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Social determinants of health and Medicare Advantage risk adjustment

The impact of social determinants of health (SDOH) on patient care is becoming recognized as being more and more critical. Over the past few years, the Centers for Medicare & Medicaid Services (CMS) has focused on addressing SDOH for all members. This shift may affect risk and quality success and requires an evolution in coding capabilities within existing documentation systems.

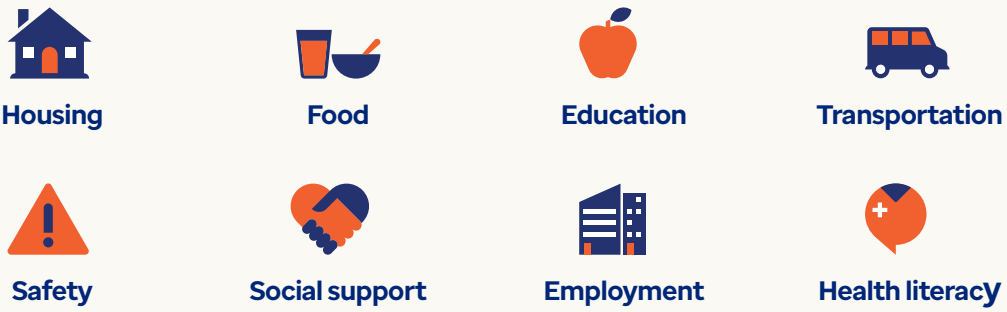
Defining social determinants of health

There is no one comprehensive list or definition of exactly what the SDOH are. Here are two of the most established definitions:

1. Social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.[1]
2. The social determinants of health are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.[2]

Both definitions contain the environmental conditions that affect health care and ultimately outcomes. There are many lists that can show just a few or up to 35 different social determinants.

The following eight are the most common:



Impacting member care

You may have many initiatives in place to close gaps, but SDOH may be standing in the way of a member's ability to get the care they need. It's important to have a line of sight into why a member isn't completing a recommended test or exam. Once you understand why they are unable to take care of their health, you can take steps to help them do so.

One example of a how SDOH can impact member care is a when a provider recommends a female patient to have a screening mammogram. She has the order from her doctor to get the test done but is unable to attend the appointment because she does not have transportation.

The provider wants the member to have appropriate screenings that will close gaps in care. Once the provider identifies a barrier in accessing medical services, what are the next steps for the provider to ensure that the patient has access to care and closes the health equity gap? Furthermore, how will other care providers of the member's care team have access to this vital information to help address this gap in care or any other chronic conditions a member may have?

Additionally, there is a lot of research to support why it is clinically important to create programs to help members affected by SDOH. For example:

- Participation in food assistance programs alleviates food insecurity and improves adherence to treatment among older adults with diabetes.[3]
- Home delivered meals after heart failure hospitalization had favorable effects on clinical status and 30-day readmission.[4]
- Participation in a tailored medical meal program is associated with fewer hospital and skilled nursing admission and less overall medical spending.[5]

Supporting social risk factors

A considerable effort is taking place to study the areas on which to focus with respect to SDOH. The Department of Health and Human Services, acting through the Office of the Assistant Secretary for Planning and Evaluation, asked the National Academies of Sciences, Engineering, and Medicine to convene an ad hoc committee to identify social risk factors that affect the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs.[6]

The committee has four objectives for supporting social risk factors in Medicare payment programs:

1. Reduce disparities in access, quality and outcomes
2. Improve quality and efficient care delivery for all patients
3. Report fairly and accurately
4. Compensate health plans and providers fairly

These objectives may be achieved through payment in the following ways:

- Adjust performance measure scores based on social risk factors
- Adjust payment directly for these risk factors
- Combine with public reporting stratified by patient characteristics within reporting units

Addressing SDOH through Medicare Advantage

We can expect more work to be done around SDOH as Medicare Advantage (MA) is uniquely positioned to address them. Fee-for-service (FFS) Medicare can benefit by addressing SDOH from an outcomes perspective and potentially lowering premiums. MA is encouraged to do this through plan design as well as the health care information that can be leveraged to improve revenue for Stars and risk adjustment.

There is a strong incentive for MA plans to focus on primary care, prevention and care management. The 2020 Final Call Letter[7] included language about having more opportunities and flexibility within MA plans to address social determinants through the following:

- Value-based payment arrangements
- Star Rating System
  - Categorical Adjustment Index (CAI)
- Risk adjustment
- Care management

Supplemental benefits focus on SDOH

The additional flexibility mentioned in the 2020 Final Call Letter shows a wide range of non-health-related supplemental benefits that MA plans can offer. Beginning with calendar year 2020, the Bipartisan Budget Act of 2018 amended section 1852(a)(3)(D).[8] Supplemental benefits are not required to be primarily health related when provided to chronically ill enrollees, if certain conditions are met. MA plans will have the ability to offer chronically ill enrollees a "non-primarily health related" item or service if the State Small Business Credit Initiative (SSBCI) has a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease. Non-health-related supplemental benefits can include:

- **Social needs benefits —** Reimbursement for community-sponsored programs, memberships and social clubs
- **Pest control —** Products and services for home pest control and/or eradication
- **Indoor air quality equipment —** Products and services, including HEPA filters, humidifiers and carpet cleaning
- **Non-medical transportation —** Transportation to obtain non-medical items and services such as grocery shopping or banking
- **Structural home modifications —** Disability-accessible fixtures, widening of hallways or doorways, and mobility ramps
- **General supports for living —** Transitional supports; subsidies for rent and/or utilities
- **Meals and food deliveries —** Healthy food options for purchase, or meals delivered at home or in congregate settings

Understanding social determinants proactively

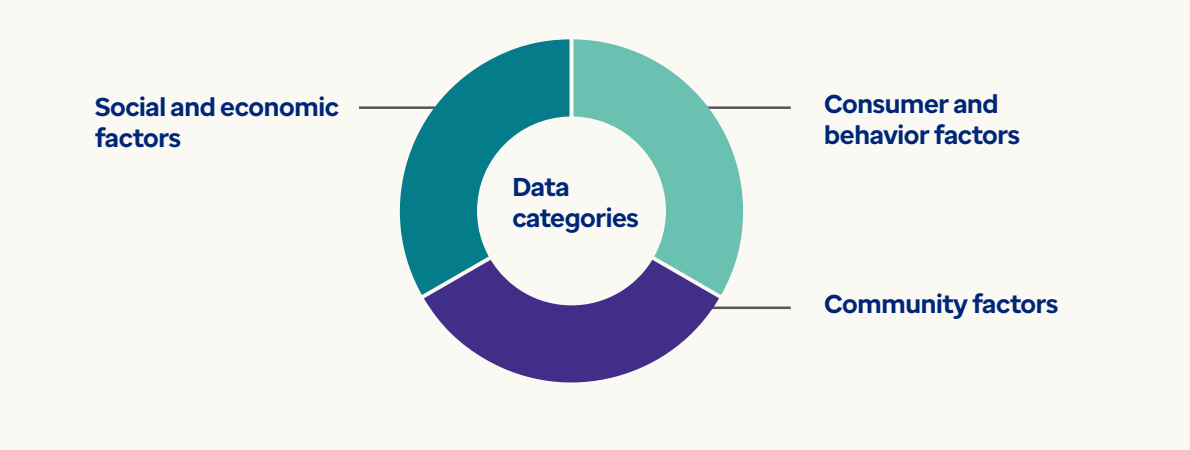
SDOH is not just limited to Medicare or Medicaid; it also applies to commercial populations. Health plans can be proactive when it comes to addressing social determinants of their at-risk members. When we look at social determinants from an analytic perspective, it's hard to take information from the member that may come from a doctor's office and get that coded into the care management systems. When you know the member as a customer, not just a patient, you can find ways to get data to interact in workflows, assessments and clinical quality. As a better picture of the member forms, you can work smarter to understand clinical impactibility and willingness to engage to change behavior and help close gaps in care.

Use results from consumer analytics from actuarial, underwriting, account management, clinical, population health management and quality programs to help you understand areas of opportunity such as:

- **Utilization —** reduce hospital admission, readmission and emergency room use
- **CM/PHM —** develop a more sophisticated identification strategy and engagement approach for clinical and behavioral programs
- **Quality —** improve Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers & Systems (CAHPS®), Health Outcomes Survey (HOS) and medication adherence
- **Risk profiling —** use non-clinical characteristics to develop more robust risk profiles
- **Underwriting —** use non-clinical characteristics to inform underwriting decisions
- **Benefit design —** use non-clinical characteristics to develop more meaningful, effective benefits

Improve operational, clinical and financial performance

It's important to take a look at the data points that drives a proactive understanding. Develop actionable indexes at the individual member level, taking several factors into consideration, such as consumer and behavioral, socioeconomic and community data. All these factors play into how the member is scored.



When you look deeply into the data, ask the following questions:

- Where are members in their family hierarchy?
- What are their avocations and hobbies?
- Do they own a home?
- What is their average online spending?
- What is their education level?
- Do they have access to food, transportation, housing and health care?

Out of this wealth of information, indexes can be created to predict the following about members:

- **Health ownership —** monitors interaction level with health care system and personal health choices
- **Financial frailty —** likelihood of deferring medical treatment over cost concerns
- **Propensity to engage —** helps prioritize and target engagement programs
- **Housing security —** likelihood of having housing issues and being homeless
- **Social isolation index —** shows propensity to have lower social ties to family and friends

These data points can also be used to solve a wide range of business problems by better understanding the consumer, not just the patient. One simple example is to identify members with hidden risk. Typically, these are members who may not understand the health system, have low levels of personal health ownership and health literacy, are socially isolated and are least likely to enroll in disease management programs.

Target and prioritize these members in outreach campaigns, because they are the most likely to enroll and benefit in the short term. Don't focus just on the member indexes but patients as well. Patient bases do differ. For example, members who are typically highly socially isolated are 20% more costly than those who are least socially isolated.

ICD-10 codes and SDOH

There is a lack of ICD-10 codes for SDOH, which reduces the ability to identify and monitor social determinants. Without proper monitoring, you can't track what members will need. CMS may require more documentation for its MA members.

There's a lot of work currently happening to ensure additional ICD-10 codes can account for more situations and scenarios. This will help health plans and providers to understand the social determinants that impact member health and help improve health outcomes. Information found in categories Z55-Z65 is for people with potential health hazards related to socioeconomic and psychosocial circumstances. Code assignment may be based on medical record documentation from clinicians involved in the care of the patient but not the patient's provider, since this information represents social information rather than medical diagnoses.

Make sure your providers are aware that there are some ICD-10 codes they can use. The CMS quoting guidelines allow for non-clinicians to use these codes for members. Coders in your organization should review these codes and be a part of the discussions on the best way to educate providers on the available codes.

Partners in the solution

Different partners help ensure we have the amount of codes needed to best document social determinants. One of the partners is Project Gravity within the Social Interventions Research & Evaluation Network (SIREN).[9] It is a national collaborative effort looking to reduce the barriers to social risk and protective factor documentation. Through Project Gravity, they are developing use cases and getting consensus so, as a medical community of clinicians together with health plans, collaboration can take place to make recommendations as to which codes should be added.

The other partner in the solution is the Da Vinci project.[10] Their goal is to help health plans and providers positively impact clinical, quality, cost and care management outcomes. They are working together to accelerate the adoption of Health Level Seven International, Fast Healthcare Interoperability Resources (HL7® FHIR®) standards to support and integrate value-based care (VBC) data exchange across communities. They want to make sure there is interoperability within technology solutions as we continue to use data to improve social determinants.

In-home assessments

Using an in-home assessment may help address and document SDOH either in homes or virtually. Being in a patient's home offers a unique opportunity to identify SDOH and document barriers to better health. Clinicians performing in-home assessments can spend more time with members and create referrals to address SDOH they observe. Ensure your vendor has a space within their documentation to capture those SDOH and uses trained clinicians who are trained to identify SDOH.

Six steps to take now

There are six steps you can take now to start engaging in strategies to address social determinants:

Educate providers on current ICD-10 codes available and their appropriate use.

Participate in Gravity and the Da Vinci Project so your voice is heard.

Leverage indexes to know your customer not just your patients, to manage your population proactively.

Keep informed — the final report from the National Academy of Sciences, Engineering and Medicine contains a lot of information how our government agencies are thinking through the social determinants.

Use in-home assessments to document SDOH and generate appropriate referrals.

For more information on SDOH, visit the Centers for Disease Control **SDOH website.**[11]

For more information:

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