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November 29th, 2018

Re: Measuring Disparities in Hospital Outcomes

To Whom It May Concern:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) efforts to measure disparities in hospital outcomes. The AAMC is a not-for-profit association representing all 152 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents nearly 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

For the past several years, the AAMC has been an active participant in the national dialogue on how best to account for social risk factors (SRFs) in quality measurement and value-based payment models. We firmly believe that the valid measurement and incorporation of individual- and community-level SRFs can help eliminate disparities in health and healthcare and has multiple benefits.

First, adjustment for SRFs raises awareness of the measurable, systematic, avoidable, and unjust differences in health and healthcare outcomes pervasive in our health system and society. Second, valid adjustment for and / or stratification by SRFs in assessing quality can, to some degree, help ensure safety net providers are not unfairly penalized for SRFs that may impact outcomes regardless of the quality of care received. Finally, if formally adopted into payment models, valid measurement of individual- and community-level SRFs **when used to isolate true quality differences** can support the development of incentives that will drive health systems forward as they innovate to close or minimize healthcare gaps.

We applaud CMS for leading the charge on the development of the methodological foundation that will eventually allow disparities measurement – and the actions incentivized by such measurement – to play a major role in the narrowing of healthcare inequities.

However, the methodology for measuring healthcare disparities proposed by Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) is not the foundation upon which we should build**. It sacrifices validity for what is currently feasible, and its proposed categorization of race/ethnicity will undermine the important goal of using measurement to incentivize healthcare equity.**

We urge CMS to pause given our following concerns:

1. **The CORE-chosen SRFs at best inadequately isolate true quality differences and at worst will mask them.**

Dual Eligibility (DE) status, the primary SRF chosen by CORE has long been used as a proxy for socioeconomic status given the income thresholds that define it. As noted in the request, evidence does exist that DE patients have poorer health outcomes than non-DE patients.

However, because of that correlation with poverty, DE status is also related to many other individual- and community-level SRFs that directly impact the healthcare outcomes of interest to CMS.

In a forthcoming article (analyses available upon request) we demonstrate that the positive relationship between a *county's* proportion of DE residents and its readmission rate is partially confounded by three relevant SRFs: county level air pollution, food insecurity, and housing instability. Indeed, the inclusion of those three SRFs in our model increases the proportion of readmission variance explained by 61%: it is a much better fit. **Without adjusting for other relevant SRFs, CORE's proposed methodology likely fails to adequately isolate measured quality differences and, should it be adopted into payment schemes, will penalize hospitals for gaps that are 'inflated' due to this lack of proper adjustment.**

Further, our analyses show that hospitals vary widely in terms of their DE patients' potential exposure to SRFs. In our analysis, for example, some hospitals treat DE patients from counties wherein 5% of residents are food insecure while other hospitals treat DE patients from counties wherein 33% of residents are food insecure. **Any between hospital comparison that assumes all hospitals' DE patients are the same is essentially invalid**.

Race/Ethnicity, the secondary SRF explored by CORE, is even more problematic as conceptualized.

First, it should be noted that there is widespread agreement that **race/ethnicity should not be used as a proxy for social risk factors**.[1] That fundamental disqualification aside, **CORE's categorization of race/ethnicity is antithetical to the stated goal of deploying quality measurement to address inequities**.

Health and healthcare inequities exist for many racial and ethnic groups including Blacks, Latinx, Native Americans/Alaska Natives, and Asian Americans. Historically, inequities in health and healthcare have been identified by comparing a given outcome for whites to that same outcome for a non-privileged racial/ethnic group. While the merits of a white referent category should be and has been debated, what has never been debated is **the illogic of putting whites into the same category as racial/ethnic minority groups when identifying the existence and magnitude of health inequities.**

It is impossible to understate the potential harm this methodological flaw could yield for racial / ethnic groups that suffer from unfair healthcare differences. The statistical mixing will grossly attenuate any true Black-white differences, making inequities much more difficult to find. What we can't find, we can't fix.

[1] National Quality Forum. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors, technical report. July 2, 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

The AAMC strongly suggests CMS abandon any plans for "Black / not-Black" comparisons. If, as stated in the RFI, "…the only groups that have been shown to be reliably distinguishable are white and black" **then only "white-Black" differences should be assessed** if CMS is committed to exploring racial healthcare inequities at this time.

2. **CORE's reliance on what is immediately feasible comes at validity's expense.**

In its technical methodology report, CORE claims that "Taken together, our results show that the Within-Hospital Disparity Method and the Dual/Race Outcome Rate Method are technically feasible."

The AAMC urges CMS to set the bar higher and move beyond "feasible" and toward "accurate and actionable". While use of DE status may ultimately be a 'transitional' methodology, it is crucial we set our sights on a longer-term, more valid measurement strategy.

The National Quality Forum's Disparities Standing Committee noted in its recent report that the lack of robust, national SRF data collected at meaningful levels (i.e. both patient and patient's home community) made the empirical testing of well-specified conceptual models difficult if not impossible.[2] That is true. However, when the alternative relies on two SRF proxy variables that either fail to account for statistical confounding (DE status) or work against the accurate identification of heathcare inequities (Black / not-Black), **the quality measurement community can better serve our nation's patients and communities by developing a long-term measurement strategy that prioritizes accuracy over expediency.**

The AAMC strongly urges CMS to develop a methodology that is more comprehensive and holistic in its approach to SRF measurement.

Specifically, the AAMC encourages CMS to lead a national research and measurement agenda that:

a. **Identifies the most impactful SRFs**. We do not now know which patient- and community-level SRFs impact the greatest number of health and healthcare outcomes. For example, while exposure to air pollution might be important to consider for pneumonia readmissions, its impact on hip replacement readmissions might be negligible. We urge CMS to support large scale, multi-level secondary data analysis that aims to identify a core set of "priority SRFs" relevant for a wide array of health and quality outcomes. **Scientists from AAMC member institutions consider the following SRFs to be both broadly impactful and measurable, and encourage CMS / CORE to explore**:
    i. Composite indices of neighborhood deprivation at meaningful, neighborhood geographies
    ii. Housing instability
    iii. Social isolation / living alone
    iv. Transportation access (both personal and community)
    v. High school graduation
b. **Standardizes definitions and response categories for those "priority SRFs"**. Health systems across the country have developed and deployed SRF screens that meet the needs of their

[2] National Quality Forum. Evaluation of the NQF trial period for risk adjustment for social risk factors final report. July 18, 2017. www.qualityforum.org/Publications/2017/07/Social_Risk_Trial_Final_Report.aspx

specific communities. Similarly, national efforts by CMMI, Health Leads, NASEM and others have facilitated the development of SRF screening tools. While such diversity can enhance local efforts, it moves us further away from the kind of robust, national data set(s) that would allow for valid SRF adjustment.

c. **Investigates data collection methodologies to identify those that yield the most valid SRF data.** Once identified and standardized, "priority SRF" variables – often highly personal and sensitive – need to be collected in ways that ensure accuracy of response. Do patients respond more truthfully to a nurse? A primary care physician? Through a patient portal? And do preferences vary between patient communities?
d. **Stratifies and / or adjusts for those "priority SRFs" in ways that allow for apples to apples comparisons without masking true differences in care quality.** Comparing the DE readmission rate of a hospital where 5% of its DE patients are food insecure to a hospital where a third of its DE patients are food insecure is not valid. Stratification on quality metrics by conceptually important and accurately measured SRFs will ensure that comparisons are just and that "positive deviants" can be identified so that their success can be learned from and replicated.

Because the **AAMC shares your commitment to realize the promise of quality measurement's role in minimizing healthcare disparities, we again urge CMS to pause to consider how to transition from a DE-based methodology to a more valid and action-oriented one**. We recognize we are in a window of opportunity to develop quality measurement strategies that address healthcare inequities, and the AAMC and its constituents are eager to "do something". However, history and common sense tell us that retrofitting methodologies once new data and tools come online is Sisyphean when cultures and processes are already in place. If the proposed DE methodology is adopted in the absence of a longer-term plan, the opportunity window will close and we will fall far short of our potential impact.

We understand that the research we suggest to identify priority-SRFs will take time. We further understand that the development of national standards and data collection processes will require substantial investments of money, personnel, and other resources.

We believe, though, that **the communities and populations that systematically experience inequities in care access and quality deserve better** that what is currently proposed. Specifically, they deserve to have the quality of their care and its outcomes accurately assessed. They deserve a methodology that will not 'hide them', likely attenuating inequities to the point of the erasure of any real differences in care quality they receive. And they deserve a methodology that offers insight into the appropriate actions a provider, hospital, or community can take to move our society closer to health and healthcare equity.

The proposed methodology fails on all three counts.

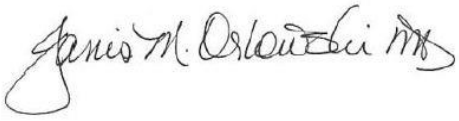
Finally, while the academic medicine community is supportive of CMS' efforts to reduce healthcare inequities through awareness raising and disparities measurement, the AAMC also urges CMS to consider **how to incentivize <u>healthcare equity</u> through its measurement programs**. Healthcare equity implies that all patients regardless of social characteristics or "risk factors" have – *and perceive that they have* – the same health-promoting opportunities as everyone else when they walk into a hospital or clinic. **Deep, authentic patient- and family-engagement** will be required to develop measures of "healthcare equity", and CMS may need to incentivize hospitals and providers to invest in the

development of the workforce, data infrastructure, and multi-sector partnerships required to create equitable opportunity for health. If the measurement community solely focuses on disparities, we fail to keep our eyes on the prize.

We welcome the opportunity to continue to help CMS identify ways to advance its disparities measurement efforts to ensure maximal impact for patients and communities. Please contact our colleague Philip M. Alberti, Ph.D. Senior Director, Health Equity Research and Policy at (202) 828-0522 to discuss ways that we can collaborate with you to reduce disparities and improve quality of care for patients.

Sincerely,

Ross M. McKinney, MD
Chief Scientific Officer



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