



November 16, 2018

Brenda Destro, PhD  
Deputy Assistant Secretary for Planning and Evaluation, Room 415F  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Dr. Destro,

On behalf of Movement is Life, I am pleased to submit the following response to the Assistant Secretary for Planning and Evaluation (ASPE) in response to ASPE's [Request for Information](#) (RFI) titled, IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

[Movement is Life \(MIL\)](#) is a multi-stakeholder organization dedicated to eliminating health disparities and promoting health equity, primarily concerning musculoskeletal conditions. Our membership includes healthcare providers, attorneys, academicians, and other partners. MIL facilitates community-based programs to help at-risk patients and convenes an annual conference in Washington, D.C. called the Movement is Life Caucus that brings together a diverse set of attendees who share our mission of promoting health equity and eliminating health disparities.

The MIL Caucus educates attendees about the need for greater health equity and provides a unique perspective on how certain social and medical factors exacerbate musculoskeletal health disparities. MIL's many priorities center around a [vicious cycle](#) of factors that affect musculoskeletal health. Many of the elements that make up the vicious cycle disproportionately affect minority populations.

MIL would like to express our support for ASPE's leadership on reducing health disparities and promoting health equity. We strongly support the IMPACT Act's requirements for ASPE's reports on health disparities within the Medicare program. The responses to this RFI will help guide ASPE's second of two reports to Congress which must be completed by October 2019.

### **Call to Action on Health Equity**

ASPE acknowledges "growing recognition that social risk factors – such as income, education, race and ethnicity, employment, housing, food, community resources, and social support – play a major role in health." We believe "growing recognition," while correct, is not the best way to characterize the current environment of studying health disparities. There is indeed [widespread acceptance](#) among the entire spectrum of health care providers, researchers, and policymakers that social factors affect health status at both the individual and population level. We strongly support efforts to improve our understanding of the causes and consequences of health disparities. **However, we believe enough evidence exists for CMS to**

**immediately take more concrete actions to address this issue. We implore ASPE to include actionable recommendations for how to address health disparities in its report.**

As you know, health policy is largely made through the healthcare reimbursement system. Conversely, healthcare reimbursements create incentives that can lead to both intended and unintended consequences. Paying providers more for adopting EHRs incentivized the intended consequence of higher EHR utilization but also had the unintended consequence of EHR systems not being able to communicate with each other.

Health inequity poses particular challenges to new value-based health care systems. According to the RFI, ASPE believes, “In many ways, beneficiaries with social risk factors may benefit the most from value-based purchasing programs and other delivery system reform efforts, since improved care coordination and provider cooperation will be of the highest utility to the most complex beneficiaries with the most care needs.” We agree that complex patients stand to benefit from the care delivery improvements sought through value-based payments. However, CMS must recognize that payment incentives within value-based payment models could hinder access to care for complex patients.

The root of the issue is how to define “quality” and “value.” Most value-based payment models establish a benchmark for what is considered good quality or value. Providers who perform well against the benchmark typically earn a financial reward while those who perform below the benchmark receive a financial penalty. Models usually do not account for the fact that some providers treat a high number of complex patients compared to their peers. This could result in providers seeking to change their patient mix for a given performance period to improve their ability to achieve a better performance score. Absent an adequate mechanism to risk adjust for medical and social complexity or a redesign of how benchmarks are calculated, providers will continue to be financially incentivized to avoid patients who fall on the wrong side of the benchmark.

It is important to recognize that social risk factors play a role in health status. The next step is to determine how we hold providers accountable for the impact these risk factors have on provider performance within value-based payment models that require providers to bear financial risk. The healthcare system is not designed to empower physicians and other healthcare providers to address many of the social issues that contribute to health complexities. **To achieve health equity, policy must recognize that patients with social risk factors often require additional resources and additional time to achieve an equitable care outcome.**

The failure to adequately account for social risk factors means many patients cannot benefit from the innovations of a value-based payment environment because they are being avoided. Major improvements to how we hold providers accountable under value-based payments are needed to make sure patients are not avoided out of fear that a complex patient will hurt a provider’s bottom line.

**At what point will HHS feel it has enough data to take additional action? Continuing to delay action means patients will continue to experience impediments to accessing equitable care.** Every payment model that is offered as an alternative to fee-for-service must include a plan for ensuring health equity. We also hope this report helps guide new payment models to better incorporate social risk factors into how providers are reimbursed.

## Defining Social Risk

We agree with ASPE's use of the National Academies of Science, Engineering, and Medicine (NASEM) definition of social risk:

1. Socioeconomic position (income, wealth, insurance status, education, occupation, food insecurity)
2. Race, ethnicity, and community context (race and ethnicity, language, nativity, acculturation)
3. Gender (gender identity, sexual orientation)
4. Social relationships (marital/partnership status, living alone, social support)
5. Residential and community context (physical environment, housing, and social environment)

All of these factors can affect health status. CMS should incorporate a risk adjustment methodology that accounts for how every element of this definition can impact quality and cost performance. There is no standard way to incorporate such a risk adjustment mechanism due to the wide variety of payment models. However, this definition should serve as the foundation on top of which all risk adjustment methodologies are built.

Using the Comprehensive Joint Replacement (CJR) program as an example, how should a patient's social risk status, according to the NASEM definition, factor into a hospital's target price? How should each element of the NASEM definition be weighted to impact risk adjustment of the target price? **We believe this definition should be the basis of a Risk Adjustment Factor (RAF) that would directly apply a risk adjustment based on a patient's social risk factors.**

To date, CMS has used dual-eligible status as a proxy measure for social risk. Relying on dual-eligible status is a crude approach, but we acknowledge it can be effective. It is certainly better than nothing. **MIL believes the use of dual-eligible status as a representation of social risk must be an interim approach until a more refined risk adjustment mechanism that incorporates all elements of the NASEM definition of social risk.**

Accepting this definition will identify the social risk factors CMS believes impact health status. This is a meaningful first step towards a robust risk adjustment framework.

## Response to ASPE's Questions

HHS is interested in how plans and providers serving Medicare beneficiaries:

**Identify** beneficiaries with social risk factors;

**Approaches** plans and providers have used to address the needs of beneficiaries with social risk factors;

**Evidence** regarding the impact of these approaches on quality outcomes and the total cost of care; and

**Disentangle** beneficiaries' social and medical risks and address each.

Identify Beneficiaries with Social Risk Factors

MIL agrees that identifying beneficiaries with social risk factors is a challenge that must be addressed. We believe that the best approach to collecting this data is to leverage existing government resources. The federal government already has much of this information in various silos. Better communication between government agencies is the most effective way to collect the information needed to account for social risk factors. For example, the Social Security Administration (SSA) likely has much of the data on social status that the Medicare program hopes to use to risk adjust payment models. Perhaps the Department of Housing and Urban Development (HUD) can help identify Medicare beneficiaries who rely on public housing assistance.

Government agencies will be most effective at collecting static information such as race, ethnicity, gender and education. However, many social, such as income, social relationships, and housing situation, can change over time. We believe that providers can play a role in capturing information on social risk factors at the point of care but we caution against an overreliance on providers to capture this information.

We have concerns about the ability of providers to collect social risk information at the point of care without additional resources being made available. Collecting this information this will require additional time and resources on the part of the provider's office to collect this information. Further, recent [studies](#) have shown that patients are often reluctant to provide this information to their provider.<sup>1</sup>

A standardized EHR element will be helpful in simplifying how this information is collected. However, Medicare must incentivize the added time and resources necessary to overcome the hesitance of patients to provide this information.

Social factors such as English proficiency already increase the length of a typical visit. The only effective way to incentivize this information collection is to create an additional payment to providers for collecting this information from patients. This incentive must account for both general patient hesitancy and the fact that the presence of social risks already leads to longer visits. CMS can also consider collecting social risk factor information during the initial Medicare visit for new Medicare beneficiaries.

Providers can be used to supplement or support data collection efforts. However, we urge ASPE to recommend that the federal government leverage existing data sources before placing the data collection responsibility on providers. **We urge ASPE and CMS to study how the federal government can leverage its own resources to compile information on social risk factors across federal agencies. CMS should also continue to study how to incentivize providers to collect this information.**

[Approaches Providers Have Used to Address the Needs of Beneficiaries with Social Risk Factors, and Evidence Regarding the Impact of These Approaches on Quality Outcomes and the Total Cost of Care](#)

Measuring for quality and value in healthcare is a relatively new field. The Medicare program has been a leader in this arena, but we believe more leadership is needed to improve how we define value in healthcare. **CMS must reform how it financially rewards and penalizes healthcare providers for value-based payment program performance to better incentivize the treatment of complex patients.** Failure to do so will result in the continuation of financial incentives for healthcare providers to avoid patients with greater social and medical complexity.

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<sup>1</sup> <http://www.annfammed.org/content/16/5/399.full.pdf+html>

CMS maintains one standard for “value” within each program with limited risk adjustment mechanisms if any at all to account for health equity. Under these programs, the less complex the patient, the easier it is to achieve the required quality or cost performance score. An [article](#) published in March by Karen E. Joynt Maddox, M.D., M.P.H. in the *New England Journal of Medicine*<sup>2</sup> highlights how the current “all or nothing” approach to quality measurement can be improved.

“APMs could reward quality improvements proportionally rather than taking an all-or-nothing approach. Currently, a primary care doctor who helps a patient with uncomplicated hypertension to reduce her systolic blood pressure from 145 to 140 mm Hg would achieve the quality metric of “blood pressure under control,” but a doctor who helps a patient with chronic kidney disease and diabetes reduce his blood pressure from 190 to 145 mm Hg — an accomplishment with much more profound clinical consequences — would receive no credit. Under a proportional-improvement-based method, clinicians would have incentives to focus on patients whose conditions had the most room for improvement. Such a system would require a more sophisticated approach to quality measurement, but as we increasingly attend to population health and capture more data electronically, it is an essential and increasingly feasible proposition.”

Changing the way we define “value” will help us better account for the social risk factors that contribute to health disparities. Value-based payment programs must be designed in a way that rewards providers for caring for the most complex patients. Unfortunately, our current systems incentivize avoidance of complex patients because of the all or nothing definition of value. **Factoring improvement into value-based payment models can help rebalance these incentives to better reward providers for treating complex patients.**

CMS has historically opposed changes to this definition of value fearing such a policy could create a two-tiered system of quality. CMS believes that all patients should be entitled to the same definition of quality.

CMS has recognized the need for risk adjustment and implemented improvements to several value-based payment programs to account for social and medical risk. For example, CMS will begin grouping hospitals in the Hospital Readmission Reduction Program (HRRP) into five groups based on the number of dual-eligible patients the hospital treats. This policy does not change the definition of quality. Rather, it creates a more level playing field that allows hospitals to compete against hospitals with similar patient population risk profiles as opposed to having every hospital compete against each other.

We are confident that ASPE will hear from many providers describing a plethora of practices they use to address the needs of patients with social risk factors. The key to the success of these efforts is a reimbursement system that incentivizes health equity by recognizing that it takes different amounts of resources to provide an equitable health outcome for different patients.

#### Disentangle Beneficiaries’ Social and Medical Risks and Address Each.

Medicare value-based payment models must not disentangle social and medical risks. CMS must recognize and account for the fact that social risks exacerbate medical risks. When developing new payment models and updating existing models, CMS must only hold providers accountable for what they

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<sup>2</sup> <http://www.nejm.org/doi/full/10.1056/NEJMp1715455>

are empowered to control. Returning to the CJR model as an example, a hospital cannot control if a patient who needs a knee replacement lives on the fourth floor of a building with no elevator. Such a scenario would require an inpatient rehabilitation stay that increases the hospital's expenditure on that patient for the episode of care. Models that fail to account for these scenarios could lead to a provider delaying or not recommending knee replacement surgery for that patient.

There is only so much that can be done to separate social risk factors from health status. In many cases, nothing can be done because many social risk factors can have a direct impact on health status. **It is therefore essential that payment models include mechanisms to reimburse providers for the additional resources required to address patients with medical complexities that are exacerbated by social risk factors.**

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

We are certain that ASPE will receive many responses from health plans and providers highlighting the commendable work they are doing to help socially at-risk patients. We feel it would be more beneficial for CMS to ask providers and health plans what additional resources they need to more effectively meet the needs of socially at-risk patients and to achieve an equitable health outcome. ASPE's report should identify gaps and recommend policy solutions that fill those gaps.

## **Conclusion**

Health equity means that some patients require additional resources to achieve an equitable care outcome as other patients. Many social risk factors can only be addressed outside of the exam room. Value-based payment models are increasingly holding providers accountable for factors beyond their control. The U.S. healthcare system cannot unilaterally solve income, education or language disparities. Healthcare providers who serve a disproportionately at-risk patient population should have their performance in value-based payment models adjusted to account for the added resources it will require to care for their patient population.

If ASPE has any questions regarding our comments or wishes to discuss our recommendations in more detail, please do not hesitate to contact Bill Finerfrock ([bf@capitolassociates.com](mailto:bf@capitolassociates.com)) or Matt Reiter ([reiterm@capitolassociates.com](mailto:reiterm@capitolassociates.com)).

Sincerely,



Mary I. O'Connor, M.D.

Chair

Movement is Life

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