Meeting Summary

Disparities Standing Committee Web Meeting 7

The National Quality Forum (NQF) convened a public web meeting for the Disparities Standing Committee on June 11, 2021.

Welcome, Introductions, and Review of Web Meeting Objectives

Ms. Elizabeth Flashner, NQF Manager, welcomed participants to the web meeting and introduced Chris Queram, NQF Interim President and CEO. Mr. Queram provided opening remarks to the Disparities Standing Committee, highlighting the critical work of the committee and NQF's enduring commitment to improving health equities. Ms. Flashner introduced NQF's staff and the committee's co-chairs, Drs. Philip Alberti and Nancy Garrett, who each gave brief welcoming remarks. Ms. Flashner reviewed the meeting objectives, which included reaching consensus on the Draft Social Risk Trial Final Report (hereafter, called the "draft report"), overall content, findings, recommendations, potential draft report gaps, and public comments for the draft report recommendation. The meeting concluded with public comments, next steps for the draft report, and final Disparities Standing Committee and co-chair comments. Mr. Isaac Sakyi, NQF senior analyst, conducted the Disparities Standing Committee roll call and thanked the Centers for Medicare & Medicaid Services (CMS) for their guidance and unwavering support during NQF's social risk trial journey and this vital work.

Social Risk Trial Overview

Dr. Sharon Hibay, NQF senior consultant, provided a brief recap of the history of the Disparities Standing Committee activities and the social risk trial, which were guided by two core principles that 1) *inequities in health and healthcare should be identified and reduced*, and 2) *performance measurement should not lead to increased disparities, nor should it penalize providers who care for large proportions of marginalized patients*. She also shard that although the trial ends with a final report to be published in July 2021, NQF's Risk Adjustment Guidance project, under the guidance of the Risk Adjustment Technical Expert Panel (TEP), will finalize the development of technical guidance on social and functional status-related risk adjustment in quality measurement.

Methods and Findings

Dr. Hibay highlighted methods and findings by which NQF staff collected, aggregated, and analyzed data for submitted measures that were considered and/or adjusted for social risks during the fall 2017 through spring 2020 measure evaluation cycles. These data included general measure information (e.g., NQF #, title, and measure type), submission responses to consideration and inclusion of risk adjustment models and social risk data elements questions, as well as process, recommendations, and decisions throughout the steps of measure evaluations.

Further, measure developers collectively submitted 314 measures and of these, 125 submitted measures included some type of rationale for adjustment of demographic, clinical, and/or social risks and 120 measures (95 percent) provided a conceptual rationale for potential impacts of social risks. A conceptual rationale supporting the inclusion of social risks in adjustment models was provided for 74 measures (59 percent), yet only 38 measures (30 percent) included individual social risk factors in the final risk model.

Draft Social Risk Trial Final Report Themes and Recommendations

Theme – Race, Ethnicity, and Gender

Dr. Hibay briefly summarized the social risk trial themes and recommendations, restating that the accountability to support the solutions for long-standing societal issues of bias and discrimination specific to health and health inequities belongs to the entire measurement community. The influence of social risks, bias, and discrimination experienced during the pandemic underscores the necessity to collect and analyze all applicable risk factors so that care delivery reflects population-defined needs. Similarly, providers implore for support to capture social risks data, equitable reimbursement and payer incentivization for significant care needs of marginalized populations, and fair performance assessment based on patient needs. Based on the multiple discussion held by the Disparities Standing Committee, the draft report clarifies that the demographic variables of *race*, *ethnicity*, and *gender* are imperfect proxies used for SES (e.g., dual eligibility and low-income subsidy) and should be each measured separately. Further, they do not adequately address the social risk factors of bias and discrimination, yet currently, no social risk factors representing the effects or influences of bias and discrimination exist.

Recommendations

Dr. Hibay also summarized key recommendations outlined in the draft report. First, the declaration that the elimination of health and healthcare inequities is a top national and performance measurement priority, which starts with consistently collecting, reporting, and submitting demographic and social risks data (e.g., race and ethnicity, education, and language). Next, is acknowledgment that without robust, standardized, and interoperable data that represents social risks, the utilization of measures to improve health outcomes and healthcare equity is significantly hampered. Recommendations also include individually assessing each measure submission for appropriateness to risk adjust, assessing the effects and unintended consequences of social risks for marginalized populations and providers who treat them to ensure measure alignment with program and policy goals.

Recommendations for NQF include formalizing the consideration and analysis of social risk factors a permanent endorsement and maintenance requirement for measure evaluations. They also recommend updating the evaluation guidance with clear expectations for the inclusion of social risk factors in risk adjustment and stratifying measure performance reporting to identify care delivery inequities between populations and settings. The draft report further recommended increasing NQF's technical assistance capacity and available resources for the measurement community to support measure development and submissions that consider and include adjustment for social risks, particularly for emerging measure developers. The guidance should include when and how to collect social risk data and include within risk adjustment models, which will be supported by the activities of the Risk Adjustment TEP.

The draft report recommended that developers should actively participate in the advancement of measurement science with each submission by striving strive to explore, test, and report the effects of social risks on healthcare delivery and outcomes inequities. These actions will ensure accurate reporting of care quality that reduces harm and unintended consequences to marginalized patients and their providers. The draft report also recommends stratification of performance data by demographic, clinical, and social risks when data is accessible, clearly defining the conceptual and empirical relationships between social risk factors and outcomes, and the rationale for including (or not) social risks in adjustment models, and asks developers to routinely seek NQF technical assistance for adjustment for social risks support in measure submissions.

Public Comment Review and Discussion

Public Comments

The draft report was open for a 30-day public comment period from April 19, 2021 through May 18, 2021, offering stakeholders the opportunity to provide feedback on the draft report and recommendations.

Nine organizations submitted a total of 22 total comments for the overall draft report findings and recommendations, including four provider, three payer, and two patient/consumer groups. NQF presented a high level- overall of the comments by grouping them into four pivotal themes:

1. NQF should adjust for social risks in quality measures .
2. Social risks data is pivotal to reversing inequities.
3. Social risks extend beyond measure endorsement.
4. Stakeholders request detailed social risks guidance.

Discussion

The Disparities Standing Committee co-chairs led the public comment discussion. NQF staff guided the members to focus on answering the social risk trials' focal question: Should quality measures adjust for social risk factors? To frame the discussion, committee members were asked to consider these four themes based on past Disparities Standing Committee activities, the draft report, and their expertise to identify actionable priorities to continue the work.

Dr. Alberti initiated the Disparities Standing Committee discussion, remarking that the information in the draft report and the public comments generally mirrors that of its collective works.

Public Comment Recommendation 1: NQF Should Adjust for Social Risks in Quality Measures

Recommendation 1 contained four items. 1) Dr. Alberti affirmed the highly favored and uniform agreement that quality measures should be adjusted for social risks. One member stated that the public comments were consistent with the committee's wish to address the use of risk adjustment and performance metrics to advance health equity. 2) The public comments agreed that each measure submission should be individually considered for risk adjustment appropriateness (i.e., demographic, clinical, and social risks). 3) NQF should adhere to equal processes, methods, and evaluation of risk adjustment models that consider social risk factors, demographic, functional, and clinical risk factors equally. The members also clarified that the application of risk adjustment is complex and that the risk adjustment of all domains (i.e., demographic, clinical, functional, and social risks) are not equal. Rather, the processes for the adjustment of all risk factors should be applied equally. 4) Public commenters also agreed that NQF should adhere to reporting and stratifying performance data by demographic, clinical and social risks in the evaluation criterion, and for each measure submission, to differentiate performance among and between measure populations. Multiple members stated that stratification is warranted. Dr. Alberti also confirmed the Risk Adjustment TEP continues activities on specific technical guidance regarding the processes and methods of adjusting for social risk and functional status factors, and clinical clusters. He further shared that the current risk adjustment TEP is developing a framework that requires that developers to build a conceptual model and then add identified variables, translate those variables into the ones that can obtained and used, and help analyze the unintended consequences of using a proxy. He encouraged members to identify specific short- or medium-term goals from the public comments.

Theme – Language Choice

A few Disparities Standing Committee members identified specific words in the public comment themes that may require thoughtful reflection prior to finalizing in the final report. They further shared concerns related to the unintended consequences to patients and providers when word selection is not precise for unadjusted measures in value-based payment models or inappropriate distribution of resources based on social risks with inappropriate risk adjustment based on risk factor selection. General member discussion noted that the spirit of the use of social risk adjustment is captured. They also recommended clarifying language and definitions for the purpose of risk adjustment and what should be risk adjusted, and the uses of stratification. The members were encouraged to discuss the overall themes, rather than debate the specific meaning of individual words, which will be the purview of the Risk Adjustment TEP in the anticipated risk adjustment technical guidance. NQF staff confirmed that the public comments and the committee discussion will be factored into the final report language.

Public Comment Recommendation 2: Social Risks Data Is Pivotal to Reversing Inequities

Dr. Alberti led the discussion for the five items within public comment recommendation 2. The public commenters recommended: 1) Develop a national social risks data reporting infrastructure that uses standardized and interoperable data elements for collection, aggregation, and risk adjustment. 2) Incentivize data collection to remedy reversible societal and healthcare inequities, and fairly measure population-defined social risks needs and care quality. Commenters supported both incentivizing and reimbursing care delivery for the collection and validation of patient-reported social risks data. 3) Incentivize and reimburse providers for the care of patient with high clinical, demographic, and social risk needs. Multiple commenters mentioned numerous unjust financial burdens in reimbursement, incentives, and resource allocations for providers who care for marginalized populations. 4) Examine measure programs and payment models for any unintended consequences of risk adjusting (or not), and the measure program policy and implementation requirements. Although beyond the scope of the project, commenters requested the examination of measure programs and payment models stressing that measures were not developed and tested for all programmatic context and implementation rules. One member stated that race and SES are often intertwined: it is SES for their Federally Qualified Health Centers (FQHC), such as the type of insurance, lack of insurance, “churn” of insurance, or under-insurance that creates a lack of care access, which is higher in Black and Hispanic populations. Although the discussion primarily focused on adjustment for social risks at the individual level, one member stated there are large real-world effects of these measures on safety net clinics. Committee members cited numerous current concerns for measures for programs that do not account for social risks. They also discussed the consequences of using non-adjusted measures in value-based payment models, such as Accountable Care Organizations (ACOs), which could lead to excluding or removing safety net providers. Other members stated the financial stakes for the safety net hospitals and providers continue to be high and hopes NQF will lead the work on perceptions around quality and how resources are distributed. Another member stated that resource distribution is at the core of avoiding, creating, and perpetuating structural disparities and racism. 5) Select social risks data elements that are accessible, yet very minimally collected. For example, one member discussed the low reporting of ICD-10 Social Determinants of Health (SDOH) Z codes in 2017 Medicare beneficiaries (which is1.4 percent of total beneficiaries). One member stated that the current goal is to select feasible data elements that quantify social risk factors and capture the actual risks of bias and unjust distribution of resources and opportunity. By considering and testing the best current data available, measurement science and risk adjustment will advance a fairer assessment of provider performance based on population risks and needs.

Patient Perspectives on Social Risks

Two patient/consumer commenters stated these recommendations would help provide information on care choices with the ability to differentiate care between providers using stratification (rather than risk adjustment), as well as for the same provider caring for patients with varying social risks. They specifically requested capturing data that represents patient priorities and characteristics. Further, patients and consumers want social risks data that is collected in healthcare to be utilized by non-healthcare social and community stakeholders to support and improve overall quality of life and reduce societal inequities. Stratified data would help patients and consumers identify how providers care for other similar patients based on social risks.

Public Comment Recommendation 3: Social Risks Extend Beyond Measure Endorsement

Dr. Garrett led the discussion for the three items in public comment recommendation 3. The public commenters recommended: 1) Developers should evaluate the effects and unintended consequences to patients and providers when adjusting (or not) for social risks before and after implementation in incentive programs. 2) Providers should collect and aggregate social risks data to identify and tailor care delivery to patient-defined needs and reduce quality of care inequities. 3) Researchers should evaluate the effects and unintended consequences of social risks to patient outcomes in measure programs and payment models for patient care and outcome inequities and test model updates to ensure providers caring for populations with increased social risks can compete and be incentivized fairly. Robust committee discussion stated that the headline for the public comments reflect that adjustment for social risks is not solely about risk adjustment technical guidance. Rather, NQF should lead national activities to understand the consequences of measure from use perspectives within programs, payment models, and for providers among and between varied populations, including previously implemented measures.

Public Comment Recommendation 4: Stakeholders Request Detailed Social Risks Guidance

Dr. Garrett led the discussion for the four items in public comment recommendation 4. The public commenters recommended: 1) NQF should catalogue available and tested social risk data for reporting and risk adjustment consideration, identifying standardized, new, and emerging data sources and application. Multiple commenters recommended that NQF maintain its leadership role and challenge the measure developer community to move beyond current measure development limitations, and understanding that quality measurement, in its currently utility, is a “color blind” concept that is not used as a lever to achieve health and healthcare equity. 2) NQF should provide developers guidance and technical assistance for data feasibility, collection standardization, and risk adjustment uses. One member recommended engaging and collaborating with other external measurement partners as conceptual frameworks continue to change, widen, and deepen over time. 3) NQF should provide detailed guidance and technical assistance on developing conceptual risk models and testing and analysis methods, emphasizing frequently used social risks data and models. One commenter stated that NQF should provide peer guidance for social risk variables and resources for data selection, consideration, testing, and inclusion methods for social risk factors, yet not be overly prescriptive in its requirements. Another member stated that measure developers and implementers should be held to evaluation and testing requirements, specifically for measures when conceptual rationales and testing demonstrate the appropriateness to adjust for social risks. 4) NQF should broaden technical assistance to measure users, including states, providers, and consumers to collect, report, and understand the purposes and uses of social risks data. One member stated that NQF should also provide technical assistance to measure users on how to implement and utilize measures that use risk adjustment to assess population-based needs and stratified performance rates to differentiate population-based performance gaps.

Dr. Garrett stated that the public comments are largely supportive and reflect the content of the draft report and the discussions of the Committee. NQF confirmed that the final report will incorporate revisions based on both public comments and the committee discussion. The members reflected on the trajectory of adjusting for social risks through both trial periods, and that most early members and public comments were in favor of the recommendation, yet a minority was opposed, compared with today where there is clearly a consensus among public commentors to adjust for social risks.

Overall Discussion of Project

Dr. Alberti provided a summary of the overall project with a review of the Disparities Standing Committee previous works, and highlighted the 2017 Disparities Standing Committee report, entitled, *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity*. This report details how performance measurement and its associated policy levers can be used to reduce health and healthcare inequities. Members inquired on NQF's ongoing role in social risks and health equity, beyond the current Risk Adjustment Guidance.

Following Dr. Alberti's remarks, the committee identified actionable priorities for NQF and CMS. Members of the committee clearly stated that additional work is needed for health equity.

NQF Actionable Priorities from the Draft Report and Public Comment Recommendations

- Finalize and implement the Risk Adjustment TEP technical guidance that provides recommendations for adjusting measures for social risks and functional status . This includes the development of concrete guidance on social risk data elements, resources, and methods for how to consider, test, and include adjustment for social risk in measure submissions, when applicable. Implement developer accountability for submitting completed measure-specific adjustment for social risk evaluation questions for each individual measure submission, if ratified. Risk adjustment will allow for providers to be compared appropriately for participation in delivery and payment models.

- Request developer accountability for submitting stratified measure performance rates and the potential negative impacts of the of the measure based on key social risk factors for each individual measure. Stratification will allow differences of quality measure scores to be known based on specific factors.

CMS Actionable Priorities from the Draft Report and Public Comment Recommendations

- Review and update measure programs, payment models, and implementation requirements based to align payment for social risks and population-based needs, so providers who care for large proportions of marginalized patients may be reimbursed, incentivized, and compete fairly in value-based payment.

- Review all policy, reimbursement, and payment reform levers within CMS' purview to address structural racism head on and advance health equity, including the allocation of health-related community resources based on patient-reported population needs.

- Collaborate with other Department of Health and Human Services (HHS) agencies and disseminate final report findings to align on goals and policies.

In response to the overall report, the committee noted the importance of clearly articulating the differences between developing new measures of that assesses bias and discrimination, stratifying measure performance by social risks, and adjusting for social risks, with each having separate intended implications for advancing health equity. A new social risk measure would attempt to quantify unfair treatment based on unjust structural or systematic discrimination or individual behaviors. Stratifying performance will assist with care delivery choices by identifying care gaps for marginalized populations.

Public Comment

Mr. Sakyi opened the web meeting to allow for general public commenting. No public comments were offered.

Next Steps

Dr. Alberti encouraged members to stay current with the activities of Risk Adjustment TEP to assist them in developing the next chapter of risk adjustment methodologies. Finally, Dr. Alberti congratulated the committee for being comprehensive in their thinking and development of recommendations described in the draft report.

Mr. Sakyi announced that the Social Risk Trial Final Report will be released on July 14, 2021. In addition, he provided information on current NQF ongoing work related to the Social Risk Trial including a CMS-funded project on Risk Adjustment that is producing a technical guidance for social and functional risks adjustment in healthcare quality measures.

Concluding Comments.

Drs. Alberti and Garrett thanked the committee members for their efforts and enthusiasm, and the meeting was adjourned.