Accounting for Social Risk in Value-Based Payment and Quality Measurement

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Social risks, including socioeconomic status, environmental and living conditions, and racial and ethnic discrimination, affect health care and health outcomes. As health care payers like Medicare and Medicaid increasingly focus on paying for value rather than volume, value-based payment (VBP) approaches and quality measures have proliferated. To the extent that social risks outside providers' control affect health outcomes, VBP approaches could inadvertently penalize providers that see large numbers of patients who face social risks. Public and private health care payers are therefore increasingly grappling with whether and how to account for social risk when measuring quality and paying for performance.

To help address these issues, the Urban Institute convened a panel of national experts on April 27, 2022, to discuss accounting for social risk in VBP (box 1). The goal of the panel was to identify policy and technical issues to help the Centers for Medicare & Medicaid Services (CMS) and other policymakers as they consider changes to Medicare, Medicaid, and VBP models to improve health equity and account for social risk. Our findings may also be useful to commercial plans to the extent they engage in VBP with providers.

This brief provides key insights from the panel discussion, organized according to the following themes:

- Adjusting payments and quality measures for social risk is likely necessary to be fair to providers and to preserve access to health care for all beneficiaries, but it is not sufficient to improve equity or reduce disparities.

- VBP programs and approaches to account for social risk should avoid reinforcing preexisting inequities.
- In addition to decisions about how to adjust quality measures for risk, the choice of which quality measures to employ could play an important role in promoting equity.
- Giving providers incentives to improve care quality or reduce disparities via quality measurement and mechanisms to account for social risk differs from investing resources in health equity, and both may be necessary.
- Data remain a significant limitation in accounting for social risk and improving equity.
- More research is needed on effective strategies to promote both value and equity in payment and delivery systems.

This brief presents background material and summarizes panelists' comments about the need to consider social risk in VBP and quality measurement. We present the views of multiple experts who attended the meeting and synthesize the discussion.

BOX 1

The Panel

The Urban Institute held a virtual panel on April 27, 2022, titled Accounting for Social Risk in Value-Based Payment and Quality Measurement. The panelists included 13 national experts on VBP, risk adjustment, quality measurement, and health equity:

- Shantanu Agrawal, Elevance Health
- Arlene Ash, UMass Chan Medical School
- Georges C. Benjamin, American Public Health Association
- Akin Demehin, American Hospital Association
- Kim Ibarra, National Quality Forum
- Karen Joynt Maddox, Washington University School of Medicine
- Gary A. Puckrein, National Minority Quality Forum
- Robert Saunders, Duke-Margolis Center for Health Policy
- Meena Seshamani, Centers for Medicare & Medicaid Services
- Karthik Sivashanker, American Medical Association
- Ledia Tabor, Medicare Payment Advisory Commission
- Amal Trivedi, Brown University School of Public Health
- Clyde W. Yancy, Northwestern University Feinberg School of Medicine

Background

Health care payers are increasingly focused on paying for value rather than volume. Under VBP approaches, providers and hospitals are paid in part based on patient outcomes. For example, Medicare's Hospital Readmissions Reduction Program assesses penalties on hospitals with high 30-day unplanned readmission rates.[1] Paying based on outcome measures like readmissions incentivizes providers to furnish high-quality care and discharge planning to improve their quality scores. Other approaches to provider payment use capitation, like in Medicare Advantage, which allows more flexibility to address some social risks like transportation challenges. However, to the extent that social risks outside providers' control also affect health outcomes, VBPs could inadvertently penalize providers that see large numbers of patients who face social risks.

Health care policymakers are increasingly interested in exploring how social risks affect quality measurement and VBP systems. Social risks include a range of individual and area-level characteristics that affect health, such as socioeconomic status, family structure, access to transportation, social support, nutrition, race and ethnicity, housing quality, and environmental pollution (ASPE 2020; National Quality Forum 2021). In practice, however, health care providers and payers do not routinely collect data on most social risks. Instead, payers and researchers use available proxy measures to adjust for these risks, including dual eligibility for Medicare and Medicaid, eligibility for low-income subsidies, and area-level deprivation indices (ASPE 2020; National Quality Forum 2021). In 2014, Congress passed the IMPACT Act, which required the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the US Department of Health and Human Services to study the effects of social risk on Medicare's VBP systems. ASPE released two reports, in 2016 and 2020, exploring the effects of social risks on costs and outcomes and proposing a framework for incorporating social risks into VBP (ASPE 2016, 2020). In addition, between 2015 and 2017, the National Quality Forum allowed the use of social risk factors in risk adjustment for new quality measures under a temporary trial (National Quality Forum 2017, 2021). The Medicare Payment Advisory Commission (MedPAC) has suggested updates to VBP approaches as well, including peer-grouping approaches to ensure providers are compared with providers treating similar shares of patients at social risk when assessing penalties and bonuses (MedPAC 2018, 2022). CMS, the Center for Medicare and Medicaid Innovation (CMMI), and individual Medicaid programs have also made or proposed changes to payment systems to promote health equity and account for social risks in payment and quality measurement.[2] Finally, international health care payment systems, including the National Health Service in the United Kingdom and New Zealand's primary health organizations, also adjust payments for area-level measures of social risk (Foley 2018; Huffstetler and Phillips 2019).

Table 1 describes current approaches to adjusting for social risk in Medicare, Medicaid, and international programs. These approaches range from using risk adjustment for dual-eligible status to using neighborhood risk scores in payment methodologies.

TABLE 1

Current Approaches to Adjustment for Social Risk in Value-Based Payment Programs

Program	Payment system	Approach to adjusting for social risk
Hospital Readmissions Reduction Program	Medicare	The program stratifies results into quintiles by the share of a hospital's patients who are dually eligible for Medicaid and Medicare and assesses penalties only within each quintile.[a]
Merit-Based Incentive Payment System (MIPS)	Medicare	The Complex Patient Bonus increases aggregate MIPS scores for providers with high average beneficiary risk scores and/or large shares of patients who are dually eligible.[b]
ACO REACH (Accountable Care Organization Realizing Equity, Access, and Community Health)	Medicare	The model will require applicants to submit a health equity plan, increases benchmarks for providers who serve a large share of underserved beneficiaries, and requires the collection of equity data.[c]
End-Stage Renal Disease Treatment Choices Program	Medicare	Providers that improve home dialysis and transplant rates for dually eligible and/or low-income-subsidy-eligible beneficiaries earn extra points, and benchmarks are stratified by the share of beneficiaries who are dually eligible and/or eligible for the low-income subsidy.[d]
Medicare Advantage	Medicare	The risk-adjustment formula for payment includes dual-eligible status;[e] quality star ratings include adjustment for dual eligibility and disability;[f] and plans can use rebate funds to address social risks like transportation access and food insecurity.[g]
MassHealth	Medicaid	This managed-care organization risk-adjustment model for payment includes a neighborhood risk score that accounts for unstable housing, disability, substance use disorder, and serious mental illness.[h]
Carr-Hill formula (United Kingdom)	National Health Service	The National Health Service adjusts payments using the Carr-Hill formula, which includes an area deprivation index, to direct additional funds to providers serving at-risk populations.[i]
New Zealand Population-Based Funding Formula	Primary health organizations	The New Zealand payment system adjusts for ethnicity and the New Zealand Index of Deprivation to direct additional funds to primary health organizations serving populations with high social risks.[j]

Sources: Authors' analysis of current approaches to addressing social risk in value-based payment from the literature and Centers for Medicare & Medicaid Services (CMS) policies. See [a] "Hospital Readmissions Reduction Program (HRRP)," CMS, last modified December 1, 2021, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program; [b] "2019 Merit-Based Incentive Payment System Complex Patient Bonus Fact Sheet," US Department of Health and Human Services and CMS, accessed July 18, 2022, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2019%2520Complex%2520Patient%2520Bonus%2520Fact%2520Sheet_27.pdf; [c] "ACO REACH," CMS, updated June 30, 2022, https://innovation.cms.gov/innovation-models/aco-reach; [d] "ESRD Treatment Choices (ETC) Model," CMS, updated July 18, 2022, https://innovation.cms.gov/innovation-models/esrd-treatment-choices-model; [e] CMS, *Report to Congress: Risk Adjustment in Medicare Advantage* (Baltimore: CMS, 2021); [f] "Categorical Adjustment Index Methodology," CMS, accessed July

18, 2022, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Supplement-for-Categorical-Adjustment-Index-.pdf; [g] CMS, "CMS Finalizes Medicare Advantage and Part D Payment and Policy Updates to Maximize Competition and Coverage," news release, April 1, 2019, https://www.cms.gov/newsroom/press-releases/cms-finalizes-medicare-advantage-and-part-d-payment-and-policy-updates-maximize-competition-and; [h] Arlene S. Ash and Eric Mick, "UMass Risk Adjustment Project for MassHealth Payment and Care Delivery Reform: Describing the 2017 Payment Model" (Worcester, MA: UMass Medical School, Center for Health Policy and Research, 2016); and [i,j] Jonathan Foley, "Social Equity and Primary Healthcare Financing: Lessons from New Zealand" *Australian Journal of Primary Health* 24, no 4. (2018): 299–303, http://dx.doi.org/10.1071/PY17153, and Alison N. Huffstetler and Robert L. Phillips, "Payment Structures That Support Social Care Integration with Clinical Care: Social Deprivation Indices and Novel Payment Models" *American Journal of Preventive Medicine* 57, 6 supplement 1 (2019): S82–S88, https://doi.org/10.1016/j.amepre.2019.07.011.

Evidence on the effectiveness of the approaches shown in table 1 is mixed. Researchers have found that the Hospital Readmissions Reduction Program stratification method successfully reduced penalties to safety net hospitals (Joynt Maddox et al. 2019; McCarthy et al. 2019), but whether the program resulted in narrowed disparities or improved outcomes for patients facing social risks remains unclear. The Merit-Based Incentive Payment System Complex Patient Bonus successfully increased bonus eligibility for providers serving a large share of dually eligible patients,[3] but it did not reduce the likelihood of penalties (Byrd and Chung 2021; Johnston et al. 2020). The UK and New Zealand programs, which have both existed for more than 20 years, similarly show mixed evidence (Foley 2018; Huffstetler and Phillips 2019). The UK neighborhood risk adjustment was associated with improvements in access to and lower wait times for care, but data on health outcomes and disparities are unavailable (Huffstetler and Phillips 2019). The New Zealand approach was similarly associated with improvements in access to care, but research on the improvements in access to care or reductions in disparities is lacking (Foley 2018).

In addition to payer approaches, hospitals and health systems are also increasingly focused on social risks. In 2010, the Affordable Care Act required nonprofit hospitals to conduct community needs assessments every three years and participate in community-level planning to improve community health (Lopez, Dhodapkar, and Gross 2021). However, research finds that these investments represent a small proportion of overall community benefit spending (Horwitz et al. 2020), with most spending focused on unreimbursed care like bad debt and Medicaid shortfalls (Young et al. 2018).

Significant debate surrounds whether to adjust quality measures and VBPs for social risk and how to make those adjustments, as shown in table 2. For example, MedPAC has supported peer-grouping or stratification approaches like that used in the Hospital Readmissions Reduction Program (MedPAC 2018, 2022). The ASPE reports to Congress, meanwhile, suggested stratifying quality measures by dual eligibility for public reporting purposes to clearly show disparities for beneficiaries and other interested parties (ASPE 2016, 2020). However, the ASPE reports did not support using peer grouping or stratification by dual-eligible status when assigning bonuses and penalties or adjusting payments. Instead, ASPE suggested bonuses or additional payments to safety net providers, similar to the Medicaid disproportionate share hospital payments, may be necessary to support safety net providers in furnishing high-quality care to all populations (ASPE 2020).

TABLE 2

Proposed Approaches to Adjusting Payment and Quality Measures for Social Risk, by Organization

	ASPE (2016, 2020)	CMS policies	MedPAC (2018, 2022)
Process measures	Do not adjust, but report separately for dual eligibles and non–dual eligibles	Do not currently adjust individual process measures for public reporting purposes	Unspecified
Outcome measures	Do not adjust, but report separately for dual eligibles and non–dual eligibles	Use stratification for HRRP readmission measure and ETC model and adjust MA star ratings for low income and disability	Do not adjust for public reporting
Cost measures	Do not adjust for public reporting, but adjust for payment	Adjust MIPS resource-use measure for dual enrollment	Unspecified
Payments	Consider broad-based payments to providers with high-risk populations rather than adjusting outcome-dependent penalties/bonuses	Use a combination of policies, including adjustments to MA quality ratings and payments, HRRP penalties, ETC Model payments, MIPS bonuses and penalties, and planned adjustments to benchmarks under the new ACO REACH model	Assess any bonuses and penalties using peer grouping

Sources: Authors' analysis of current approaches to addressing social risk in value-based payment from ASPE (2016, 2020) and MedPAC (2018, 2022) and the Centers for Medicare & Medicaid Services (CMS) policies from table 1. See US Department of Health and Human Services, Office of the Assistant Secretary for Planning Evaluation (ASPE), *Social Risk Factors and Performance under Medicare's Value-Based Purchasing Programs* (Washington, DC: ASPE, 2016); ASPE, *Second Report to Congress on Social Risk and Medicare's Value-Based Purchasing Programs* (Washington, DC: ASPE, 2020); Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, 2018); and MedPAC, "Mandated Report: Designing a Value Incentive Program for Post-acute Care," In *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, 2022).

Notes: ASPE is Office of the Assistant Secretary for Planning and Evaluation. CMS is Centers for Medicare & Medicaid Services. MedPAC is Medicare Payment Advisory Commission. Dual eligibles are people eligible for both Medicare and Medicaid. HRRP is Hospital Readmissions Reduction Program. ETC is ESRD Treatment Choices. MA is Medicare Advantage. MIPS is Merit-Based Incentive Payment System. ACO REACH is Accountable Care Organization Realizing Equity, Access, and Community Health.

Many of the debates about adjusting for social risk may result from different prioritization of underlying goals and values. For example, the core goals of VBP include

- incentivizing providers to efficiently provide high-quality care to all patients, including those with high social risks, and thereby improve health outcomes;
- monitoring quality in payment systems that may have strong incentives to reduce the cost of patient care by potentially compromising quality; and
- increasingly promoting equity in service provision and quality.

When social risk factors directly affect patient outcomes independent of the quality of care provided, many organizations argue that VBPs and quality measures should be adjusted to avoid misclassifying providers as giving poor-quality care, unfairly penalizing providers that treat large shares

of patients with social risks, and discouraging providers from serving at-risk communities (ASPE 2020; MedPAC 2018, 2022; Nerenz et al. 2021). Additionally, it may be counterproductive for VBP programs to increase payments for providers that serve at-risk populations only to later reduce those payments through inadequately risk-adjusted quality measures.

Given the diversity of current approaches and potentially competing goals and values, the Urban Institute convened the previously discussed expert panel to discuss the role of social risks in VBP and quality measurement. The following section details the panel findings.

Findings

Adjusting payments and certain quality measures for social risk is likely necessary to be fair to providers and to preserve access to care for all beneficiaries, but it is not sufficient to improve equity or reduce disparities.

Under some VBP approaches (e.g., the Hospital Readmissions Reduction Program and the Merit-Based Incentive Payment System), providers and hospitals are ranked by performance on quality measures and then receive bonuses or penalties according to their rankings. Under such systems, panelists expressed that basic fairness to providers may require that payments, bonuses, and penalties be adjusted or stratified for social risks to avoid penalizing providers for the types of patients they serve.

Panelists also emphasized the importance of preserving access to care. People facing social risks often also face barriers to care like a lack of transportation (Syed, Gerber, and Sharp 2013), inadequate provider supply in their area,[4] and discrimination (Skopec, Gonzalez, and Kenney 2021). VBP approaches that create incentives to avoid these patients will only further exacerbate access gaps, underscoring the need to adjust payments for social risks. Additionally, baseline provider performance measures reflect existing selection incentives, inequities, and structural disparities. VBP programs should avoid setting performance benchmarks that "bake in" the incentives and inequitable outcomes of the status quo. One panelist noted that quality measures may be more related to the patient population a provider serves than to the care provided, meaning unfavorable selection could also affect currently used quality measures. Using new equity-focused quality measures and consistently measuring access disparities could help reduce these incentives. A 2021 report examined and rated the currently available approaches to health equity measures and gave the CMS Office of Minority Health's Health Equity Summary Score the highest ratings (Maksut 2021; RAND Health Care 2021).

Panelists also shared that though the selection of quality measures, risk adjustment of payments, and risk adjustment of quality measures are separate levers, VBP programs should be designed so these levers all pull in the same direction. If the goal is to improve equity, any risk-adjustment approaches should be combined with resource allocation and quality measures specifically designed to support that goal. If quality measures that focus on and encourage improvements in health equity are not in place, any risk-adjustment payments or additional resources given to providers may not be used to address health equity.

Though most panelists agreed that accounting for social risk in quality measurement and VBP was important, nearly all emphasized that it was not sufficient to improve health equity or reduce disparities. Adjustment for social needs may make the payment system fairer to providers that serve at-risk patients and it may help preserve access to care, but panelists did not expect such adjustments to necessarily have a significant effect on outcome disparities or health inequities. Directly addressing disparities and inequities, according to panelists, will require targeted investments, community partnerships, and new ways to measure quality. For example, equity-focused measurement approaches like CMS's Health Equity Summary Score could illuminate quality differences by race and ethnicity or by dual-eligible status both across providers and within a provider's practice and incentivize providers to close gaps (Maksut 2021).

Panelists also noted that the approach to adjusting quality measures for social risk should depend on the intended use of the measures. If measures are to be used to assess bonuses and penalties, many panelists agreed they need to be adjusted or stratified to avoid harming safety net providers. For publicly reported quality measures, such as the readmission measures included in Hospital Compare, panelists generally preferred stratification to preserve information for patients and make disparities visible. CMS already uses this approach in some cases, including creating confidential provider-level reports on readmission disparities for hospitals.[5] But stratified reporting to show disparities could be expanded to public-facing reports or other measures and programs, as contemplated in a rule CMS proposed this year.[6]

Panelists recommended a similar approach for quality measures shared only with providers as part of quality-improvement programs. For these measures, which are intended to drive provider-level care improvements, many panelists supported stratifying measures by dual eligibility, race and ethnicity, and other available factors to allow providers to see and address quality gaps. One panelist suggested that Medicare and Medicaid measures of blood pressure control could be stratified by race and ethnicity to show providers how their performances vary across subgroups and to help them target interventions to underserved patients and those most at risk of negative outcomes.

Finally, the panel discussed how structural racism and bias may drive observed differences in care quality and outcomes by race and ethnicity both across providers and within a provider's practice. Panelists expressed concern that if discrimination, rather than social risks, drives poor quality or outcomes, adjusting for social risks could hide the presence and prevalence of such bias. Additionally, quality measures that rely on averages across all patients, rather than measuring or comparing quality performance by subgroups like race and ethnicity, may mask differences in care within a provider's practice that could be driven by implicit bias. One study found Medicare Advantage plans with higher overall star ratings had larger disparities in care quality by race, ethnicity, and socioeconomic status (Meyers et al. 2021). Some panelists suggested that stratifying quality measures by race and ethnicity for public reporting may be a more appropriate approach than adjusting the measures for uncovering the effects of bias both across providers and within a provider's practice.

VBP programs and risk-adjustment approaches should not reinforce preexisting inequities.

Though social risk is highly correlated with overall health, the relationship between social risk and health care spending is more mixed.[7] Panelists noted that structural racism, bias, and social risks reduce access to care, lowering spending despite high health care needs. Because VBP and risk adjustment both give more resources to populations and locations with historically higher spending, they run the risk of entrenching differences in access to care driven by social risk or bias; the panelists emphasized that thoughtful VBP and risk-adjustment approaches should instead seek to encourage access for the patients with the greatest health care needs, rather than entrenching existing spending patterns. New approaches to risk adjustment, or programs specifically designed to reallocate resources to historically underserved populations rather than to high-spending populations, will likely be necessary to improve health equity.

VBP programs, particularly those run by CMMI, also have a significant opportunity to assess the effects of VBP on equity and to develop models that can effect positive change. Panelists suggested several ways that CMMI could monitor and evaluate its models and VBP programs to better address health equity and reduce health disparities. One panelist suggested that CMMI monitor the effects of VBP programs on access to care, particularly for historically underserved groups, to ensure the program does not worsen any preexisting access inequities. Another panelist suggested that VBP programs start with a hypothesis about how they will improve health equity or reduce disparities and then rigorously test that hypothesis. Panelists also suggested that CMMI build equity into its models and evaluation plans from the beginning, as it will with the ACO REACH (Accountable Care Organization Realizing Equity, Access, and Community Health) model.[8] One panelist suggested CMMI evaluations directly explore whether programs reduce disparities, improve outcomes, and improve access to care for at-risk populations.

In addition to decisions about how to risk adjust quality measures, the choice of which quality measures to employ could play an important role in promoting equity.

Panelists discussed the use of quality measures at length. One panelist noted that it is not always clear what quality programs are measuring, because many outcomes may depend more on the patient population being served than on any processes put in place by providers and hospitals. For example, if institutions that rank as high quality do not serve many patients facing social risks, their quality scores may be more of a reflection of their surrounding population or implicit or explicit limits on access to care among at-risk populations, rather than a reflection of the care the institution provides. This distinction is important for programs that compare quality and assess bonuses and penalties across providers because, without risk adjustment, such approaches may inadvertently reward providers for serving lower-risk populations.

Panelists also discussed the role of quality measurement. If quality measurement is expected to drive provider performance to improve equity, then any measures need to be relevant to the provider, be actionable, and clearly illustrate gaps in care for at-risk groups. Several panelists noted that physicians do not typically see information about disparities in care by race and ethnicity for their

populations, so stratifying quality measures by race and ethnicity or by readily available proxies for social risk like dual eligibility could prove beneficial. For example, one panelist noted that quality measures for hypertension and diabetes control could easily be stratified by race and ethnicity to help providers direct attention and resources to addressing gaps and providing better care to at-risk populations. However, stratification is likely less feasible for measures affecting small populations and for small providers.

For public-facing measures or measures used to determine bonuses, quality measurement invites or outright requires competition among providers. The panel noted that we already adjust for a range of diagnoses, many of which are highly correlated with social risk, to level the playing field. Adjusting for social risk in this context would therefore be a relatively minor change. Changing the measures to better reflect performance on advancing equity and narrowing disparities would be a larger adjustment, and several panelists felt it would have a larger effect on improving outcomes.

Several panelists proposed additional areas where they would like to see quality measures developed. These included measures designed to capture any changes in access to care during VBP implementation, preferably stratified by race or ethnicity or social risk. Panelists also recommended developing measures of social risk and outcomes that would allow providers, systems, and CMS to see progress on improving equity and reducing disparities.

Some panelists emphasized that measurement burden is a substantial issue, so any new measures should be replacing old ones, not adding to that burden. Developing new measures is also time consuming and expensive, so any new measures should be highly targeted to fill gaps in current quality programs. Panelists also questioned whether there were ways to redesign measures or capture data automatically to reduce measurement burden. For example, stratifying existing measures of diabetes or hypertension control by race and ethnicity could help providers and payers address equity gaps without increasing measurement burden. One panelist noted that in the proliferation of quality measures, policymakers should not lose sight of the goal of measurement: to improve the lives and health of patients.

The panelists also discussed patient-reported measures and largely agreed on these measures' importance. However, several panelists noted that known systematic differences in survey response rates by race and ethnicity could mean these measures reinforce existing inequities (Brinkman et al. 2021).

Giving providers incentives to improve care quality or reduce disparities via quality measurement and risk adjustment differs from investing resources in health equity, and both may be necessary.

VBP creates incentives for physicians and health care systems to provide efficient, high-quality care. The combination of payment incentives and quality measures is designed to encourage cost reductions without accompanying reductions in care quality. Risk adjustment also plays a role in this process by ensuring physicians serving patients with higher medical risks receive sufficient payment to cover their patients' care. However, panelists noted that providing incentives for efficient and high-quality care differs from paying directly for programs that will improve equity or reduce disparities. One panelist

noted that providers and health care systems are not generally required to spend any quality bonuses, risk-adjustment payments, or other extra payments on improving care, reducing disparities, or otherwise adjusting care processes to better serve patients. If such investments are desired, CMS will have to set specific spending requirements and monitor their implementation. For example, though nonprofit hospitals are expected to engage in charity care and community benefit spending to maintain their tax-exempt statuses, little of this spending appears to be focused on social risks (Horwitz et al. 2020), and nonprofit hospitals tend to spend less than for-profit hospitals on charity care (Bai et al. 2021). This suggests that broad requirements to invest in the community or in underserved populations do not yield targeted programs to address social risks or improve health equity.

Panelists also noted that social risks vary greatly in how readily they can be addressed by a provider. Providers can help patients with mobility impairments procure the necessary durable medical equipment to be able to complete activities like preparing meals, shopping, and transportation, for example, but providers likely cannot address air pollution. Even health systems have limited levers to address large-scale social risks like a lack of affordable housing. To improve equity and reduce health disparities, both population- and individual-level investments will be necessary, but panelists noted that population-level investments are not necessarily the role of the health system. They shared that giving providers extra resources through VBP is not likely to significantly improve health equity or reduce disparities, particularly for disparities caused by large-scale social problems. Instead, supporting community partners may be a better approach.

The panel also agreed that improving health equity will require long-term, large-scale investments that go beyond the typical scope and time frame of VBP initiatives. One panelist noted that investments in equity may take decades to show success, unlike the typical five-year evaluation time frame for CMMI models. Population-level investments will likely be slow to show a return on investment in health outcomes, because the damage from social risks like poor air quality or systemic racism build up over time and take significant time to dissipate.

Data remain a significant limitation in adjusting for social risk and improving equity.

Several panelists noted that data limit the ability to adjust for social risks because CMS, health systems, and providers do not routinely collect individual-level data on social risks. One panelist also raised that the new Z codes included in ICD-10 enable reporting of social risks, but they are not routinely used, so social risks cannot easily be collected from claims data. Other panelists noted that CMS also does not have consistent data on functional status, which is routinely measured in postacute care and is highly correlated with both health and social risk (ASPE 2020; Rhee et al. 2020).

Because of data limitations, programs like MassHealth, the UK National Health Service, and New Zealand's primary health organizations use area-level measures, rather than individual-level measures, to adjust payments for social risk (Huffstetler and Phillips 2019). Panelists debated whether this approach is an adequate substitute for individual-level measures; some argued that area-level measures are a good alternative given the lack of individual-level data, whereas others questioned whether such measures would perpetuate the effects of segregation and gentrification.

One panelist raised the issue that the effects of social risks cannot be separated from the effects of race and systemic racism. The remaining panelists agreed, and some noted that ignoring race runs the risk of baking structural racism into the health care payment and delivery system. Panelists suggested reporting quality measures stratified by race and ethnicity could uncover disparities both across providers and within a provider's practice. However, even data on race and ethnicity are subject to significant errors and data-collection limitations (Jarrín et al. 2020).

More research on effective strategies to promote both value and equity in payment systems is needed.

Several panelists shared that evaluations of VBP programs have emphasized cost to mixed results, but evidence on whether VBP significantly improves patient outcomes, for whom, and under what circumstances is lacking. Without this evidence, panelists found it difficult to recommend a focus on VBP and social risks as a tool to improve health equity or reduce disparities. Panelists expressed a desire for research to determine whether any processes or practices to reduce inequities might be universally applicable across hospitals and physician's offices.

Panelists noted that it would be helpful to have a baseline of what good, equitable care looks like and what resources are necessary to support such care. One panelist said that providing "good" care is often a matter of a physician's care processes, including patient-management approaches. Active patient management, especially for patients who face social risks, will be necessary to reduce health disparities and inequities.

Finally, panelists noted some deficiencies in the current approaches to health equity research. One panelist said centering health equity research in Medicare and Medicaid misses the very large population with employer-sponsored insurance. If private insurance does not incorporate evidence-based approaches pioneered in Medicare or Medicaid, the effects on health equity and health disparities will be substantially limited. Additionally, panelists agreed that the typical five-year period for evaluations of VBP and other CMMI payment models may be inadequate for interventions designed to improve equity, reduce disparities, or address social risks. Given the long-standing nature of health disparities and the deep relationship between social risks and health, improvements in health outcomes or reductions in health disparities could take far longer than a typical evaluation cycle to become visible.

Discussion

Policy organizations, including ASPE, CMS, and MedPAC, have proposed different approaches to accounting for social risk in VBP (ASPE 2020; MedPAC 2018, 2022).[9] Debates have emerged about whether, when, and how to adjust quality and payment measures for social risks faced by enrolled patients (Nerenz et al. 2021). But when we asked panelists to weigh in on these debates, an interesting consensus emerged. Panelists largely agreed that the details of risk adjustment matter, but they also consistently noted that focusing narrowly on incorporating social risk could lead to losing sight of the larger health equity problem. Panelists observed that the US health care system, as it currently stands, is inequitable and yields worse outcomes for people of color, people facing social risks, and other groups with high social risks. Though adjusting for social risks is perhaps necessary to promote patient access

to care and to preserve fairness for providers in VBP systems, it is not sufficient to identify areas for improvement, suggest solutions, or address inequities.

With this larger context in mind, the panelists suggested several ways that VBP systems could be adjusted to better investigate and address health inequities. VBP systems could be designed with health equity as a core focus, as with the new CMS ACO REACH model.[10] These systems should also build in outcome measures and evaluations that directly address how the model improves or worsens disparities in access to care, quality of care, and health outcomes. The panelists also supported stratifying quality measures by race and ethnicity and/or by social risk both for public reporting and for giving providers feedback on their performances. This approach could help providers identify and work to narrow gaps if data were provided in a timely manner, though provider-level stratification would be difficult for smaller populations. Finally, the panel identified structural racism as a key underlying driver of inequity that cannot be divorced from social risk. Race-blind evaluations and outcome measures may miss important effects of VBP models on key at-risk populations and allow biases in access to and the provision of care to go unnoticed and persist.

Overall, the panelists broadly agreed that adjusting payment for social risk is likely necessary to preserve access to care for patients facing social risks but is insufficient for reducing inequities. Several panelists also noted that adjusting for social risks is merely an incremental change, because many of the clinical risk adjustments already in use are highly correlated with social risks. The panelists also supported reporting stratified quality measures to make disparities in care and outcomes more visible. However, many panelists strongly emphasized that improving health equity is a much larger enterprise that will require far more resources, commitment, and structural change than mere updates to risk-adjustment systems used in VBP.

Notes

1 "Hospital Readmissions Reduction Program (HRRP)," Centers for Medicare & Medicaid Services, last modified December 1, 2021, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.

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