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Accounting for Social Risk Factors in Medicare Payment

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SNP Alliance Executive Roundtable Meeting

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Committee on Accounting for SES in Medicare Payment Programs

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Statement of Task

Issue five brief reports that:

1. Provide a definition of *socioeconomic status* for the purposes of application to Medicare quality measurement and payment programs;
2. Identify the social factors that *have been shown* to affect health outcomes of Medicare beneficiaries;

Statement of Task

3. Specify criteria that **could** be used in determining which social factors *should* be accounted for in Medicare quality measurement and payment programs;
4. Identify methods that **could** be used in the application of these social factors to quality measurement and/or payment methodologies; and
5. **Recommend** existing or new sources of data and/or strategies for data collection.

Identified Social Risk Factors

1. Socioeconomic position
2. Race, ethnicity, and cultural context
3. Gender identity and sexual orientation
4. Social relationships
5. Residential and community context

Criteria for Selecting Social Risk Factors

Three overarching considerations encompassing five criteria could be used to determine whether a social risk factor should be accounted for in performance indicators used in Medicare value-based payment programs. They are:

A. The social risk factor is conceptually and empirically related to the outcome.

B. The social risk factor precedes care delivery and is not a consequence of the quality of care.

C. The social risk factor is not something the provider can manipulate.

Social Risk Factor Framework

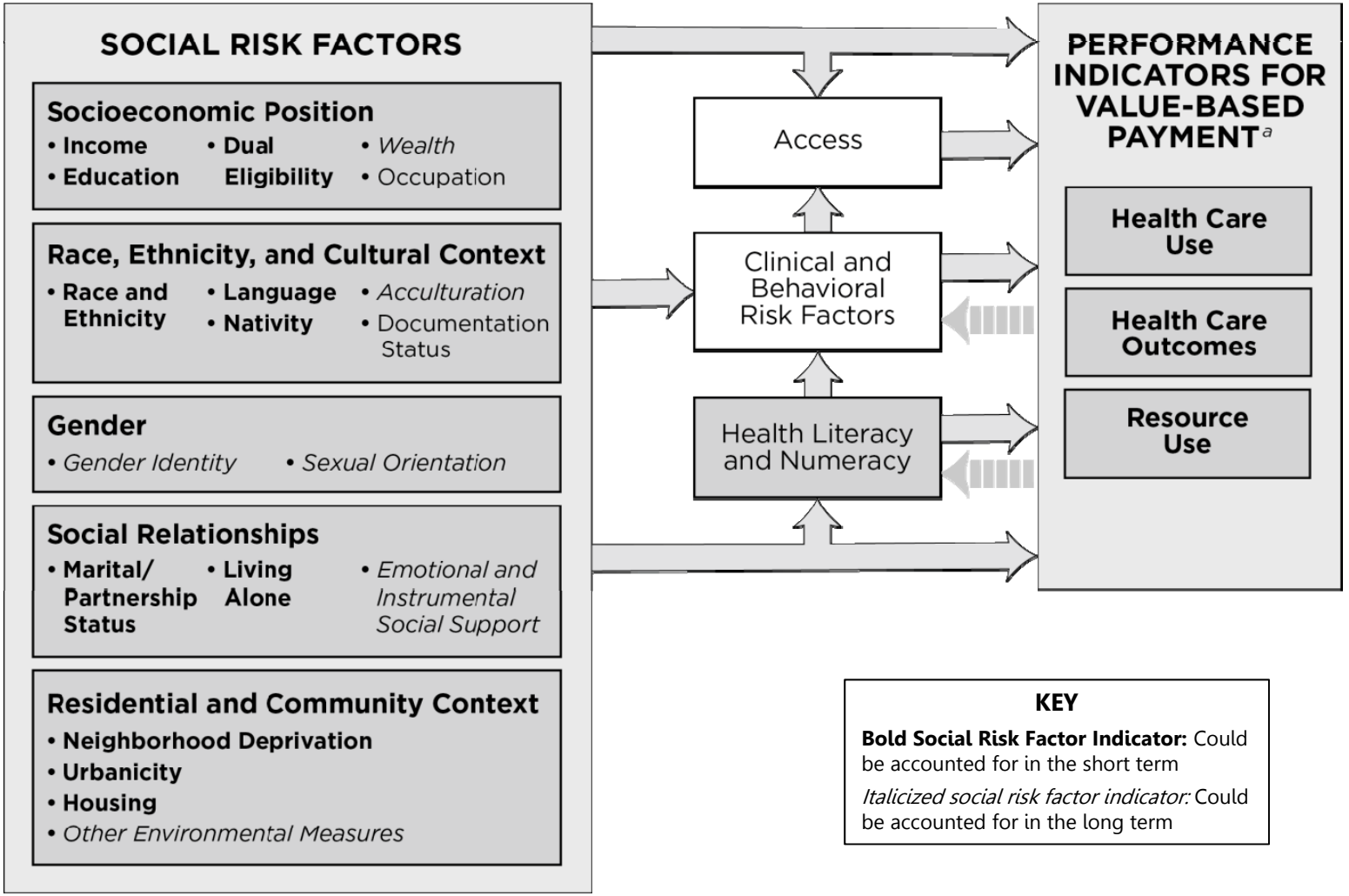

FIGURE: Conceptual framework of social risk factors and performance indicators for value-based payment.

Sources of Data

- Existing and new sources of CMS data
  - Enrollment and claims records
  - Special surveys
- Data from providers and plans
  - Electronic health record data
  - Administrative data that providers and plans send to CMS
- Alternative government data sources
  - Social Security Administration data
  - American Community Survey data

Guiding Principles for Choosing Data Sources

1. CMS should first use data it already has.
2. CMS should then look for opportunities to use existing data collected by other government agencies (including elsewhere in HHS).
3. To the extent that a social risk factor is relatively stable, CMS should examine the feasibility of collecting additional data at the time of enrollment in Medicare.
4. Where social risk factors change over time and have clinical utility, requiring data collection through electronic health records or other types of provider reporting may be the best approach.
5. For social risk factors that reflect a person's context or environment, existing data sources that can be used to develop area-level measures should be considered.

Multiple Methods Proposed

Strategies to account for social risk factors for measures of cost and efficiency may differ from strategies for quality measurement, because observed lower resource use may reflect unmet need rather than the absence of waste.

Lower cost is not always better but higher quality always is better.

Unintended Consequences

- Different methods have different potential adverse consequences
- Combinations of methods may minimize risks of any method alone
- Any approach should minimize unintended consequences and be monitored to ensure the absence of unintended adverse consequences, especially for patients with social risk factors

Methods

A. Stratified Public Reporting
B. Adjustment of Performance Measure Scores
C. Direct Adjustment of Payment
D. Restructuring Payment Incentive Design

Accounting for Social Risk Factors in Medicare Advantage Plans: An (unofficial) Example

A. Stratified Public Reporting for Patient Characteristics

How would CMS do this?

CMS could show performance on HEDIS clinical quality of care and CAHPS patient experience scores separately, for example, for dual-eligible enrollees compared to other enrollees, as they now do by race and ethnicity.

A. Stratified Public Reporting

What does this mean for plans?

- Plans could use this information to benchmark against other plans with a similar make-up of patients with better clinical quality or patient experience scores and from which they could learn better practices.

- They can compare the differences in clinical quality or patient experience between high- and low-risk groups within their membership and also compare subgroups between themselves and other plans.

A. Stratified Public Reporting

What does this mean for patients with social risk factors?

- Patients could use this information to choose plans with the best quality ratings for someone like them.

A. Stratified Public Reporting

What are possible upsides or downsides?

- Because this is the only method that presents quality information for different subgroups, it is crucial to highlight disparities that may exist.
- CMS could use this information to monitor the effect of adjusting quality ratings or payment for social risk factors to ensure that goals to reduce disparities are achieved.

B. Adjustment of Performance Measure Scores

How would CMS do this?

CMS could add social risk factor indicators (like race and ethnicity) to the current risk adjustment formulas for the Star Ratings System beyond the recent adjustment for dual eligibility and low income via the Categorical Adjustment Index for the Medicare Advantage Quality Bonus Payment system.

B. Adjustment of Performance Scores

What does this mean for plans?

- Some plans that do not receive a bonus now but that have more patients with social risk factors than average would have an adjusted performance score that may be good enough to earn a bonus.
- Some plans that currently receive a bonus but have more advantaged patients than average might not receive a bonus if adjustments were added.
- Plans serving greater shares of socially at-risk populations (such as Special Needs Plans) would generally benefit, which might help them better serve their patients.
- In addition, base payments to plans could change with advantages to Special Needs Plans, for example.

B. Adjustment of Performance Scores

What does this mean for patients with social risk factors?

- They may have easier access to better plans, for which disincentives to enroll at-risk members will be reduced.

- Current providers of care to at risk patients may see more resources and may be able to use them to improve care for at-risk patients.

B. Adjustment of Performance Scores

What are possible upsides or downsides?

- Incorrect adjustment could remove all incentives to reduce disparities in performance between patients with high and low levels of social risk factors, but accurate adjustments could avoid this concern.
- This method does not make disparities apparent unless paired with stratified reporting as described under category A.
- **Due to the benefits of stratified reporting, any adjustment is better when paired with stratified public reporting than not.**

C. Direct Adjustment of Payment

How would CMS do this?

CMS could adjust the base payment formula to account for the estimated additional costs of providing care at the same level of performance for socially at-risk populations.

C. Direct Adjustment of Payment

What does this mean for plans?

Similar to adjustments of performance scores (category B).

- Some plans that receive lower quality scores now but that have greater than average shares of patients with social risk factors would see their quality score increase and might quality for the bonus associated with the Star rating system.

- Some plans that currently receive a bonus but have more advantaged patients might receive a smaller bonus if adjustments were added. **Special Needs Plans**, as with safety-net hospitals and the HRRP, would generally benefit, which might help them better serve their patients.

C. Direct Adjustment of Payment

What does this mean for patients with social risk factors?

- Current providers of care for at risk patients may see more resources and may be able to use them to improve care for at-risk patients.
- If plans no longer have incentives to avoid patients with social risk factors, this would increase access for these patients

C. Direct Adjustment of Payment

What are possible upsides or downsides?

- As with adjusting performance scores, any adjustment is better when paired with stratified public reporting than not.

- Combining stratified reporting with adjustment of performance measure scores is neither better nor worse (albeit different) than combining stratified reporting with direct adjustment of payments.

D. Restructuring Payment Incentive Design

How would CMS do this?

CMS could entirely redesign the program. For a simple option, CMS could pay for improvement. This would mean that CMS awards bonuses to plans that improve on quality or patient experience measures relative to their own benchmark.

D. Restructuring Incentive Design

What does this mean for plans?

If the program sufficiently accounts for the differential costs of caring for patients with social risk factors in the incentive payment, this would avoid unintentionally redistributing resources away from plans who serve socially at-risk populations. This would reduce incentives for plans to avoid patients with social risk factors.

D. Restructuring Incentive Design

What does this mean for patients with social risk factors?

If plans no longer have incentives to avoid patients with social risk factors, this would increase access for these patients. If the program awards plans for improving quality, this would encourage plans to improve the quality of care for all patients. If this is done specifically for patients with social risk factors, this would incentivize plans to improve the quality of care for these patients, which could also help reduce disparities.

D. Restructuring Incentive Design

What are possible upsides or downsides?

- Incentives could be designed to explicitly encourage specific policy goals, such as reducing disparities.
- Incentiving improvement by at-risk group has better properties than directly paying on disparities if the goal is to reduce disparities.
- This method does not affect publicly reported measures, so it does not make disparities apparent unless paired with stratified reporting as described under category A.

Conclusion

"The committee's four goals would best be achieved through payment based on performance measure scores adjusted for social risk factors (or adjusting payment directly for these risk factors) when combined with public reporting stratified by patient characteristics within reporting units."

Concluding Remarks

- Any policy that modifies incentive payments does not address the payment system at large.
- Accounting for social risk factors does not solve the problem of safety-net financing
- Other payment reforms may be more effective at incentivizing high-quality care for socially at-risk populations

Concluding Remarks

- Although this series focuses on Medicare payment, the approaches the committee identified to account for social risk factors in quality measurement and payment could be applied to other payers
- Accounting for social risk factors is necessary but insufficient by itself to achieve health equity.

Concluding Remarks

"Together, accounting for social risk factors in quality measurement and payment in combination with complementary approaches … may achieve the policy goals of reducing disparities in access, quality, and outcomes, and quality improvement and efficient care delivery for all patients, and thereby promote health equity."

Visit

nationalacademies.org/MedicareSocialRiskFactors
to download the full report

For more information,
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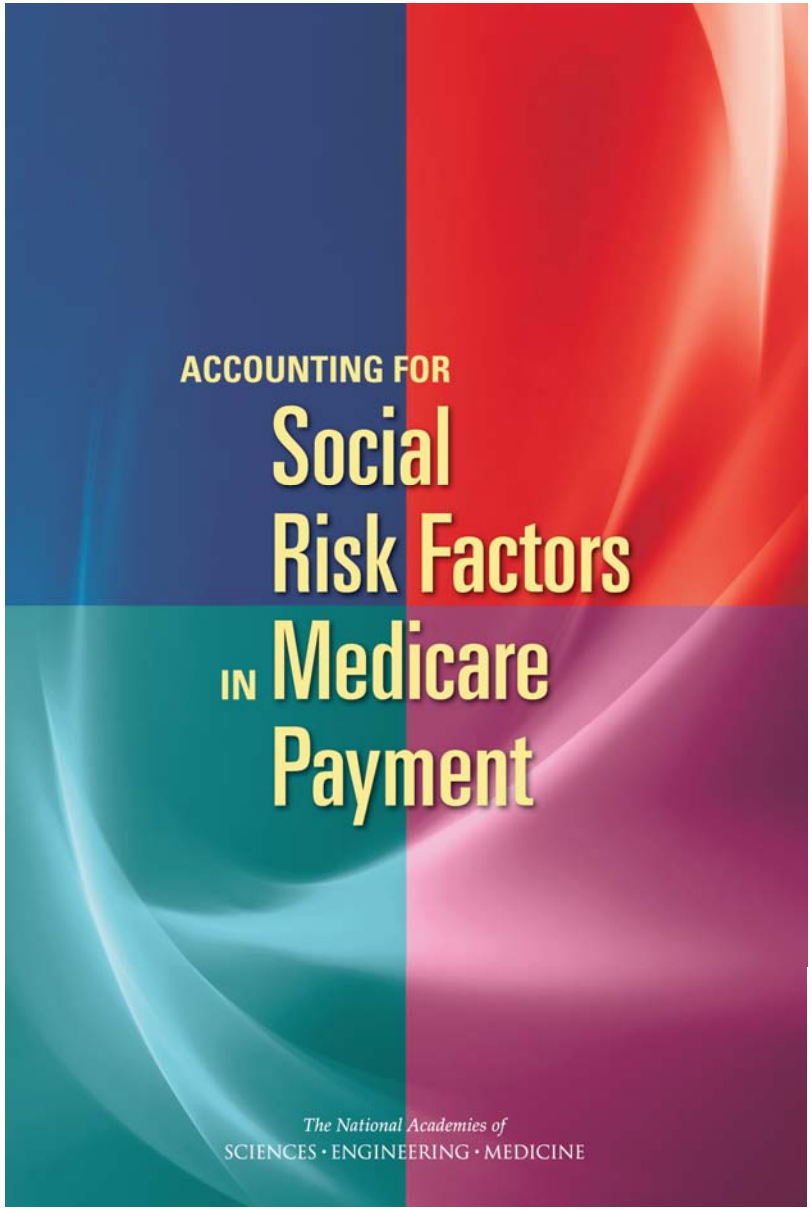
Thank you!



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Summary of Data Availability

SOCIAL RISK FACTOR	Indicator	DATA AVAILABILITY 1	2	3	4
SEP					
	Income		■		
	Education		■		
	Dual eligibility	■			
	Wealth			■	
Race, Ethnicity, and Cultural Context					
	Race and ethnicity		■		
	Language		■		
	Nativity	■			
	Acculturation				■
Gender					
	Gender identity				■
	Sexual orientation				■
Social Relationships					
	Marital/partnership status		■		
	Living alone			■	
	Social support			■	
Residential and Community context					
	Neighborhood deprivation		■		
	Urbanicity/rurality	■			
	Housing		■		
	Other environmental measures				■

1. Available for use now
2. Available for use now for some outcomes, but research needed for improved, future use
3. Not sufficiently available now; research needed for improved, future use
4. Research needed to better understand relationship with health care outcomes and on how to best collect data

Source: Table S-1

What social risk factors might not need to be accounted for?

"If there are substantial barriers to collecting social risk factor data (such as high cost) and/or if early pilot testing or modeling in a multivariable model suggests only marginal gains from including any given indicator in any method of accounting for social risk factors in Medicare performance measurement and payment, inclusion of that indicator may not be warranted"

What is a "marginal gain"?

- Does not reflect a strictly quantitative value
- Unlikely to be a threshold under which the effects of any social risk factor are "marginal"
- Reflects a balance of competing considerations, including data considerations (collection burden and accuracy) and other selection criteria

Research Suggestions

To determine which social risk factors *should* be accounted for:

1. How can ASPE/CMS implement the use of an initial set of social risk factors on a rapid timeline?
2. How can ASPE/CMS implement the use of an expanded set of social risk factors?
3. How can ASPE/CMS monitor and refine the use of social risk factors in VBP?

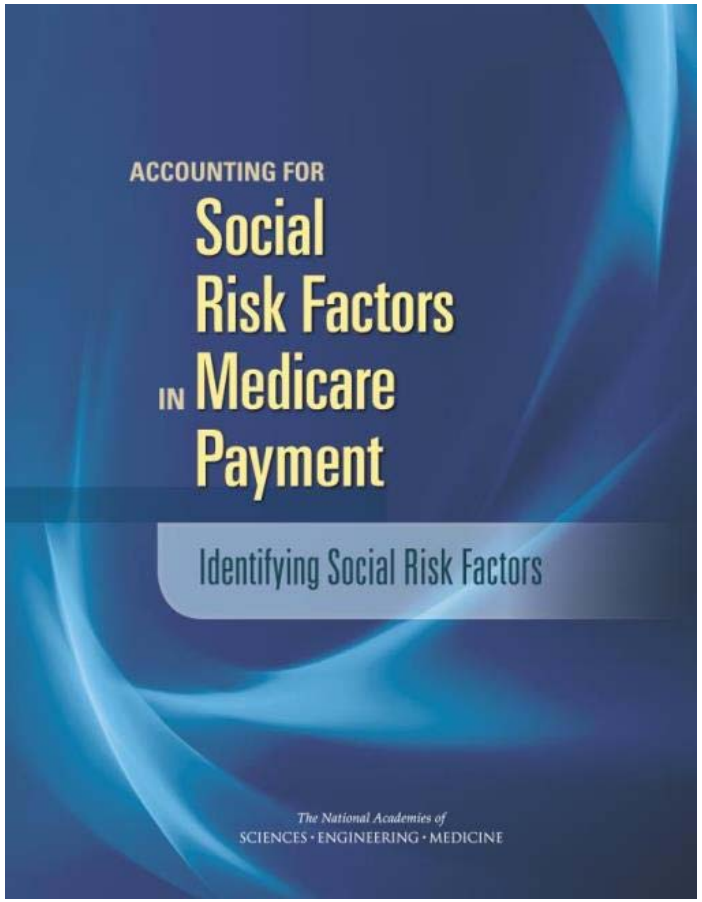
Health Literacy

- Product of an individual's skills and abilities (including reading and other critical skills), sociocultural factors, education, health system demands, and the health care context
- Not a social risk factor itself, but a more proximal risk factor that is influenced by (more distal) social risk factors
- Modifiable (or otherwise addressable) by the health care system

Disability

- Important factor but not a distal social risk factor in the way in which the committee defined social risks factors
- Product of of social risk factors and health conditions
- Can be addressed by the health care system more directly than other more distal social risks factors

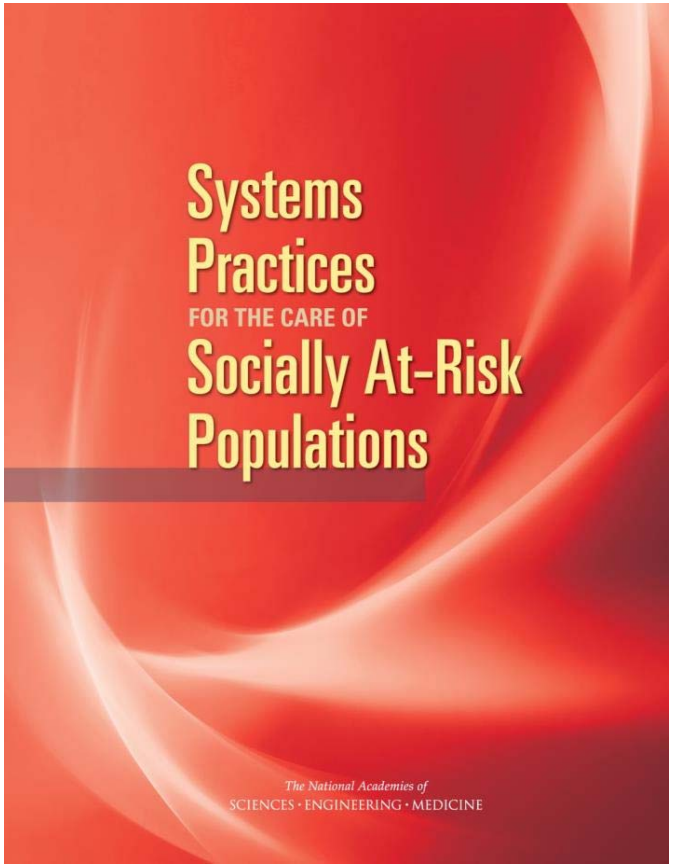
Report 1: Identifying Social Risk Factors



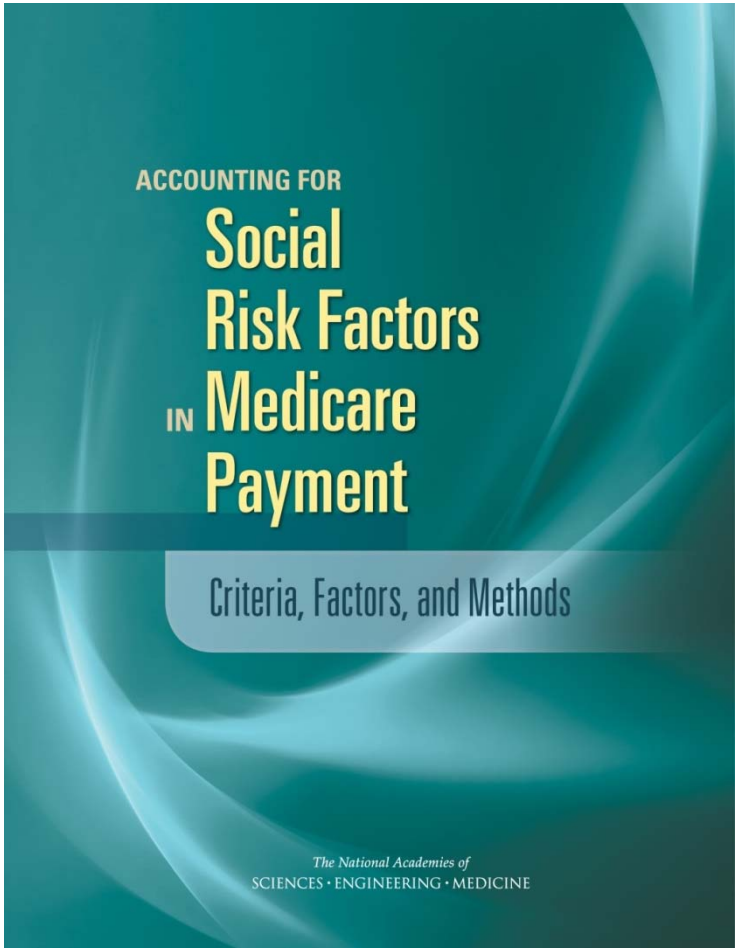
In its **first report**, the committee presents a **conceptual framework** and described the results of a **literature search** linking social risk factors, including socioeconomic position, to health-related measures of importance to Medicare payment and quality programs. (January 2016)

Report 2: Systems Practices for the Care of Socially At-Risk Populations

In its **second report**, the committee identifies six community-informed and patient-centered **systems practices** show promise for improving care for socially at-risk populations. (April 2016)

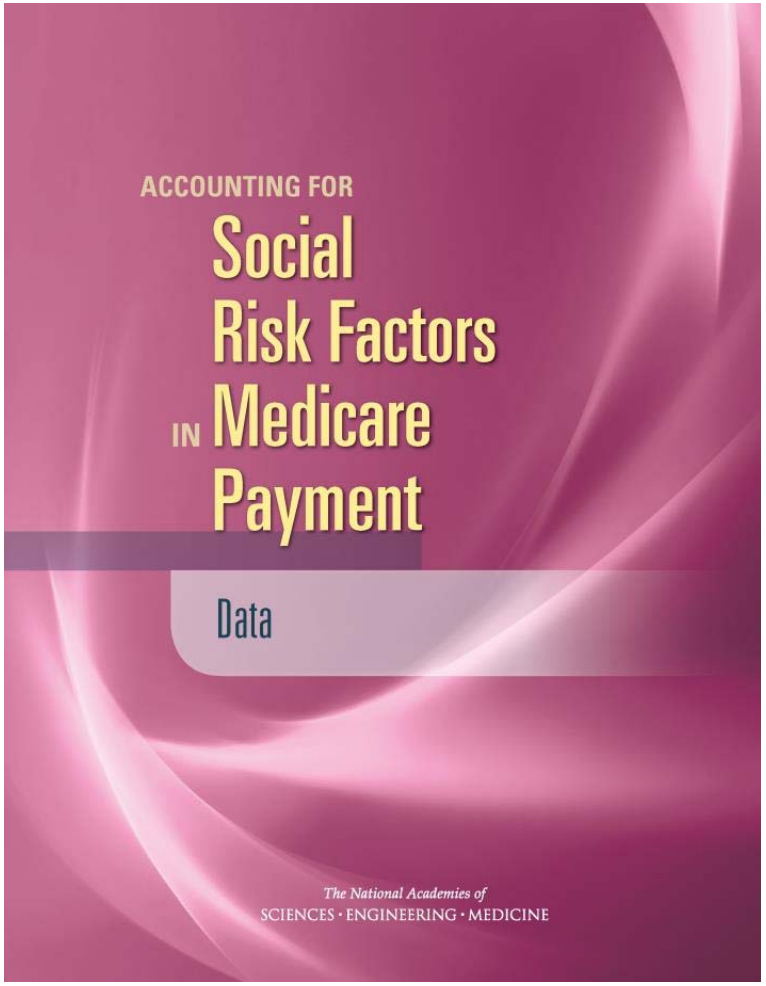


Report 3: Criteria, Factors, & Methods



In its **third report**, the committee provides guidance on which **social risk factors** could be considered for Medicare accounting purposes, **criteria** to identify these factors, and **methods** to do so in ways that can promote health equity and improve care for all patients. (July 2016)

Report 4: Data



In its **fourth report**, the committee provides guidance on **data sources** for and **strategies to collect data** on social risk factor indicators that could be accounted for in Medicare quality measurement and payment programs (October 2016).