AAMC Suggested Comments for
NQF Draft Report on Risk Adjustment for Sociodemographic Factors

Background:
On March 18, the National Quality Forum (NQF) released an important draft report concerning sociodemographic status and risk adjustment. The report, which contains eight recommendations, was produced by an NQF expert panel of 26 individuals representing a diverse group of stakeholders (including Atul Grover, M.D., from the AAMC). These recommendations were approved by the vast majority of panel members. If finalized, the recommendations would change NQF’s policy to allow sociodemographic variables to be a factor in the risk-adjustment methodology for certain accountability measures.

It is important for AAMC member institutions to submit comments.

NQF is accepting general comments on the report and on each of the eight recommendations. The AAMC believes there will be many organizations submitting comments on this report and strongly encourages teaching hospitals and faculty practices to weigh in and support this report and its recommendations. For your convenience, we have included support language in this document. Please feel free to use all or part of the comments below, and to supplement these comments with experiences from your own institution.

Comments were submitted on April 15, 2014 at the following portal:
General Comments:

The AAMC strongly supports the recommendations in this draft report as a first step to improved quality measurement. As measurement shifts from simple process measures to complex outcome and resource measures, patients and providers will benefit from NQF policies that encourage robust risk adjustment and are flexible enough to consider the purpose and specifics of individual measures. Programs such as CMS’s Hospital Readmission Reduction Program (HRRP) show the unintended consequence of not adjusting for sociodemographic variables in a pay-for-performance program: safety-net providers lose scarce resources necessary to care for vulnerable patients which potentially entrenches disparities.

The new recommendations hold providers accountable for their performance. Experts on the steering committees will have the flexibility to review and assess the impact of sociodemographic factors within the context of each measure and, in most cases, we believe these factors should be included in risk adjustment. The recommendations appropriately note the need for better data to fully risk adjust; and the need for guidance to properly implement these measures which has often been absent or not followed.

The report clearly identifies the key issues related to risk adjustment and their importance to patients and providers while acknowledging the challenges in collecting sociodemographic data. The AAMC strongly recommends that NQF adopt these recommendations and that NQF, CMS, and other payers should implement the recommendations as soon as possible.

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Recommendation 1: When there is a conceptual relationship (i.e., logical rationale or theory) between sociodemographic factors and outcomes or processes of care that is not primarily mediated by quality of care, and empirical evidence that sociodemographic factors affect an outcome or process of care reflected in a performance measure, the analytic method should differ based on the purpose as follows:

- *For purposes of accountability* (e.g., public reporting, pay-for-performance), those sociodemographic factors should be included in risk adjustment of the performance score (using accepted guidelines identified in #3) unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate; and

- *For purposes of identifying and reducing disparities*, performance measures should be stratified on the basis of relevant sociodemographic factors when used in analysis by individual providers, policymakers, researchers, and the public working to reduce disparities.
Comments for Recommendation 1:

The AAMC supports recommendation 1 as currently written. Academic centers are committed to serving and improving the health for all patients of all demographic, socioeconomic, and clinical backgrounds. Adjusting for patient factors can help both improve health care and reduce disparities.

This recommendation recognizes that measurement has different purposes which require different risk adjustment needs. Programs such as CMS’s Hospital Readmission Reduction Program (HRRP) show the unintended consequence of not adjusting for sociodemographic variables in a pay-for-performance program; safety-net providers lose scarce resources necessary to care for vulnerable patients which potentially entrenches disparities. Excluding sociodemographic factors from accountability measures can create an incentive for some providers to avoid those patients.

The recommendation also stresses the importance of reporting both risk-adjusted and unadjusted measures to identify disparities.

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Recommendation 2: The NQF criteria for endorsing performance measures used in accountability applications (e.g., public reporting, pay-for-performance) should be revised as follows to indicate that patient factors for risk adjustment include both clinical and sociodemographic factors:

2b4. For outcome measures and other measures when indicated (e.g., resource use, some process): an evidence-based risk-adjustment strategy (e.g., risk models, risk-stratification) is specified; is based on patient factors (including clinical and sociodemographic factors) that influence the measured outcome (but not primarily mediated by the quality of care factors related to disparities in care or the quality of care) and are present at start of care;14,15 and has demonstrated adequate discrimination and calibration OR rationale/data support no risk adjustment/stratification.

14. Risk factors that influence outcomes should not be specified as exclusions.

15. Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care, such as race, socioeconomic status, or gender (e.g., poorer treatment outcomes of African American men with prostate cancer or inequalities in treatment for CVD risk factors between men and women). It is preferable to stratify measures by race and socioeconomic status rather than to adjust out the differences.
Comments for Recommendation 2:

The AAMC supports recommendation 2 as currently written. The current policy to exclude “factors related to the disparities in care” from all measures creates a one-size-fits all approach which creates unintended consequences for patients when it is applied to public reporting and pay-for-performance programs.

This change adds flexibility to the NQF policy. Experts reviewing measures can now consider ALL patient factors (clinical and sociodemographic) for risk adjustment for accountability purposes and to ensure that provider performance is as accurate as possible.

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Recommendation 3: The same guidelines for selecting clinical and health status risk factors for adjustment of performance measures may be applied to sociodemographic factors and include the following:

• Clinical/conceptual relationship with the outcome of interest
• Empirical association with the outcome of interest
• Variation in prevalence of the factor across the measured entities
• Present at the start of care
• Does not represent the quality of care provided (e.g., treatments, expertise of staff)
• Resistant to manipulation or gaming
• Accurate data that can be reliably and feasibly captured
• Contribution of unique variation in the outcome (i.e., not redundant)
• Potentially, improvement of the risk model (e.g., risk model metrics of discrimination, calibration)
• Potentially, face validity and acceptability

Comments for Recommendation 3:

The AAMC supports recommendation 3 as currently written. Appropriate inclusion of sociodemographic and clinical factors will improve risk adjustment.

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**Recommendation 4:** When there is a conceptual relationship and evidence that sociodemographic factors affect an outcome or process of care reflected in a performance measure submitted to NQF for endorsement, the following information should be included in the submission:

- A detailed discussion of the rationale and decisions for selecting or not selecting sociodemographic risk factors and methods of adjustment (including a conceptual description of relationship to the outcome, empirical analyses, and limitations of available sociodemographic data) should be submitted to demonstrate that adjustment incorporates relevant sociodemographic factors unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate.
- In addition to identifying current and planned use of the performance measure, a discussion of the limitations and risks for misuse of the specified performance measure.

**Comments for Recommendation 4:**

The AAMC supports recommendation 4. This recommendation ensures that the NQF steering committees have the ability to evaluate whether a sociodemographic adjustment is appropriate for a specific measure. It also ensures that the reasons sociodemographic adjustments are included (or excluded) are transparent and open to public comment.

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**Recommendation 5:** When performance measures are used for accountability applications such as public reporting and pay-for-performance, then purchasers, policymakers and other users of performance measures should assess the potential impact on disadvantaged patient populations and the providers serving them to identify unintended consequences and to ensure alignment with program and policy goals. Additional actions such as creating peer groups for comparison purposes could be applied.

**Comments for Recommendation 5:**

The AAMC suggests recommendation 5 should be strengthened. While NQF is not responsible for implementing measures, NQF should have a strong policy to encourage all measure users to identify potential inequities that can arise from implementing measures. As such, we believe users of performance measures “must” assess the impact on disadvantaged populations.

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Recommendation 6: NQF and/or others such as CMS, Office of the National Coordinator (ONC) for Health Information Technology, and the Agency for Healthcare Research and Quality (AHRQ) should develop strategies to identify a standard set of sociodemographic variables (patient and community-level) to be collected and made available for performance measurement and identifying disparities.

Comments for Recommendation 6:

The AAMC supports recommendation 6. One limitation to including sociodemographic variables in risk adjustment is the lack of reliable and consistent data. Having a better set of variables will help to identify disparities and more properly adjust provider performance. Any additional data collection and reporting should be accompanied by an adequate investment in building a standard data set.

Recommendation 7: NQF should consider expanding its role to include guidance on implementation of performance measures. Possibilities to explore include:

- guidance for each measure as part of the endorsement process;
- guidance for different accountability applications (e.g., use in pay-for-performance versus pay-for-improvement; innovative approaches to quality measurement explicitly designed to reduce disparities).

Comments for Recommendation 7:

The AAMC supports recommendation 7 as currently written. NQF measures go through a deliberate measure review process, but once the measure is endorsed, there is no corresponding process to evaluate whether the measure is being applied appropriately in accountability programs. NQF should integrate implementation considerations into the measure review process. Providing guidance on measure implementation is the first step to addressing this gap.
**Recommendation 8:** NQF should make explicit the existing policy that endorsement of a performance measure is for a specific context as specified and tested for a specific patient population (e.g., diagnosis, age), data source (e.g., claims, chart abstraction), care setting (e.g., hospital, ambulatory care), and level of analysis (e.g., health plan, facility, individual clinician). Endorsement should not be expanded without review and usually additional testing.

**Comments for Recommendation 8:**

The AAMC supports recommendation 8 as currently written. This recommendation does not change NQF policy, but it highlights a very important point: NQF endorsement applies only to the detailed specifications and testing that was submitted to NQF. NQF-endorsed measures are not always used as specified. CMS has applied measures designed for one type of provider in other programs without sufficient testing of those measures. For example, measures approved for the outpatient reporting hospital program had to be suspended because the data collection mechanism was designed for physicians’ offices. While NQF does not enforce implementation of its measures, it needs to be clear about what an endorsed measure is and how it should be used.