Appendix XX: Public Comments

Comments were solicited for the Draft Social Risk Final Report from NQF members and the public in six posed questions. The received comments are categorized by posed public comment questions. The commenter name, organization, comment, and proposed responses are listed.

1. What general comments, feedback, or additional recommendations do you have for the report?
2. In the context of demographics versus social risk factors, (e.g., race versus racism), what approaches are used to assess social risk in health care performance measurement?
3. What other mechanisms, sources, or recommendations will increase the inclusion of social risk data throughout performance measurement?
4. What additional recommendations do you have for the National Quality Forum (NQF) to advance social risk adjustment and stratification?
5. What mechanisms or other recommendations could payers and government agencies employ to address social risks?
6. How could providers, researchers, and other stakeholders support demographic and social risk factors to improve health and healthcare equity?

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Betty Chu, Henry Ford Health System	**Question 1 comment:** The Henry Ford Health System strongly supports the recommendations made by the Disparities Standing Committee in its report on the Social Risk Trial. Addressing the social determinants of health for our patients is a key component of effective and sustainable clinical and community-based care. Within our system-wide Diversity, Equity, Inclusion and Social Justice 3-Year Strategic Plan, we have committed to systematically capturing the social needs of our patients, identifying disparities, and developing innovative solutions to address these barriers to care. We would emphasize the following points in indicating that support: The rationale for including social risk factors in risk-adjustment models is the same as that for including clinical risk factors - accurate and unbiased measurement of quality requires the statistical adjustment of factors affecting a score that are NOT quality of care. Adjustment for social risk factors will neither mask disparities nor excuse poor-quality care. The initial report by the NQF Expert Panel in 2015 and published papers by other authors since then have shown how adjustment can be done in a way that controls for	We appreciate the commenter's support on the recommendations included in the NQF Social Risk Final Report. We agree that risk adjustment, when done appropriately, would not mask disparities nor excuse poor quality care. We share the same concerns that all risk factors (i.e., demographic, clinical and social risks) should be considered and reviewed consistently across measures. This is the premise of the need for specific and actionable recommendations. The NQF

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	non-quality factors while leaving the "quality signal" used to compare entities unaffected. Monitoring and reducing health disparities at the societal level is a very important goal, Unadjusted measures, or stratified measures, can be used for the former; fairly and accurately measuring and reporting the quality of care provided by health care entities, adjusted measures can be used for the latter. Many safety-net providers are providing above-average or excellent care; these accomplishments are masked in the absence of social risk adjustment, so that those providers are not identified for public reporting and consumer choice purposes nor rewarded appropriately in financial incentive programs. We are very concerned about the number of measures coming through the NQF endorsement process where one or more social risk factors are clearly identified as significantly affecting a measured health outcome, but then the decision is made by the developer or the measure steward to not include those factors in the final risk adjustment model. These decisions are not being made in the same way for clinical risk factors, and one core principle that should be permanently adopted by NQF is that clinical and social risk factors should be treated the same in developing risk-adjustment models.	Risk Adjustment Technical Expert Panel (TEP) was established in 2020 to provide additional concrete guidance on when and how to adjust for social and functional risks. Please refer to the Risk Adjustment Guidance project page for more information.
Janice Tufte, Hassanah Consulting	**Question 1 comment:** I feel the Social Risk draft II covers most of the issues that need to be addressed when looking forward to better capturing and utilizing and balancing social risk factors and clinical concerns. I think a couple of issues could be added into the document 1) Polypharmacy I believe should be called out in regards to clinical care -regular medication management as well as reconciliation as medications can cause new patient condition concerns that are important and might greatly impact the health of patients through toxicity 2) The best care possible that involves important shared decision making as well as	We appreciate the commenter's extra suggestions on the data sources and risk factors (i.e., demographic, clinical, and social risks). The NQF Risk Adjustment Technical Expert Panel (TEP) was established in 2020 to provide additional concrete guidance on when and how to adjust for social

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	patient centric individualized care taking into account the patient's medical state and social risk factors	and functional risks. The Risk Adjustment Environmental Scan Final Report provides a comprehensive list of key social risk factors that have been used by measure developers and researchers and identified future opportunities.
Erin O'Rourke, America's Health Insurance Plans (AHIP)	**Question 1 comment:** America's Health Insurance Plans (AHIP) commends the National Quality Forum (NQF) for its leadership on the challenging issue of accounting for social risk factors in performance measurement. The shift to a healthcare payment system based on value necessitates the underlying measures be as accurate, fair, and unbiased as possible to ensure the promotion of health equity, that healthcare disparities are not inadvertently worsened, and that outcomes improve for all. We support NQF's recommendation that all stakeholders commit to identifying, prioritizing, implementing evidence-based solutions to address disparities. For far too long, discrimination and systemic racism have served as barriers to health equity for minority and underserved communities. Health insurance providers know that ending these barriers is key to an equitable health care system. AHIP concurs with the importance of eliminating disparities and recognizes that measurement is a powerful tool for both identifying disparities and motivating change. We agree better data on patients' social determinants of health is essential to improving both care and performance measurement. Better data will support stratification to identify disparities, confirm patients' needs are being met, and ensure value-based payment models and alternative payment models are fair to providers serving vulnerable populations. We recognize the challenge of the current lack of data and encourage NQF and measure developers to look to the work of the Gravity Project and others to increase the availability of interoperable data on SDOH—particularly those socioeconomic barriers that are not permanent but can emerge and abate but greatly impact health care access and health outcomes (e.g., food insecurity, housing instability, transportation	We appreciate the commenter's support on the recommendations included in the NQF Social Risk Final Report. We share the concerns of the urgent need for data collection of social risks to improve population-based healthcare inequities and fairly assess provider performance. In this report, we recommended policymakers and payers to "establish and institute payment codes for the collection of social risks data by healthcare providers (e.g., physicians, advance practice nurses, pharmacists, physician assistants, case managers, social workers, community health workers, or other providers), and incentivize providers for reporting data in

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	barriers, social isolation, etc.). Underscoring these challenges is the need to address issues of trust about the sharing of potentially sensitive data and to ensure that individuals maintain agency in providing their demographic information. We encourage stakeholders to work with consumers to promote understanding of why this data is being collected, how it will be used, and the need to remove policy and operational barriers to data collection. Finally, we support the recommendation to make the consideration and analysis of social risk factors a permanent component of the NQF endorsement process. Allowing consideration of all potential factors that could influence the results of a measure will ensure the accuracy of NQF endorsed measures. The trial period has shown the value of these discussions and the importance of continuing to allow the consideration of social risk factors.	measure reporting, health programming, and VBP models." We believe paying for reporting is the first step to the right direction.
Deborah Paone, SNP Alliance	**Question 1 comment:** The SNP Alliance is a national leadership nonprofit organization of health plan organizations, representing 2 million enrolled beneficiaries. Special needs plans (SNPs) are specifically authorized and designed to meet special care needs of Medicare beneficiary groups with high care and condition complexity with additional requirements beyond general Medicare Advantage plans. We have advocated for years for attention to social risk issues in quality measure development, testing, and use in performance evaluation. We've surveyed SNPs and offer an issue brief found at: snpa-briefing-paper-on-sdoh-paone-final-6172019.pdf (snpalliance.org). The SNP Alliance supports the recommendations of the Disparities Standing Committee in Social Risk Trial Report #2, especially: Making social risk factor analysis required as a permanent component for NQF endorsement Measure alignment–particularly across settings and programs. Clear expectations —and cohesion across NQF groups/committees. Need for increased technical assistance and available including to users of the measure (such as by States). We also strongly recommend that:	We appreciate the commenter's support on the recommendations included in the NQF Social Risk Final Report. We share the commenters' request for a broader incorporation of social risks data in measure testing, as well as increased measure developers engaging diverse communities to clearly capture population priorities and barriers and guide the providers' selection and use of measures.

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	NQF require measure stewards/developers to publish information about testing results from use of the measure in diverse communities (e.g., showing measure results by income level, dual-eligible status, disability, language) so that all potential users of the measure understand when the measure should/should not be used and how it should be adjusted if it is used. We have identified important methodological and other considerations: 2017-snp-guidelines-for-measure-developers-on-sdoh-ses-vsn-31417.pdf (snpalliance.org) NQF require measure stewards to include detail about what social risk factors significantly impact measured outcome results in their specifications. If a measure is not appropriate for use with specific groups or if case-mix for social risk adjustment is recommended in terms of scoring the results—this should be described clearly. NQF encourage measure developers to work with non-majority populations to understand what measures matter, and what impeded the ability of that group to reach that outcome. For example, if outcomes from an episode of care post-procedure is the focus, what is most important to that group and what barriers do they encounter to reach that outcome. NQF require stratified measure results to be published so that like entities being measured can be compared to other like entities, so that the influence of social risk factors that are outside of the control of the entity--can be separated out. We support attention to the use of measure results to drive quality improvement in different populations.	
Phoebe Ramsey, Association of American Medical Colleges (AAMC)	**Question 1 comment:** The AAMC supports the recommendations to be undertaken across stakeholders. Genuine progress to eliminate health and health care inequities will require partnership and planning to define and standardize social risk factors, streamline the collection of appropriate data, and report and improve measure performance. We commend the Social Risk Trial for acknowledging that this will be an iterative process, and that beginning with the use of demographic data capturing gender, race, ethnicity, and culture does not mean that those factors themselves represent an individual's inherent risk. Rather, such demographic factors may be critical until it is feasible to quantify social risk factors that capture the actual risks of bias and unjust distribution of resources and opportunity that create the social and structural conditions	We appreciate the commenter's support on Social Risk Final Report. We share the commenter's recommendation to temporarily use demographic factors to capture social risks until the measurement community identifies and/or develops suitable and quantifiable social risk data

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	that heighten inequities. Additionally, we agree that the next steps in this work must begin to examine the conceptual and empirical relationships between social risk and health outcomes that precede care delivery. Advancing measurement science necessary to support adoption and inclusion of social risk in risk adjustment can only be accomplished through enacting policies to support the collection of patient-level data. The AAMC agrees that this can be accomplished best by permanently formalizing the submission, analysis, and evaluation of social risk factors for all NQF measure endorsement and maintenance submissions and through evaluating and redesigning payment models to support health care equity and incentivize providers for reporting this critical data in measure reporting, health programming, and payment models. We are heartened that a new NQF Risk Adjustment Technical Expert Panel will pick up this mantel and develop clear technical guidance for measure developers about how best to conceptualize, assess and determine whether to include social and functional status factors in quality measures. We urge the NQF to review the endorsement process for instances where submissions clearly identify where social risk factors affect a measure's health outcome, yet ultimately is not included in the measure's risk adjustment model. The AAMC has observed this recently, in particular with readmissions measures under review for maintaining endorsement. We are concerned that the inclusion of social risk factors in risk adjustment models is not treated the same as clinical risk factors. We strongly believe that accurate and unbiased quality measurement requires statistical adjustment of all factors affecting performance that are not quality of care. Finally, the AAMC is committed to addressing the role that providers and researchers will have to play to eliminate inequity in health care and health outcomes. We agree that providers must share the responsibility of collecting, reporting, analyzing, and improving the delivery of care based on the needs of the populations and communities they serve.	elements that evaluate experienced bias and discrimination of marginalized populations. We also agree that measures should be evaluated for conceptual and empirical relationships between social risks that precede care delivery and health outcomes in adjustment models, as well as quality of care concerns based on social risks. Please refer to the Risk Adjustment Technical Expert Panel (TEP) for additional concrete guidance on when and how to adjust for social risks.
Samantha Tierney and Somosree	**Question 1 comment:** While working in the performance measurement area, we have seen several instances where inadequate risk adjustments have had unintended consequences. Hence, we applaud NQF's Social Risk Trial initiative and appreciate the	We appreciate the commenter's support on Social Risk Final Report. Based

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Dutt, American College of Physicians (ACP)	opportunity to comment on the report. The COVID-19 pandemic has further highlighted the inequities that exist in care delivery, and has underscored the importance of understanding and considering all risk factors, including social risks, in the healthcare performance improvement arena. After reviewing the report, we have some comments for the committee to consider. 1. We appreciate NQF recognizing its role in efforts to eliminate healthcare inequities by considering the inclusion of social risk factors in NQF measure submissions. However, as highlighted in both the Social Risk trial reports, there remains little guidance on the social risk concepts and variables to be used in performance measurement. This led to a lot of variability in the factors that were included by the measure developers. Some were better indicators of social risk than others. For better analysis, we need more standardized concepts. We understand that NQF recognizes this issue and we look forward to NQF providing more concrete guidance regarding standardized social risk factors, in the near term. 2. As mentioned in the report, there are a couple of readily available sources that can be used to identify and record patient-level social risks: the ICD-10 Z Codes and the Supplemental Data Elements of an eCQM. However, they are rarely being used to collect social risk information. We understand that there are several barriers to use these codes, like, having a standardized EHR-based screening tool, inadequate knowledge among providers and medical coders, and so on. Policy makers should make this a priority and incentivize physicians and groups to work towards resolving these barriers. If we can utilize these readily available data sources and further improve on them, that will help us to understand the causes of the disparities in care. We can then analyze and include these factors in risk adjustments. 3. We strongly believe that social risk factors are equally important as individual patient level clinical variables and should be prioritized and included in the same manner in performance measures. If we don't account for social risk factors, we can penalize physicians who serve a major proportion of our marginalized patient population and mask these disparities in care. By using the performance measures in accountability programs without adjusting for social risks, we risk taking away resources from those	on the number of measures evaluated in both trials, we agree that the measurement community seeks more support from NQF in the form of guidance, technical assistance, and resources. An NQF immediate actionable priority could be a formal cataloging of all social risk data elements considered and included in adjustment models, stratified in measure specifications, and in reported performance rates for measure submissions. We also agree that select social risk data elements are available for use by providers and developers, that policies and payment changes could improve social risks data reporting, and that the use of these data elements should be evaluated for unintended consequences of use.

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	physicians and patients who may need them the most. NQF will have to work with policy makers to address this concern and ensure that NQF endorsed measures are not leading to unintended consequences.	
John Shaw, Next Wave, Inc.	**Question 1 comment:** Next Wave applauds the findings and recommendations in the NQF Social Risk Trial Final Report. We have actively followed these efforts and provided input on them for many years through participation in a number of NQF initiatives. With a renewed focus on and investment in Health Equity, the report provides a strong foundation to now move forward into implementation. We offer a few suggestions to help facilitate this movement based on our experiences and NQF, CMS, and state health policy initiatives. NQF should take a **leadership r**ole in disseminating broadly the knowledge gained in providing technical assistance to measure developers, updates to measure endorsement criteria for social risks, and innovative data sources and approaches identified during measure evaluations. Expand recognized and listed stakeholders beyond policymakers, payers, providers, and researchers/research funders of healthcare delivery to also include **Community-based organizations** in other health related sectors, and the patients themselves and their caregivers. Much of the focus of efforts to date look at the healthcare delivery viewpoint which only impacts approximately 10% of Health. This has already begun and NQF, but more attention to these other stakeholders and incorporation of their voice and ideas holds promise to close the Health Equity gap more quickly and effectively.	We appreciate the commenter's support on Social Risk Final Report. We are pleased you have identified NQF as the leader to advance NQF's from trial work into implementation activities, including increased NQF guidance, technical assistance, and resources. We are also heartened with your recommendation to expand the circle of measure engagement to include community-based stakeholders, specifically as the report defines social risks as conditions or factors that may influence health outcomes, including socioeconomic status, race and ethnicity, gender, social relationships, residential and community context, and health literacy.
Koryn Rubin, The American Medical Association (AMA)	**Question 1 comment:** The American Medical Association (AMA) appreciates the opportunity to comment on this draft report and recommendations. The AMA has long recognized that racial and ethnic health inequities are an unjust and major public health reality in the United States and we support the work of the National Quality Forum (NQF) to ensure that performance measures used for accountability purposes are	We appreciate the commenter's support on the recommendations included in the NQF Social Risk Final Report. The NQF Risk

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	adequately adjusted both for clinical and social risk factors when appropriate. We support the key recommendations for all stakeholders and appreciate the recommendations to consistently collect these data and to permanently evaluate each measure undergoing NQF review and endorsement consideration to determine whether risk adjustment of social risk factors is warranted. Regarding the last recommendation, the AMA is disappointed that that the review process thus far has been passive and while we may have a better understanding on how some variables may impact performance scores, the pilot and its extension have not yielded useful advancements beyond some measures possibly including social risk factors. We believe that the field would be better served if this work could have identified new and emerging data sources from which social risk factors could be applied, worked with developers to understand the feasibility of data collection and use for risk adjustment, and update the measure evaluation criteria based on these findings. In addition, the purpose of the new Risk Adjustment Technical Expert Panel is not clear, particularly as it relates to the Scientific Methods Panel. It would be useful to understand what this new group will contribute beyond just adding on another layer of endorsement review. We also believe that additional education and detailed guidance on the development of conceptual models and proper methods by which the testing and analysis of clinical and social risk factors in the models should be conducted would be useful since we continue to see the same approaches and data elements used across measures and over time. Furthermore, we strongly encourage NQF to emphasize and evaluate the potential unintended consequences that the inclusion or exclusion of social risk factors or use of proxies may play when a measure is used for accountability purposes. The absence of end users' reporting any concerns or issues with a measure should not be considered acceptable and developers must begin to evaluate the potential implications that their measurement decisions may have when a measure is used for pay-for-performance or public reporting for example. The recent study by Alberti and colleagues serves as a good example of the potential negative unintended consequences. Specifically, they found that due to the differences in the dual eligible (DE) population stratifying by DE-only	Adjustment Technical Expert Panel (TEP) was established in 2020 to provide a concrete guidance on when and how to adjust for social and functional risks. For more information, please refer to the Risk Adjustment Guidance project page. The NQF project team and the Risk Adjustment TEP will produce a step-by-step technical guidance and minimum standards on how to adjust measures for risk factors (clinical, social and functional). In collaboration with the Scientific Methods Panel (SMP), and we will align the evaluation criteria for reviewing risk adjustment models.

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	within the confidential Hospital Disparities Reports are misleading and further exacerbate inequities, which is counter to the goals of quality and its related incentives to close or minimize healthcare inequities.[1] 1 We also encourage NQF to consider adding recommendations for health information technology vendors and standard setting bodies. These stakeholders play an important role in advancing and standardizing the capture of these data and it would be a mistake to not include recommendations for them in this report. Thank you for the opportunity to comment. [1]Alberti, Philip., Baker, Matt., Dual Eligible Patients Are Not The Same- How social risk may impact quality measurement's ability to reduce inequities.	
Janice Tufte, Hassanah Consulting	**Question 2 comment:** Zip codes are a good start as access to services such as food, transportation, broadband, jobs etc. is documented	We agree with the commenter's suggestion. In fact, this report finds that one of the routinely social risk factors by developers is zip code and may be used to identify community and access social risks.
Erin O'Rourke, American Health Insurance Plans (AHIP)	**Question 3 Comment:** We recommend NQF look to the work of the Gravity Project as well was the new lists of Z codes as ways to enhance claims and EHR data with additional information on social risk factors that could be leveraged for performance measurement.	We agree with the commenter's suggestion. The NQF Risk Adjustment Technical Expert Panel (TEP) was established in 2020 to provide additional concrete guidance on when and how to adjust for social and functional risks. Its Risk Adjustment Guidance Environmental Scan Final Report provides a comprehensive list of key social risk factors that have

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		been used by measure developers and researchers and identified future opportunities.
Deborah Paone, SNP Alliance	**Question 3 comment:** Some of the possible avenues to improve the availability and usability of social risk information include: Standardize SDOH fields, definitions, and data elements across electronic health record platforms Extend health information exchanges to reach home and community-based services providers and build capacity for interoperability across service sectors Connect SDOH assessment information in a data repository with permissions so that the individual does not have to repeatedly provide information on SDOH issues.	We appreciate the commenter's suggestions on standardizing social risks standardization, infrastructure, and data collection and sharing.
Clarke Ross, American Association on Health and Disability (AAHD)	**Question 4 Comment:** NQF Measures Adjusted for Social Risk (pages 33-36) The report includes a variety of CAHPS surveys, but not the CAHPS HCBS (Home-and-Community-Based Services). The report should state applicability of the report's approach to the CAHPS HCBS. Any expectation and desire for future analysis would be helpful to the disability and aging communities engaged in HCBS, Consistent Use of Individual Functioning Measures (pages 33-36). We are not expert at the current use and potential challenges of the individual functioning measures. We assume that the NQF Social Risk Adjustment analysis and report will use the almost identical functioning measures used by the NQF patient experience and functioning committee.	We appreciate the commenter's thoughtful recommendation to include community stakeholder engagement, specifically individuals with disabilities and the aging, as well as the use of functional and patient experience content. This report is based on a review of all measures submitted to NQF during fall 2017 and spring 2020. The CAHPS HCBS measure was not submitted for re-endorsement during this time period. However, according to the technical report of the HCBS CAHPS, the publicly reported results use the following factors in the

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		case-mix adjustment: self-reported physical health, mental health, age, sex, education, residential independence, and proxy response. For additional concrete guidance on when and how to adjust for social and functional risks, please refer to the Risk Adjustment Guidance project page.
Erin O'Rourke, America's Health Insurance Plans (AHIP)	**Question 4 comment:** There are specific resources, structures, and policies that need to be put in place before performance measurement and value-based payment systems can be used to appropriately assess and incent equitable care. These include data standards for sociodemographic data and equity measures, IT infrastructure to collect and share interoperable data, financing to build this infrastructure to make this information more interoperable. It also requires additional investment support and resources to address socioeconomic barriers to health. The federal government should help invest in this infrastructure to promote the standardized collection and greater interoperability of sociodemographic data in a secure fashion. Measures that are used for public reporting or value-based purchasing should accurately and fairly reflect the quality performance of the measured entity. Solutions or adjustments to quality measures and performance reporting should be (a) meaningful, such that adjustments are significant enough to address the systematic disadvantages that are faced by providers and payers who serve vulnerable populations; (b) transparent, such that entities can project their eligibility for the proposed adjustments; and (c) should not harm those high-performing organizations and plans who have made significant investments in attaining high performance.	We appreciate the commenter's support on the recommendations included in the NQF Social Risk Final Report. We agree that a standardized ecosystem infrastructure is required to evaluate social risks for endorsement, implementation purposes, and fair provider assessment and incentivization based on diverse population needs.

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John Shaw, Next Wave, Inc.	**Question 4 comment:** NQF should formalize collection and public reporting of social risk performance statistics for both measure developers and NQF itself. If performance measurement and public reporting are drivers of improvement in healthcare and health, they should also be beneficial for the measure development and endorsement enterprise itself. The Committee and other commenters have identified candidate metrics in recommendations.	We appreciate the commenter's support on Social Risk Final Report. NQF's encourages developers to report performance by social risks and recognizes the value in stratifying performance by social risks.
Janice Tufte, Hassanah Consulting	**Question 5 comment:** Utilize the outcome and reporting knowledge to better allocate $$ to address disparities	We agree that further research is needed to assess the impact of risk adjustment on measure performance, as well as resource allocation to help address measurement-driven and population-based disparities.
Erin O'Rourke, American Health Insurance Plans (AHIP)	**Question 5 comment:** The following federal policies and research would be helpful for payers to advance their own work to address social risks and their ability to support providers' efforts to address social risk, such as through value-based pay arrangements: 1) MLR: Medically related social services that address social risks should be considered as Quality Improvement Activities under in the Medical Loss Ratio calculation. 2) Capitated Rate: HHS should enumerate which medically related social services could be included in health plans' capitated rates while allowing States to choose amongst the enumerated list based on socioeconomic needs prevalent in the State to provide greater clarity and direction to health plans. 3) Benefit Structure: Continue Flexibility granted health plans during the pandemic to quickly adjust benefits to address emerging socioeconomic needs. 4) Sustain Current Work for ROI: CMS and CMMI should sustain both CMMI-driven and plan-developed SDOH models to ensure health plans' current work and investments are	We appreciate the commenter's comprehensive and specific policy recommendations to incentivize social risks data reporting, as well as payment and program guidance. Although these recommendations are beyond the scope of this report, we believe they are important policy suggestions for federal agencies to consider.

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	not curtailed. For example, CMMI made Special Supplemental Benefits for the Chronically Ill (SSBCI) under Medicare permanent. Similar permanence should be given to CMMI Medicaid demonstrations related to addressing social risks. 5) Develop the Evidence Base: More evidence is needed to determine which interventions work best for which populations and under which conditions to properly determine which interventions to fund, pursue, and reimburse. Similarly, more discussion should revolve around which SDOH stakeholders believe should be "medicalized" such that the health care system address and pay for addressing them versus those SDOH that should not be "medicalized". 6) Interagency Collaboration: Government Agencies should improve collaboration amongst each other (USDA, HUD, HHS, DOL, DOT) to create joint funding streams and waivers to address social risks.	
Deborah Paone, SNP Alliance	**Question 5 comment:** The SNP Alliance has surveyed special needs health plans that are members of the SNP Alliance over the last several years and they've offered many emerging practices on addressing special populations with clinical, behavioral health, and social risk needs. See our brief at: snpa-briefing-paper-on-sdoh-paone-final-6172019.pdf (snpalliance.org). Some emerging effective practices include: Employ outreach strategies effectively and in a tailored/customized way to reach various sub-groups in a way that meets the person where he/she/they are and in a way that is most acceptable and as early as possible to identify risk factors. With the individual, create an enhanced care management approach that makes use of the SDOH risk information in addition to functional status, medical status, behavioral health status and other information to craft a plan that works. This may mean social risk issues are prioritized ahead of some medical management issues that are not as acute and may require involvement of non-traditional service organizations. Collaborate with providers and community agencies as partners working on the larger underlying social risk issues.	We appreciate the commenter's support on Social Risk Final Report. We agree that social risks, by nature of the definition, are outside the purview of healthcare; therefore, necessitate risk evaluation in a community context to "treat" medical and non -medical needs. For providers, a broad social risks evaluation may also include identifying community resources to counter the negative effects of social risks. For developers, NQF encourages evaluating the unintended consequences of including and not including

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	Work with others to support ways that address limited access, such as supporting telehealth and mobile units Work with ethnically and linguistically diverse community leaders/agencies embedded in neighborhoods to improve information sharing, education, outreach, and access to services and that help increase individual engagement and "activation" in self-care practices.	social risk in adjustment models. Please refer to the [Risk Adjustment Technical Expert Panel (TEP)]() for additional concrete guidance on when and how to adjust for social risks.
John Shaw, Next Wave, Inc.	**Question 5 comment:** One of the major challenges identified by the committee and other commenters is the inconsistent use of existing tools to collect social risk data like the ICD-10 Z-codes and EHR social risk fields. The use and accuracy of race, ethnicity, and language (REAL) data is also a concern. Without consistent and accurate collection of this data, it is difficult to envision success in addressing Health Equity for the foreseeable future. To help address this gap and accelerate innovation, we recommend that NQF encourage CMS and other payers to provide fiscal incentives for the effort needed. This "Pay to Report" investment strategy was shown successful in significantly overcoming "paperwork burden" resistance in state and federal payment program and quality initiatives, particularly when provided as new resources rather than re-cutting a fixed pie. These investments should be extended to service providers in other health related social sectors in local communities as well.	We appreciate the commenter's support on Social Risk Final Report. We share your concern that numerous barriers exist for under reporting and inconsistent and inaccurate reporting of social risks data. As a positive and actionable step in reducing health disparities, providers may need to be incentivized to collect and report robust, standardized, and accurate social risks data.
Janice Tufte, Hassanah Consulting	**Question 6 comment:** Support community efforts that understand the needs of the community and where resources are needed to improve the health and healthcare for their members. Important to create a realistic pipeline for educating and mentoring population representative health workers / professionals to better meet the needs of the people.	We appreciate the commenter's thoughtful suggestions on understanding the needs and effects of the community as recommended in our report: "The Disparities Standing Committee encourages measure developers to carefully conceptualize pathways or

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		methods for considering how social risk factors affect the measure being developed. Too often a data-driven approach is used, and important potential risk factors may be omitted without due consideration. Developers are encouraged to seek NQF technical assistance for adjustment for social risk use in measure submissions."
Clarke Ross, American Association on Health and Disability (AAHD)	**Question 6 comment:** The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda. The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise. We write to express our appreciation of this work: Consistent Collection of Data on Race, Ethnicity, Education, and Language (pages 4 and 19). We appreciate and support the recognition of individuals with disabilities in the page 4 discussion of "marginalized populations." We agree and support the NQF	We appreciate the commenter's support on the Draft Social Risk Final Report. We agree that all populations should be assessed for performance, which begins with consistent collection, analysis, and public reporting of demographic, clinical, and social risk factors to detect gaps and inequities. Please refer to the Risk Adjustment Technical Expert Panel (TEP) to provide additional concrete guidance on when and how to adjust for social risks. Its Risk Adjustment Guidance Environmental Scan Final Report provides a comprehensive list of key social risk factors that have

Commenter	Comment	Proposed Response
	recommendation for consistent collection, analysis, and public reporting of demographic data. For future work, we encourage NQF to consider collecting, analyzing, and public reporting the applicability of the following demographics: race, ethnicity, disability status, age, sex, sexual orientation, gender identity, primary language, rural/urban environment, and service setting. For almost the past two years, the Consortium for Citizens with Disabilities (CCD), the Disability and Aging Collaborative (DAC), and the Disability and Rehabilitation Research Coalition (DRRC) have consistently recommended consistent collection, analysis, and public reporting: The COVID-19 pandemic has reemphasized the longstanding structural inequities of our health systems. Moreover, the pandemic has exposed major holes in our data systems that prevent an effective way to even identify health disparities. Rightly, this failure has reenergized a push to improve data collection systems and build in the capabilities of those systems to collect, report, and verify data stratified by key demographic factors including by race, ethnicity, disability status, age, sex, sexual orientation, gender identity, primary language, rural/urban environment, and service setting. Data should be collected to permit intersectional analysis across multiple demographic categories, such as race and disability.	been used by measure developers and researchers and identified future opportunities.
Deborah Paone, SNP Alliance	**Question 6 comment:** The SNP Alliance recommends use of the following approaches: Sampling – measure developers should specify minimum sample sizes needed for different populations to ensure accurate results in each population sub-group. For example, if the minimum size is 1000 and only 20 people with disabilities are in the sample, is the result valid/accurate for people with disabilities? This may be especially important with self-report measures/PROMs. Methods of administration and scoring – NQF should require developers and stewards to identify if methods of administration (e.g., such as in a self-report survey) need to be tailored or customized based on different populations and how to do so. Likewise if there are different scoring scales that have been validated in various sub-groups or if the scoring differs by population characteristics (or if some kind of adjustment is needed	We appreciate the commenter's support on Social Risk Final Report. We share your belief that increased NQF guidance on measure evaluation and risk adjustment will support the measure developers, including guidance on sampling, methods, units of analysis, variables, and stratifications. We also agree that a robust dissemination plan, including

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	prior to scoring)—this should be identified. Unit of Analysis – If there are population-based measure results, we recommend using the smallest geographic unit as possible—such as the 9-digit zip code—in order to reveal differences that may be masked when using larger geographic areas. This is particularly important when those with health disparities comprise a small proportion of the larger population. Variables – Test all measures using dual eligible, low-income, and disabled status as proxies (to start) and provide guidance on use of other variables. NQF could serve in a leadership role in this. Since DE-LIS-disabled status is known/collected and since the National Academy and ASPE have both found dual eligible status to be a reliable proxy for SDOH risk factors, these can be used in testing now. This will get us started with a common approach--as we collectively work on standardizing definitions and datasets for other social risk factors. Stratify reporting results to compare like entity to like entity, in terms of their patient/beneficiary/enrollment population characteristics. This should become the norm. NQF can provide important guidance here. Dissemination – To move forward, information must be shared and it must be in a way that is accessible to various stakeholders. We must include as goals: educating and learning and be inclusive as we go along.	NQF technical assistance and resources is warranted. The NQF Risk Adjustment Technical Expert Panel (TEP) was established in 2020 to provide additional concrete guidance on when and how to adjust for social and functional risks. For more information, please refer to the Risk Adjustment Guidance project page