
March 16, 2017

Shantanu Agrawal, M.D.
President and CEO
National Quality Forum
1030 15th Street, N.W., Suite 800
Washington, DC 20005

Dear Dr. Agrawal:

As representatives of our nation's hospitals, health systems and other health care organizations, we congratulate you on your appointment as president and CEO of the National Quality Forum (NQF) and look forward to working with you on a number of critical quality-related issues.

As very active and involved members of the NQF, we want to call your attention to a troubling issue: the appropriate risk adjustment of quality measures using sociodemographic (SDS) adjustment. While our organizations continue to appreciate NQF's willingness to engage on this important subject of whether and how to account for SDS factors in assessing provider performance, **we must express our disappointment that NQF has taken a stance on SDS adjustment that is not in line with current science or widely held provider beliefs.** This letter presents our specific concerns regarding NQF's position on SDS adjustment in hopes of engaging you in conversation regarding potential improvements to the NQF trial period and communications. Our concerns include:

- NQF's apparent disregard for the evidence-based link between sociodemographic factors and patient outcomes as shown in a growing body of work, including the NQF's own landmark expert panel report on sociodemographic adjustment;
- Recent public statements that downplay the role of directly adjusting quality measures to account for sociodemographic factors;
- NQF's suggested link between the 21st Century Cures Act and NQF's Executive Committee recommendation to "consider other approaches in addition to quality measurement to address the unintended consequences of federal payment programs"; and
- The inadequacy of NQF's SDS risk-adjustment "trial period."

These issues are discussed in detail below.

**NQF'S RECENT MEASURE ENDORSEMENTS DISREGARD SCIENCE ON SDS ADJUSTMENT**

In December 2016, the NQF announced its endorsement of 30 hospital admission and readmission measures. Only two of the measures included sociodemographic adjustment. The NQF's December 12 NQF press release announcing the measure endorsements suggests that the evidence is insufficient to warrant sociodemographic adjustment for hospital readmission measures. However, this assertion contradicts the mounting, robust evidence of the strong connection between sociodemographic factors and provider performance, and the many plausible mechanisms for accounting for such factors.

**The evidence showing the link between sociodemographic factors and patient outcomes has only continued to grow since NQF's own task force cited a substantial number of well-done studies in its landmark report, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors***. Most recently, this connection was clearly shown in a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and in the National Academy of Medicine's (NAM) series of reports on accounting for social risk factors in Medicare programs. Both reports provide evidence-based confirmation of what hospitals and other providers have long known – patients' sociodemographic and other social risk factors matter greatly when trying to assess the quality of health care providers.

The NAM reports show that performance on a variety of outcomes – readmissions, cost and patient experiences – is affected by social risk factors. The ASPE report demonstrates that hospitals and other providers caring for large numbers of poor patients are more likely to receive penalties not only on the Hospital Readmissions Reduction Program (HRRP), but also on a range of pay-for-performance programs for physicians and post-acute care providers as well. Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can adversely affect patients and worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients. It also can mislead and confuse patients, payers and policymakers by shielding them from important community factors that contribute to worse outcomes.

**Fortunately, both the ASPE report and the NAM series show there are a number of plausible mechanisms by which sociodemographic information can be incorporated meaningfully into quality measurement.** NAM's expert panel states that accounting for social risk factors "would best be achieved through payment based on performance measure scores adjusted for social risk factors (or adjusting payment directly for these risk factors) when combined with public reporting stratified by patient characteristics within reporting units." These suggestions align well with several of the strategies proposed in the ASPE report.

In light of this evidence, we urge NQF to better incorporate the findings from the aforementioned reports in NQF's endorsement work going forward.

**PUBLIC STATEMENTS DOWNPLAY ROLE OF QUALITY MEASUREMENT**

We also are concerned that NQF's public statements about the endorsement project downplay the role of quality measurement in accounting for sociodemographic factors. The same December 12 press release notes the NQF Executive Committee's recommendation to "consider other approaches in addition to quality measurement to address the unintended consequences of federal payment programs." However, the December monthly newsletter sent to NQF members appears to suggest "other" approaches to accounting for sociodemographic factors are preferable to statistical risk adjustment. Indeed, the newsletter states:

> "…[A]ddressing the problem through payment policies, not through statistical adjustments that suffer from the lack of data and enough precision, makes a lot of sense."

In a similar vein, we are concerned that NQF appears to believe that it is only necessary to adjust for sociodemographic risk factors for pay-for-performance programs as the resolution adopted by the Executive Committee singles out the HRRP. Yet, **the impact of sociodemographic factors on performance is just as relevant to quality reporting programs as it is to pay-for-performance programs.** Incorrectly characterizing a hospital's performance to the public it serves by failing to adjust for all of the factors other than hospital care that contribute to patient outcomes can mislead patients with regard to the quality provided at their community hospital, cause reputational damage to hospitals, and seriously hamper a hospital's ability to drive quality forward.

Considering that NQF's mission is to endorse measures that hold all parts of the health care field, including our member hospitals, accountable for providing the highest quality and safest outcomes, we believe that NQF must take a stronger position on the role of quality measurement in accounting for sociodemographic factors.

**NQF SUGGESTS CURES ACT MANDATES FOCUS ON APPROACHES OTHER THAN QUALITY MEASUREMENT**

We are confused by NQF's attempt to link the 21st Century Cures Act's sociodemographic adjustment requirements to the Executive Committee recommendation to examine approaches other than quality measurement. Specifically, the NQF's December 12 press release states:

> "The 21st Century Cures Act includes a provision to change the HRRP so that hospitals' performance is judged in comparison to like hospitals, instead of a national benchmark."

When placed in this context, it almost appears as if the 21st Century Cures Act mandates an approach different and separate from quality measurement. In fact, the 21st Century Cures Act allows the Centers for Medicare & Medicaid Services (CMS) to adjust the measures in the HRRP in the future. The peer group comparison referenced in the statement is a "transitional adjustment" in which CMS assigns each hospital to groups based on the proportion of patients dually eligible for Medicare and Medicaid, and compares each hospital's performance to others within its dual-eligible grouping. However, after this transitional adjustment, CMS "may take

into account" the findings of the two reports on socioeconomic adjustment in Medicare mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (one of which is the aforementioned ASPE report).

In other words, the 21st Century Cures Act does not signify an end to using risk adjustment to account for sociodemographic factors, nor is it an acquiescence that payment programs are the best way to account for important social risk factors. Rather, it is the beginning of the development of proven adjustments. We urge NQF to reassess its position regarding the future of SDS adjustment in light of the Cures Act.

**TRIAL PERIOD ON SDS ADJUSTMENT IS INADEQUATE**

In stark contrast to the conclusions of the aforementioned ASPE and NAM reports, NQF's sociodemographic risk-adjustment "trial period," which includes the measures that are the subject of the December press release, has identified only two readmission measures that include sociodemographic adjustment. Both of these measures are for post-acute care, and neither is used in a Medicare quality reporting or pay-for-performance program at this time. NQF appears to believe that sociodemographic adjustments for readmissions are only appropriate for the post-acute care setting, but when those very same patients' readmissions are assessed from the hospital perspective, the SDS adjustments are no longer important. **In light of the significant evidence from the NAM and ASPE reports showing the linkage between sociodemographic factors and hospital performance, this position cannot stand.**

We strongly urge NQF to continue its work on the sociodemographic adjustment "trial period." We will be sending a separate letter to the NQF board seeking an extension of the trial period and offering additional suggestions for enhancements of the trial period, including clarifications of criteria for testing and evaluation of the trial period process. We look forward to discussing the forthcoming suggestions with you and your staff.

As you meet with each of our organizations over the next few weeks, we look forward to sharing our views in greater detail. If you have further questions, please contact Nancy Foster at nfoster@aha.org, Jayne Hart Chambers at jchambers@fah.org, Ivy Baer at ibaer@aamc.org, or Beth Feldpush at bfeldpush@essentialhospitals.org.

Sincerely,

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