ISSUE SUMMARY

Hospital and physician quality measures and programs, where appropriate, should be adjusted to account for the sociodemographic status (SDS) of patients. Without this risk adjustment, hospitals and physicians who treat the nation’s sickest and most vulnerable patients continue to be inappropriately penalized by quality performance programs.

Issue

Over the past five years, Medicare has moved to link provider payments to quality and efficiency outcomes. In general, the AAMC supports this transition. However, numerous outcome measures (i.e., readmissions, mortality, episode payments, etc.) are greatly influenced by conditions that occur outside of the provider’s control. For example, a patient who is discharged from a hospital and does not have access to a pharmacy or lacks family to ensure that an appropriate care plan is followed is far more likely to return to the hospital than a patient who has these supports. The current provider quality programs and measures are not adjusted to account for this variation in patient populations and, as a result, unfairly penalize hospitals and physician groups that care for the most disadvantaged and vulnerable communities.

Background

Characteristics of low-SDS patients include low income, minimal education, English as a second language, inability to access pharmacies, lack of a familial or community support infrastructure, and lack of access to primary care physicians, among others. Low-SDS patients tend to be sicker and, for a number of reasons, may not have access to preventive care. There is no single measure of SDS (also referred to as socioeconomic status [SES]), and there is no consensus on how best to adjust quality measures or programs to account for this patient population. There is, however, overwhelming evidence that Medicare’s quality programs (such as the Hospital Readmissions Reduction Program [HRRP]) disproportionately penalize those institutions and physicians who care for low-SDS patients.

There have been and continue to be many federal initiatives to examine the inclusion of SDS into provider quality programs, including the following:

- In July 2016, the National Academies of Sciences, Engineering, and Medicine released the third report from its Committee on Accounting for SES in Medicare Payment Programs. The committee describes four approaches the Centers for Medicare and Medicaid Studies (CMS) could implement to account for SES factors, including changes to data reporting and payment adjustments.

- In 2015, the Medicare Payment Advisory Commission (MedPAC) reiterated its 2013 recommendations to modify the HRRP to address SDS factors, specifically by stratifying hospitals by the proportion of low-income Medicare beneficiaries they treat. MedPAC reports that such an approach could be implemented quickly, while ensuring “hospitals with the highest shares of low-income patients will still have an incentive to continue improving their readmission rates.”

- In 2014, the National Quality Forum (NQF) convened a technical expert panel to examine risk adjustment for SDS and other social determinants of health. The panel made 10 recommendations for incorporating SDS risk adjustment into quality measurement and reporting, including that all measures used in accountability or payment programs should be risk adjusted for clinical factors and sociodemographic factors. The NQF is currently conducting a trial period to put these recommendations into action.

- CMS has recognized the role of SDS factors in the Medicare Advantage program, particularly how plan performance on quality metrics is affected by the proportion of low-income Medicare beneficiaries they enroll. In 2016, CMS finalized a policy to adjust the Medicare Advantage Star Ratings metrics for plans that serve a disproportionate number of low-income beneficiaries.
The AAMC strongly supports policies that would adjust hospital performance in the HRRP and other quality programs by SDS.

AAMC Policy Recommendations

- Pass legislation to ensure that the HRRP, along with other quality programs as appropriate, is adjusted for SDS.
- Implement regulations that incorporate SDS adjustments into the existing provider quality programs, as appropriate.
- With regard to the CMS Hospital Compare Star Ratings: Stratify the overall star ratings by the number of measures reported; remove flawed measures from the ratings, most notably, the PSI-90 composite measure; and adjust the star ratings for SDS, as has been implemented in the Medicare Advantage star rating system.

Related Issues

- Health Care Quality
- Medicare Physician Payment and Quality

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Web Resources

AAMC Government Affairs and Advocacy
www.aamc.org/advocacy

AAMC Hospital Payment and Quality
www.aamc.org/hospitalpaymentandquality

Journal of the American Medical Association (JAMA)
Report: Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program