The Merit Based Incentive Payment System: Exposing the Disparity Among Providers

Who Serve Dual Eligible Beneficiaries

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Abstract

Healthcare systems are moving towards a higher level of provider accountability for the quality and outcomes of care. In achieving this mission, The Centers for Medicare and Medicaid has implemented various value-based purchasing models including: The Physician Quality Reporting System, Hospital Value-Based Purchasing Model, and The Merit Based Incentive Payment System (MIPS). MIPS is one of the largest programs and is built off of the value-based payment models that exists in nearly all Medicare settings. The system was created to analyze clinical quality measures, but the concern centers around it failing to address social risk factors such as income, race, and other social determinants of health.

Providers that disproportionately serve vulnerable populations such as dual eligible patients, are at a great risk of being financially penalized under MIPS. The dual eligible population, those who qualify for both Medicare and Medicaid, have many barriers such as lack of transportation and disabilities that prevent them from accessing care. These factors, known as the social determinants of health, are unmeasured in Medicare claims data but are associated with health outcomes and impact providers performance. Since MIPS fails to address these public health factors, providers who serve a disproportionate share of medically and socially complex patients are more likely to receive a financial penalty compared to their peers who do not serve

this population. In order to align payments and ensure value-based purchasing programs achieve their intended goals, the relationship between social risks and performance metrics needs to be better understood and aligned.

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1.0 Background

The United States healthcare system is unlike any other in the world. The U.S. does not have a uniform health insurance system and as a result health insurance is not guaranteed for all citizens. Along with these factors, the U.S. spends about $3.5 trillion on health expenditures making up 18% of GDP(CMS,2017). This is more than twice the average spent among other developed countries. Despite these expenditures on health care, compared to other industrialized countries, Americans still have lower life expectancy, higher rates of infant mortality, and a greater burden of debilitating chronic diseases. It is known that 80% of health outcomes are attributable to social, environmental, and behavioral factors, while only 20% are attributable to medical care (Bradley,2013). Although these statistics hold true, providers are increasingly held accountable for consequences of social risk factors that present in the healthcare system, despite a small investment outside the system to address these social determinants of health.

As mentioned, the U.S. spends a disproportionate amount on health care spending compared to social services spending. In comparison to the $3.5 trillion that the U.S spends on health care; social services only receive $357 billion in funding (Historical data,2019). The social service funding is used towards various forms of in-kind assistance for lower income individuals such as food stamps, school meals, low-income housing, and assistance in meeting home energy bills. Although a direct causation cannot be inferred, countries with a more equivalent allocation of spending between social services and health care tend to have healthier populations. The figures below portray the concept behind this thought.
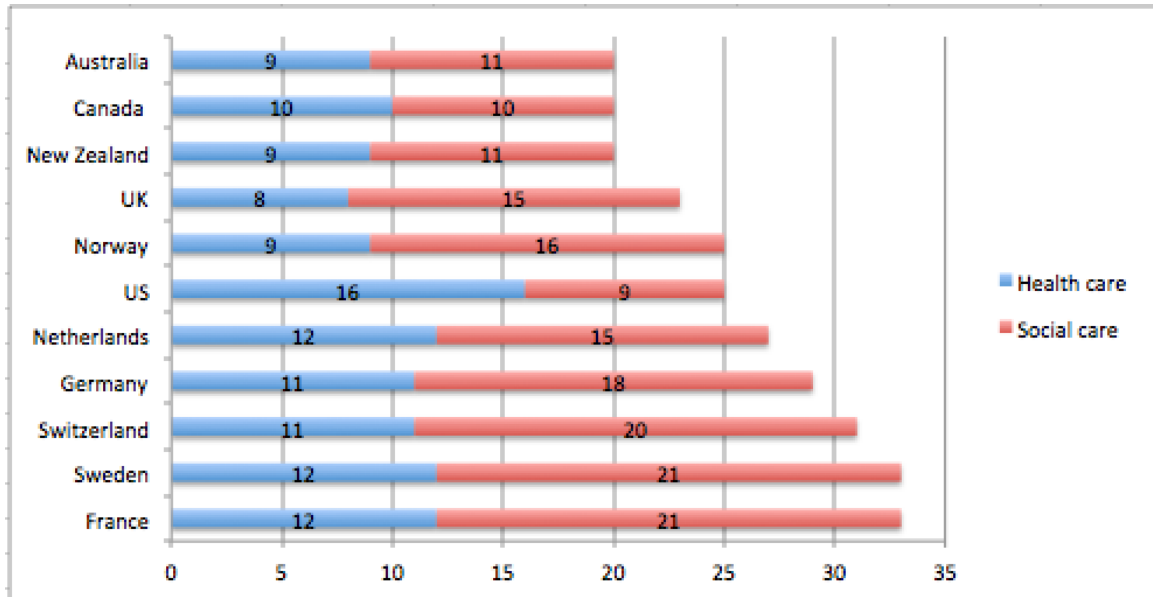
Figure 1. Health and Social Care Spending as a Percentage of GDP

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012.   [e] 2011.

Figure 2. Select Population Health Outcomes and Risk Factors

Exhibit eight compares health and social care spending as a percentage of a country's GDP. Based on data, the U.S. spends about 16% on health care and only 9% on social care. In comparison both France and Sweden spend 21% on social care and only 12% on health care. In looking at exhibit nine, France has a life expectancy of about 82 years and an infant mortality rate of 3.6. In contrast, the U.S. has a life expectancy of 79 years and an infant mortality rate of 6.1. This reinforces the statement that higher health care spending is not equivalent to a healthier population.

As seen in these exhibits, relative to the U. S.'s OECD counterparts, the U.S. spends comparatively less on social services, but disproportionately more on health care. The neglect of social service financing in the U.S. has caused an increase in unaddressed factors that impact health including poor housing, food insecurity, financial instability, and lack of transportation.

When these social risk factors go unaddressed it exacerbates health risks especially for the lower income population and may lead to sustained cycles of poor socioeconomic status and health. For example, individuals living in poverty are at an increased risk for developing poor health outcomes. Lack of education leads to a lower income, which leads to limited options on where an individual can live and their food choices. Poor quality housing can cause asthma among children and a poor diet can lead to multiple comorbidities such as high blood pressure and diabetes. When and if these patients access care, it is often at a later stage in the disease's progression making it more costly and difficult for providers to treat the patient. If these underlying social risk factors are not taken into consideration when evaluating providers performance, those providers serving more disadvantaged patients will be penalized under value-based purchasing programs. In addition, the resources to address the high needs and costs of their patients will be taken away due to the systems penalization methods.

2.0 Policy History on Alternative Payment Models

In 2010, President Obama recognized the need for change within healthcare, specifically the insurance sector. Under the Obama administration, Congress passed the Affordable Care Act (ACA), which marked the beginning of a significant perspective shift towards value-based purchasing programs (VBP). During this time, CMS was a major catalyst behind creating and implementing alternative payment models (APM's) that could incentivize change for providers. Prior to APM's, most health services were financed under a fee for service model. Under this structure, a physician was paid a fee for each particular service provided. The model rewarded physicians for volume and quantity of services provided regardless of the patient's outcome. Under the ACA, rather than focusing on the volume of care, providers were challenged to address the quality and value of their care, which became known as VBP. Although fee for service models still exists today, in some APM's such as MIPS, there is a mix of a fee for service component and a VBP component (Medicare Access,2016). Although these two components exist, more of an emphasis is placed on the VBP component in attempt to control costs and improve patients' health outcomes.

In April of 2015, President Obama further signed into law the Medicare Access and CHIP Reauthorization Act (MACRA). The act changed the way Medicare rewarded providers. It initiated rewards for the value of care over volume of care. The act streamlined multiple quality improvement programs under MIPS and provided bonus payments to providers for participation in alternative payment models (Medicare Access, 2016). This system tied an increased percentage of participating physicians Medicare fee for service payments to outcomes through

MIPS. This model measures providers based on certain clinical outcomes, which either penalizes or rewards them for their clinical practice.

MIPS operates by combining previous VBP programs into a single program. Parts of the Physicians Quality Reporting System, the Value Modifier, and the Medicare Electronic Health Record (EHR) incentive program can be seen in MIPS. Physicians engaged in MIPS are measured on four metrics; quality, promoting interoperability, improvement activities, and costs (Background: MACRA and MIPS,2016). Performance on these categories are weighted and put into an overall score. The score translates to an upward, downward, or neutral payment adjustment that providers will receive two years after the performance period. For example, 2016 performances will impact provider's Medicare payments in 2018. Once this program is fully phased in, it will be the largest mandatory pay for performance program for physicians.

2.1 Quality Measures used in MIPS

Providers who participated in MIPS are assessed against four measures. In 2019, quality measures accounted for 50% of a provider's final score. When a provider submits measures for MIPS, each measure is assessed against a benchmark provided by CMS to determine how many points the measure can earn. Additionally, providers can earn bonus points in the quality category through reporting additional high priority measures, end to end measure reporting, year over year category improvement, and small practice bonus (Quality Measures,2019). Examples of measures include 30-day all cause hospital readmission, asthma control, and hemoglobin A1c levels.

In every type of care setting examined, providers that disproportionately served beneficiaries with greater social risk factors tended to have worse performance on the quality measure portion. In essence, the system is taking money away from providers who serve the poor and giving it directly to providers who serve the wealthy (Frakt,2017). Providers who serve a wealthier subset of the population will have better quality measures because their patients do not experience the same social barriers as lower income patients. Wealthier patients have the necessary resources to take care of their health, while lower income patients experience barriers in achieving positive health outcomes. As a result, medical practices could select patients who are more likely to stay healthy and have better outcomes making it appear that their physicians provide higher quality care. Since the quality measure accounts for the highest percentage of points, it is concern for most providers who serve lower income patients.

In addition to the quality measures, providers report on promoting interoperability (30% final score), improvement activities (20%), and cost measures (0%). In order for providers to achieve a bonus they are held accountable for a variety of measures that address many angles of patient care. Further supporting the concept that disadvantaged practices will perform poorly under MIPs, researchers found that nearly 30% of the medical practices eligible to participate in MIPS the first year were penalized because they failed to report any data. Many of these practices were likely to be smaller and lack functional electronic health records suggesting that Medicare could focus on technical assistance efforts and electronic infrastructure support on such practices. Since meaningful use of EHR's is included in the final MIPS score, providers who work in practices with limited electronic upgrades will lose points in this category. These practices are often in disadvantaged areas which when combined with a complex patient mix further decreases providers overall score.

2.2 Conclusion on MIPS

In 2019, MIPS expanded to include physical therapists, occupational therapists, qualified speech language pathologists, audiologists, clinical psychologists, and registered dieticians (CMS). This VBP model, continues to expand into non-traditional clinician's work. As this model and others similar to it, continue to gain interest it is important to surface issues related to the quality of care provided, especially focusing on vulnerable populations.

Prior to MIPS, the Medicare Value Based Payment Modifier Program was the largest mandatory pay for performance program for physicians. In an analysis of the programs first year, practices that served higher medically and socially risk patients had lower quality and higher costs. In contrast, practices with high social risk only had lower quality and lower costs (Chen,2017). However, the largest driver of penalties in this program was failure to register and report measures. This may have reflected practices lack of infrastructure or technology which makes reporting difficult, especially among higher risk practices that lack access to electronic health records.

Even in this program, the implications of VBP programs on providers serving higher risk patients was known. Despite the continued growth of pay for performance programs, there is an increasing concern that these programs hold providers accountable for their patient's risk factors that are outside of their control without providing the resources required to address the root causes of these social risk factors. This exacerbates health disparities among marginalized populations and makes it more difficult for physicians to provide better quality of care for complex patient populations.

3.0 MIPS impact on providers serving dual eligible beneficiaries

Under MIPS, providers who see a higher subset of dually eligible beneficiaries are at an increased risk for penalization (Chen,2017). In October 2014, Congress passed the Improving Medicare Post-Acute Care Transformation Act, which required a closer review of social risk factors with performance under existing payment systems. Two important findings suggested that Medicare beneficiaries with social risk factors had worse outcomes on many quality measures regardless of the providers they saw, and dual enrollment status in both Medicare and Medicaid was the most powerful predictor of these poor outcomes.

All patients who qualify as dually eligible are low income and have few resources. Providers who serve this population are tasked with managing the care of not only an older population, but also an economically disadvantaged one. These beneficiaries have poorer outcomes on cancer screenings, diabetes control, infection rates, and higher spending per hospital admission episode (Report to Congress,2017). Providers disproportionately serving dual eligible patients were more likely to face financial penalties in most VBP programs. Several studies have shown that larger hospitals, teaching hospitals, and safety net hospitals which traditionally serve more disadvantaged patients are more likely to rank poorly on quality measures (National Academies,2016).

One study analyzed the effects of Medicare's first year's pay for performance program. Researchers discovered physician practices that served a disproportionate share of medical and socially high-risk patients were more likely to receive a penalty compared with other practices (Chen and Epstein, 2017). Patients treated at practices categorized as high social risk face challenges such as transportation, food, housing, and security, which are unmeasured in

Medicare claims but are associated with health outcomes. Fewer resources also make it more difficult for practices who serve these patients to attract qualified clinicians. Practices categorized as high social risk may only treat both high and low risk patients in a less expensive style because they have significant unmet health care needs (Chen,2017). Findings suggest that if current performance patterns persist, practices that serve higher proportion of social or medically complex patients may fare poorly under MIPS.

In addition, an analysis provided by the Medicare Payment Advisory Commission discovered that not only were hospitals serving the lowest income patients more likely to be penalized under VBP programs, but their average penalty was also double that of those hospitals serving the fewest low income patients (Accounting for Social Risk Factors, 2016). Studies also examined neighborhoods and found that neighborhood resources such as living in poverty and low educational achievement were associated with worse hospital performance on health care process measures for VBP programs (Jha,2011). In comparison, provider organizations located in neighborhoods with higher socioeconomic status were more likely to have above average performance rankings. Based on these finding, this is concerning evidence, as safety net hospitals are a vital component in the healthcare industry in providing care to more vulnerable communities.
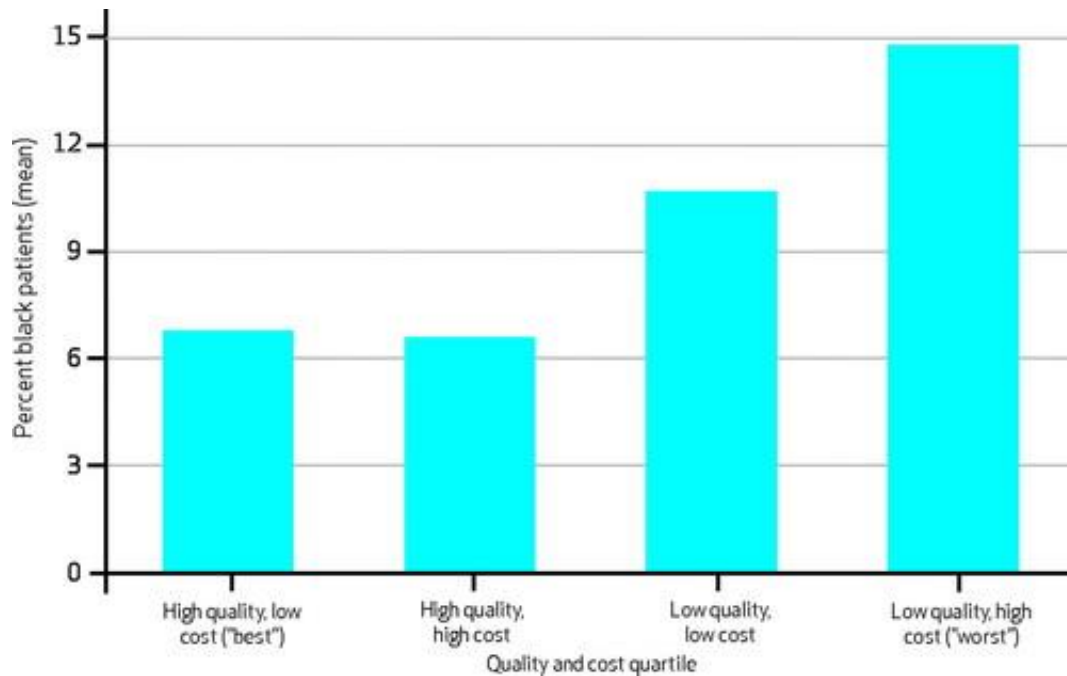
Figure 3. Cost and Quality

Figure 3, provides visualizations of hospitals performance on quality and cost based on the percentage of patients based on insurance status. As seen, hospitals with the highest percentage of lower income patients also had the highest cost and lowest quality for managing their care.

Demographic Factors of Dual Eligibles and Non-Dual Eligibles[1]

Factor	Duals	Non-Duals
Income	60% $10,000 or less 0% > $40,000	9% $10,000 or less 24% >$40,000
Years of Schooling	29% 0-8 Years 25% 9-12 Years 25% High School Grad. 4% Vocation/Tech. 10% Some College 7% College Degree	7% 0-8 Years 13% 9-12 Years 32% High School Grad. 8% Vocation/Tech. 17% Some College 24% College Degree
Race/Ethnicity	43% Minority 58% White 20% Black 12% Hispanic 11% Other	19% Minority 81% White 8% Black 7% Hispanic 4% Other
Disease Prevalence	8% Alzheimer's 25% Pulmonary Disease 30% Diabetes 15% Stroke	3% Alzheimer's 17% Pulmonary Disease 25% Diabetes 10% Stroke
Smoking Status	23% Current Smoker	12% Current Smoker
Health Status	19% Excellent/Very Good 52% Fair/Poor	44% Excellent/Very Good 24% Fair/Poor
Functional Limitation	70% Mobility Limitation 26% No Limitations 20% IADL Only 26% 1-2 ADLs 28% 3-6 ADLs 63% >1 Physical Condition 20% >1 Mental/Cognitive Condition 38% Both Physical and Mental/Cognitive Conditions	46% Mobility Limitation 57% No Limitations 13% IADL Only 20% 1-2 ADLs 10% 3-6 ADLs 53% >1 Physical Condition 5% >1 Mental/Cognitive Condition 17% Both Physical and Mental/Cognitive Conditions
Residential Status	84% Community 16% Long-Term Care 16% Live with Spouse	98% Community 2% Long-Term Care 55% Live with Spouse

Figure 4. Demographics of Dual Eligibles

Figure 4 further reinforces the fact that dual eligible beneficiaries are in lower socioeconomic status, have fewer social supports, and are in poorer health than non-dual eligible beneficiaries.

4.0 Risk Adjustment

Prior to the ACA, insurers could deny coverage to higher risk individuals and write exclusions into policies or impose unaffordable premiums for individuals with pre-existing medical conditions(aapc). As a result, this left the highest risk patients unable to access insurance or healthcare. In order to combat this issue, President Obama introduced risk adjustment as one of the main components of the ACA. Risk adjustment minimizes costs to insurers for individuals who present as a higher risk to the insurer. For example, an insurer who enrolls a greater number of higher risk beneficiaries with greater medical complexities will receive additional compensation to make up for the extra costs associated with those members. As a result of risk adjustment, insurers reimbursement rates should reflect a more accurate payment for the costs of treating their higher risk member population. However, because the characteristics of risk adjustment are based off of demographic data, a holistic picture of an individual's health risks are not fully captured.

Risk adjustment models generally use individual's demographic data such as age, sex, and diagnoses to determine a risk score. CMS uses a hierarchical condition category (HCC) to calculate risk scores, which predicts spending from diagnoses grouped into categories that encompass conditions with similar cost patterns. Medicare's HCC relies on ICD-10 coding to assign risk scores to patients. This model ranks diagnoses into categories that represent conditions with similar cost patterns. Longer term conditions such as diabetes and COPD will be risk adjusted, while acute illnesses and injuries will not. Shorter term illnesses are not predictive of ongoing healthcare costs, so they are not accounted for in the risk adjustment system. For example, a patient with multiple chronic conditions is expected to have a higher health care

utilization record and higher costs. That individual would have a higher risk adjusted score, so the insurer is paid a price that reflects the patient's complexity. HCC's help to predict health care resource utilization and costs to the health care entity.

Risk adjustment can benefit both providers and patients. For patients it helps improve the opportunity they have for identified care management programs. For providers, since payments are closely tied to patient's health outcomes, it reflects a more accurate quality of care provided. However, in certain populations such as providers who serve a higher proportion of dual eligible patients, risk adjustment does not consider all of the necessary factors equitably.

4.1 Accounting for Social Risks

Currently, Medicare's HCC model is not taking into account socioeconomic concerns such as food insecurity or neighborhood disadvantage. The HCC model, like most other risk adjustment models, encompass, few if any social risk factors. If social risk factors were more accurately accounted for, providers serving complex patients might receive a more equitable reimbursement than they are currently given. Therefore, accounting for case mix of patient's socioeconomic status and medical complexities might minimize the impact pay for performance has on healthcare disparities.

Potential issues that remain unsolved in Medicare risk adjustment include a limited perception on claims data. Claims data is generated for billing purposes as a result of patient's encounters with the health care system. These files may contain helpful information on demographic, diagnoses, delivered services, and prescriptions. However, since claims data is

used for billing purposes, it often cannot holistically capture patient's social risk factors. It paints a minimal picture for patient's risk factors contributing to health outcomes.

Accounting for social risk factors is a commitment to achieving health equity within the healthcare field. It requires a collaboration of providers, health systems, and payers coming together to achieve a universally high standard of health care quality for all patients. When value-based purchasing appropriately recognizes the challenges of caring for patients with social risk factors combined with creating incentives that lead to improved care, then health equity can be achieved.

In order to determine if a social risk factor should be accounted for in VBP programs, three considerations can be made. First, is the social risk factor related to the outcome? Meaning is there empirical evidence and a valid reason that there is a relationship between the two variables. Establishing a conceptual relationship to meet this criterion can be challenging as many social risk factors operate through multiple pathways. However, in reviewing the literature researchers have used the fundamental cause theory to establish a relationship between race and health outcomes. This has established a conceptual relationship between these two factors, so it would be appropriate to recognize them in VBP programs.

Second, does the social risk factor precede care delivery and is it not a consequence of the quality of care? To achieve goals of VBP programs, it is critical to consider whether risk factors are the consequences of provider efforts. If a factor can be influenced by the provider, then accounting for it may diminish incentives to improve that risk factor. For example, if health literacy improves health care outcomes and can be improved by providers, then using the level of health literacy in risk adjustment would deter incentives to do that (Accounting for Social Risk factors, 2016). Also, the timing of a risk factor must be carefully considered. In thinking about

risk factor timing, it may be useful to prioritize slowly changing factors over rapidly changing ones. For example, marital status and living alone are indicators of social support. Both can change rapidly especially in older individuals.

Lastly, social risk factors cannot be manipulated by the provider. This aides in protecting social risk factors that might create incentives for providers to engage in unproductive behavior or deliver suboptimal care for the purpose of a higher payment. This has been seen in terms of coding patient diagnoses more completely in order to ensure higher payments to providers (Accounting for Social Risk factors, 2016). Modifying the measurement of social risk factors may be less likely if measures are externally collected and reported. It may be more likely if measures used were based on providers reporting. For example, if hospitals reported patients who were referred to receive meal delivery as a measure of food insecurity and financial stress, hospital might increase referrals even to patients who do not need that type of support. Ways to combat this include, continually monitoring measures to identify if there is any large change from the normal threshold and prioritizing specific coding over vague coding. For example, enrollment in a specific nutritional assistance program that is valid over a subjective measure of food insecurity. These are all recommendations that should be considered when deciding which social risk factors are appropriate to incorporate into alternative payment systems.
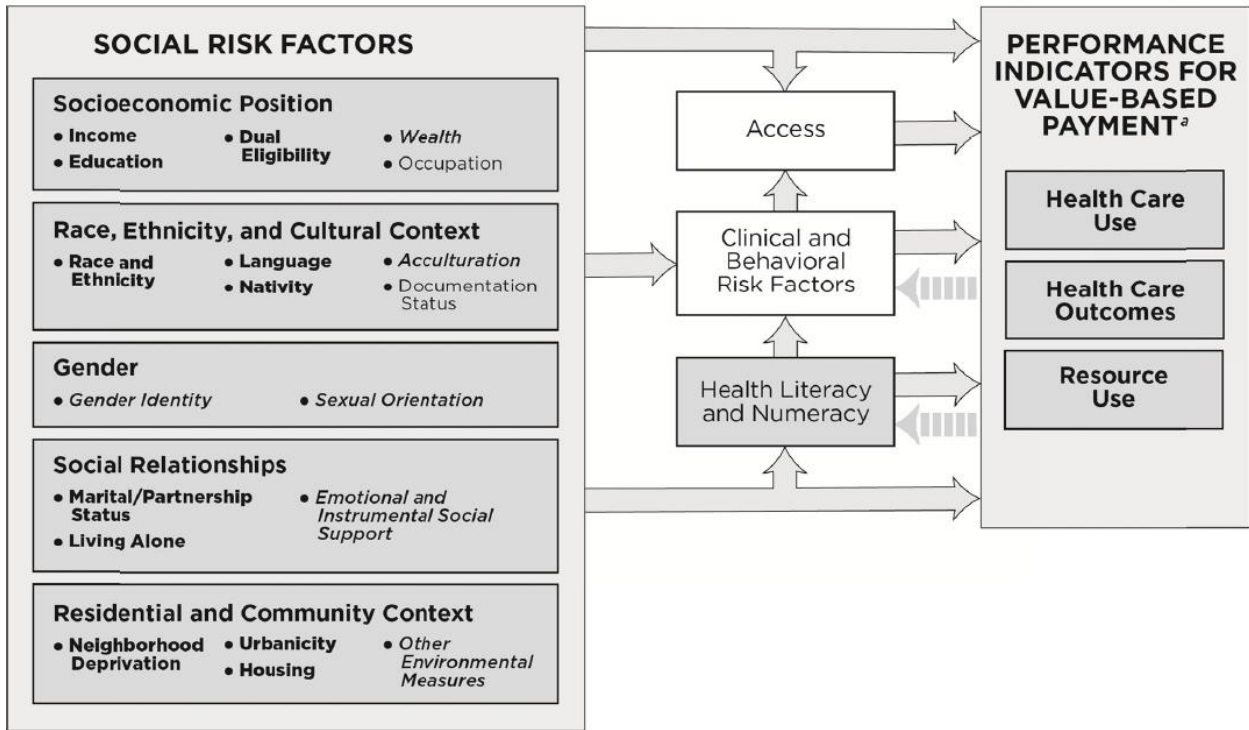
Figure 5. Social Risk Factors

The above framework illustrates which factors could potentially be included in a VBP system. The bold lettering signifies indicators that could be accounted for in a Medicare VBP programs in the short term. The italicized letters signify longer term inclusion in Medicare's VBP programs.

4.2 Considerations Adjusting for Social Risk Factors

As mentioned in order to account for some disparities among patients, certain risk factors are adjusted for such as age and clinical co-morbidities. Most measures used within the Medicare VBP programs are used to profile providers against one another to show the quality of care provided or accountability they have towards patients (Hierarchical Conditions Category, 2019).

Risk adjustment should fairly compare providers to one another on their patient's outcomes rather than to their patient's social risk factors, which providers have no direct control over. Researchers have argued that, in order for a more equitable practice among providers, social risk factors need to be more heavily monitored. Adjusting for these factors recognizes the greater challenges that are faced in achieving a better performance for beneficiaries like the dual eligible population, with greater social risk factors. This population has greater medical complexities and healthcare needs. Failing to adjust for these patient's social factors can penalize providers for providing necessary additional services to their patients.

In comparison, a common argument that researchers have suggested is that adjusting for these factors could lead to masking disparities in the quality of care provided. Although it is not certain, directly adjusting for these measures could forgive the delivery of subpar care to beneficiaries with social risk factors. Accounting for social risk factors that hold providers to different standards of care, could create the perception that patients with social risk factors are entitled to lower quality of care (Report to Congress,2017). In addition, neither an adjusted or unadjusted score provides information to the patient about which provider is better tailored to meet the patient's needs. This limits the ability socially at-risk patients have to identify providers who will deliver the best care to them. Only stratification of social risk factors will reveal that insight to patients.

As shown, there are both positive and negatives points to adjusting for social factors. However, under the current system social risk factors are not fully being addressed leading to unfair penalties among providers serving vulnerable patients. Social determinants of health are powerful predictors in determining an individual's health outcomes. In order to better capture these social factors, they should be explicitly measured and stratified. Even if the concerns

mentioned above are not found to be true, without a change, perception of inequitable treatment can further increase distrust in the healthcare system among vulnerable populations.

5.0 Additional Policies to Reduce Disparities in Pay for Performance

Additional policy considerations for beneficiaries with high social risk should involve a greater dedication towards health equity, understanding the population's risk factors and patterns of care, and building collaborative partnerships within various care sectors. Through these considerations, there can be a greater effort towards pay for performance programs on reducing disparities while also ensuring the structure of the program does not exacerbate health by failing to account for patient's social needs. Through improved methods, providers performance can be more accurately assessed and providers serving more vulnerable patients can be given adequate resources to take care of them.

Promoting health equity can be attained by creating policies that hold providers accountable for achieving equity and rewarding providers that excel in that area. The creation of a health equity measure within the existing Medicare value-based purchasing program could incentivize providers to achieve a certain standard for beneficiaries with higher social risk factors (Report to Congress,2016). Applying a different payment threshold for rewards based on the reporting mix of social risk factors could achieve a better quality of care and equity. Weighting measures differently in the payment formula to adjust their importance to providers can achieve a different mindset for providers as well as adding a bonus for achieving low disparities. If measures were gauged off of baseline performances rather than compared to competitors, providers serving more socially disadvantaged groups could see an improvement in scores and reimbursement.

In addition, adding a health equity quality measure could improve providers scores. Although measuring healthcare quality is a challenging endeavor, a quality metric should be

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based on credible data because one hospital is not like another. Quality measures help providers prioritize areas, so if VBP programs can include a health equity quality measure provider would be more intent on reducing disparities. If a hospital is penalized for worse outcomes it should be because of poor care processes and not because of more vulnerable patients.

Another potential way to minimize disparities includes Medicare rewarding practices for providing the best care to lower income patients at least as well as it rewards practices for providing the best care to higher income patients. This could help break the cycle of fewer resources for lower quality practices (Demeester,2017). In one study, researchers tested an alternative incentive payment approach with some of California's largest managed care health plans. The approach used the incentive payments as a starting point, but then adjusted them based on the organizations weighted capitation rates and patient income. Under the program, the providers received a budget to take care of their patients rather than payments for separate services. The adjustment greatly reduced payment differences due to patients' income, race/ethnicity, and region (James,2012). It also reduced medical spending and improved quality of patient care relative to providers paid through traditional fee for service approach.

In addition, creating a payment formula that accounts for social and medical risk can improve vulnerable population's health and potentially lessen inequality. When social risk measures are added, they can be used in addition to policies that explicitly target a reduction in disparities when evaluating provider performance. Since the social determinants of health account for 80% of health outcomes, providers should be given the support and resources to support patients with their social needs. In 2017, MassHealth's social determinants of health payment model used existing Medicaid data to support care for vulnerable members and improve payment equity. A payment model was developed that added available social determinants of

health variables to medical diagnoses (Ash,2017). Using existing Medicaid claims and enrollee files, variables such as disability, mental illness, housing issues, and a neighborhood stress score were identified and assigned to patients.

The payment model identified and allocated appropriate costs accounting for members medical, psychological, and social risks. For example, given a certain neighborhood stress score, providers who serve higher social risk patients were given more money per year to support the needs that address their patients' social factors. Examples include using the additional money to help pay for a patient's rent, connecting patients to community health workers, or buying a refrigerator for a patient's insulin. The results showed that paying an additional $50 per patient to providers who serve in socioeconomically distressed neighborhoods, can support innovations that address their patients' social complexities. When additional payments are recognized for individuals social and medical risk, it can address the root causes of poor health and high healthcare as well as improve health equity.

These strategies have the potential to improve and account for all patient's risk factors into VBP programs. Developing a health equity measure, measuring providers on their own baseline performances, and expanding the resources they have to serve their population can help achieve their goals in meeting the criteria for VBP programs. When pay for performance programs have stronger incentives and adequate risk adjustment, potential health disparities can be eliminated. In addition, tailoring interventions to personally meet providers needs will create a better care experience for the patient and a better reimbursement process for the provider.

6.0 Conclusion

As similar to all healthcare systems, healthcare in the United States was organized to treat and care for sick individuals. However, because of the lack of investment in social services, the U.S. must recognize both social and medical risk factors in their healthcare system. This has created challenges to both patients and providers. Patients, specifically low-income individuals, lack the necessary support outside the hospital to live a healthy life, while providers are tasked with managing their patients' complex conditions. This places an undue burden on physicians to remedy their patients' problems while also securing they are providing high quality treatment.

In order to achieve and hold providers to a higher quality of care, VBP programs were implemented. They intended to increase the quality of care delivered and to improve patients' health outcomes. However, as shown by research, patients who have greater social risk factors are not fully accounted for in the current system and the providers who serve them are not supported with the necessary resources.

MIPS and other VBP programs have the potential to enhance rather than threaten access to high quality care for beneficiaries with social risk factors. This can be done by creating complimentary policies to the current risk adjustment system that improve the current pay for performance structure to meet the needs of providers serving more vulnerable populations. When measures integrate social and medical risk providers can be more accurately assessed on the quality of care given to their patients. This leads to providing greater support and targeted rewards for better outcomes for socially at-risk beneficiaries. It is difficult to medicalize social services in the U.S. healthcare system. However, one step towards achieving this includes a balance between holistically capturing patient's health care needs in pay for performance

programs and creating more tailored policies towards reducing disparities. When this can be

done it can efficiently improve care delivery for vulnerable patients and lessen the disparities that

exist in our current healthcare system.

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