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Future-proof your risk adjustment solution by accounting for social determinants of health

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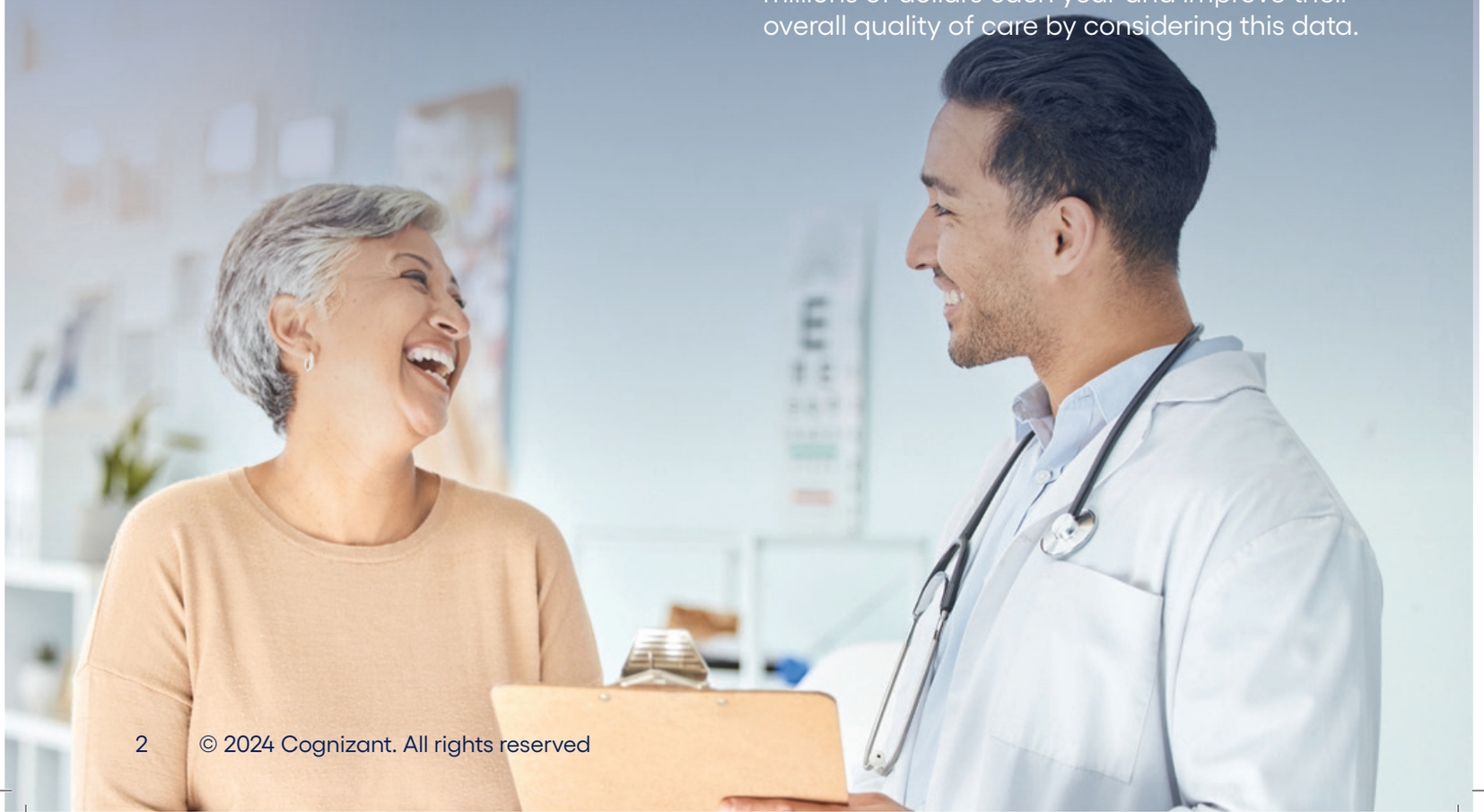
As of 2021, healthcare spending in the United States grew to a staggering $4.3 trillion, equating to over 20% of the total GDP of the United States. A deeper dive into healthcare spending reveals the U.S. has an annual per capita of about **$12,000**—a staggering rate approximately 50% higher than other developed countries. To add insult to injury, the U.S. is ranked far outside the top 10 for providing the best healthcare, currently in the 30th position. If you're probably scratching your head trying to grasp this discrepancy, you're not alone. What is causing the disconnect between spending and quality of care? One of the major contributing factors to the discrepancy is the lack of widespread adoption of new sources of information and technologies that can lower healthcare costs and improve administration.

One example of new sources of information that can help healthcare payers, particularly those who administer Medicare Advantage (M.A.) plans, accurately determine and possibly control risk is the concept of social determinants of health (SDOH).

SDOH, the non-medical factors that influence health outcomes, are grouped into five categories: **economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.** The ideology behind SDOH is that these non-medical factors impact member health and longevity. The list below is an example of the impact these factors have:

- Physical environment (Housing) - 10%
- Lifestyle (tobacco use, diet and exercise, alcohol, etc.) - 30%
- Access to quality healthcare - 20%
- Social determinants of health - 40%

When we look at the impact that these factors have on an individual's health, we can conclude that by incorporating these factors into risk adjustment, health plans can potentially save millions of dollars each year and improve their overall quality of care by considering this data.



A deeper dive into SDOH

We are all born on the same planet, but we have vastly different lives and experiences, and U.S. healthcare is just as diverse. Over the years, there have been numerous integrations, and advancements to the technology health plans use to administer M.A. These improvements have brought us all closer to the "information access nirvana" to which we all strive. Just like people, our technology is becoming more and more emotionally intelligent. Accounting for SDOH instantly gives health plans a larger view of the status of their health populations—which allows them to proactively determine necessary steps to keep their members healthy. A deeper dive into SDOH can lead to the following conclusions:

1. **Economic stability** – Having a steady income often means an escape from poverty, which translates into living a healthier overall life

2. **Education access and quality** – The more educated you are, the more likely it is that you will live a long and healthy life

3. **Healthcare access and quality** – The better the level of care one receives, the better the chances are living an ailment-free life

4. **Neighborhood and built environment** – People that live in "privileged communities" have a better chance of maintaining good health

5. **Social and community context** – The more disconnected one feels from their community, the more likely they are to ignore personal health issues

Impacts of SDOH on risk

Risk adjustment has gone through many changes throughout the years, and all of them can be tied back to the goals of **improving member health** and **member experiences** while **lowering the cost of healthcare**. Unfortunately, for the most part, U.S. healthcare does not incorporate SDOH into risk adjustment formulas and quality measures. As a result, members can be negatively impacted. For example, health plans that cover lower-risk members are not affected; however, plans with a member population deemed "higher risk" can be overlooked or penalized with a higher cost of care.

In the past few years, the federal government has initiated multiple projects for SDOH data collection. The Centers for Medicare and Medicaid Services (CMS) has simultaneously published advanced notices for the payment year **2023**, in which SDOH data collection will be required. BMS and the National Committee for Quality Assurance (NCQA) have published multiple quality measures for plans and providers to capture SDOH data to expedite the collective growth towards better care outcomes.

Throughout the healthcare journey, from enrollment to claims, plans and providers are already encountering key aspects of SDOH data—whether they know it or not. This data is either ignored, or the current systems are not equipped to extract it. From a clinical coding perspective, Z codes play a large part in this madness. In short, provide descriptions for when the symptoms a patient displays do not point to a specific disorder but still warrant treatment. The codes, which address and account for factors outside of a member's health, are published in ICD-10-CM to understand surrounding factors that may lead to an unhealthy life. According to CMS, for the 2021 reporting year, the five most commonly used Z Codes were:

1. Z59.0 **Homelessness**
2. Z63.4 **Disappearance and death of a family member**
3. Z60.2 **Problems related to living alone**
4. Z59.3 **Problems related to living in a residential institution**
5. Z63.0 **Problems in relationship with spouse or partner**

An additional factor

Another factor to keep in mind—the one which is probably most often overlooked but may be the most important—is the **physician**. Physicians must collect multiple mandatory data points for **CMS**, **state**, and **exchange** agencies. Requiring them to collect SDOH data would be taxing and likely "the straw that breaks the camel's back." Instead, the best practice is to use already existing data fields that are collected throughout the patient's journey: from enrollment to encounters to claims. Consolidating this data into one digestible view would yield the best results without burdening physicians. With the help of these data sources and the power of machine learning and A.I., relevant data fields can be extracted from siloed data sources to build an accurate and impactful SDOH profile for each member.

In summation, health plans should look for emerging methodologies that can directly impact the health of their member populations. By doing so, they can help erase healthcare inequalities and build toward a future of more affordable and accessible healthcare. A handful of health plans currently account for SDOH in risk adjustment and are reaping the benefits. Not only do these health plans have better intel about their member population, but they can also use that intel to initiate programs that help to improve member health, enhance the member experience and decrease the total cost of healthcare.

Contact us to learn more, visit www.cognizant.com/trizetto

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