to be admitted in the first
8 place and readmitted after the fact.

9 And I think that my own
10 philosophical bent is to suggest that, I think
11 similar to Steve, that you look around that
12 neighborhood and you realize there are huge
13 differences in the populations being served
14 locally.

15 Another interpretation may be that
16 poor people are just admitted to bad
17 hospitals, right? And I think that is sort of
18 the other extreme of this, that people who are
19 disadvantaged are going to low-quality
20 hospitals. I think you have to get at that
21 through a mix of measures and looking at
22 processes and saying, you know, what's really

1 going to affect the patient and the outcome
2 that is related to the hospital care versus
3 what is going on outside the hospital and how
4 you adjust for that.

5 MEMBER BERNHEIM: Can I ask a
6 follow-on?

7 So, again on this concept of -- I
8 mean, I am really just trying to think about
9 this --

10 MEMBER GROVER: Uh-hum.

11 MEMBER BERNHEIM: -- because I
12 think it is relevant to sort of how we would
13 make recommendations about what variable you
14 would or wouldn't use.

15 If these were targeted to ACOs
16 instead of hospitals, so that there was a
17 sense that there was more of a community-level
18 responsibility for the readmissions or the
19 follow-on care for these patients, would that
20 change your thinking? I mean, is this more
21 about sort of the hospital is not responsible
22 for the fact that there is lots of ambulatory-

1 sensitive conditions because it is just not
2 their purview? I mean, how would that change
3 how you think about that hospital-level
4 variable?

5 MEMBER GROVER: Well, I think if
6 you are talking about an ACO that says, "Well,
7 we're going to be responsible for all this
8 stuff," yes, I probably would consider it
9 differently, although I would still want to
10 take into account the fact that there are
11 differences in populations. And you could
12 probably see this among Medicare Advantage
13 plans as well. If you've got a Medicare
14 Advantage plan that's got 60-percent duals,
15 you might want to adjust the metrics for
16 bonuses for that MA plan compared to one in
17 which you've got 5- or 10-percent duals.

18 So, I think it would make some
19 difference, but it is more a sense of there's
20 lots of levers here. They're not all in the
21 hospital. And how can you better figure out
22 what is within the control and not within the

1 control of the provider whose outcomes you are
2 trying to measure?

3 MEMBER PONCE: This is for Steve.
4 I was convinced with your arguments about
5 whether or not -- yes, you should -- but your
6 outcome was a high bar. You know, it was your
7 outcome of it is not just about a birth
8 outcome, but about getting them to third
9 grade, the immunization.

10 And so, I think the question,
11 then, this high-level question for this group
12 is it is not just adding these as risk
13 adjusters, but thinking about what the
14 outcomes should be. I think that was your
15 message, and that is something you should
16 think about.

17 So, posing it another way, if you
18 had just looked at conventional birth
19 outcomes, do you think you would have seen
20 that compression?

21 MEMBER LIPSTEIN: So, you know, I
22 think by giving the example of the high bar of

1 getting to third grade, it was my notion of
2 just looking at what didn't happen to the
3 patient after 30 days. Is it nearly as
4 important as what did happen to the patient
5 after 30 days? Just keeping them out of the
6 hospital may not be a good indicator of what
7 really has happened to them, especially given
8 where they live. And that is the point I was
9 trying to make.

10 But, if you just assess outcome at
11 the day of discharge on a healthy baby, it
12 doesn't necessarily mean that you are going to
13 have a good outcome by third grade or long-
14 term. That is the point I guess I was trying
15 to make.

16 I was going to respond to
17 Susannah's query because she was asking about
18 kind of a methodological question about
19 whether or not individual dual eligibility or,
20 you know, the socioeconomic status of the
21 individual versus the socioeconomic status of
22 the hospital.

1 And what concerns me about that is
2 that we are using, especially in the case of
3 readmissions or Value-Based Purchasing, we are
4 comparing people. We are comparing one
5 person's socioeconomic status to another. And
6 it is very variable across the country.

7 So, for example, if the Medicaid
8 program pays you at 100 percent of cost in
9 California and pays you at 40 percent of cost
10 in Arkansas, to suggest that those two
11 hospitals have the same resources available to
12 care for patients just gets you to the wrong
13 answer.

14 And so, that is why this whole
15 area of Medicaid eligibility or Medicaid
16 status as an indicator of the socioeconomic
17 status of either the individual or the
18 hospital just worries me a lot. It gets you
19 to the wrong place. It doesn't get you to the
20 right place.

21 And so, at least within state --
22 and this was Gene's idea earlier -- if you

1 come up with benchmarks within state, at least
2 you are dealing with a standardized Medicaid
3 program. And that at least makes the result
4 a little bit closer to consistent across those
5 providers.

6 CO-CHAIR NERENZ: Tia?

7 MEMBER SAWHNEY: Just a comment,
8 the difficulty of what we are doing. We have
9 talked a lot about disadvantaged populations
10 and the very incredibly-dedicated people that
11 are working to improve that. But we should
12 keep in mind that there are also sharks out
13 there and very bad providers who couldn't
14 practice in any other hood. And their story
15 always would be that they're not really bad;
16 it is just their population.

17 A near and dear case in Chicago, a
18 hospital that kept coming in again and again,
19 a self-proclaimed safety-net hospital, and
20 asked for and got all kinds of preferential
21 treatment from the Medicaid program, et
22 cetera, was shut down this year because they

1 were taking homeless people and doing
2 unnecessary tracheotomies at \$150,000 a pop,
3 and were caught on wiretap discussing this.

4 So, we can't eliminate all
5 deviation. We do want to be able to discern
6 who the bad apples are.

7 CO-CHAIR NERENZ: Just let me
8 speak in support of that point. I think that
9 could be overlooked in some of our discussion,
10 that there's this intellectual challenge that
11 we can't avoid, that we don't want to label
12 providers as bad if they are not bad, but we
13 don't want to label providers as good if they
14 really are bad. And so, somehow we have to
15 try to end up at that point because the really
16 bads do exist. So, an excellent point.

17 I think, Norbert, you are still
18 on?

19 MEMBER GOLDFIELD: Just I
20 definitely agree with that statement, and I
21 have said that in my first slide, what you
22 just said, David. I definitely agree.

1 Even though it is not part of the
2 conversation, I just want to highlight, partly
3 in comment to yours, is that some of the
4 conversations we have with states is to try to
5 give ACOs, for example, or whatever the month
6 is, an leg up for the first year. So, the
7 adjustment can be dynamic. It doesn't have to
8 be static. So, that is not really part of the
9 panel, but certainly, as we think obsessively
10 about implementation, you know, that is
11 something just to be cognizant of.

12 And certainly, we want to
13 encourage providers to take on the sickest and
14 the poorest people, but it doesn't necessarily
15 have to be over 10 years. You know, it could
16 be a period of time. With data, there should
17 be an expectation of some improvement or maybe
18 the risk adjustment has selected it out.

19 CO-CHAIR NERENZ: Thank you for
20 giving me the opportunity.

21 What I am going to try to do is
22 follow the sequence in which people put their

1 tags up, but if you have something that must
2 immediately follow on something someone just
3 said, that is okay and just indicate, like
4 Steve just did, or put your hand up. I will
5 try to recognize and follow that, because
6 sometimes you don't want to lose track of a
7 point.

8 So, yes, please.

9 MEMBER LIPSTEIN: Susannah and
10 Norbert both made a point about ACOs. BJC is
11 an ACO, and we have about almost 40,000
12 attributed lives.

13 But one of the important things to
14 remember about ACOs is that it is a provider
15 enrollment model, not a patient enrollment
16 model. And one of the things we could study
17 is how many of those providers or those
18 primary care physicians -- it is a primary
19 care attribution model -- how many of those
20 primary care doctors are really in Census
21 tracts of what I described?

22 So, what we have found, at least

1 in the ACOs that we have studied, is that a
2 lot of these are enrollment models in more
3 affluent than less affluent communities. And
4 so, you are not going to get a normalized
5 distribution of patients by looking in ACOs.

6 MEMBER SUGG: So, just a couple of
7 comments. So, when I was first thinking about
8 this last night, you know, the pathway, yes-
9 or-no pathway, I was actually standing before
10 the pathway thinking, is there such a thing as
11 a quality measure? I mean, does that really
12 exist? Can we actually come up with a measure
13 that measures what we want?

14 And so, to get back to what Tia is
15 saying, what I hear from the city and
16 different grant-funding agencies is: we want
17 to know what we are paying for. We want to
18 know what we are getting for our money. And
19 we want to make sure that we get rid of the
20 bad apples.

21 But the problem I see with how the
22 quality measures get rolled out is we get rid

1 of maybe some of the bad apples, but we get
2 rid of a lot of good apples in the process.
3 And how do we develop a quality measure that
4 gets at what are we paying for and get rid of
5 the people that truly are not giving quality
6 service?

7 So, in my practice I have people
8 who are schizophrenic, diabetic, and they use
9 crack on a regular basis. I will work with
10 those folks for five years. We may get them
11 housed. We may get them on meds. We may get
12 their Alc from 14 to 11, which for us is a
13 hallelujah.

14 I will suffer financially under
15 the current system. That said, I still want
16 to get rid of the bad apples. So, I really
17 struggle with how do we come up with
18 something. We are never going to be pure
19 because we can't possibly get all the
20 socioeconomic factors that could be put in the
21 equation. That is just not financially
22 possible. But how do we come close enough

1 that we get what we want and not ding the
2 people that maybe just need some extra
3 training or some mentoring or better
4 resources, and they are not truly the bad
5 apples?

6 And that is where I really
7 struggle with even the whole concept of
8 quality. You know, it is going to be sort of
9 a shadow of what we are really trying to
10 measure, but how do we come close with that?

11 The other thing, because I think
12 language is important, I really get concerned
13 when I see articles that say socioeconomic
14 status is not associated with pay for
15 performance in this or that way, when the
16 reality is what it is actually saying is
17 perhaps Medicaid as a proxy is not. And we
18 know that and we know what questions to ask.
19 But I can tell you my state legislatures will
20 not know those questions. They will just see
21 the headline and maybe the title of the report
22 and make an assumption. And I struggle with

1 that, of how we also communicate when we talk
2 about these measures.

3 MEMBER CASALINO: The bad apples
4 question keeps coming up. I think there are
5 three reasons why a hospital or a medical
6 group that takes care of a socially-
7 disadvantaged population, let's say, might
8 have bad scores, bad quality scores, right?

9 One is the patients are just
10 really hard to take care of, right?

11 Two is they may not have
12 transportation to get their mammograms, to
13 take a process measure, and so on. We have
14 had lots of examples today.

15 So, the patient bag, that's No. 1.
16 The second is they may be bad apples, right?
17 They may just not care. They may not be good
18 at improving, whatever.

19 And the third is they might be
20 good apples in terms of their intentions and
21 even their skills, but they might lack
22 resources, as Atul keeps pointing out, right?

1 So, either one or all three of
2 those, or two out of the three of those, could
3 be in effect at anytime, right? So, there is
4 going to be no perfect solution to this.

5 But I think that, if you have a
6 method that pays both absolute score and
7 improvement over time, which some programs do
8 have now, and that pays based on both your
9 kind of performance in comparison to everybody
10 else, leaving open for question at the moment
11 who "everybody else" is, and for organizations
12 in your category, okay, then I think the bad
13 apples are always going to get paid really
14 poorly under that formula and the good apples
15 that just are having a tough time because they
16 don't have the resources and it is a hard
17 patient population, there will still be some
18 shift of resources to the really highest-
19 performing hospitals who may be in better
20 situations. But at least there won't be this
21 total shift of money from East St. Louis to
22 Scottsdale, and the good apples will have some

1 chance.

2 So, I think some kind of a
3 compromise is probably the best we are going
4 to be able to do. Without that compromise, we
5 put the good apples and the bad apples in the
6 same barrel and leave them forever, basically.

7 MEMBER BHAREL: Larry said
8 everything I was about to say much better than
9 I would say it.

10 You know, I think when we went
11 back, I have had up most of the time Kevin's
12 initial picture, and we talk about to adjust
13 or not. And when we say, "Yes, adjust," and
14 then, it says, "Well, are we, then, developing
15 a two-tier system?", I mean the truth of the
16 matter is in our current situation we already
17 are in a two-tier system or three or four.
18 And depending on where you look, it is either
19 within a city with two different hospitals,
20 one for certain types of patients, another for
21 another, or it is within a hospital system or
22 it is within an ACO where patients are already

1 getting differentiated care.

2 So, you know, I think Tia's point
3 about how do you make sure these abuses don't
4 happen, we have to do that even in the current
5 system. I think that is always an issue.

6 And one of the ways to do that is
7 to look at things like pay for improvement,
8 which has already been said. But, for
9 example, if you look at my own program where
10 we've tried extensive integration across the
11 community spectrum, five years ago our pap
12 smear rate for women, for multiple reasons,
13 was 19 percent, 1, 9.

14 But, through multiple different
15 incentives, including HRSA publicly making
16 available reports, our pap smear rate now is
17 50 percent. If you were to just do pay for
18 performance, we still wouldn't make it. But
19 we are hugely celebrating that as an
20 achievement. So, I think there are ways to
21 make this work if we think creatively.

22 MEMBER GARRETT: I just wanted to

1 follow up on a point that Nancy made. So, we
2 have heard a number of presentations today,
3 some of which showed a small effect of SES
4 adjustment, some of which showed a large
5 effect. And I am not sure that that is really
6 relevant for a decision about whether to risk-
7 adjust for these factors or not.

8 To me, it is interesting to see
9 that there are differences in how we are
10 applying these methods, but I think we need to
11 decide whether in principle we should control
12 for these social determinants. And then, if
13 so, it is the "how" and what's the best way to
14 do it. And whether or not they end up
15 affecting the outcomes and the results is not
16 really relevant, I think, to that question
17 about the principle.

18 MEMBER CASALINO: Before you
19 control for other things, like clinical
20 factors, if SES doesn't affect outcomes, then,
21 in principle, why would it be relevant? I
22 mean, if I was really convinced that it made

1 no sense, it added nothing, to put in SES
2 variables, then why would it make sense for me
3 to say, "But I think SES variables are
4 important ethically; therefore, I want them
5 in."? I don't see that.

6 MEMBER GARRETT: Yes. So, I guess
7 what I am saying is, if we believe that there
8 is enough evidence that social determinants do
9 affect outcomes, then we would decide, yes, we
10 should risk-adjust. And then, the "how" gets
11 into, okay, well, what's the best way to
12 measure that. In some situations we are going
13 to see a bigger effect than in others because
14 of the measurement and because of the
15 processes underlying it.

16 So, if we believe there is enough
17 evidence that there is an association, then I
18 think we could make that first decision. Does
19 that make sense?

20 CO-CHAIR NERENZ: I've got Sean,
21 Susannah, Pam, and Kevin so far.

22 MEMBER O'BRIEN: I wanted to talk

1 about the inclusion of hospital-level percent
2 summary measure of an SES factor, percent
3 Medicaid or percent other types of examples of
4 measures that have been adjusted for. When
5 you include those types of variables in the
6 model, I think it is important to talk about,
7 well, what's the motivation for adjusting for
8 them. And it really changes the
9 interpretation of what question you are asking
10 and answering.

11 So, all the models express
12 performance of a unit of like a hospital
13 relative to some group. And so, your question
14 is, relative to whom? And if you don't adjust
15 for hospital-level covariants or hospital-
16 level summaries, by default, it is relative to
17 everyone. And you can leave aside the
18 question of who is everyone. Is it
19 nationally? Is it some subset of interest, as
20 Dr. Casalino indicated?

21 But when you adjust for hospital-
22 level summary statistics like that, you are

1 implicitly saying the relevant comparison is
2 relative to other hospitals that share that
3 same summary measure. And that may or may not
4 be the relevant comparison for some particular
5 purpose of interest.

6 And I just think, when this is all
7 wrapped in the questions about complicated
8 modeling questions, sometimes it is hard to
9 think through these issues. If there are no
10 real case-mix confounding issues going on,
11 there still may be reasons for wanting to look
12 at homogeneous competition pools, as Dr.
13 Casalino's paper called them, when comparing
14 groups of hospitals, you know, for
15 incentivizing performance and avoiding
16 unintended consequences.

17 So, if we are going to make any
18 kind of recommendations about the inclusion or
19 not inclusion of adjustment for case-mix
20 variables, I just think we have to really make
21 those two distinct issues. One is adjusting
22 for patient-level and one is the hospital-

1 level summaries of case mix. When you adjust
2 for the latter, you are changing the question
3 that you are asking and answering with the
4 model.

5 MEMBER BERNHEIM: Sorry, I was
6 reacting to a different speaker. So, two
7 quick things.

8 One is just this idea of sort of
9 there is a lot of concern about the unintended
10 consequences. And I just want to raise again
11 sort of the intended consequences and reflect
12 a tiny bit on my own clinical practice and
13 experience at Yale, where it is fairly large
14 underserved population, and the hospital has
15 done some astounding things recently to
16 improve readmissions among the low SES
17 patients, including setting up respite beds,
18 so that they are never discharging homeless
19 people to nowhere.

20 And that took an enormous
21 investment of resources at a hospital that is
22 losing a lot of money on the Readmission

1 Reduction Program right now. And I don't know
2 if that would have happened, but it is
3 certainly providing better care to these
4 patients. It is certainly ensuring better
5 outcomes.

6 And so, again, just in the mix,
7 and it is not straightforward on either side,
8 but I do feel like I am seeing -- and I am
9 actually asking myself different questions in
10 my clinical practice. I am finding that I am
11 thinking about this SES issue so much that
12 sometimes things that I would have just said,
13 like "I can't do this today," I am finding
14 myself in a setting that I have always worked
15 in and thought I was the most committed
16 provider, like going the extra mile to ensure
17 different care for patients.

18 So, I just want us to keep in mind
19 I don't know what would happen if you put this
20 in there, but you are going to set a different
21 standard, and there are both intended and
22 unintended consequences with the current

1 measure. So, I worry about both sides of
2 that, and I don't think it is a simple answer.

3 And there was something else, but
4 I have forgotten it. So, I will wait. If it
5 is important, it will come back.

6 MEMBER OWENS: So, I just wanted
7 to build on something Nancy said, and then,
8 Larry, you followed up on. And I think the
9 question is not, "Do you make a blanket
10 statement, yes, you adjust or account for
11 socioeconomic status or, no, you don't?"
12 Rather, for me, my answer would be you need to
13 consider it.

14 My concern is, if you come up with
15 a blanket statement that says, "Yes, you
16 should risk-adjust," that will become policy.
17 Every measure will have SES, and we have gone
18 down a trajectory that really was not
19 intended.

20 But I do think it is an important
21 consideration, and perhaps if you go down the
22 path of NQF endorsement kinds of things, you

1 would need to specify why it wasn't or what
2 you did to consider it. Maybe that is, for
3 me, more of the question than the blanket
4 statement of, "Yes, do this" or "No, don't do
5 that." I don't see it as a possibility.

6 CO-CHAIR NERENZ: Okay. Just a
7 quick response. And again, let me just
8 express my own previously-unstated
9 assumptions, but I think this is a really
10 important point.

11 When I have thought about this
12 first big meta-question, which I think we
13 phrased as, "Should we do this?", I actually
14 am doing a quick mental translation that
15 essentially makes it "Can CMS do it?" or "Can
16 measure developers do it?", as opposed to the
17 current position that says, "No, you cannot."

18 I wouldn't take it quite as far as
19 I heard you express it, to say you must or
20 this must now be a characteristic of every
21 NQF-endorsed measure. I had never sort of
22 understood a yes answer to our first question

1 to imply that. But, again, that is just
2 purely in my own head, my own assumption.

3 But I thank you for bringing that
4 up, and I would be interested if --

5 MS. PACE: I mean, I think the
6 question really is, "Should it be considered?"
7 And I think, if we work through -- it is kind
8 of, have we had enough discussion? And we
9 have a few more questions about whether it
10 should be considered. Then, the "how" gets
11 into, you know, if it is not related to a
12 particular outcome, as someone already brought
13 up, then there is no point in adding it to a
14 model.

15 But, you know, some of where we
16 want to get to with the recommendations, as we
17 talked about earlier, and Kate just mentioned,
18 is principles. You know, when people submit
19 a measure to us, would there be particular
20 analyses we would want to see that justified
21 including or not including?

22 So, I think you're on the right

1 track. It is definitely not going to be a
2 black-and-white and applies to every
3 situation.

4 CO-CHAIR NERENZ: So, maybe just
5 to paraphrase, it is currently the case --
6 again, I am trying to imagine myself in the
7 position of a measure developer -- even if
8 there were empirical data or analysis with
9 which to include an SES factor, one would
10 probably not bring a measure forward with
11 that, just because the current NQF policy says
12 no.

13 Where I think we may conceivably
14 shift to is to say a measure developer can
15 include that. But, if in a particular domain
16 it didn't make sense, no empirical
17 relationship, no good available data, you
18 wouldn't have to. Is that a fair restatement?

19 MS. PACE: Yes. I think that is
20 what we really want to try to work through
21 these questions of whether we should consider
22 it. Then, how we look at selecting risk

1 factors. And then, how you think about
2 putting them in a model.

3 CO-CHAIR FISCELLA: I wanted to
4 respond to Larry's query of why would you
5 consider it if it doesn't seem to make a
6 difference or maybe not much. And a couple of
7 thoughts come to mind.

8 One is that it may not make a
9 difference nationally, but it may make a
10 difference in a particular state, in a
11 particular locality. It may not make a
12 difference right now, but our healthcare
13 system is changing enormously rapidly, and
14 resources are going to be distributed in very
15 different ways and deployed in very different
16 ways. And I think it is very hard to predict
17 what is going to happen. So, it might make a
18 difference today; it might make a difference
19 tomorrow.

20 We have conceptual reasons why SES
21 and resource deployment make a difference.
22 And at worst, if one were to do that, one may

1 actually develop the data on which to make
2 better decisions in the future. You would
3 begin to see, well, what conditions, at least
4 currently, where it is making a difference
5 versus those where it is not.

6 And right now, we don't really
7 have good data on that. We have selected
8 examples that people have published. But, by
9 and large, we really don't know the answer to
10 that question: for which measures, for which
11 conditions and which regions does it matter
12 more or less?

13 CO-CHAIR NERENZ: So far, I just
14 run right down the table. I have got Atul,
15 then Steve, then Larry.

16 MEMBER GROVER: Getting back to
17 this question of, is it a can you use this as
18 part of risk adjustment, I think part of it
19 depends upon whether you are talking about a
20 process measure or an outcome measure. On the
21 outcome measures, I would say, yes, you would
22 probably want to default on the side of

1 measuring it.

2 But we were having this
3 conversation the other day with colleagues
4 around, well, should that affect at all, SES
5 affect the ability of a nurse to administer
6 antibiotics in a timely way? Well, probably
7 not, right? Like I could go down that path of
8 saying, well, you know, she's really rushed
9 and she's got five patients, but probably not,
10 right? So, you would probably think on a lot
11 of the process stuff maybe you wouldn't
12 include this.

13 So, I think, yes, getting to "Can
14 you," but then, I think it becomes very
15 difficult, and I don't know how this works at
16 NQF particularly well. But if you have got
17 measure developers, and you may want to say,
18 "Well, don't use it within the risk adjustment
19 at the individual level," or maybe you do, but
20 how do we actually, then, decide when it comes
21 to policy? Because, again, some of these
22 things are very small shifts in, you know, 260

1 hospitals moving a decile. Well, maybe all of
2 those, then, just went from no penalty or a
3 small penalty back to gaining money.

4 And I think, somewhere in there,
5 there needs to be room to give guidance that
6 NQF can say to CMS, if they adopt a measure,
7 you know, "You should adjust this for
8 socioeconomic status." And I just don't know
9 where the flexibility is or the mandate is in
10 that process right now.

11 MEMBER LIPSTEIN: I guess I was
12 going to caution us against our experiential
13 lens. And the reason I was going to caution
14 us is because many of us work in or around
15 academic medical centers because we are
16 academics or researchers.

17 Academic medical centers and
18 teaching hospitals, in particular, have
19 resources that not all hospitals have. And
20 their ability to care for a sociodemographic
21 segment at scale, not one patient in one
22 examining room and one discipline at a time,

1 but at scale, is different than it is in a
2 rural hospital or it is in a Community Health
3 Center that is independent of an academic
4 medical center.

5 So, I just caution those who do
6 see patients and do research, if they do it in
7 a teaching hospital environment, those
8 teaching hospitals -- Boston Children's
9 Hospital is an example -- have resources that
10 other communities just don't have. So, that
11 would be one point I would make.

12 The second is that we have to
13 acknowledge that NQF-endorsed Quality
14 Indicators are determining millions and
15 millions of dollars of federal government
16 funds flow. And we are going to see this
17 change dramatically in the next three years,
18 as Medicaid dollars flow disproportionately to
19 25 states compared to 25 other states.

20 And so, I don't think we can
21 ignore that in our policy recommendation:
22 that whatever we decide has implications for

1 federal government, federal taxpayer dollar
2 funds flow. And if don't risk-adjust, the
3 money may go one way, and if we do risk-
4 adjust, the money may go a different way.
5 That's irrefutable almost.

6 So, this decision/recommendation
7 we are making has lots of consequences. And
8 I have expressed my concern about this: if
9 you don't risk-adjust, money will flow
10 disproportionately to providers who don't
11 disproportionately serve the kinds of Census
12 tracts that I talked about earlier.

13 CO-CHAIR NERENZ: Larry first.
14 Then, Tia.

15 MEMBER CASALINO: Again, just
16 maybe at the risk of putting my foot in my
17 mouth, just some practical context, I think,
18 for the decision about whether to include risk
19 adjustment in an incentive program of whatever
20 kind.

21 And very specifically to the
22 question of whether NQF, which I take it has

1 been saying, "We don't want to hear about SES
2 as an adjuster for proposed quality measures,"
3 to, I mean, NQF could say, "You must show us
4 in some detail or with some data that you
5 considered whether SES should be a risk-
6 adjuster or not, and why you decided yes or
7 no." That is separate from the question of,
8 if it should be, what you do with it, right,
9 in terms of the payment form it takes?

10 So, if that is an important
11 question, I think practical context would say
12 you have to look at the kind of real-life
13 world of the people who set up incentive
14 programs. Now the real-life world of those
15 people is, whether they work for a commercial
16 health plan or whoever, their job is to set up
17 an incentive program. And their job is to do
18 it fairly fast, right? I mean, that's what
19 their boss wants, whatever context they are
20 in.

21 And I'm not attributing bad faith
22 to people at all; quite the contrary. But any

1 things that complicate that are not welcome,
2 right?

3 So, Alyna headed a study that we
4 did in Chicago, and not very many years ago.
5 Alyna, you can probably -- correct me if I get
6 the details wrong, but the gist of it was she
7 went out and interviewed a lot of people who
8 were responsible for running, instituting pay-
9 for-performance programs at major health
10 plans. And of these people who were doing it,
11 and there were a fairly large number of them,
12 almost none -- this was about, what, seven
13 years ago? -- almost none had even thought
14 about the questions we are discussing today.
15 They were actually surprised by them, right?

16 Now I don't think that would still
17 be true today. But, once they heard about
18 them, they still didn't really want to think
19 about it because it was in their way.

20 So, this is why it is so
21 important, I think what NQF does. This would
22 change fast if NQF says, "No, you have to at

1 least show us how you thought about this,
2 ideally, with some data, and why you are not
3 proposing that as a risk-adjuster." That
4 would kind of force people who, otherwise, you
5 know, would rather not have to deal with this,
6 because it is politically controversial and,
7 as we can see today, it is a thorny
8 methodological issue as well. So, there is a
9 lot at stake here really in what NQF decides.

10 MEMBER CHIN: I can't see the
11 queue, if I'm in the queue, or else maybe I'm
12 in now.

13 CO-CHAIR NERENZ: Okay. Let me
14 just say, yes, because we can't see your
15 intent, Marshall and Mary Beth, you just have
16 to jump in like you just did. And then, we
17 will let you do that.

18 MEMBER CHIN: Okay. So, I have
19 been thinking throughout about how can the
20 issues that have come up be practically framed
21 with an NQF mandate in a sense, but still be
22 relevant.

1 If I had to summarize, I mean, I
2 heard from Helen Burstin and Chris Cassel this
3 morning that they were very open to us going
4 beyond sort of the traditional expectations at
5 NQF. They specifically said that the world
6 has changed. And so, they seem to be very
7 open to hearing new perspectives that may go
8 beyond traditional recommendations.

9 Similarly, Kate's request in the
10 group seemed to be, well, it would be great if
11 we would provide a list of key principles to
12 use, and she was pretty open with that also.
13 They will use them or not use them as they see
14 fit.

15 I think the other part of the
16 context is that I think overall, a point made
17 at last week's NQF MAP meeting, NQF has had a
18 hard time addressing the disparities issue
19 coherently.

20 In the past, maybe it is like two
21 or three of us in this group that were on this
22 Health Disparities/Cultural Concept Committee.

1 But that was, again, a very forced Committee
2 where the goal was to try to come up with like
3 40 disparity measures, which was kind of a
4 losing battle from the beginning.

5 You know, this Committee is like
6 the next one that is close to the disparities
7 issue, and it is a key issue, this risk
8 adjustment. But there hasn't really been sort
9 of an overall coherent look of, if we are
10 going to think about equity as one of the
11 pillars of quality, how are we going to come
12 up with it in a coherent, sort of consistent,
13 holistic way? And there has been plenty of
14 holes.

15 So, I think this Committee really
16 is a great opportunity. And I think we have
17 been given sort of the green light and the
18 open door here to really sort of, as people
19 like Larry said, and Steve also, really sort
20 of discuss the issues which are relevant,
21 which are: it is going to be public
22 reporting. It is going to be incentive

1 payment. It is going to be, as we are talking
2 about, what would you might think about
3 adjusting on an individual level for SES
4 versus the ecological hospital/regional basis?

5 I think we should go for it. This
6 is a great opportunity, and we shouldn't be
7 constrained, I think.

8 CO-CHAIR NERENZ: Thank you.

9 MEMBER SAWHNEY: I am going to
10 introduce the constraints. The fact is you
11 can't risk-adjust anything without data. And
12 if you are going to risk-adjust at the system
13 level, you need to have the data at the system
14 level. And, by and large, we don't have it
15 today.

16 That is the reason why we have
17 relied heavily over the decade on claims data.
18 Because, even though we all hate claims data,
19 in many respects it is standardized.

20 Patient address or insured is
21 available either from the clinics or from the
22 insurance companies. So, address is

1 something, and so geocoding has good
2 possibilities. The constraint there, though,
3 is that address under HIPAA is identity. And
4 it is hard to pass addresses around either in
5 address format or geocoded format because it
6 is telling precisely where insureds are.

7 So, it is like who runs it through
8 the geocoders to get it to an aggregation
9 level where it is no longer identified. Or
10 how do we change practice standards, which is
11 a very difficult thing to contemplate, to
12 gather data that we're not consistently
13 gathering today?

14 So, we are not adjusting for SES.
15 I mean, at the conceptual level, I think we
16 all want to adjust at SES, but we need to be
17 specific as to what SES variable and whether
18 it is doable.

19 CO-CHAIR NERENZ: Thank you.

20 Just a very quick process
21 observation, but we will continue here, and,
22 actually, for some reason, it all now has

1 moved to this side of the table.

2 (Laughter.)

3 No, that is okay. Once we get
4 done with that sequence, I am going to call a
5 temporary pause. I'm looking at the clock and
6 thinking of our overall agenda, and we will
7 just try to take stock a little bit of where
8 we are.

9 So, before anybody else puts a
10 nametag up, let's just take care of those that
11 are up. And then, I want to do a little take-
12 stock pause. And then, we will certainly get
13 right back into our discussion.

14 Actually, I have Atul. Let's see,
15 have I not crossed-off Atul? Okay. I have
16 Tia. It's up to me. Okay. I have got
17 Norbert, Alyna, Pam, Rachel, in that order.
18 Okay. I got Pam, right?

19 MEMBER GOLDFIELD: So, I think
20 some of the issues that Tia obsesses about I
21 obsess about also in terms of implementation.
22 Because, for me, at the end of the day it is

1 implementation.

2 But I think there is a good
3 solution and there are solutions. In fact, I
4 was just curious and I emailed one of the
5 states. And they have decided to collect
6 homelessness data.

7 Don't forget, when DRGs were
8 implemented in 1982, it was preceded by six
9 years of pilot tests at states. And I would
10 say that, especially with something as
11 controversial, you know, I guess -- it is not
12 controversial to me -- but I think what is
13 interesting is not the "whether," but I think
14 what is interesting to me is the "how" and the
15 "what".

16 And so, I think different states,
17 CMS could be encouraging different states to
18 try to collect information in different ways.
19 For sure, at least in this one very large
20 state, they will be collecting homelessness
21 data in the next few months. And so, we will
22 have data.

1 And here is the bottom-line point:
2 we will not only have data; six months after
3 that we can adjust payment rates. We can
4 adjust looking at outcomes within a year. No,
5 it's not immediately, but it is pretty quick.
6 So, I am totally onto the program, which is
7 why I have tried to encourage states. Because
8 I think CMS, for issues that are different,
9 not so much in terms of your area, but since,
10 for example, the readmission penalty is a
11 zero-sum game for sure, the AHA is not about
12 to start dispossessing suburban hospitals, and
13 neither is the Federation, and try to give
14 more money to safety-net institutions.

15 I want to just take exception to
16 Larry's comment with respect to the private
17 sector, what they are thinking about. Until
18 very recently, most of them couldn't care less
19 about Medicaid. You know, it was just a part
20 of the book of business. Now they are very
21 interested in the Medicaid book of business,
22 you know, for obvious financial reasons. And

1 I get that.

2 But what is happening in several
3 states is that state Medicaid programs are
4 mandating that private insurers look at data
5 in a particular way. So, stronger states as
6 opposed to weaker states are mandating that
7 the benefits managers, or whoever is
8 calculating the rates, start to think about
9 these type of issues, whether it be
10 incarceration, homelessness, and so forth.

11 So, bottom line: I think there is
12 a two-track road that we can take here.
13 Obviously, you all know that I believe that it
14 is not "whether," but "how". But that could
15 be done in an experimental type of way,
16 encouraging states to do, and you could also
17 format some suggested definitions. You know,
18 for example, homelessness, do you recommend
19 the HUD definition? Obviously, we are not
20 going to decide that by tomorrow.

21 But I have been steeped into that
22 literature for quite some time, as I discuss

1 with different states. So, I think it is
2 imminently possible. And we could have
3 socioeconomic disparity risk adjustment
4 certainly within a year and a half.

5 MEMBER CHIEN: Just listening to
6 the discussion, it makes it sound like we are
7 going to flip a switch and all the quality
8 measures are going to be risk-adjusted. And
9 then, we are going to flip a different switch,
10 and we'll flip it down, and then, they're not
11 going to be risk-adjusted.

12 So, I think the problem is that
13 what is happening with socioeconomic status is
14 that it feels invisible. And when it is
15 invisible, you can't tell what people are
16 doing with it.

17 So, I think it is the option or
18 the requirement to see it both ways which
19 tells us what might be happening at the
20 patient level or the provider level or the
21 state level. And so, it is actually do it,
22 but do it both ways.

1 MEMBER OWENS: Yes, I was just
2 going to reflect on measure development from
3 wearing a measure developer hat and the
4 submission to NQF, and whether it comes across
5 in terms of -- well, there are two parts to
6 your submission to NQF. You put together a
7 well-specified indicator and you show it and
8 very well could present it both ways on SES.
9 That could be a bucket, you know, as part of
10 the consideration with SES.

11 But there is another part out of
12 the NQF, and that is, then it is implemented,
13 right? And not all measures are implemented
14 in the same thing. A lot of the AHRQ -- a lot
15 of NQF measures are implemented by CMS, but,
16 frankly, for AHRQ QI measures, they are
17 implemented in all different kinds of ways.
18 And I can't project all of those ways.

19 Some are used for quality
20 improvement. Well, within a hospital, it
21 would make no sense to risk-adjust on
22 socioeconomic status. So, if you make that

1 part of NQF endorsement mandated, that might
2 be a bit problematic. On the other hand, it
3 may actually increase the validity and
4 reliability of the measure. Without testing,
5 you wouldn't know.

6 So, I guess I am trying to
7 separate out the measure specification and
8 going through endorsement as it is for
9 reliable and valid data. And then, maybe
10 building on what you said, Helen, which is,
11 what if NQF moves towards "For what purpose?"
12 and what you need to do for what purpose? And
13 say a little bit more about that
14 implementation because now you have got some
15 analysis to support it.

16 Still, it is a consideration, but
17 I guess I would like personally to stay away
18 from sort of a mandate to do it, when you
19 can't know all scenarios, and to separate
20 those two aspects of this NQF document.

21 MEMBER WERNER: So, I just want to
22 comment on something which has come up a

1 couple of times, which is about whether it is
2 feasible to do this because of data
3 availability concerns, and just say that I
4 don't think that the lack of current available
5 data on SES should hamstring us against
6 recommending that it be there. Because,
7 often, it is a strong recommendation from an
8 organization like the NQF that really tips the
9 scale and makes people start to collect this
10 data.

11 You know, 20 years ago, we didn't
12 have information about the kind of quality
13 that is being delivered at hospitals that we
14 have today. And the reason that we do is
15 because CMS said that we needed it.

16 And so, I think that that data can
17 become available. And it is important to keep
18 in mind that these things change, and that it
19 is not that hard to start collecting new data
20 in many cases.

21 I do have sort of a followup. I
22 don't know if it is a procedural question. It

1 may be too detailed for this conversation
2 right now.

3 But, when I hear you talk about
4 sort of the vision for recommending adjustment
5 for socioeconomic status, there is a lot of
6 different ways to measure that, what
7 socioeconomic status is. And I am not sure
8 that the science is currently available to
9 know how to best do it. And I am just
10 wondering if this is something where we just
11 kick the can down the road and say we
12 recommend adjusting for socioeconomic status,
13 but we are not sure how to define that, or if
14 that is something that is going to have
15 further followup.

16 CO-CHAIR NERENZ: Okay. Let me
17 try to respond. Again, I have no special
18 standing here than that I happen to be in this
19 quadrant of the room.

20 (Laughter.)

21 And again, the NQF folks can
22 answer.

1 I will try to respond just to the
2 very end of that, but, then, see if I can try
3 to pull some threads together and take stock
4 of where we are.

5 I don't think is charge is
6 specified in terms of literally SES as sort of
7 a single measurable concept. I think our
8 charge is phrased as "sociodemographic
9 variables," which I think actually makes the
10 task somewhat easier because we are not asked
11 to decide whether a single great measure of
12 SES exists or whether it is available or even
13 conceptually what it means.

14 Again, my own personal
15 understanding has been that we are talking
16 about domain of variables, meaning variables
17 plural. Some may make sense for one measure.
18 A different set may make sense for a different
19 measure.

20 So, I don't sort of feel a problem
21 or concern or barrier just on the label "SES".
22 In fact, to me, SES is part of the larger

1 domain of sociodemographics.

2 MEMBER WERNER: Do you mean to
3 separate SES from sociodemographics? I sort
4 of meant sociodemographics in a larger way.
5 And it sounds like what you're saying is that
6 the charge is not to specify what
7 sociodemographic variables are.

8 CO-CHAIR NERENZ: Again, just kick
9 me under the table if I am wrong here. It
10 seems like that clearly enters the discussion
11 under the "how". And we have already had some
12 things about, well, percent Medicaid is good
13 or not good or Census tract versus zip code is
14 good or not good. And this has entered the
15 discussion already. And clearly, it seems to
16 me, under the larger "how" umbrella, we are
17 absolutely right into it. Is it a good
18 variable or a bad variable? Is it a good
19 variable for this kind of measure or that kind
20 of measure? So, I don't think we're done with
21 that issue.

22 MEMBER WERNER: My question is,

1 are we going to define it by the end?

2 MS. PACE: If we could, that would
3 be great.

4 (Laughter.)

5 But, you know, I suspect that we
6 are not going to get to that level of
7 granularity to say this is the best way to
8 capture all of the various things that we are
9 talking about.

10 I know there is a lot of interest
11 in talking, but when we move on to the next
12 topic, we want to talk about selecting risk
13 factors. What are the general principles?
14 Are there some unique things? And, you know,
15 as David said, you have already talked about
16 some of the problems with some of these risk
17 factors.

18 You know, people have their
19 special interests. Whether that should
20 translate into a recommendation -- you know,
21 that's why we were trying to look at, do these
22 variables correlate with other variables that

1 are maybe easier to measure? You know,
2 someone also mentioned the problem, well,
3 sometimes when you use proxy measures, you get
4 the wrong answer.

5 So, we do want to try to work
6 through those, and we will see. I can't say.
7 You know, ideally, that would be great. I'm
8 not sure that, as you've all mentioned, the
9 difficulties with data will lead us there, but
10 maybe, then, there's some short-term and
11 longer-term recommendations that we need to
12 think about for some of the more problematic
13 areas.

14 CO-CHAIR FISCELLA: Just a quick
15 comment. I mean, at least from my
16 perspective, I would see this as a first shot
17 at coming down, hopefully, with some very
18 important principles that sets us in a general
19 direction. I think the more specificity we
20 can have, the better, but what is realistic
21 within a two-day I think is really the
22 question.

1 But I wouldn't see this, and I
2 hope NQF wouldn't, as a one-time initiative.
3 I think if we do go down this path of figuring
4 out at least some of the time accounting for
5 sociodemographic and the social disadvantaged,
6 that this would be an ongoing effort, where --
7 I don't know -- three years, five years down
8 the road, we look again at the data. We look
9 at new data that has been collected and maybe
10 figure out better ways to do it.

11 DR. BURSTIN: Just to pile on a
12 bit, I especially like your term, Rachel, of
13 not wanting to kick the can down the road, and
14 we don't want to, just to make that very
15 clear. We want to be able to come out of this
16 with as much clarity as we can for both the
17 measure development community and those who
18 implement measures. If there is additional
19 work to do, we will try to seek additional
20 funding to keep this work going. It is
21 really, obviously, critically important.

22 And I could start list out a list

1 of the other sort of major measurement science
2 kind of issues that trip us up. I think there
3 is a really important role here for us to get
4 groups like this together to do this work.

5 And this, just from my
6 perspective, has been an amazing discussion
7 that I have not heard at a lot of other tables
8 before.

9 So, we will try to do whatever we
10 can in the context of this project. And I
11 think the developers are also looking to us to
12 give clarity. So, the more we could say those
13 variables might work, those are problematic
14 for the following reasons, that I think is a
15 good starting point.

16 CO-CHAIR NERENZ: Okay. Let me
17 tiptoe gently out on a limb and try to see if
18 I can capture the sense of the room, and you
19 will, then, tell me if I have or haven't, on
20 this first big question, which I would sort of
21 phrase as: in principle, should NQF consider
22 or allow the inclusion of sociodemographic

1 variables in adjustment for performance
2 measures?

3 My sense of the sense of the room,
4 it is yes, but with several important
5 qualifications. And I am just going to pick
6 people at random to look at it.

7 In terms of a couple of Pam's
8 comments, in the sense that I'm thinking of
9 it, the "yes" does not have the meaning of
10 "shall" or "must" as applied to any one
11 particular measure. It has the sense of "may"
12 or "can".

13 And in saying that, I am thinking
14 of kind of a visual metaphor where my sense
15 is, up until now, that particular door has
16 been closed or at least that it has been
17 closed. I think now what we are saying is
18 that door should be open.

19 Now it doesn't imply that we have,
20 then, blessed everything that might walk
21 through that door. That's the "how" and that
22 is the detail. But at least we are saying

1 something quite significant if that door
2 should be open in principle.

3 We are also, in saying in
4 principle yes, not saying that there is a
5 standard SES variable that would be automatic
6 included in relation to any measure. We are
7 not saying that all performance measures would
8 naturally or inevitably have this form of
9 adjustment. It may make sense someplace; it
10 may not make sense. But I think what I am
11 hearing is that, where it does make sense,
12 that we would like that to be done in
13 principle.

14 Also, in terms of Tia's thing,
15 there clearly are questions of feasibility and
16 data availability that would be part of the
17 "how" question. So, a "yes" here does not
18 force movement into directions where it is not
19 good because the data don't exist. We don't
20 end up saying that such-and-such performance
21 measure should be adjusted by a variable for
22 which data do not exist. Okay.

1 So, I am seeing a few nods, but
2 also, Larry, I know you had your hand up.

3 I am just trying to see if we can
4 take at least a preliminary position that this
5 first big question would be answered yes, with
6 all of those caveats, and then, swing into
7 what I think will be even the bigger
8 discussion of the "how's," the "when's".

9 Okay, Larry?

10 MS. PACE: I am just wondering,
11 because we have had a lot of discussions about
12 the potential benefits of this, could we very
13 actively ask about the potential negatives, so
14 that we have those out on the table?

15 CO-CHAIR NERENZ: And I guess I
16 should ask, as a process, are we being
17 transcribed?

18 MS. PACE: Yes.

19 CO-CHAIR NERENZ: Okay. Because,
20 clearly, I mean, I'm thinking again of the bad
21 apples example. I mean, that has been out
22 there.

1 MS. PACE: Okay.

2 CO-CHAIR NERENZ: And I think,
3 again, a couple of the presentations pointed
4 out situations in which an approach to
5 adjustment was taken, and it didn't seem to
6 matter. Okay. I mean, I guess that would be
7 at least a type of negative where you might
8 attempt to do it and find it made no
9 difference, and, therefore, had wasted some
10 time.

11 And actually, then, if you went
12 deep down that path and committed to a whole
13 lot of data collection that didn't currently
14 exist, and in the end result it made no
15 difference, that would be a negative. But I
16 think that's on record already.

17 MS. PACE: Okay.

18 CO-CHAIR NERENZ: Burden of data
19 collection, that would be another one. Fair
20 enough.

21 Tia?

22 MEMBER SAWHNEY: We have talked

1 about it in terms of it benefitting providers
2 who are working in challenging circumstances.
3 But, to the extent it is a zero-sum game, it
4 is going to make other providers look worse,
5 and they are not going to take kindly to that
6 and they are not going to take kindly if there
7 is money attached to it.

8 I mean, I have worked in state
9 government. I understand the political
10 ramifications of taking money away from
11 people.

12 CO-CHAIR NERENZ: Fair point.

13 Yes?

14 MEMBER CASALINO: Yes, it seems to
15 me that your questions -- the discussion the
16 last 45 minutes or so has made me think that
17 the question you are trying to ask isn't
18 actually a yes-or-no question. I think there
19 are three possibilities for NQF, right?

20 One would be leave it as it is,
21 right? We don't want to hear about SES in
22 proposed quality measures.

1 The other would be, as you put it,
2 open the door and say, "You can bring this up"
3 or "We welcome it if you bring it up." And
4 also, maybe go on to say, "And if you do want
5 to consider this, yes, here are things that
6 you ought to think about."

7 So, I think those were the two
8 possibilities you were raising. But I think
9 there is a third, which would be, "No, if you
10 want to propose a measure, you have to show us
11 that you considered whether SES should be
12 brought into it or not, ideally with some
13 data. And if you decide not, that's fine, but
14 we would like to see the justification one way
15 or another."

16 So, I would say there are three
17 possibilities rather than two. And I suspect
18 we may have maybe not that much division about
19 a yes-or-no question. I don't know; we might
20 have more across the spread of the three
21 possibilities. I don't know.

22 CO-CHAIR NERENZ: Just could I add

1 a friendly amendment, that the last two of the
2 three I would consider variations of "yes," at
3 least in terms of the question posed to us.
4 Okay. Thank you.

5 I'm kind of losing track. I think
6 Gene was up next or Steve.

7 MEMBER CALLAHAN: Following on
8 that idea, I'm concerned that, if we say we
9 are now in a permissive mode, and that NQF
10 will be looking to us to provide evidence in
11 some form that we have considered the use of
12 sociodemographics in our models, that Karen
13 and others are going to have to come up with
14 some criteria for judging how well we did
15 that.

16 I mean, you know, if you look at
17 reliability, there are certain techniques in
18 determining reliability, and the same with
19 validity. In the same way, that not only will
20 we have to think about how we define and what
21 is the domain of sociodemographics -- you
22 know, what's in; what's out? -- but we will

1 also have to define sort of a scientific
2 methodology of how well we tested to provide
3 evidence that we should or should not include
4 these variables in there.

5 So, I just caution us -- I mean,
6 I'm not above looking at that issue, but we
7 have complicated the road, you know, the
8 pathway.

9 MEMBER CALLAHAN: This is Mary
10 Beth.

11 CO-CHAIR NERENZ: Go ahead.

12 MEMBER CALLAHAN: May I speak?

13 CO-CHAIR NERENZ: Yes, go ahead.

14 MEMBER CALLAHAN: I'm in favor of
15 including sociodemographic and socioeconomic
16 factors, but in terms of just throwing out a
17 con, I think that in medical settings, as
18 guidelines come out, as I was involved in the
19 KDOQI guidelines, I think sometimes as
20 recommendations or suggestions come out, the
21 medical community, even though they may just
22 be suggestions and "can use," the medical

1 community feels like they are being pushed
2 upon.

3 Now I think these are good things,
4 but I'm just saying, you know, you asked for
5 the possible negatives, and I think that could
6 be seen as one.

7 CO-CHAIR NERENZ: Good point.
8 Thank you.

9 MEMBER GOLDFIELD: Just a quick
10 thing. I think another variation on the
11 friendly amendments is that, again, states, as
12 I have already highlighted, states are going
13 to down the road with or without NQF. So,
14 that is a given. Okay? It is already
15 beginning to happen.

16 The question is, I think, whether
17 or not NQF can provide -- and I think they can
18 provide -- really additional expertise and
19 suggestions on how the data collection can
20 occur. So, I think that is a part of the
21 process.

22 And with respect to my OASIS

1 colleage, I mean, I have to believe that the
2 group here can provide advice to the NQF group
3 as to what are the criteria. Maybe I am being
4 eternally optimistic, but I don't think it is
5 impossible.

6 MEMBER LIPSTEIN: So, I tried to
7 convert your construct into a non-
8 methodological researcher vocabulary, which
9 is --

10 CO-CHAIR NERENZ: I didn't think
11 it was that bad.

12 MEMBER LIPSTEIN: -- as it relates
13 to sociodemographic adjustment of performance
14 measures, including outcomes, you could leave
15 the door closed, the way it is now. You could
16 open the door or you could open the door and
17 walk through it.

18 MEMBER CASALINO: And make people
19 walk through it.

20 MEMBER LIPSTEIN: And that was in
21 English, so I understood that.

22 (Laughter.)

1 So, you could open the door and
2 make people walk through it.

3 And the reason I want to push for
4 a third option is because I don't think we
5 have three to five years. When you said that,
6 Kevin, you scared me a little bit, because I
7 do think that our regional safety nets are in
8 a volatile place right now.

9 If this was the only conversation
10 taking place in America about how to reward,
11 punish, or pay, then we could say, "Yes, we've
12 got three to five years to think about this."
13 But, in the context of the Budget Control Act
14 of 2011 and the Affordable Care Act and the
15 American Taxpayer Relief Act of 2013, these
16 hospitals, these providers are going to
17 struggle if we don't move quickly.

18 And so, it may be that, if we open
19 the door -- is it Lawrence or Larry? -- and
20 Larry said we make people walk through it, we
21 can say, "If you walk through this door,
22 here's the upside and here's the downside."

1 And the downside is that we may
2 have a bad apples that get rewarded
3 inappropriately or a few good actors that get
4 punished inappropriately. But, on balance,
5 okay, we think the implications of walking
6 through that door are better than the
7 alternative.

8 And so, I would push for that
9 third alternative.

10 CO-CHAIR NERENZ: Let me clarify
11 for understanding. How is the third
12 alternative different from Larry's one that
13 said the door is open and you must at least
14 say that you thought about it? I don't know
15 how to keep translating it.

16 And maybe there is a flavor of
17 this that says, if a measure can be adjusted
18 through some acceptable technical means with
19 available data, it should be. Is that okay?

20 MEMBER GROVER: Because of the
21 time limits, also -- I'm probably the only
22 registered lobbyist at the table. But we are

1 talking about the SGR and we are talking about
2 moving towards another quality metric that
3 would collapse the Value Modifier and PQRS and
4 all these other things.

5 And again, we are going to be up
6 in the very, very short time, hopefully, if
7 they can get it done, to have to deal with
8 this policy issue in the very near future.
9 And it would be sure nice to have something
10 out there for both Congress and CMS.

11 CO-CHAIR FISCELLA: Yes, Steve, I
12 wasn't suggesting that we take three to five
13 years to do this at all. All I'm saying is
14 that we shouldn't let the enemy be the perfect
15 of the good, and the process will continue to
16 evolve and improve over time. I just want to
17 be clear about that.

18 MEMBER BERNHEIM: I just want to
19 go back to some of our earlier conversations
20 because most of the reaction has to do with
21 how payment penalties are applied to
22 hospitals, and that does not have to be dealt

1 with through risk adjustment of measures.

2 And, in fact, I suspect that risk adjustment
3 of measures wouldn't actually have the impact
4 that people wanted based on what we have done.

5 I mean, one of the slides I didn't
6 show, but it is very similar to what is in
7 that paper, 3 percent of low SES hospitals
8 would go from being penalized to not
9 penalized, 3 percent.

10 And I know we are going to fight
11 about what the risk adjuster is and whether
12 Medicaid status works, but the first job of
13 these measures is to look at quality. And the
14 problem is, if you ask people to bring data,
15 they are going to bring data that looks like
16 what I brought, and they are going to say
17 there's a small difference. And we're going
18 to say, "I don't know if it is because those
19 high outlier hospitals have patients they just
20 can't accomplish low readmission rates with or
21 whether it is because they are not doing what
22 they need to." And I worry about hanging up

1 the entire endorsement process if we spend all
2 of the NQF endorsement time in the future
3 arguing about what the right risk-adjustment
4 measure is and whether I have tested my
5 measure right.

6 And then, we end up with something
7 where I don't know what the criteria is. I
8 don't know what this Committee would have us
9 do with the readmission measures, given that
10 the differences between the low and high SES
11 hospitals aren't that great and risk
12 adjustment doesn't make a big difference.

13 So, if we open the door, I think
14 we have to have really clear criteria and some
15 priority based on sort of, you know, what
16 kinds of outcomes is it more important to do
17 this in? Do you prefer clinical factors over
18 SES? And if they seem to be adequate, would
19 you prefer a measure that did or didn't?

20 And I think it becomes
21 complicated. But, again, I wouldn't let the
22 payment be this thing that makes us all so

1 anxious that we drive forward. Because we can
2 tell Kate right now, "We don't like the way
3 you're doing the payment penalty," but we
4 think we don't know enough with the quality
5 measures to necessarily drive that fast.

6 I mean, that's my caution. I
7 think you could cause more good than harm.

8 MEMBER LIPSTEIN: Susannah, I have
9 to disagree. In other words, the data that
10 you brought using the surrogates for
11 socioeconomic status that you utilized showed
12 that there wouldn't be a difference in payment
13 methodology. But other papers are coming
14 forward and other research was presented that
15 showed something different, using other
16 surrogates for socioeconomic adjusters. And
17 at least we have to be open to other folks'
18 point of view beyond the people that CMS pays
19 to do this. I mean, don't we have to be open
20 to other people?

21 MEMBER BERNHEIM: Of course. But
22 I will say Atul's paper on the patient level

1 shows very little difference. The OASIS shows
2 almost no difference. I mean, there is a real
3 mix of data here, right?

4 And this is my concern: if you
5 tell developers you have to have investigated
6 every single possible socioeconomic variable,
7 and if you see a difference, you have to risk-
8 adjust for it, it is not clear to me that you
9 are improving quality measurements and it is
10 not clear to me that you are going to get any
11 quality measures through again.

12 I'm not saying you shouldn't do
13 this. I'm saying we shouldn't push so hard to
14 do this that we lose track and set NQF and CMS
15 in a position of sort of not being able to
16 move forward with quality measures.

17 These measures have brought down
18 Medicare patients' readmission rates, which
19 hasn't happened in 10 years, right? I mean,
20 there's a lot of people whose lives are
21 better. There is a risk/benefit to this, and
22 we just have to be conscious of that.

1 And if it is about the payment
2 policy, I mean, it is a separate --

3 CO-CHAIR NERENZ: Steve,
4 microphone.

5 Okay. Let me just say that this
6 is why we all came here. This is good.

7 (Laughter.)

8 Let me, first of all, speak in
9 support of the beginning part of your thing
10 about that you don't strictly have to do risk
11 adjustment of the measure in order to have
12 some effect on how you apply the penalty.

13 I would point out, and I
14 understand perhaps it wasn't clear when I went
15 through the MedPAC recommendation, that is, in
16 fact, what that recommendation was about. If
17 you remember, nowhere in those slides was
18 there an adjusted and an unadjusted measure.
19 The measure at the hospital level did not
20 change.

21 It is about how you group
22 hospitals in order to apply the penalty. And

1 that is why there were some questions about,
2 well, gee, how are your things different from
3 Susannah? Well, they're not really because we
4 weren't seeking to do the same thing.

5 So, I agree, absolutely, but I
6 don't think that somehow splits us or takes us
7 in different directions. At least my sense,
8 then, is that, as it relates to any one
9 performance measure, it may be technically
10 possible and powerful and good to do
11 adjustment. And I think in our open-door
12 analogy, we are saying that that door should
13 be open, where in the past it has not.

14 But we recognize absolutely that
15 some desirable policy outcomes may be achieved
16 by changing the way the penalties are applied
17 without literally adjusting the measure. But
18 that second point doesn't trump or somehow
19 argue against the first one.

20 Are we all okay with that?

21 MEMBER BERNHEIM: And I wasn't
22 arguing that we shouldn't consider the door.

1 It was a cautionary tale about how we approach
2 it.

3 CO-CHAIR NERENZ: Understood.

4 MEMBER ADAMS: Okay. I actually
5 had a different, completely different point.
6 So, I don't know if you guys wanted to respond
7 to her first.

8 MEMBER OWENS: So, to speak to the
9 point about walking through the door and
10 keeping separate the measure technical
11 specifications defining the measure and its
12 implementation, something stronger could be a
13 stronger recommendation of what is required
14 regarding implementation and what that might
15 look like.

16 If you are to apply this to this
17 program, you must consider X, Y, and Z. And
18 that is what the measure developer is
19 recommending or has done some testing around.
20 I mean, it is separating out those two parts
21 of what is a reliable and valid measure and,
22 then, what's its application.

1 You could make the recommendation
2 NQF. "NQF, you have to move towards for what
3 purpose and what is the measure developer's
4 recommendation of how this is a valid and
5 reliable measure for implementation."

6 Do you see what I'm saying. And
7 make that a more active -- in other words,
8 walk through that door.

9 But, Steve, to your point, your
10 focus is really on the implementation of the
11 measure, how does that go into payment
12 programs, rather than -- what I hear you
13 saying, but correct me if I'm wrong -- rather
14 than, in that particular measure, no matter
15 how it is applied, doing something about risk-
16 adjusting on SES. Yours is about once it gets
17 to the payment program, once it is sent the
18 other way.

19 I don't know. I'm just trying to
20 disaggregate it and to come to some
21 compromise.

22 MEMBER GROVER: I think it

1 depends. And certainly, we had this
2 conversation when it was being implemented on
3 the readmission side.

4 If you do it in the risk
5 adjustment itself, are you disadvantaging
6 particular individuals who are at risk in some
7 way versus, if you stratify, which is what we
8 eventually came up with as a proposal, in
9 terms of how you implement the payment side of
10 this, can you do it in a way that helps not
11 already disadvantaged providers, but that
12 doesn't sort of treat a whole class of
13 citizens more poorly?

14 MEMBER LIPSTEIN: I think, Pam,
15 what I was responding to was the idea that the
16 end goal -- and this is what I brought up --
17 the idea that the end goal is to bring down
18 Medicare's payments for readmission rates.
19 So, that is the end goal, and that is the
20 definition of quality.

21 Then, I think what I want to do is
22 illuminate the fact that, while we bring down

1 the readmission rate for Medicare, there are
2 other costs. So, in other words, all the
3 money that is being spent to reduce those
4 readmission rates is being shifted to somebody
5 else because Medicare isn't paying for that.
6 It could be shifted to commercial payers.

7 But in those hospitals that can't
8 do cost-shifting because they don't have a
9 commercial payment base, they don't have
10 anybody to shift it to. So, they're paying
11 the penalties. They don't have a commercial
12 payment base, and they are beginning to really
13 suffer.

14 And so, what I want to say is,
15 when we walk through that door, we need to
16 illuminate the fact that the end outcome may
17 not be an improvement in quality. It may be
18 just a big cost shift. And that is what we
19 have got to come to grips with.

20 MEMBER CASALINO: I'm sorry about
21 that. I'm from New Jersey; I'm used to just
22 speaking louder and faster, like certain

1 politicians there and other New Jerseyites, or
2 at least the latter part.

3 (Laughter.)

4 Originally from New Jersey.

5 I think, you know, Pam and
6 Susannah raise a really good point. A lot of
7 the energy in the room comes around really how
8 measures are used for payment or for public
9 reporting, three of us and other people, many
10 other people in the room, I mean three of us
11 most recently, that is where a lot of the
12 concern comes from.

13 And that doesn't, as Susannah
14 pointed out and Pam, really have anything
15 intrinsically to do with whether the measure
16 itself has to be risk-adjusted statistically,
17 as opposed to what gets done with the measure
18 once it is there.

19 So, I think that, for me, and I
20 think for some of us, that is a distinction
21 that, while it is clear, in a way I think it
22 is easier to keep forgetting it, right?

1 So, it does, in terms of these
2 three possibilities, leave the door closed,
3 open it and let people walk through, or open
4 it and require people to walk through -- what
5 are we talking about? Susannah and Pam took
6 it that we are talking about the measure
7 itself; should it be statistically risk-
8 adjusted so that it will automatically get
9 used for payment or pay for performance,
10 right?

11 There might be different feelings
12 about requiring people to present why they do
13 or do not want to risk-adjust the measure if
14 NQF was given some thoughts about what might
15 be appropriate uses of this measure in pay for
16 performance and public reporting.

17 CO-CHAIR NERENZ: Let us turn to
18 Alyce.

19 MEMBER ADAMS: Okay. So, this
20 discussion has been fantastic and really
21 interesting.

22 One of the things I am still

1 struggling with a little bit is this issue of
2 the construct of race and ethnicity as being
3 similar or separate from socioeconomic status.
4 And here's my issue, my dilemma:

5 So, in terms of quality metrics,
6 we are moving towards a world where we
7 consider equity to be a component of quality.
8 And in our goal to improve equity, we actually
9 want to compare across racial and ethnic
10 subgroups in an effort to identify differences
11 that should not be there.

12 And as part of that construct, we
13 want to control for things like clinical
14 differences, but not for SES, because of its
15 tight correlation with race/ethnicity, right?
16 So, that is sort of the one piece. It is
17 stratification, but not for risk adjustment,
18 but, rather, for direct comparison purposes.

19 We, then, on the risk-adjustment
20 side are talking about SES, race, ethnicity,
21 gender, and age as potential risk adjusters.
22 And that's where I get a little bit stuck on

1 race/ethnicity. And the reason is there is,
2 it seems to me, a qualitative difference
3 between saying the resources of a particular
4 neighborhood are such that it disadvantages
5 the providers or it puts additional barriers
6 up for the patients. It is something else to
7 put a variable that says "X" percent Black or
8 "X" percent Hispanic should be adjusted for.
9 Do you see what I mean?

10 Because, to me, that doesn't
11 necessarily speak to resources per se, but it
12 is, rather, wrapped up in all these other SES
13 measures. And so, I am really struggling with
14 that particular component of it.

15 Gender and age are similar, except
16 that most of our quality, many of our quality
17 measures anyway actually already adjust for
18 gender and age based on the nature of the
19 quality metrics themselves.

20 And so, part of me is wondering to
21 what extent, if we believe that race and
22 ethnicity are not primarily measures of

1 biological differences, but primarily measures
2 of socioeconomic differences and things like
3 that and social/political history, what have
4 you, are we doing well enough with our
5 clinical adjustment to say we can get rid of
6 those variables; we don't need them in there?

7 And so, I don't know what others
8 of us are feeling, but I am really struggling
9 with that, of whether or not those variables
10 should really be a part of, you know,
11 sociodemographic measures that we actually use
12 for risk adjustment specifically.

13 CO-CHAIR NERENZ: If I could just
14 observe, a perfectly good point. I think, at
15 least to my ear, that is in the "how". Which
16 variables, which relate, which are markers for
17 what others?

18 So, rather than get deeply into
19 that in terms of response, I guess I think
20 this can surface many times over the next day
21 and a half or day and a quarter, or whatever
22 we have.

1 Okay. Norbert?

2 MEMBER GOLDFIELD: So, two
3 comments. At the end of the day, the reason
4 I'm here is because it is very clear to me
5 that certain types of SES variables must be
6 included in the risk adjustment.

7 On the payment side, the response
8 that people talked about the payment side,
9 there are 50 different ways to screw the
10 patient or the provider. That's just how it
11 works. And that's okay. You know, we
12 recognize that.

13 So, I'm not interested in all the
14 different machinations which Bob Fetter, and
15 so forth, were among the world's experts in
16 how to do that.

17 What I'm interested in, and what I
18 often think about, is what is a poster-child
19 example? A poster-child example of SES is
20 homelessness. Okay? So, if we can get, I
21 mean, from my perspective, if we could have
22 homelessness built into risk adjustment, and

1 I'm more than willing, in deference to
2 Susannah and others, to do a data collection,
3 which is what we are going to do in several
4 states, to do a data collection and
5 understand.

6 But, from my perspective, we
7 really not, even though at the end of the day
8 it's all payment -- I mean, I get that -- but
9 part of payment is having a risk adjustment
10 that takes into account all the different
11 populations. And if I were to take a poster-
12 child example, if we can't agree on
13 homelessness, there's nothing to talk about,
14 frankly.

15 MEMBER SUGG: So, I know we focus
16 a lot on the readmission data because it is on
17 everybody's plate right now, but I just want
18 to make sure we come back to the other
19 disparity that is going to happen if we don't
20 do socioeconomic adjustment. And that's that,
21 when physicians get their reports and it shows
22 that they are poor quality because they take

1 care of certain groups of patients, they will,
2 voting by their feet, leave that and just
3 increase the disparity.

4 And I just want to make sure that
5 that piece doesn't get lost with our
6 readmission piece being so prevalent. I think
7 it is easy to do because we have more data
8 about the readmission, and we don't really
9 have hard data, but I think everybody around
10 the table can pretty much imagine what will
11 happen as far as people being willing to serve
12 in those underserved areas.

13 MEMBER BERNHEIM: Could you just
14 say what measures we are referring to?
15 Because I think it is really important that we
16 don't -- because the whole world isn't about
17 readmissions because I do think it is
18 different for different measures. So, what
19 kinds of measures are you referring to in that
20 setting where you think it is going to be a
21 problem?

22 MEMBER SUGG: So, I am talking

1 about the public reporting, like physicians'
2 individual quality scores that will be
3 available on the web. And if you do these
4 quality scores and not risk-adjust for the
5 socioeconomic parameters of the patients they
6 serve, then it will make individual physicians
7 less likely to take on risky patients.

8 CO-CHAIR NERENZ: Some of these
9 are HEDIS-like measures: mammography rate,
10 medication. But some of them are maybe
11 outcome, and it depends on the context. It
12 depends on the payer. A1c control, for
13 example, is an --

14 CO-CHAIR FISCELLA: So, I have
15 been thinking about the issue of, you know,
16 relatively-modest effects. I agree that, at
17 least for the outcomes we have looked at, that
18 the effects aren't enormous, although I think,
19 as some of us have said, that if you are doing
20 multiple reporting, over time these effects
21 can be cumulative as well as set up feedback
22 loops.

1 But in some ways I think the fact
2 that the effects are moderate is perhaps a
3 good thing in terms of moving forward because
4 it means, one, that the really egregious
5 providers, adjusting for SES is not going to
6 adjust away the fact that they are doing a
7 horrible job.

8 And it means perhaps that
9 initially for things like rehospitalizations
10 that the shifts are not going to be seismic,
11 for the reasons Norbert has already alluded
12 to. Politically, it would become very, very
13 difficult if there was a huge initial shift
14 with this. So, it actually may not be such a
15 bad thing from my perspective.

16 DR. BURSTIN: Just a comment, and
17 perhaps some of this is I think we need to
18 sort of do a little bit of discussion at your
19 break and perhaps bring a formal proposal
20 forward that I think we can work with.

21 I mean, at least the way I see it,
22 we are in a transition phase. We currently

1 have one stop, yes/no, endorsement, which I
2 think makes this problematic, and we recognize
3 that.

4 I do think, though, for the sake
5 of this discussion, I think we have clearly
6 heard that we should allow developers for
7 certain kinds of measures, using certain kinds
8 of variables, all TBD to follow our
9 discussions, to consider you putting
10 sociodemographic variables in their risk-
11 adjustment model if justified.

12 I think what we are clearly
13 getting into the discussion of, the forcing it
14 is I think more about the implementation of
15 the payment, and it may be that we can
16 actually add a second principle there. And
17 Kate may be helpful here in helping us think
18 this through. For certain kinds of uses,
19 there may be more of a suggestion to
20 demonstrate that you should do it or not do it
21 as opposed to leaving it fully optional.

22 So, I think there are ways for us

1 to create a pathway here that I get the sense
2 people would agree to. But perhaps during the
3 break we could try to write that up.

4 MS. PACE: But I think that, you
5 know, we are going to have tomorrow to come up
6 with specific recommendations. So, what we
7 were hoping to do today is really air all of
8 the issues, the pros and cons, the things that
9 we need to consider. And obviously, we have
10 multiple ways that we can try to move forward.

11 I also want to challenge us to
12 separate the policy response from the
13 performance measurement. If we really have a
14 reliable and valid indicator of quality, why
15 can't that be used for public reporting versus
16 pay for performance versus accreditation?
17 What is it that is going to change that
18 reliable and valid indicator of quality?

19 So, to me, the question is -- and
20 I think our statisticians can help us with
21 this -- if we put something into a statistical
22 risk model, and we start looking at the

1 results of that, I think we are basically
2 asking the question, if the average provider
3 cared for my case mix, this is what we would
4 expect the outcome to be.

5 And so, the question is whether
6 looking at the average provider -- right now,
7 we are looking at clinical and health status
8 factors. And so, the question is whether
9 looking at those patient-level SES indicators,
10 whatever they might be, need to go into that
11 mix when we are asking the question, if the
12 average provider took care of my mix of
13 patients, what would the outcome be?

14 And I think part of that question
15 is what kind of unmeasured clinical severity
16 is accounted for by those factors. And, you
17 know, one of the things that we have talked
18 about -- and I will leave you with this
19 question. We can go to break and we will come
20 back and talk more methodological.

21 But if we did include these in
22 risk adjustment, and we have these questions

1 up here about the responsibility for
2 addressing these disadvantaged populations,
3 and many of you have already presented the
4 higher cost of having interpreters for people
5 that English is not their primary language or
6 higher cost of taking care of patients that
7 don't have a home to go to when they leave
8 your hospital.

9 But there are some strategies that
10 can address those things. Is that part of the
11 quality question? Who is responsible for
12 that?

13 But, if we adjusted for those
14 things, we would still, I think -- and this I
15 my question -- so, if we had those things in
16 the risk adjustment and we're asking that
17 question about, if the average provider took
18 care of my mix of patients, would we still see
19 the difference in applying those good
20 strategies for taking care of these more
21 difficult patients?

22 So, I don't know if we can go to

1 break with some of those questions, and then,
2 come back and really get into some of the key
3 things about how we would select risk factors
4 and how we would adjust. But I just wanted to
5 kind of lay those out there for you.

6 Why don't we go ahead and come
7 back at quarter until 4:00, 3:45?

8 Thank you.

9 (Whereupon, the foregoing matter
10 went off the record at 3:27 p.m. and went back
11 on the record at 3:46 p.m.)

12 MS. PACE: Okay. We are going to
13 reconvene.

14 (Pause.)

15 Okay, everyone, we are going to
16 reconvene.

17 We are really going to move into
18 the "how" questions. We on our agenda had
19 this kind of parsed out to first talk about
20 the factors and, then, the methods.

21 And what I am going to do is just
22 present a couple of slides, just in usual kind

1 of considerations, just kind of to frame this.
2 And then, we will take off from there.

3 And I'm going to go ahead and do a
4 few slides on adjustment models, as we have
5 been talking about. And then, we will have
6 the open discussion, because I am afraid we
7 will end up kind of crossing those two topics
8 anyway. So, we might as well get this out of
9 the way.

10 So, I just wanted to put this out
11 here. These certainly are things that we can
12 add to or subtract from, but these tend to be
13 some of the usual considerations for selecting
14 risk factors.

15 One is that there is a clinical or
16 conceptual relationship with the outcome of
17 interest. Usually, we look for an empirical
18 association with the outcome of interest. As
19 part of that empirical analysis, often looking
20 for contribution of unique variation versus
21 redundant. If, you know, two variables are
22 basically highly correlated and accounting for

1 the same thing, you may not need both of them.

2 From a risk model standpoint in
3 the context of quality performance
4 measurement, we want things that are not
5 related to the quality of care because that is
6 what we are trying to do, is isolate
7 differences that we want to attribute to
8 differences in quality.

9 So, we have already talked about
10 we really want to focus on things that are
11 present at the start of care, not things that
12 happen days into the care that is started.

13 Accurate data that can be reliably
14 captured, and I think that is something that
15 we are going to need to come back to because
16 that certainly is a consideration. And data
17 limitations often are a practical constraint.

18 And often, you know, we want to
19 see improvement in the risk model metrics.
20 Does it improve discrimination? Does it
21 improve calibration? We have talked about
22 improving the moderate effect on the overall

1 r-squared or C statistic, but one question we
2 might want to look at is, does it improve
3 calibration when you look at different levels
4 of caring for patients with these different
5 factors?

6 Okay. Next slide.

7 So, we will come back to this in
8 terms of your thoughts about how you select
9 risk factors and how that applies to
10 sociodemographic factors, whether there are
11 some of those that don't apply or new ones.

12 So, let's move on, and I am going
13 to just mention a few things about the
14 methods. And basically, what many of us are
15 used to is comparison of observed-to-expected
16 outcomes for the accountable entity, often
17 indirect standardization, which is, then,
18 extended to multivariable statistical models.

19 Go on.

20 And as we already said, the models
21 for risk adjustment are used to isolate the
22 effect of the quality of care. And I think,

1 as Susannah and others have mentioned, they
2 purposely do not include all the variables
3 related to the care provided. You know, if
4 your goal is strictly to predict the outcome,
5 you would include lots more, but, purposely,
6 we are not including those variables related
7 to treatment and the care processes versus, as
8 I said, an explanatory model.

9 And so, one thing that we need to
10 keep in mind when we are looking at model
11 metrics -- for example, r-squared or a C
12 statistic -- they are not necessarily going to
13 achieve the same values that you might have
14 when you are doing a total explanatory model
15 that you are including those treatment kinds
16 of variables.

17 Okay. Next slide.

18 The other thing that we want to
19 talk about, and certainly we can have some
20 discussion, I think people seem to be in
21 agreement that stratification is a way of
22 doing risk adjustment versus just these

1 statistical models that we often think of.
2 And stratification could be done by
3 constructing risk categories based on SES or
4 other sociodemographic factors.

5 And this could be done, as we have
6 talked about, within a provider organization
7 or accountable entity or something that we are
8 kind of terming "organizational
9 stratification," like David presented that is
10 what the MedPAC recommendation is. And
11 certainly, then, there could be combinations
12 because, actually, the MedPAC recommendation,
13 they are using the risk-adjusted, the
14 clinically risk-adjusted performance rate and,
15 then, stratifying organizations. And you all
16 may have some other suggestions that we should
17 be considering.

18 Next slide.

19 So, this is just to illustrate
20 what we're talking about, stratification
21 within an accountable entity, the hospital,
22 the physician, where you actually would look

1 at the patients served by that organization
2 and perhaps dividing them into quintiles by
3 median income that was determined by the
4 Census tract of where that patient lived. And
5 then, each provider would have five
6 performance rates for each quintile of the
7 variable.

8 I think, as was pointed out, when
9 you have low numbers to begin with, and then,
10 you have a provider dividing those cases into
11 five, we get into other issues with
12 reliability.

13 And then, the next slide.

14 And this is just another
15 representation of what the MedPAC
16 recommendation is about, what we're calling
17 organizational stratification, where you just
18 use the performance rate using, in that case,
19 already risk-adjusted for the clinical
20 variables, but, then, using stratification to
21 identify peer groups in terms of looking at
22 comparing performance within peer groups.

1 So, I think that is my last slide.

2 So, I think, with that, I'm going
3 to turn it back over to Kevin, and we want to
4 have some discussion. We can decide whether
5 you want to try to start with factors or leave
6 it open to both factors and approaches to risk
7 adjustment.

8 Kevin?

9 CO-CHAIR FISCELLA: My suggestion
10 is to continue with what we have and go to
11 risk factors. I know Alyce raised this
12 question as sort of a prelude to getting into
13 this.

14 So, it gets into what are the
15 sociodemographic risk factors that should be
16 considered. What are the criteria we should
17 use both at an individual level and at an
18 organizational level, since those are both
19 open questions on the table, if we are going
20 to stratify under some type of stratification,
21 at what level it would be done?

22 So, why don't we just open it up

1 to thoughts about criteria for those
2 sociodemographic factors that warrant
3 consideration?

4 MEMBER SUGG: So, I wanted to
5 follow up with what Alyce started talking
6 about with race because that is something that
7 I have been thinking a lot about recently.

8 And some of this actually comes
9 from my front desk staff who tell me that,
10 when they are doing the intake for
11 registration and they start to talk about
12 race, they often get perplexed looks from the
13 person standing in front of them. And then,
14 when they get to ethnicity, they get even more
15 perplexed looks about, well, first of all, why
16 are you asking? And secondly, what does that
17 really mean and how do I identify myself?

18 And I especially have issues
19 around ethnicity because at Harborview we have
20 the International Medicine Clinic. And so, we
21 have a large Southeast Asian and Somali
22 population that we take care of. But when I

1 see somebody who came over as a refugee 20
2 years ago, ethnicity in some ways makes sense
3 to me. When I see their granddaughter in
4 clinic, not so much because they're
5 Americanized, and although ethnically they
6 relate they're Cambodian, I don't know that
7 that particularly changes anything I'm going
8 to do medically for that person; whereas, it
9 definitely would with their grandmother.

10 So, I have spent a lot of time
11 kind of figuring out why do we still ask this.
12 I mean, part of it is disparities. We want to
13 make sure that groups are not being
14 discriminated against, and I think that is an
15 important variable. But, beyond that, I
16 actually am not sure how I use that clinically
17 anymore.

18 MEMBER LIPSTEIN: Yes. No, if
19 we're having any conversation about what risk
20 factors -- and, Kevin or David, keep me honest
21 there -- when I raised the issue earlier of
22 Census tract housing vacancy rate, you would

1 call that a risk factor?

2 Okay. So, the article that we
3 presented, which the manuscript is with the
4 peer-reviewed Journal now, and that will
5 become available during our work here. So,
6 the Census tract variables that I presented in
7 that paper, including especially focusing on
8 the one that didn't get a lot of discussion,
9 was high housing vacancy rates, and that would
10 apply to -- so, for example, the discussion we
11 were having just before the break of
12 individual doctors, and individual doctors who
13 serve those Census tracts characterized by
14 difficult life circumstances, that would apply
15 in that kind of a setting as well as the
16 institutional setting.

17 I did have one other question I
18 wanted to ask. And the question is, if
19 measure developers -- I think that is what
20 they are called -- if measure developers were
21 required to look at the impact of
22 socioeconomic variables on an outcome, and

1 they could conclude either they do have an
2 impact or they don't have an impact, okay, one
3 of the two, that would be good public
4 information to have. If they include that it
5 doesn't have an impact, then there would be no
6 consequence of adjusting for them. So, why
7 not go ahead and do it? Because that would at
8 least quiet the people who believe it really
9 did have an impact and didn't. And then, if
10 it really did have an outcome, then you would
11 want to adjust for it.

12 So, it seems to provide rationale
13 that the provider community, if they really do
14 believe that these variables affect or impact
15 outcome, it would take another obstacle out of
16 the way to progress in improving outcomes if
17 we actually adjusted for things that don't
18 affect outcomes because no one could argue the
19 result.

20 MEMBER SAWHNEY: A true story. I
21 did work, strategy work, for the Cook County
22 Health and Hospital System, but I was using

1 the State discharge database. And I noted the
2 Cook County Health and Hospital System, less,
3 though, than any other hospital in the State,
4 could not identify the race and ethnicity of
5 its patients.

6 And I'm like, what's so wrong with
7 these incompetent people at the front desk
8 that they can't fill the form out correctly
9 and get it into the database? Until I spent
10 an evening in the ER of the Cook County Health
11 and Hospital System, and I just literally
12 watched people come and go. It is an
13 experience everyone should have.

14 And I sat there, tried to look at
15 people and figure out what their race and
16 ethnicity was. How exactly do you classify
17 the woman who is in full burka and speaking
18 Arabic? What category do you put her in?
19 But, clearly, she has a social disadvantage in
20 the healthcare system. And I wouldn't put her
21 under White, but she doesn't fit in the other
22 boxes, either. So, if the front desk put her

1 under "other," I understand why they would use
2 "other".

3 CO-CHAIR NERENZ: Just as a quick
4 response to that, with all due respect to the
5 complexities and agreeing with the points you
6 make, three or four years ago, there was an
7 IOM committee addressing the issue of the
8 standard collection of race/ethnicity data,
9 including a couple of language variables. A
10 template exists, at least in the form of the
11 report of that group.

12 And I can say, upon having
13 implemented that in essentially faithful
14 detail at Henry Ford, at least in our
15 environment -- emphasized, in our environment
16 -- it works pretty well.

17 So, granted, it is challenging and
18 there are clearly places and people for whom
19 it is very complicated, but at least that
20 template does exist, and recommended as a
21 standard template.

22 MEMBER SAWHNEY: A counter-example

1 is my children are of mixed race and ethnic
2 and minority religion and wear the uniform of
3 the religion. And they look kind of strange
4 by our society's standards, but they are not
5 socially-disadvantaged. So, it is a tough
6 one.

7 Now, that said, there are some
8 unique challenges that I don't know how to
9 figure out. Granted, this is an incidence
10 problem. It is an incidence, not an outcome
11 problem.

12 But the threat of violence, if you
13 are a young man and you're Black on the street
14 of Chicago is very different than if you are
15 White.

16 The birth outcomes, which those
17 are outcome measures, we don't know what is
18 going on and we sure would like to fix it, but
19 birth outcomes are very different by race.

20 So, I would prefer to stay away
21 from race, when possible, but I am not sure
22 that is always possible. It does have an

1 impact in our society.

2 MEMBER CALLAHAN: Hi. This is
3 Mary Beth Callahan again.

4 So, just kind of thinking outside
5 the box possibly, if we took away the idea of
6 race and ethnicity, but looked at the barriers
7 that those things created for people, and I
8 know that that would have some barriers
9 itself. And I don't know if it would be a
10 person filling this in themselves or someone
11 at the administration desk filling this in.
12 I don't know how we would get this data.

13 But if we are looking at language
14 barriers or homelessness or low literacy or no
15 health insurance or unemployment, so we are
16 looking at the barriers that some of those
17 things create. That is just an outside-the-
18 box way of looking at another situation.

19 MEMBER BHAREL: I have two
20 comments that are semi-related. First, this
21 wasn't my main comment, but on the
22 race/ethnicity one, I would like us to just

1 keep those on -- from my point of view, I
2 think they must remain on the table. Most
3 race and ethnicity in well-trained centers --
4 we actually went through a very extensive
5 training in our Health Center -- it is about
6 asking the patient, not looking at them. So,
7 just to take that off the table. And it can
8 be collected very well if well-trained
9 individuals do it.

10 And we are here to talk about
11 socioeconomic disparity, but, given the
12 history of our country, race and ethnicity
13 remains an issue at every level, and
14 particularly at low socioeconomic status. So,
15 I would like to advocate for that to stay on.

16 But I am here to advocate for
17 homelessness as a factor. And you have heard
18 my arguments about it before, but just a
19 couple of things that have come in the
20 readings and discussion, just to highlight.

21 So, homelessness, again, can be
22 kind of this composite that takes into account

1 all of these different issues that we are
2 talking about, and would be a great place to
3 start experimenting with some of these issues
4 that we are talking about.

5 In terms of data collection, I
6 think it is really parallel to the race and
7 ethnicity. If you want to do it correctly, it
8 can be done correctly, and there is actually
9 at the federal level, HUD requires, as an HMIS
10 system that is used federally, which is the
11 Homeless Management Information System, where
12 every state has tracking of when individuals
13 stay at a shelter.

14 So, taking away the issues of
15 being able to cross information between two
16 different state groups, an organization like
17 Medicaid could see what patients, and their
18 panel, have slept at shelters. So, there are
19 ways to get at the data.

20 And Norbert is gone now, but New
21 York is doing it at a clinic level and
22 requiring it when there is Medicaid funding

1 involved. Massachusetts is looking at it as
2 part of their payment reform, requiring
3 individuals to report on homeless status. So,
4 there are ways to get at the information.

5 The other thing, some of the
6 questions came up around, you know, these
7 should be consistent things that are traits.
8 Very much agreed. Most homeless individuals,
9 thankfully, are transiently homeless, 80
10 percent of them. So, it is a state at a given
11 period of time. That said, to become even
12 transiently homeless is in itself a marker of
13 chronic stress and other issues, but it can be
14 used if you looked at it, say, on a yearly
15 basis.

16 Thank you.

17 CO-CHAIR FISCELLA: Just to
18 clarify, Monica, in terms of race/ethnicity,
19 how are you advocating that it be used? You
20 said "collection," but once it is collected,
21 what are you suggesting?

22 MEMBER BHAREL: So, my point was

1 really about the issue around collection to
2 not be the barrier. So, I think if we are
3 looking at socioeconomic determinants of
4 health, the traditional ones have not -- you
5 know, it is considered in disparity, but not
6 necessarily in sociodemographics. And I would
7 advocate for including in something that might
8 be measured and, then, adjusted for.

9 CO-CHAIR NERENZ: Okay. Actually,
10 in my sequence -- and a quick apology -- I
11 said Alyce, and I heard someone else say
12 "Alyse," and I wasn't listening carefully.
13 What is correct?

14 MEMBER ADAMS: It's Alyce. That's
15 okay. And its spelling, it throws everybody
16 off. It's all right.

17 CO-CHAIR NERENZ: All right. We
18 will get it correct from now on. Okay.

19 MEMBER ADAMS: Okay.

20 CO-CHAIR NERENZ: You are next.

21 MEMBER ADAMS: So, just briefly, I
22 just wanted to reiterate, it is true, the gold

1 standard now is to ask people what they are,
2 not for the provider to make that assessment.
3 And that's helpful.

4 But I think it is also important
5 -- and I don't want to get too far down the
6 rabbit hole of race/ethnicity -- but this
7 issue of sort of would it matter. So, I am
8 sort of going down this list and trying to
9 check off each of these boxes, as it were some
10 other type of factor.

11 One of the things I run into is
12 that, with race/ethnicity, truly it depends on
13 the subgroup. So, sometimes what you will
14 find, for example, is that when you control
15 for other socioeconomic factors, sometimes
16 race falls out, but not always.

17 And so, trying to figure out
18 race/ethnicity as a single factor is
19 challenging in the context of risk adjustment
20 because, yes, sometimes it is almost saying
21 the same thing as SES; sometimes it is not.

22 And so, I really struggle. I am

1 not sort of advocating for throwing it out
2 completely, but I do think that it requires a
3 little bit, a lot of thoughtfulness about
4 exactly what do we think we are capturing when
5 we talk about race/ethnicity. And my guess is
6 it is not truly biology, nor is it purely SES.
7 So, we just need to figure out what that is
8 that we are trying to capture with that and
9 whether or not we're getting it through other
10 means.

11 MEMBER PONCE: Thank you.

12 So, I think for race/ethnicity I
13 have the other concern, which is that, if it
14 is included in a model, it might be picking
15 up. So, racial/ethnic might look like they
16 are doing better, but it might be an access
17 problem. So, they're not getting access to
18 care at the individual level.

19 So, I go back and forth whether it
20 should be at the individual level, but at what
21 is termed organizational or neighborhood or
22 system level, I do think it is important to

1 get at the compositional racial/ethnic, you
2 know, clinical profile.

3 And the ACA does have a mandate on
4 collection of race/ethnicity. I was with
5 David on that IOM panel. So, an Arab would be
6 White. It is self-reported. That is No. 1.
7 That is the gold standard. It shouldn't be
8 assessed by the front desk.

9 Going through this checklist, I
10 want to have a friendly amendment on, and
11 building off of what Rachel said earlier on
12 accurate data that can be reliably captured,
13 data limitations. If that is going to be one
14 of the criteria, then, you know, some of the
15 variables that are really important might be
16 thrown out.

17 MEMBER SUGG: I wanted to make
18 sure people understood. The front desk was
19 not choosing the race. They were asking the
20 patient. And the confusion was on the
21 patient's end of how they saw themselves.

22 And I'm not saying that we should

1 throw race out. I just think maybe it is
2 worth thinking about how we are going to use
3 that data and where it is important and where
4 it isn't. But it is never about somebody
5 checking it off and making an assumption, but
6 it is about sometimes from the patient level
7 they don't quite know how to answer the
8 questions.

9 MEMBER PONCE: I agree. Thanks
10 for the clarification.

11 MEMBER BARGER: As a researcher
12 for race/ethnicity, it's interesting how your
13 subjects or your patients have difficulty
14 answering the question. And I find the
15 younger ones actually want to check more than
16 one race because that's one of the choices.
17 And then, as researchers, we don't really know
18 what to do with more than one race. And so,
19 we sort of leave them out when we do it.

20 I think that the data should be
21 collected because, especially for perinatal
22 things, there is huge racial differences. I

1 mean, the difference is Black women die at
2 three or four times the rate of White women in
3 this country, and it is the largest disparity,
4 although my husband tells me, no, it's male
5 and female mortality rate that's larger.

6 So, I think we should collect it.
7 I'm not so sure that we should adjust for it.
8 I think it allows us to report about those
9 differences.

10 I go along with what someone said
11 about, at this day and age, a lot of things
12 are geocoded. In California they geocode this
13 chart where you live with your discharge data.
14 Birth certificate data is geocoded. And the
15 Census does do a good job, and there are lots
16 of variables in the Census that Steve has
17 pointed out, and I think Pam pointed out, that
18 you can use to allow for sociodemographics
19 that get at access, poverty of resources,
20 those kinds of things, that might be a little
21 bit more stable. So, that is what I would
22 say.

1 CO-CHAIR NERENZ: Okay. We've got
2 Dionne, Gene, and Larry so far.

3 MEMBER JIMENEZ: Should I press
4 the right button.

5 So, the point I wanted to make
6 was, I mean, I think it is really important to
7 have some sort of income indicator in there,
8 but I know we want to be cognizant that it may
9 be difficult to figure out which one to use,
10 based on what the quality measure is going to
11 actually be used for.

12 So, my example would be for
13 measures that are used for the Value-Based
14 Purchasing Program. I mean, that is supposed
15 to be only applied to sort of the Medicare
16 population. But, then, when the measure
17 developers are trying to do something, what if
18 that same quality measure might be used on the
19 commercial side or on the Medicaid side?

20 So, when we try to develop this
21 criteria, we have to keep that in mind. And
22 maybe there should be sort of -- I don't know;

1 maybe you have to require multiple variables
2 that need to be tested on the side.

3 In terms of the race thing, I
4 totally agree from a personal standpoint it is
5 always very hard for me to like check that box
6 of White because I don't feel that that is my
7 race.

8 And also, you see the demographics
9 of the country changing. But I think it is
10 critically important that the information
11 still be collected. Like I totally agree with
12 what Mary is saying and Alyce and others. It
13 should be collected, but not necessarily
14 adjusted for, as you see the demographics
15 changing, as well as over time people are
16 becoming more affluent and less socially-
17 disadvantaged, you know, for some parts of the
18 race. So, I think you are leaving out a big
19 group of low-income White people as well, too.

20 MEMBER NUCCIO: I would just like
21 to chime-in on the idea that I'm really not
22 sure what race measures or what it represents.

1 One could argue that what we are trying to
2 measure and we claim to measure SE, economic
3 status or something, but I would argue that it
4 more likely is more cultural perspective on
5 how healthcare gets delivered and should be
6 received.

7 And so, in that sense, trying to
8 use the value of race in a prediction model,
9 I don't know what that represents in that
10 equation. Is it representing the economic
11 status of the individual? Is it representing
12 decisions about whether or not you should or
13 should not receive vaccinations and when you
14 seek healthcare?

15 So, I am really not terribly
16 excited about including it in an equation
17 because I don't know what it is that I
18 ultimately predict when it is in there.

19 CO-CHAIR NERENZ: I am wondering
20 if I could just call this friendly amendment,
21 but I am just checking the framing issue for
22 our discussion. When we talk about any one of

1 the social demographic variables, so let's
2 just now use race because we have been talking
3 about it, presumably, when we speak favorably
4 about it, we're not crossing the line to say
5 that it should or must be included in all
6 measures in all possible models. Again, I
7 think we are talking about "can" or "might".
8 And again, I see a few nods around the table.
9 We ought to check that.

10 I also, I think, have the
11 auxiliary assumption that the actual
12 interpretation or meaning of it in a model,
13 meaning how it influences the dependent
14 variable, can vary measure-by-measure. And it
15 may be a proxy for something like income or
16 education somewhere, but it may have a
17 different influence someplace else.

18 I am imagining that a measure
19 developer in explaining an adjustment model,
20 bringing it forward to NQF, could include
21 either a verbal or a diagrammatic conceptual
22 model of how the included variables are

1 presumed to influence the outcome, whether
2 they are direct or indirect effects, whether
3 they are variables that are presumed to
4 essentially mean what on their face they say,
5 as opposed to being the best-available proxy
6 for something else that cannot be measured.

7 So, again, I am throwing out a few
8 assumptions here, but I think what is in my
9 head when we have this discussion about
10 variables is mainly that they can be useful,
11 but we are not seeking to decide whether they
12 must be included. Is that fair? Okay.

13 MS. PACE: But I do think, if
14 there is agreement on something that should
15 not be included, that is certainly fair game
16 as well.

17 CO-CHAIR NERENZ: Yes, and I would
18 be okay with that. And then, presumably,
19 there would be a rationale why that is
20 strictly a bad idea and why it may be a bad
21 idea across the board, if we have that.

22 Okay. Larry, you were next?

1 MEMBER CASALINO: Two points. One
2 is, you know, all day this has been a very
3 hospital-centric discussion and a very
4 hospital-centric/readmission-centric
5 discussion. And it is easy to understand how
6 that happened, but it is a mistake, I think,
7 right?

8 So, if we talk, for example, about
9 how data can be -- or we talk about
10 race/ethnicity. Where does that data come
11 from? CMS has data on that and can say
12 whether it is good or not, but, right, it's
13 there at CMS?

14 There's Census data on that,
15 right, which you could use not for
16 individuals, but you could use for -- you
17 could see where the Census tracts are that the
18 hospitals confirm or medical groups, and do
19 some kind of organizational-level assessment
20 there.

21 But are we talking about physician
22 offices collecting this information? And how

1 accurately will they do it? And I think any
2 of us who have spent time in small practices
3 know that it is ridiculous to think that small
4 practices are going to collect that
5 information accurately. It is just never
6 going to happen, either if it were mandated,
7 I don't think.

8 So, specifically to the race
9 discussion, but more generally to our
10 discussion I hope the rest of today and
11 tomorrow, I think let's try to think of other
12 cases, because we are going to have public
13 reporting for individual physicians. We are
14 going to have public reporting for medical
15 groups. We are going to have payment for
16 individual physicians and medical groups, pay
17 for performance.

18 And there is going to be lots of
19 yowling, for example, about, you know, "It is
20 really hard for me to get my pap smear rates
21 up to 50 percent. You cannot compare me to a
22 physician in Mill Valley, California, where

1 the women want to get mammograms every week,
2 and they have nannies and they have BMWs to
3 drive and get there." So, I think we need to
4 consider that case, too.

5 The other point is just we can
6 spend the two days discussion race/ethnicity.
7 It is an important subject. But I'm looking
8 at, actually, the 3:30 questions on the
9 agenda, and they are quite different kind of
10 questions, as I read them, than what variables
11 should we use. I won't read them, but I will
12 just point out they are different, and I think
13 they are interesting.

14 CO-CHAIR NERENZ: Agree. Thank
15 you.

16 Susannah? That's too bad; I don't
17 have anybody else with a nametag on.

18 (Laughter.)

19 CO-CHAIR FISCELLA: Yes, I wanted
20 to comment a little bit on the perinatal issue
21 because I think it does highlight the
22 challenge. The relative Black/White rates of

1 low birth weights haven't changed in 50 years.

2 As you get into very early
3 gestation births that are extremely premature,
4 the rates get up to close to fourfold, and
5 these are not accounted for by traditional
6 sociodemographic variables. And, of course,
7 this has big implications for cost, for
8 hospitals, for readmissions to the NICUs,
9 which are very, very high-cost areas.

10 So, the question, then, becomes,
11 well, what do you do? In this particular
12 case, and it is probably fairly unique in that
13 we don't understand the pathways; a lot of
14 people think it is due cumulative lifelong
15 disadvantage and perhaps even early prenatal
16 factors in the mother themselves, but we
17 really don't know.

18 But what we do know is that there
19 is a huge difference, and it will matter in
20 terms of the infant's readmission and NICU
21 stays. And so, when you have a variable like
22 that, what should we do? Should it be

1 included? Should it not be included? Should
2 it be stratified? Or should we forget race?

3 MEMBER SAWHNEY: I would summarize
4 what I had said earlier, in that race would be
5 not my priority if other variables work, but
6 there are situations where there's no
7 substitute for race.

8 MEMBER GARRETT: So, there is a
9 point that we have been focusing a lot on the
10 readmissions measures which raised a question
11 for me, which is, do we consider patient
12 satisfaction to be a type of outcome measure
13 that we might be including in this or not?
14 The question is whether we would consider
15 patient satisfaction to be a type of dimension
16 that we would in the outcome measure
17 definition.

18 MS. PACE: Yes, we consider
19 experience with care a patient-reported
20 outcome. And so, yes, it would be in the
21 discussion, and that is part of our questions
22 to you all. When we talk about these things,

1 is there a difference by type of outcome? So,
2 I don't know if you want to say that it should
3 be the same or there are different
4 considerations, but we should consider that,
5 yes.

6 CO-CHAIR NERENZ: Since I don't
7 see a nametag up at this instant, perhaps --
8 no, that was an omen.

9 (Laughter.)

10 Just in terms of responses to the
11 question that Karen put forward, are there any
12 variables in this set that we are talking
13 about that people feel should not be included
14 as a matter of principle? Karen talks about
15 there were no answers to that. I may take
16 that to say that we don't think there are.
17 But are there?

18 MEMBER CASALINO: Let's look at
19 Kevin's question just as a particular case.
20 And I would like to hear what would people do.

21 So, this is a subject area I'm not
22 familiar with. So, if you have higher

1 perinatal or you have higher premature birth
2 rates in certain ethnic groups, say, right,
3 even after adjusting for other factors, right?
4 And let's say you want to look at individual
5 obstetricians' C-section rates, and you think
6 high rates are bad, right? And this is a
7 performance measure or a proposed performance
8 measure.

9 So, you bring in various clinical
10 factors. And I would just ask the group,
11 would other factors be brought in and how?
12 What would they be and how would you bring
13 them in?

14 And individual physician, an
15 obstetrician, you're looking at C-section
16 rates. Now, obviously, if you have a high
17 African-American percentage of patients in
18 your population, you're going to have higher
19 C-section rates, everything else being equal,
20 because you have more premature births, right?

21 MEMBER BARGER: African-American
22 women do have higher C-section rates, but it

1 is not necessarily because they have more
2 premature births.

3 MEMBER CASALINO: All right.

4 MEMBER BARGER: Because you don't
5 do C-sections for premature births
6 necessarily. I mean, it is not a standard of
7 care.

8 So, it is a good question, and it
9 is one we have struggled with. In California,
10 we have something called the Quality Maternity
11 Quality Care Collaborative. And I'm on the
12 Data Committee, and we're actually given
13 physicians now almost real-time data on their
14 statistics, one of them being their C-section
15 rates.

16 And so, then, the question is, you
17 know, the obstetricians come back and say,
18 "Well, you know, I have this high-risk group.
19 I take care of obese women." You know, they
20 have X, Y, and Z.

21 And so, we are now being able to
22 sort of fairly quickly adjust. We are on the

1 verge of giving them the adjusted rates,
2 right?

3 And it is sort of like some of the
4 data here. So, being on the Data Committee,
5 I have been looking at the adjusted rates.
6 And really, once you adjust, it still doesn't
7 make a whole lot of difference, but it will
8 certainly make quiet their objections to being
9 compared. And so, I think, from that
10 standpoint, I am for adjusting, just because
11 I think, then, there is no way that they can
12 sort of say, "It doesn't really apply to me."

13 MEMBER CASALINO: How are you
14 adjusting for that?

15 MEMBER BARGER: Oh, we are
16 adjusting for age, ethnicity, BMI,
17 comorbidities such as preclampsia, which is a
18 reason. So, we are adjusting for preexisting
19 conditions.

20 MEMBER CASALINO: Income?

21 MEMBER BARGER: We don't have
22 income. So far, we are not doing income or

1 SES. Maybe we did. I wish I had them. I
2 don't have my computer here. I just have my
3 iPad, so I don't have all the things, but a
4 fair number of things.

5 MEMBER CASALINO: And you are
6 adjusting for individual physicians?

7 MEMBER BARGER: Yes.

8 MEMBER CASALINO: So, there is no
9 stratification. So, this makes differences
10 invisible --

11 MEMBER BARGER: Uh-hum.

12 MEMBER CASALINO: -- and are of
13 different patient groups, right?

14 MEMBER BARGER: Uh-hum.

15 MEMBER CASALINO: They just get a
16 single number adjusted, right?

17 MEMBER BARGER: Uh-hum, uh-hum.
18 They just get an adjusted rate.

19 So, anyway, but it is also done on
20 an organization level. So, I mean, it is a
21 pretty very cool thing. So, each hospital who
22 is part of the group can look at within their

1 kind of hospital, within their region, within
2 the state. So, it provides like the
3 benchmarks, the average for the state or
4 within their teaching hospital group, or
5 whatever kind of group they want to compare
6 themselves to. So, it's pretty cool.

7 And then, where you are getting
8 dinged, it actually gives you the -- if you
9 are the hospital, you can find the patient
10 that you are getting dinged for. And then,
11 you can go back and look at the records and,
12 then, go to the provider and say, "Why did you
13 do this C-section?" or "Why did you do this
14 induction?", or whatever. And if it is coding
15 issue, they can fix the coding issue.

16 So, it is now making sure that the
17 data is really, really clean, because, then,
18 the physician would say, "Oh, the data was
19 bad." Well, then, here's the data you gave
20 us. Either fix your coding or is it correct,"
21 right? So, I mean, it's cool.

22 So, I think that it is fine to do

1 it, but I want some data that we can use.
2 Some of the problem is this sort of dual race,
3 you know, where do you put those people? And
4 sort of what another person said is, I think
5 what Gene said is, what are we measuring? In
6 the perinatal, we are measuring some long-term
7 kind of thing because we know, even if you
8 control for acquisition of education, acquired
9 wealth, all of those things, the perinatal
10 things still are there. Among high-income
11 women who are very wealthy, who are Black
12 versus White, there's still a huge difference
13 for pre-term birth. So, I think that it is a
14 proxy measure for something beyond access,
15 beyond where you live, access to grocery
16 stores and resources.

17 CO-CHAIR NERENZ: Sean? Then,
18 Steve. Then, Susannah.

19 MEMBER O'BRIEN: I was just
20 thinking it would really help clarify my own
21 thinking if somebody could give an example of
22 a measure or a scenario where you would really

1 want to avoid adjusting for a sociodemographic
2 factor. But I think of lots of scenarios
3 where you could very easily defend not
4 adjusting variables, if you had issues of data
5 availability and cost of collecting the data
6 or data quality or a situation where just
7 adjusting really made no impact. So, I can
8 envision lots of those scenarios.

9 But it used to be that you didn't
10 need to really worry about the reason for not
11 adjusting because the NQF policy said the door
12 was closed, and that was your reason and you
13 kind of said, "Well, we don't want to mask
14 differences." And you didn't have to really
15 think too hard about whether that held water
16 or not.

17 But if we are opening the door at
18 this point, then, presumably, that is no
19 longer a good enough reason. And I know there
20 are good examples. I think it would be
21 helpful if someone could kind of lay out a way
22 of thinking about it and an example of here's

1 a scenario where you really wouldn't want to
2 adjust for any demographic variables.

3 CO-CHAIR NERENZ: Go ahead.

4 MEMBER COHEN: Yes, it is not so
5 much that we don't want to -- I'll talk about
6 the miSCRIPT program, which is purely a
7 quality improvement program. And we might get
8 slightly better models, but it is not worth
9 it.

10 So, essentially, in miSCRIPT we
11 look at 30-day surgical outcomes. So, it is
12 an acute situation, and all of the risk
13 factors are probably all represented in 30 or
14 so clinical variables, even though we do
15 include race and ethnicity. But it is purely
16 quality improvement. Money is not involved,
17 which makes a big difference, you know, I
18 would suppose.

19 And the data that we are using we
20 give to hospitals so it is blind to everyone
21 else. And it is sufficient for them to do
22 their drilldown or to do comparison to other

1 hospitals to see where they fall on many
2 different outcomes, so they can allocate their
3 resources well, even though there might be
4 some unknown bias with not including these
5 things that might take a little effort.

6 The difference, we expect this to
7 be small, and it is not really worth
8 additional complexity, you know, to go through
9 that process.

10 And also, a very important part of
11 the program is to identify best hospitals for
12 purposes of case studies and leadership and
13 that. And that really won't change very much
14 if you do it. So, it is not a matter of it
15 doesn't help, but it is really not worth the
16 resources to do it in that sort of pure
17 quality improvement context.

18 Does that answer it?

19 MEMBER O'BRIEN: Yes, I think that
20 is a scenario where you can very well defend
21 not doing it. But I guess I would kind of
22 reframe my question. Imagine a scenario where

1 the data were available. They were high
2 quality. It made a difference in terms of how
3 performance was assessed. In one of those
4 situations, what is an example where you would
5 be doing the wrong thing by adjusting?

6 MEMBER LIPSTEIN: Okay. So, Sean,
7 what I was going to say was I would never ask
8 the question, "Can you think of an example
9 where we should not risk-adjust or we should
10 risk-adjust?" It's always risk-adjust and not
11 risk-adjust. You always want to do both.

12 And the reason, you want to look
13 at unadjusted data and you want to look at
14 adjusted data, and you want to be able to look
15 at them side-by-side because that illuminates
16 for you, or, hopefully, it will illuminate for
17 you whether something makes a difference or it
18 doesn't make a difference. So, you know what
19 you should be working on.

20 And so, one of the reasons why I
21 always nervous about risk-adjusting for race
22 is because the interpretation of that is

1 sometimes that either the provider -- there's
2 a discriminatory situation as opposed to a
3 disparities situation, which is you are using
4 race as a surrogate for something else. And
5 because people of color, at least in the
6 cities where I live in, are not randomly
7 distributed across your communities -- in
8 every city I have lived in there is an
9 Apartheidian element along racial and ethnic
10 lines.

11 So, when you look into small --
12 somebody talked about small building blocks of
13 geography -- what you find it either there are
14 access disparities, service disparities,
15 prenatal disparities, to get at Larry's
16 outcome issue around birth weights. But you
17 want to do the "and", not the "or".

18 And it becomes very illuminating.
19 And we can talk about birth outcomes or we can
20 talk about readmissions. You want to
21 illuminate what is happening.

22 MEMBER SAWHNEY: I would also say

1 that sometimes you cannot separate cause and
2 effect or what happens before someone comes in
3 from what happens once they get in. So, there
4 are certainly scenarios where there could be
5 racial differences in outcomes. And yet, that
6 may be because there are, in fact,
7 differences. When patients present a problem,
8 the disadvantaged and the advantaged were put
9 on different treatment paths.

10 And if you just adjust the
11 outcomes according to national or state index
12 of racial difference outcomes, then you have
13 masked that. You have masked that problem.

14 So, was it the race? Was it a
15 disadvantaged person walked through the door
16 or was it how it was carried through the
17 system, through the treatment? And that can
18 happen. I am hoping it doesn't happen often.

19 The other thing is, it was alluded
20 to earlier, but let me point out there, you
21 know, let me put the White rednecks of the
22 world -- and I don't meant that too

1 pejoratively because I come from a White rural
2 low SES area, and those areas can be very
3 challenged, too, the areas east of East St.
4 Louis in southern Illinois.

5 CO-CHAIR NERENZ: Okay. I have at
6 the moment Susannah, Helen, Nancy, Larry,
7 Kevin, in the order of plackets going up.
8 Does anybody want to go out of order because
9 speaking immediately to a preceding point?

10 Okay. Yes, go ahead. Go ahead.
11 Good.

12 CO-CHAIR FISCELLA: Yes, I'll be
13 quick. One possible example might be on the
14 experience of care, like the CAHPS measures,
15 where a person feels not respected. I
16 believe, at least from the literature I have
17 seen, that African-Americans are more likely
18 to have that experience in hospital settings.
19 And the question becomes, is that something
20 you would want to adjust for or not, for
21 example?

22 DR. BURSTIN: And just another

1 thought. I mean, just to the issues that came
2 up earlier about whether it is within
3 someone's control, whether it is logical to
4 actually adjust for something, one could make
5 the argument, for example, CLABSI, central
6 line bloodstream infections within a hospital,
7 completely within the control of the
8 providers, would not be necessarily an outcome
9 perhaps that this group would think should be
10 adjusted in that way.

11 So, I don't think we want to have
12 a blanket statement about all outcomes,
13 either. I think it should have a logic model
14 here for why would you would adjust or not
15 adjust. And I think that was brought up this
16 morning in a lot of the discussions.

17 CO-CHAIR NERENZ: Susannah?

18 MEMBER BERNHEIM: Just to add on
19 that, I mean, the sort of obvious thing is, if
20 the patient of low socioeconomic status, those
21 hospitals are doing worse, if you knew that it
22 was because they were providing lower-quality

1 care, you wouldn't want to risk-adjust for it,
2 right? The SES, is it really a marker of
3 poor-quality hospitals? And that is the sort
4 of classic scenario in which you wouldn't want
5 to be adjusting. And it is also what we are
6 trying to tease apart, as sort of how much is
7 a quality issue versus a patient-level,
8 inherent factor.

9 MEMBER BARGER: I think part of
10 what Larry was trying to do, to try to use the
11 race and premature birth example to say sort
12 of, can we start to say something about
13 criteria you would want to use? And I am
14 going to throw a couple of things out there
15 for people to react to.

16 So, I would say, if we thought
17 race, in that case if we thought that it was
18 really just a marker for more underlying
19 disease, I would preferentially risk-adjust
20 for the underlying disease rather than the
21 race. If we thought it was a marker for
22 quality of care, I would not adjust for it.

1 If we think it sort of meets these criteria,
2 which those criteria aren't up anymore -- we
3 are looking at a different slide number. Can
4 you go back to Karen's where we think that
5 there is a relationship with the outcome that
6 both conceptually makes sense, which I think
7 is really important, as well as empirically
8 and unique. So, it is not actually a proxy
9 for something that we can better measure. And
10 we don't think it is because they are getting
11 poorer-quality care.

12 And I think that the example you
13 gave is one of the few where you might think
14 about race because it is so well-studied and
15 so hard to understand. There are very few
16 other situations where I would argue that race
17 was the better variable. So, in general, if
18 I was making a list of things you would
19 consider adjusting for, I would put race lower
20 down. But I think in the unique circumstance
21 where a lot of research has gone into it, and
22 it seems to be biologic, it doesn't seem to be

1 mediated by care quality at the time or even
2 during the prenatal time, and there is some
3 conceptual model that somebody has that makes
4 sense, then you are starting to get to sort of
5 criteria for a measure where you would use
6 race. And I think you could start to do
7 something similar with other variables.

8 CO-CHAIR NERENZ: Nancy, you're
9 next.

10 MEMBER GARRETT: So, I just wanted
11 to respond to -- a couple of people have
12 mentioned, I think Alyna and Steve, the
13 importance of doing this both ways. And I
14 agree with that. Analytically, I think that
15 is really important. I think it is very
16 challenging, practically.

17 I mean, the current process is
18 that a measure is endorsed from NQF, and then,
19 it is released into the world to be used in
20 many different ways. And you would almost
21 have to have two measures, one adjusted and
22 one not adjusted.

1 And so, to give an example, the
2 diabetes measure that I talked about that was
3 NQF endorsed being used in Minnesota, then
4 adopted by pay-for-performance programs, by
5 payers, being used for public reporting. But,
6 at the same time several years ago in
7 Minnesota, there was a lot of noise around
8 this issue about, well, it's not fair; we need
9 to look at risk adjustment for SES factors.

10 And so, Minnesota Community
11 Measurement created a measure that is risk-
12 adjusted for SES. And what we used was a very
13 rough proxy. It is payer. So, there are
14 three payer groups, Medicare, Medicaid, or
15 commercial. And so, the rate is risk-adjusted
16 by payer status, which I think has a lot of
17 weaknesses. There's lots of variations within
18 the Medicaid population, for example. But it
19 is a step towards having a risk-adjusted
20 measure.

21 That measure is on page 150 of a
22 200-page report. Most people don't know it is

1 there. If you go to the website and use the
2 public reporting portal, you see the
3 unadjusted rate, and that is what is used for
4 all the pay-for-performance programs, et
5 cetera.

6 So, I think while doing it both
7 ways really makes sense analytically, I think
8 we have to make a recommendation of whether
9 risk adjustment should be part of that
10 endorsement process for the measure that is
11 released.

12 MEMBER LIPSTEIN: The example I
13 gave about test scores earlier from third-,
14 fifth-, and eighth-grade reading scores is why
15 I kind of take a different point of view than
16 that. Because if you adjust a student's
17 third-grade reading score so it looks like he
18 is reading on the third grade, but he is
19 really reading at kindergarten level, but you
20 have adjusted it because he comes from a
21 single-parent household as opposed to a two-
22 parent household, or something like that. You

1 don't want to mask the fact that the student
2 isn't reading at grade level because you want
3 to be able to get that child the resources
4 they need.

5 And so, that's why the unadjusted
6 score is really important. What I don't want
7 to do is not adjust that reading score, so
8 that all we do is take resources away from the
9 child that's not reading on third-grade level.
10 And that's the challenge I think we have by
11 only reporting one way or the other.

12 MEMBER CHIN: This is Marshall
13 with a question maybe for NQF staff. The
14 issue of at what stage to bring in risk
15 adjustment in the NQF process, whether it is
16 upfront where measure developers who are
17 looking for approval of a measure are asked,
18 for example, to show how the measure performs
19 in different strata, in different races,
20 ethnic groups, for example, as well as
21 providing sort of an appropriate risk-
22 adjustment tool for given purposes. I mean,

1 that is one option.

2 The other is, if it is not part of
3 the approval process, but it risk adjustment
4 is an issue for the user. So, CMS, for
5 example, or if a state like New York is doing
6 cardiac report cards. Can you tell us a
7 little bit about, from your perspective, at
8 what stage the risk adjustment comes in from
9 NQF's perspective?

10 MS. PACE: This is Karen Pace.

11 And typically, we want that as
12 part of the measure that the Steering
13 Committee and, ultimately, the membership and
14 the CSAC and Board endorse the risk-adjustment
15 model as part of that because there's a couple
16 of reasons.

17 One is we are endorsing a national
18 standard. And so, you know, if we just
19 endorsed the base measure, and then, say the
20 implementer adjusts it in a way that works for
21 them, then we have kind of moved away from a
22 national standard. And people really think

1 that how it is risk-adjusted has direct
2 applications for its validity as an indicator
3 of quality.

4 So, we to this point haven't
5 considered that part of the measure that is
6 examined in terms of NQF endorsement.

7 Does that answer your question?

8 MEMBER CHIN: I think so. I guess
9 the second part is, then, well, it came back
10 to the beginning about like different
11 purposes. So, I guess like, then, you know,
12 would NQF then say, "Well, we're endorsing
13 this measure and this particular risk-
14 adjustment formula for purpose A or purpose
15 B."? What is the thinking there?

16 MS. PACE: Well, again, as we said
17 at the beginning, currently, NQF endorses
18 measures that are considered suitable for
19 accountability applications. And I guess the
20 shorthand way of describing that is, if you
21 have a reliable and valid indicator of
22 quality, the thinking is that, you know,

1 reporting it, public reporting requires a
2 valid indicator of quality. Pay for
3 performance requires a valid, reliable and
4 valid indicator of quality.

5 So, I guess we haven't -- and
6 certainly, it is open to discussion if you can
7 come up with specific rationale why you would
8 have, you know, a different risk-adjustment
9 model because you were going to use it in
10 payment versus using it in public reporting,
11 keeping in mind that what happens to it in
12 policy is not just about the computed
13 performance measure; it is, then, about how it
14 is looked at in terms of putting policy around
15 it.

16 But, you know, that is certainly
17 open for discussion. We, to date, haven't
18 come up with a strong rationale of why a
19 measure that would be considered reliable and
20 valid for public reporting would not be a
21 reliable and valid measure to be used in
22 payment, pay-for-performance program. But,

1 definitely interested in hearing discussion
2 about that.

3 MEMBER CHIN: Thank you.

4 CO-CHAIR NERENZ: Okay. I don't
5 want to close off -- at this moment, what I
6 have, I have Larry, Nancy, Alyna, and Pam.
7 And, Susannah, is your tab up? Okay, I
8 thought so.

9 Let me just suggest, after those
10 four, let's just do a quick pause and a time
11 and agenda check. But let's go through those
12 four who have indicated they --

13 MEMBER CASALINO: Yes, I mean,
14 Sean's original question, and Susannah's
15 response, and then, Marshall's question and
16 Karen's response, made me think some more
17 about this question of NQF opening the door
18 and saying, "You can step through this if you
19 want," as opposed to NQF opening the door and
20 saying, "You have to step through it. And
21 'have to' means you have to tell us why you
22 are or are not proposing some SES thing as a

1 risk adjuster."

2 And, you know, I have to say I
3 find it very hard to think about. I think I
4 have, and I think maybe we all have -- it is
5 hard to think about SES versus clinical
6 factors. I mean, I am asking this not to make
7 an argument, but as a sincere question.

8 If there is some outcome -- let me
9 not specify an outcome -- but we know that
10 there is some clinical variable that makes
11 that outcome more likely, then there's no
12 question that NQF is going to require
13 adjustment for that variable. NQF is not
14 going to say, "Well, you may adjust for this
15 if you want." You know, you have to do it,
16 right?

17 And again, I don't mean this as a
18 rhetorical question. It is a sincere
19 question. So, if it is also shown that coming
20 from a low-income Census tract, say, a very
21 low-income Census tract, is also associated,
22 and independently, with this outcome, with

1 this poor outcome, is that different or is
2 that not different from the clinical variable
3 being associated with the outcome?

4 If it is different, then why
5 wouldn't we require the data be adjusted for.
6 And if it is not different -- if it is
7 different, how is it different and why is it
8 different, and how do we deal with that?

9 So, low-income Census tract, big
10 effect; clinical variable, big effect. Are
11 they different? Are they not different? What
12 are the implications?

13 MS. PACE: And I think that is
14 exactly what we are trying to say. If these
15 are the considerations for identifying
16 clinical variables, is there any reason that
17 these same things don't apply equally to the
18 sociodemographic ones? And what would be the
19 rationale for saying they shouldn't be
20 included?

21 I mean, to date, the rationale has
22 been around this idea that including them, for

1 example, in a statistical risk model obscures
2 differences. And because we are concerned
3 about disparities and wanting to identify and
4 reduce them, that the thinking was that that
5 was adding to the problem versus the solution.

6 But, you know, we have had a lot
7 of studies and discussion, and I think really
8 questioning that premise and assumption, and
9 that is why you all are here, to help us
10 think --

11 MEMBER CASALINO: And, Karen, when
12 you say that, it is a very rational answer,
13 which I have always accepted. But, then, it
14 makes me think we don't want to obscure the
15 differences in care for people from low-income
16 tracts, low-income Census tracts, for example.
17 But how is that different from saying we don't
18 want to obscure for diabetics, when we risk-
19 adjust for diabetics?

20 And that's where I realize, wait a
21 second, I'm just not thinking clearly about
22 this.

1 MS. PACE: Right. No, I think
2 that is exactly why this is being called into
3 question.

4 CO-CHAIR NERENZ: It is a good
5 question.

6 MS. PACE: Do we really have a
7 strong rationale for saying that those are
8 different? And, you know, I think that's what
9 we are trying to work through. But I think
10 part of it is a logical question. Is there
11 really a difference when we think of it, just
12 kind of going down this list? And you talk
13 about a sociodemographic factor. You could
14 check off these things for all the
15 sociodemographic factors we were talking
16 about.

17 And so, the question is, what is
18 the uniqueness that we should consider either
19 saying, "No, they shouldn't be in." or, "Yes,
20 they should always be in."?

21 CO-CHAIR NERENZ: Does anyone have
22 an immediate followup response to these last

1 couple of points?

2 (No response.)

3 I guess I will just have to say
4 for myself, I have been asking the same
5 question Larry just posed and saying I
6 personally don't think there should be a
7 difference, that setting a low bar for low
8 income is not fundamentally different from
9 setting a low bar for diabetes. Now I think
10 politically we might say there are some
11 differences, but, technically, the effects,
12 how the concepts play, I would ask the same
13 question.

14 MEMBER GROVER: This is in
15 response to that. And that's I'm trying to
16 think about, as we talk in our clinical health
17 systems, one of the things that we hope to do
18 by collecting data, better data about
19 race/ethnicity, is to see how we are doing as
20 individual providers, as health systems, at
21 treating minorities compared to our outcomes
22 on non-minorities.

1 And I am trying to get my head
2 wrapped around how all that shifts, then, as
3 we report on metrics. If we risk-adjust for
4 race, for SES, those are the indicators we
5 look at, are we going to sit there and look at
6 our numbers and our outcomes on Black patients
7 and White patients, and either say, "Well, now
8 they're risk-adjusted and they look the same"
9 or "Yes, I know that, from a quality
10 standpoint, all Black patients do worse, so I
11 don't need to worry about them." I'm just
12 kind of trying to wrap my head around this.

13 MEMBER CASALINO: What you are
14 saying, it sounds to me like Black versus
15 White or poor versus rich. It has a valence
16 for us that diabetic versus non-diabetic
17 doesn't. And I think that is part of the
18 reason it is hard to think about, you know.

19 CO-CHAIR NERENZ: Susannah?

20 MEMBER SAWHNEY: I agree it is a
21 social -- I'm sorry.

22 If you are lower SES, you come in

1 and there are things against you when you walk
2 through the door, and those should be adjusted
3 for. But it is also possible -- possible; it
4 is not in every environment -- that you didn't
5 get the same experience once you got in, too.

6 MEMBER CASALINO: In this same
7 space, right?

8 MEMBER SAWHNEY: In this medical
9 system.

10 So, communication issues, you
11 know, we are talking about a population that
12 is stigmatized and maybe don't speak that
13 well, don't speak English that well or have
14 cognitive impairments, or maybe just bad
15 personal hygiene. You know, are the providers
16 even spending the same amount of time talking
17 to those patients to educate them as they
18 would with me? And then, to add to it, of
19 course, I will then ask them a lot more
20 questions and they will end up spending more
21 time.

22 But the point is, I mean, is the

1 system doing -- okay, they're coming in with
2 disadvantages, but is the system doing at
3 least a level amount of effort, if not more,
4 in the face of that disadvantage?

5 MEMBER BERNHEIM: Right. I mean,
6 I think it is all about the causal pathways,
7 right? I mean, so it is true that I could do
8 a particularly poor job with my diabetics.
9 And so, you could argue, if I have worse
10 outcomes for my diabetics, we would want to
11 not risk-adjust for that.

12 But, generally speaking, if I am
13 caring for a patient -- I'm trying to use
14 readmissions as an example -- if I am caring
15 for patient who is multi-morbid and they are
16 in my clinic, and I am measuring -- give me a
17 clinic outcome -- my Alc's. That is not a
18 great example. But, then, you have got more
19 of this issue of process measure.

20 So, mortality, right? Let's use
21 mortality because that is a definite outcome
22 and it is simpler.

1 (Laughter.)

2 My diabetic -- and age, let's use
3 age right? Age, they are at higher risk, and
4 there are some small ways in which the care
5 that they walk into and the care that I
6 provide in that setting can better or less
7 meet their needs that affect it. But, with
8 SES, you blow this whole thing wide open. It
9 is much more complicated, and that is why it
10 is different. There is no question they come
11 in sicker, but we can account for that pretty
12 well.

13 And there is no question in the
14 literature that in lots of settings they are
15 going to poorer-quality providers and
16 receiving poorer-quality care. And I don't
17 want to lose track of that.

18 Now there is also probably other
19 stuff that is going on, and I may be hurting
20 providers if I don't. So, I'm not saying it
21 is simple, but, to me, it is obvious why
22 diabetes is different than SES.

1 The diabetes causal pathway to
2 worse outcomes is more biologic and less
3 easily influenced by the quality of care. The
4 causal pathway with SES is totally intertwined
5 with disease severity and quality of care and
6 other factors. And so, it is much harder to
7 figure out what to do within a risk-adjustment
8 model.

9 If I have accounted for the higher
10 diabetes rates, I have no issue, right?
11 Actually, I know people that don't like this
12 argument, but I actually think we account for
13 a fair amount of SES in these models, but it
14 is just by doing the clinical risk adjustment.
15 I mean, if you put SES in alone, and then you
16 throw all the clinical stuff, I will tell you
17 we have looked at how strong a risk factor it
18 is. It is less of a risk factor than a lot of
19 the clinical diseases and more than some. It
20 is sort of in the middle, once you account --
21 we have done it for mortality as well. We
22 have done it for I think kidney complications.

1 I don't know if my team is on the phone. We
2 have looked at other outcomes, too.

3 I am a little readmission-centric,
4 I admit.

5 (Laughter.)

6 I mean, I have a whole different
7 theory about process measures. So,
8 mammography rates, I think about them
9 differently, and we can go down that path, but
10 I'm not going to do that right now. I'm
11 really thinking about outcome measures.

12 But I do think different outcome
13 measures are different, right? I mean, I
14 think you have to think about the outcome. I
15 think the way it plays out when you have got
16 a patient you have got in the hospital, and
17 you are really having a lot of control of what
18 happens is very different than if you are
19 looking at population base and looking at
20 outpatient. I think it depends on the
21 measure.

22 MEMBER CALLAHAN: This is Mary

1 Beth.

2 I just want to go back for a
3 second to Thu's presentation and whoever that
4 person was that was just talking, which may
5 have been Thu, for all I know. I think in
6 Thu's presentation, she talked about enabling
7 services, which we kind of refer to as
8 ancillary services sometimes, but support
9 services for an individual.

10 And I would guess that in Thu's
11 situation -- I really don't know -- but there
12 are probably more funds or grants that might
13 be available to you in that situation than a
14 normal primary care physician in another
15 situation. And I don't know; I might be
16 wrong.

17 But what allows you to provide
18 those enabling services that doesn't allow the
19 normal primary care physician to? And how is
20 that going to be able to pull in the strength
21 of the patient and activate the individual
22 self-management from whatever people come in

1 your door? Whereas, the primary care
2 physician, because they don't necessarily have
3 those services, won't be able to do. And I
4 just think that is an important factor to
5 think about as well.

6 MEMBER QUACH: So, this is Thu.

7 While there are some additional
8 funds to pay for some of the enabling
9 services, it is definitely not enough. For
10 example, at our Health Center we provide 11
11 Asian languages services and 11 Asian
12 languages. None of the funds that we get can
13 really account for that.

14 We have just added Burmese and
15 Karen on for some of the emerging immigrant
16 population, not because we reach a threshold
17 number, but because it is the right thing to
18 do as we work towards health equity.

19 So, while there are some
20 additional funds, you know, it is definitely
21 far from enough. And we aren't getting paid
22 on the enabling services piece.

1 MEMBER CALLAHAN: You are or you
2 are not?

3 MEMBER SUGG: I don't know about
4 the rest of you; my head is kind of spinning
5 right now.

6 (Laughter.)

7 So, I can't take credit for this
8 analogy. It was from the Medical Director at
9 Harvard who brought this up. So, when you
10 think of things like hand-washing in my
11 clinic, are we going to socioeconomically
12 adjust for that? No. We are not. I mean,
13 there are certain things we are not going to
14 do, because that is really a process thing
15 that is not patient-centered at all.

16 However, I am held accountable for
17 my pneumovaxes. Okay? Do we
18 socioeconomically account for that? I would
19 say maybe because we still have to look at
20 culturally what is acceptable, and we still
21 have to look at health literacy, which is part
22 of socioeconomic, and how to adjust for that

1 becomes a little more problematic.

2 And the other piece of this that
3 is kind of one of those feel-good things that
4 we talk a lot about, patient-centered care.
5 So, if I have talked through my rationale of
6 why you should get your pneumovax and gave you
7 the pros and cons, and you have been on the
8 web and looked at all the stuff that's on the
9 web and say no, I'm still dinged for you no
10 decision because I didn't get my pneumovax
11 rate up.

12 And so, I kind of feel like the
13 powers that be that make these decisions have
14 to say either we are going to have patient-
15 centered care where the patient can say no,
16 and I don't get dinged for it, or we don't.

17 And so, those are the other things
18 when I am looking at what we have to put in
19 these variables when we are doing quality
20 measures, is the patient has to be in there in
21 some way. And some of these things really I
22 think we have to do socioeconomic adjustments

1 for.

2 The other thing, at some point, I
3 would like to get back to income because I
4 feel like that is an indicator that I have not
5 heard anything that I feel really confident
6 that will really help in my particular
7 situation with my patients. If I look at even
8 Census tract data, where my clinic is located
9 is right across the street from the shelter,
10 which has about 300 people, and right next
11 door to condos that go for about \$2.5 million.

12 So, what would my Census tract
13 data look like and how would that be taken
14 into account? And I know that Seattle is a
15 little different because we have all this sort
16 of Microsoft money that kind of mucks things
17 up, but I think there are other urban places
18 that suffer that same thing. You know, how do
19 you adjust for income without just, frankly,
20 having to ask the patient what their patient
21 is?

22 I tried to Google our Census

1 tract. I tried to see zip code and I tried to
2 see Census tract because I was curious what is
3 the income they have in our area.

4 CO-CHAIR NERENZ: Okay. I have
5 got Alyna and Monica, and then, I know Ninez
6 wants to jump in. We must, with some
7 desperation, do an agenda check shortly.

8 (Laughter.)

9 So, let's go Alyna, Monica.

10 Ninez, are you right on point with
11 something here? Go ahead with that. Then,
12 Alyna, okay.

13 MEMBER PONCE: So, one thing we
14 haven't considered is looking at
15 stratification measures, like income and
16 equality and residential segregation. So,
17 that is something we could throw in the mix.

18 MEMBER CHIEN: That was at least a
19 quarter of what I was going to say.

20 (Laughter.)

21 But I wanted to go back to NQF's
22 goals because I think in the beginning we were

1 saying that, if you want a one-size-fits-all
2 and the only solution you want an answer to is
3 do we risk-adjust or not, I think it is going
4 to be like this.

5 The answer is it depends on what
6 you're using it for. So, I think the focus on
7 finding that answer in the actual variables
8 that you want to put in the model is not the
9 right place to start. You want to decide what
10 people are using it for, and then, you can
11 decide if you want to adjust and make it not
12 transparent, adjust and make it transparent
13 and do it two ways, or do stratification.

14 So, then, I would like to ask two
15 things. One is it sounded like, when we
16 started talking, that we were talking about
17 risk adjustment and it was kind of a catchall
18 phrase for doing it one way and the other way,
19 and looking at the difference and stratifying.
20 And the way the conversation has evolved, it
21 is sounding very much like it is an on/off
22 switch again.

1 And then, the other thing is I
2 think I need to know more about NQF's process
3 that it puts people through and how you
4 specify the measures, to see where might be
5 the easy place to insert discussions about
6 what risk-adjustment model to use, what
7 purpose you think the measure is going to be
8 used for, and specifying, "Oh, if you're going
9 to do it this way, and you really want to do
10 it for quality measurement, then we suggest
11 stratify because it does matter if there's a
12 difference." Or you're doing it for spending
13 and you're trying to -- I don't know -- do
14 some capitation. Then, you would want to
15 go --

16 MS. PACE: I think we will talk
17 with you about some of that offline because,
18 you know, the NQF process, it may too much to
19 get into right here, given our time of the
20 agenda.

21 But I think, as David has said, it
22 is not just a yes/no, black/white. Part of

1 what we are going to be doing tomorrow is
2 recommendations about, if so, how; what
3 factors; when; what circumstances; what
4 outcomes; what use, et cetera? So, those are
5 all exactly the questions that we need to work
6 through and make recommendations about. So,
7 we really don't intend it to be a yes/no
8 response.

9 CO-CHAIR NERENZ: Okay. A quick
10 time observation. We have just passed five
11 o'clock; 5:30 is our at least agenda-scheduled
12 adjournment time. And my inclination and
13 myself is to think of that as a hard stop.
14 There are only so many times the synapses can
15 fire.

16 (Laughter.)

17 And there is a dinner reservation.
18 You know, there are reasons to take that
19 seriously. And I have no doubt that, for
20 those people gathering for dinner, these
21 conversations are going to keep running.

22 We need to check, though, how to

1 use this last half-hour. The agenda shows a
2 couple of things. There is a public comment
3 period that may actually not take its allotted
4 time.

5 We were going to at least see if
6 together we could tee-up some possible
7 recommendations or at least the framework for
8 recommendations. And actually, there is a
9 chunk that we have essentially not done that
10 was, essentially, the methods discussion.
11 What about regression-based models versus this
12 stratification, that stratification? I'm
13 dreading the direct-versus-indirect
14 standardization discussion.

15 But what I am really dreading is
16 even putting a toe in that water after 5:00 in
17 the afternoon because it strikes me as a very
18 important and detailed discussion on its own,
19 and I just don't know that in the time and
20 brain resources available we can do that.

21 So, a couple of thoughts. One is
22 that in this last block of discussion I don't

1 think I have heard what I would call just
2 fundamental disagreements or just conflicts
3 that must be resolved before we can move
4 farther. Clearly, there are some somewhat
5 different perspectives, but at least to my
6 ear, we are talking about some cautions, some
7 reminders.

8 You know, we have had a different
9 sense of how race and ethnicity play in, but,
10 again, our charge is not to say global yes/no
11 on race/ethnicity. I think we have used it as
12 an example of the pros and cons of different
13 things. At least that is how I have been
14 hearing it.

15 So, as I think about time between
16 now and 5:30, I don't have in my notes here,
17 you know, these are some just burning-hot
18 conflict issues that somehow we have to sort
19 out. I'm sorry if I missed them, but I
20 haven't heard.

21 As I look at the slide in front of
22 us, this is actually a set of principles,

1 basically. I don't know that I have heard
2 anybody say that this is wrong or otherwise
3 bad. So, I think there is perhaps in front of
4 us already at least some foundation in writing
5 for moving to a set of recommendations.

6 So, that said, I don't know that
7 we have a crucial set of things that
8 absolutely must be done in the next 20 to 25
9 minutes, but I know we must do public comment.
10 And then, at least we need to say something
11 about what are we going to do tomorrow, given
12 what we have done today.

13 (Laughter.)

14 Okay. So, Karen, am I --

15 MS. PACE: No, I think that is
16 fine.

17 CO-CHAIR NERENZ: So, what do you
18 want us to do?

19 MS. PACE: Well, why don't we open
20 the lines for public comment and see if we
21 have people that want to add some thought to
22 the conversation?

1 And then, I think your question
2 about are there any conflicts, we really do
3 want those raised. I agree, I haven't heard
4 any that are like head-on conflicts that we
5 are concerned about.

6 And then, we can talk about
7 tomorrow.

8 But, Operator, would you open the
9 lines and see if anyone has any comments?

10 And I will ask people in the
11 audience. I think maybe the easiest thing is
12 to come up to this microphone here.

13 THE OPERATOR: At this time, if
14 you have a question or a comment, please press
15 *, then the number 1 on your telephone keypad.

16 (Pause.)

17 And there are no comments at this
18 time.

19 MS. PACE: Okay. So, we will
20 start with -- go ahead and sit down.

21 (Laughter.)

22 We had one that came in on the

1 webinar chat. So, I am going to let Suzanne
2 mention that.

3 MS. THEBERGE: Sure. This comment
4 came in earlier this afternoon from David
5 Keller.

6 "I also would say that it would be
7 hard to argue to practitioners and communities
8 that SES doesn't make a difference. Not risk-
9 adjusting will make it hard to sell in the
10 community."

11 MS. PACE: Okay. All right.

12 Yes? And please tell us your name
13 and who you are with.

14 MR. DEMEHIN: Thank you and good
15 afternoon, everyone.

16 My name is Akin Demehin. I'm a
17 Senior Associate Director with the American
18 Hospital Association.

19 And first, I just want to add my
20 commendation to this Committee for really
21 bravely tackling what is an incredibly-complex
22 issue. I definitely feel like I have learned

1 a tremendous amount from the discussion, and
2 that everyone, regardless of your viewpoint on
3 the issue, has brought so much perspective and
4 such thoughtful perspective.

5 That being said, I am very glad it
6 is you at the table rather than me.

7 (Laughter.)

8 I wanted to reflect a little bit
9 on one of the discussion points that the
10 Committee had earlier. And really, the
11 central question was, if NQF should allow for
12 the inclusion of sociodemographic variables in
13 measures, how strong a recommendation should
14 it be? Should it be "We'll allow for it, but
15 you don't have to," or should it be, "We
16 expect you to assess for sociodemographic
17 variables as part of the endorsement process
18 and demonstrate whether an adjustment is
19 needed or not," and then, to apply that
20 adjustment if it is warranted?

21 From the perspective of the AHA,
22 we would really favor a fairly-strong

1 recommendation from this Committee, at least
2 based on the conversation we have heard so
3 far. The notion of really expecting that
4 outcome measures, when they come to NQF for
5 endorsement, have been assessed for the impact
6 of sociodemographic variables on the
7 performance results, do we expect that every
8 measure will necessarily require a
9 socioeconomic adjustment? No. And I think
10 there are several very good examples that many
11 of you have articulated today that demonstrate
12 that.

13 But we think that including a
14 fairly-strong recommendation in this area
15 could really be a great opportunity to
16 strengthen the value of NQF endorsement in a
17 couple of ways.

18 We think -- and I think a couple
19 of folks alluded to this earlier -- that the
20 way an outcome measure portrays performance
21 based on SES has a direct bearing on its
22 validity as an outcome measure, and we think

1 it needs to be understood before it can be
2 considered a national standard.

3 And the other reason is we think
4 that it really acknowledges the reality, and
5 several of you also alluded to this, that NQF
6 outcome measures become publicly reported.
7 They become tied to payment, and they have the
8 ability to move substantial dollars around in
9 the healthcare system. And our members are
10 incredibly concerned that, if those dollars
11 are allocated based on performance
12 measurement, that they be done so in a fair
13 way.

14 And then, as a final comment, I
15 absolutely agree, particularly with the
16 measure developers in the room, that there
17 need to be some boundaries, some very clear
18 and consistent criteria for what is expected
19 when measures are submitted into the NQF
20 endorsement process, what kinds of analyses,
21 what kinds of factors. We absolutely agree
22 that we shouldn't create something that is

1 overly subject to interpretation, overly
2 burdensome, et cetera.

3 So, looking forward to a continued
4 robust discussion tomorrow, and thank you very
5 much.

6 MS. CHAMBERS: Hi. I'm Jayne R.
7 Chambers. I'm a Senior Vice President for
8 Quality at the Federation of American
9 Hospitals.

10 And I, too, want to thank you for
11 your robust discussion today. It has been
12 quite educational and really wonderful to see
13 people bring so much variety to the table and
14 to have such a civil discussion about a topic
15 that we have been talking about at length for
16 a number of years. So, thank you very much
17 for that.

18 I should probably just say "ditto"
19 to everything that Akin just said, but the
20 Federation members have long thought that
21 measures, when we're looking at them for
22 outcome purposes and for accountability

1 purposes in that context, should be adjusted
2 for sociodemographic information and data.
3 And the question that you tackle tomorrow,
4 which is how to do that, is at the core of all
5 of that.

6 But I appreciate very much that,
7 from the discussion and what we have heard
8 today, that at least having the discussion
9 about how to do that and opening the door to
10 doing that has been very important, and we
11 would encourage you to continue down that
12 road.

13 And I also agree that the
14 developers need to have as much clarity as
15 possible when they are bringing forth their
16 measures in how they should, what they should
17 be presenting, what should be tested, and how
18 they should be looking at it. So, I
19 appreciate that as well.

20 Thank you.

21 MR. SHAW: John Shaw from Next
22 Wave in Albany.

1 And I also want to give kudos to
2 the whole group. I came down for another
3 round of fireworks and find that I did not
4 miss them at all.

5 (Laughter.)

6 One of the things that may make
7 the discussions tomorrow easier when we try to
8 say, do you risk-adjust it or not, it depends.
9 What does it depend on?

10 And I am not an MD, but I do know
11 that, when I am speaking to MDs, they want to
12 know the mechanism or the causal pathway of
13 what is really impacting on this. And if we
14 step back and look at things from the whole
15 system and model the whole system, as a
16 country, we are spending more money and we're
17 getting worse outcomes.

18 In recent years, people have been
19 modeling where and why and, basically, focused
20 on the dual-eligible population, the folks
21 with multiple chronic conditions, and people
22 with behavioral or substance abuse disorders.

1 In that population, guess what? We have
2 poorer outcomes and higher costs.

3 So, that is where a lot of the
4 anxiety is on the part of the providers. That
5 is where a lot of the priority attention
6 probably should be if we are trying to move
7 the cost curve and really implement all of the
8 Triple Aim.

9 With that in mind, keep in mind
10 that, if the mechanisms are different, and
11 here what is driving that population is not
12 what most of the healthcare people are
13 providing; it is what is happening after you
14 provide that. It is what are the mechanisms
15 for engaging the patient, engaging their
16 informal caregivers, engaging the community,
17 and paying for however much of that, and not
18 pretending that it is all for free.

19 In long-term care supports and
20 services, where a lot of the dual-eligible
21 impact is, we are trying to push everything
22 into home and community services in an

1 informal caregiving environment where, with an
2 aging population, we have got fewer and fewer
3 people, period, able to provide that or
4 willing to provide that or able to provide
5 that.

6 So, can we really start looking at
7 in the sociodemographic measures those items
8 that really get at what makes it effective
9 once the person leaves the hospital, leaves
10 the clinic, and so on? What has worked? And
11 we have heard a number of examples of what
12 happens if the local taxing district provides
13 resources to do that. If grants provide that,
14 fine. If those are not available, then maybe
15 we should invest some of the healthcare
16 dollars outside of the building and into the
17 community.

18 And IRS has apparently really
19 pushed that and gotten the ball rolling quite
20 a bit.

21 Thank you.

22 MR. SIGNER: Good afternoon.

1 I'm Bill Signer. I'm here on
2 behalf of Health First, which is an MA plan in
3 New York. It is one that focuses on low-
4 income folks. We have about 109,000 members.
5 About 55 percent of them are dual-eligibles.
6 That is where we market. Everybody else is
7 below 200 percent of the poverty line.

8 I have listened today, and other
9 than the tools comments, I think everybody has
10 focused on hospitals. MA plans are being
11 affected by quality measures. Quality
12 measures do have an impact on payment.

13 And I think that a lot of the
14 plans that are focused on low-income folks are
15 very concerned that, especially if you are in
16 an urban area, not that we should get more
17 money, more money should be directed to us,
18 but we should be able to get as much as the
19 fee-for-service system is. And the STAR Bonus
20 Program is designed to help with that.

21 So, our concern is, and what we
22 are looking at is that plans that have 50

1 percent or more dual-eligibles, and we have
2 80-percent low-income subsidy folks, are seven
3 times less likely -- less likely -- to score
4 four stars, which is what you need to score.

5 Now our providers are pretty good,
6 but the problem is that the clinics that we go
7 to are overcrowded. The demand for services
8 exceeds the supply. And our folks are upset,
9 frankly, when they don't get seen. Or we have
10 language barriers. All the criteria that you
11 have talked about, we are seeing.

12 And our improvement scores are
13 good, but because there isn't a socioeconomic
14 status adjustment and some recognition for
15 plans that are focused on this large
16 population of dual-eligibles, we are going to
17 lose funds. And what we are concerned is that
18 our members who get extra benefits, like they
19 can't pay for over-the-counter drugs; we pay
20 for that for them. There was discussion of
21 transportation. We pay for that for them, and
22 many other services we provide to them. If we

1 can't give that to them, what they are going
2 to end up doing is falling out of the system
3 and going to the fee-for-service and ending up
4 costing more to the system. So, we are
5 concerned that there need to be some
6 adjustments here, so it recognizes plans like
7 ours and what we do.

8 The one question I had to the
9 group was there was a discussion about
10 collecting both raw data and adjusted data,
11 and which we should do. We view the
12 collection of raw data as being very, very
13 important because it does give us guideposts.
14 It helps us understand where we need to
15 improve and how we should improve.

16 What I am not quite sure because I
17 am not a statistician is why you can't collect
18 the raw data and, then, adjust it afterwards.
19 So, it would one collection, but, then, you
20 would adjust it. So, it would seem to me you
21 would get the best of both worlds. You would
22 know whether we are doing well or not, and you

1 would also adjust it.

2 And also, I would wonder from
3 looking at some of the charts we had here, if
4 you do the adjustments and, then, stratify,
5 which is the other thing I think is very, very
6 important, comparing like plans in our case to
7 like plans for like hospitals to like
8 hospitals, then you will find out who are your
9 good providers and who aren't. Because you
10 will see within that category who is above and
11 who is below the line. That seems to answer
12 the question of getting rid of the bad, not
13 rewarding the bad actors.

14 Thank you.

15 MS. PACE: And, Operator, would
16 you check one more time if there are any
17 comments on the phone?

18 THE OPERATOR: If you have a
19 comment, please press *1.

20 (Pause.)

21 MS. PACE: Okay.

22 THE OPERATOR: And there are no

1 comments at this time.

2 MS. PACE: There is or isn't?

3 THE OPERATOR: There is not any
4 comments at this time.

5 MS. PACE: Okay. Thank you.

6 MEMBER LIPSTEIN: Would you read
7 again the comment from the webinar?

8 MS. THEBERGE: Sure. Just give me
9 one moment to pull that up.

10 "I also would say that it would be
11 hard to argue to practitioners and communities
12 that SES doesn't make a difference. Not risk-
13 adjusting will make it hard to sell in the
14 community."

15 MEMBER LIPSTEIN: The reason I
16 thought that was important is there is a
17 second bullet that says that "A usual
18 consideration for selecting a risk factor is
19 an empirical association with the outcome of
20 interest."

21 Sometimes if there is not an
22 empirical association, risk-adjusting will

1 help facilitate buy-in of the provider
2 community. It is a point that came up
3 earlier, and I thought that that's what the
4 webinar commenter was speaking to.

5 Because I think for all of us who
6 have done this Six Sigma stuff, we know that
7 the effectiveness of the solution equals the
8 quality of the solution plus the acceptance of
9 the solution. And risk-adjustment, even if
10 there isn't an empirical association, may
11 facilitate acceptance.

12 CO-CHAIR NERENZ: A couple of
13 quick things. I know, Dionne, you have had
14 your card up, Susannah, and we are really
15 closing in now on 5:30.

16 MEMBER JIMENEZ: What I was trying
17 to say is, because I know Kate is only here
18 this afternoon, I wanted to kind of tag along
19 to Alyna's point about it would be really
20 helpful to have more information from CMS to
21 know sort of what is the process that happens.
22 Because it seems like a lot of our issues and

1 concerns are really around the implementation,
2 and I know NQF has a set role around defining
3 criteria for measure selection. But it would
4 be also helpful to get information from CMS
5 about what happens afterwards. Because we
6 know there are adjustments that happen when
7 you are actually designing like the Value-
8 Based Purchasing Program, for example.

9 And one example, I could point to
10 that is, when you are looking at the patient
11 experience-of-care domain, looking at the
12 HCAHPS Survey, you know, they combine, for
13 example, cleanliness and quietness of the
14 environment.

15 And so, it just would be helpful
16 to know sort of like more about the rationale
17 and that processing, and how it can interplay
18 with this.

19 CO-CHAIR NERENZ: I am wondering
20 if maybe at this point --

21 MS. GOODRICH: I don't understand
22 what your question is.

1 MEMBER JIMENEZ: To provide more
2 information sort of about the process of how
3 the adjustments that are made on the
4 implementation side happen, you know, outside
5 of sort of just selecting NQF-endorsed
6 measures, like what happens at the CMS level.
7 So, it doesn't have to be now, but it could be
8 at a later time.

9 MS. GOODRICH: It might be
10 helpful. We had talked about doing this, but
11 we weren't able to make the logistics work.
12 I actually have some of the people at CMS who
13 actually handle the payment policy side,
14 which, unfortunately, is not my shop, talk a
15 little bit more about exactly that. I do
16 think that would be helpful information. I
17 know that we have provided to NQF some sort of
18 fact sheets and that sort of thing about that
19 kind of thing.

20 I mean, essentially, just sort of
21 in a nutshell, we do work closely with the
22 payment folks in helping to define the policy.

1 So, it is really isn't just about the
2 measures. It is sort of at the same time that
3 we are deciding what the measures are, we are
4 also trying to decide what the supporting
5 methodologies should be, and we work in
6 partnership with our colleagues at CMS who do
7 that work as well.

8 But, obviously, that is extremely
9 high-level. There is a lot more detailed work
10 that goes into that, usually doing quite a bit
11 of analysis using our data of the different
12 scoring methodologies and how that would be
13 impacted sort of across the spectrum. So,
14 there is quite a bit of data analytics that
15 goes into those decisions.

16 CO-CHAIR NERENZ: Okay. I am
17 wondering, we may need to turn to Karen and
18 Helen a bit, and just tell us what do you want
19 us to think about overnight that might be
20 clarified and facilitated by a glass of wine
21 or two.

22 (Laughter.)

1 MS. PACE: Okay. Well, the last
2 question that we didn't get to was, not that
3 we have answered any of these questions, but
4 we have certainly been airing the issues.

5 (Laughter.)

6 But the next question is, you
7 know, if we are going to do it, and if we have
8 identified the right factors, what is the
9 approach we should take? Should it be a
10 statistical risk model? Should it be leaving
11 the clinical things in the statistical risk
12 model and, then, stratifying, stratifying
13 within a provider or stratifying as in the
14 example of MedPAC's recommendation of
15 stratifying by some socioeconomic factor to
16 identify like peer groups for purposes of
17 comparison, whether it is comparison for pay
18 for performance or comparison for how you are
19 doing against your peer group.

20 So, that is what our next set of
21 question was about, and we really are going to
22 have to, I guess, maybe start off with that in

1 the morning, to at least have some discussion
2 of the issues around that.

3 What we were hoping to do
4 tomorrow, then, is to start kind of working
5 through these and have a strawman set of
6 recommendations that you all would list, and
7 then, break into smaller groups to really kind
8 of discuss some of those recommendations in
9 more detail.

10 So, if that sounds okay to start
11 off that way, we will ask you to dream about
12 that tonight. And also, if you can come up
13 with the answer tonight in your restful sleep,
14 then we would love to hear that as well.

15 CO-CHAIR NERENZ: Okay. So, you
16 can send an email at 2:00 a.m. if you just
17 can't sleep thinking about it.

18 MS. PACE: Right, right.

19 (Laughter.)

20 But I want to thank everyone for
21 the great discussion. It has been very
22 stimulating, lots of issues raised, and we

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knew that there would be. We know there aren't any easy answers, but, hopefully, tomorrow we can start finding a path to something that will make sense.

(Whereupon, at 5:27 p.m., the meeting was adjourned.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Sociodemographic Factors
Expert Panel Meeting

Before: NQF

Date: 01-15-14

Place: Washington, DC

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