NATIONAL QUALITY FORUM

Memo

TO: NQF Risk Adjustment Expert Panel
FR: Karen Pace and Helen Burstin
DA: 05/02/14
SU: Preparation for conference call Friday, 5/9, 11:00 am-3:00 pm ET

This memo provides background for the upcoming conference call. The purpose of the call is to:

- Review comments, particularly those with different perspectives or suggestions;
- Attempt to resolve objections, fairly consider all comments, decide on a disposition, and explain the reasons; and
- Discuss potential options for responses to comments including clarifications or potential modifications.

Actions

- Review this briefing memo prior to the conference call
- Review the comments received
- Identify any issues that are not reflected in this memo so that they can be discussed by the Expert Panel
- Be prepared to assist with resolving issues, gathering information, or drafting revisions.

Conference Call Information

Friday, May 9, 11:00am - 3:00pm ET

Speaker Line: (877) 226-6417 *(for NQF Staff/Expert Panel Members; no conference code required)*

Webinar link: http://nqf.commpartners.com/se/Rd/Mt.aspx?348386

In order to speak, you must be dialed into the phone line. The webinar will stream audio and slides.

Contents

- NQF process for addressing comments
- Information about working with the Excel file
- A summary count of comments received
- Major themes and questions for the Expert Panel's consideration

NQF Process for Addressing the Comments

- As a voluntary consensus standards organization, NQF follows OMB Circular A-1109 on Voluntary consensus standards
  4.a.(1).(v) Consensus, which is defined as general agreement, but not necessarily unanimity, and includes a process for ***attempting to resolve objections by interested parties, as long as all***

comments have been fairly considered, each objector is advised of the disposition of his or her objection(s) and the reasons why*, and the consensus body members are given an opportunity to change their votes after reviewing the comments.*

- NQF staff review and categorize comments; identify themes; prepare draft responses or seek input to answer questions for committee review and modification
    - Working with co-chairs

- NQF prepare briefing materials, which are sent to the committee 1 week prior to the call.

- The committee discusses comments on a conference call (5/9, 11:00-3:00)
    - Need to focus on key issues and questions

- Redline report with any changes sent to CSAC 1 week prior to call

- Comments, Panel responses, final recommendations, and revised report go to CSAC for approval (6/10 conference call), then to the Board.
  An important element of the CSAC and Board's decisions is the balance of stakeholder perspectives because in numbers, there are many more provider and health professional organizations than other stakeholder groups.

Excel File

- All comments are in the Excel file posted on SharePoint.
- The file is sorted by commenter organization, but you can resort on any field.
    - Some columns with admin data are hidden to simplify the display.
- You can filter on the various column fields – commenter, commenter organization, question (general comments or specific recommendations, support, suggestion, or issue/theme.
    - Use the filter arrow buttons in the columns to make selections.
    - Note: Some commenters put all comments in general comments vs. by specific recommendation.
- To view the entire cell contents – select a cell and view in the formula box at the top (also able to scroll). Or, if you double-click on the cell, it will open to show the full text and you can use the up/down keys to move the cursor through the expanded cell.
- Each comment has ID # in column A – use that for reference vs. the row number, which can change depending on how the file is sorted.

Summary Counts of Comments Received

- 667 comments
- 158 organizations (or individuals)
- 143 commenters were in support of the recommendations
- 7 commenters were opposed to the recommendations
- 7 commenters provided mixed comments (supportive and not supportive) or reservations
- 5 commenters were supportive of most recommendations but opposed to Recommendation 7 - NQF having role in guidance on implementation

Do not support the recommendations

- CMS (purchaser)
- Consumer-Purchaser Alliance (consumer) (composed of 33 consumer and purchaser organizations; submitted by National Partnership for Women & Families)
- Consumers Union/Consumer Reports (consumer)
- Kaiser Permanente (provider)
- The Leapfrog Group (purchaser)
- NCQA (quality measurement, research and improvement)
- St. Louis Area Business Health Coalition (purchaser)

Some comments were a mixture of negative and positive comments or reservations (they are categorized as "?" in the support column)

- Armstrong Institute for Patient Safety and Quality at Johns Hopkins University (quality measurement, research and improvement)
- HealthPartners (provider; also measure developer)
- Mathematica (quality measurement, research and improvement)
- Press Gainey (quality measurement, research and improvement)
- RWJF (quality measurement, research and improvement)
- The Joint Commission (quality measurement, research and improvement)
- Yale HRET (quality measurement, research and improvement)

Support recommendations related to sociodemographic adjustment, but not #7 - NQF having role in guidance on implementation

- American Academy of Neurology (health professionals)
- American College of Cardiology (health professionals)
- Highmark (health plan)
- Pharmacy Quality Alliance (quality measurement, research and improvement)
- UHC (quality measurement, research and improvement); also does not support Recommendations 5 and 6

Pattern of Comments and Implications

The number of comments in support of or opposed to the recommendations alone does not necessarily dictate the outcome of the NQF process. The number of organizations representing the various stakeholder groups varies substantially, so the pattern of comments across the various stakeholder groups is an important element of the Consensus Standards Approval Committee (CSAC) and Board decisions. NQF was founded on the principle that patients are central to the mission of quality of healthcare so consumer and purchaser representatives comprise the majority of the CSAC and Board seats. It is notable that most commenters representing consumers and purchasers did not support the recommendations; however there were two consumer groups that did support the recommendations (Community Catalyst and Service Employees International Union).

Table 1. Pattern of Support or Lack of Support across Stakeholder Groups

	Total	Support Recommendations 1-4	Do Not Support Recommendations 1-4	Mixed Comments or Some Reservations	Info only
Consumer	4	2	**2**	0	
Health Plan	7	7	0	0	
Health Professionals	26	26	0	0	
Provider Organizations	83	81	**1**	1	
Public/Community Health Agency	20	20	0	0	
Purchasers	3	0	**3**	0	
Quality Measurement, Research and Improvement	15	7	**1**	6	1
Supplier and Industry	3	3	0	0	
Total	158	143	**7**	7	1
NQF Members	68	56	**7**	5	

Expert Panel Review of Comments

NQF is committed to resolving objections and fairly considering all comments when deciding on a disposition and explaining the reasons. This process begins with the Expert Panel.

Themes

To focus the Panel's discussion, NQF staff have identified the major themes expressed in the comments as well as discussion questions and reviewed with the co-chairs. This is only a starting point and the Panel members might add and modify through their discussion.

- **Masking disparities, masking quality problems, different standards**
  Commenters agreed with the recommendation that stratification was the method to identify disparities. However, some commenters objected to sociodemographic adjustment for purposes of public reporting and pay-for-performance and urged continuation of NQF's existing criteria. They expressed concerns that adjusting for sociodemographic factors masks disparities, masks quality problems, creates different standards, and reduces the incentive to improve and reduce disparities. Other commenters noted that the analyses that are needed to include adjustment for sociodemographic factors would highlight where there are disparities (i.e., significant coefficient in a risk model). Some commenters suggested that both adjusted and stratified data be publicly reported.
  1. *Should the recommendations regarding sociodemographic adjustment (first part of #1, #2, #3) be modified?*
  2. *Are there ways to resolve or mitigate concerns about sociodemographic adjustment masking, accepting, or increasing disparities? (see draft suggestions in the Appendix A)*
     a. *Monitor for increasing disparities*
     b. *Some incremental implementation and evaluation (e.g., pilot, additional analyses)*

c. *More transparency*

3. *Should the disparities recommendation (the second part of recommendation #1) be separate so that it is adequately emphasized?*
4. *Can the disparities recommendation be strengthened? For example:*
    a. *Publicly report the sociodemographic-adjusted score but also make other data available, such as:*
        i. *all data should be made available to anyone for additional analyses;*
        ii. *with the description of the measure, identify if it is disparities-sensitive and provide strength of the association for any sociodemographic factors included in the model*
        iii. *make provider-level drill-down data available: case mix characteristics, stratified performance data if numbers are sufficient, stratified performance data by large categories such as insurance categories, observed and expected counts, other?*
5. *Are there additional ways to explain or demonstrate what risk adjustment does and doesn't do?* (*e.g., a commenter suggested explaining adjustment from the perspective of confounding: The report would benefit from an introductory discussion of what confounding is, what adjustment is, why case-mix (or severity) confounding is bad and why we all agree to risk-adjust, and then extend this argument to the identically analogous case of SES and even race/ethnic mix adjustment, which is just as valid and no more harmful than case-mix (or severity) adjustment.- David Mann*)

- **Evidence of Harm**

Some of the objections to sociodemographic adjustment were based on the perception that the primary reason for the recommendations was potential harms to disadvantaged patients related to not adjusting for sociodemographic factors and that there was insufficient evidence of such harms. Therefore, they concluded that a change in the criteria related to adjusting for sociodemographic factors is not warranted.

6. *To respond, the Panel has been asked to identify additional references for evidence (positive or negative) for both the unintended consequences of not adjusting for sociodemographic factors and the unintended consequences of adjusting for sociodemographic factors to update the report. [We also will correct the cited reference #24 on p.14 – the text was correct, but the citation is Joynt, K. E., & Jha, A. K. (2013). Characteristics of hospitals receiving penalties under the Hospital Readmissions Reduction Program. JAMA, 309(4), 342-343)]*
    a. *What evidence does or does not exist for harms to patients related to <u>both</u> adjusting <u>or</u> not adjusting for sociodemographic factors (positive or negative)? (e.g.,* Werner, RM, Asch, DA, & Polsky, D. Racial profiling: The unintended consequences of coronary artery bypass graft report cards. *Circulation*, 2005, *111*, 1257-1263.)
    b. *Given the questions about what may or could happen <u>in the future</u>, what types of evidence are relevant and available?(see information provided in comments in Appendix B)*
7. *Is it appropriate or useful to clarify or expand on the following in the report?*
    a. *There is a large body of evidence about the relationship between a variety of sociodemographic factors and a variety of health outcomes*
    b. *There are existing methods for risk adjustment and control of confounding to ensure comparability of performance measurement across providers and avoid incorrect inferences (confounding can cause an overestimation or underestimation of effect)*

c. *The accepted guidelines for selecting risk factors would require separate analysis of each individual performance measure and in addition to a conceptual reason include the following types of evidence: empirical association with the outcome, differential distribution of the factor across entities being measured, present at the start of care (not after care begins, contribution of unique variation (not redundant).*

- **Definition of quality, healthcare responsibility, reduce incentive to improve, impede progress on outcomes such as readmission**

  Some commenters thought that the discussion about what healthcare providers can control or influence reflected a narrow view of healthcare quality and provider responsibility to adjust care based on sociodemographic factors. Some expressed concern that sociodemographic adjustment would impede progress that is being made on readmissions and that hospitals would abandon efforts to reduce readmissions (or potentially other important outcomes).

  8. *Is it appropriate or useful to clarify or expand on the following in the report? The Expert Panel agrees that providers/plans need to provide care based on the characteristics of the patients served; should not lower goals or standards when providing care to disadvantaged patients; and need to identify and reduce disparities.*
     a. *The discussions about control and influence were an attempt to describe some of the thinking related to the guidelines for selecting risk factors and how they apply to sociodemographic factors. For example, providers do not control the characteristics of patients that are present at the start of care – whether clinical (e.g., health conditions) or sociodemographic (e.g., income). Risk adjustment does not contradict broad views of health and healthcare quality reflected in the IOM definition of healthcare quality; or others such as AHRQ's: "Doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results"; or CMS definition from its QI Roadmap: "Right care for every person every time".*
     b. *Risk adjustment for certain factors does not absolve providers/plans from the responsibility to use interventions appropriate for those factors when present in the patients served whether clinical factors (e.g., recognizing and addressing co-morbidities) or sociodemographic factors (e.g., recognizing and addressing non-English speaking).*
     c. *Risk adjustment potentially improves comparability between providers. It does not place a limit on the scope of interventions that could be used to mitigate the effects of sociodemographic factors such as the number of language translations or interpreters available; discharge clinics for patients without primary care providers. Risk adjustment creates a "level playing field" so that differences across providers/plans in addressing or not addressing the sociodemographic factors will be reflected in the adjusted performance measure scores.*
     d. *Risk adjustment does not set a different goal for patients with different risk factors – the same goal for blood pressure control of < 140/90 or preventing deterioration of health status that results in a hospital readmission applies to those with relevant clinical risk factors (e.g., multiple com-morbidities)as well as those with relevant sociodemographic factors (e.g., difficulty purchasing medication).However, adjustment could change the estimate of the provider's performance (either up or down).*
        - *Could this concern be mitigated by making observed data available (see #4 above)?*
     e. *Risk adjustment does not remove the focus of improvement related to the performance measure nor the need to work collaboratively with other settings depending on the performance measure. By measuring and comparing performance on risk-adjusted rates,*

providers and others can identify when performance is lagging or providers/plans that are achieving excellent performance. For improvement, providers/plans always need to examine their own raw unadjusted data and data stratified by relevant clinical and/or sociodemographic characteristics to identify patients who are and are not achieving desired outcomes and potential strategies to improve. Risk models should be updated on a periodic basis so that improvements are reflected in updated model coefficients.

- **Methods**

  Some comments were about methods or description of methods in the report.

  "Not primarily mediated by quality" should not be a requirement for selecting risk factors

  Comments by a statistician and an epidemiologist caution against focusing on causal pathways. The statisticians on the Panel also recommended that this language is not needed. It is difficult to define in order to operationalize and therefore, could potentially add burden to the measure development process.

  9. *Are the requirements for a conceptual and empirical relationship as well as the other guidelines for selecting risk factors sufficient for identifying appropriate factors and circumstances? Would it be preferable to identify specific situations of concern where adjustment for sociodemographic factors should not be considered (e.g., patient safety measures, more specification related to process measures)?*

- **Disagree with characterization of making more "accurate" or "correct" conclusions and suggest language that risk adjustment improves comparability**

  10. *Should the language be changed? One of the core principles (#5) used the language "avoid making incorrect inferences about performance". Some options to consider are: improve comparability; ensure comparability; avoid incorrect inferences; make meaningful comparisons; make meaningful conclusions about quality; other? The key concept would be to emphasize the value in adjustment in making valid comparisons of and conclusions about relative performance of plans and providers rather than on having "accurate" measure of performance for any one plan or provider.*

- **Implementation is the issue, not measurement**

  Some of the objections were based on the perspective that the issue (harm to providers or patients through lack of adjustment) was really about how the measures were used in pay-for-performance programs and not about measurement per se. Some suggested alternative ways to structure incentive programs. Some advocated for peer group comparisons as recommended by MedPAC. However, some other commenters suggested that the alternatives of stratification and peer groups for comparison explicitly accept or create different standards. One commenter noted specific mechanisms for adjusting payment for services based on higher needs related to sociodemographic factors and therefore, adjustment for performance measures could result in overpayment.

  11. *Is it appropriate or useful to clarify the following?*
      a. *Although concerns about impact of payment incentive programs might have been the impetus to re-examine NQF's policy on risk adjustment, the primary basis for the recommendations is that they are consistent with accepted practices and guidelines for selecting risk factors for performance measurement and epidemiologic approaches to handle*

confounding in order to enable comparisons and avoid incorrect inferences about quality when used for accountability purposes.

b. *The concerns of the Panel have not just been limited to issues of payment incentive programs. Rather the concerns of the Panel are also set in the context of public reporting and the validity of inferences or comparisons made with performance measures that are not adjusted for sociodemographic factors when appropriate. Alternatives to adjustment that may be useful in P4P contexts do not address a deeper concern that failing to consider sociodemographic adjustment can yield performance measures that may be fundamentally misleading to patient consumers, purchasers, payers, and regulators.*

- **Burden to developers, guidance to developers**

  Some of the objections were based on burden to measure developers and concern that developers would not develop performance measures that required sociodemographic risk adjustment. Other commenters cautioned about potential developer burden and suggested more guidance for developers would be needed.

  12. *Can the recommendations for measure submission be clarified or be made more specific so that developers are not faced with an endless number of possible analyses?*

- **Data burden, feasibility**

  Some commenters saw sociodemographic data limitations as a reason to delay implementation. Other commenters cautioned about the potential of making data collection too burdensome. Some commenters noted that potential adjustment for sociodemographic factors would provide incentive to collect the necessary data. Some commenters noted other efforts related to data on sociodemographic factors, specifically *recent IOM work Capturing Social and Behavioral Domains in Electronic Health Records: Phase 1*

  13. *Can the Panel outline feasible steps/expectations regarding availability of sociodemographic data? (e.g., initially expect to use variables readily available in existing data sets (e.g., Medicaid status); then use address for geocoding to census tract data; then standard definitions and data collection processes)*

- **Factors, community factors**

  Some commenters suggested other factors that should be considered or that more attention should have been given to community factors.

  14. *Does the Panel think that more detail can be provided about community-level vs. patient-level factors, the relationships between community-level and patient-level factors, and their separate or combined use in risk adjustment, ?*
  15. *Should the report emphasize that risk factor selection is based on the specific measure and that the use of community-level variables will inevitably be different for different measures or for different units of measurement (e.g., plan, physician, hospital)?*

- **Implementing the recommendations and monitoring impact**

  Some commenters suggested more research, incremental approaches to implementation, and monitoring impact. Other commenters suggested immediate implementation and review of endorsed measures to identify those that might require an ad hoc review.

16. *Are there some incremental approaches that could be considered?*
17. *What could be monitored to ensure that disparities are not worsened?*
18. *Should we add a recommendation for a standing NQF committee on disparities that is explicitly charged to monitor impact?*

- **Clarifications**

  Some comments requested specific clarifications or indicated the need for clarification. Following are some specific clarifications.

  19. *Specific clarifications:*
      a. *The recommendations apply to performance measurement for any setting or level of analysis including health plans.*
      b. *The recommendations apply to outcome performance measures (including cost and resource use and PRO-based performance measures) and some process measures. The recommendations are purposely not prescriptive in terms of factors and methods – that needs to be determined for each individual measure.*
      c. *The recommendations do not mean that all performance measures should be adjusted for sociodemographic factors – that has to be determined for each individual performance measure.*

Appendix A - Identifying and Monitoring Disparities

Thoughts on strengthening the second part of recommendation #1 – *"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, policy makers, and the public working to reduce disparities."*

#1. Separate this out from the first recommendation and make it an additional stand-alone recommendation. This will emphasize disparities as a central issue.

#2. More clearly articulate the different functions of stratified data in terms of disparities and information useful to members of disadvantaged groups. Conceivably, these functions include national monitoring of disparities in quality, targeted quality improvement intended to reduce if not eliminate these disparities, and provision of relevant data to patients.

Function #1: National monitoring*.* Systematically tracking overall disparities, (i.e. assessing disparities in quality data that is aggregated across providers) for each measure could not only inform the AHRQ National Health Disparities Report (NHDR), but also provide a method for tracking in reducing these disparities progress while at the same time assessing any unintended consequences of considering sociodemographic adjustment for performance measures. This information about disparities could be summarized for each measure by race, ethnicity, language, SES etc. through the release of an annual NQF disparities report that could inform the NHDR.

Function #2: Quality Improvement**.** Quality improvement (QI) that is specifically focused on reducing disparities (rather than simply seeking to improve quality for the entire population requires is an important means for reducing with-in provider disparities. This type of QI requires disparities data available at the provider level. The second part of recommendation #1 suggests that these data would be made available to the public. These data would be adjusted for clinical risk factors; data would be released to the public only when cell sizes permitted reliable estimates. Potentially, these data could be available through hyperlinks, i.e. drill downs on reporting sites.

Function #3: Information relevant to patients. Patients tend to be most interested in how various providers perform for patients like themselves. Drill downs described above (with the same caveats) would be available to patients.

#3 Add an additional recommendation for the formation of a standing NQF disparities committee. A standing disparities committee would review implementation of the revised policy, including key decisions by developers, assess trends in disparities and monitor for unintended consequences of the revised policy. Such a committee would also help ensure that disparities don't get lost, but rather remain an integral part of quality measurement. Notably, the committee would be explicitly tasked with examining evidence for masking disparities and lowered expectations and incentives for care to disadvantaged patients by monitoring disparities both between and within providers. For example, the committee would review decisions regarding when measures are adjusted for SES and how. It would asses the impact of the revised changes on disadvantaged patients and on safety net providers). It would recommend the collection of additional SES-related measures, whether individual or community-based, for consideration. Last, the committee would suggest ways to better address and/or integrate healthcare equity and value.

Appendix B – Information Related to Harm from Comments Received

No Harm

While health and drug plans may need to consider alternative methods to reach certain populations or ways to change health or drug behaviors, there is no consistent evidence that plans with large percentages of disadvantaged beneficiaries are unable to provide high quality care. A number of plans with high numbers of disadvantaged beneficiaries demonstrate they have been able to achieve high Star Ratings, and do so without making additional adjustments to the Star Ratings. This implies that less successful plans need to change their approach. Further, the argument that not risk adjusting has the effect of driving providers/insurers away from low SES patients is directly contradicted by the growth in D-SNPs (322 plans in 2012 with 1,303,408 enrolled; 353 plans in 2014 with 1,576,291 enrolled) as the Star Rating program has been implemented.
Centers for Medicare & Medicaid Services

Actual Harm

Our member plans have actually experienced physician practices wanting to avoid or even drop from their patient panels disadvantaged patients who may be labeled as non-adherent and/or difficult because of the life challenges they are dealing with because it is the most expedient way to meet performance targets. Risk adjustment methodologies that take these challenges into account when measuring quality would recognize the extraordinary effort that may be required, instead of having the unintended consequence of penalizing the health plan, health systems and providers for providing the much needed care.
Association for Community Affiliated Plans

Our patients have high rates of readmissions, prescription non-adherence, and poor patient behavior. As a result, safety net hospitals' reimbursement is adversely affected by readmission penalties and our quality indicators are compromised, thus constraining our resources and ability to expand population health services to disadvantaged populations.
Bon Secours Baltimore Health System

The Medicare Advantage Star Rating system measures plan quality and rewards plans based on performance. The lack of sufficient sociodemographic adjustment in the Star Ratings has resulted in wide performance gaps between plans primarily serving disadvantaged members and those that do not. Without sufficient risk adjustment, these gaps will worsen.

A funding disparity is already emerging in 2015 which will result in low income plans having considerably less quality bonus funding than plans serving the more affluent. Members of low income plans – primarily disadvantaged, high needs, and vulnerable – will disproportionately lose benefits they rely on to stay healthy (e.g., transportation to care, eyeglasses). Providers serving disadvantaged MA members

will also be impacted by the loss of funds. Low income plans will have less funding to improve performance and continued financial pressure may ultimately force them to close. Plans and providers will both find it less attractive to serve disadvantaged members.
Healthfirst

Possible Harm

We concur with the authors that that failure to risk adjust appropriate quality measures, for example, readmissions, for socioeconomic factors is almost certainly having significant unintended negative consequences. These include potentially misidentifying certain organizations as delivering poor quality care and disproportionately applying financial penalties to organizations that care for large numbers of vulnerable populations.
Loyola University Health System

As we celebrate the 50th anniversary of the enactment of the Civil Rights Act of 1964, there are still too many well-intentioned public policies that have an adversely disparate impact on communities of color, and that help to perpetuate unacceptable disparities in critical outcomes. The thorough, thoughtful, and technically unimpeachable work of the Expert Panel on Risk Adjustment for Sociodemographic Factors provides a clear blueprint for assuring that such impacts can be minimized in the development and application of accountability measures for public health care programs.
Bruce Vladeck, Nexera, Inc.

Expectation of Harm

If such adjustments are not made, the hospital, doctor, or other health care provider is inappropriately being held accountable for the poverty and lack of appropriate resources in the community they serve, and the public will receive misleading information about the quality of care provided by these providers. Further, payment systems built from unadjusted measures will 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.
Alabama Hospital Association

…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.
American Hospital Association

Without this consideration of characteristics, inaccurate assessments will be made of quality measures and relative outcomes. By association, this further extrapolates to inaccurate assessments of the practitioners' quality and commitment in dis-advantaged communities. And, with the combination of these inaccurate assessments, a potential sequela is that, with reduced resources, entities with artificially lowered quality scores (albeit, inaccurately calculated) will be targeted for reductions of existing or future resources. This would be a grave example of mistaken decisions based upon mis-interpreted data. Tragically in this case, it is the ultimate beneficiaries of our efforts, i.e., our patients, who will suffer.
American Medical Group Association

Without appropriate adjustment for sociodemographic factors in public reporting, providers for the underserved can be mischaracterized as poor performers. As a result, disadvantaged patients may seek care in settings where their care may actually be worse. Safety net providers may suffer volume and revenue losses that further impair their ability to adequately care for the needy. Providers, reacting to this measurement bias, may decide to practice in settings where there performance is more fairly measured and represented.
Boston Medical Center

The unintended consequences of these SES variables on safety-net hospitals in particular — and overall provider performance — can be devastating. Payment penalties for lower than expected performance outcomes in safety-net hospitals that are already struggling financially can further stress their already tight budgets and possibly lead to closure, thus impeding health care access for this vulnerable patient population. In addition, excluding SES variables from public reporting of accountability measures can create an incentive for some providers to avoid these patients.
California Hospital Association

Risk adjustment accounting for socio-economic determinants of health is an important step in reducing health disparities, as it lowers the risk of providers "cherry-picking" patients and therefore reducing access to care for those populations most at-risk. Additionally, risk adjustment protects safety net providers from being inaccurately portrayed as low-performing in performance and public reporting. This is of particular importance in a state like California, which has a significant managed care presence and (like many states) is moving towards transparent public reporting on health care quality measures.
California Primary Care Association

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.
Children's Hospital and Research Center Oakland

Payment systems built from unadjusted measures will 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.
CHRISTUS Health

We are very appreciative that NQF is an organization of such high integrity that it would reverse its opposition to sociodemographic risk adjustment in accountability measures in light of growing evidence that the lack of such adjustment may harm the nation's most disadvantaged patients. By structuring VBP as a competition—and not controlling for sociodemographic risk factors—safety net hospitals have been unable to avoid penalties and now just assume them in their budget forecasts. Consequently, policymakers have (unintentionally) impeded efforts to improve hospital performance in the most vulnerable communities, which is exacerbating health disparities.
Greater New York Hospital Association

Risk adjusting performance measures is important for eliminating health disparities, particularly in terms of discouraging provider "cherry picking" and ensuring safety net providers are not disadvantaged in payment or public reporting.
Kentucky Primary Care Association

Ultimately it is in our society's best interests to find ways to incentivize the provision of care to our nation's most adversely affected individuals and communities. At present, with no risk adjustment for the social determinants of health, we have in effect done just the opposite: incentivized the "cherry picking" of healthy individuals with fewer barriers to good care and good outcomes.
Kokua Kalihi Valley

At times providers must completely redesign the surrounding environment in order to take effective care of patients… Unless we understand these details, providers will become very disillusioned and are likely to withdraw from disadvantaged populations.
Mark Kelley, M.D., Massachusetts General Hospital

Some have argued that addressing sociodemographics in payment policy and performance outcomes will excuse poor quality care and obscure disparities. But as NQF and others have concluded, overlooking these factors may hasten bad behavior of another form, incentivizing providers to avoid serving patient populations with challenging clinical and social circumstances.
Montefiore Medical Center

Staying at the status quo leaves providers serving higher-risk patients at a payment disadvantage, which can further exacerbate health care disparities when resources are needed to invest in and maintain needed clinical and nonclinical interventions. Further, non-safety net providers may choose not to serve the most disadvantaged patients, even those newly insured under the ACA, potentially worsening health care access and disparities.
National Association of Community Health Centers

Hispanic physicians and other physicians, hospitals, clinics, and other healthcare facilities that provide care for dominant Hispanic patient panels, tend to serve disadvantaged populations with chronic diseases as a part of the safety net located in health professional shortage areas with limited resources, referral networks, and community leadership support for public health education. Current NQF policies that avoid inclusion of the socio demographic factors tend to portray these safety net providers as providing poorer quality outcomes compared to providers in more affluent areas.
National Hispanic Medical Association

Lack of adjustment for SES/SDF creates a de facto penalty for serving the most medically and socially complex patients. Mainstream providers, less experienced than community health centers in handling these complexities, are inadvertently incentivized to cherry-pick their patients. FQHCs are required, as a condition of their federal grant, to offer their services to all patients, regardless of income or complexity.
Oregon Primary Care Association

Our member hospitals and increasingly their employed physicians are feeling the impact of payment penalties for care they are need to provide for a vulnerable population whose lives are impacted by socio-demographic disparities. The hospital readmission reduction program and the pay-for-performance metrics rates that are affected by low-volume data portray care in rural areas as sub-standard, and unfairly penalize those who rightly need the resources to address the healthcare needs of their populations.
Rural Wisconsin Health Cooperative

Financial incentive programs shift resources within the health system by providing more or less funds to providers, systems of care and health plans across the U.S. based on quality performance. These shifts will have real-life impacts—reshaping the availability of resources and existence of safety net providers to care for vulnerable patients in each community.
Service Employees International Union

The RHC unanimously agrees that public reporting and P-for-P systems, without risk-adjustment methodologies (1) unfairly penalizes those health care providers committed to treating the sickest and poorest in our community; (2) can provide strong disincentives for providers to actively perform the outreach and engagement strategies that are most effective in reaching disadvantaged populations - this disincentive may actually drive up health care costs, as the sickest and poorest will then receive less preventative services that are proven to reduce illness (and cost) long-term; and (3) can unfairly transfer resources from those "doing the right thing" - urban and rural providers that care for the poorest and sickest - to those that do not or will not through either direct penalty systems, or through more subtle, longer-term effects of misuses of "pubic reporting" that may drive consumer choice away from high-quality providers that are not given credit in the metric systems for the complex, high-poverty populations that they actually treat so well.
St. Louis Regional Health Commission

We agree that without further refinement of our measurements, that appropriately include sociodemographic adjustments, health disparities could become embedded in our delivery system. Evidence shows that hospitals that treat the poorest patients are disproportionately more likely to incur penalties under the program.
Trinity Health

Adjusting for patient factors will help us serve this population. Excluding some sociodemographic factors from the accountability measures will create incentives for some providers to avoid caring for patients with these factors.
UAB Health System

Without adjustment, performance results may lead to inaccurate and misleading findings that quality is worse in low-income areas, or that providers and plans serving these communities are providing services of lower quality. When significant P4P funding is linked to these findings, policymakers may unintentionally shift resources from disadvantaged to advantaged communities, thus exacerbating health disparities.
WellCare Health

There is a concern that a socioeconomic adjustment would only serve to mask disparities and reduce the impetus to address them; however, without such adjustment, the very institutions providing care to these populations will see diminished resources to provide this care.
Yale – New Haven Hospital