

The ABFM Foundation and Social Innovation Ventures Present

# Designing Future State to Account for Social Risks in Medicare Payments

W O R K S H O P

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## Summary

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# Summary: Workshop on Adjusting Medicare Payments for Social Risk.

*On March 31, 2022, 18 federal & Industry experts gathered at the Cosmos Club in Washington, DC, to discuss the future state of incorporating social risk factors into Medicare Advantage (MA) payment adjustments. Specifically, the group discussed operational pathways that would ensure social risk-based payments address social needs rather than increasing profit margins for health insurers.*

## **Summary of Findings.**

Attendees achieved general consensus around the need for an operational strategy to maintain budget neutrality, recalibrating existing dollars in healthcare to incrementally improve health gaps due to social factors for targeted populations employing a combination of community measures of social risk and individual risk measures. The latter are typically health condition-associated risk but could include patient self-reported social needs. The community social risk and individual factors could be combined to determine increased and/or redistributed payments to MA plans that would be used to fund supplemental benefits and support for addressing social needs. Payment adjustments would need to be sufficient to address the social needs of the target population, but the group felt that addressing certain social needs would be too expensive and not optimally directed through healthcare dollars, such as housing insecurity. The suggestion to allow insurance companies to incorporate social interventions into the Medical Loss Ratio (MLR) was strongly endorsed, but there could be constraints to this approach based on limitations in current MLR regulations. Funding adjustments for providers (medical and non-medical) would necessitate infrastructure and benefit dollars. The CMMI-led multi-payor demonstration design of payment adjustment for neighborhood social risk and comorbidities (HEART Payments) was widely endorsed for mechanism, adjustment robustness, and accountability mechanism (annual reporting of allocation areas without line item accounting).

## Workshop Plan.

Dr. Bob Phillips, MD, MSPH opened the conversation with a 10-minute summary of foundational work on incorporating social risk into payment adjustments, including a series of specific case studies and cost estimates for addressing social needs. Lapedra Tolson then conducted a 10-min walkthrough of the storyboarding exercise and expectations.

### Storyboard Exercise

This exercise effectively revealed the breadth of perspectives and insights among the three groups, which spurred in depth discussions. As a starting point for storyboarding, each group received the same beneficiary scenario demonstrating the care and cost implications of not meeting a social need:

Beneficiary fails to see provider because of lack of transport	Beneficiary's DM/Sugars skyrockets	Hyperosmolar Hyperglycemic Nonketonic Syndrome (HHNS)	Beneficiary must visit the emergency room	Beneficiary goes home without sufficient care and support
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The group was tasked with creating the ideal risk payment adjustment scenario (future-state) across three swimlanes to address the beneficiary's needs:

Provider

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Medicare Advantage MCO

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Center for Medicare

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**Note:** View the group boards and pictures [here](#).

### Group Playback

Each group participated in two rounds of iterative discussion and 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

With the six thinking hats technique, the group can view critical moments from six different perspectives. Through it, we explore a range of perspectives beyond instinctive positions.

**Note:** For the results of the Six Thinking Hats, see the [Appendix](#)

### 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 or health systems.

**Note:** For the results of the Accountability and Compensation discussion, see the [Appendix](#)

## Debrief Guide: High-level Findings

At a glance:

- *Patients often do not trust insurers or the healthcare system.*
- *Providers should adapt their practice to address social needs directly or in partnership with community based organizations (CBOs).*
- *Beneficiary-specific social need data are difficult to obtain and maintain for the most disadvantaged populations. There is an ethical obligation to address identified social needs; collecting the data is a burden and the inability to address social needs is a source of burnout.*
- *MA plans should fund medical and non-medical providers to enable them to address social needs.*
- *Payment adjustment for social risk should be based on a curvilinear relationship rather than thresholds.*
- *Accountability means resources flow through primary care and CBOs to the patient and community.*

### Finding 1: Patients often do not trust insurers or the healthcare system

Insight	Recommendation
<p>Workshop participants noted that patients may not trust health systems regarding inquiries about their social needs. We need to empower the whole care team at the community level to help with accountability instead of just the primary care provider (PCP).</p> <p>Diverse clinician teams reflective of the communities they serve are</p>	<p>To build trust, there should be an effort to build personal relationships in conjunction with visits. Additionally, clinicians should work with CBOs as a "trust bridge" so that patients can feel comfortable providing the appropriate information to enable clinicians to address social needs. CBOs can take any shape as long as they are credentialed to provide social care and/or care coordination to the patient.</p> <p>Clinics need resources to recruit staff that look like and come from their communities and whose jobs are to work at trust and meeting needs (CHWs, Social workers, etc.). Resources should also enable</p>

<p>needed to help build trust and better identify &amp; address social needs. Patient-provider concordance has been shown to improve outcomes. A patient's medical home may be not only with their PCP, but rather their OBGYN, other medical specialist, or non-medical care team member such as a therapist or even barber or clergy member.</p>	<p>partnerships with CBOs to support warm hand-offs between care team members (ie PCP, specialist, CBO) and address social and medical needs.</p>
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**Finding 2:** Providers should adapt their practice to address social needs directly or in partnership with CBOs

<b>Insight</b>	<b>Recommendation</b>
<p>Clinicians must have the resources and staff to adapt their practices to meet social needs and/or closely collaborate with CBOs to meet those needs. The medical needs must still be addressed for these populations, but there is an entire additional layer of staff, care coordination, and services that are needed to adequately address medical and social issues for populations with higher social risk factors.</p>	<p>Clinical practices (typically PCPs, but in some cases specialists) should invest in new staff that are non-clinicians to assist with care coordination and possibly social service provision. Some clinical practices, such as, but not limited to, robust FQHCs, could offer social services directly. But most clinical practices could only offer a limited range of social services such as travel vouchers, in addition to home visits. CBOs are generally better equipped to provide social services. CBOs need to seamlessly communicate with PCPs and specialists around an individual's care plan.</p> <p>Telehealth holds great promise in enabling clinical practices and CBOs to evaluate and address social needs.</p> <p>Funding for care coordination and social service provision could be achieved using the existing processes for supplemental payments from MA plans. Insurance companies should be able to incorporate social interventions into the Medical Loss Ratio (MLR), but there could be constraints to this approach based on limitations in current MLR regulations.</p> <p>Sanjay Basu's use of the Commonwealth Fund ROI calculator offers some guidance for cost thresholds for addressing social needs. The group felt that the monthly housing cost estimates were beyond what Medicare could afford to pay for and non-healthcare dollars</p>

	through other government services would likely be a more efficient use of resources.
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**Finding 3:** Beneficiary-specific social need data are difficult to obtain and maintain for the most disadvantaged populations. There is an ethical obligation to address identified social needs; collecting the data is a burden and the inability to address social needs is a source of burnout.

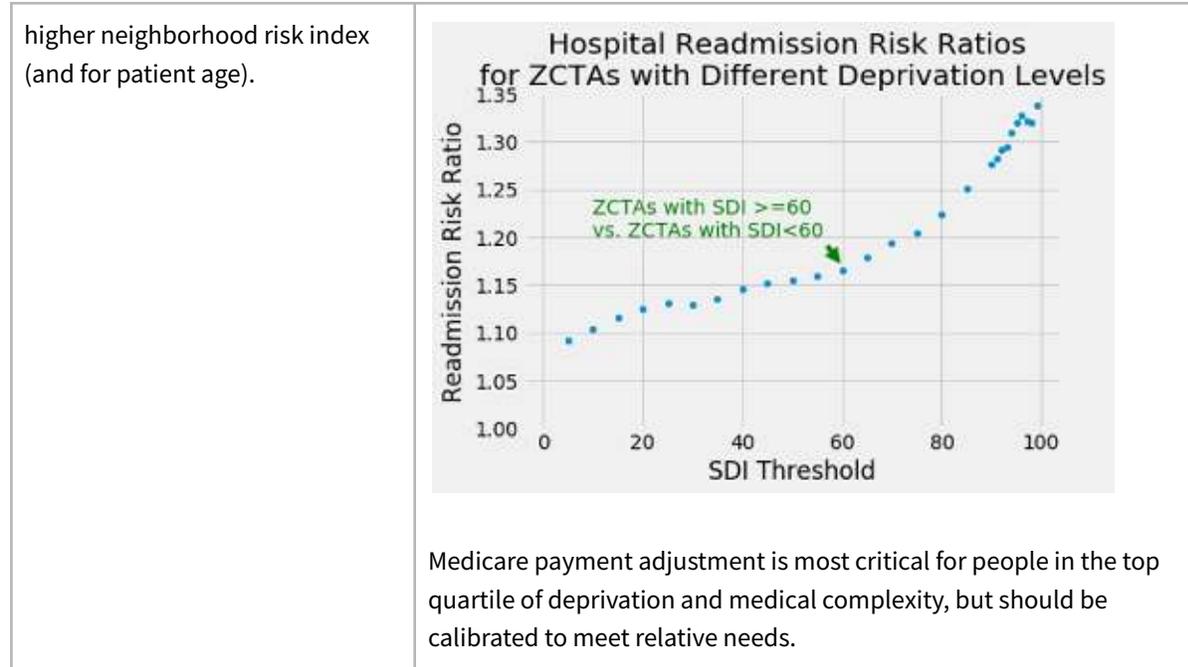
Insight	Recommendation
<p>Workshop participants felt that patients may be reluctant to share social needs data during care visits, particularly those where they don't already have trusted relationships. This reluctance limits clinicians' and other care teams' ability to understand the beneficiary's health and social needs. At an individual level, data should only be collected that will benefit that patient. At a population level, data beyond the individual patient's needs can help inform population-level management and resource allocation. Data collection is a burden for clinics. Patients with greatest social needs are least likely to seek care and be screened, and their life situations change frequently making patient-reported data less reliable. Patient-level social risk is also highly game-able. There is insufficient sharing of collected social need data across the healthcare system.</p>	<p>People share personal needs when they see its value and have trust. Allow the patient to choose who they share their sensitive data with but enable its use more broadly, with their permission. The Center for Medicare should provide access to a centralized hub for data and analytics. There should be a dual level approach – community data and clinician level. Interoperability is key, allowing a variety of data collection entry points, like using pharmacists.</p> <p>Collection burden, lack of reliability, and fungibility make individual-level social risk assessment limited, making community-level risk assessment through small-area social deprivation indices a critical element of social risk payment adjustment.</p> <p>Individual assessment of social risk, such as using variables like patient demographics and disease comorbidities, can still remain part of payment adjustment, but its utility would be improved if burden can be reduced, social need data can be shared, and high-risk patient assessment can be decentralized (collected outside of healthcare).</p> <p>Combining individual data and community-level social risk measurement balances the strengths of both approaches. Community level measurement can determine the foundation of payment adjustment and individual measurement can be used to titrate more precise resource allocation within a community.</p>

**Finding 4:** MA plans should fund medical and non-medical providers to enable them to address social risks

Insight	Recommendation
<p>MA plans currently do not provide additional benefits, funding or incentives to address social risks in a meaningful way. There are some token interventions like home delivered meals or isolation focused interventions, but these are not scaled and limited in scope.</p>	<p>To support clinicians in serving social needs, Medicare may provide a transportation benefit, broaden the post-discharge home visit waiver, and use telehealth more robustly and on a permanent basis.</p> <p>Medicare can also provide greater flexibility in paying for services like offering a monetary benefit voucher, provide payment for food and not just meal delivery, direct payment for community health workers or other staff that support care coordination and social service provision.</p> <p>The payment adjustment for social <i>risks</i> needs to be sufficient to adequately address social <i>needs</i> for the targeted population such that long term health outcomes are improved.</p>

**Finding 5:** Payment adjustment for social risk should be based a curvilinear relationship rather than thresholds

Insight	Recommendation
<p>Relative risk of poor outcomes and relative need increase with neighborhood deprivation and condition complexity; it is not fixed or linear. Research from ABFMF and CVP demonstrates an inflection in risk of 30-day hospital readmission at the upper quartile of the Social Deprivation Index (SDI) leading to an increase in relative risk of 17-34%. This is consistent with findings using the Area Deprivation Index (ADI).</p> <p>This recommendation is similar to how New Zealand adjusts payments, ie, they rise rapidly for</p>	<p>Payment adjustment should rise as social risk increases based on small-area social deprivation indices. Based on our findings, the relationship between the social risk and payment would initially rise in a linear relationship for the first 3 quartiles and around the 4th quartile of social risk, the payment increase should be more exponential.</p>



**Finding 6:** Accountability means resources flow through primary care and CBOs to the patient and community

Insight	Recommendation
<p>There is a risk that payment adjustment for social risk may lead to dollars flowing to the community but rather remaining within MA plans. Payment systems should be designed to ensure that risk-adjusted payments pass through to primary care and/or community-based partners to fund social services.</p>	<p>There needs to be just enough accountability without overburdening clinicians or community-based partners.</p> <p>Accountability should demonstrate fidelity of funds flow and include reporting of categorical use, but the latter should not increase burden on primary care.</p>

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