The ABFM Foundation and Social Innovation Ventures Present

Designing Future State to Account for Social Risks in Medicaid Payments

W O R K S H O P

Summary

The workshop convenings have been made possible through generous support from The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy, and Arnold Ventures, a philanthropy dedicated to tackling some of the most pressing problems in the United States through research, education, and advocacy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund and Arnold Ventures, its directors, officers, or staff. Additional support has been provided by the American Board of Medicine Foundation, 3M Health Information Systems, and the Samueli Foundation.

Summary: Workshop on Adjusting Medicaid Payments for Social Risk.

On May 12, 2022, 22 CMS & Industry experts gathered at the Cosmos Club in Washington, DC for a workshop focused on the future state of incorporating social risk factors into Medicaid payment adjustments. Additionally, the group discussed ways to ensure social risk-based payments actually address social needs rather than increasing profit margins for health systems and insurers.

Workshop Plan

After welcome and introductions, Dr. Robert Phillips provided a 10-minute overview of past work and case studies on incorporating social risk into payment adjustments. Lapedra Tolson then conducted a 10-minute walkthrough of the storyboarding exercise and expectations.

Storyboarding Exercise

There was a great mix of perspectives and insights among the three groups, which spurred in depth discussions. As a starting point for storyboarding, each group received two beneficiary scenarios:

Scenario 1: Ms. Koval

Elderly dual-eligible widow with three chronic health conditions, living in a poor neighborhood struggling to manage healthy meals, transportation, and care coordination	Primary care is part of a health care system that is geographically spread out, so misses appointments, falls behind in chronic care management. Lack of assessment and support and becomes more frail	Multiple falls lead to repeat Emergency Department visits and hospitalizations with no discharge transition support	- Worsening frailty and quality of life - Very high, unnecessary costs - Lack of tap of existing community support (aging services, meals on wheels) - More likely to be placed in a nursing home

Scenario 2: The Parker Family

Rural, poor family distant from health care and social services and without broadband - Must drive 90 miles to reach nearest clinic	- Breaks in Medicaid coverage - Lack of developmental tracking and preventive care - Lack of WIC, SNAP	- Rural Health Clinic loses its Critical Access Hospital partner (loss of cost-based reimbursement and support for social workers, behavioral health, etc.) - Telehealth/Tele-social services not able to fill gaps	- Poor health outcomes - Prolonged hunger - Poor educational attainment - Poverty cycle reinforced - Higher downstream costs

The groups were tasked with creating the ideal risk payment adjustment scenario (future-state) across three swimlanes to address both beneficiary scenarios:

Provider (Care Team)

- Home and Community-Based Services (HCBS)
- Medical Provider

Medicaid-Managed Care Organization

State Medicaid

***Note**: View the group's boards and pictures here.*

Group Playback

Each group's playback was discussed by the larger group, which provided feedback and questions for each round.

Six Thinking Hats

Lastly, the groups were asked to examine critical moments from the perspective of the six thinking hats that could impede success of their ideal risk payment adjustment scenario at the end of the exercise:

- Societal, Economical, Political, Technological, Legislative, and Environmental

Debrief Guide: High-level Findings

At a glance:

- *Evaluate the role of Medicaid in the SDOH initiative*
- *Improve access and care by focusing on the patient's true needs*
- *Community involvement is vital to addressing diverse problems in a community-based approach*
- *Patients and families need help navigating services*
- *There is a disconnect between technology and interoperability*
- *Variability is necessary in medical care*
- *Different types of providers require different payment considerations*

Finding 1: Understanding the unique role and nature of Medicaid is critical to designing effective SDOH payment adjustment strategies for this heterogenous program

Insight	**Recommendation**
Defining Medicaid's role would include defining their direct responsibilities and how they balance supporting SDOH initiatives that are known to yield health outcomes (e.g., housing, broadband access) with direct care delivery. Medicaid should also consider coordinating with other agencies.	Adjust Medicaid payments for social risk such that they can support social needs. Consider a default option to avoid multiple solutions or states not addressing social risk adjustments Massachusetts Model sets aside large pot of money ($1billion+) which does not flow through health systems but can be accessed by clinicians/clinics to address social needs (often with CBO partners).

Finding 2: SDOH Payment adjustment will only improve access and care if it is effectively focused on the patient's true needs

Insight	**Recommendation**
Beneficence, one of the four core principles of medical ethics , implies that any service or procedure should only be provided with the intention of providing benefit to the patient. Doctors should consider the patient's individual context and needs. Patients should understand their own care plans and have access to them. The question is: what should Medicaid focus on? Would it be better to evaluate and measure SDOH individually or to apply known SDOH data	Small-area deprivation indices are useful for adjusting payments because they reduce burden of data collection, are more reliable, especially for the most disadvantaged, have low potential for gaming, and offer transparency for payers and providers. Having risk-adjusted payments enables assessment of individual patients' social needs and tailoring meeting those needs.

for communities and census tracts? Both the provider and the patient will be aligned during the care process with this dual approach.	

Finding 3: Community involvement is critical if SDOH-adjusted payments are to address diverse problems in any community-based approach

Insight	Recommendation
To account for variation and differences in solutions, it is crucial to understand the community where care is provided. Further, patients have greater trust when there is greater community representation within the provider and care workforce. By leveraging existing community resources, we can support care delivery and coordinate between organizations on a local level.	Social Risk Payments and/or social need resource pools (like in Massachusetts) are needed in order to shore up the community safety net and build it where it doesn't exist. Building up this safety net should be expected to increase trust and resilience, off-loading the work from clinical care, but enabling them to screen and refer for services–both of which are needed for health care to feel confident in screening patients.

Finding 4: Patients and families need help navigating services

Insight	Recommendation
It is clear that patients and families need assistance navigating services. The medical community needs to think about how coordination and services look for different providers or within communities. Supporting coordination across organizations and even between state and federal agencies is essential.	Community Care Collaborative of Massachusetts is an ACO of Federally Qualified Health Centers that created an electronic platform for: 1) identifying patients with social needs; 2) prescribing/referring to CBOs and other community partners; 3) directing payment to CBOs/partners; 4) tracking receipt of services, and; 5) sharing a care plan. This is an excellent model that works due to technological solutions and an adaptive network. It supports expansion of community services without passing funds through health care.

Finding 5: There is a disconnect between technology and interoperability

Insight	Recommendation
Coordination and communication require data interoperability. There is a need for portability and ownership of health plans and patient data. A major role for telehealth is that it could significantly reduce strain on the healthcare system, reduce barriers to rural care, aid patients with limited mobility, and expedite timely care and independence.	The Office of the National Coordinator and CMS have joint roles in assuring EHR interoperability which will be important for closing the loop on paying for social needs and referrals to community partners. They should test the limits of their authorities in this regard before deferring to new, Congressional action. Telehealth should be recognized as a critical tool for disadvantaged populations and supported.

Finding 6: Variations in needs across states and communities served by Medicaid demand flexible approaches to risk-adjusted SDOH payment models

Insight	Recommendation
Healthcare providers vary greatly in size and capacity, and solutions must be highly flexible to accommodate these differences. Medicaid and the payment recipient must be viewed at the community level, organization level, provider level and potentially the patient level. We must also take into account the complex relationship between payment recipient, payment format, and outcome measurement in connection with interventions and timeframe for measuring outcomes.	The lessons of Massachusetts' social risk support and Maryland's HEART Payments should feed into a broader CMSCM plan for Medicaid so that practices and communities of all sizes and types can address social needs. This would assure that there is a common and core capacity to assess risk and meet needs and the variation is in community response, not foundational policy.

Finding 7: Different types of clinical teams will require different SDOH risk adjustment considerations

Insight	Recommendation
In areas with low utilization, the per member/per month calculation is problematic. When care is less clinical in nature, we need to account for the Medical	CMS typically has to justify new payment models based on cost savings or containment. Many rural areas are caught in a loop that reinforces poor access because historical geographic pricing in underserved areas

Loss Ratio calculation. Accounting for the limited percentage of risk adjustment available is crucial when considering value-based solutions. Medical care is still primarily paid for by fee-for-service.	assures that they will not attract MCOs or health systems to provide care. Access disparities lead to life expectancy disparities measured in years of life lost. CMS will need to reframe intentions in these areas from saving money to saving lives, much like the arguments for paying for smoking cessation treatment twenty years ago. Health plans should be allowed to include social need payments or services in their MLR. It is difficult to adjust payments for social risk in a purely FFS model and create the incentives to care for social needs. New hybrid or fully capitated models are more likely to be successful.

Accountability and Compensation Open Forum Discussion

The last section of the workshop included an open discussion on how to ensure that every dollar of social risk-based payment goes to addressing social needs rather than increasing profit margins for health insurers.

There were two options provided by the facilitators to open the discussion:

- For every point increase in SDI, there is a commensurate $30 increase per member/per month premium
- Upon meeting a SDI threshold every provider above that receives an enhanced payment

Insight	Recommendation
Medicaid has a lot less money than commercial payers because it comes from taxpayers and state Medicaid, so we have to make do with what we have. State Medicaid has the power to increase funding. Medicaid needs money, not health systems. It may be more beneficial to alter risk adjustment and quality measures before adding more dollars. With regard to Medicaid and reducing disparities, we need to rethink how we qualify and quantify - if we just look at risk adjustment, then lots of money is coming in, but we need to balance it out also on the quality side. We also need	**First step:** Payers should be allowed to incorporate SDOH into MLR, then assess the degree of impact. Set the rates year after year from this. If we see that it is helping, then the opportunity for more money might be an option. Incorporate ADI data into a risk adjustment model? Cannot do zero to 60, it is zero to 10.

to consider how to account for the money. The burden of collecting this data may not be worth it in a fee-for-service model. Finally, equity should be incorporated into value-based contracts.	

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