



**ASPE**  
ASSISTANT SECRETARY FOR  
PLANNING AND EVALUATION

OFFICE OF  
HEALTH POLICY

# EXECUTIVE SUMMARY

## Report to Congress: Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program

The Second of Two Reports Required by the Improving Medicare  
Post-Acute Care Transformation (IMPACT) Act of 2014

March 2020

**U.S. Department of Health & Human Services**

Office of the Assistant Secretary for Planning and Evaluation

# Executive Summary

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## I. Introduction

In recent years, the U.S. Department of Health and Human Services has embraced value-based purchasing (VBP) as a strategy for the Medicare program to achieve greater value for the nation's health dollar, as measured by quality outcomes and cost of care. While definitions of VBP vary, the general policy objectives are to move away from fee-for-service payments, to pay for health care quality versus quantity of services provided, and to incentivize the provision of person-centered, coordinated care. Under these policies, providers<sup>1</sup> that participate in Medicare are held financially accountable for both the cost and quality of health care services. While strong incentives for achieving VBP objectives are critical, it is also important to apply such incentives fairly—that is, to recognize when these incentives place certain providers at a relative disadvantage. In this regard, there has been considerable discussion on whether VBP programs should account for differences in populations between providers and, in particular, whether programs should account for beneficiaries with social risk factors—people for whom factors such as income, housing, social support, transportation, and nutrition might adversely affect access to health services or desired health outcomes.<sup>1-7</sup> The ongoing transition to VBP has been accompanied by growing recognition that to achieve VBP's objectives, the nation's health care delivery system must draw upon social and community services to address social risk factors.<sup>8,9</sup> These services most often are provided by networks of non-profit community-based organizations that have long-standing, trusted relationships across the nation, in both rural and urban communities.

This Report will explore emerging trends among providers who are addressing social risk factors in part by developing linkages with social service and other community-based organizations.

Congress responded to the need to develop high-quality evidence to guide policy decisions about the role of social risk in VBP in part by calling for this Report. Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (P.L. 113-183) called for the Secretary of Health and Human Services (HHS), acting through the Office of the Assistant Secretary for Planning and Evaluation (ASPE), to conduct a study evaluating the effect of individuals' socioeconomic status (SES) on quality measures and measures of resource use under the Medicare program. The statute requires four components:

- “Study A,”<sup>2</sup> which focused on SES information currently available in Medicare data, and Medicaid eligibility and urban-versus-rural location.<sup>3</sup> Study A introduced the broader concept of social risk factors to replace SES and was submitted as a Report to Congress in December 2016.

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<sup>1</sup> Note that in this Report the term “providers” is used to indicate physicians, hospitals, dialysis facilities, nursing facilities, Medicare Advantage contracts, etc.

<sup>2</sup> The term “Study A” is based on the statutory mandate in section 2(d)(1)(A) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

<sup>3</sup> Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, Section 2(d)(1)(A)

## Executive Summary

- “Study B,” which expands the analyses by using non-Medicare datasets to examine the impact of risk factors on quality resource use, and other measures, is the subject of this Report.<sup>4</sup> Study B was due to the Congress in October 2019.
- An examination of non-Medicare data sources to inform and contextualize Studies A and B focusing on data availability and use.<sup>5</sup> The National Academies of Science, Engineering, and Medicine (NASEM) prepared a set of five reports commissioned by ASPE and released in 2017 on this topic. This Report builds on and extends the NASEM data work.
- Recommendations by the Secretary on 1) how CMS should obtain access to the necessary data on SES (if the data is not already being collected) and how to address barriers to access to the data, and 2) how CMS should account for SES in quality, resource use, and other measures and in payment adjustments based on those measures, if Studies A and B find a relationship between SES and quality and resource use measures.

This Report presents the results of Study B and builds on the framework and considerations introduced in Study A. This Report addresses three policy questions:

1. Should some or all of Medicare’s value-based purchasing programs account for social risk by adjusting measures and/or payment based on those measures?
2. Should HHS routinely collect more extensive and detailed data on beneficiaries’ social risk factors than is currently available?
3. How can HHS achieve better outcomes for all Medicare beneficiaries by facilitating the ability of providers and communities to address social risk factors and integrate health and social services?

The first two policy questions are guided by Congress’ request for Study B. The third policy question furthers HHS’s goal to improve health outcomes for all Medicare beneficiaries. This Report uses both Medicare and non-Medicare data sources to address the policy questions. In addition, this Report outlines policy options that could potentially address social risk factors, and quantifies the impact of these options on providers serving beneficiaries with social risk factors. It also expands on the data findings requested by the Congress in Study C. As required by statute, this Report provides evidence and recommendations related to the issue of accounting for social risk factors in Medicare’s VBP programs specifically. However, since VBP programs are only one part of the larger goal of providing high-value, person-centered care, it also addresses the current state of efforts and future options for more comprehensively addressing and integrating social risk factors within the Medicare program and the broader health care system.

## II. Main Findings

Study A laid out three strategies for accounting for social risk in Medicare’s VBP programs to ensure that all Medicare beneficiaries receive the highest-quality health care services. The findings in this Report reinforce the need for such strategies. Proposed solutions that address only the measures or programs without considering the broader delivery system and policy context are unlikely to mitigate the full

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<sup>4</sup> Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, Section 2(d)(1)(B)

<sup>5</sup> Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, Section 2(d)(1)(C)

## Executive Summary

implications of the relationship between social risk factors and outcomes. VBP programs need to be leveraged to enhance access to and provision of high-quality care for beneficiaries with social risk factors.

The findings in this Report build on those of Study A, particularly the strategies for accounting for social risk in Medicare’s VBP programs (Figure 1.1). The first strategy, “measure and report quality,” deals with collecting and using social risk information. The second strategy, “set high, fair quality standards,” refers to the use of social risk information in quality and resource use measures and in VBP programs. Finally, “reward and support better outcomes” addresses the need to address beneficiaries’ social needs directly.

**Figure 1.1. Strategies for Accounting for Social Risk in Medicare’s Value-Based Purchasing Programs**



Looking across the quantitative and qualitative analyses conducted for this Report, the following three main findings emerge.

- A. FINDING 1: Beneficiary social risk information is not routinely or systematically collected across the health care system, and there is not always standardized terminology to capture beneficiary social risk information.**

A prerequisite to measuring and reporting quality for beneficiaries with social risk factors is knowing beneficiaries’ social needs. A consistent theme found throughout the qualitative research in this Report was the lack of available information on beneficiaries’ social risk. Currently, when individual-level social

## Executive Summary

risk information is collected, it may be recorded using one of the many screening tools available and documented in varying locations, including electronic health record (EHR) fields, free text notes, or as diagnoses. This lack of standardization in data collection and documentation makes it difficult to share data meaningfully between providers, payers, and social service organizations.

Despite these limitations, there is broad interest in having information on beneficiaries' social risk. All the EHR vendors included as case studies in this Report are incorporating social risk information into their tools in response to client demand. Additionally, submitters to ASPE's RFI (Request for Information) on provider and health plan approaches to improving care for Medicare beneficiaries with social risk factors discussed the need for standards on social risk data collection to support interoperability.

**B. FINDING 2: After accounting for additional social and functional risk factors, dual-enrollment status remains a powerful predictor of poor outcomes on some quality and resource use measures in Medicare's VBP programs. Functional status is also a powerful predictor of poor outcomes on some measures but is not always included in measure risk adjustment.**

Setting high, fair quality standards for all beneficiaries involves accurately accounting for differences between beneficiaries that may affect health outcomes. This Report evaluated additional individual-level social risk factors available in the Medicare Current Beneficiary Survey (MCBS): marital status, education, language, living alone, income, wealth, and private health insurance. It also included the area-level social risk factors of the social capital index and social deprivation index. When each social risk factor was evaluated separately, all the individual-level social risk factors were associated with higher spending and readmission rates. However, when all of the social risk factors were included together, only a couple were still associated with poor outcomes. Dual enrollment in Medicare and Medicaid was associated with both higher spending and readmissions, and social relationships (not being married or living alone) was associated with higher spending. In the total per capita cost measure (TPCC), dual enrollment was a stronger predictor of higher costs than social relationships—confirming Study A's finding that dual enrollment is the most powerful predictor of poor outcomes among the social risk factors evaluated. This finding points to the need to assess health equity and provide adequate information on providers' performance based on who they serve.

This Report also evaluated the current medical risk-adjustment approaches. It assessed the extent to which unmeasured functional risk factors (defined as physical or cognitive impairments that impair functioning) may contribute to observed worse outcomes among dually enrolled beneficiaries using both claims-based and patient self-reported functional limitations. In most quality and resource use measures evaluated, functional risk was associated with both dual-enrollment status and poor outcomes, indicating that not accounting for functional risk may increase the observed effect of dual-enrollment status.

**C. FINDING 3: Although many organizations are working to improve equity by addressing social risk, which interventions are effective, replicable, and scalable remains unclear due to limited evaluation.**

To reward and support better outcomes for beneficiaries with social risk factors, successful strategies need to be identified and disseminated. Many organizations are working to improve care for beneficiaries

with social risk factors, but some interventions may be more effective than others. Although many submitters responding to ASPE's RFI described interventions to improve care for these beneficiaries, few of these interventions have been rigorously evaluated. The limited published evidence on the effectiveness and return on investment of certain interventions may be a starting point for organizations looking for new ways to improve care. However, evaluations of more and different types of interventions are still needed, including evidence on whether interventions are effective in different patient populations, across a range of organizations, and scaled to larger or smaller groups.

### III. Recommendations

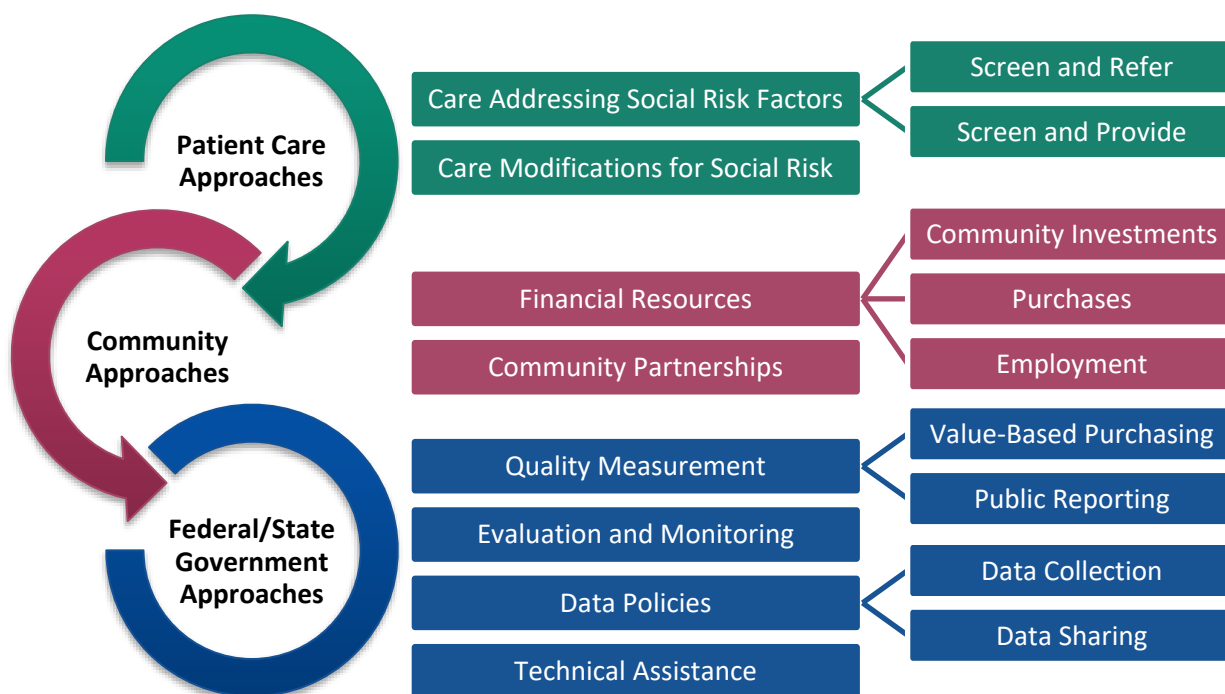
The recommendations included below build on the framework and considerations introduced in Study A and the policy questions introduced earlier for this Report. Recommendations are required by Congress in the IMPACT Act.

Policy questions:

1. Should some or all of Medicare's value-based purchasing programs account for social risk by adjusting measures and/or payment based on those measures?
2. Should HHS routinely collect more extensive and detailed data on beneficiaries' social risk factors than is currently available?
3. How can HHS achieve better outcomes for all Medicare beneficiaries by facilitating the ability of providers and communities to address social risk factors and integrate health and social services?

As discussed in the emerging areas section (Section 3 of this Report), addressing social risk factors and supporting better health outcomes will require connections between every level of the health system and the community (Figure 1.2). Providers can screen for social needs and refer beneficiaries to organizations to address those needs. Social needs may be better addressed through community collaborations, including referral networks and partnerships within and outside the health care system. Payers, including health plans and government agencies, can maintain social risk information about beneficiaries and fund infrastructure development to address social needs. At each of these levels, value-based care is an important tool to align incentives across the health care delivery system to address social needs.

Figure 1.2. Approaches for Health Care Systems to Invest in Addressing Social Risk



Adapted from: Gottlieb L, Fichtenberg C, Alderwick H, Adler N. Social Determinants of Health: What’s a Healthcare System to Do? *Journal of Healthcare Management* 2019;64:243-57. doi:10.1097/jhm-d-18-00160.

**A. A Comprehensive Strategy to Account for Social Risk in Medicare’s VBP Programs**

As Medicare’s VBP programs mature, it is important to shift from modifying individual programs to adopting and implementing strategies that cut across all programs and health care settings. Quality reporting and VBP programs need to work in concert to create aligned incentives that drive providers to improve health outcomes for all beneficiaries. Thus, the recommendations in this Report apply to *all* of Medicare’s quality reporting and VBP programs to create a comprehensive approach to account for social risk.

The recommendations in this Report build on the three-part strategy for accounting for social risk in Medicare’s VBP programs (Figure 1.1) introduced in Study A. The strategy lays out a comprehensive approach to move towards programs that incentivize providers and plans to improve health outcomes by rewarding and supporting better outcomes for beneficiaries with social risk factors. This requires measuring and reporting quality by social risk (Strategy 1). Support is also needed to reward and support better outcomes for all beneficiaries, including those with social risk factors (Strategy 3). These two strategies provide support for providers to be held to the same high, fair quality standards for all beneficiaries (Strategy 2). As this strategy is realized, VBP and quality programs will need to align incentives for providers to improve care for socially at-risk beneficiaries. Rather than adjusting quality measures and VBP performance scores for social risk, this strategy focuses on supporting providers in addressing social risk (Strategy 3).

## Executive Summary

Although the recommendations are discussed in detail within each of the strategies, they are more likely to be successful if the recommendations across the strategies are implemented together as a comprehensive approach to addressing social risk in Medicare. For example, the recommendations for Strategy 2: Set High, Fair Quality Standards for All Beneficiaries discuss how to account for social risk in VBP measures and programs. The recommendations do not support adjusting outcome measures for social risk factors, nor do they support using peer groups for VBP performance score calculations. However, under the current VBP measures and programs, providers treating more socially at-risk beneficiaries may have worse performance and the recommendations for Strategy 2 alone do not address this disparity. Therefore, this comprehensive strategy directly addresses the disparity in outcomes by providing additional tools and resources to safety-net providers.

Changing VBP quality measures and performance scores alone, without providing incentives to improve health equity or additional tools and resources, is unlikely to improve care for socially at-risk beneficiaries. This comprehensive strategy seeks to respond to the third policy question evaluated in this Report, “How can HHS achieve better outcomes for all Medicare beneficiaries by facilitating the ability of providers and communities to address social risk factors and integrate health and social services?”

However, some of the key components needed to make this comprehensive strategy successful are not yet available. More work is needed to develop both health equity measures to reward providers for improving care for beneficiaries with social needs, as well as VBP payment adjustments and supplemental benefits to support providers’ efforts. Thus, the recommendations across the three strategies need to be implemented in phases.

Some of these recommendations could be implemented soon, while others require more development before implementation can proceed. For example, changes to measures’ medical risk adjustment methodology (Recommendation 2.1) could be implemented in the near future, as the indicators of functional risk assessed in this Report are already available. On the other hand, health equity measures or domains (Recommendations 1.3 and 2.2) are not yet readily available, and measure developers and endorsement organizations need to build such measures before they can be incorporated into VBP programs and replace current transitional approaches such as the categorical adjustment index (CAI). For this reason, implementing some of the recommendations in this Report requires more developmental work so that the Medicare program can implement a comprehensive approach to addressing social risk.

Some recommendations can be implemented alone, while others should be implemented together to achieve the policy goals described above. For instance, efforts to increase the sharing of social risk data across federal agencies and across the health and social service sectors at the local level (Recommendation 1.2) can proceed without the need to wait for other recommendations. On the other hand, implementing Recommendation 2.5 by removing peer grouping from the Hospital Readmissions Reduction Program (HRRP) and the CAI from the Medicare Advantage Star Ratings needs to be implemented along with additional actions to help providers achieve high quality outcomes for all beneficiaries. The goal of implementing these recommendations together is to hold all providers to the same high standards while giving providers additional tools and resources to help achieve these high standards. Additionally, this comprehensive approach calls for enhancing risk adjustment methodologies.



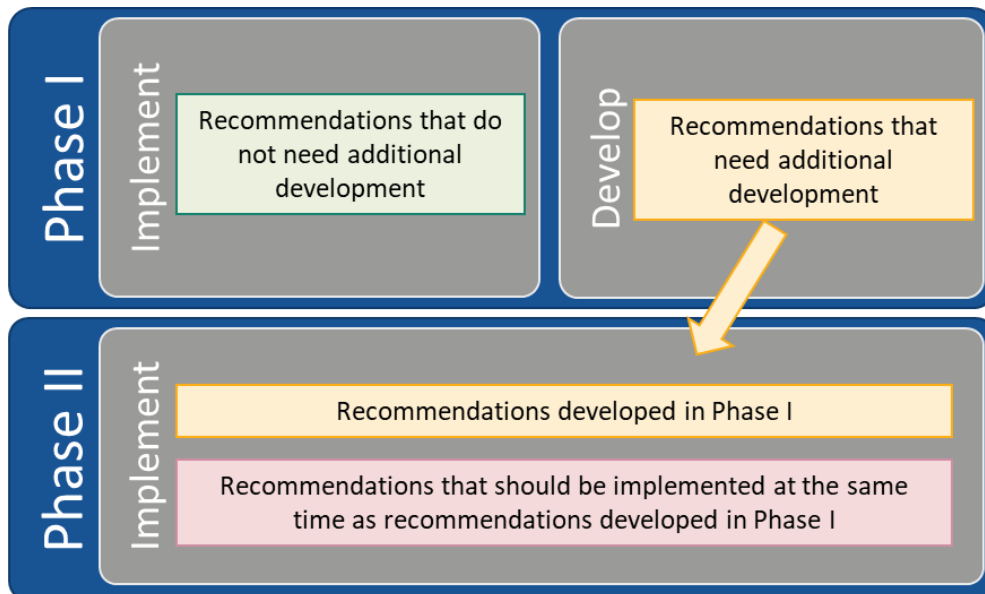
## Executive Summary

Without implementing these recommendations together, providers treating more socially at-risk beneficiaries would lose the current protections of peer grouping and the CAI. These actions and tools could include supplemental benefits and additional payment adjustments to providers (Recommendation 3.1), a standard risk adjustment framework that includes functional risk adjustment (Recommendation 2.1), or including health equity measures or domains in VBP programs (Recommendation 2.2). For example, it may be appropriate to remove peer grouping from the HRRP once the readmission measures use the standard risk adjustment framework that includes functional risk adjustment. As actions and tools to help providers achieve high-quality care for all beneficiaries are implemented, their impact on safety-net providers will need to be assessed, and further modifications may be necessary.

For these reasons, the recommendations included in this Report may be implemented in two phases (Figure 1.3).

- Phase 1: recommendations that are ready to be implemented independently in the first phase can begin now.
- Phase 2: recommendations that require further development can then be implemented in the second phase. Some recommendations do not require further development, but should be implemented in phase 2 at the same time as other recommendations that do require development, such as Recommendation 2.5 discussed above. Removal of peer grouping from programs should be implemented in the second phase, after actions and tools to help providers achieve high-quality care for all beneficiaries through one or more of the methods discussed above.

Figure 1.3. Implementation Phases



Note: Implementation phases including specific recommendations are presented in the summary section after the detailed recommendations.

### B. Recommendations

#### Strategy 1: Measure and Report Quality for Beneficiaries with Social Risk Factors

This strategy includes collecting data on social risk and reporting quality measures by patient social risk to guide and encourage providers to identify and address patients' social needs and reduce health disparities. Separately reporting quality measures for those patients with and without social risk will facilitate measuring progress toward closing the gap in performance on quality measures between these two groups of patients.

**Recommendation 1.1: HHS should support and inform the development of data collection and interoperability standards for social risk. CMS should explore ways to encourage providers to collect social risk information.**

This recommendation addresses Congress' requirement that the Secretary make recommendations on obtaining access to social risk data.

Study A included the consideration "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." Since that time, there has been an increased focus on collecting and using beneficiary social risk information. However, there is still no consensus on how the data will be used, an important question that needs to be answered before data collection can be standardized. Deciding how data will be used will help to determine (1) which questions should be asked, and (2) how the responses should be documented. For each of these issues, there are opportunities to provide standards and/or to encourage data collection.

The choice of screening tool determines which questions will be asked. Currently numerous tools are widely used. The ideal screening tool depends on the planned use of social needs information. If the primary goal is to direct beneficiaries to services to address their social needs, providers need more detailed information to make appropriate referrals, implement interventions, and track resolution of needs over time. On the other hand, if social risk is used to risk adjust measures, payments, or population monitoring, less detail may be sufficient. Already, CMS has developed a social risk screening tool used in the Accountable Health Communities model and the social risk items proposed for the post-acute care screening tools.<sup>10,11</sup> These instruments are required for specific programs but could be used more broadly for the Medicare population. Alternatively, HHS could provide standards on which screening tool should be used but allow providers and plans to determine whether or not to use it to collect social risk information.

Knowing who needs information on the beneficiary's social risk also affects how the data should be documented. Here there are also various options worth considering. Currently, as noted earlier, social risk information can be captured in clinical documentation and/or in recording diagnosis codes. The federal government, state government, and health plans can most easily access information documented as a

## Executive Summary

diagnosis codes in claims because claims are submitted to the payer for reimbursement. HHS may need additional social risk information for VBP program monitoring and evaluation.

For other health and social service providers, it may be easier to access information from clinical documentation, as providers may be able to share EHR information more easily than they can share claims. Yet if multiple parts of a single health system need the information, provider notes may be sufficient. However, different documentation methods may be ideal for different parts of the health care system. One solution may be to create “crosswalks” to translate social risk information from one format to another. Additionally, EHR captured data and/or diagnosis codes may need to be expanded to allow capture of more detailed social risk information. As with screening tools, HHS could provide standards for data documentation with or without encouraging providers and plans to document social risk factors.

HHS has developed data standards for documentation of some social risk information. The Office of the National Coordinator for Health Information Technology (ONC) included social, psychological, and behavioral standards in the 2015 health information technology certification criteria, providing interoperability standards (LOINC (Logical Observation Identifiers Names and Codes) and SNOMED CT (Systematized Nomenclature of Medicine—Clinical Terms)) for financial strain, education, social connection and isolation, and others.<sup>12</sup> ONC has also released a draft 2020-2025 Federal Health IT Strategic Plan for public comments, including an objective to integrate health and human services information.<sup>13</sup> Additional stakeholder efforts are underway to expand the availability to capture additional social determinants of health data elements for use and exchange. This includes the Gravity Project to identify and harmonize social risk factor data for interoperable electronic health information exchange for EHR fields as well as proposals to expand the ICD-10 (International Classification of Diseases, Tenth Revision) z-codes, the alphanumeric codes used worldwide to represent diagnoses.<sup>14,15</sup>

**Recommendation 1.2: Federal and state agencies should consider policies regarding how and when to share social risk data across agencies. HHS should explore whether some social risk data can/should be shared at the local level between health and social service providers.**

This recommendation addresses Congress’ requirement that the Secretary make recommendations on obtaining access to social risk data.

In addition to, or even before, new social risk information is collected, existing information should be shared to reduce the burden of new data collection. This was discussed in the National Academies of Sciences, Engineering, and Medicine’s (NAEM) report on data sources as well as in the submitted responses to ASPE’s request for information on provider and health plan approaches to improving care for Medicare beneficiaries with social risk factors.<sup>16</sup> The NAEM report specifically identified data elements collected by the Social Security Administration, the Census Bureau, and Centers for Disease Control and Prevention’s (CDC’s) National Center for Health Statistics.

Such data sharing has been promoted by the bipartisan Commission on Evidence-based Policymaking’s report and the Foundations for Evidence-Based Policymaking Act of 2018,<sup>17,18</sup> and these new developments are promising as improvements to the current state, in which sharing and linking data

## Executive Summary

across agencies or departments within the federal government can be difficult and burdensome. For example, this Report intended to use Medicare beneficiaries' individual-level responses to the American Community Survey (ACS) and Medicare claims to evaluate the effect of the social risk factors available in the ACS on quality and resource use measures included in Medicare's value-based purchasing (VBP) programs. However, at the time of submission, the merged Medicare-ACS data were not yet available. A standard agreement across federal agencies that addresses confidentiality and security could make such data sharing smoother than the current process that requires each project to create a new agreement from scratch.

Within the Department, efforts have begun to understand the current state of data sharing across agencies, including an evaluation of challenges in doing so in the 2018 report "The State of Data Sharing at the U.S. Department of Health and Human Services" by the HHS's Office of the Chief Technology Officer. As these challenges are addressed to allow data sharing across the Department, the next logical step would be to expand this analysis to additional departments and identify and address challenges in data sharing across the federal, state, and local governments.

Beyond sharing current administrative data, the Department, including ONC, the Office for Civil Rights (OCR)—which enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule—and the HHS Office of the Chief Technology Officer (CTO), should explore whether and how health and social service providers can share their social risk data. The necessity for and type of data to be shared would depend on the utility of the available data to providers and addressing any data security, privacy, or governance concerns for sharing and documentation. As data needs and uses will depend on the specific health and social service providers involved, these decisions should be made at the local level.

### **Recommendation 1.3: Quality reporting programs should include health equity measures.**

This recommendation addresses Congress' requirements that the Secretary make recommendations on accounting for social risk in quality and resource use measures.

This recommendation also mirrors the second consideration in Study A: "Consider developing and introducing health equity measures or domains into existing payment programs to measure disparities and incent a focus on reducing them." Currently, no quality reporting programs explicitly include health equity measures that provide incentives to reduce health disparities. Including health equity measures can help providers prioritize areas for particular focus, and specific measures targeting equity within existing quality reporting programs can motivate a focus on reducing disparities and signal that health equity is an important component of delivery system transformation. These measures could also encourage providers to address health equity through service enhancements, patient engagement activities, and adoption of best practices to improve performance in this domain. Public reporting of health equity measures or domains would support monitoring of health disparities over time and help inform consumers' choice of providers.

Implementing this recommendation, however, will first require measure developers to create health equity measures. Health equity could be measured in various ways, including the difference in

## Executive Summary

performance on particular measures between socially at-risk and other beneficiaries within a providers' population, comparing performance for socially at-risk populations across providers, or evaluating improvement in measure performance for a providers' socially at-risk population over time. One existing measure is the Health Equity Summary Score developed by CMS OMH.<sup>19</sup> The use of health equity measures in VBP programs is discussed in Recommendation 2.3.

**Recommendation 1.4: Quality and resource use measures should be reported separately for dually enrolled beneficiaries and other beneficiaries.**

This recommendation addresses Congress' requirement that the Secretary should make recommendations on how to account for social risk factors in quality and resource use measures.

This recommendation builds on the first consideration in Study A: "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." This Report also finds that dual enrollment is the strongest predictor of poor outcomes, and for that reason recommends stratifying reported measures by dual enrollment in quality reporting programs.

Since Study A was published, substantial progress has been made on stratified reporting of measures. Currently, CMS's Office of Minority Health (OMH) Mapping Medicare Disparities tool compares quality and resource use outcomes for dually enrolled and non-dually enrolled beneficiaries,<sup>20</sup> and CMS has begun providing hospitals with confidential reports of pneumonia readmission rates for dually enrolled compared to other beneficiaries.<sup>21</sup> These efforts could be expanded either by including additional measures or providers on OMH's Mapping Medicare Disparities tool or by adding stratified measures to CMS's compare websites (Hospital Compare, Nursing Home Compare, Home Health Compare, Dialysis Facility Compare, Long-Term Care Hospital Compare, Inpatient Rehabilitation Facility Compare, Physician Compare, Hospice Compare, and Medicare Plan Finder). This additional information could allow policy makers and providers to measure and track quality, outcomes, and costs for beneficiaries with social risk factors over time to reduce disparities and improve care for beneficiaries with social risk factors. However, adding stratified measures may be confusing, rather than helpful, for beneficiaries using these tools to select a provider. For that reason, it may be most appropriate to include these stratified measures on a separate data site rather than websites designed to help patients select high-quality providers.

**Recommendation 1.5: Quality and resource use measures should *not* be adjusted for social risk factors for public reporting.**

This recommendation addresses Congress' requirement that the Secretary should make recommendations on how to account for social risk factors in quality and resource use measures.

As discussed in Recommendation 1.4 above, stratified reporting is important to monitor disparities and improvements over time. However, in public reporting, it is also important to hold providers accountable for overall results, regardless of social risk. For this reason, quality and resource use measures should also be reported for a provider's overall population without adjustment for social risk.

**Recommendation 1.6: Composite scores should *not* be adjusted for social risk factors for public reporting.**

This recommendation addresses Congress' requirement that the Secretary should make recommendations on how to account for social risk factors in quality and resource use measures.

In addition to *not* adjusting measures for social risk in public reporting (Recommendation 1.5), composite scores, such as star ratings, should *not* be adjusted for social risk factors. Composite scores used for public reporting should *not* use measures that are adjusted for social risk factors. They should also *not* use other methods to account for social risk, such as peer grouping.

### Strategy 2: Set High, Fair Quality Standards for All Beneficiaries

This strategy aims to hold providers accountable to the same standards in VBP programs to improve care and health outcomes for all Medicare beneficiaries. It recognizes that beneficiaries with social risk factors may require more supports and resources to achieve the same outcomes. A standard, comprehensive risk-adjustment framework for all outcome and resource use measures, including functional risk factors, improves provider comparisons across measures.

**Recommendation 2.1: Measure developers and endorsement organizations should create a standard risk-adjustment framework that includes functional risk for all risk-adjusted outcome and resource use measures used in Medicare programs.**

This recommendation addresses Congress' requirements that the Secretary make recommendations on accounting for social risk in quality and resource use measures.

Measures used in VBP programs would benefit from a standard risk adjustment framework that sets a consistent policy for a number of reasons. First, the current lack of standardization across measures makes it difficult to accurately assess the role of social risk, as social risk is correlated with medical risk: both comorbidities and functional status. Thus, measures that include more medical risk adjustment are likely to see a smaller effect of social risk, making it difficult to compare and track disparities across measures and patient populations. Second, the use of different risk adjustment methods and factors make it difficult to compare performance across measures. If a provider does better on one measure than another, it may be due to differences in performance or differences in the measures' risk adjustment.

As discussed in Chapter 5, current outcome and resource use measures in Medicare's VBP programs use a variety of risk-adjustment methods and measures. These include different methods to adjust for medical risk such as comorbidities, functional risk adjustment, or reason for hospitalization (diagnosis). Some measures include social risk adjustment using the beneficiary-level risk factor of dual enrollment status. Despite the general consensus on the importance of medical risk adjustment, however, many measures currently used do not include functional risk adjustment. To fully account for differences in health status

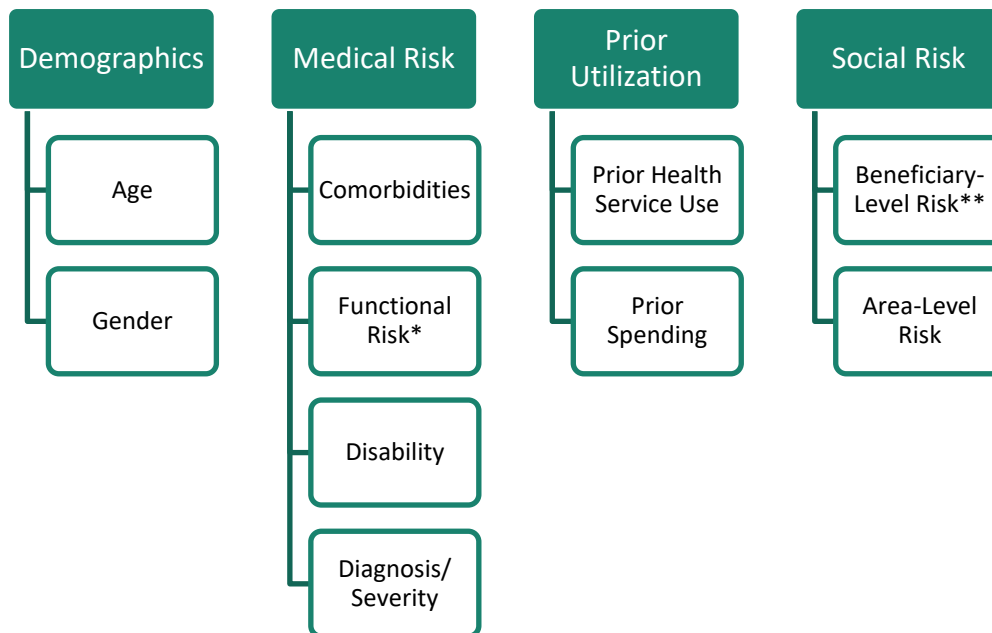
## Executive Summary

between beneficiaries, it is important for measure developers to follow a consistent policy across measures and to account for functional risk factors in *all* outcome and resource use measures' risk adjustment. One possible approach to account for functional risk factors using ICD codes is presented in this Report. Note that this recommendation does not apply to measures that do not use risk adjustment, such as process measures where the same process is expected for all beneficiaries.

Figure 1.4. illustrates the different factors that can potentially be used in risk adjustment and that should be considered for a standard risk-adjustment framework. Social risk factors are depicted in the figure's right column, but are not recommended to be included in the risk-adjustment of process or outcome measures. Demographics and medical risk adjustment are widely accepted as appropriate and important risk-adjustment factors. Some measures include prior utilization, but not all. Almost no measures at this time include social risk, except patient experience of care survey measures. Social risk factors are *not* recommended for the standard, clinical risk-adjustment model. Recommendations 2.3-2.5 discuss the appropriateness of adjusting for social risk by type of measure.

As discussed in more detail in this Report's introductory chapters, the appropriate risk-adjustment approach may depend on the planned use of the measure (i.e., public health surveillance, population health management, quality improvement, quality reporting, VBP, or program evaluation). The standard risk-adjustment framework as suggested by this recommendation may need to specify different risk-adjustment methods for different uses (i.e., standardized age/gender adjusted outcomes for population health management, clinically risk-adjusted quality measures stratified by patient subgroups for quality reporting, etc.).

**Figure 1.4. Potential Risk-Adjustment Variables**



\*This Report includes the recommendation to include functional risk in the standard risk adjustment framework.

\*\*This Report includes the recommendations to adjust resource use and patient experience measures for dual enrollment status as a beneficiary-level social risk factor, but *not* to adjust quality process or outcome measures for social risk.

Note: This Report does not include specific recommendations for other potential risk adjustment variables.

**Recommendation 2.2: Value-based purchasing programs should include health equity measures and/or domains.**

This recommendation addresses Congress' requirements that the Secretary make recommendations on accounting for social risk in quality and resource use measures and in determining payment adjustments based on these measures.

This recommendation is similar to recommendation 1.3, but focuses on the use of health equity measures in VBP programs rather than quality reporting programs. Currently, no VBP programs explicitly include health equity measures that provide incentives to reduce health disparities, although the Merit-based Incentive Payment System (MIPS) program does include some optional health equity activities in the improvement activities performance category. As with public reporting of health equity measures, including health equity measures in VBP programs can help providers prioritize areas for particular focus, help providers focus on reducing disparities, and signal that health equity is an important component of delivery system transformation. Once health equity measures are developed for public reporting, they can be included in existing VBP programs as allowed by statute.

**Recommendation 2.3: Resource use and patient experience measures should adjust for social risk factors in VBP programs.**

This recommendation addresses Congress' requirements that the Secretary make recommendations on accounting for social risk in quality and resource use measures.

### **1. A framework for considering social risk adjustment by type of measure**

As discussed above in Recommendation 2.1, measures used in VBP programs would benefit from a standard risk adjustment framework that sets a consistent policy. Policies could be established across all types of measures or separately for each type (process, outcome, patient experience, and resource use).

One solution that has been advocated for accounting for social risk in Medicare's VBP programs is adding social risk factors to all measures' risk adjustment to "level the playing field." The appeal of this approach is that it recognizes the greater challenges that may be faced in achieving the same outcomes for beneficiaries with social risk factors and may reduce the likelihood that concerns about performance could worsen access to care for these groups. Such considerations are particularly appropriate in situations in which measure performance is closely tied to social risk, and the consequences of this risk on outcomes are truly beyond providers' control, making the benefits of adjustment outweigh the drawbacks. In this case, it would still be important for VBP programs to include incentives for providing high-quality care for socially at-risk beneficiaries in other ways, such as including health equity measures or domains as discussed in Strategy 1 above.

Alternatively, risk-adjustment policies could be developed by type of measure, in conjunction with a set of criteria on the appropriateness of risk-adjustment.



## Executive Summary

As described in Chapter 5, measures are *less* appropriate for social risk adjustment if:

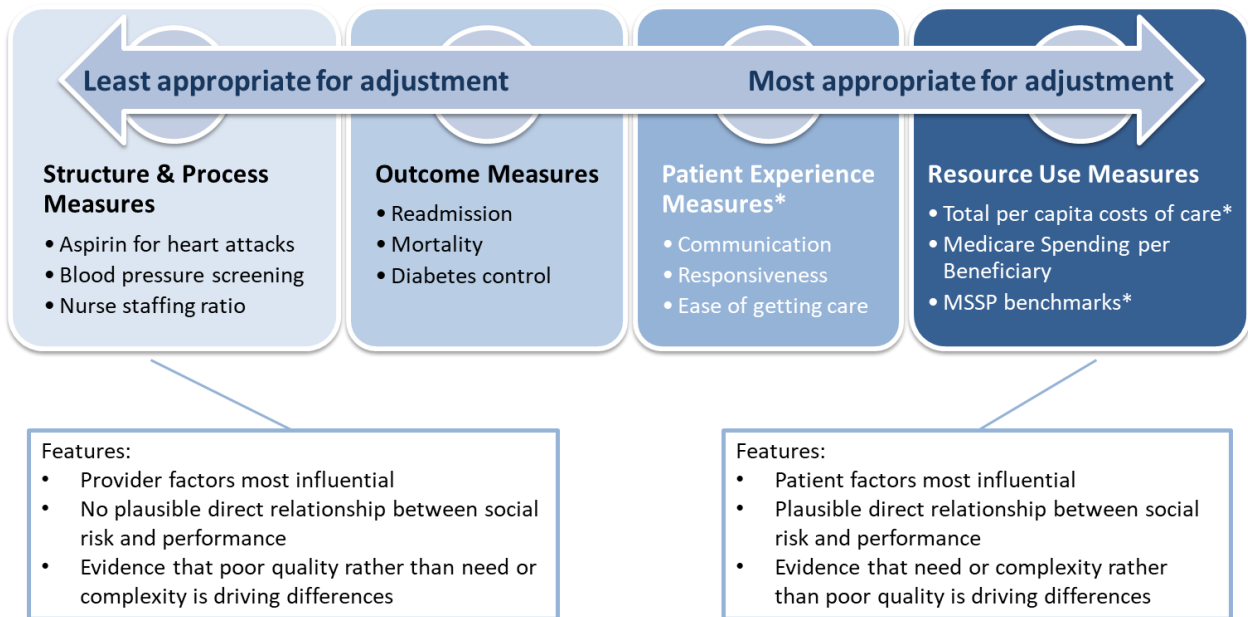
1. They are predominantly under the control of the provider,
2. There is no plausible direct relationship between the social risk factor and the outcome, and
3. There is evidence that provider bias, rather than patient need or complexity, is driving differences in performance.

Measures are *more* appropriate for social risk adjustment if the differences in outcomes or utilization are:

1. Predominantly related to patient factors,
2. If there is a plausible direct relationship between the social risk factor and the outcome, and
3. If there is evidence that patient need or complexity, rather than provider performance, is driving differences in performance.

Given that the role of social risk varies by type of measure, the appropriateness of adjusting measures for social risk may be better considered along a continuum, as shown in Figure 1.5.

**Figure 1.5. Considerations for Adjusting Quality and Resource Use Measures for Social Risk by Measure Type**



\*=measure currently adjusted for social risk factor(s)

Note: MSSP=Medicare Shared Savings Program.

## 2. Adjust resource use measures for social risk to recognize more resources may be needed to achieve same outcomes

To account for the fact that it may require additional resources to achieve the same high quality care for socially at-risk beneficiaries, *all* resource use measures should adjust for social risk. In order to provide a consistent governing principle, all resource use measures should adjust for social risk. Some current

## Executive Summary

resource use measures adjust for social risk, including the MIPS total per capita cost measure, which adjusts for the HCC (hierarchical condition category) risk score that in turn includes dual-enrollment status. Others, such as the Medicare Spending per Beneficiary measure, do not adjust for dual-enrollment status, even though the analyses in this Report find that dually enrolled beneficiaries have higher episode spending driven primarily by greater use of institutional and community-based post-acute care to meet their greater medical and social needs.

To provide consumers with information on the care that they should expect to receive, however, measures should *not* be adjusted for social risk in public reporting programs, but instead reported for dually enrolled beneficiaries and other beneficiaries separately as described in Recommendation 1.4.

### 3. Adjust patient experience measures for social risk to account for response tendencies

Patient experience measures, such as those collected by the CMS Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, are currently adjusted for social risk using factors such as education, dual enrollment, and language.<sup>22</sup> These adjustments seek to account for differences in response tendencies associated with social risk factors, rather than differences in the quality of care provided.<sup>23,24</sup> For example, individuals with less education and those who report better general and mental health provide more positive ratings and reports of care than others in the same health insurer contracts.<sup>22</sup> In order to accurately assess the care provided and compare patients' experiences, these measures should continue to adjust for social risk factors.

**Recommendation 2.4: Process and outcome measures should *not* be adjusted for social risk in value-based purchasing programs.**

This recommendation addresses Congress' requirements that the Secretary make recommendations on accounting for social risk in quality and resource use measures.

Although Recommendation 2.3 recommends risk adjusting patient experience and resource use measures for social risk, for other types of measures, the drawbacks of adjusting for social risk are considerable for both process and outcome measures.

#### 1. Process measures should *not* be adjusted for social risk

First, there are many quality measures for which there is no plausible role for any type of risk adjustment. Pure process measures such as giving aspirin for a heart attack, for example, are primarily under providers' control, and should be done regardless of a beneficiary's social risk profile. Second, adjusting the process of care quality measures risks masking disparities, potentially reducing the long-term ability to identify and reduce them. Third, adjusting quality measures may have a negative impact on transparency for consumers. Finally, to the degree that differences in measures reflect actual differences in provider performance, adjusting the measures directly could excuse the delivery of differential care to beneficiaries with social risk factors. For these reasons, process measures should *not* be adjusted for social risk factors.

### 2. Outcome measures should *not* be adjusted for social risk

In terms of appropriateness for adjusting for social risk, outcome measures fall in the middle of the spectrum shown in Figure 1.5 above. For many outcome measures, the provider has some control in the care given in the care setting, but outcomes are assessed at some point after the health care encounter. With 30-day readmissions, for example, providers can improve outcomes for socially at-risk beneficiaries through discharge planning, follow-up care, referrals for social services, and building relationships with community-based organizations. To hold all providers accountable to the same, high standards for all beneficiaries, therefore outcome measures should *not* be adjusted for social risk.

Because achieving the same high-quality outcomes may be more difficult for socially at-risk beneficiaries than for other beneficiaries, it is important to assist providers in achieving these high-quality outcomes for all beneficiaries. Rather than risk adjusting outcome measures for social risk to avoid VBP payment adjustments for worse outcomes for socially at-risk beneficiaries, programs should provide support in other ways. This could include additional payments or bonuses to safety-net providers. Although they are for different purposes, there are already existing payments and bonuses that target safety-net providers, including the current DSH payments and the bonus points for small practices and practices with a higher share of medically and socially complex patients in the MIPS program. It could also include sharing best practices. Both of these recommendations are discussed in Strategy 3 below. To provide consumers with information on the care that they should expect to receive, moreover, measures should also *not* be adjusted for social risk in public reporting programs, but instead reported for dually enrolled beneficiaries and other beneficiaries separately as described in Recommendation 1.4.

**Recommendation 2.5: Value-based purchasing programs should *not* use peer grouping or categorical adjustments for social risk factors. Where these adjustments are currently in place, they should be removed when additional actions and tools are implemented to help providers achieve high-quality care for all beneficiaries.**

This recommendation addresses Congress' requirements that the Secretary make recommendations on determining payment adjustments in VBP programs.

In addition to *not* adjusting process or outcome measures (Recommendation 2.4), VBP performance scores should *not* be adjusted for social risk factors. This recommendation applies to using peer grouping to assign VBP payment adjustments, such as in the HRRP, and other methods like the CAI used in the MA Star Ratings program. Similar to the arguments against adjusting quality measures for social risk presented in Recommendation 2.4 above, peer grouping establishes different quality standards across providers. Under peer grouping, providers who serve more socially at-risk beneficiaries may avoid negative payment adjustments, even though they may have lower scores compared to providers with fewer socially at-risk beneficiaries. Instead, safety-net providers should have additional tools and resources to help them achieve high-quality outcomes for all beneficiaries, as discussed in Strategy 3 below. These additional tools and resources should be available for all providers that treat a large proportion of socially at-risk beneficiaries, regardless of their performance on specific measures or programs. For example, peer grouping compares performance across similar providers rather than all providers, but is still dependent

## Executive Summary

on an individual provider's performance. Bonus points in a VBP program, on the other hand, provide additional resources to all safety net providers, regardless of their performance. For that reason, bonus points in VBP programs are appropriate as additional tools and resources, while peer grouping or the CAI are not. Once these additional actions, tools, and resources are available, approaches such as peer grouping or the CAI should be removed from VBP programs.

### Strategy 3: Reward and Support Better Outcomes for Beneficiaries with Social Risk Factors

This strategy recognizes that providing additional supports and resources is foundational to address beneficiaries' social risk in order to improve care and outcomes. Such additional supports may include sharing best practices through learning networks and encouraging medical providers to build links with social service providers. Additional resources to meet beneficiaries' social needs may be made available through alternative payment models, supplemental benefits that address social needs, or additional payments. Targeted payments to support providers' efforts to address social risk factors may also be made through VBP incentive payments.

**Recommendation 3.1: CMS should continue to support providers and plans addressing social risk factors through models, supplemental benefits, and VBP payment adjustments. HHS should continue to develop approaches to address beneficiaries' social needs. Additional research is needed on best practices for providing care to socially at-risk beneficiaries. Best practices, once identified, need to be scaled.**

This recommendation addresses Congress' requirement that the Secretary should make recommendations on how to account for social risk factors in determining payment adjustments based on quality and resource use measures.

It is clear that simply adjusting measures does not fully address the tough, real problems underlying the pervasive differences in performance across measures and programs that were examined in this Report. Social risk factors are powerful, and to truly begin to "solve" the problem by making things better for beneficiaries with social risk factors and the providers who serve them, these factors need to be explicitly recognized and addressed. This recommendation to support providers and plans addressing social risk factors goes hand-in-hand with Recommendations 2.3-2.5 focusing on risk adjustment and other methods for accounting for social risk in Medicare's VBP programs. This Report recommends adjusting resource use and patient experience, but *not* process or outcome measures, for social risk. However, achieving the same high-quality outcomes may be more difficult for socially at-risk beneficiaries than for other beneficiaries. It is important to assist providers in achieving these high-quality outcomes for all beneficiaries with the resources (through models, supplemental benefits, and VBP payment adjustments) and tools (such as best practices) to achieve these outcomes.

Currently, Medicare provides payment adjustments for providers treating socially at-risk beneficiaries in some settings but not others (see table in the appendix to this chapter). Specifically, Medicare provides

## Executive Summary

DSH payments to hospitals treating a large proportion of dually enrolled beneficiaries as required by Congress, and has used administrative authority to provide bonus points for practices with a higher proportion of socially complex patients in the MIPS program. Although the recommendation that outcome measures should *not* be adjusted for social risk encourages providers to achieve the same high-quality outcomes for socially at-risk beneficiaries as their other patients, it is important to recognize that achieving these outcomes may require more resources for socially at-risk beneficiaries. Without additional payment adjustments, providers have reported that they may be disincentivized to treat socially at-risk beneficiaries, jeopardizing access to care.

CMS should also support providers and plans working to address beneficiaries' social needs through supplemental benefits. New flexibilities in the Medicare Advantage (MA) program will allow health plans to provide supplemental benefits that are not necessarily health-related but have a reasonable expectation of improving or maintaining the health or overall function (including benefits that secondarily address social risk factors), but these benefits are only available to beneficiaries with chronic conditions enrolled in MA plans.<sup>6</sup> Although a small percentage of plans are offering these new supplemental benefits in the first year available, interviews with MA plans before these new flexibilities were implemented found that plans were considering a variety of approaches, including screening beneficiaries for social needs and referring to community organizations to address those needs ("screen and refer"), and screening for social needs and directly providing services to address the needs identified ("screen and provide").<sup>25,26</sup> As these flexibilities are implemented, it will be important for MA plans and others to evaluate the extent to which any supplemental benefits address Medicare beneficiaries' social needs and impact quality and resource use measures.

Finally, knowledge about best practices to address beneficiaries' social risk is an important tool for achieving high quality outcomes for all beneficiaries. As evidenced by the responses to ASPE's RFI, providers and health plans are already implementing numerous interventions to address beneficiaries' social risks. Within HHS, a number of agencies including CMS, the Administration for Community Living (ACL), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration for Children and Families (ACF), work to address social risk factors. States in the Medicaid program are also taking various steps to address beneficiaries' social needs. However, the evaluations of these approaches are not yet mature, making it difficult for organizations wanting to adopt new interventions to choose effective approaches. HHS, through CMS's Innovation Center, has begun to develop and evaluate new models to address social risk and should continue to do so. For example, the current Accountable Health Communities model and evaluation will help to build the knowledge base about effective interventions, along with findings from evaluations of state models.<sup>27,28</sup> Additional models including incentive payments or alternative payment structures to address beneficiaries' social needs

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<sup>6</sup> The Bipartisan Budget Act of 2018 (Public Law No. 115-123) amended section 1852(a) of the Social Security Act to expand the types of supplemental benefits that may be offered by MA plans to chronically ill enrollees. These include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees.

## Executive Summary

should be developed under various authorities to allow best practices to be identified, tested, disseminated broadly, and scaled.

**Recommendation 3.2: Learning networks, such as Quality Improvement Organizations (QIOs), should share best practices across providers.**

This recommendation addresses the policy question of how the federal government can facilitate the ability of health plans, providers, and communities to address social risk factors and integrate health and social services.

This recommendation to share best practices across providers goes hand-in-hand with Recommendations 2.3-2.5 focusing on risk adjustment and other methods for accounting for social risk in Medicare's VBP programs. This Report recommends adjusting resource use and patient experience measures, but *not* process or outcome measures, for social risk. However, achieving the same high-quality outcomes may be more difficult for socially at-risk beneficiaries than for other beneficiaries. It is important to assist providers in achieving these high-quality outcomes for all beneficiaries with resources and tools, such as best practices, to achieve these outcomes.

As more interventions are evaluated and the evidence of the effectiveness of different approaches grows, it is important to share this knowledge across the health care system. Currently, Quality Innovation Network Quality Improvement Organizations (QIN-QIOs) have an opportunity to identify and disseminate effective practices across providers.<sup>29</sup>

**Recommendation 3.3: HHS should encourage medical providers and plans to build links with social service providers to better address beneficiaries' social needs.**

This recommendation addresses the policy question of how the federal government can facilitate the ability of health plans, providers, and communities to address social risk factors and integrate health and social services.

VBP programs provide incentives for medical providers and plans to build relationships with social service providers. Current chronic-care management services, paid for by Medicare in addition to office visits, include coordinating community and social services for beneficiaries with multiple chronic conditions.<sup>30</sup> Nonetheless, one of the common themes in the submitted responses to ASPE's RFI was the difficulty of coordinating social and medical services. Although non-profit hospitals are currently required to conduct community-needs assessments and provide community benefits, there is much more than can be done.<sup>31</sup> Health care providers can screen for social needs and refer beneficiaries to organizations that can address those needs. However, many RFI respondents brought up challenges to this "screen and refer" approach. These included challenges in maintaining an up-to-date directory of social service providers, understanding eligibility criteria for different services, "closing the loop" after a referral is made to find out whether services were actually received, and the capacity of social services to meet beneficiaries' needs. Some providers and plans are going beyond "screen and refer" to "screen and provide" by providing services, such as food or housing, in concert with community organizations.

## Executive Summary

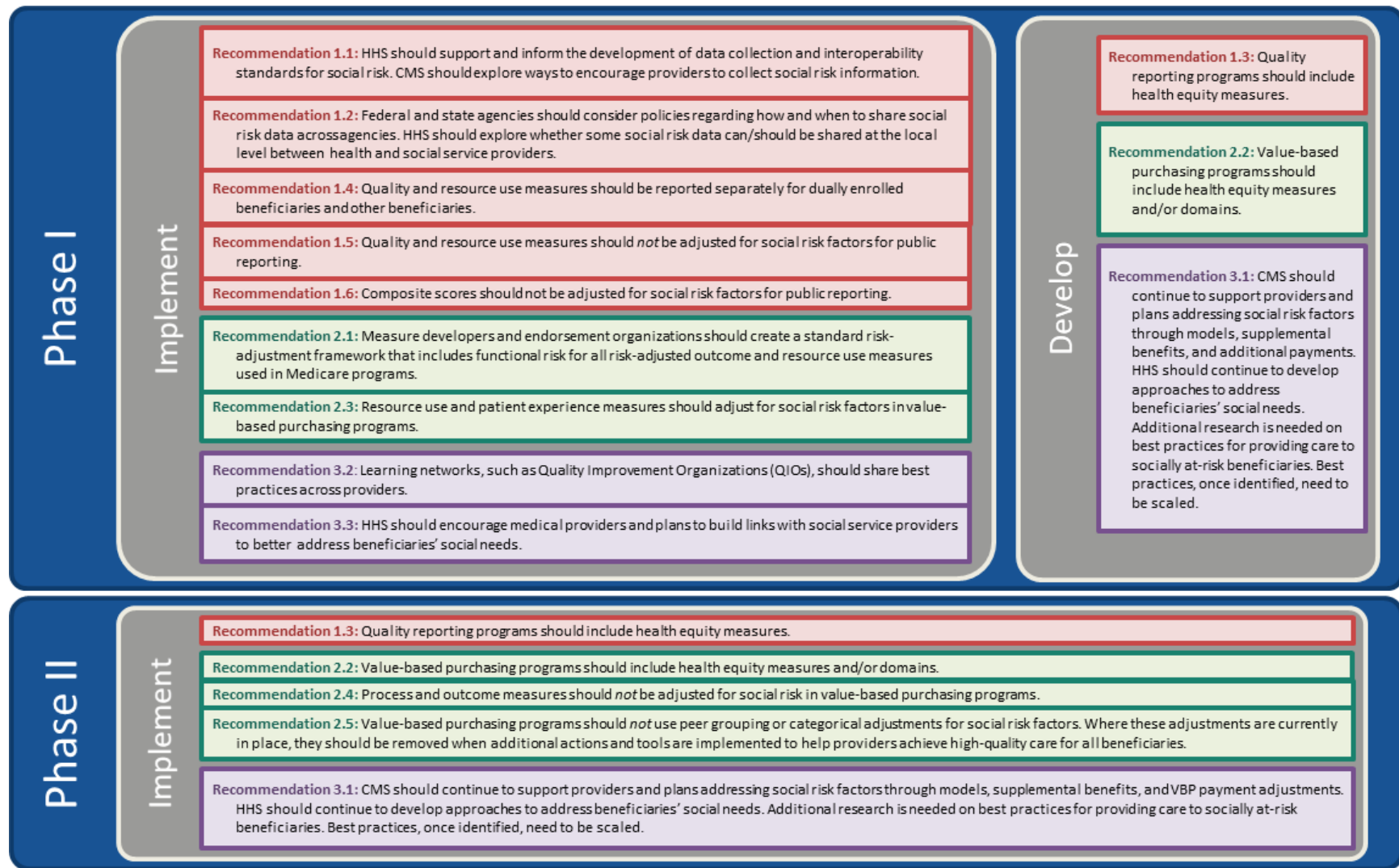
Better coordination between medical and social service providers could reduce these challenges. Specifically, HHS could encourage more community relationships through some of the recommendations above, such as developing data collection/interoperability standards, developing and testing new models for addressing social risk, and working with providers to evaluate and disseminate best practices for addressing the social needs of beneficiaries through home and community based services and social supports.

### C. Summary of Recommendations

The comprehensive approach to addressing social risk in Medicare's VBP programs introduced above can be implemented in phases depending on the amount of development needed for each recommendation, as discussed earlier. Some recommendations can be implemented alone, while others should be implemented together to achieve the policy goals. For instance, implementing Recommendation 2.5 by removing peer grouping from the Hospital Readmissions Reduction Program (HRRP) and the CAI from the Medicare Advantage Star Ratings needs to be implemented along with additional actions and tools to help providers achieve high quality outcomes for all beneficiaries, such as adjustments to supplemental benefits and additional adjustments in payments to providers (Recommendation 3.1), a standard risk adjustment framework that includes functional risk adjustment (Recommendation 2.1), or including health equity measures or domains in VBP programs (Recommendation 1.3).

For these reasons, the recommendations included in this Report may be implemented in two phases. Potential timing for implementing each recommendation is shown in Figure 1.6.

Figure 1.6. Implementation Phases for Recommendations





## Executive Summary

In particular, Recommendations 1.5, 1.6, 2.3, 2.4, and 2.5 address how to account for social risk in measures and programs, including both VBP programs and quality reporting programs.

**Table 1.1. Recommendations: Whether to Adjust for Social Risk Factors by Type of Measure and Program**

Measure Type	Whether to Adjust for Social Risk Factors	
	Quality Reporting Programs	VBP Programs
Process Measures	No	No
Outcome Measures	No	No
Patient Experience Measures	Yes	Yes
Resource Use Measures	No	Yes
Program Performance Scores	No	No

Note: VBP=value-based purchasing.

“No” indicates a recommendation *not* to adjust for social risk factors.

“Yes” indicates a recommendation to adjust for social risk factors.

## IV. Next Steps

This Report’s analysis and recommendations address the policy questions put forth in the IMPACT Act. However, they also raise additional questions and propose new policies that should be evaluated for their effectiveness of achieving the intended results and potential unintended consequences.

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

The findings about the current state of data collection for social risk factors suggest some changes that could improve social risk data collection and use to improve health outcomes. First, social risk measures and data collection tools could be standardized across federal, state, and local programs. Additionally, within the health care system, social risk factors could be mapped to electronic health record (EHR) fields and/or diagnosis codes. Existing EHR fields and diagnosis codes could also be expanded to include additional social risk factors and more information about beneficiaries’ social needs. Much work is already being done to improve social risk data collection, but these are typically private efforts and many groups are working in the same area. As these efforts mature, it may be appropriate for the Department to set data collection standards and common data elements for social risk factors so that data can be collected in a systematic way and easily shared. Once this information is available, tracking progress in improving outcomes for socially at-risk beneficiaries will be important.

### B. Set High, Fair Quality Standards for All Beneficiaries

These illustrate the difficulty of assessing the role of risk factors across measures, particularly when risk-adjustment approaches differ so much between the various quality and resource use measures included in Medicare’s nine VBP programs. A standard risk-adjustment approach that could be used across measures and programs, and modified as necessary and appropriate, would help to address this issue.

This Report does not specify exactly which factors should be included in such a standard risk-adjustment approach, but the findings about the medical and social risk factors evaluated provide some insights.

## Executive Summary

Including functional risk adjustment would likely improve current medical risk adjustments that currently only use comorbidities. Including functional risk factors would also allow social risk to be assessed more accurately because some of the effect currently attributed to social risk may actually be due to functional risk. Additional analyses to determine which functional risk factors should be included is still needed.

In terms of including social risk factors in the standard risk-adjustment approach, this Report's findings suggest that including dual-enrollment status makes only small average differences in program impacts between safety-net or high-dual providers and other providers. In terms of additional sources of social risk information (beyond Medicare data), the findings suggest that dual-enrollment status is a good proxy for social risk, and adding any of the additional measures of social risk evaluated (including other Medicare or survey data) would not substantially improve the measure risk adjustment beyond what is achieved by including dual-enrollment status. Note, however, that the small sample sizes of the MCBS make the findings using this survey less conclusive; results from the forthcoming analysis using the American Community Survey may be different and shed more light on these conclusions.

### C. Reward and Support Better Outcomes for Beneficiaries with Social Risk Factors

Providing high-quality care for all beneficiaries requires understanding which approaches are successful for socially at-risk beneficiaries specifically. Such understanding in turn requires rigorous evaluations of current interventions to determine what works, and sharing and promoting best practices across the health care system. Since many current interventions include referrals to social service providers, the health care system needs community resources and links to social service providers to address beneficiaries' social needs, as well as a better understanding of their efficacy. The cost of these interventions and services should also be evaluated to understand the additional resources needed to achieve high quality outcomes for socially at-risk beneficiaries.

Equally important will be tracking supplemental benefits to address social needs provided by the promising flexible state and federal policies as they are implemented, including their success in improving health outcomes for socially at-risk populations. It will also be important to understand what supplemental benefits MA plans offer with the new flexibilities for supplemental benefits authorized by the CHRONIC Care Act, as well as the extent to which any additional benefits address Medicare beneficiaries' social needs and impact quality and resource use measures. Additionally, by ensuring that the measures and programs are relevant for dually enrolled beneficiaries through reporting measures separately for dually enrolled and other beneficiaries and including health equity measures in VBP programs, Medicare's VBP programs will be better able to incentivize high-quality care for socially at-risk beneficiaries.

Beyond the specific approaches needed for socially at-risk beneficiaries, future work should evaluate the success of the move to value-based programs. Addressing social needs is only one part of moving to value-based care. As new VBP programs are adopted and existing programs mature, it will be important to understand whether these programs are achieving their objectives and avoiding unintended consequences.

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