National Quality Forum

Moderator: Social Risk Trial
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OPERATOR: This is Conference # 3576775.

Erin O'Rourke: Good afternoon everyone. This is Erin O'Rourke. I'm one of the Senior Directors here at NQF. Thank you so much for taking the time to join us this afternoon. We're excited to have the opportunity to reconvene our disparity standard committee and provide you an orientation to NQF's new social risk trial in today's web meeting.

With that, I'm honored to welcome back the co-chairs of the Disparity Standing Committee, Marshall Chin and Ninez Ponce, and I wanted to give them the opportunity to welcome everyone.

Marshall Chin: Hello, everyone. This is Marshall Chin, the co-chair from the University of Chicago and thank you, everyone, for your participation and contributions. We're aiming to finish the prepared part of presentations of slides over the next 45 minutes, (full house), an hour and 15 minutes for the discussion of the committee and the public.

Ninez Ponce: Great. Welcome everyone. It's Ninez Ponce from UCLA Center for Health Policy Research. As with Marshall, we're so thankful to you for giving us your time and glad that we are able to reconvene. So, let's (inaudible). We have a lot to discuss.

Marshall Chin: I'll just add that we'll aim to basically do the presentations without interruption so that we have the hour and 15 minutes for discussion preserved.

Tara Murphy: Great. Thank you, both. Hi, everyone. This is Tara Murphy, project manager on this project. It's nice to be working with all of you again. We're going to go right ahead and move along into our team introductions and committee roll call.

I'll start by noting the members of this new NQF Social Risk Trial team. Elisa Munthali, our Senior Vice President, joins us today. Erin O'Rourke, Senior Director. Two new faces to the project, (Nicolette Mijas), is a new director here at NQF and (Shekinah Gorem) will be our senior project manager. (Turun Ahmin) will also be a consultant on this project but won't be on the call today.

I'll take a quick moment here to just remind everyone to please keep your lines on mute if you're speaking. The committee members have all been given open lines so that we can have an open discussion, but we do know that background noise always seems to seep through even though we don't intend for it to. So, just remember to keep your lines on mute.

Going to move in to a quick roll call since we're all pretty well familiar with each other, if you could just give a very, very brief introduction, just a little bit here, so we can move forward into our presentation and leave plenty of time for our committee discussion. We've already heard from co-chairs Marshall Chin and Ninez Ponce.

So, moving right along, Phil Alberti. I know that – (I saw) an e-mail that he might be a little late. But, Phil, are you able to join the call? OK. Susannah Bernheim?

Susannah Bernheim: Hi. I'm here. You just want me to say hello or you want – what else – you wanted an introduction?

Tara Murphy: Whatever you'd like to give, just a high level points like personal elevator pitch.

Susannah Bernheim: I'm senior director overseeing measure development at the Yale CORE Center.

Tara Murphy: Great. Thank you, Susannah. Michelle Cabrera?

Michelle Cabrera: Yes. This is Michelle Cabrera, Healthcare Director for SEIU California which represents 700,000 members in California, in and outside of the healthcare industry.

Tara Murphy: Thank you, Michelle. Juan Emilio Carrillo?

Juan Emilio Carrillo: Present. Greetings to everybody. I am Associate Professor in Weill Cornell Medicine and work with Disparities Solutions Center at the Mass General Hospital.

Tara Murphy: Thank you. Lisa Cooper? Lisa Cooper, are you on?

OK. Ron Copeland?

Ron Copeland: Hello. This is Ron Copeland, Senior Vice President and Chief Equity, Inclusion, and Diversity Officer at Kaiser Permanente.

Tara Murphy: Hi, Ron. All right. Jose Escarce? Jose? OK. Traci Ferguson?

Traci Ferguson: Yes. This is Traci Ferguson. Chief Medical Director of Medical Management, WellCare Health Plans. (We) manages Medicare Advantage and Medicaid Plans based out of Tampa.

Tara Murphy: Thank you, Traci. Kevin Fiscella? I think Kevin also e-mailed. He might be unavailable. Nancy Garrett?

Nancy Garrett: Hi, this is Nancy Garrett. I'm the Chief Analytics Officer at Hennepin Healthcare which is a Safety Net Provider in Minneapolis.

Tara Murphy: Thanks, Nancy. Romana Hasnain-Wynia?

Romana Hasnain-Wynia: Hi, this is Romana. I'm the Chief Research Officer at Denver Health which is the Safety Net Provider for Denver County.

Tara Murphy: Thank you. Lisa Iezzoni?

Lisa Iezzoni: This is Liza. I'm Professor of Medicine at Harvard Medical School.

Tara Murphy: David Nerenz?

David Nerenz: Hi, Dave Nerenz, Center for Health Policy & Health Service Research, Henry Ford Health System, Detroit.

Tara Murphy: Thank you. Yolanda Ogbolu? Yolanda?

Yolanda Ogbolu: Hi. Hi, everyone. This is Yolanda Ogbolu, I'm Assistant Professor and Director of Global Health at University of Maryland Baltimore, School of Nursing, and also the Chair on the Social Determinants of Health Taskforce with the Maryland (Cataract) Center.

Tara Murphy: Thank you.

Lisa Cooper: Hi, everyone. It's Lisa Cooper. I was actually on the line but got disconnected. So, I just want to say I'm on. I'm Professor in the Department of Medicine at Johns Hopkins School of Medicine and also jointly appointed in the School of Public Health and the School of Nursing.

Tara Murphy: Thank you so much, Lisa. So, glad you could join.

Bob Rauner?

Bob Rauner: Yes. I have two hats and two titles which gets confusing about a third of its – running a committee health nonprofit that works with some safety net clinics and the other two-thirds, chief medical officer (position) at ACO that also includes safety net clinics, so I kind of do health system work to support my population health (habit).

Tara Murphy: Thank you, Bob. Eduardo Sanchez? I think Eduardo said he couldn't attend. Sarah Scholle? Tom Sequist? Christie Teigland?

Christie Teigland: Hi. It's Christie Teigland. I'm Vice President of Advanced Analytics at Avalere Health which is an advisory services company that a wholly-owned subsidiary of Inovalon that does a lot of work with health plans across the country.

Tara Murphy: And Mara Youdelman? Mara, are you on?

OK. Is there anyone else who joined after their name was called? All right.

Thank you all so much. That was good and quick.

So, moving right along, we'll move in to our meeting objectives for today. We have a couple items that we hope to get through this afternoon. We'll be providing you with an overview of the work related to disparities that NQF is currently doing. We'll introduce our new social risk trial project, that is the project that we are convened for today and hopefully give you a little background on (time and to how) this relates to the previous trial that we discussed back in at 2017.

We'll review the risk-adjusted measures that were submitted to the fall 2017 cycle and the spring 2018 cycle. These are the measures that were posted to the web in the list of measures that is currently available on the social risk trial page. And we will also discuss Standing Committee guidance and – excuse me – Disparity Standing Committee guidance to CDP standing committee and developers regarding risk adjustment.

And with that, we will move right along. I will turn it over to Erin, to give an overview of our committee charge and overview of our past work. Erin?

Erin O'Rourke: Great. Thank you so much, Tara. Again, I want to go through this fairly briefly to make sure we have plenty of time for committee discussion but please address me if this is too fast so we can move on to the next slide.

The work of this disparities standing committee builds on over a decade of NQF's work to address health equity. I know that many of you have been involved in these different projects we have listed on the slide but we're really excited to have this opportunity to work with you as a standing committee and to continue to convene you rather than (teach you) folks on committees one-off to support a specific project so that we can start to build this continuity and guidance across NQF's work.

Next slide. To just briefly reorient everyone to your (charges as a) committee, we're hoping to have you provide a crosscutting emphasis on disparities across all of NQF's work to help us provide guidance for how measurement can be used to proactively address disparity as well as I continue to evaluate the results of the social risk trial where we're allowing (measures) to come forward with adjustment for social risk when there's both conceptual and empirical evidence to support doing so.

So, moving on to the next slide. So, the – to meet the second part of the charge, the committee developed the roadmap for promoting health equity and reducing disparities. This roadmap identified four main strategies of how we could leverage measurement to help reduce disparity.

The first was to identify disparities using techniques such as ratification of the current measures and then to prioritize reducing any disparities found. The second was to implement the evidence-based intervention that we know can reduce disparities emphasizing that this would really need to be tailored to the findings – (to) the measures as well as the community that there was no one "silver bullet" to reduce disparities. It would need to be much more nuanced than implementing one single strategy.

The third was that we need to invest in the development of measures that can directly assess health equity and the use of some of those evidence-based interventions to reduce disparity. And then finally, we need to incentivize the reduction of disparities as well as the achievement of health equity.

Next slide. So, we wanted to highlight this final strategy today because our scope of work really gives us the chance to do a deeper dive into us – one of the main outstanding questions that we weren't able to resolve during the last project; particularly this question of whether or not it's appropriate to adjust measures for social risk factors.

As part of the incentivize, the reduction of disparities strategy, this really emphasize the need to make sure that providers serving vulnerable population and those at risk had the resources that they need to promote health equity and to succeed in this transformation to value-based purchasing.

And as everyone on this committee is well aware by now, one of the key outstanding questions was what is the appropriate role for risk adjustment in measures used for public reporting of value-based purchasing specifically in doing this sort of adjustment necessary to protect access or does making these adjustments threaten to mask healthcare disparities?

Next slide. So, the committee recognize that clinicians and providers disproportionately serving individuals with social risk factors can provide high-quality care. However, there's growing evidence that social risk can affect a person's health outcomes and that's various questions about how to ensure that we are unfairly penalizing those providers serving these populations.

Moreover, safety net organizations, they have a (pair) mixed with lower reimbursement rates that might be – and they may not have the infrastructure that they need to improve quality, protecting organizations disproportionately serving individuals with social risk factors can help to ensure that access to care is not reduced.

At the same time, the committee reiterated the need to make sure that at-risk populations have access not just to care but to high-quality care. And then the community noted there's a need to ensure that the (DBT) programs promote improvement transparency and fairness as well as proposing some methods that could be used to improve the fairness of value-based purchasing program

And then finally, the committee emphasized that risk adjustment may be an appropriate technique to ensure that value-based purchasing programs are fair as well as stratifying the measures to ensure that were monitoring for disparities.

Next slide. So, I did want to also quickly reorient everyone to the findings of the initial social risk trial and how we got to where we are today with some of these questions.

So, moving on to the next slide, prior to 2014, NQF actually had a policy that prohibited the inclusion of social risk factors in the risk adjustment models of endorsed measures. The NQF's Board of Directors approved a two-year trial

period back in 2015 that would allow measures to be submitted for endorsement that potentially included risk for social factors.

Next slide. This policy change came out guidance from an expert panel that I know several of you served on. This panel provided guidance stating that every measure needs to be assessed individually to determine if social risk adjustment is appropriate and they emphasize that not all measures should be adjusted for these factors, that there need to be both a conceptual basis and empirical evidence to support the adjustment.

Given some of the concerns to about masking disparities, the NQF board chose to implement these changes on a trial period. And during that time, if adjustment was determined to be appropriate for a given measure, NQF would endorse one measure with specifications to compute the measure with – that is adjusted for social risk as well as the version that only uses clinical factors to allow for stratification.

Next slide. So, we wanted to highlight some key recommendations they came out of the risk adjustment panel as part of the background for this current scope of work. Again, I don't want to belabor this because I know Marshall wants to get to conversation but we did want to bring this back for you all.

The first recommendation here really highlights that there should be both a conceptual relationship and empirical evidence and when there – both of those pieces are present, that sociodemographic factors should be included in the risk adjustment model and then there should also be specifications that allow for stratification.

Recommendation 4, the committee recommended the NQF revise our criteria. We have done that on a "trial basis" to support the previous trial and the current trial that we're now asking you (help us) evaluate.

Recommendation 6 emphasize that when there's a conceptual relationship and evidence that social risk factors that affect an outcome a process of care reflected in the measures submitted to NQF for endorsement, developers should include the rationale and their decision for selecting or not selecting social risk factors as well as the methods they use for adjustment.

And when the identify how the measures plan to be used, they should include the discussion of the limitation and risks (for misuse) of the specified performance measure. Again, this is updates that NQF has made on some of the forms that we require of the developers so they now have the opportunity to provide this information to the standing committees considering measures for endorsement.

Next slide. Recommendation 7 note that the NQF should consider expanding its role to include guidance on implementation of performance measures. Potential ways to do this include guidance for each measure as part of the endorsement process as well as guidance for different accountability application.

Recommendation 8, the committee noted that NQF should make explicitly existing policies that endorsement is for a specific context as specified and tested. Again, for those of you that have been involved in some of our standing committees, it is a reoccurring concern that measures are not always used in the way they're submitted to NQF. They may be implemented outside of the level of analysis or patient population care setting that NQF standing committees have had the opportunity to review the testing for.

Recommendation 9 noted that when measures are used for accountability application, users of measures should assess the potential impact on this advantage patient population and the providers (that plan) serving them to really identify any potential unintended consequences and to ensure alignment with the ultimate goals of the program or the policy.

And then Recommendation 10 noted that NQF should develop strategies to identify a standard set of social risk factor that should be collected and made available for both the purposes of performance measurement as well as to identify potential disparities..

Next slide. So, as I noted before, we implemented this policy around allowing adjustment for social risk factors on a trial basis. From April 2015 through April 2017, any measure that was submitted for endorsement was considered to be part of the trial.

We initially focus the trial on risk-adjusted outcome measures. Developers were required to provide information on the potential conceptual relationship between social risk factors and the outcome of their measure.

And if there was a conceptual relationship, we also work required them to submit some additional empirical analysis to evaluate the strength of the relationship between social risk factors in the outcome of interest. We continue to keep the evaluation of risk-adjusted models as part of the validity criterion that work was done by the relevant standing committee evaluating measures for potential NQF endorsement.

Next slide. So, just to give you a – I think you've all seen this slide before but to just bring you back to some of that the sample that we had last time, there were about 300 measures that NQF review during the trial about 125 or so were outcome or intermediate outcome measures.

A third utilized some form of risk adjustments and out of that about one third, 65 had a potential conceptual basis for adjusting for for social risk factors. Of those that had a conceptual relationship, 43 found either – (found) small effects and social risk factors were ultimately not included.

Twenty-one were submitted for endorsement with adjustment for a social risk factor. And ultimately, 17 were endorsed with that – with adjustment for social risk.

So, moving on to the next slide, some key findings that we wanted to highlight for you all today. The first child demonstrated that adjusting measures for social risk factors is feasible but was challenging. Developers noticed – noted problems getting access to the right data. Developers also used different approaches for both developing their conceptual relationships as well as conducting their empirical analyses.

And we heard from some of the standing committee members that it made it difficult to compare across measures about the appropriateness of the decision to include or not included a social risk factor.

Ultimately, the NQF Board of Directors recommended that we extend the trial period so that we could continue to examine the impact of social risk factors and whether continuing to allow measures to come forward with these adjustments is the right path for NQF.

We're implementing this as part of our new health equity program and I did want to briefly turn it over to Elisa Munthali to share a little bit about the equity program and NQF (sore) care.

Elisa Munthali: Thank you so much, Erin. I just wanted to thank everyone for being on the call and for your continued work on the health equity standing committee. As Erin mentioned, we've been in this space for about 10 plus years and many of you have helped to leave the work and health equity and so we really appreciate your continued partnership with us.

What we did on soon after you've created the roadmap for health equity, we launch that across our entire organization. And so, on this work is borne out of the quality measurement department where Erin and the rest of our colleagues and I work. But our counterpart to quality measurement is quality innovations and they focus on improvement.

And so, in everything that we're doing, we have woven in health equity. So, the roadmap is essentially our roadmap as NQF to eradicating disparities and moving towards a more equitable community and nation.

We – when we initially rolled it out, I think we were very enthusiastic and thinking that we would be able to handle all of the inquiries and requests for us to partner with different entities and organizations. We quickly realized that this is such an important topic to so many but we want really ready yet in terms of building our infrastructure. And so, we taken a little bit of time to make sure we have the resources in place and to move many of the projects forward.

We're very happy to be in partnership with CMS and that they were able to fund this work around social risk as Erin had just highlighted to you and we're in discussions with them about potential other work that goes beyond just looking at social risk factors.

In addition to that, our health equity programs and the work that our quality innovations team is doing, that work is not – that's work that you may not see as readily as you see the work on the quality measurement side because ours is under statute for it to be more open and transparent.

But they have been forging quite a bit of – quite a number of partnerships with different entities including, very recently, partnering with Aetna Health Foundation on concepts around food and security and homelessness. That's part of work that they did in our measure incubator.

We also just launched a project on social determinants of health data integration. This is through our quality innovations department but it also incorporates the leadership of our national quality partnership. And so, through this work, we've brought together experts and other leaders across the public and private sector to think about how we can better integrate data on social determinants of health into clinical practice.

So, you may have gotten announcements. I think they're still looking for folks to participate in this effort and this is located on our website under projects and you can look under NQP Social Determinants of Health Data Integration.

So, I will turn it back to Erin but I wanted to take a few minutes to tell you how important what you have done has meant to NQF and how we've integrated that within our entire organization. Erin?

Erin O'Rourke: OK. Thank you so much, Elisa.

Marshall, Ninez, do you want to see if people have questions early or shall we keep going?

Marshall Chin: Was Elisa leaving the call at this point in time or she'll be on the call for the rest of time?

Elisa Munthali: I'll be on for the rest of the time.

Marshall Chin: OK. Let's go ahead then and we'll do Q&A discussions (at the end).

Elisa Munthali: Great. Thank you.

Erin O'Rourke: OK, great.

Marshall Chin: Thank you.

Erin O'Rourke: Great. (Nicolette), could I turn over to you to give everyone an overview of our new project?

(Nicolette Mijas): Yes. Sounds good. Thank you, Erin. Thanks, Elisa.

My name is (Nicolette), I'm a new director here in the Quality Measurement Department. I'll provide brief overview of the note – the new social risk trial projects and the aim goals and the scope of this new trial period.

So, this – NQF was awarded a contract from CMS. This were kicked off in May 2018 to review measures submitted for endorsement or maintenance, so review all measures over a three-year period. And this trial period really is a follow-up to the previous two-year socioeconomic status trial that ended in April 2017.

This Newark also provides the opportunity to take a more in depth look and to explore some of the challenges from the initial trial period and also builds upon the board's recommendation to continue to explore adjustment for social risk factors.

And so, on the goals of the work explore the inclusion of social risk factors and risk adjustment models. So, this includes how developers are adjusting the rationales that they're using, which factors they are including and whether or not the factors are proving to be significant in the models that they're using to adjust.

And we really hope that the end of the trial period, we'll be able to – and the committee will help NQF make a final determination whether or not there is a permanent policy change to NQF's policy to allow for the inclusion of social risk factors and measures that are submitted for endorsement so that one of the

end goals and the main goals of this work is to really determine if that final policy change should be made permanent.

And so, to come to this decision, during this trial period, we're allowing developers to submit measures for endorsement with social risk factors included in the model. We also hope to explore and build upon some of those unresolved issues from the initial trial period to help advance the science of risk adjustment.

So, some of these issues included and hope that by the end of this period and throughout, we'll be able to help clarify the preferred methodology in determining what the conceptual basis should be for adjustment hopefully to provide more clarifying guidance for developers on selecting different social risk factors and then which empirical analysis to use to support the factor selection.

And we also wanted to explore alternative data sources and provide more guidance on how to obtain data sources and measure these advanced social risk factors.

And then a couple other unresolved issues and these were points that both Marshall and Ninez has really pointed out as being important to the committee and important to discuss this time around was really exploring the impact of the implementation of these types of measures and value-based purchasing and so really expanding this conversation and looking a little bit at the real world implications of measures and risk adjustment especially these measures that are used in population, better serving patients that are at those extremes of social risk. And this is something that we hope to do and we hope to start this conversation today as part of the discussion period.

And so, a few updates from the previous trial, we will be collecting additional information beyond what was collected the first time to help support the standing committee's review of the risk-adjusted models. We will be on examining additional details of the model including which factors were considered the significant levels.

All of these information and all of the measures that are collected will be posted in a transparent process on NQF's website and on the project page and it will include all the key details of all of the measures that are included and including the model that they're used, the different approaches that they're using, factors that they considered as well as their approach and whether or not they found the factors to be significant.

And so, this will be updated on our website on the project page every June and December. So, at this point, we have the June list published for the trial and the necklace will be updated in December.

So, at this point, in the project, we have reviewed and compiled the first list of measures which include measures that were submitted during the fall 2017 and spring 2018 cycle and we're also in the process of collecting and summarizing the information for measures that were submitted as part of this fall 2018 cycle and we've also shared our frequently asked questions document with members to provide more information on how they're able to engage in this project. Think you could (put them) – thank you, Tara.

And so, the – here's just the breakdown of the timeline and the deliverables. As you can see, we're at the November 5th, our first orientation call with the committee. There will be a series of seven different meetings that we're excited to convene and bring the Disparities Committee together to talk more about this project and to have a great discussion and this will go up until December 2020.

You can also see that we will be updating the list that provided on our websites at various periods between them and then we hope to really having the final report and the decision on the social risk factor trial period which will conclude in May 2021.

And so, with that, I'd like to turn it over to (Shekinah) to talk a little bit more about the preliminary findings from this trial period.

(Shekinah Gorem): Thank you, (Nicolette).

As (Nicolette) stated, we have begun collecting and reviewing newly submitted and maintenance measures evaluated during the fall 2017/spring 2018 and fall of 2018 cycles.

The next two slides show a summary of the submission. There were total of 172 measures submitted, 69 utilized some form of risk adjustment, 65 measures included a conceptual model outlining the potential impact of social risk and 23 measures included a social risk factor in their model.

This slide takes a deeper dive into the collected data. I won't read every point on this slide.

Here, you see early findings of the data collected thus. (Rates) are still examined as a potential variable. There is a disconnect between the conceptual relationship and empirical analysis and concerns (persist) about potential differences in quality and impact on these various – on disparities, however, there is growing evidence about the impact on access if measures are not adjusted.

With that, I would turn it over to Erin to review standing committee and developer guidance.

Erin O'Rourke: Great. Thank you. So, just one final point before we open for our conversation, we wanted to lay the groundwork about this question (Nicolette) raised develop guidance should we provide – be providing both to measure developers, submitting measures to NQF as well as due to standing committees reviewing measures.

So, if we can move on to the next slide. Our measure developer guidebook does include instructions for completing the risk adjustment portion of the measure submission form. And as part of that, we include examples of social risk factors including patient level, proxy variables, and patient community characteristics developers could consider, instructions for noting the conceptual rationale that supports or doesn't support adjusting for social factors, some examples of the type of analyses that may be appropriate for determining whether a measure should include adjustment for social risk

factors, instructions for comparing scores with or without the risk factors as well as request for updated testing, if necessary.

The details of the final physical risk model, the information required to stratify a version of the measure that's clinically adjusted only, and measure results of the social risk variables.

I think, as part of our trial, what we're were hoping to do here is to work with you through the next few years to make some of these more concrete. In particular, I think we've heard a desire for guidance that developers can really rely on to know if their meeting what this committee (as all), the standing committee would like to see as far as adjusting or not adjusting for social risk.

So, we move on to the next slide. We also did want to highlight what we're providing to our standing committees evaluating the measure. Specifically, we give them an overview of risk adjustment and the background on our work and disparities and this question of the appropriateness of adjusting for social risk.

We also list some considerations that should be taken when deciding if the risk adjustment is appropriate and an overview of what information the developer was required to provide the committee.

Again, similarly, we've heard some guidance from standing committee that they'd like additional input from the disparities committee on how they should be evaluating the information that developers are giving them. And wed like to, obviously, not today, but over the course of the next few years, work through what sort of guidance you would like to see us provide to the standing committee to help them make their decisions.

NQF's policies are non-prescriptive. We ask developers to put forward what they feel is their best measure and expect risk adjustment model but we've heard from both developers and the standing committees for a desire for more input from this committee as well as our scientific methods panel on how they should be considering these measures.

So, one of our – the key things we're hoping to achieve in this new trial is some updated guidance for those parties. So, I think with that context in mind, I'd like to turn it over to Marshall and Ninez to help lead the committee conversation.

Marshall Chin: Well, thank you so much, NQF team and thanks so much for staying on schedule that – you did it, in terms of getting the slides done in time so we have over an hour and 15 minutes left for committee discussion in public comments and discussion also, so thank you very much.

And so, when we're preparing for the call, the NQF staff, Ninez and I, we came up with – as a start, three discussion questions. And they're basically just want to set the stage for some of the it is the key elements for us to address as a committee.

(We'll probably) start with a broad question of really what is social risk factor adjustment fit within its overall impact in terms of (past) the care and reimbursement value-based payment, the impact upon populations. And this discussion was put upfront so that we don't lose site of the overall goal here. Because when we start getting micro, it's possible to lose the forest for the trees in terms of discussion. The questions – second and third question do start to getting to the trees. The specific issues for the community to target in terms of the new social risk factor trial as well as the advice that the committee would have then for developers and the measure community.

Before we start with the committee discussion, we ask Bob Rauner and David Nerenz if they just take a few minutes to recap discussion that they had raised on – up some e-mails about experience that Bob was having in terms of the organization regarding the issue of social risk factor adjustment.

And David had summarized in a very eloquent way a whole variety issues which really are the key ones that the overall committee is trying to grapple with. And so, Bob, maybe, Bob first and then David. Just take a couple minutes each to maybe sort of highlight that discussion and those key points and then we'll launch in to the overall discussion with the committee. Maybe Bob?

Bob Rauner: Yes. Hearing me OK?

So, kind of what I was (throwing) out there is basically a summary of kind of what we're seeing in an actual ACO contract and, I think, really, the roots of our problem is that we've got, on both sides, you've got – on our side people like us looking at the disparities and, of course, this our FQHC clinic that's working on these. But in between is the insurance companies seem to have a very little or no understanding about how these applies to things and I've actually have talked to the contracting folks at Blue Cross, Blue Shield which is the source of our – the contract I was (posting) data from.

And the problem – one of the biggest problems I run into is people from the insurance side just don't really get some of this stuff and see the end - the consequences of their measurement. And so, we're just trying to figure out dilemmas of how we can do that and my hope in being on this panel is finding ways to get our insurers to pay more attention to some of these things.

Kind of – so, I guess, that's kind of the short version of why I threw that out there as an example of trying to put some of the stuff into perspective as to how it gets used in the real world sometimes.

Marshall Chin: And for those members of public who needed a little more context, the basic situation was that there was an FQHC involved ACO that has a lot of – (basically) a lot of social risk factors and they are basically losing the ACO a lot of money. And so, it creates this tension between the need to serve the at-risk populations but it's killing the ACO financially. And so, a very difficult situation for the ACO and the FQHC and the patients to being.

And, David, (you've sent us a very eloquently) summarized, like the key core issues that our committee is dealing with. And so, maybe, could you share some of your points there?

I think you're on mute, David. We can't hear you. Are you there, David? We can't hear you. So, either you're on mute or maybe David dropped off. We'll give David a few more seconds. If not, then we'll just proceed with the discussion. Are you there, David?

Erin O'Rourke: Operator, this is Erin from NQF. Is David Nerenz on the line? Do we still have him?

Operator: His line disconnected. I believe he's dialing back in now.

Ninez Ponce: OK. We'll give him another minute.

Then so, Bob, is there anything else you want to add to the context of your story?

Bob Rauner: Yes. I mean, (this is) a dilemma for my side. Actually, I asked David for what his – what he would do in my shoes and we're trying to figure out, like, a workaround for us. So, for example, for those who didn't look at the presentation, it's one of 15 clinics that – with a net effect of about $700,000 loss by keeping them in our ACO.

I think the ultimate source of why – what's happening is these are people coming in who had no health insurance and now, suddenly are on health insurance. And so, they're filling that – those unmet backlog of health services like colon cancer screening, getting their diabetes back under control, and so the same thing kind of applied to a lot of the exchange plans how they're caused so much higher across the country because when you take people with no health insurance and suddenly give them health insurance, that (backlog) drives up their prices for at least the first year that they're in health insurance.

And so, how do you not – how do you make that not penalize all your safety net clinics for participating these contracts as they need some of the funding and value-based purchasing to really provide these services.

Marshall Chin: Thanks, Bob. David, are you back on the line?

David Nerenz: Yes. Sorry. Just at the instant of significance, the call dropped on my cellphone. I had to …

Marshall Chin: No problem. So, go ahead, Bob – or go ahead, David.

David Nerenz: Yes. I just – I thought (last thing) was a wonderful illustration of the tangible concern that our panel in 2014 got talking about and focused on.

After that point, there'd been a concern that most of the shared about – if you adjust for some of these social and economic factors, will these mass disparities or will it excuse poor quality care for vulnerable population. And those are perfectly valid concerns. But there's a parallel set of concerns that I think Bob's example illustrates.

If the differences that you see in a set of measures and particularly outcome measures, I think, are most vulnerable to this, if the differences that you see do not (reflect) quality of care, at least not very much, then if you don't adjust, you penalize these providers financially, you hold them off in public (as being) poor doctors or hospitals. You strongly discourage them from serving the very people that we think are in need of the services they can provide.

And we felt on that panel, and I still feel to this day, that's a real problem. And that's why, I tend to be favorable to the idea of adjustment in circumstances where its appropriate.

Now, there are a couple things, a little different in Bob's example. Like we said, it's – (if) there's a cost factor here that didn't really come under our purview on the 2014 panel. You've got the issue of people who are just sort of backlogged for services they need which they produces cost when they enter into an insured arrangement.

It's not quite clear how the concepts and quality of care plays in to that, but I think, still, there are examples where the standard kind of quality metrics used in ACO settings look bad, look worse, for some providers like the one (you) showed as an example.

And then you're down to the fundamental question. Is it truly poor-quality care? Is it something else going on? And if you don't have a way to adjust for the (else), are you really creating an incentive for those people to be left out of ACO networks to move their practices, to shrink or close their practices?

So, I just thank Bob for brining that forward to us.

Marshall Chin: Thank you, David, and thank you, Bob.

So, we'll now move to, like, the discussion questions. And so, if you go back to the slide, you see that the first question, how should the disparities committee explore the impact of social risk adjustment and reimbursement in access to care including the impact of the implementation and measures and value-based purchasing on providers caring for population at extremes of social risk.

So, in some ways, it's at the question of – it's a typical question that the committee is grappling with regarding the social risk factor trial. Then there's the purpose of the use of measures. In some ways, you can divorce the two in terms of thinking about the methods and risk factor trial with how the measures will be used.

And so, we'll open to the committee now in terms of discussion of this first bullet. We have a couple sub-bullets (that some we need) to cover, (your) reaction to the scenario Bob shared as well as the rule of stratification and (talk a lot) about the social risk factor adjustment mostly with quantitative progress models.

And then the rule of stratification has been mentioned a number of times such as in the previous 2014 adjustment report. And it's also in, like, some of the recommendation of the NQF, we have not really explored that in as much detail in conjunction with the issue of progression and social risk factor adjustment.

So, let's open up to committee now.

Nancy Garrett: This is Nancy Garrett. I just wanted to ask Bob a question about the scenario. So, I understand some of the excess cost had to do with potentially what your theory is on unmet needs of that population. To what extent did performance on quality measures have a financial impact as well on that ACO arrangement?

Bob Rauner: This contract should actually won't hurt so from quality side, the way of the commercial and project – contract works. You had to meet a certain threshold of – they have a point scale of 0-20 and have to get at least 10, otherwise, you get none of your health savings even if you achieved the actual savings. So, because we're actually high enough above, even though they're bringing us down a little bit on some of their cancer measures, for example, it's actually not going to cost us from the quality side.

However, if you're on a Medicare Shared Savings ACO contract, you actually lose percentages for every quality measure potentially. So, if you're in a Medicare shared savings arrangement, you actually would lose money based on lower performance and quality. And many of the fact – the risk – the quality measures they're using in these contracts, things like cancer screening, blood pressure control, AIC control.

I think David's got his study. They published a year or so ago showing that you'll score lower based on socio-demographics (sort of) would hurt you on a Medicare Shared Savings because of the way they calculate it.

And part of the problem is just that each insurance company seems to keep approaching this very differently and it could be primarily financial, it could be primarily quality, how it may or may not hurt you and it's one of those things when till you actually get in the middle of it, you don't see those things.

So, short version, the Blue Cross contract, they actually won't hurt us because of the threshold were high enough that what that – whatever they bring us down won't hurt us there. It's primarily financial.

Nancy Garrett: OK. Thank you.

Susannah Bernheim: So, Marshall, this is Susannah. I will say that I think that this differentiation between adjustment or accounting for social risk and payment versus quality is a critical one and that we should be very careful as a committee to separate those two levers because as you know, I've long been a proponent for the payment measure accounting for social risk in various ways in payment policy as being both a more powerful and effective way of addressing disparity.

So, if we think about social risk and this is aligned with some of the stuff that Kevin put in his e-mails. If we think about social risk and payment and what we want to incentivize is allocating and giving safety net hospitals the kinds of resources that they need to provide the best care they can or to tailor it or to provide extra social support and follow-up, if you use payment as a lever, you're likely to improve quality and you're likely to incentive keeping those patients.

So, incorporating social risk into the way the payment is done which is what they ended up doing in the readmission reduction program by saying we're going to set thresholds differently for safety net hospitals to me is sort of potentially all upside in terms of the risk adjustment or, again, there's other ways to do besides (risk adjustment), the incorporation of social risk in the payment schemes and that's really what Bob, (I think), points out whereas with the quality measures, it's a more complex issue. It's not a never do but it – the risk of incorporating the quality measures is setting – saying the colonoscopy rates for poor people should be 30 percent and for rich people should be 50 percent.

Obviously, that's no – not what (anybody) but if you bake it in to your thresholds for quality measure, your incentivized – your incentives aren't as perfectly aligned as when you build it into the payment, not – now, I don't know as an NQF committee how much we can say about payment but I love that it's been brought into this discussion and I would be careful – I mean, the one thing I'll say about what David is I wouldn't sort of wave our hands and think about them similarly because I think the incentives that you build by bringing themi into payment measures are very different than by bringing them into quality measures and it benefits us to be thinking about those two concepts separately.

And in these alternative payment models, you have both levers. And so, CMS and other pairs are smart, they can use it in the proper lever and get the kind of results we all want to see.

Marshall Chin: Susannah, thanks for those comments, Marshall here again.

Can you – (and this is where the message) gets tricky here. And so that – can you – can you hard pass but (can you crack it) taking us systematically through this so in other words, when you say payment, you could say there's adjustment for payment that has nothing to do with quality.

So, for example, you could adjust a capitation rate for a population or a fee schedule rate for patient population based solely upon social risk factor, nothing to (quality). Yet, also, when people use this term, value-based payment, sometimes, that means payment that is linked to quality so a risk factor adjustment for payment in that latter case would be related to quality.

So, when you make a distinction between adjustment related to quality and adjustment that's related to payment and but this is conundrum of some payment is linked to quality, can you help us sort of think about how do we sort of make sense of this in a clear way?

Susannah Bernheim: I am happy to take a brief stab at it. There may be others on the committee who have a better way to do it and I think that because of the different payment models have such a variety of ways that they incorporate both expected payment and expected quality, we probably want to think about whether to do a deep dive.

So, I'm going to do mini version of that and just to give the committee room and them I'm happy to do more offline with folks. So, I think you're exactly right. I mean Bob gave an example where the payment and the quality are really separated, right, and what they were getting hurt on was what was the anticipated cost of caring for a particular population.

In that case, you can really separate the payment piece, right? They could have built a model for anticipated payments that took into account the kinds of patient that the FQHC was taking care of and then they would have looked like they were doing better compared to the threshold set for them. So, they're separated enough that it's easy.

In some programs, there sort of classic pay-for-performance. You can choose to change – adjust the measure and then what you just – then you'll see whether an institution – that sort of an extreme of doing it at a side that I had

concerns about is you adjust the measure and then even if the rates are different for different groups, they look sort of like you're doing equivalently well, so an institution can look like they're doing well on colonoscopy with poor patients at a lower level and look like they're doing well at a higher level of the – higher SES patients.

What they did in HRRP and it's not a perfect example but because it's a real example, I'll use it is that the case with the quality measure results is linked to payments. But rather than changing the quality measure results, they gave the results based on all hospitals without adjustments but they assessed the payment threshold. They decide where you're going to get penalized based on whether you're safety net hospital or not.

So, here, the measure is unchanged and you can see the relative performance on the measure regardless of the kinds of patients that the payment threshold is adapted to, say, we are going to set the threshold for payment differently. It's a – to me, it's an important differentiation. Some people think this is meaningless but I think it's a really important differentiation. And that's sort of the middle ground where the payment is directly linked to results on the measure, it's an alternative to changing the measure.

Juan Emilio Carrillo: Can I jump in? This is Emilio. I think that that makes a lot of sense, looking at those levers. But there's a lot of – there's a lot in the weeds that really have a major effect and we need to understand the success of an ace depends on the projected versus observed cost of care as we mentioned.

And then the quality measures, the patient experience measures and then there's a multiplier that's based on the diagnoses that are put in when bills are submitted. So, for example, a harried provider who has a lot of patients, I mean, his or her way who has to put in an ICD-10 code for – CPT code for the care of the provider, might just put in that patient came in and he had diabetes.

If that provider had put in the patient had diabetes with retinopathy and nephropathy, that multiplier, as they add up, these types of diagnosis that are reported would be higher and that multiplier makes a huge impact in the weight of the quality measures. Now, a health center, what resources do they

have to help the docs do the billing, what resources do they have to hire someone who (always see) the way the billing is put in. They don't.

So, basically, there is a lot of billing capability and multiplier enhancement that cannot happen without those resources. So, I think that we need to also dive into – this is just an example of some components of ACOs that are very important to consider.

Marshall Chin: Thanks, Emilio. And just to – so, a time check, maybe what we can do is that, this discussion on the first question, we'll cap at 2:15 Eastern time to allow half an hour, then for the remaining two questions that are more specifically related to the social risk trial.

Other thoughts? Comments?

Nancy Garrett: This is Nancy Garrett. So, I – just building on the previous discussion, I'm looking at Slide 12 where our previous recommendations including really trying to make sure that organizations that are serving individuals and social risk factors can still do so and one way to do that is additional payments for organizational factors that are outside the control of those organizations.

And I guess my concern is that, as I heard the outline of this next trial, it's really looking at each measure one at a time kind of in isolation and whether it make sense to risk adjust that measure. And I just don't know that that's going to follow our recommendation which is more about looking at the payment system (and) the way that works and the fact that safety net providers get lower reimbursements to start with.

And so, you're starting out with a situation of disparities in terms of how the payment works. So, I'm just a little concerned that the trial is kind of just like the first one and are we really going to get to some of these bigger questions the way that it's laid out?

Michelle Cabrera: Hi, this is Michelle Cabrera and I agree with that. And I have kind of a couple of thoughts and one question.

One question is are there certain measures that's based on our experience and our understanding of those measures maybe are inappropriate for use in payment models at all? And I asked the question to sort of – without knowing the answer, just a question.

And have we thought as well about providing guidance to individuals who would seek (to use) quality measures in payment models to maybe sort of flag for them? These – if you're going to attempt to use this in a payment model, it should be in consultation with, you know NQF because we know starting out that there – that this particular measure is susceptible to these kinds of outcomes based on how to interact with the social determinants.

So, I don't – I'm kind of throwing out really broad question because let you largely because I don't work in the world of measure development but I – the way I'm thinking about it seems to me that there are certain things that we would know are a lot more susceptible to these sorts of dynamics (interplay) than others and we could flag those upfront for people who are seeking to use them in payment scheme. So, that's just one question that I have.

The other – and this is a comment is that to Bob's point about what the impacts are (to) individuals who come into the ACO and they have pent-up demand, I mean, I think we sort of think about these things in terms of the lack of resources to providers and pent-up demand from that patient population.

And I wanted – I just want to pause and reflect that some of those pent-up demand is sort of – it goes back all the way to the beginning of that person's life and there are compounding issues that likely may never be resolved no matter how great the quality of care. So, I do think that there is a way that we have to consider that there are different dynamics for different populations.

Marshall Chin: So, really tough important questions, Michelle.

And so, people who either want to answer those or bring up additional issues?

Bob Rauner: Yes. This is Bob and I kind of along the same lines. I was – when I saw this coming up in this call, I was kind of thinking, are we doing what (the panel)

was originally coming to do or are we kind of moving to the side a little bit where it seems like sometimes it looks like our charge now is more of a – I guess, more of a basic signs approach to how do quality from our risk get effected by social determinants and stuff like that.

Are we still going to be able to focus a little bit on how do these measures actually get used in the field and how – what are the intended consequences and what policy and payment issues do we make sure people are aware of.

And so, I was kind of wondering in my mind how we're doing around the – down the basic science within individual measures approach going forward, are we going to keep a big focus how this actually get used for – in a CPC Plus program and Medicare Shared Savings and try to provide more input to make sure that the measures don't get used inappropriately.

Marshall Chin: Well, Bob, this is Marshall. I'll give you my take and others, please, chime in. When you look back at Erin's earlier slide about the initial charge to committee, it didn't compass both that it had – it was both narrow in terms of looking at the impact of social risk factor adjustment on quality measurements then also more broadly it was that general roadmap for the disparity in – with general actions that NQF and others could take to advance health equity.

And the reason – I mean, we came up with like these three study questions to start with is that in some ways it's hard to have the discussion about either in isolation. So, in other words, it's – I mean, Nancy said that it's hard to like have a meaningful discussion about the social risk factor trial without thinking about the wider context of alternative payment models, value-based payment, how the measures will be used.

Similarly, it's – for our charge, it's hard to – it's almost meaningless to have the discussion about like the (water pulse) issues unless we address the social risk factor trial charge in detail also. So, I'll just say that I think it is some type of mix and how we do that mix I think that they'll need to be determined. But for me doing either isolation just to make sense.

Traci Ferguson: And this is Traci Ferguson. I did want – I have also included terms of the discussion is that I know we've been talking at sort of an institutional view and level. But looking at how we can look at more from a provider level.

So, if you have providers that maybe not part of an ACO but may have a large panel that has a lot of membership that have (significant) social risk factors that how can we, as an organization, provide that same level of assistance and maybe adjustment to how other payers of insurance company or even Medicaid or Medicare pay that individual provider at that level.

And then as an insurance company, we utilize and we have different programs for the individual provider at the pay for performance. So, we give them additional incentive if they meet certain performance measurement.

So, I think that our charge as a committee is also not to look at what that – knowing that base measures are going to be utilized not by accreditation or at the level of (bracket) institution but you have health plans out there creating their own payment plan and – to incentivize provider that will be able to provide those organizations with enough guidance so that they're accurately utilizing the right measures and taking into account those measures that should be sort of adjusted for the social risk factor.

And it's one thing to talk about when you're looking at populations of adding on that (SQAC). When we go into – as a health plan, when we go into a new market, there are times when we will understand that there likely because of the population that there may be some either pent-up utilization or just the market experience and we will back that in of what we're going to see for year one knowing that they're going to – there's going to be some – they're going to have to subsidize that population with another population until we get to a point where we can sort of control and better manage them so that maybe something that's going into sort of your want, you have to sort of bake in that it's going to take – there's going to be a delta where they're not going to break even and it maybe year two – hopefully year two and not, like, year three.

Michelle Cabrera: But, Traci, this is Michelle again and I think that goes to the point I was trying to make earlier which is can we really say with confidence that we're going to

be able to earn some of these things around one-year period. My experience with different value-based (clinic models) is that they're looking for that sort of, OK, we will (conceive) maybe one year to you to how to get yourself an order but we want to see results within four years, within five years or whatever.

And just being wholly inappropriate, if you're talking about particularly growing some population with long histories of no access to the health system or very limited access to the health systems, other factors that, in reality, it would take much longer than a year to start to realize the kinds of quality indicators that we would want to see or particularly (inaudible) population that we would want to see to a population. And we provide guidance to a variety of folks experimenting in this space into these (units) about how to account to that.

Lisa Iezzoni: This is Lisa Iezzoni. Can I make a comment?

Male: All yours.

Lisa Iezzoni: Yes. OK. Thank you. The State of Massachusetts MassHealth on the Medicaid program has kind of moved to ACOs over the last six months or so and the state put together advisory committees to come up with the delivery systems reform incentive payment quality measurement structure and they actually advertised in the whatever the state Federal Register equivalent is to identify people who would serve on this quality measurement committee.

And I was struck because they explicitly asked for representatives from the disability community where recognizing that for MassHealth, for Medicaid, persons with disabilities were going to be, number one, expensive but also, number two, are going to have disparities in their care and be an issue for quality of care to really focus on in developing quality measures.

I was struck by your slide on I think it was like Slide 31 about the different or on page – that was Page 29 on that social risk factors considered in the fall 2017-2018 review cycles. There's nothing about disability in there at all.

I mean, I could think that maybe your Medicare status might be that maybe but that's not really disability and I think one of the things that I'm concerned about is the ability to avoid having patients come into your plan. It's very easy to avoid having persons with disabilities to come if you don't have highly adjustable exam tables, if you don't have ramp entrances, et cetera even though that's against the law.

And so, I'm just concerned about the fact that maybe because we don't have data, that might be one of the reason at some of those – that disability isn't considered by any of the many risk factors that you're looking at for the 2017 to 2018 cycle. But all I can say is that in Massachusetts, and trust me, I go to these – these committee meetings have happened every month religiously and the disability point of view has been really central to a lot of the conversation about both quality measures and about the payment and setups.

Marshall Chin: Yes. Thank you, Liza. That's a great point. And maybe note takers, please, please add that for like – the notes for like the upcoming second discussion question because that's quite questions relevant for the new social risk factor trial.

We have like three more minutes this last – I mean, first discussion question. Any more comments or questions or discussion on that first more general discussion question?

David Nerenz: Yes. David Nerenz here. Just for a second, just a reminder, I think when we talked about a lot of these issues of adjustment, Susannah is right, some good things could be done on the payment side but there's a whole other context we have to keep in mind and that's the domain of public reporting where there's really no payment as part of the picture.

We've got systems whether it's a number, whether it's a star rating whatever where we represent to the public here are good doctors and bad doctors and here are good clinics and bad clinics, good hospitals, bad hospitals. And I think where we have to look carefully with the issue of adjustment is that we actually representing these different entities fairly and accurately in that

context. So, I don't think (payment) adjustment has a lot to do in that particular context.

Marshall Chin: Thank you, David. So, we just have a couple of minutes left for any other comments about this – the more general context in the issue of reimbursement, (asset of care), value-based purchasing, implementation of these measures.

Ninez Ponce: Hey, Marshall, it's Ninez. I just wanted to underscore what Nancy Garrett said about Slide 12. Again, I think it gets at we started this committee to actually examine the results of the trial and then we expanded and starting to look at that risk adjustment alone can't get us to eliminate disparities.

And so, our reports from the previous period on getting at the framework, establishing a culture and structure of health equity which is really important. And so, I was happy to see that one of the – on Slide 12 and this could possibly help Bob's problem is that – in the – that there could be some additional, I'm looking for the Slide 12 that Nancy suggested, additional payments for organizational factors outside the control safety net organization and also provide coaching and technical assistance in QI and disparities reduction.

Marshall Chin: Yes. Thank you, Ninez. And I'm actually going to pass the baton to you now for taking this committee through questions two and three.

Ninez Ponce: OK. Sounds good. So, this is – thank you for putting the slide up. Can we go back to our discussion sections? Thank you.

There's also – I think we've been very good on cue with comments but there's also a raised hand function in case we get into a situation where it's going to list a lot of reactions as we get into the weeds on this part.

So, the next two questions are about the social risk trial. So, what does the disparity standing committee think are the most important unresolved issues to solve with the new social risk trial?

And these could be related to the data and the analysis. I mean, Liza Iezzoni raised the nonexistence of disability and what was done in the previous trial. Kevin sent an e-mail asking about the justification for race ethnicity. So, open up to everybody.

Lisa Cooper: So, this is Liza Cooper and one thing I guess I'm wondering about is to what extent are we pushing use of specific like social risk factors like – our collection of specific risk factors because I don't know that a lot of these – like the safety net providers, I guess my concern is do they – are they – do they have the systems in place and are they collecting the data on social risk factors so that they could even adjust for them if they needed to?

Like to what extent are people actually aware of the codes that they can use or are they – do they have systems in place actually like capture that information?

Romana Hasnain-Wynia: So, this is Romana and I can at least address that question from the Denver Health perspective as a safety net. So, we do have – we have the capacity and we are capturing a social risk factor data into (EPIC). Our bigger concern right now organizationally is not so much about using the data for risk adjustment but rather if we're collecting it, what are the actionable – what are the action steps that we can take as an organization to help our patients who are experiencing social risk such as food and stability or housing and security or any other social risk.

So, at this point in time, we haven't really started talking at least at the leadership level about the use of the data at this point for risk adjustment. We do where we can do risk tearing within our own system to evaluate the level of care a patient might need, but this is something that I can definitely bring into our leadership team.

Ninez Ponce: Thank you.

Christie Teigland: This is Christie Teigland and I want to comment on this from a perspective of I'm also on this newly formed scientific method panel and I think we're seeing the same old same old. And by that, I mean, what we're seeing comes through is essentially people only their SES factor is dual eligible status and that's all

that they have and we know that there are many, many others social determinants of health that impact outcomes.

But even with that, and I saw this in at least eight measures that I reviewed and others on the committee share my concern, (Karen Joint) and I were most verbal probably about it. But this are measures where when you stratify the rates by dual and non-dual and one was discharged to community for example and we saw a 26 percentage point gap disparity in rates from dual to non-dual.

And maybe that doesn't speak to quality. I mean, there – only 26 percent of dual eligibles are successfully discharged within the right timeframe compared to 52 percent of non-duals and I – it probably speaks to the fact that they really don't have a good home to go to.

So, it may not be worsening their quality, it maybe bettering their quality to recognize that. But they ultimately – and they had other – of 233 clinical variables in the model, so really adjusting for all of the clinical risk factors and, of course, then when you add one little dual status factor, it's not going to have a huge impact on model performance. That's – I'm economist, that's pretty clear. That's not rocket science.

But you kept all the 233 variables in and so, ultimately though, the argument was even though this was a hierarchical model, so, you're already controlling for differences in quality between hospitals, between facilities, between nursing homes, between whatever, you're controlling for that which is really what CMS is set all along is really through differences in quality. We don't want to – we're not adjusting for that.

So, it's appropriately used hierarchical model to adjust for facility. And then there are still disparities, this big disparity between duals and non-duals within facilities, right? And they said, now, we're not going to adjust for dual status because it could mask different disparities in quality.

Even with all those clinical adjusters with the hierarchical controlling for facility quality whereas the argument before was like, yes, it is within a facility and we still see disparities, it's just their release. It's – these people have issues that make them much harder to discharge the community.

So, not having the right data I think is a big issue and then interpreting these findings, I mean, so, if you – if we put this in the context of quality measures where for the Medicare Advantage Plans, for example, they will get – they will not get the added bonus payments.

If you are a dual plan here and your rate was 26 percent compared to other plans who didn't have duals and their rates were 52 percent you would look really, really bad even though it had everything to do with your population and the difficulty of just charging them to the community.

So, I don't know the answers to this but it seems like we're back to the same old – we're going to mask quality issues even though the evidence in my mind looks pretty darn clear.

Ninez Ponce: Thanks, Christie. Would – and I think this maybe a question to the NQF staff. So, there's – we're glad that there's a lot of intersections across the different health equity efforts at NQF. But for NQF staff, how would you like this standing committee to make recommendations or assimilate some of this information from the scientific committee?

Erin O'Rourke: Sure. This is Erin. I can start and, Elisa, if you have anything to add, I think we want to make sure that we're carrying those messages between the scientific method panel and the disparities standing committee.

I think we're perhaps may be struggling internally as a staff with some of the same questions that you all have raised in that there is evidence on both sides as to whether adjusting or not adjusting is the appropriate path forward and I think that when the – but we want to make sure we're examining what NQF can control and that is looking at the measures and our endorsement recommendations and so to what is the best possible measure to recommend people use with some of the larger questions that came up earlier as to how they're implemented and some of these other levers that existed as far as payment.

I think we do want to differentiate that the scientific method panel is more (charge) just looking at individual measures and making recommendations to

the standing committees considering endorsement. I think for the disparities committee, we'd like to maybe have you take a broader view, maybe help us work do some of the guidance on what risk factors may be appropriate to look at.

I think the question about is there a key set of variables we'd want everyone looking at is that feasible, not feasible, right now, NQF takes a non-prescriptive approach. Also thinking through perhaps how you would recommend standing committees make these recommendations to Christie' point of a lot of people look at this barrier or several developers have looked at this barrier that changing the model performance is that the right lens to look at that through.

So, I don't know if that's exactly articulated correctly. But I think we're hoping the disparities committee can continue to help us put this in the context of promoting equity and that this is one potential strategy and we want to make sure that we're threading that needle between harnessing the power to validate purchasing to reduce disparities with not inadvertently causing access issues by some of that examples that came up earlier of making it harder to compete.

So, I don't know if that exactly answered those questions.

Ninez Ponce: That's helpful. I just – I want to get back to Lisa's question on – Lisa Copper's question on may be they're not aware of the codes in use or should we be more prescriptive – now it's Lisa Iezzoni's concern like should we be more prescriptive as the standing committee to say like here are – here's the list of social risk factors beyond dual eligible – eligibility status.

Erin O'Rourke: I think any guidance that you can provide us to what data is available, what factors should be looked at I think would be a great resource for our developers.

As far as the question on being more prescriptive, we may leave that to the committee. Currently, our policy is to be non-prescriptive and just ask the board to put forward what they feel is the most appropriate model for their measure. But I think that's the question we'd like to explore with the

committee is are there a key set of variables that should always be examined or is continuing this non-descriptive approach the best path forward.

Ninez Ponce: OK. Thank you.

Robert Rauner: So, this is Bob. I'd like to kind of proposed that one thing that will help us out is actually of all of these potential risk factors, what should the ones that really stand out and the most actionable and helpful from the FQHC perspective.

So, for example, a lot of racial and ethnic disparities are really proxies for other things like household income and access to care and other issues and addressing those might be the main thing that will make a difference. Like for example, another FQHC unable to prepare out of control diabetics, the biggest thing to jump out is that most of out-of-control diabetics come from the household side of the one, meaning, they were lonely, had to help and no resources.

And so, it might help to let us say let's look at all these various things and one of the things that really are things that are actionable will help us make a difference whether it be dual eligible status or household side of one or food and security (potential) like that. I can't remember the name, we had that person (a man at) our last meeting who said out of all the (inaudible) data, the two things that jumped out were loneliness and food and security.

So, maybe it would be better to target toward a couple big buckets rather than getting lost in splitting hair so.

Lisa Cooper: Right. So, do you guys received the codes that Kevin shared in his e-mail?

Ninez Ponce: In the e-mail that you just sent, Lisa?

Lisa Cooper: Yes. I mean, there are tons of them but there might be a way to sort of group or like highlight or prioritize the one that we really would like people to use.

Romana Hasnain-Wynia: Did he – this is Romana, did he send those to everybody?

Lisa Cooper: Yes. He did.

Erin O'Rourke: I think he just sent it right before the meeting, Romana.

Romana Hasnain-Wynia: Yes. I didn't get it. I wonder if he's still using an old e-mail. I just didn't get it.

Lisa Cooper: OK. Yes. He replied. Well, it was like the message replied to the whole group. Anyway, there's a link. It's like a link in his e-mail.

Ninez Ponce: Yes, on an attachment.

Lisa Cooper: Yes, (on an) attachment.

Ninez Ponce: We can resend it but that's – I think that's a good – I mean, we can't resolve this right now in this call but maybe that's a good follow-up, a task for us to do because, Romana, you raised food and stability, housing risk. I think the question of – which is really important is when race is put in, is that – and what it is exactly capturing?

Lisa Cooper: Yes. I – what I – I think one thing I saw – I saw an article written where they sort of characterized social determinants of health according to Maslow's hierarchy of needs.

And then if you basically take the ones that are sort of at the baseline – like basically, I think housing and food and security are kind of like the ones that are like necessary for life. And then there are always other things that would make your life better but they're not like make or break.

So, we took that approach and we sort of went with these things that are – I mean, I don't know. I think they are (all) important. But if we definitely – that things that are like at the top of Maslow's hierarchy are at the bottom …

Ninez Ponce: Yes. Yes. Well, that gets to that conceptual framework need, too. I just want to be mindful for – I think Ron has to leave at 11:30, it's already 11:31, if you want to comment.

Ron Copeland: Yes. (I have to) step out. So, thank you. I guess my take on what we discussed so far is it seems like we're not – we're trying to put forward recommendation that makes a pretty, I think, legitimate assumption about the

playing field, i.e., the level of fragmentation amongst stakeholders and this – those receiving care, those paying for care, those providing care.

The fragmentation that exists across the country right now I think is still pretty significant. So, when you to start talking about risk taking in population health management and trying to align risk because out of population level, you only can have sustainable impact and proving the health of a population as opposed to just one individual, if the folks who are among those stakeholders have a shared relationship in terms of the risk, so, they have alignment of the incentives.

And so, I think some of the economies that we've been discussing, do we want to measure quality or do we want to do risk adjustment – resource risk adjustment based on the risk factors that are present on the population and should those lines cross and so on is also recognizing some of fragmentation and trying to propose something that assumes that you can get people aligned. And how do you that in a way that doesn't blind you to true quality improvement opportunities and yet at the same time you recognize when you calculate and identify these social risk factors and they have a role.

How does a small practice or individual practice, how do they scale up management of resources and infrastructure to identify these things and manage that if they're not part of a bigger systems? And so, we just have – one size does not fit all unfortunately in what we're addressing.

So, I just think as we calibrate this and talk about potential solution sets, we really need to be clear about who are we talking about or what are optimal models for providing care to a population of patients that would make these things work and does that model already available through 60 percent, 70 percent of the current playing field or is it a small number that doesn't apply to enough people so it doesn't make practical sense to get there.

And then – and I think that's under risk factors, the social risk factors. I think while there are some that are kind of foundational as opposed to others that might be more refined, I think when you talk about a population, you have to

do the analysis on a population to determine which ones are the critical ones for that group as opposed to so many these are critical ones for every group.

And people have their basic needs met in our (locking) and some of these other areas, how that accounted for? So, there's got to be some flexibility on the – based on the needs assessment that then allows for folks to (savor) this set of needs that is characteristic of say 60 percent, 70 percent, 80 percent of our population. This is what we're going to need to resource and provide to manage against.

But it's just hard for me to imagine lots of fragmented practices being able to play in this race despite tensions to resource differently and incentivize differently because of the need for scalable infrastructure and data analysis to manage this on a consistent basis.

So, those are just some of the disconnects that I'm experiencing as we talk about what we're committing to do and how do we advise in this space. And then last thing I'll say about race and ethnicity is while it is true that when you stratify data by race/ethnicity, you may see disparities and get underneath those.

And so, you have – there's like a congregation of risk factors that are driving them underneath that. What I would also say that we will be naive to believe that structural and policy embedded racism and discrimination is also an operative factor that it can override even the provision of resources for social factors when people go to try to receive care.

So, I don't think it's one or the other. I think both are (operative) and I think we just can't forget that in our thinking about where impact is and where our solutions that will, at the end of the day, drive health of the population, improvement in some quality and then bring effective utilization under control and cause where CMS is clearly trying to accomplish as well as improving care.

So, those are just obligations I would share before taking off on this first set of conversations.

Ninez Ponce: Thank you. Thanks, Ron, and it is just the first-step conversation.

Marshall Chin: This is Marshall. I want to say that Ron has this amazing sort of track record of basically listening intently and then halfway through the conversation in like two or three minutes having like the most insightful concise comments that capture the core of the issue. So, thanks, Ron.

Ron Copeland: Yes. (I hope this is) helpful. So, I'm going to sign off now but look forward to staying connected in being part of our next conversation. So, thank you.

Ninez Ponce: Thank you. OK. So, let's continue and I'm hoping someone from NQF resent the e-mail to Romana or …

Romana Hasnain-Wynia: I got it. Thank you.

Ninez Ponce: Good. Thank you. That was interesting because I think we – there's an (STF) that committee on many years ago that David and Kevin shared, one of the recommendations was on peer group comparison and I think in some ways I think Ron elevated it's to not just doing the metrics for peer group comparison but actually tailoring an understanding with the need – that needs are going to be different in this fragmented system. So, I think that that was a good reflection.

Any other reflections on the data gotten to date or last question here, major developers of hearing to the recommendation of the NQF risk adjustment for SES report. So, Erin, is that last question is that for us, I mean, would an NQF have more insight on that, the NQF staff on the adherence?

Erin O'Rourke: That's true. That might …

Female: Go ahead.

Erin O'Rourke: Apologies. I was going to say, I think there's a staff rule that I think we also want to make sure we're gathering the data that would allow the committee to take that to maybe help us into that question and think through. I know that some of you were on that initial committee and are helping us carry those spreads through.

So, I think for – at this point, it would be I think most useful to make sure that we're collecting the information that you all need to help us work through that issue of are we presenting the right information to the standing committees and are developers doing what you'd hope they 'd be doing. And I think I got someone off so I apologize.

Ninez Ponce: I'm sorry with that. OK. And if – for us to carefully look at that that is that the website that you said that gets updated in June and you referenced a social risk trial website or a site for us to take a look at.

Erin O'Rourke: Sure. As part of the work for this new trial, we are creating a list of all the measures that have been submitted for NQF and some of the initial findings as to whether they were adjusted or not, the conceptual basis that was included or not.

And I think it's meant to be a resource for our standing committees as well as our other stakeholders and this committee to make the work of this trial more transparent. So, we will be sending that around to the committee. We don't want to (burn you) with going to the NQF website for (this year).

So, we'll keep you in the loop as that's refreshed but I think to what we're hoping here is that it's a tool and a resource and we'll send that around when we update it that you can peruse and see if there is information that we're not collecting that maybe useful to you as you do these analyses going forward.

Ninez Ponce: OK. Any comments on that?

Susannah Bernheim: Ninez, I was just going to make a quick comment. This is Susannah.

Ninez Ponce: Yes. Go ahead.

Susannah Bernheim: So, I think just very briefly, so, as a developer, we have certainly tried to adhere to the spirit of the trial and developed some deeper analytics to try to parse out when we see in effect the extent to which it seems to be driven by institution versus individual.

Christie made a statement to the hierarchical model takes care of that but we don't we find that that's entirely true. And so, we've done these deeper what we call decomposition analyses and I will say one of the frustrations is that often then the results that we present which are more nuanced get sent back to you guys as with the small effects that they didn't adjust and that's really not the basis on which we're making that decision, which leads me to my suggestion for our committee which is I think it's very hard for us to determine if people are meeting the spirit of it.

Because for each of these measures, there's a fairly deep analysis that has begun to sort of build the conceptual model, make a case for what variables are or not available to be used and then do the right analytic work to make a decision.

And so, I think we are at risk of making the wrong determination if we just go based on how many end up risk adjusted which is mostly what we have and it feels to me – and I don't know that we have the resources for this but it feels to me like we almost need somebody to sort of compile almost a qualitative study of the – what's come in because I think it's an important question.

I'm sure that there are some applications coming in that are not taking this seriously and others that are taking it very seriously and for us, to understand the results, we do need a better sense of whether people are sort of diving in. But that takes some work.

So, I don't know either from our committee or NQF has a suggestion how to do that. But I think it's worth trying to understand if we're going to build criteria where we think it's been done well and where we haven't as a starting place for what might be a good criteria for people really adhering to the goal of the trial.

Ninez Ponce: I think that makes sense. I have a question for NQF. So, the list of variables that were used, the social factors, I think what would be helpful is which ones were used to invoke individual versus community level factors.

So, I think the community level factor isn't very clear to me except maybe some of the ZIP code. But even again use of ZIP code level variables might just be proxies or conceptually measuring a community phenomena where the person lives and also whether this is at the individual level or it's collected at the facility level. So, I think that would be in terms of just giving me a sense of what measures are being considered, I think that would be helpful.

Erin O'Rourke: This is Erin. Sure. We can try to check that from the measure submissions.

Ninez Ponce: Yes. I'm also wondering too why race ethnicity had its own – like there were six and then there's ethnicity too, it had …

Erin O'Rourke: Sure. I think, to be honest, it was a data entry issue. The data isn't standardized on the measure submission form. So, when it was entered into our database that we're using to track this, it was entered different ways and then when we put the slide, we didn't have a chance to really clean up the data to combine all that. So, that was a data entry issue I think for like it's broken down in different ways.

Ninez Ponce: Great. Thank you. And I think there's already been some suggestions of looking at some ICD-10, looking at the list that Kevin had sent.

Erin O'Rourke: Yes. Yes. And I think we can also see what we can do about – to that suggestion about trying (to add) some more qualitative data rather than just the numbers because I think we agree that the raw numbers are not what's important here but rather some of the nuances underneath them that might not show up in quantitative data.

Ninez Ponce: Yes. And then probably more on Susannah's suggestion about criteria, I think that's a good rule of ethics for our committee is to come up with some criteria to help with whether the measure developers are adhering to our recommendations.

I'm not sure if this could all come out in this conversation now but I think it's something that we can follow up in further conversations. Shall we go to the – there's another set of questions we have to delve into. So, can we go to the next one?

Yolanda Ogbolu: This is Yolanda Ogbolu, while you're turning the page, I had some questions and some additional comments about kind of the categorization requests around social risk measures.

Currently, it's really long list and I hear people asking for them to be broken down by various categories and I think that would be extremely helpful for us to be able to do specifically some of the work that Lisa Cooper voiced out about prioritizing some of the measures.

Currently, the – if I'm looking at the right format, (I received) the Excel file, it's a pretty long list than having them categorized even by social determinants of health, type, measures versus the community as others has missed – mentioned where disability would be extremely helpful.

The other comment or question I had was around the conceptual models that individuals have submitted as it relates to having the measures assessed. I didn't know if others in the committee, I guess those who are involved in development, you have some idea.

But for individuals like me, I would find it very interesting to have a deeper understanding of what conceptual models have been utilized in terms of justification for certain measures and if the committee could have any input on those conceptual models and whether they really are conceptually linked in terms of the measures that we're thinking about?

And then the final comment I wanted to make was something that – I can't remember who made this comment but it was about loneliness. I know that on the social measures – social risk factor model from the Institute of Medicine, sorry to be using the wrong name, the social risk factors, there's a whole big thing on at least one of the blocks as it relates to social isolation and I'm not sure that we've had any movement on social isolation as a potential social risk measure at all either. So, with that, I'll stop.

Ninez Ponce: Thank you. Thanks so much, Yolanda. I think that comment was from Bob. I mean, yes. Thank you. So, let's go to the last set of (discussion, set of questions). Does the committee have any guidance for the standing

committees and CSAC evaluating measures or measure developers specifically is the NQF adhering to the recommendations of the NQF risk adjusted for SES report?

That's a big broad question. And then getting more into the specifics, is reporting both adjusted and unadjusted rate a path forward, what rate should be used to determine payment? And as you're thinking about approaches, thinking about outcome measures if that should be the sole focus of adjustment for social factors or might there be some scenarios when process measures should also be considered for adjustment.

I also note that it was reported that intermediate outcome was reported in NQF staff. There could be some clarification with those intermediate outcomes and be really helpful for us, too.

Marshall Chin: And, Ninez, we should leave five minutes for public comment as well to wrap up.

Ninez Ponce: OK. Thank you. I think we answered the last part about NQF being more prescriptive or not and we've discussed some of the social risk factors, I think the last piece we've discussed. Any suggestions, comments or a way to move forward in this discussion for this set of questions?

Hearing none, I think I'm thinking that you do – you have – our committee members are thinking about this and NQF staff. But it may be trying to get it to specifics that probably could be discussed offline or subsequent discussions.

So, I think I'm going to do going, going, gone for any input on this set of questions. But knowing that it's not the last time that we'll discuss this.

Erin O'Rourke: I mean, this is Erin. I don't want to (cause) - if anyone did have some thoughts but as well people are perhaps gathering them. Like I think the committee has given us a lot of great advice from the conversations to date.

So, I think, again, this is trying to get some initial thoughts out there and I think if there's anything else people want us to think about at this point but a

lot of these were meant to be questioned, we can continue to explore through the trial in the next several years. We don't necessarily need an answer today.

But we just want to make sure that we're teeing up the conversations that the committee thinks we need to be having and collecting the data that you need to support your guidance to NQF and to the field. So, I apologize if the questions were challenging on the site to answer today. It wasn't – it was meant just to make sure we're getting you what you need to go forward if that's helpful for context.

Ninez Ponce: Yes. Excellent. Thank you. Thank you. Yes. Certainly, it will help tee up our conversation. So, I think that I'm going to hand it off to Marshall to open up for public comment.

Marshall Chin: Yes. Thank you, everyone. Thank you, Nunez. So, operator, can you open up the line for public comments? So, anyone who – from the public who would like to make a comment or ask a question.

Operator: Yes, sir. At this time, if you'd like to make a comment, please press star then the number one. And you do have a question from John Shaw with NextWave.

John Shaw: Hello. I just wanted to say that I enjoyed the discussion greatly. I think we're really on the right track. I just want to say the goal in all of this is to improve health and health equity. Measures and risk adjustment are only tools.

And so, if we keep that in mind that I think should help. There was a lot of issue on focus on how measures are used and that's been an ongoing discussion over the years between the map and the measure endorsement. Maybe we need at some point accountability for endorsed measure users.

Measures of how our users of measures, so, insurance plans and payers using measures like they're using them appropriately and do we need to give them guidance to do so.

The other issue I heard discussed by many people is the discussion of quality versus payment and its effect on a fair playing field. And to my mind, what I

actually heard is there are resources needed to achieve the same level of quality and yet through the – are we masking disparities and so on, just – OK, we want to have the same level of health outcomes for everyone for health equity but it may take more resources to get them for these socially disadvantaged populations.

So, one of the things that look like only one of the measures looked at insurance status and when we look at margins, private pay tends to be at least 20 percent higher than cost. Medicaid is typically 80 percent of cost and just varying that insurance mix has a huge impact on resources and sort of gets that payment versus quality tradeoff.

The other thing is that there are different approaches at the facility and provider level that should be looked at. Maybe ask the question, to achieve equal quality, what does a safety net facility or FQHC or provider need more resources to do? So, why do they need more resources? Is it filling the gap for people living alone that don't have informal supports and were relying on the patient implicitly to carry on post-discharge care and things like that?

So, can we specify and look at during the measure endorsement process? OK. For this measure, if there is what appears to be a social risk factor there, what are the actions that providers have to take in order to be able to achieve the same outcomes and can that help focus some of the discussion with the measure developers. That's it.

Marshall Chin: Thanks very much, (John).

Operator: OK. The next comment comes from Koryn Rubin.

Koryn Rubin: Hi, this is Koryn Rubin from the American Medical Association. I have a comment and then also a question potentially with – to consider.

First, thank you for everyone's time and attention on this matter. I just want to echo some of the comments made by David Nerenz in Henry Ford. Based on our evaluation of whether it's the ACL program, the MIPS program or CMS public reporting physician compare part of the challenge is the program designs particularly the benchmark methodology and the need for the

methodologies to be refined to take into consideration social risk factors and other clinical factors that make achieving the target really difficult for providers that serve patients with social risk needs or other more severe clinical condition.

But that is also still the need for the better risk adjustment methodology. And so, I hope that the committee can consider some of these other factors that are impacting how providers perform and address patients with social risk factors.

Then my question is I might have missed it because I had to step away from my phone for a little bit, but I didn't hear any discussion in terms of how this work and then also NQF's new action team will play into ASPI's second report that is supposed to be released next year. They just put out RFI asking specifically how to tackle social risk factors in quality measurement, including data capture.

And so, what – whether what stated here will trickle down on to CMS or is there then just going to be a reliance on what ASPI comes up with since that was a charge through the IMPACT Act for ASPI to make recommendations to HHS for CMS programs? Thank you.

Marshall Chin: Thank you very much, Koryn. I'll send that question to – Erin's way if you haven't answered that question as well as, Erin, we're going to wrap up with next steps with the committee.

Erin O'Rourke: Great. Thank you, Marshall. Thank you, Koryn, for the question. I think we certainly want to make sure that we're aligning with ASPI and contributing to that work as we can.

I don't have an answer for you today on exactly what that channel of communication between NQF and ASPI would be. But I think it's a great point and something we should look into further. I might pass to Elisa, I don't know if you have anything to add about the work of the action team.

Elisa Munthali: No. I think it's a good consideration for us inasmuch as we did talk a little bit about the distinction between the work we're doing in quality measurement

and that is part of the quality innovations team and the work that the national partners are doing.

Those members that will be seated on the committee must be NQF members. CMS is an NQF member and to the extent that they have representation on the action team, we hope that that will help to inform ASPI's work. But we also would do the same because we're at NQF and so we'll make sure that we keep our lines of communication between CMS and ASPI open so that we can share what we know will be good work and hopefully informative foundational work for them for their report coming up.

Erin O'Rourke: OK. Thank you. And I know we're out of time, I will do this very briefly. But thank you so much to everyone for joining the call today and for all your thoughtful conversation and insights. This has been tremendously helpful to us as we get this work underway.

And a special thank you to Marshall and Ninez for your leadership today and for helping us prep and we are excited to have the opportunity to be working with you all again and I will be in touch shortly. So, thank you so much for your time today and your – the work we know you'll be doing to support this child over the next several years. Have a great afternoon everyone.

Marshall Chin: Thank you very much, everyone.

Female: Thank you.

Female: OK. Thank you.

Female: Thanks, bye-bye.

END