



# MEDICAID SOCIAL RISK ADJUSTMENT IN OREGON: A STAKEHOLDER ANALYSIS

PREPARED BY  
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# INTRODUCTION

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With the increasing recognition of the important role a person's social and environmental context plays in their health outcomes, health care and clinical systems across the United States have been focusing more on the social determinants of health. One mechanism to improve resource allocation and address health inequities is to account for a patient's risks through risk adjustment modeling. While risk adjustment has been occurring in some clinical settings, there is little agreement on how best to incorporate social information into such risk and payment models. Furthermore, there is an absence of published material examining the planning and implementation of these models, and even less incorporating the various health system perspectives. This issue brief highlights a set of key principles heard across partners in the Oregon Medicaid system to consider as the state defines and develops its risk adjustment methodology.

## Who We Are

The Oregon Primary Care Association (OPCA) is a non-profit membership association of Oregon's 32 Federally Qualified Health Centers (FQHCs), also known as Community Health Centers (CHCs). OPCA's mission is to lead the transformation of primary care to achieve health equity for all, and the organization does this by providing its members operational support, training and technical assistance, and policy and advocacy support at both the state and federal levels. In addition, OPCA partners with health centers to advance the goals of health system transformation: better health, better care, lower costs and health equity.



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# BACKGROUND

In 2012, Oregon underwent a significant Medicaid transformation by establishing Coordinated Care Organizations (CCOs) which provide comprehensive care for Medicaid patients. CCOs engage a network of all types of health care providers (physical health care, addiction and mental health care and dental care providers) who work together in their local communities to improve coordination and care for patients in that region. CCOs receive a global budget, accept full financial risk, and work to lower total cost of care while improving health outcomes. They are regional, locally governed, and accountable for access, quality, and health care spending. (1) Since the inception of the CCO model, Oregon has increasingly looked for innovative ways to incentivize care transformation around the social determinants of health (SDH). In 2019, Oregon initiated CCO 2.0, the future iteration of this transformation, which guides the next five-years of contracts for CCOs and Medicaid innovation. The goals of CCO 2.0 include: improving behavioral health, increasing value and pay for performance, maintaining sustainable cost growth, and an increased focus on SDH and health equity. (2) As of October 2019, there were 15 CCOs and 32 FQHCs in the state serving approximately 25% of the Oregon population. (3)

**Figure 1: Various Goals of Risk Adjustment**



Oregon isn't alone in the recent trends to align cost control, quality of care, and health outcomes. These efforts have seen Medicaid programs nationally move from traditional volume and fee-for-service-based payment models towards value-based payment efforts targeting clinical and quality metrics. (4) These efforts have enabled healthcare to move upstream in an attempt to address the root causes of poor health outcomes and develop strategies to address patients health-related social needs, such as lack of housing, food insecurity, and transportation. It is well documented that these social needs, and systems-level social determinants of health (SDH), contribute greatly to health outcomes and patients with social vulnerability are costlier to the health system.(5,6) Despite an amplified commitment to address non-clinical needs, health systems rarely obtain sustainable funding sources for this work. (7)

One strategy to better resource clinics and health systems serving complex patients, and to account for the varying costs associated with caring for different patient populations, is to incorporate medical diagnoses, age, and sex in risk adjustment payment models. To date, however, risk adjustment has mostly failed to incorporate social factors.

# BACKGROUND

Preliminary research is showing that risk models which incorporate social data – such as a person's income, housing, or education level – are far more predictive than those that don't include such factors when it comes to forecasting use of services and ultimately health care costs.(8,9) Studies indicate that factors such as poverty, disability, and housing instability, are associated with higher readmission rates.(10) Social risk adjustment (SRA) is a group of methodologies which seek to incorporate social factors in risk adjusted payment strategies.

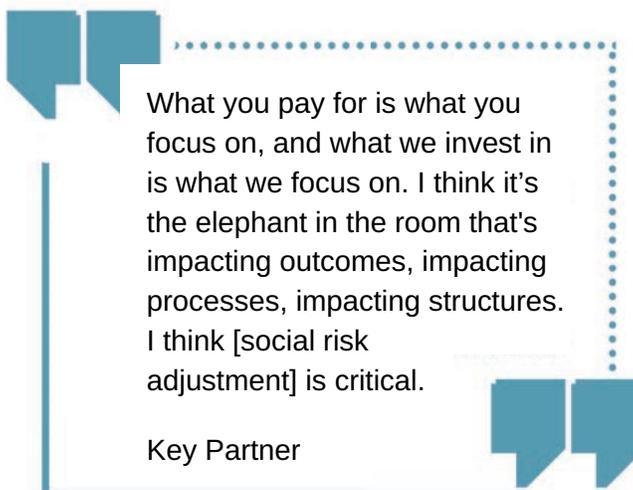
**Figure 2: A potential SRA Model based on existing Risk Adjustment Per Member Per Month Strategies**



At a time when our local, state and national leaders are calling on standards to achieve health equity, it should be noted that a failure to account for social factors in value-based payment reform has been documented to result in a cycle where the most socially complex patients and their clinicians lose money and health systems with less vulnerable patients experience increased reimbursement.(11, 12) In these cases, health plans are therefore incentivized to cherry-pick the healthiest, most profitable patients, which may, in turn, exacerbate disparities.(13,14)

Currently, Massachusetts and Minnesota have implemented payment adjustment for social risk, and many more are considering doing so in the near future. Yet today, there is very little agreement on how best to incorporate social information into payment allocation. Furthermore, there is an absence of published material examining the planning and implementation of social risk adjustment. At the time of these interviews, there was no evaluation of various health system perspectives on social risk adjustment.

With Governor Brown's priority area of focusing on social determinants of health, Oregon is exploring risk adjustment that is inclusive of social factors which makes the interviews and themes distilled in this issue brief relevant and timely to consider.



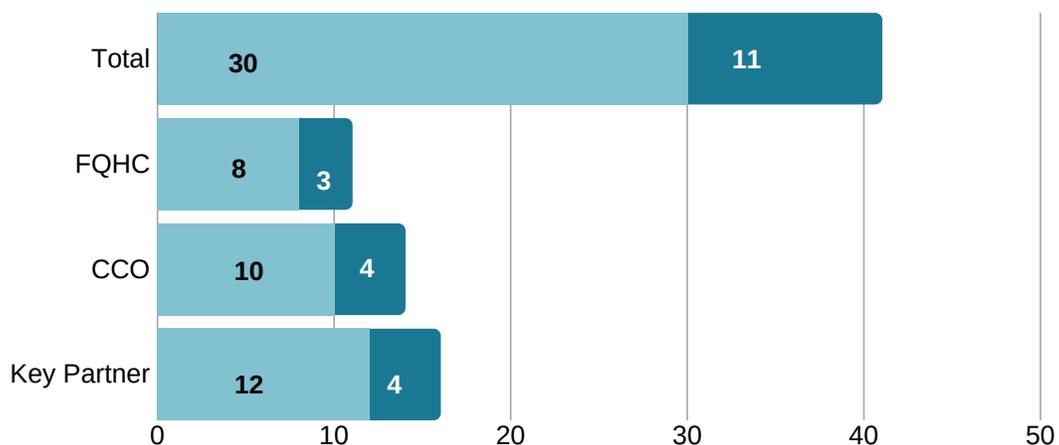
# METHODS AND RESULTS

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The goal of this evaluation was to understand how various stakeholder perspectives from within Oregon’s Medicaid and healthcare system inform our state-level strategy on social risk adjustment, including challenges and opportunities. More specifically, this issue brief aims to distill a key set of core principles and serve as a catalyst for conversation regarding strategies going forward.

In total, 41 individuals were invited to participate and 30 were interviewed. Eight individuals representing Federally Qualified Health Centers (FQHCs), or Community Health Centers (CHCs), 12 representing key state partners in policy and research, and ten CCO representatives were interviewed. Eight of 15 CCOs participated and seven of 32 FQHCs participated. Interviewees represent geographic variation and serve urban, rural, and frontier populations.

**Figure 3: Number of Interviews and Invitations**



**Interviews were analyzed and themes were grouped in the following categories:**

1. Health systems characteristics and readiness for innovation,
2. Perspectives on goals and vision,
3. Methodologies and intervention characteristics,
4. Perspectives on developing a patient-centered model, and
5. Considerations for implementation.



# RESPONDENT VOICES

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"This type of project is perfectly well suited for a statewide performance improvement project where we are all collectively working towards one goal, we have to show milestones, we have to show progress to the theme. It can happen in a much more thoughtful and collaborative way." CCO Partner

"[Health care] still does episodic care. And oftentimes, solving social needs, really shifts that attention to treatment in the moment. And if you start moving the responsibility away from states to health systems, you lose the ability to go upstream and focus on the preventive issue, or the issue that that's causing the social disparity in the first place." Key Partner

"There's no standardization. Clinics are using z-codes differently or not at all. And people are using different screening tools. Those are kind of the loose ends that need to be addressed before we can really come to kind of a universal model around that." CCO Partner

"I think that getting a commitment from the CCOs and from the State - that the direction is to risk adjust for social complexity - that alone would really be very motivating. Right now, it's implied, but it's not explicit." Clinic Partner

"A pro to [screening] at the clinic level is that you can integrate it into the care plan. You're not just focusing on somebody's health needs, but you're focusing on their social needs, and you'll get better health outcomes when you understand and are focused on meeting the patient where they're at. So regardless of what's gathered at the state level, it has to translate to the care plan and what's right for patient centered care." Key Partner

# DISCUSSION

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**Health System Characteristics:** The Oregon healthcare system has increasingly focused on improving equity and addressing individual social needs, particularly in the Medicaid population. This culture coupled with current frustration with payment models and systems fragmentation - for example with EHRs and screening protocols - has resulted in significant buy-in for payment adjustment for social complexity. Buy-in is a necessary ingredient for successful policy change, and Oregon is well-situated to implement SRA.(16)

**Perspectives on Goals and Vision:** The tension between addressing individual member social needs and broader social determinants of health is felt nationwide. Screening for social needs and building EHR documentation, workforce, and referral systems has gained significant traction in the past decade. More recently, many have called out this movement for not addressing the root causes of social needs such as macro-level education, poverty and housing policy. Addressing individual social needs is an imperative effort, necessary for mediating individual circumstances, but is not sufficient at improving the underlying social and economic conditions in communities which foster improved health outcomes for all. (17) Respondent discussion of medicalizing these broader social factors and creating clinical workflows to address them within healthcare mirrors this dichotomy of perspective.(18) Respondents also struggled with methodologies of how this might be done- many focus on existing structures and reporting methods as a starting place while recognizing the limitations of replicating medical models for social factors. Interviewees echoed the national conversation when discussing the goals and vision for SRA and funding allocations. Consensus must be found to maintain buy-in and alignment for any future SRA policy.

**Methodologies for SRA:** Respondent discussion of data sources illuminated the diversity of opinion throughout the state. Using publicly available data, the Integrated Client Services Warehouse, Medicaid enrollment data, or member screening each present unique challenges and opportunities. While immense innovation has occurred in utilizing EHR systems to document patient social needs, implementation challenges with provider time and workforce and aggregation capacity are well documented.(19,20) EHR fragmentation and various screening protocols throughout the state further complicate this discussion. Respondents were very mixed in their opinions about ICD-10 Z-codes which similarly echoes the national conversation where there are champions and critics.(21,22) Lack of consistent SDH domains in screening protocols, lack of definitions for these domains, and lack of consensus regarding the use of coding, such as ICD-10 z-codes, have been documented as barriers nationally and are relevant to Oregon. Various states have chosen differing data sources, screening tools, and documentation methods, further highlighting the absence of a standard methodology for SRA.(23)

**Perspectives on Patient Centered Model:** Oregon's CCO model hinges on community participation and many respondents discussed the need for clarity on community perspectives for SRA. Further, many discussed a desire not to burden patients with screening and a fear that current privacy protections and legal frameworks were not robust enough. This is especially imperative given the sensitive nature of social needs.(24) Further research is needed to anticipate unintended consequences of increased data documentation and data sharing across the health system.

A series of recommendations is outlined below. These represent respondent perspectives and the findings of a thorough qualitative analysis.

# RECOMMENDATIONS

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## 1

### **TRANSPARENT LEADERSHIP**

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Moving forward, in an effort to be strategic and unified, there was a consensus that the State should manage the development of a well-articulated strategy and process for SRA planning and implementation. Working groups could be formed to begin a multi-stakeholder engagement process for planning, including perspectives from different regions (urban versus rural) and community-based organizations. A roadmap articulating not only a process but the vision, would create transparency and a shared understanding. Many respondents expressed this would be a catalyst for continued action related to social risk within healthcare.

## 2

### **DON'T LET PERFECT BE THE ENEMY OF THE GOOD**

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There is no perfect strategy for social risk adjustment. Participants indicated value in the State moving forward with a fundamental model, perhaps focused on a few domains initially, and to continue to refine over time. An iterative implementation process with formal feedback mechanisms would be critical for success. Furthermore, process measures could be used to incentivize the antecedents of future data sources (clinic screening itself, coding, use of publicly available data, etc.).

## 3

### **DEFINE AND UPLIFT THE RATIONALE FOR SOCIAL RISK ADJUSTMENT**

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Given the wide range of concerns and ideas to improve Oregon's state-level opportunity, it became clear that there should be a well-articulated purpose and mission behind SRA to ensure alignment throughout health system partners and across the state. This will create a shared purpose and reduce potential future confusion. A unified vision will also enable more robust tracking of outcomes, including potential unintended results to ensure SRA goals are being met.

# RECOMMENDATIONS

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## 4

### **GOAL CLARIFICATION: SOCIAL NEEDS V. SDH**

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Respondents were split in how they discussed SRA and there should be agreement on the goal behind SRA. On the one hand, some focused on increasing funds to primary care settings to build staff and workflows that identify individual patient needs and refer to resources. On the other hand, some expressed concern this wouldn't get to the root cause of poor health outcomes and the upstream factors driving the need to address individual social factors in the first place. Consensus should be found here as this implicates all SRA decision making including data sources, funding changes, and level of community versus clinic investment.

## 5

### **PATIENT AND COMMUNITY CENTERED**

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The State should incorporate patient and community voices in SRA planning and implementation. Existing frameworks for this exist in Oregon and can be leveraged moving forward. Community based organizations have a wealth of expertise and knowledge and their voices should be brought forth in the process. SRA relies on sensitive data and engagement from the beginning will help to reduce confusion and mistrust in SRA methodologies.

## 6

### **DATA SOURCE DECISIONS**

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There was a wide variety of opinions on the data best used to drive SRA across the state. Oregon is at a great opportunity to make decisions based on what is available and build upon what needs to be created to help achieve state-level goals. For this reason, the State should take stock of its strengths and weaknesses regarding data collection to best inform decision making. This includes what is currently available, what is missing, and what the alternatives are for generating increased information exchange with regard to social and health data. This will inform where progress and resources should be directed. Data source decisions should be made transparent at all levels.

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