Report to Congress:

Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs

A Report Required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

United States Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Washington, D.C.
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Executive Summary

I. Background

There is growing recognition that social risk factors – such as income, education, race and ethnicity, employment, community resources, and social support – play a major role in health.\textsuperscript{1-3} Despite ongoing efforts, significant gaps remain in health and in life expectancy based on income, race, ethnicity, and community environment.\textsuperscript{4-7}

At the same time, the health care system is increasingly moving towards higher levels of provider accountability for the quality, outcomes, and costs of care. Value-based or alternative payment models, which tie payment to the quality and efficiency of health care delivered, are in place in nearly all Medicare settings, including in hospitals, outpatient settings, and post-acute facilities.

These two issues are intersecting. If beneficiaries with social risk factors have worse health outcomes because the providers they see provide low-quality care, value-based purchasing could be a powerful tool to drive improvements in care and reduce health disparities. However, if beneficiaries with social risk factors have worse health outcomes because of elements beyond the quality of care provided, such as the social risk factors themselves, value-based payment models could do just the opposite. If providers have limited ability to influence health outcomes for beneficiaries with social risk factors, they may become reluctant to care for beneficiaries with social risk factors, out of fear of incurring penalties due to factors they have limited ability to influence.

In many ways, beneficiaries with social risk factors may benefit the most from value-based purchasing programs and other delivery system reform efforts, since improved care coordination and provider cooperation will be of the highest utility to the most complex beneficiaries with the most care needs. Therefore, in order to properly align payments and ensure value-based purchasing programs achieve their intended goals, the relationships between social risk and performance on these programs need to be better understood. This report, mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 or the IMPACT Act (P.L. 113-185),\textsuperscript{8} shares empirical analysis using existing Medicare data to help address these questions and provides considerations for policymakers while additional work using other data sources continues.

II. Definitions and Scope

The social risk factors examined in this report were dual enrollment in Medicare and Medicaid as a marker for low income, residence in a low-income area, Black race, Hispanic ethnicity, and residence in a rural area. Disability was also examined as it is related to many social risk factors, available in claims data, and already used in some Medicare payment calculations. Note that there are many other social risk factors that were not examined in this report due to data limitations; many of these will be addressed in Study B, also mandated under the IMPACT Act. Providers (here, hospitals, health plans,
physicians, dialysis facilities, skilled nursing facilities, and home health agencies) in the top quintile of
the proportion of their beneficiaries with each social risk factor (for example, the physicians with the
highest proportion of dually-enrolled beneficiaries) were considered “safety-net” providers for the
purposes of this Report.

Medicare payment programs were selected for analysis if they were currently operational or defined in
statute, and if they incorporated quality and/or efficiency metrics into payment (Table 1):

Table 1: Medicare Payment Programs Included in this report

<table>
<thead>
<tr>
<th>Program</th>
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<tbody>
<tr>
<td>1) Hospital Readmissions Reduction Program</td>
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<td>2) Hospital Value-Based Purchasing Program</td>
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<td>3) Hospital Acquired Condition Reduction Program</td>
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<td>4) Medicare Advantage (Part C) Quality Star Rating Program*</td>
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<td>5) Medicare Shared Savings Program</td>
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<td>6) Physician Value-based payment modifier Program†</td>
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<td>7) End-Stage Renal Disease Quality Incentive Program</td>
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<td>8) Skilled Nursing Facility Value-Based Purchasing Program‡</td>
</tr>
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<td>9) Home Health Value-Based Purchasing Program‡</td>
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</table>

*Includes Part D metrics where applicable. †Note that these program sunsets, and is replaced by the Merit-Based Incentive
Payment System (MIPS) in 2019. ‡The SNF VBP and HHVBP programs are too new to have program-level data yet available for
analysis; thus for the purpose of this report only certain measures that may be used in these two programs were analyzed.

III. Findings

A. FINDING 1: Beneficiaries with social risk factors had worse outcomes on many quality measures,
   regardless of the providers they saw, and dual enrollment status was the most powerful predictor
   of poor outcomes.

Beneficiaries with social risk factors had poorer outcomes on many quality measures, including process
measures (e.g., cancer screening), clinical outcome measures (e.g., diabetes control, readmissions),
safety (e.g., infection rates), and patient experience measures (e.g., communication from doctors and
nurses), as well as higher resource use (e.g., higher spending per hospital admission episode). This was
true even when comparing beneficiaries at the same hospital, health plan, ACO, physician group, or
facility. Dual enrollment (enrollment in both Medicare and Medicaid) was typically the most powerful
predictor of poor performance among those social risk factors examined. For the most part, these
findings persisted after risk adjustment, across care settings, measure types, and programs, and were
moderate in size.

B. FINDING 2: Providers that disproportionately served beneficiaries with social risk factors tended
to have worse performance on quality measures, even after accounting for their beneficiary mix.
Under all five value-based purchasing programs in which penalties are currently assessed, these
providers experienced somewhat higher penalties than did providers serving fewer beneficiaries with social risk factors.

In every care setting examined, providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. Some of these differences were driven by beneficiary mix, but some of the difference persisted even after adjusting for beneficiary characteristics. As a result, safety-net providers were more likely to face financial penalties across all five operational Medicare value-based purchasing programs in which penalties are assessed, including programs in the hospital, physician group, and dialysis facility settings. They were also less likely to receive bonuses in Medicare Advantage. The single exception was that ACOs with a high proportion of dually-enrolled beneficiaries were more likely to share in savings under the Medicare Shared Savings Program, despite slightly worse quality scores.

However, in every setting, be it hospital, health plan, ACO, physician group, or facility, there were some providers that served a high proportion of beneficiaries with social risk factors who achieved high levels of performance. This suggests that high performance is feasible, with the right strategies and supports.

C. Interpretation of Findings

The first question motivating this research was “Do beneficiaries with social risk factors have worse outcomes due to their social risk profile, or because of the providers they see?” The answer is both – dual enrollment status is independently associated with worse outcomes, and dually enrolled beneficiaries are more likely to see lower-quality providers. The second question was “Do providers that serve beneficiaries with social risk factors perform worse due to the high proportion of beneficiaries with social risk factors, or do they provide lower-quality care overall?” The answer, again, is both. Providers serving high proportions of beneficiaries with social risk factors tended to perform worse in part due to the patient population, and in part due to poor performance overall.

However, these analyses cannot determine why such patterns exist. Beneficiaries with social risk factors may have poorer outcomes due to a host of factors, including higher levels of medical risk, worse living environments, greater challenges in adherence and lifestyle, and/or bias or discrimination.

Some of these factors are beyond providers’ control, such as higher levels of medical risk and worse living environments. Some of these factors are probably under some influence from clinicians, such as adherence and lifestyle choices. And some of these factors are entirely under clinicians’ control, including bias and discrimination.

Providers serving these beneficiaries may have poorer performance due to a similarly long list of factors, including fewer resources, more challenging clinical workloads, lower levels of community support, or worse quality of care. Again, some of these factors are under providers’ control, and some are not.

Many of these factors, for both beneficiaries and providers, are not easily measured with current data. Yet understanding the “whys” is essential to finding lasting and meaningful solutions. There is clearly a need for more research in this area.
D. Potential Solutions

A number of potential solutions for if and how to account for social risk in Medicare programs have been proposed. It is important to note that quality measures are used in two ways for these programs: 1) reporting to providers and the public; and 2) to determine payment adjustments such as bonuses and penalties. Thus, potential solutions can be relevant to adjusting the measures for reporting, adjusting the measures for the purpose of determining payments, or directly adjusting the payment methodologies without adjusting the measures themselves.

i. Adjusting quality and resource use measures

Quality and resource use measures can be and are used for multiple purposes. Some measures are used purely for quality improvement, typically within a health care system or clinical practice to identify and track specific clinical areas for improvement. Many of these measures are processes of care that are based upon steps within clinical practice guidelines, such as whether or not a Hemoglobin A1C was ordered for diabetic patients. Generally, measures used for this purpose are not risk adjusted at all, even for clinical co-morbidities, as providers are most interested in using these measures to track performance within their organization, and not for comparative performance purposes.

Most measures used within the Medicare programs are used for public reporting and accountability, or value-based purchasing, although they may also be valuable for providers to track for quality improvement as well. These measures are typically used to profile providers against one another, usually as a requirement of the statute authorizing the quality or value-based purchasing program. In order to “level the playing field,” these quality and resource use measures may be adjusted for a variety of risk factors, most commonly age and clinical co-morbidities. The goal of risk adjustment is to fairly compare providers to one another on patient outcomes, such that the main differences in performance are related to the quality of care provided, rather than to patient factors over which providers have no control, such as clinical conditions. It is measures used for public reporting and payment that are the focus of this report.

Public reporting of quality measures serves important informational purposes. For one, it allows beneficiaries to make informed choices of their providers and health plans. Second, it provides useful information to providers and plans as they monitor their performance and implement programs to improve quality. Finally, it provides Medicare and other purchasers with information to monitor programs and guide value-based purchasing decisions. Whether these measures should be adjusted for social risk factors prior to reporting has been the subject of debate.

Some have argued that measures used for public reporting and accountability should be adjusted for social risk factors, in order to “level the playing field.” Advocates of this approach argue that adjusting measures for social risk factors recognizes the greater challenges that may be faced in achieving high performance for beneficiaries with social risk factors, and may reduce the likelihood that concerns about performance could lead to worse access to care for these groups by penalizing providers who serve them. They also argue that failing to adjust for differences in the populations served by different providers may lead to inaccurate representations of the quality of care a provider is furnishing to
patients. Advocates of this view argue that, without adjustment, some of the differences in reported performance reflect differences in the populations providers serve, rather than the performance of the providers themselves.

Supporters of adjusting measures for social risk factors note that there may be situations in which measure performance is so closely tied to social risk and its consequences, in ways that are truly beyond providers’ control, that achieving policy goals necessitates adjustment. For example, there is significant evidence that dually-enrolled beneficiaries, on average, are more medically complex and have higher healthcare needs. Therefore, poor performance on measures of care utilization may reflect patient need or complexity rather than poor quality of care, and failing to adjust may penalize providers for providing additional needed services to these groups. Currently, some care utilization measures, as well as the self-reported health status measures used in the Medicare Advantage program and the patient experience measures used in many current Medicare payment programs, are adjusted for social risk.

Others, however, have argued that adjustment for social risk is not appropriate. First, they argue that adjusting measures for social factors risks masking disparities in the quality of care provided, thereby significantly reducing the long-term ability to identify and reduce them. Second, at least to the degree that differences in quality are related to poor performance, bias, or discrimination, they argue that directly adjusting measures could excuse the delivery of worse care to beneficiaries with social risk factors. Third, opponents of adjusting for social risk suggest that doing so may reduce incentives for providers to participate in alternative care delivery models, and therefore providers may miss opportunities to provide better-coordinated and tailored care to vulnerable beneficiaries. Finally, they argue that adjusting the measures may have a negative impact on transparency for consumers and others.

Opponents of adjusting measures also argue that broad adjustment is inappropriate because there are many quality measures for which there is no plausible role for adjustment – pure process measures such as giving aspirin for a heart attack, for example, should generally not be adjusted for social risk since they are entirely under providers’ control, and should be done regardless of a beneficiary’s social risk profile. Under this theory, there is no reason that social risk should be directly associated with performance on process measures, and poor performance in these scenarios is more likely reflective of poor quality than of need or complexity. Currently, the majority of process and clinical outcome measures used in Medicare payment programs are not adjusted for social risk.

ii. Adjusting payments

Whether a decision is made to adjust the measures themselves for reporting purposes, a separate decision is possible with regard to adjusting payment (penalties and bonuses) for social risk. One option is to base the penalty/bonus calculation on adjusted measures; this has some of the pros and cons above, though does not negatively impact transparency since the adjustment is applied after reporting.

However, another option for accounting for social risk in Medicare’s value-based purchasing programs lies in not adjusting the measures themselves, but instead in altering the mechanism by which performance is translated to payment. Such alterations could be used to give additional “credit” to
providers that serve a high proportion of beneficiaries with social risk factors. If these payment adjustments were linked to improvement or achievement in performance for beneficiaries with social risk factors, they could potentially provide additional incentives to improve care and outcomes for these groups, and provide financial support while preserving accountability.

Such an approach preserves the transparency of the measures, but still recognizes the challenges inherent in achieving high quality and good outcomes for beneficiaries with social risk factors. It might also offset concerns that, in the absence of some type of accounting for social risk, value-based purchasing models could result in providers becoming reluctant to care for beneficiaries with social risk factors out of fear of incurring penalties due to elements they have limited ability to influence.

iii. Addressing the Underlying Issues

Finally, some point out that neither adjusting the measures, nor altering value-based payments, addresses the fundamental problems underlying the pervasive differences in performance across measures and programs. Social determinants of health are powerful, and to make things better for beneficiaries with social risk factors and the providers who serve them, these factors need to be explicitly measured and their impact tracked, perhaps via the use of new measures that specifically capture providers’ performance for beneficiaries with social risk factors. Such new measures could include calculating performance on current measures for subgroups of beneficiaries with social risk factors, or specific measures of health equity comparing performance between beneficiaries with social risk factors and other beneficiaries.

Once measured and recognized, these issues could be addressed with financial and technical assistance. Such assistance should be tailored to recognize the unique characteristics of beneficiaries with social risk factors and the providers that disproportionately serve them, and directed toward the goal of achieving highest quality of care for all patients.

IV. Strategies and Considerations

The Department’s goal is to develop value-based payment programs under which all Medicare beneficiaries receive the highest quality healthcare services. In the context of the findings above, however, it is clear that doing so will require a multipronged approach, as proposed solutions that address only the measures without considering the broader delivery system and policy context are unlikely to mitigate the full implications of the relationship between social risk factors and outcomes. Ideally, value-based purchasing programs can be leveraged to enhance, rather than threaten, access to and provision of high-quality care for beneficiaries with social risk factors.

Therefore, the Department proposes for consideration a three-part strategy (Figure 1):
First, performance on quality and outcomes should be measured and reported specifically for beneficiaries with social risk factors. Doing so would allow policymakers and clinical leaders to identify, track, and address disparities in care.

Second, high, fair quality standards should be set for all beneficiaries. Whether the most “fair” standard is one that does or does not adjust for social risk will depend on the type of measure and how the considerations outlined earlier apply to that particular measure. Additionally, all measures should be studied to determine whether accounting for frailty, medical complexity, functional status, or other factors might improve their ability to fairly and accurately assess provider performance.

Meeting quality standards, particularly for outcome measures, may be harder for beneficiaries with social risk factors, who face specific challenges to achieving good health outcomes. Therefore, value-based purchasing programs should:

a) provide specific payment adjustments to reward achievement and/or improvement for beneficiaries with social risk factors, and

b) where feasible, provide targeted support for providers who disproportionately serve them.
First, leveraging the power of value-based purchasing to provide specific payment adjustments to reward providers for successfully achieving high quality and/or good health outcomes in beneficiaries with social risk factors may provide important incentives to focus on these individuals, and help offset any real or perceived disincentives to caring for them.

Second, providing targeted support, for example through quality improvement programs designed specifically for beneficiaries with social risk factors, is also critical to ensuring that all beneficiaries can have the best health outcomes possible. Another key component of support is ensuring that current base payments are adequate to support high-quality care for beneficiaries with social risk factors.

Considerations for how these strategies might be applied to Medicare payment programs are provided below. Note that these are general considerations, and not all apply to each program reviewed.

### A. STRATEGY 1: Measure and Report Quality for Beneficiaries with Social Risk Factors

**Consideration 1:** Consider enhancing data collection and developing statistical techniques to allow measurement and reporting of performance for beneficiaries with social risk factors on key quality and resource use measures.

The ability to measure and track quality, outcomes, and costs for beneficiaries with social risk factors over time is crucial as policymakers and providers seek to reduce disparities and improve care for these groups. However, there are two things that would need to be addressed for this to be feasible: first, data would need to be collected on enough beneficiaries for performance assessment by subgroup; and second, statistical techniques to allow calculation for subgroups would need to be developed.

**Consideration 2:** Consider developing and introducing health equity measures or domains into existing payment programs to measure disparities and incent a focus on reducing them.

Quality measures help providers prioritize areas for particular focus, and specific measures targeting equity within existing value-based purchasing programs can therefore incent a focus on reducing disparities. This could be achieved by adding a health equity measure or domain to existing programs.

**Consideration 3:** Prospectively monitor the financial impact of Medicare payment programs on providers disproportionately serving beneficiaries with social risk factors.

Many of the programs examined in this report are new or in evolution. Prospectively monitoring the financial impact of Medicare payment programs on providers disproportionately serving beneficiaries with social risk factors is critical as the programs continue to change. One example of such prospective study is the section in this report examining the hospital-wide readmission measure, which has been proposed for implementation in the HRRP. Analyses here demonstrate that moving to such a measure, in the absence of other changes to the program, could disproportionately impact the safety net. Similarly, analyses in this report examining future changes to the HACRP demonstrate that these may negatively impact safety-net hospitals. These types of analyses are important for policymakers to consider as Medicare’s value-based purchasing programs continue to evolve.
B. STRATEGY 2: Set High, Fair Quality Standards for All Beneficiaries

**Consideration 1:** Measures should be examined to determine if adjustment for social risk factors is appropriate; this determination will depend on the measure and its empirical relationship to social risk factors.

There is not an all-encompassing approach to whether or not measures should be adjusted for social risk. These decisions should consider the benefits and concerns of adjustment discussed above. Additionally, empirical evidence on the relationship between the social risk factor and the outcome, including whether there is evidence that need or complexity is driving differences in performance, or if the differences in performance are related to true differences in the quality of care delivered to beneficiaries with social risk factors, should be considered. Such decisions should be continuously evaluated as new data on social risk and better data on medical risk become available and as new measures are introduced into the programs.

**Consideration 2:** The measure development community should continue to study program measures to determine whether differences in health status might underlie the observed relationships between social risk and performance, and whether better adjustment for health status might improve the ability to differentiate true differences in performance between providers.

Some of the observed relationship between social risk factors and performance on quality measures may be the result of underlying differences in medical complexity, frailty, disability, and/or functional status. For example, dually-enrolled beneficiaries are more likely to have poor functional status, and therefore may be more likely to be readmitted after a hospitalization. However, data on these factors are not broadly available and will require further development. In order for value-based purchasing programs to be as accurate as possible, and to avoid unfairly penalizing providers that serve socially or medically complex beneficiaries, both quality and resource use measures should be continuously improved to account for differences in these and other components of medical risk.

C. STRATEGY 3: Reward and Support Better Outcomes for Beneficiaries with Social Risk Factors

**Consideration 1:** Consider creating targeted financial incentives within value-based purchasing programs to reward achievement of high quality and good outcomes, or significant improvement, among beneficiaries with social risk factors.

Achievement and/or improvement for beneficiaries with social risk factors should be rewarded, and this could be done via payment adjustments within existing value-based purchasing programs to reward providers that do so. Leveraging the power of value-based purchasing to provide specific payment adjustments to reward providers for successfully achieving high quality and/or good health outcomes in beneficiaries with social risk factors may provide important incentives for doing so, and help offset any real or perceived disincentives under value-based purchasing programs to caring for these beneficiaries. Such opportunities would also highlight the need to focus on these groups to improve outcomes.
### Consideration 2: Consider using existing or new quality improvement programs to provide targeted support and technical assistance to providers that serve beneficiaries with social risk factors.

Improving care delivery by providers serving at-risk populations would serve both to reduce disproportionate penalty burdens on these providers, and more importantly, to improve care for the most socially at-risk Medicare beneficiaries.

### Consideration 3: Consider developing demonstrations or models focusing on care innovations that may help achieve better outcomes for beneficiaries with social risk factors.

One promising strategy for identifying and testing innovative strategies that may meet the unique needs of beneficiaries with social risk factors is via demonstrations or models. Examples include the demonstration programs in Medicare Advantage that focus on coordinating benefits between Medicare and Medicaid, and CMMI’s Accountable Health Communities model.

### Consideration 4: Consider further research to examine the costs of achieving good outcomes for beneficiaries with social risk factors and to determine whether current payments adequately account for any differences in care needs.

It might require more resources to achieve good outcomes for beneficiaries with social risk factors, but how much and what type of resources is poorly understood. Future research should determine whether current payments, typically based only on differences in medical risk, adequately account for these differences in care needs. Note that this is a different consideration than additional value-based purchasing adjustments as outlined in Consideration 1 above – this consideration instead refers specifically to whether providers should be paid more to care for beneficiaries with social risk factors via higher base payments, regardless of performance. Disproportionate Share Hospital payments in the hospital setting are one current example of such add-on payments for social risk, and payments to MA contracts to provide care for beneficiaries are also higher for beneficiaries with social risk factors. However, currently, no such provision exists for physicians in the outpatient setting, skilled nursing facilities, dialysis facilities, and other care types. This should be studied.

Table 2 demonstrates how these recommendations and considerations were applied to programs analyzed in this report:
### Table 2: Application of Considerations to Programs in this report

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Considerations</th>
<th>HRRP</th>
<th>HACRP</th>
<th>HVBP</th>
<th>MA Quality Star Program</th>
<th>Medicare Shared Savings Program</th>
<th>Physician VM</th>
<th>ESRD QIP</th>
<th>SNF VBP</th>
<th>HHVBP</th>
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<tbody>
<tr>
<td><strong>Strategy 1:</strong> Measure and Report Quality for Beneficiaries with Social Risk Factors</td>
<td>• Pursue reporting for beneficiaries with social risk factors</td>
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<td></td>
<td>• Develop health equity measures</td>
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<td>• Prospectively monitor program impact on providers disproportionately serving beneficiaries with social risk factors</td>
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<td><strong>Strategy 2:</strong> Set High, Fair Quality Standards for All Beneficiaries</td>
<td>• Consider measures for adjustment on a case-by-case basis</td>
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<td>• Improve risk adjustment for health status in program measures</td>
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<td><strong>Strategy 3:</strong> Reward and Support Better Outcomes for Beneficiaries with Social Risk Factors</td>
<td>• Provide payment adjustments to reward achievement and/or improvement in beneficiaries with social risk factors</td>
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<td></td>
<td>• Use existing or new QI to support providers that serve beneficiaries with social risk factors</td>
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<td></td>
<td>• Encourage demos / models focusing on beneficiaries with social risk factors²</td>
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<td>• Conduct research on the costs of caring for beneficiaries with social risk factors</td>
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n/a = not applicable.  
1= Program has a statutorily set list or type of measures; thus this consideration is not applicable  
2=Many of these programs do not have demonstration/model authority; the concept would be to design demonstrations or models that addressed key issues salient to beneficiaries with social risk factors, which might influence outcomes under these programs.  
HRRP=Hospital Readmissions Reduction Program; HVBP=Hospital Value-Based Purchasing Program; HACRP=Hospital-Acquired Conditions Reduction Program; MA=Medicare Advantage; Medicare Shared Savings Program=Medicare Shared Savings Program; VM=Value-based payment modifier; ESRD QIP=End-Stage Renal Disease Quality Incentive Program; SNF VBP=Skilled Nursing Facility Value-Based Purchasing; HHVBP=Home Health Value-Based Purchasing
V. Conclusions
Social factors are powerful determinants of health. In Medicare, beneficiaries with social risk factors have worse outcomes on many quality measures, including measures of processes of care, intermediate outcomes, outcomes, safety, and patient/consumer experience, as well as higher costs and resource use. Beneficiaries with social risk factors may have poorer outcomes due to higher levels of medical risk, worse living environments, greater challenges in adherence and lifestyle, and/or bias or discrimination. Providers serving these beneficiaries may have poorer performance due to fewer resources, more challenging clinical workloads, lower levels of community support, or worse quality.

The scope, reach, and financial risk associated with value-based and alternative payment models continue to widen. There are three key strategies that should be considered as Medicare aims to administer fair, balanced programs that promote quality and value, provide incentives to reduce disparities, and avoid inappropriately penalizing providers that serve beneficiaries with social risk factors. Measuring and reporting quality for beneficiaries with social risk factors, setting high, fair quality standards for all beneficiaries, and the provision of targeted rewards and supports for better outcomes for beneficiaries with social risk factors, may help ensure that all Medicare beneficiaries can achieve the best health outcomes possible.

VI. Next Steps
The findings outlined in this report represent only the beginning of a body of necessary work around fair and accurate quality measurement in the context of Medicare’s increasing use of value-based purchasing programs. The IMPACT Act lays out specific additional requirements for Study B, including the examination of specific social risk factors not currently available in Medicare data such as health literacy, limited English proficiency, and Medicare beneficiary activation (the degree to which beneficiaries have the knowledge, skill, and confidence to manage their health and health care). Based on the findings in this report, future work may also include examining the impact of measuring and accounting for functional status or frailty on the relationship between social risk factors and performance, and identifying care innovations associated with the achievement of good health outcomes for beneficiaries with social risk factors.

VII. References


