

# Consumer-Purchaser ALLIANCE

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National Quality Forum  
1030 15th Street NW  
Suite 800  
Washington, DC 20005

April 16, 2014

## **Re: Draft Report on Risk Adjustment for Sociodemographic Factors**

Dear Dr. Cassel,

We are writing on behalf of the Consumer-Purchaser Alliance (C-P Alliance) – a collaboration of leading consumer, employer and labor groups working together to promote the use of performance measurement in health care to inform consumer choice, value-based purchasing, and payment. Our mission is to strengthen the voice of consumers and purchasers in the quest for higher quality, more affordable health care. We thank the National Quality Forum (NQF) for the opportunity to comment on this important topic area and applaud the Technical Expert Panel (TEP) for its diligence and attention to this complex and important issue.

The TEP was charged with answering the question, “what, if anything should be done about sociodemographic factors in relation to outcome performance measurement?” Current NQF policy states that clinical factors, such as disease severity and comorbidities, are the only appropriate reasons for risk adjusting a performance measure, out of a desire to make disparities visible in order to motivate efforts to improve care for disadvantaged populations.

### **Major Recommendations from the TEP**

The majority of the TEP recommended that risk adjustment based on sociodemographic factors be applied to certain measures used in accountability programs (pay-for-performance and public reporting) if certain conditions are met. The recommendation was based on the belief that “current policy is unintentionally weakening the network of providers that serve disadvantaged populations, which could end up worsening disparities.” In accordance with that view, the TEP also recommended altering the current NQF criteria to allow for sociodemographic adjustment “sometimes” instead of “never” (as reflected in existing criteria).

### **Overarching Comments**

Our perspective is grounded in the belief that performance measurement should enhance our ability to identify and eliminate disparities. We are deeply worried that the proposed change in NQF risk adjustment criteria would obscure our ability to see differences in outcomes that correlate with sociodemographic factors. However, we are also concerned about the unintended consequences of using outcome measures in accountability strategies (payment and reporting) that could result in additional harm to disadvantaged populations by inappropriately penalizing

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providers working with these populations, reducing the resources available for such providers to improve care for these populations, or by inadvertently making it more difficult for disadvantaged patients to find willing providers and access to the care they need. Given these concerns, we propose thorough consideration of an approach in which the measures themselves are not risk adjusted for sociodemographic factors, but instead appropriate adjustments are made in the application of provider accountability strategies. This would enable us to continue to see the true extent of variations in outcomes for different populations.

We also believe it is extremely important that we not promote a cramped definition of what constitutes the provision of good quality care by providers. It is true that providers cannot control all aspects of patient outcomes and that patient choices, life circumstances, sociodemographic factors and the availability of community resources can all contribute to outcomes. Nonetheless, we have evolved well-beyond the point of defining good care as simply following established standards within the confines of the care setting. We increasingly strive for patient- and family-centered care, recognizing that such care is essential to achieving the good outcomes we seek for all populations. Providers are increasingly learning how to “meet their patients where they are,” recognizing the role of non-medical factors, and adapting care practices to address patients’ needs and circumstances. Many safety net providers are now achieving significant improvements in outcomes among patients facing very challenging life circumstances (outside of the healthcare system). We believe this progress could be seriously undermined by the position that adjusting for sociodemographic factors achieves a truer picture of the quality of care providers deliver. Instead, we should be advancing the position that high quality care must be patient-centered and requires more than adherence to clinical standards.

Finally, we have an overarching concern that there is not a sufficient evidence base for the underlying assumptions about unintended consequences from which the TEP recommendations derive.

We further elaborate on these concerns below.

## **The evidence for policy change is not sufficient**

The recommendation to risk-adjust for patient-level sociodemographic factors is not accompanied by sufficient evidence showing that the current policy is resulting in harm to disadvantaged patients. Further, the recommendations are not grounded in evidence that any of the proposed actions would *prevent* or *preclude* harm from occurring. This is inconsistent with NQF’s standards of scientific acceptability. Basing decisions on sufficient evidence is a core tenet of NQF’s activities and foundational to the measure endorsement process. It is critical that NQF

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continue to safeguard this reliance on research and science. Diminishing one of NQF's core principles could potentially undermine the larger measurement enterprise.

### **Potential for negative impact on the measure development and endorsement process**

We applaud NQF for including multiple measure developers on the TEP. Based on the report language, however, it is still unclear to what extent (a) risk adjustment for sociodemographic factors is expected, and (b) measure developers should be prepared with corresponding evidence. This has been discussed in the various town halls that NQF has coordinated following the public release of this report. Both NQF staff and members of the TEP have confirmed that this report language will be clarified. We believe this is a critical step in mitigating any confusion around measure developer expectations which might make them less likely to submit proposed measures for endorsement. We also believe the lack of specificity creates the potential danger that Steering Committees may come to expect that risk adjustment for sociodemographic factors will be used in most performance measures. We oppose any recommendation that sociodemographic adjustments are presumed necessary and that measure developers must prove otherwise before presenting a measure for endorsement. This type of broad interpretation of the recommendations would not do justice to the thoughtful qualifiers included in the TEP deliberations and could foster Steering Committee misinterpretations that lead to fewer meaningful outcome measures emerging from the endorsement process.

A range of consumers, purchasers, and measure developers have also questioned the feasibility of measure developers collecting sociodemographic information needed for certain risk adjustment. There is apprehension about lengthening the time it takes for measure developers to bring measures forward for endorsement evaluation. Further, requiring developers to collect this information for their measures could lead to a lack of standardization and eventually questions regarding measure validity. The Expert Panel did, itself, point out that the lack of high quality and readily available sociodemographic data presents a major barrier to implementing its recommendations. The recent Tri-Committee SGR bill recognized this important limitation and proposed significant federal support for efforts to identify sociodemographic data and analyze its effects on performance measurement to inform future payment policy. However, the Tri-Committee SGR bill has not been enacted and the legislated temporary patch does not provide federal support to address the challenges in identifying and collecting sociodemographic data. These data collection challenges, especially without federal support, are likely to delay the development of meaningful outcome measures if risk adjustment is required.

## **The impact of the proposed change on patients is unknown**

We do not believe the TEP has sufficiently explored the potential unintended consequences of risk adjusting some outcome measures. We believe risk adjustment could possibly create another set of unintended consequences entirely, such as (1) masking disparities in the outcomes of care for disadvantaged populations, (2) reducing incentives for providers to adapt the care they provide in ways that meet the needs of disadvantaged patients, (3) lowering the expectations that providers can and should provide high quality, patient-centered care for all patients, regardless of their sociodemographic characteristics, (4) accepting a different standard of care and prolonging lower health outcomes unnecessarily for those with difficult life circumstances, and (5) limiting accountability to only that which is directly under the provider's control instead of galvanizing the community to take action to meet these patients' unique needs.

Given the weight of these potential consequences and the lack of evidence in this area, we do not believe it would be prudent to immediately accept these recommendations. We urge instead that a pilot approach be adopted so that additional data can be collected and evaluated.

Furthermore, we have great respect for the TEP members and recognize that many have dedicated their professional efforts to reducing disparities in health care. But as we move forward with further exploration of these issues, we urge involvement of patients and families as partners in designing future research and testing in this area. We also encourage further consideration of the need for unadjusted outcome data to support scientific research, public health activities, and ratings based on factors not included in governmental comparisons.

## **Changes to how performance is measured may not be the most appropriate way to address a payment problem**

The report identifies two potential problems with the current environment: (1) reduced resources for providers who serve disadvantaged patients, and (2) unwillingness of providers to serve disadvantaged patients as a result of payment implications of federal quality programs, such as the Hospital Readmissions Reduction Program. These two problems are related to payment policy, not measurement methodology. We believe policy makers should consider alternate payment strategies (e.g. stratification, peer-grouping) to address these problems and we strongly support ensuring that providers serving disadvantaged populations have adequate resources to deliver care and improve quality. We encourage the development of an incentive program that rewards those who do the best at caring for sicker and more disadvantaged patients, rather than simply implementing a technical adjustment to performance measures that may reduce the penalties to those caring for proportionately larger populations of patients with

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difficult life circumstances. Further, we do not believe that changes to the NQF evaluation criteria are the necessary or appropriate strategies to address the challenge at this time.

Approaching the challenge as a matter of payment and reporting policy would also enable consideration of both provider and community resources. The report appropriately points out that these factors affect outcomes, but does not address these important factors in its recommendations.

### **Some recommendations are outside of scope**

The report notes that half of its recommendations were outside the NQF's scope of work. We agree and believe that the TEP report is not the appropriate vehicle to consider recommendations five through eight, which, for example, pertain to NQF's role in providing guidance for measure implementation and appear to overlap with the core mandate of the Measure Applications Partnership (MAP).

Overall, the report notes that these measurement issues are complex and will require careful attention to details when implemented. We are eager to move in a positive direction and towards consensus that can utilize the best of each perspective so that patients and providers can receive care and deliver in ways that are best suited for the challenges each face. We believe that without additional testing, evidence and explanation of these details, implementation is premature. We believe further evidence regarding these issues and exploration of alternative strategies are needed, and we do not recommend any immediate change in NQF's current risk adjustment policy.

We appreciate the opportunity to provide comments. Please do not hesitate to contact us if you have questions.

Sincerely,

Debra Ness

William Kramer

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