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***RE: National Quality Forum Draft Report: Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors***

Dear Drs. Cassel and Conway:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the National Quality Forum's (NQF) draft recommendations from its expert panel convened to consider whether quality measures should be risk adjusted for sociodemographic factors, such as Medicaid status, income, education and homelessness. Given that NQF-endorsed measures are extensively used in the Centers for Medicare & Medicaid Services (CMS) programs, we address our comments to both NQF and CMS. If adopted by NQF, the panel's recommendations would change NQF's existing measure endorsement criteria to allow NQF-endorsed measures to include sociodemographic factors in their risk adjustment approach when there is a conceptual link to what is being measured, and evidence suggesting adjustment is necessary and appropriate. We commend NQF for convening a highly-qualified expert panel to address this consequential issue, and thank the panel for its balanced, thoughtful and comprehensive review.

**The AHA strongly supports the conclusions and recommendations in the draft report and urges NQF to adopt them as soon as possible. Indeed, the AHA's support of the expert panel's recommendations is rooted in the commitment of America's hospitals to provide high quality care to all patients, and to address health care disparities.** A large body of evidence demonstrates that sociodemographic factors such as income and insurance status affect many patient outcomes, including readmissions and costs. Sociodemographic adjustment allows for all providers to be fairly and accurately assessed on the quality of care they provide and their contribution to patient outcomes while mitigating negative unintended consequences of measurement. Identifying appropriate sociodemographic adjustments also may help to highlight the impact of those factors on patient outcomes, allowing them to be addressed.



If adopted, the implementation of the recommendations would be a complex undertaking for all involved in the quality measurement enterprise. However, the timely and effective enactment of the recommendations is critical. The negative unintended consequences of failing to adjust measures for sociodemographic factors are substantial. **We strongly urge CMS to adopt the NQF panel's recommendations and adjust its measures in its many quality reporting and pay-for-performance programs. Moreover, we urge NQF to place a high priority on working with CMS to rapidly address its measures. Lastly, we concur with the panel's recommendation that NQF expand its role by developing more detailed implementation guidance for measures, and clarifying for what uses a measure is endorsed.**

The AHA's detailed comments are below.

## **WHY RISK ADJUSTMENT FOR SOCIODEMOGRAPHIC FACTORS MATTERS**

Failing to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to worse outcomes. Hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, as the research cited by the expert panel's report demonstrates, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying those other factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities will be diminished.

It has long been known that patient outcomes are influenced by factors other than the quality of the care provided. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. **Risk adjustment is meant to create a "level playing field" that allows fairer comparisons of whether providers are doing all they can to ensure the quality of care.** For this reason, NQF's current measure endorsement criteria require that when there is a conceptual relationship and evidence demonstrating a link between an outcome and *clinical* factors such as age, severity of illness and co-morbid conditions, those factors should be included in risk adjustment. Without risk adjustment, provider performance on most patient outcomes reflect differences in the patients being served, rather than true differences in the underlying quality of services provided.

Despite the substantial evidence that sociodemographic factors such as poverty and insurance status also affect certain patient outcomes such as hospital readmissions and costs, NQF, CMS and others have hesitated to include them in risk adjustment. One commonly cited concern is that sociodemographic adjustment may "mask" information about health care disparities. **The AHA strongly agrees that identifying and reducing health care disparities is critically important. However, as the expert panel correctly identifies, the current approach of not adjusting measure scores in accountability programs for sociodemographic factors actually reveals little about health care disparities.** As noted in the draft report, "neither observed nor [sociodemographically] adjusted performance rates alone can provide any

information on disparities.” In order to determine whether disparities exist, one has to examine scores for *each* sociodemographic group. To understand the factors that contribute to disparities, it is necessary to conceptualize what factors might be associated with the outcomes of interest, and then to analyze the relative role of each of those factors in leading to the outcome. The current approach used to measure and report outcomes, such as CMS’s measures of mortality, readmissions and cost per beneficiary, does not include this type of analysis, and effectively assumes that any disparities in outcomes are attributable only to either how sick the patient is or to the quality of care provided by the hospital. By contrast, the development of risk adjustment for sociodemographic factors would reveal more information about the potential underlying causes of disparities. Indeed, in order to apply sociodemographic adjustment, measure developers would need to proactively identify and analyze sociodemographic factors associated with patient outcomes, making them more visible and more likely to be addressed.

Some observers assert that socioeconomic adjustment creates a lower standard of care for providers treating disadvantaged patients. **This is not the case. Such adjustment would more accurately hold all of the providers being measured to the same standard of care.**

**Adjusting for community factors that influence outcomes would enable more accurate comparisons of the quality of care provided by eliminating confounding factors beyond providers’ control.** The application of sociodemographic adjustment has the same intended purpose as risk adjustment for clinical factors – to create more accurate and fairer comparisons of the quality of care provided. To be clear, we support sociodemographic adjustment only for those measures where there is a conceptual link to the outcome being measured, as well as evidence of an effect. For example, a measure of hospital-acquired central-line blood stream infections is unlikely to warrant sociodemographic adjustment because the outcome is influenced only by a patient’s severity of illness and the interventions provided by the hospital. However, for outcomes such as readmissions, the inclusion of sociodemographic factors in risk adjustment acknowledges that a patient’s outcome can be influenced by community factors, such as the availability of pharmacies, public transportation to get to needed follow-up appointments or other resources that support patient recovery.

**Moreover, if measures are not adjusted for sociodemographic factors when necessary and appropriate, then providers are inappropriately being held accountable for issues such as poverty and lack of appropriate resources in the community they serve.** Further, the public could be misled into believing the care provided by those serving disadvantaged communities is of lesser quality than it actually is, and that the care provided by those serving the most advantaged populations is better than it actually is. Payment systems built from unadjusted measures would unfairly limit reimbursement to those serving disadvantaged communities, reducing their ability to provide needed services to their patients, while rewarding those providers serving advantaged communities.

**In the long run, the lack of sociodemographic adjustment could actually entrench health care disparities, to the detriment of both patients and providers.** Early experience with the hospital readmissions program clearly demonstrates that hospitals caring for the poorest patients are disproportionately more likely to incur penalties under the program because the measures are not adjusted for sociodemographic factors. Data from the fiscal year 2014 inpatient prospective payment system final rule show that approximately 77 percent of hospitals in the top decile of disproportionate share hospital (DSH) payments, which reflects how many

impoverished patients hospitals treat, incur a readmissions penalty. By contrast, only 36 percent of hospitals in the lowest DSH decile will receive a penalty.

In response to these compelling data, many observers have responded that sociodemographic adjustment is still unnecessary because some providers treating disadvantaged populations have achieved better outcomes on some measures than other providers. The AHA is proud that many hospitals have succeeded in achieving positive outcomes despite the challenges of serving disadvantaged communities. However, the success of these hospitals is not sufficient justification for failing to adjust for the impact of sociodemographic status. Instead, the high-performing hospitals are worth studying and emulating because they have succeeded despite a lack of sociodemographic adjustment that leads to an understatement of their true level of performance.

## **RECOMMENDATIONS FOR IMPLEMENTATION**

While we understand that the review process for these recommendations is not yet finalized, if they are adopted by NQF, their timely and effective implementation is absolutely critical to improve the fairness and accuracy of accountability programs.

**We strongly urge CMS to adopt the panel's recommendations given the need for sociodemographic adjustment of measures in several of its programs. Moreover, given that most providers are affected by CMS's reporting programs, we urge NQF to work with CMS to address those measures in the initial stages of implementing the panel's recommendations. Lastly, we encourage NQF to adopt the panel's recommendation to expand NQF's role by developing more detailed measure implementation guidance, and clarifying for what context a measure is endorsed.**

Review of the NQF portfolio. As an initial step to facilitating CMS's uptake of the panel's recommendations, we urge NQF to undertake a review of its portfolio of endorsed measures in order to identify which measures currently used in CMS's programs could benefit from sociodemographic adjustments. NQF could use a variety of mechanisms to identify those measures, such as reviewing previously submitted public comments when measures were submitted for endorsement. For example, the AHA and several other groups have urged that the readmissions measures and the Medicare spending per beneficiary measure be adjusted for sociodemographic factors. NQF also could solicit input from the public, CMS and measure developers who may wish to update their measures.

Once the list of measures possibly needing adjustment is identified, NQF should develop a process to get the measures reviewed, and if needed, updated with sociodemographic adjustments. This process would need to give measure developers an adequate amount of time to assess and appropriately adjust measures, as well as consider NQF's measure endorsement cycle. NQF measures are endorsed for a three-year period. During this period, measures receive minor updates through an annual review process. At the end of the endorsement period, measure developers are required to re-submit detailed measure specification and testing data through a process called "maintenance review." However, NQF also provides another mechanism – known

as *ad hoc* review – that allows for substantive changes to be made to measures during the three-year period. For example, *ad hoc* reviews have been used to expand the endorsement of a measure to cover more types of providers (e.g., expansion of an infection measure to include post-acute facilities as well as inpatient hospitals). We believe the inclusion of a sociodemographic adjustment would qualify as a “substantive change” under NQF’s current *ad hoc* review criteria.

**The AHA recommends that NQF use a combination of *ad hoc* reviews and the maintenance review process to ensure that measures are updated in a timely manner.** In general, if a measure is due for a full measure maintenance review in less than one year, then it would be sufficient to ask the measure developer to assess the measure against the new criteria for sociodemographic adjustment, and incorporate any warranted adjustment by the time the measure is submitted. However, for other measures that will continue to be endorsed for an additional one to three years, NQF should initiate *ad hoc* reviews. In implementing the *ad hoc* reviews, measure developers could be given a 30- to 60-day period to review their measures in order to determine whether an adjustment is needed. NQF should work with those developers who may need extended time to develop an adjustment approach to determine whether to review the changes during an *ad hoc* review or at the time of measure maintenance. Finally, CMS could incorporate the measures into its programs by proposing them no later than the time of the next annual payment rules.

The need for more explicit implementation guidance from NQF. **The AHA strongly supports the expert panel’s recommendation that NQF provide more explicit guidance on the implementation of its endorsed measures, including guidance on how measures should be used in specific programs.** Although NQF-endorsed measures are extensively used in accountability programs, NQF’s endorsement process does not explicitly consider how specific programs are constructed. Yet, it is clear that how a measure actually is implemented affects how well a measure works in a given program. In the context of the expert panel’s recommendations, implementation guidance would ensure that measure implementers correctly apply the risk adjustment methodology.

To date, unfortunately, some measures that carry the label “NQF endorsed” have been used in a manner inconsistent with how the measure actually obtained that endorsement. For example, the AHA has long been concerned about the reliability of the claims-based Patient Safety Indicators (PSIs) used in several CMS programs such as the hospital inpatient quality reporting program, value-based purchasing program, and hospital-acquired conditions reduction program. Several PSIs obtained NQF endorsement based on measure testing data from all-payer claims data. Nevertheless, in implementing the measure, CMS uses Medicare-only claims. As a result, the PSI measures, which already have significant reliability issues, become even less reliable, as demonstrated by a CMS-commissioned study released in 2012. In this case, NQF guidance could have cautioned that measure reliability is not guaranteed if the measure is not used in an all-payer context.

**The AHA also urges, as requested by the expert panel, that NQF make more explicit that a performance measure is endorsed for specific care settings, patient populations, data sources and levels of analysis (e.g., facility, health plan, individual clinician).** Indeed, the

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ability of a measure to accurately portray performance is based on how the measure is tested. Unfortunately, there are instances in which measures are used in ways inconsistent with how they are specified and tested. For example, CMS finalized a measure assessing the proportion of patients experiencing one or more major falls with injury for the long-term care hospital quality reporting (LTCHQR) program. While we agree that reducing patient falls is a critically important goal, the measure in the LTCHQR is specified, tested and received NQF endorsement for use in nursing homes, and does not fit LTCHs because the specifications are designed for collection using a nursing home patient assessment instrument. The practice of using measures for one care setting and applying them to another without adequate specification and testing compromises the accuracy and credibility of measure results, making it difficult to determine whether improvements are being realized.

Thank you for the opportunity to comment on this important work. If you have questions, please contact me or Akin Demehin, senior associate director for policy, at (202) 626-2365 or [ademehin@aha.org](mailto:ademehin@aha.org) or Nancy Foster, vice president of quality and safety policy, at (202) 626-2337 or [nfoster@aha.org](mailto:nfoster@aha.org).

Sincerely,

/s/

Rick Pollack  
Executive Vice President