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Adjusting Medicare Payments For Social Risk To Better Support Social Needs

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Social determinants of health have greater influence on health than does health care, yet Medicare and most other payers have yet to adjust payments to better support the capacity of health care providers to address social needs. The 2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act directed the secretary of Health and Human Services (HHS) to review evidence linking social risk with performance under existing federal payment systems and to suggest policy options. In response, HHS produced two reports and commissioned a series of five additional reports from the National Academies of Sciences, Engineering, and Medicine (NASEM). The second HHS report suggests that area-based (or, geographically based) measures of social deprivation could play a role in payment adjustment.

The goal of social-needs payment adjustment is to use a reliable, defensible, and transparent mechanism to increase resources to clinics based on the social risk of their patient population, and to align this mechanism with processes that enables clinics to identify at-risk patients who can benefit from those resources. To advance these goals and seek consensus around a policy use case for incorporating social risk into federal payment systems, we convened a diverse group of stakeholders for a policy design workshop. The workshop produced consensus on a demonstration model for a payment adjustment based on a census-tract social deprivation index.

Use Of Area-Based Social Risk Factors For Payment

Of the two reports to Congress produced by HHS as required by the IMPACT Act, the second builds on evidence and recommendations from the NASEM series. While the second report stopped short of proposing a mechanism to adjust payments for social needs, it does suggest that small-area (typically census-tract)-based measures of social risk could play a role in payment adjustment, as they do in the UK and New Zealand.

Disappointingly, HHS advised a "watchful-waiting," policy, acknowledging the need for practice support, including payment support, for improving care quality for patients with social risk, but not going so far as to call for implementation of new payment models. The NASEM committee was more forceful about the need for immediate change, saying, "It is possible to deliver high quality care to socially at-risk populations, but it is harder on average and costs money, and providers who disproportionately serve socially at-risk populations frequently have fewer resources." The final report in the NASEM series stated:

"By accounting for the increased resources (i.e., estimated costs) needed to care for socially at-risk populations, directly adjusting payments avoids unintentionally redistributing resources away from (i.e., underpaying) providers who serve patients with

social risk factors and reduces incentives to avoid these patients. More favorable allocation of resources to these providers would increase their resources, which they could invest in reducing disparities and improving quality and efficiency."

The NASEM committee recommended that the Centers for Medicare and Medicaid Services (CMS) test a composite neighborhood deprivation measure versus a simple single indicator (such as median household income) and contrast their performance at the census-tract level. The committee also recommended that CMS weigh the simplicity of a single indicator against the increased precision from a composite measure for use in the short term. They recommended conducting research on measurement and data collection to better capture neighborhood deprivation in rural areas and to assess the performance of any given variable (single or composite) across multiple geographic areas. To be clear, using geographic measures of deprivation was not their only recommendation but a candidate among many.

Use of social risk factors to inform payment for health care is not novel, and neither is using area-based measures. England and New Zealand currently use small area-based social risk indices to adjust federal resources for health care and social services. England uses the Car-Hill Index for adjusting clinical payments and English Indices of Deprivation for adjusting resources for social services. New Zealand uses the New Zealand Deprivation Index for adjusting payments for general practice. The New Zealand Index includes measures of both small-area social needs and ethnicity. The goal in the UK, as in New Zealand, is to increase resources to those caring for deprived populations to improve health equity. The US has developed related indices of social risk constructed for their ability to predict meaningful differences in cost, health care use, disease prevalence, and mortality. These US indices include the Social Deprivation Index and the Area Deprivation Index, which are available for every census tract in the country. Massachusetts already adjusts Medicaid payments using the Neighborhood Stress Score.

The use of small-area-based indices of social risk increases the likelihood of aligning health care resources with population needs in the most reliable and transparent manner. Reliability relates to knowing that what is being measured is consistent in assessing risk in all neighborhoods. Transparency means that stakeholders have clear understanding of the data used to adjust their payments.

The alternative, collecting social needs data from individual patients, is more likely to disadvantage already disadvantaged patients whose social situations are often in flux and who are less likely to access care regularly and thus less likely to report their needs. Peter Smith, emeritus professor of health policy and global health economics at the

University of York, helped develop the current payment adjustment process in the United Kingdom and explained at a British Embassy event that the use of small-area deprivation indices was partly based on his team's own finding that patient-level collection disadvantaged the most deprived neighborhoods for precisely these reasons. We would expect to see similar dynamics play out in the US. The groundbreaking 2006 study *Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States* was not only one of the first studies to demonstrate stunning differences in life expectancy across US communities but also explained that health care access barriers share some of the blame. Therefore, it is critical to assess social risk using a process that is not dependent on patient visits particularly in support of community-based interventions. Non-visit-based data collection also reduces clinician burden and provides a transparent basis for applying the same policy to all clinicians in a given area.

Using area-based indices weighted for their ability to predict health inequity can assure that appropriate resources flow to practices and other stakeholders in the health supply chain for disadvantaged populations. Tools that assess individual patients' social needs can then direct those resources to meet their needs.

Shaping Social Risk Payment Policy

Two recent issue briefs nicely set the stage for our workshop by summarizing state and federal efforts to assess and address patients' social needs, but both only lightly touch on payment adjustments needed to address them. To delve more deeply into the nuances of the payment adjustment for social risk factors, our workshop included staff from CMS, the Center for Medicare and Medicaid Innovation (the Innovation Center), the Assistant Secretary for Planning and Evaluation, and the Agency for Healthcare Research and Quality, two leaders of state Medicaid social determinants policy, state health planners, health care payers, consumers, providers, and several social determinants researchers.

The structure of the workshop used human-centered design tools and practices including use-led innovation, iteration, and service blueprints.

Based on prior efforts to incorporate risk adjustment into payment and our belief in scalable and equitable innovations, we framed the workshop with the principles outlined in exhibit 1.

Exhibit 1: Key elements of a policy to account for social risk in CMS payments

1	Adjustment for social needs, with a goal of resolving patients' social risk and supporting community interventions
2	Proportionality to area disadvantage; designed to address social needs, not solely health care costs
3	Geographic, small-area indices that are created based on patient and population outcomes, as a viable, reliable, sustainable mechanism for payment adjustments
4	Reduced burden of social risk capture for providers, payers, states; reduced inequities between states created by the current environment in which states must propose a method of payment adjustment to federal partners in order to have any process
5	Predefined goals of reduced total cost and improved patient health outcomes used to titrate funding rather than simply looking for cost offsets that do not align with accountability or expectations of meeting social needs

Source: Authors' analysis, as presented to the workshop "Designing Future State to Account for Social Risk in CMS Payments."

Through the lens of these principles, we sought reactions to four potential scenarios for implementing a payment adjustment model for CMS:

- Scenario 1: Medicare Advantage, program change
- Scenario 2: Medicare Advantage, the Innovation Center model (demonstration)
- Scenario 3: Medicare fee-for-service, the Innovation Center models
- Scenario 4: Medicaid

Reaching Consensus On A Path Forward

Using the Delphi Method for consensus building, the group settled on Scenario 3: Medicare fee-for-service, the Innovation Center model as the best opportunity for

success given several factors, including: data standards, measurement methodology, political will, capacity to assign and assess accountability, and potential to achieve budget neutrality. A schematic of this model is available here.

Workshop participants identified the Social Deprivation Index and Area Deprivation Index as existing, viable small-area measurement options to support payment adjustment. The question of how much payments should be adjusted was not addressed. Participants envisioned that these payments will be employed in clinical settings for disadvantaged populations, with providers receiving either enhanced payments adjusted for medical and social risk or a social risk bonus. These additional funds would then be directed to meeting social needs such as transportation, food insecurity, housing instability, or supporting community-based organizations skilled at addressing social needs. For example, the Hennepin Health System has instituted pass-throughs of Medicaid funding for supports such as food and housing stability vouchers. This is in addition to increasing the capacity of clinical systems to address social needs and their health impacts. Such payment models will likely require accountability mechanisms to ensure that the adjusted resources are being used to meet patient and population needs.

Adjustment for social risk is a critical step toward equitable health care delivery and reversing the tendency of health care resources to aggregate in the places and populations with the least need—a phenomenon labeled the "Inverse Care Law." Precision geographic approaches to assessing social risk, such as the one we've described, can also support collaboration among the federal, state, local, and private agencies that address social determinants of health.

The next step in fulfilling the intent of the IMPACT Act to identify policy options for incorporating social risk factors into payment is to build on the findings from this workshop to refine a Innovation Center Investment Proposal or change request to an existing program (such as Primary Care First) for use of the Social Deprivation Index or Area Deprivation Index to adjust payments by the end of 2022. We aim to summarize cost and equity benefits and prepare a future state package that aligns with the Innovation Center implementation needs. Discussions with stakeholders since the workshop suggest that there may be appetite for broader application than an Innovation Center modification. This could include vendors who currently manage risk adjustment for multiple state Medicaid managed care programs. We will identify change agents and decision makers as well as sustainability plans. We will also invite stakeholders outside of health care to assist in the design to ensure that adjusted payments can lead to desired outcomes. By doing the policy design pre-work in advance of the government's traditional mechanisms, we hope to accelerate innovation and make it more equitable and scalable.

Additional Considerations For Adjusting Payments For Social Risk

Other recent *Health Affairs* blog posts have made the distinction between "social needs" and "social determinants," or "community drivers of health," and the need to address both. Research has shown that assessing social risk can be achieved on a population scale, while social needs are particular to patients and communities and require on-the-ground assessment. Drawing these distinctions is important because addressing social needs at the individual level is unlikely to be enough to compensate for the impact of community social risk factors. Health care providers need to be agents of addressing social determinants at both levels, a capacity called community-oriented primary care, which was the foundation of community health centers in the US. To enable practices to address social risks and needs, payments need to reflect the costs of caring for deprived patients and the deprived communities in which they live. To develop the capacity to address community drivers of health, providers will require payment adjustment consideration beyond accounting for individual social risk or related costs.

Authors' Note

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Kevin Fiscella • 4 days ago

This article should be read by every CMS policy maker. As the authors clearly state, promoting health equity requires aligning resources with health needs. Based on this self-evident premise, the authors make a cogent case for Medicare to implement social risk adjustments to Medicare payments using area-based measures (which are objective and not subject to ICD-10 upcoding). Medicare should implement this change now and refine the payment structure based on its experience and rigorous evaluation.

Any primary care practitioner who has worked with socially diverse patients knows that the playing field for payment is not fair - to the detriment of the health of patients at social risk. Health is a holistic construct that includes physical, mental and social dimensions. Each of these health dimensions is underestimated in the presence of social risk further contributing to the Inverse Care Law. Social risk affects traditional medical risk as measured by the Medicare HCC when patients avoid care during the calendar year or when they decline testing due to cost and access barriers. Since the HCC is reset each calendar year, it means that patients at social risk have falsely low medical risk scores. Social risk likely underestimates mental health risk when

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