

Addressing Social Needs Electronic Clinical Quality Measure Summary of Technical Expert Panel (TEP) Meeting

April 2024

Prepared by:

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(YNHHSC/CORE)

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Background

The Centers for Medicare & Medicaid Services (CMS) contracted with Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (Yale CORE) to re-design a measure of screening for social needs (food insecurity, housing insecurity, transportation insecurity, utility insecurity). The re-designed measure is an electronic clinical quality measure (eCQM) evaluating hospitals addressing social needs. The contract name is Measure & Instrument Development and Support (MIDS): Development, Reevaluation, and Implementation of Outcome/Efficiency Measures for Hospital and Eligible Clinicians, Option Period 3. The contract number is HHSM-75FCMC18D0042.

As part of this project, CORE assembled a national Technical Expert Panel (TEP) of stakeholders including experts and consumer advocates who contributed to obtain their input through the measure re-design process. The purpose of this TEP was to assemble a group with diverse perspectives and expertise to advise on conceptual, technical, and implementation considerations of the measure under development. A schedule of TEP meetings can be found in [Appendix A](#).

This report summarizes the feedback and recommendations received from the TEP during the project's third TEP meeting held in February 2024. During the third meeting, CORE presented updates on the measure and solicited TEP input on the need for and approaches to peer grouping and the importance of the measure. The full meeting minutes can be found in [Appendix B](#) and a detailed list of TEP members can be found in [Appendix C](#).

Measure Development Team

The CORE Measure Development Team provides a range of expertise in outcome measure development, health services research, clinical medicine, statistics, and measurement methodology. See [Appendix D](#) for the full list of members for the CORE Measure Development Team.

The TEP

In alignment with the CMS Measures Management System (MMS), Yale CORE held a 30-day public call for nominations and convened a TEP for the development of a re-designed measure evaluating hospitals addressing social needs. CORE solicited nominations for TEP members via a posting on CMS's website and emails to individuals and organizations identified by the CORE Measure Development Team, and through email notifications sent to CMS physician and hospital email listservs. After reviewing the TEP nominations, CORE confirmed a TEP of 20 members (see [Table 1](#) for members). The appointment term for the TEP is from November 2022 to March 2024.

CORE hosted the third meeting for the project on February 29, 2024, via Zoom webinar/teleconference. Many TEP members (15 of 20) attended the meeting on February 29, 2024. See [Appendix C](#) for the full list of TEP members. The TEP meetings follow a structured format consisting of the presentation of key issues identified during measure development, as

well as CORE’s proposed approaches to addressing the issues, followed by an open discussion of these issues by the TEP members.

Specific Responsibilities of the TEP Members

The role of the TEP is to provide feedback and recommendations on key methodological and clinical decisions. TEP members are required to:

- Complete and submit all nomination materials, including the TEP Nomination Form, statement of interest, and curriculum vitae
- Review background materials provided by CORE prior to each TEP meeting
- Attend and actively participate in TEP conference calls
- Provide input on key clinical, methodological, and other decisions
- Provide feedback on key policy or other non-technical issues
- Review the TEP summary report prior to public release
- Be available to discuss recommendations and perspectives following TEP meetings and public release of the TEP Summary Report to CMS
- Provide formal assessment on measure importance

TEP Members Present for Third Meeting

Table 1. TEP Member Name, Affiliation, and Location

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Health Information Technology	Care Management/ Social Services	Health Equity
Rosie Bartel	Chilton, Wisconsin	X	-	-	-
Gail Grant, MD, MPH, MBA, Director, Clinical Quality Information Services	Cedars-Sinai Medical Center, Los Angeles, California	-	X	-	X
Karen S. Johnson, PhD, Vice President, Practice Advancement	American Academy of Family Physicians, Leawood, Kansas	-	X	-	X
Barbara Kivowitz, MSW, PFA	Sutter Health, Los Angeles, CA	X	-	-	-
Roger Lacoy	PFCCpartners, ATW Health Solutions, Des Moines, Iowa	X	-	-	-

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Health Information Technology	Care Management/ Social Services	Health Equity
Nikolas Matthes, MD, PhD, MPH, MSc, Measure developer	IPRO, Lake Success, New York	-	X	-	X
Ned Mossman, MPH, Director of Social and Community Health	OCHIN, Portland, Oregon	-	X	X	X
Juan Nañez, RN, BSN, Director of Programs	PHIX - Paso Del Norte Health Information Exchange, El Paso, Texas	-	X	-	X
Marilyn Parenzan, MBA, RHIA, CPHQ, Project Director, Clinical Quality Informatics, Measure Developer	The Joint Commission, Oakbrook Terrace, Illinois	-	X	-	-
Shannon Sims, MD, PhD, FAMIA, Senior Vice President, Emerging Markets	Vizient, Inc., Chicago, Illinois	-	X	X	-
Karthik Sivashanker, MD, MPH, CPPS, Vice President Equitable Health Systems; Medical Director for Quality, Safety and Equity, Psychiatrist	American Medical Association; Brigham Health, Norwood, Massachusetts	-			X
Megan V. Smith DrPH, MPH, Senior Director, Community Health Transformation	The Connecticut Hospital Association, Wallingford, Connecticut	-	-	-	X
Tressa Springmann, CHCIO, CPHIMSS, Senior Vice President and Chief Information and Digital Officer	LifeBridge Health Systems, Baltimore, Maryland	-	X	-	-

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Health Information Technology	Care Management/ Social Services	Health Equity
Nālani Tarrant, MPH PMP, Director, Social Drivers of Health	National Associations of Community Health Centers, Bethesda, Maryland	-	-	-	X
Kevin Wake	Kansas City, Missouri	X	-	-	-

Third TEP Meeting

CORE held the project’s third TEP meeting on February 29, 2024, to further discuss development of the ASN eCQM, which will measure how hospitals address the social needs of their patients. The purpose of the TEP is to provide feedback to CORE on proposed methodologies.

TEP Meeting Overview

Prior to the meeting, CORE provided TEP members a copy of the PowerPoint slides for review. During the TEP meeting, CORE solicited feedback from the panel on a change from ordinal measure scoring to narrative percentages, summary scores for domain-level comparisons, inpatient and outpatient setting criteria, testing methodology, measure importance, and proposed methodology for peer grouping facilities for measure result reporting. As the TEP functions in an advisory-only capacity, no motions to vote or approve concepts were undertaken. The TEP meeting presenters were Leianna Dolce, Sarah DeSilvey, Faseeha Altaf, and Mariel Thottam. Following the meeting, CORE provided TEP members unable to join the teleconference with a copy of the meeting recording and opportunity to provide written feedback with an invitation to complete the Qualtrics survey on measure importance.

The following bullets represent a high-level summary of what was presented and discussed during the TEP meeting. We also included meeting minutes with unique identifiers removed in [Appendix B](#).

Background and Approach

- CORE started the meeting by reviewing the purpose of having a technical expert panel for the Addressing Social Needs (ASN) Electronic Clinical Quality Measure (eCQM). CORE then reviewed the specifications of the ASN eCQM, noting the measure assesses screening and follow-up on four social domains including food insecurity, housing with sub-domains of housing instability and homelessness, transportation insecurity, and utility insecurity. CORE shared that CMS originally planned for use of the measure in a

national program measuring hospitals. However, CMS is now considering adding the measure to three additional national programs, including:

- Merit-based Incentive Payment System (MIPS) for clinicians and clinician groups,
- Medicaid (CMCS) and the Children’s Health Insurance Program (CHIP), and
- The Hospital Outpatient Quality Reporting (HOQR) program.

CORE reviewed updates to the measure resulting from public comment and CMS collaboration, including a change in scoring methodology moving from an ordinal score to a narrative percentage with summary outcome. CORE reviewed inpatient and outpatient setting criteria, measure testing progress (alpha and beta testing), and an overview of state-level feasibility testing for the CMCS program. CORE additionally reviewed measure development challenges, and invited TEP members to discuss measure importance, reflecting on whether the measure is easy to understand and if the measure can differentiate good care from poor quality care. The TEP members also discussed the consideration of peer grouping to compare facilities that care for populations with higher proportion of patients with identified social needs and higher burden of follow-up activity with similar facilities. CORE reviewed the measure development and implementation timeline to close the meeting, noting upcoming next steps for measure development, including consideration of voluntary reporting in applicable rules for 2026, early signaling as the ecosystem adapts to USCDI standards, and response to additional testing results.

Summary of TEP Input (including both teleconference and written responses)

- When asked about the revised scoring narrative, TEP members generally agreed the six percentage rates allow CMS, facilities, and practices to gather meaningful data to improve standardized assessment and follow-up and provides more information that can inform future changes in measure specifications. Several TEP members noted declinations to follow-up were not included in the narrative scoring method. The TEP members were reminded of the range of possible follow-up actions, the breadth of which decreases the likelihood that a patient would decline a qualifying follow-up. The TEP noted autonomy is an important consideration for this measure while still allowing for the broad range of qualifying follow-up actions.
- When asked about the summary score for domain-level comparison, TEP members acknowledged the mission of the ASN measure to increase both the percentage of patients that screen negative and the percentage of patients screening positive with follow-up. However, several TEP members asked if the measure would assess adequacy or success of the follow-up intervention and how to handle decline of follow-up. The TEP members recommended reviewing declination of follow-up in the revised scoring option for a future version of the measure.
- When asked about the measure definition and setting criteria, TEP members requested more information on qualifying evaluation and management visits as criteria for the outpatient measure. One TEP member noted the large volume of inpatient and outpatient visits that might qualify for the measure and the number of times a patient

may be asked to complete a social needs assessment to understand how CORE is thinking about measurement benefit versus burden. The TEP members agreed there is a critical need to standardize social need assessments and follow-up actions because data are currently stored in notes and other non-structured, easily extractable fields. It was emphasized that data from these non-structured fields cannot be easily used, reported, or measured; therefore, documenting in the standards recommended in the measure is important. Follow-up interventions are particularly difficult to identify because data are not directly linked to positive screens. The TEP acknowledged CMS' priority to create a process change that promotes systematic collection of social need data across settings and use of data to improve quality of care and discharge planning. The TEP noted many care settings may not have capacity to fully implement the USCDI aligned SDOH data elements in the measure.

- When asked about applying payer status as a method for peer grouping facilities to ensure facilities caring for higher proportion of patient populations with social needs are not penalized, several TEP members agreed on this method and recommended reviewing other methods including dual eligibility, area deprivation index, system size or volume, geographic location, and resources. One TEP member shared some patients may be hesitant to share their social need or payer status to preserve pride. Another TEP member noted using payer status (Medicaid) was okay, but not sufficient on its own. TEP members proposed applying stratification by payment status as awareness over a more sophisticated methodology because it is too early. Several TEP members suggested applying overall payer mix.

Next Steps

Ongoing Measure Development

CORE will continue to solicit feedback from TEP members and other relevant stakeholders during the measure development process.

Conclusion

The TEP provided valuable feedback on elements of measure development, testing methodology, approaches for peer grouping, and measure importance. During the meeting, TEP members reviewed and commented on the revised scoring narrative. The TEP members approved testing methodology and stated a systematic push for standardized social needs assessments across care settings is clear and necessary for creating usable data. Following the meeting, all TEP members were asked to complete a survey on measure importance; asking them to rate their level of agreement with the following statements:

- “The INPATIENT Addressing Social Needs Electronic Clinical Quality Measure is easy to understand and useful for decision making,”
 - The TEP members responded: 5 strongly agree, 6 agree, 1 neutral, 1 disagree, 1 strongly disagree.

- “The INPATIENT Addressing Social Needs Electronic Clinical Quality Measure could differentiate good from poor quality care among providers (or accountable entities),”
 - The TEP members responded: 2 strongly agree, 3 agree, 6 neutral, 2 disagree, 1 strongly disagree.
- “The OUTPATIENT Addressing Social Needs Electronic Clinical Quality Measure is easy to understand and useful for decision making,”
 - The TEP members responded: 3 strongly agree, 5 agree, 4 neutral, 1 disagree, 1 strongly disagree.
- “The OUTPATIENT Addressing Social Needs Electronic Clinical Quality Measure could differentiate good from poor quality care among providers (or accountable entities),”
 - The TEP members responded: 2 strongly agree, 3 agree, 7 neutral, 0 disagree, 2 strongly disagree.

CORE will take the feedback from this TEP meeting into consideration in ongoing measure development activities. CORE intends to facilitate a follow-up TEP Engagement to disseminate testing results and collect final performance measure in the Fall.

Appendix A. TEP Call Schedule

A list of TEP meetings scheduled.

TEP Meeting #1

Tuesday, November 29, 2022 – 2:00-4:00PM EST (Zoom Teleconference)

TEP Meeting #2

Thursday, March 2, 2023 – 1:00-3:00PM EST (Zoom Teleconference)

TEP Meeting #3

Thursday, February 29, 2024 – 1:30-3:30PM EST (Zoom Teleconference)

Appendix B. Detailed Summary of OP4 TEP Meeting #3

Addressing Social Needs eCQM Technical Expert Panel (TEP) Meeting: Meeting #3 Meeting Minutes

Meeting Information: Addressing Social Needs eCQM Technical Expert Panel (TEP) Meeting #3

Date: Thursday, February 29, 2024

Participants:

- **Technical Expert Panel (TEP) Members:** Rosie Bartel, Gail Grant, Karen Johnson, Barbara Kivowitz, Roger Lacey, Nikolas Matthes, Ned Mossman, Juan Nanez, Marilyn Parenzan, Tressa Springmann, Shannon Sims, Karthik Sivashanker, Megan Smith, Nalani Tarrant, Kevin Wake
- **Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE):** Faseeha Altaf, Jin Cho, Sarah DeSilvey, Leianna Dolce, Laura Gottlieb, Roisin Healy, Floraine Evardo, Erin Joyce, Amena Keshawarz, Tina Loarte-Rodriguez, Patricia Faraone Nogelo, Katherine O’Hare, Mariel Thottam, Elizabeth Triche, Brooke Villarreal, Nicole Voll, Ariel Williams, Si Zhou, Stephanie Lambert
- **Centers for Medicare & Medicaid Services (CMS):** Raquel Myers
- **Centers for Medicare and Medicaid Innovation (CMMI):** Sarah Downer, Gigi Crane

Welcome

- Ms. Mariel Thottam greeted participants and welcomed feedback from the Technical Expert Panel (TEP), stating their feedback is crucial to the development of the Addressing Social Needs (ASN) electronic clinical quality measure (eCQM), but noting the ultimate decisions will be made by the Centers for Medicare & Medicaid Services (CMS).
- Ms. Thottam encouraged participants to use the virtual meeting controls (e.g., chat, raise hand) as needed, provided information on confidentiality and funding sources, and provided an overview of the meeting agenda, including:
 - Settling in;
 - Reintroductions;
 - Measure Grounding;
 - Measure Updates;
 - Measure Testing Progress;
 - Measure Importance;
 - Discussion on Peer Grouping; and
 - Next Steps.

Goals

- Ms. Thottam reviewed the meeting goals, including:
 - Bringing TEP members up to date on measure progress;
 - Discussing measure importance; and
 - Receiving feedback on peer grouping possibilities.

Re-Introductions

- Ms. Thottam introduced herself as the Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (CORE) Stakeholder Engagement team lead and meeting facilitator, and reviewed discussion decorum expectations.
- Dr. Sarah DeSilvey introduced herself as the project co-lead.
- Ms. Leianna Dolce introduced herself as the project co-lead.
- Ms. Faseeha Altaf introduced herself as the testing division lead and noted she was stepping in to present the testing results on behalf of Ms. Nicole Voll, who was unexpectedly unable to present.
- Ms. Thottam acknowledged the additional members of CORE’s ASN eCQM team who were in attendance.
- Ms. Thottam acknowledged the TEP members (listed in the presentation slides) and stated they would forego introductions since the TEP members met previously.
- Ms. Thottam reviewed the TEP member responsibilities and the role of the TEP, including the meeting purpose of gaining stakeholder input from a range of perspectives to inform measure development, and promoting public transparency in measurement.
 - The TEP members were asked to disclose any updated conflicts of interest in the meeting chat (none were disclosed).

Measure Grounding

- Ms. Dolce noted the ASN eCQM assesses screening and follow-up on four social domains including food insecurity, housing with sub-domains of housing instability and homelessness, transportation insecurity, and utility insecurity.
 - The measure has evolved from the existing Inpatient Quality Reporting (IQR) program screen-only measure to a screen-and-intervene measure that holds providers accountable for addressing positive screenings with follow-up action.
 - The development of the eCQM measure is aligned with the United States Core Data for Interoperability (USCDI) Version 2 (v2) Gravity Project Social Determinants of Health (SDOH) instrument, diagnosis, and intervention data elements (e.g. data elements in Office of the National Coordinator for Health Information Technology [ONC] Certification by January 2026), including:
 - Screening instruments represented by Logical Observation Identifiers Names and Codes (LOINC);
 - International Classification of Diseases, Tenth revision, Clinical Modification (ICD-10-CM) diagnoses; and
 - Interventions by Systematized Nomenclature of Medicine — Clinical Terminology (SNOMED CT).
 - CMS is committed to the use of the USCDI-aligned data sources and has clarified it will not build Healthcare Common Procedure Coding System (HCPCS) codes for this measure to allow for

- administrative-only reporting as a patch, in alignment with their Health Equity Framework and Digital Quality Measure Roadmap.
 - Full implementation and reporting of the measure will take time.
 - The measure is aligned with gold standard screening approaches when available.
- Ms. Dolce provided an update on the measure use, noting CMS originally planned for use of the measure in a national program measuring hospitals, and is now considering adding the measure to three additional national programs evaluating outpatient providers, including:
 - Merit-based Incentive Payment System (MIPS) for clinicians;
 - Medicaid and the Children’s Health Insurance Program (CMCS); and
 - The Hospital Outpatient Quality Reporting (HOQR) program.

Measure Updates

Updates from Public Comment and CMS Collaboration

- Dr. DeSilvey reviewed the updates resulting from public comment and CMS collaboration.
 - For all settings, the methodology changed to a narrative percentage with summary outcome, instrument criteria were updated, and possible peer grouping for equitable comparison is being explored.
 - The measure is being adapted for application to outpatient settings including consideration for a state Medicaid measure.
 - For the outpatient setting, the measure is allowing non-evaluation & management (E&M) encounters to participate in performance of screening/intervention, and
 - Exploring allowing outpatient emergency department (ED) visits and non-provider E&M visits (e.g., care management, grant-funded roles at Federally Qualified Healthcare Centers [FQHCs] performing social needs assessment and intervention) to qualify in the numerator.

Measure Specifications

- Dr. DeSilvey described the updated ASN eQIM scoring as a narrative percentage reflecting whether patients were assessed for social needs via an approved instrument or ICD-10-CM code, and whether, if assessed as positive, the patient received follow-up for any needs identified.
 - It is a non-risk adjusted episode-based process measure;
 - The proposed measurement period is one calendar year;
 - The data source is the electronic health record (EHR);
 - Supplemental elements include payer, race, ethnicity, and sex; and
 - The proposed implementation standard is Quality Data Model (QDM) with eventual translation to the Health Level Seven International (HL7) Fast Health Interoperability Resources (FHIR) standard.

All Setting Scoring Methodology

- Dr. DeSilvey noted several public commentators expressed concern that the ordinal scoring method moved beyond the intent of the quality measure to apply unsubstantiated greater value to declinations and positive findings.
 - In response to stakeholder concerns, the scoring approach is shifting toward a narrative percentage with a roll-up summary score, to allow the measure to assess quality more meaningfully.
 - The need to fairly compare high- and low-burden settings may be addressed with peer grouping.
- Dr. DeSilvey reviewed the original ordinal scoring approach and contrasted it to the new narrative measure scoring approach.
 - The updated narrative scoring provides percentages for five categories of possible outcomes to assessment and follow-up (did not assess, assessment declined, assessed positive but no intervention, assessed positive with intervention, and assessed negative), which will allow CMS and practices to gather meaningful data to improve assessment and follow-up practices and will provide more information to inform future changes in the measure specifications.
 - The measure for housing instability includes both homelessness and housing instability, which are assessed separately as they are, by definition, mutually exclusive, and are then combined into a single housing measure; the subdomain of housing insecurity, inadequate housing, is not currently included in the measure.
 - The measure will produce a summary score for domain-level comparisons across facilities, and the calculation of the measure which has a numerator that is the sum of patients assessed negative and patients assessed positive with follow-up. The denominator is all eligible encounters.
 - The intent of the measure is to increase both the percentage of patients that screen negative, and the percentage of patients screening positive with follow-up.
- A TEP participant asked if intervention and follow-up were used as equivalent terms in the presentation.
 - Ms. Dolce confirmed these terms were equivalent.
- A TEP participant asked why declinations in screening were not included in the measure numerator.
 - Dr. DeSilvey noted CMS intends to move away from declinations being an allowable exclusion, as the definition of what is allowable as follow-up is generous and includes providing education about possibilities.
- A TEP participant asked if there is a measure to assess adequacy/success of the follow-up intervention.

- Ms. Dolce responded adequacy and success of follow-up are not yet included, but it could be included in future versions of the measure.
- A TEP participant noted the closing the loop of follow-up may be an inappropriate requirement for hospitals, and they requested the intervention list.
 - Ms. Dolce noted the components of follow-up have not changed since public specification of the process, and she provided the intervention list in the meeting chat (included below).
 - At one time, there was discussion about possibly not counting education, but it was decided that it is important to keep it to offer a gentle on-ramp for the measure.

Action	Definition
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers
Assistance/Assisting	To give support or aid to; help
Coordination	Process of organizing activities and sharing information to improve effectiveness.
Counseling	Psychosocial procedure that involves listening, reflecting, etc., to facilitate recognition of course of action/solution.
Education	Procedure that is synonymous with those activities such as teaching, demonstration, instruction, explanation, and advice that aim to increase knowledge and skills, change behaviors, assist coping and increase adherence to treatment.
Evaluation of eligibility	Process of determining eligibility by evaluating evidence.
Evaluation/Assessment**	Determination of a value, conclusion, or inference by evaluating evidence.
Provision	To supply/make available for use.
Referral	The act of clinicians/providers sending or directing a patient to healthcare professionals and/or programs for services (e.g., evaluation, treatment, aid, information etc.)

* Gravity Project, <https://confluence.hl7.org/display/GRAV/Food+Insecurity>

**This action type will be excluded as it is satisfied by screening

- A TEP participant asked if there was a minimum threshold for the percentage of encounters having an assessment (versus declinations).
 - Dr. DeSilvey responded this was explored with CMS and there is no minimum assessment threshold at this time, but that could be reconsidered in the future.
- A TEP participant noted the team had been busy since the last TEP meeting, noting appreciation for the interim work. This measure appears to assume screening at every encounter, and they asked if there is a provision for recently screened patients (e.g., patients previously seen during the same month).
 - Dr. DeSilvey noted the intent for the inpatient measure is to screen during every encounter, and there is consideration for repeat screening in the outpatient measure.
- A TEP participant noted understanding of the rationale for including declination in the measure and asked about the measure's handling of declination to follow-up (e.g., I have this need, but I don't want your help).
 - Dr. DeSilvey noted declination of follow-up is not one of the current scoring options and the options for follow-up are generous; she stated this could be a potential consideration for a future version of the measure.

All Setting Instrument Selection Criteria

- Dr. DeSilvey reviewed the instrument selection criteria, noting addition of the new criterion “must be relevant to the population and setting of the measure.” The updated criteria include:
 1. Must be relevant to the population and setting of the measure
 2. Must be digitally encoded in instrument terminology standards (presently LOINC)
 3. Must meet validation criteria
 - a. For most domains, the base threshold of validity is face validity, as assessed by domain subject matter experts.
 - b. If a domain has a recognized gold standard instrument (e.g., food insecurity), the threshold rises to require evidence of testing against the standard and meeting at least industry standards of sensitivity (70%) and specificity (70%)
 - c. If no validated instruments meeting the gold standard are practical for clinical use, the requirement to meet the gold standard may be postponed until pragmatic tools are available.

Inpatient Setting Criteria

- Dr. DeSilvey noted there was no change in the inpatient measure criteria; inclusion criteria include patients of all ages with discharge from acute care hospital or critical access hospital (CAH), regardless of prior hospitalizations or known social need, and exclusion criteria include patient died prior to discharge, patients discharged against medical advice, and transfer to another acute care hospital.
 - The measure includes documentation of the screening with an ICD-10-CM code, and when you have a patient that is known to the system to have a social need, simply redocumenting it and driving a coordinated plan on that need counts.

Outpatient Setting Criteria and Measure Definition

- Dr. DeSilvey shared the proposed criteria for the measure adapted for the outpatient setting, noting the inclusion criteria did not change, and includes all patients seen for an eligible visit type based on Current Procedural Terminology (CPT) and HCPCS codes (E&M visits modeled after the Depression Screening and Follow-up measure without Skilled Nursing Facility [SNF]-related codes), with patients not having any CPT or HCPCS codes in the eligible visit list being excluded.
- Dr. DeSilvey noted:
 - The outpatient ASN measure denominator includes patients of all ages with a qualifying visit type, regardless of previous outpatient visits or previously identified social needs.
 - The outpatient ASN measure numerator is satisfied by assessment/follow-up at ANY outpatient visit during the year, including encounters outside the denominator qualifying visit list (such as ED visits).

- Benefits to this approach include that it acknowledges screening may take place at non-qualifying visits but does not require it, it follows clinical practice, it respects the wish of EDs to be acknowledged for work in this space as well as their workload concerns, and it acknowledges CMS’s desire to begin a glidepath to screening accountability in the ED.
 - Although the inclusion of encounters outside of the E&M codes adds a layer of complexity, the binding data standards create a clear path for analysis. Within the denominator of qualifying visits, the measure will query all encounters for:
 - Positive assessment encounters as evidenced by LOINC and relevant ICD-10-CM codes (and their associated SNOMED CT intervention codes);
 - Negative assessment encounters as evidenced by LOINC;
 - Declinations as evidenced by documented SNOMED CT codes; and
 - If none of the above, the patient was not assessed.
 - Timing of screening is aligned with the existing Screening for Depression and Follow-Up measure, and includes assessment documented up to 14 days prior to the encounter and intervention documented up to 2 days post encounter; this aligns with similar measures in the ecosystem and accounts for clinical workflow.
- Dr. DeSilvey shared a table that summarized the comparison of the measure for the inpatient and outpatient settings:

	INPATIENT	OUTPATIENT
Qualifying Encounters	All admissions	Specified evaluation & management visits
Frequency	Every admission, all domains	Once per year, all domains
Measurement Level	Episode	Patient
Timing (Assessment)	Documented during the visit	Documented up to 14 days prior to the encounter
Timing (Follow-up)	Documented during the visit	Documented within 2 days after the encounter

TEP Discussion of Measure Definition and Criteria

- A TEP participant asked if newborns were included.
 - Dr. DeSilvey and Ms. Dolce confirmed it is an all-ages measure that includes newborns.
- A TEP participant requested more details about the inclusion criteria (coding criteria) for the measure. If they were understanding correctly that for inpatient it is anyone that is admitted and on the outpatient side it is a narrower cohort of patients.

- Dr. DeSilvey noted the measure is directly aligned with the existing Depression Screening measure and includes a robust breadth of visit types (e.g., preventive visits, obstetric visits, psychology visits).
- Ms. Dolce shared the measure includes all patients seen for an eligible visit type, including new or existing patient E&M; well patient visits; group instruction visits; a range of gynecology visits; psychiatric diagnostic evaluation; psychotherapy services; evaluative and therapeutic otorhinolaryngologic services; assessment of aphasia and cognitive performance; developmental and behavioral screening and testing; neurobehavioral exam; psychological and neuropsychological testing; health behavior assessment and intervention; physical therapy evaluations; occupational therapy evaluations; preventive medicine; individual counseling; cognitive assessment and care planning; psychiatric collaborative care management; cancer screening; and depression screening. Specific codes include:
 - Patient encounter during the performance period (CPT®): 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, 99078, 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99401*, 99402*, 99403*, 99483, 99492, 99493
 - Patient encounter during the performance period (HCPCS): G0101, G0402, G0438, G0439, G0444
- A TEP member asked about events where the patient is unable to respond and if a family member or friend could respond (and what happens if the patient cannot respond and has no one to respond on their behalf); they requested clarification on what follow-up means, because they thought it could encompass anything from a social worker holding the patients hand to navigate community resources, to offering someone a link to a database of available services.
 - Dr. DeSilvey noted there was a screenshot in the meeting chat (included above) which defined the follow-up categories included in the measure, and stated it was true there is a breadth of possible options that could be considered follow-up for purpose of the measure, which includes everything from offering to connect someone to services and documenting that as education, to the incredibly complex work of care coordination and ongoing care planning. Given the massive process effort for a nationwide systematic screen-and-intervene measure. This was considered a good place to start, and over time the options will narrow so we can hold providers to a higher standard. As we change the intervention qualifying list over time, it will be necessary to look at how that affects other elements in the measure going forward. We are exploring response by proxy because it is an all-ages measure, and we must account for parents responding as a proxy for their young children (12 years of age is the customary

start for autonomous answering of screening instruments). Reporting by proxy is part of the measure specification and included in implementation testing.

- A TEP participant noted the large volume of inpatient and outpatient visits that might qualify for the measure (e.g., 35 million inpatient visits and perhaps a billion outpatient visits), noting the number of times the measure would need to be executed annually; they asked how CORE is thinking about measurement benefit versus burden. They shared there is already a lot packed into the admission and discharge processes and it seems like this is most likely to be captured on the outpatient side. They stated that we all know how cramped providers are for time and they worry about that and wondered what public comment had to say about it.
 - Dr. DeSilvey noted the desire for continuous evaluation of the status of the measure from a process perspective and a willingness to refine as we go. The measure is built for this moment in time when there is a significant requirement for implementing and standardizing the processes that will drive the data that we are evaluating in this measure. There is an intent to see where we are in a few years, and to decide then if we want to refine it. Certainly, the burden consideration was part of specifying the outpatient version of the measure, to ensure we are aligned with best practice. The great thing about an eCQM is that the data will all be standardized, which allows us to think about integrated, right-sized screening and intervention over time. If we are all using the same data elements in all these different settings, we can start thinking about sharing assessments, interventions, and outcomes. The process is the first push and once the process is there and we have initial data, we can figure out how to refine the measure as we go. Hard wiring the data will help us think about the burden responsibly as we move forward.
 - The TEP participant further explained just because it is an eCQM does not mean that it is automated, and there are lots of ways you could gather data. The data is generated, whether it is the patient providing information, or a loved one, or through direct questioning by the care team. Standards help, but somehow the data needs to get into the EHR, and that is where the burden happens. They suggested being mindful of the burden. The risk of not being mindful to burden is that you will get people doing a checkbox approach without the improvement.
- A TEP participant asked whether patient reporting of screening data was allowable. In other words, rather than putting that documentation burden on our staff, is it possible for patients to do it themselves. They asked about regulatory alignment as the Joint Commission already has a requirement to implement around SDOH for all inpatients. As the previous commenter noted it is a burden, and they stated they are already on that journey and through these conversations about standardization and quality, that there is alignment with other government and regulatory bodies. Many of us are currently implementing the HTI-1 legislation (ONC's Health Data, Technology, and

Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing Final Rule). They recommended the work in this swim lane be mindful of the expectation of all other legislative requirements that providers on a nonprofit margin need to comply with for the government to get the numbers it wants.

- Dr. DeSilvey responded that patient completion of a screening instrument to report social need is a best practice. She noted all the HTI-1 requirements are aligned with this measure and the measure was built to comply with it, which is the beauty of aligning with standards. The measure was built to directly align with the National Committee for Quality Assurance (NCQA) Social Needs Screening and Intervention (SNS-E) and CMS Dual Eligible Special Needs Plans (DSNP), and it aligns with as many recommendations as we could possibly fold in.
- A TEP participant provided a counterpoint to some of the previous comments, noting many people on this call have been working toward standardization to build onto the structured data that exists in a lot of silos, and we have worked to get social risk/social needs data into EHRs, and into places where data can be acted on and used in appropriate ways. We have reached a point where it is a priority for CMS to think about systematic data collection. They urged the TEP to think about it through that lens. Yes, there is potential for burden, and on the other hand, as someone who has tried to push for social risk and social needs measures through both inpatient and outpatient programs with mixed results in the last three or four years, CMS's priority will continue to be promoting the systematic collection of data across care settings. What this team is doing is like super-alignment. When you get to a point where the Joint Commission requirement can be met through an eCQM, that is alignment. We know that even CAH are doing this screening, and it is just historically put in the notes with free text where it cannot be used, shared, reported, or measured. They acknowledge the work that is going on by necessity in many communities and would like us to think of this as a shift in how we are meeting these priorities.
 - A TEP participant noted agreement.

Measure Testing Progress

- Ms. Altaf reviewed the testing goals, noting utilization of multiple data sources for initial testing; Alpha testing was being conducted with data from one large hospital and Beta testing was being conducted with data from a data warehouse with access to data from 12 hospitals and outpatient departments.

Alpha Testing

- Ms. Altaf noted Alpha testing is intended to support understanding clinical workflow and identifying where the data is stored in the EHR.
 - Inpatient data was extracted from one large hospital (1,500 beds) using Epic EHR over a 2-year period, and a random sample of 10,000 adult and 10,000 pediatric inpatient encounters was selected.

- Outpatient data (for MIPS) was pulled separately from outpatient departments associated with the same hospital, using a random sample of 10,000 adults and 10,000 pediatric patients with at least one qualifying encounter; all other outpatient encounters during the same 2-year period for those patients were included.
 - Data analyzed included demographics, diagnosis codes (Z-codes), structured flowsheet data referencing SDOH terms, and clinical notes (such as progress notes or social worker notes) using Natural Language Processing (NLP) and other methods to extract data for inpatient and outpatient settings.
- Key takeaways included:
 - The literature indicates use of structured data, but the data are not easily extractable (Alpha testing supported this).
 - For social needs assessment, limited screening occurs in flowsheets, hospitals are not consistently using LOINC codes for screening, very few Z-codes are utilized, and keyword searches reveal social risk assessment in the progress note.
 - Follow-up interventions are difficult to identify and are not directly linked to positive screens.

Beta Testing

- Ms. Altaf noted the Beta testing, which is still ongoing, will capture data element feasibility, measure score approximation across sites for reliability, and data element validity; CORE is approximating measure scores due to inability to test electronic measure specification in the current data ecosystem.
 - It was challenging to identify testing partners due to the aspirational nature of the proposed measure.
 - The clinical workflow was discussed with the testing partner around data capture through an eCQM Feasibility Scorecard to:
 - Identify the extent to which data are readily available in structured formats across the EHR system, if they were likely to be accurate, and if they were coded with a standard terminology;
 - Identify, using a dataset of all inpatient encounters over a 2-year period, demographic factors and diagnosis codes (Z-codes); all structured flowsheet data referencing SDOH terms; and clinical notes (e.g., progress notes);
 - Approximate the measure output across multiple facilities including the percentage of encounters with domains screened and the percentage of encounters with Z-codes;
 - Approximate the measure score using Z-codes, flowsheets, and unstructured notes; and

- Calculate reliability statistics.
 - Signal-to-noise is the proportion of signal out of total variation; it ranges from 0–1, where values closer to 1 indicate having more of a quality signal than noise.

CMCS Testing Overview

- Ms. Altaf shared details of State-level feasibility testing that is currently in process, noting the goal is to facilitate multiple states completing eCQM Feasibility Scorecards supplemented by IQR testing.
 - North Carolina, Rhode Island, and Massachusetts have accepted invitations to participate, and CORE is waiting for responses from New York, Washington, and Michigan regarding participation.
 - Two states declined to participate.

Measure Development Challenges

- Ms. Altaf noted measure development challenges including:
 - Limited implementation of SDOH USCDI standards impacts eCQM testing because standardized SDOH LOINC (screening) and SNOMED CT (intervention) codes are not fully implemented in most facilities.
 - Electronic specifications rely on standardized terminology.
 - There is currently a large push to catch facilities up to the standards.
 - Timeline risk with delays to beginning testing due to the ecosystem not being ready for an eCQM in this area.
 - CORE is expediting testing to complete it before contract closure in March, and working with testing partners to tailor testing needs to suit their current EHR environment, while meeting CMS testing requirements.

Measure importance

- Ms. Thottam noted one of the roles of the TEP is formal standardized assessment of the importance of the Inpatient and Outpatient ASC eCQM, reflecting on whether the measure is easy to understand and if the measure can differentiate good care from poor quality of care.
- Ms. Thottam noted the TEP would be queried via survey following meeting regarding the question of measure importance, with the survey results being shared with the TEP via email.
 - You will be asked to ***“Please specify your level of agreement or disagreement with the following statements via the survey (see below) and provide information regarding why you choose this ranking”*** for each program.
 1. **The Addressing Social Needs Electronic Clinical Quality Measure is easy to understand and useful for decision making.**
Scale: *Strongly disagree, disagree, neutral, agree, strongly agree*

2. The Addressing Social Needs Electronic Clinical Quality Measure could differentiate good from poor quality care among providers (or accountable entities).

Scale: Strongly disagree, disagree, neutral, agree, strongly agree

TEP Discussion of Measure Importance

- Ms. Thottam asked the TEP whether they had any questions or concerns they would like to resolve prior to answering questions on measure importance.
- A TEP participant noted they just met with a hospital that is collecting SDOH information and using it to evaluate readmissions. They are addressing the social needs with the patient, family, and care team during compassion rounds that brings everyone to the table to help reduce readmissions. Their information technology (IT) department used the SDOH data to evaluate readmissions to “slice and dice” the SDOH information and apply it to readmission data. It was eye opening and is helping them create better discharge plans. (several emoji/reactions in support).
- A TEP participant complimented the testing approach and commented they were thinking back to the days of “meaningful use” when we wanted to standardize race and ethnicity data, which essentially applied a major incentive and then ultimately penalties of not meeting the standard of having certified software. We are too early in testing to know that, but it may be that CMS could use the same type of incentive/disincentive process to encourage organizations to start standardizing data collection in that way that will be most useful for this. They did not know if this was good or bad news, but if we were able to accomplish it then, we can accomplish it here too with the right alignment of incentives and mission-driven need.
- A TEP participant noted these are process measures, and asked about when all is said and done, what is the measurable clinical quality outcome we are striving for? The question can this measure differentiate good care from poor care is very qualitative. They asked if there is a specific quality outcome we are targeting to know when we are successful.
 - Dr. DeSilvey noted there is an initial goal and a global goal. The mission of the measure is to create a standard practice that does not yet exist, and like any early process measure, the goal is to implement processes that are not standardized at present. The early goals of this measure are to implement the processes and measure them in order to improve, so we can reach the ideal state of having patients screened either negative or positive, and follow-up when needed. Whether or not that goal is sufficient as a quality outcome on its own is important for the TEP to reflect on.
 - There are also secondary benefits of this that we know will come down the pipe. We understand how significantly social needs impact almost every other major health condition in the ecosystem (e.g., food insecurity. and the Centers for Disease Control and Prevention [CDC] top

ten diseases of concern; homelessness, discharge planning, and readmissions without medical respite).

- One of the things we know when developing this measure and standardizing this process, is screening for and identification of social risks is deeply interconnected with almost every other clinical outcome we can possibly imagine in the ecosystem, which is the reason CMS is leaning into this. It is difficult to control and improve other quality measures if we do not collect this information well.
- A TEP participant noted CMS often uses the wording “a measure differentiating good from poor quality care” in their process recommendations for all their quality measurement programs, and this is not specific to the ASN eCQM. This is ultimately the question CMS asks in all its measurement programs.
- A TEP participant noted the results of alpha testing were not surprising. They asked how these results impact the implementation plan for this measure and how hospitals would be incentivized to adopt standards for screening and easily extractable documentation of that screening.
 - Dr. DeSilvey noted it is clear we are going to need a very gentle “on-ramp”/early signal about this emerging measure, and alignment with other elements in the ecosystem such as the implementation of HTI-1 in 2026, along with a long attestation period before the ASN eCQM enters the reporting programs. This alignment of regulatory drivers is essential to adoption of the measure.
 - Ms. Dolce noted CMS is not the only organization/agency pushing for adoption of these standards, and this follows proposals from other organizations and where the system is signaling they want to go; while this is aspirational, we hope to incentivize it in a few additional ways as we move closer to implementation. By leveraging USCDI, we are aligned with other requirements that are coming down the pipeline (e.g., quality measures, instrument requirements).
 - Ms. Thottam reminded the TEP to expect the aforementioned survey in their email following today’s meeting and stated that the team would share the results with the TEP; she encouraged the TEP to email with any additional questions as they prepare to respond to the questions.

Peer Grouping Discussion

- Ms. Dolce noted consideration of peer grouping as facilities that care for populations with higher incidences of social needs have a higher burden of follow-up activity.
 - The goal is to ensure facilities are not penalized for caring for patient populations with more social needs.
 - Facilities’ scores will be compared to similar facilities based on the peer group method for their CMS reporting program.
- Ms. Dolce introduced the discussion questions:

Program	Grouping	Method
IQR	Proportion of Medicaid patients	Payer Status
MIPS	Proportion of Medicaid patients	Payer Status
CMCS	TBD	TBD

1. What do you think about the use of payer status collected by the measure logic to peer group facilities by **percentage of Medicaid patients** for IQR?
2. How would you propose the **CMCS** program be peer grouped, if at all?

- Ms. Thottam facilitated the round robin discussion and requested the participants respond to both questions during their turn.
- Ms. Dolce shared a reporting example for reference in discussion:

EX Domain	Low Medicaid Percentage			
	# of Encounters	Facility Rate	Peer Group State Rate	Peer Group National Rate
Facility Summary Score	N/A	68%	58%	45%
1. Did not assess patient	40	20%	20%	35%
2. Patient declined assessment	14	7%	18%	12%
3. Patient assessed positive but no intervention/ follow-up action taken	10	5%	50%	39%
4. Patient assessed positive and intervention/ follow-up action taken	16	8%	12%	8%
5. Patient assessed negative	120	60%	0%	6%
Total	200	100%	100%	100%

TEP Discussion of Peer Grouping

- A TEP participant thought peer grouping was hard to decide about because they live in a heavily German neighborhood, and culturally people there are hesitant to share their social needs status because they are proud people, which makes it hard to know when someone needs help. People hide their Medicaid card, and it would be hard to be put into a group like that. For most people, Medicaid is secondary coverage. These are hard-working people, and it is one of those things people where they live hide. The health team here is very good about asking these questions and about using the information

and then even at a meeting I attended this morning they said we really need to know so that they can help people, and if we are going to be asking that question, how do we make sure we are doing that. At first, the health team did not marry the social needs with the readmissions, and then they realized that many readmissions were connected with social needs, and when you can put this information together they can use it to help people understand what it really means to help a family member go to their home (e.g., what does it mean to dress a wound or to give 24-hour care). We started transition (or compassionate) rounds where we do not talk about the illness, and rather we discuss what life is going to be like for the family when the person goes home.

- A TEP participant noted Medicaid is a common proxy for socioeconomic status (SES) as it is simple and straightforward in the hospital setting. They wondered if Medicaid and Medicare dual eligibility was considered because it would align with what is currently going on in the IQR program and Hospital Readmissions Reduction Program (HRRP). They suggested considering hospital bed size for peer grouping. For CMCS, they did not think it should be peer grouped, or at least that it could be a separate group of its own.
 - Ms. Dolce noted these are all things that CORE previously considered and using the Medicaid percentage was the final idea from a lot of conversation. Part of why we are coming to you as a TEP is to revisit the things you feel are important, and CORE is happy to raise these considerations with CMS again. We thought about dual eligibility specifically, and one of our considerations was that it could result in excluding some of the pediatric patients from the measure and would give a different look at the facility type than including all patients.
 - Dr. Laura Gottlieb asked for clarification about reporting of adult and pediatric patients, and whether they would be reported as separate categories.
 - Ms. Dolce clarified CORE is currently planning to report adult and pediatric results together, and stated this question could be re-visited, although we have many categories/percentages being reported already, with six domains potentially split by peer group.
- Dr. Gottlieb recommended additional adjustment characteristics based on literature for quality peer grouping: area deprivation index (ADI)/resources (which has been used by Veterans Administration [VA]), payer mix more broadly (e.g., Medicare, duals), system size/volume, scope/scale of services, geography/census region, and accreditation status.
 - A TEP member expressed support for the elements recommended by Dr. Gottlieb.
- A TEP member noted their agreement with Dr. Gottlieb's recommendation, and in particular the API which has been used by VA and by CMS for other programs' risk adjustment. They stated that the proportion of Medicaid patients seems too narrow and not representative of the unique differences as with some other factors (e.g. ADI, social determinant index). If you were only to use the Medicaid percentage, you would have to consider states beyond the state being measured when you start doing the national

comparisons as some states have expanded Medicaid while others have not, and the state eligibility requirements vary and so that is not a good national comparator. If you were to use something else like ADI, then you could use the same thing across all programs including CMCS.

- A TEP member thought using Medicaid status okay, but not sufficient on its own. They suggested flagging patients who have multiple complex health conditions that may be chronic. A lot of attention is going toward getting the patient's health needs met, which could require the family to spend a lot of money on that along with dealing with insurance refusals for care (especially in Medicare Advantage). That could result in people losing time from being able to attend to their own needs. They suggested thinking about diagnostic criteria that reflects multiple complex chronic conditions that could be applied at any age, and suggested considering needs due to climate disaster (e.g., flooding, fires, earthquakes) leading to a need to deal with all the SDOH at once. A person can be housed one day and the next day their house could slide over the side of a mountain. They could imagine an unintended consequence that if people are asked about SDOH, but then the follow-up interventions are inadequate, by the third time someone is asked without having successful resolution they may just not bother to answer anymore, and declinations could increase even as their need continues. If someone responds once and then declines several times after that it could flag lower quality of care and that patients are not receiving what they need.
 - A TEP participant noted agreement with this point. They personally deal with some social needs because of their multiple conditions resulting from a Healthcare-associated Infection (HAI) but none of their healthcare providers know about them because they are good at hiding them, and so they do not ask about them.
- A TEP participant noted agreement on considering dual eligibility, and unintended consequences due to social driver needs being asked but intervention is inadequate, resulting people not answering the screening tool.
- A TEP participant stated that they were the German person discussed earlier. They thought using Medicaid was probably okay, because of where we are with this measure and the overall challenges with the data, and they agreed with the idea of a slow on-ramp. For where we are with this measure now, it is probably more about building the credibility for providers, so they do not feel they are being unjustly evaluated. Stratification by payment status can be used to provide this type of reassurance and awareness around these issues. That is probably more important than using the most sophisticated methodology because it is too early.
- A TEP participant noted appreciation for the previous comments and the challenge in looking across Patient Protection and Affordable Care Act of 2010 (ACA) expansion states. It is not realistic to do a combined Medicaid/Uninsured category for a variety of reasons, especially on the inpatient side. They noted IQR is pay-for-reporting and MIPS

is voluntary. They recommended tossing out peer grouping for now and suggested just providing context, using the IQR model. IQR currently has a mandatory measure for reporting these rates, and you could report the historic rates for transparency on if there was improvement, rather than just grouping into percentages and comparing them.

- A TEP participant stated for the first question, they thought it made sense to use payer status and the proportion of Medicaid patients to show the patient mix the hospital is serving. Seeing the payer mix is a good standard for the type of population that the hospital is serving. For the second question, they thought continuing the methodology to collect payer status makes sense for CMCS so long as when you are looking at differences in quality between the programs you use the same standard.
- A TEP participant noted they concur with a lot of things already said. Their first impression about peer grouping was that hospitals with higher incidences of social need will need to complete more follow-up actions and thus have higher burdens. That seems like it might have been the impetus behind this peer grouping concept. Their initial impulse was that using Medicaid might be appropriate. They asked if there had been consideration to just using the percentage of patients that screen positive for social need.
 - Dr. DeSilvey shared the team was trying to construct a measure that would not be easily subject to gaming. Thus, they tried to identify an independent variable to allow for peer grouping that was independent of processes at the hospital. When we stepped back from the percent screening positive and considered existing independent variables from the process of screening/intervening, we identified Medicaid status as a proxy.
- A TEP participant noted they have little experience to answer what was most appropriate for peer grouping. They thought alignment and consistency was critically important to make the measure actionable.
- A TEP participant noted specific comments resonated for them. They were unsure if grouping by Medicaid was sufficient, and suggested the overall payer mix may be more important. They highlighted the importance of getting accurate information from patients. The hospital they work with is a safety net hospital and there are issues of trust with patients of color, regarding sharing of information that is accurate.
- Ms. Thottam opened the floor for additional comments/questions and asked the CORE team for impressions.
- Dr. DeSilvey noted gratitude for the expertise and opinions shared from different stakeholder perspectives.
- Ms. Dolce noted the difference in implementation and roll-out due to expanding Medicaid eligibility by states is one of the things they would carry forward from this discussion for the peer grouping options.

- Several TEP participants expressed appreciation of the updates CORE shared and their progress on the measure since the last engagement of the TEP.

Next steps

- Ms. Dolce reviewed the measure development and implementation timeline, noting upcoming measure development next steps in response to the ecosystem signals and additional testing results. These next steps included:
 - 2024 measures under consideration (MUC) submission;
 - A CMS blog post on new standards;
 - Consideration of voluntary reporting in applicable rules for 2026; and
 - Continued measure testing as the ecosystem adapts to USCDI standards.
- Ms. Dolce noted the TEP's feedback will be utilized as CORE continues to develop the ASN eCQM, and the TEP minutes would be distributed on March 7, 2024.
- Ms. Dolce thanked participants and encouraged them to reach out with any additional feedback or questions via email at CMSaddressingsocialneeds@yale.edu.

Appendix C. List of all TEP Members and Information

Table 2. TEP Member Name, Affiliation and Location

Name	Title, Organization	Location
Rosie Bartel	Consumer/Patient/Family Caregiver	Chilton, Wisconsin
Nabil Chehade, MD, MSBS	Executive Vice President, Chief Population and Digital Health Officer, MetroHealth	Broadview Heights, Ohio
Terrisca Des Jardins, MHSA	President, Molina Healthcare of Michigan	Troy, Michigan
Gail Grant, MD, MPH, MBA	Director, Clinical Quality Information Services, Cedars-Sinai Medical Center	Los Angeles, California
Karen S. Johnson, PhD	Vice President, Practice Advancement, American Academy of Family Physicians	Leawood, Kansas
Barbara Kivowitz, MSW, PFA	Consumer/Patient/Family Caregiver	Los Angeles, California
Roger Lacey	Consumer/Patient/Family Caregiver	Des Moines, Iowa
Nikolas Matthes, MD, Ph.D, MPH, MSc,	Measure Developer, IPRO	Lake Success, New York
Ned Mossman, MPH	Director of Social and Community Health, OCHIN	Portland, Oregon
Juan Nañez, RN, BSN	Director of Programs, PHIX-Paso Del Norte Health Information Exchange	El Paso, Texas
Marilyn Parenzan, MBA, RHIA, CPHQ	Project Director, The Joint Commission	Oakbrook Terrace, Illinois
Anand Shah, MD, MS	Vice President, Social Health, Kaiser Permanente	Moraga, California
Shannon Simms, MD, Ph.D, FAMIA	Senior Vice President, Emerging Markets, Vizient Inc.	Chicago, Illinois
Karthik Sivashanker, MD, MPH, CPPS	Vice President- Equitable Health Systems; Medical Director for Quality, Safety, and Equity, American Medical Association; Brigham Health	Norwood, Massachusetts

Name	Title, Organization	Location
Megan V. Smith, DrPH, MPH	Senior Director, Community Health Transformation	The Connecticut Hospital Association, Wallingford, CT
Tressa Springmann, CHCIO, CPHIMSS	Senior Vice President and Chief Information and Digital Officer, LifeBridge Health Systems	Baltimore, Maryland
Walter G. Suarez, MD, MPH, FHIMSS	Executive Director, Health IT Strategy and Policy (KP-HITSP), Kaiser Permanente	Washington, DC
Nālani Tarrant, MPH PMP	Director, Social Drivers of Health, National Association of Community Health Centers	Bethesda, Maryland
Kevin Wake	Consumer/Patient/Family Caregiver	Kansas City, Missouri
Janelle White, MD, MHCM, FAAP	System Medical Director of Community Health, Atrium Health	Charlotte, North Carolina

Appendix D. List of CORE Team Members.

Table 3. Center for Outcomes Research and Evaluation (CORE) Team Members

Name	Role & Team	Team
Faseeha Altaf, MPH	Division Lead	Testing
Kojo Danquah-Duah, MPH	Project Manager	Project & Testing
Sarah DeSilvey, DNP, FNP-C	Project Co-Lead	Project
Leianna Dolce, BS	Project Co-Lead	Project
Karen Dorsey-Sheares, MD, PhD	Senior Project Director	Project & Testing
Floraine Evarado, MPH	Research Support	Project
Amena Keshawarz, PhD, MPH	Division Lead	Project
Tina Loarte-Rodriguez, DNP, RN	Health Equity Associate Director	Project
Katherine O’Hare, MSW	Project Coordinator	Project
Elizabeth Triche, PhD	Director of Digital, Health Equity & Innovation Division	Project & Testing
Brooke Villarreal, DNP, MSN	Associate Director of Digital Product Development	Testing
Nicole Voll, MPH, PMP	Testing Lead	Testing
Nicole Walton, BS	Project Coordinator	Testing