In the report series *Accounting for Social Risk Factors in Medicare Payment*, an ad hoc, expert committee of the National Academies of Sciences, Engineering, and Medicine identifies social risk factors that can affect the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. What follows is a series of key questions and answers, providing a broad overview of the committee’s work.

**WHAT IS A SOCIAL RISK FACTOR AND WHY IS IT IMPORTANT FOR MEDICARE PAYMENT?**

- Social risk factors capture how social relationships and contexts influence the health care outcomes of Medicare beneficiaries. The committee identified five social risk factors that influence provider performance measures used in Medicare value-based payment (VBP):
  1. Socioeconomic position;
  2. Race, ethnicity, and cultural context;
  3. Gender;
  4. Social relationships; and
  5. Residential and community context.

- Health care providers (such as hospitals and physician groups) and health plans that serve greater shares of Medicare beneficiaries with social risk factors appear to produce worse health care outcomes on average compared to providers and plans that serve more advantaged patients. This may partly be due to the influence of social risk factors. However, patients with social risk factors have also historically received poorer-quality care.

- Providers and plans can reduce the negative effects of social risk factors on health outcomes, but interventions to do so may require substantial effort, time, and costs. Thus, achieving good outcomes for patients with social risk factors may be difficult and costly. Nevertheless, it is possible to provide high-quality care and achieve good outcomes for patients with social risk factors, and the committee identified promising strategies to do so.

- Current Medicare VBP generally does not account for social risk factors and thus disadvantages providers and plans that serve greater shares of patients with social risk factors. This may lead some providers and plans to avoid socially at-risk populations, thereby reducing their access to care and lowering the quality of care. These unintended consequences of current Medicare payment systems could result in widening health disparities.

**WHAT DOES IT MEAN TO ACCOUNT FOR SOCIAL RISK FACTORS IN MEDICARE PAYMENT?**

- Accounting for social risk factors in Medicare payment can help to achieve four policy goals:
  1. Reducing disparities in care access, quality, and outcomes;
  2. Quality improvement and efficient care delivery for all patients;
  3. Fair and accurate reporting of quality and outcome measures; and
  4. Compensating providers fairly.

- Accounting for social risk factors seeks to minimize the influence of factors that are largely beyond providers’ control or recognize that these factors make it harder and/or more costly for providers to achieve performance benchmarks. Adjustment for social risk factors would be very similar to the adjustment for clinical risk factors in current payment models.
HOW COULD THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) ACCOUNT FOR SOCIAL RISK FACTORS IF IT CHOOSES TO DO SO?

• The committee identified methods in four categories that could be used individually or in combination to account for social risk factors. These categories are:
  1. Stratified public reporting;
  2. Adjustment of provider performance measure scores;
  3. Direct adjustment of payment; and
  4. Restructuring payment incentive design.

See the box below for an example of how these methods might work in the Hospital Readmission Reductions Program.

• 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 efficiency. Thus, lower cost is not always better, while higher quality is always better if achieved at reasonable cost.

• To achieve the committee’s four policy goals, the committee endorsed payment based on performance measure scores adjusted for social risk factors (or directly adjusting payment for these factors) when combined with public reporting stratified by patient characteristics within reporting units (for example, reporting performance for patients by race and ethnicity within a hospital). Improving health equity may also require quality improvement interventions.

• Accounting for social risk factors is not without risks. Some worry that doing so would excuse or institutionalize poor quality care, reduce incentives to improve care for patients with social risk factors, and obscure disparities. However, the committee identified ways to account for social risk factors that can avoid or diminish these risks. Combinations of methods may help to guard against the risks of any method alone, and any approach to accounting for social risk factors should use them.

• Showing quality information for different subgroups within health care providers and health plans (i.e., public reporting stratified by patient characteristics within reporting units) is the only strategy that makes disparities visible. Therefore, such stratified public reporting must be part of any approach that seeks to monitor and reduce disparities.

• Identifying the best methods to account for social risk factors—and which social risk factors to include in any method—requires research, which CMS can conduct or support. This research may show that a smaller set of factors is sufficient.

• Although the committee’s task is focused on Medicare, the committee’s conclusions and recommendations could apply to other health care payers, such as private insurers.

EXAMPLE:
ACCOUNTING FOR SOCIAL RISK FACTORS IN THE HOSPITAL READMISSION REDUCTIONS PROGRAM

• Since October 2012, the Centers for Medicare & Medicaid Services (CMS) reduces base payments to acute care hospitals with the highest readmission rates for six conditions. For 2017, the maximum reduction is 3 percent.

• To determine the payment reduction, CMS calculates a hospital’s excess readmissions, which capture an individual hospital’s performance compared to hospitals nationally. The excess readmission measure currently accounts for some demographic characteristics, clinical comorbidities, patient frailty, and planned readmissions. It does not currently account for social risk factors.
METHODS TO ACCOUNT FOR SOCIAL RISK FACTORS

A. STRATIFIED PUBLIC REPORTING FOR PATIENT CHARACTERISTICS

• How would CMS do this? CMS could show readmission rates separately for patients who identify as white, black, Hispanic, or other racial and ethnic groups. This would show the public readmission rates for each of those groups.

• What does this mean for hospitals? Hospitals could use this information to compare with other hospitals that have a similar make-up of patients with better readmission rates from which they could learn better practices.

• What does this mean for patients with social risk factors? Patients could use this information to choose hospitals with the best readmission rates for someone like them.

• What are possible upsides or downsides? Because this is the only method that presents quality information for different subgroups, stratified public reporting is crucial to highlight disparities that may exist. CMS could use this information to track whether the program is increasing disparities, as some have worried.

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 formula.

• What does this mean for hospitals? Some hospitals that receive a penalty now but that have more patients with social risk factors than average would have an adjusted performance score that may be good enough to lower or eliminate their penalty. Some hospitals that do not currently incur a penalty but have more advantaged patients than average might receive a penalty if adjustments were added. Safety-net hospitals would generally benefit, which might help them better serve their patients with social risk factors.

• What does this mean for patients with social risk factors? Adjustments could reduce incentives to improve care among hospitals whose penalties are lowered or eliminated, but increase incentives to improve care among hospitals whose penalties are increased. If more accurate adjustment reduces the impact that the types of patients a hospital serves has on its readmission rates and therefore on its penalties, this would reduce incentives for hospitals to avoid patients with social risk factors. This could increase access to care for patients with social risk factors.

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

• What does this mean for hospitals? Effects for payment adjustments are similar to adjustments of performance scores (category B): some hospitals that receive a penalty now but that have greater than average shares of patients with social risk factors would see their penalty lowered or eliminated. Some hospitals that do not currently incur a penalty but have more advantaged patients might receive a penalty if adjustments were added. Safety-net hospitals would generally benefit, which might help them better serve their patients with social risk factors.

• What does this mean for patients with social risk factors? Also similar to adjustments of performance scores, this method could reduce incentives to improve care for these patients among hospitals whose penalties are lowered or eliminated, but increase incentives to improve care among hospitals whose penalties are increased. If more accurate adjustment reduces the impact the types of patients served have on a hospital’s penalties, this would reduce incentives for hospitals to avoid these patients and increase access to care for them.

• What are possible upsides or downsides? This method does not make disparities apparent unless paired with stratified reporting as described under category A. 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 hospitals that reduce readmissions relative to their own benchmark. As another example, performance on (clinically adjusted) readmission rates could be awarded points on a scale, and there could be two scales—one for patients with high levels of social risk factors and one for patients with low levels of social risk factors. CMS could then add the points from the two scales together (with or without weighting for the differential costs of reducing readmissions for patients with social risk factors) and add additional points for improvement (i.e., reducing readmissions).

• What does this mean for hospitals? 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 providers who serve socially at-risk populations. This would reduce incentives for hospitals to avoid patients with social risk factors.

• What does this mean for patients with social risk factors? If hospitals no longer have incentives to avoid patients with social risk factors, this would increase access for these patients. If the program awards hospitals for reducing readmission rates, this would encourage hospitals to improve the quality of care and reduce readmission for all patients. If this is done specifically for patients with social risk factors, this would incentivize hospitals to improve the quality of care and reduce readmissions for these patients, which could also help reduce disparities.

• What are possible upsides or downsides? Incentives could be designed to explicitly encourage specific policy goals, such as reducing 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.