Possible to account for disadvantaged populations in Medicare's payment programs

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A new report from the National Academies of Sciences, Engineering, and Medicine says that Medicare's value-based payment programs could take into account social risk factors - such as low socio-economic position, residence in disadvantaged neighborhoods, or race and ethnicity - but any proposal to do so will entail both advantages and disadvantages that need to be carefully considered. This is the third report in a series of five that addresses social risk factors that affect the health care outcomes of Medicare beneficiaries and ways to account for them in Medicare payment programs. It was outside the study's statement of task to recommend whether social risk factors should be accounted for in value-based payment or how.

The Patient Protection and Affordable Care Act of 2010 and subsequent legislation require the Centers for Medicare & Medicaid Services (CMS) to implement value-based payment programs. Although CMS payment models cover a spectrum of approaches, the agency is moving steadily from paying for volume, such as fee-for-service payments, to paying for quality, outcomes, and costs, such as in value-based payment programs. Essentially, value-based payment aims to align payment and care delivery goals to improve health care quality and outcomes, while also controlling costs.

Nevertheless, concerns have been raised that Medicare payment programs that do not account for social risk factors, particularly value-based payment programs, may underestimate the quality of care provided by health systems that disproportionately serve socially at-risk

populations. Patients with social risk factors may require more resources and care to achieve the same health outcomes as advantaged patients. At the same time, health care providers serving more vulnerable populations historically have been less well-funded than providers who care for larger proportions of patients with commercial insurance. Because current Medicare quality measurement and payment programs do not account for these differences, providers serving vulnerable populations may be more likely to fare poorly on quality rankings and receive penalties under value-based payment. This dynamic, in turn, may potentially increase disparities.

The committee that carried out the study and wrote the report developed five criteria to help CMS determine which social risk factors should be accounted for in Medicare value-based payment programs. It then applied the criteria to various social risk factors and determined that in the short term, CMS could account for several social risk factors in Medicare value-based payment programs, including: income, education, and dual eligibility; race, ethnicity, language, and nativity; marital/partnership status and living alone; and neighborhood deprivation, urbanicity, and housing. The committee noted that some additional social risk factors present practical challenges for use in Medicare value-based payment programs but are still worthy of consideration for inclusion in the longer term. These factors include wealth, gender identity and sexual orientation, emotional and instrumental social support, and environmental measures of residential and community context.

The committee found that CMS payment programs, which currently do not account for social risk factors, have several disadvantages, including giving providers and insurers the incentive to avoid serving patients with social risk factors, underpaying providers who disproportionately serve socially at-risk populations, and underinvesting in the delivery of quality care. While accounting for social risk factors in valued-based payment

programs would likely diminish these harms, it could also potentially introduce new ones, such as reducing incentives to improve care for patients from vulnerable populations. Thus, the committee concluded that it is important to minimize potential harms to patients with social risk factors, including monitoring the effect of any specific approach for any unintended adverse effects.

To address the committee's four policy goals of reducing disparities in health care access, quality, and outcomes; improving quality and efficient care delivery for all patients; fair and accurate public reporting; and compensating providers fairly, the committee identified four categories encompassing 10 methods on how to account for social risk factors in Medicare value-based payment programs. Those categories are:

- stratified public reporting, which seeks to make quality of care for socially at-risk and other patients visible to consumers, providers, payers, and regulators;
- adjustment of performance measure scores, which accounts for social risk factors statistically, in an effort to more accurately measure true performance;
- direct adjustment of payments, which explicitly uses measures of social risk factors in payment but by itself does not affect performance measure scores; and
- restructuring payment incentive design, which implicitly accounts for social risk factors in payment.

The committee concluded that a combination of reporting and accounting in both performance measures and payment are needed to achieve its four policy goals. Considerations around the trade-offs of various methods are different for cost-related performance and quality performance, and strategies to account for social risk factors for measures of cost and efficiency may differ from strategies to measure

good outcomes and improvements in care quality. Lower cost is not always better, for example, when it reflects unmet needs, but high quality is always better.

"Accounting for social risk factors in Medicare payments is not intended to obscure disparities that exist, but rather bring disparities to light," said Donald Steinwachs, committee chair and professor at Johns Hopkins Bloomberg School of Public Health in Baltimore. "Payment systems should include sufficient incentives for quality improvement for both socially at-risk populations and to patients overall."

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