Advancing Health Equity through APMs

Guidance on Social Risk Adjustment

Contents

Call to Action

Health inequities related to race, ethnicity, disability, sexual orientation, gender identity, language, and geography continue to persist in society due to socioeconomic factors at the individual and community level, implicit and explicit biases, and structural racism.[1] Health care payment and delivery reforms that do not address these issues run the risk of perpetuating disparities in health outcomes of vulnerable populations and increasing health care costs. The Health Care Payment Learning & Action Network (LAN) calls on private and public payers, purchasers, providers, community-based organizations, individuals, families, their communities, and other relevant stakeholders to work together to eliminate health inequities. The LAN encourages these groups to begin incorporating design elements that advance health equity into new and existing Alternative Payment Models (APMs) in an aligned manner. This guidance document follows the 2021 release of Advancing Health Equity Through APMs and specifically focuses on how social risk adjustment for payment, a core design element of the Health Equity Advisory Team (HEAT)'s theory of change, and complementary core components can advance health equity.

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[1] In this document, the terms *health inequities* and *health disparities* are used. These terms are related, but distinct. We use *health inequities* to mean "unjust and avoidable differences in the distribution or allocation of resources between marginalized and dominant groups that lead to disparities." We use *health disparities* to mean "measurable differences in health outcomes that result from inequities."
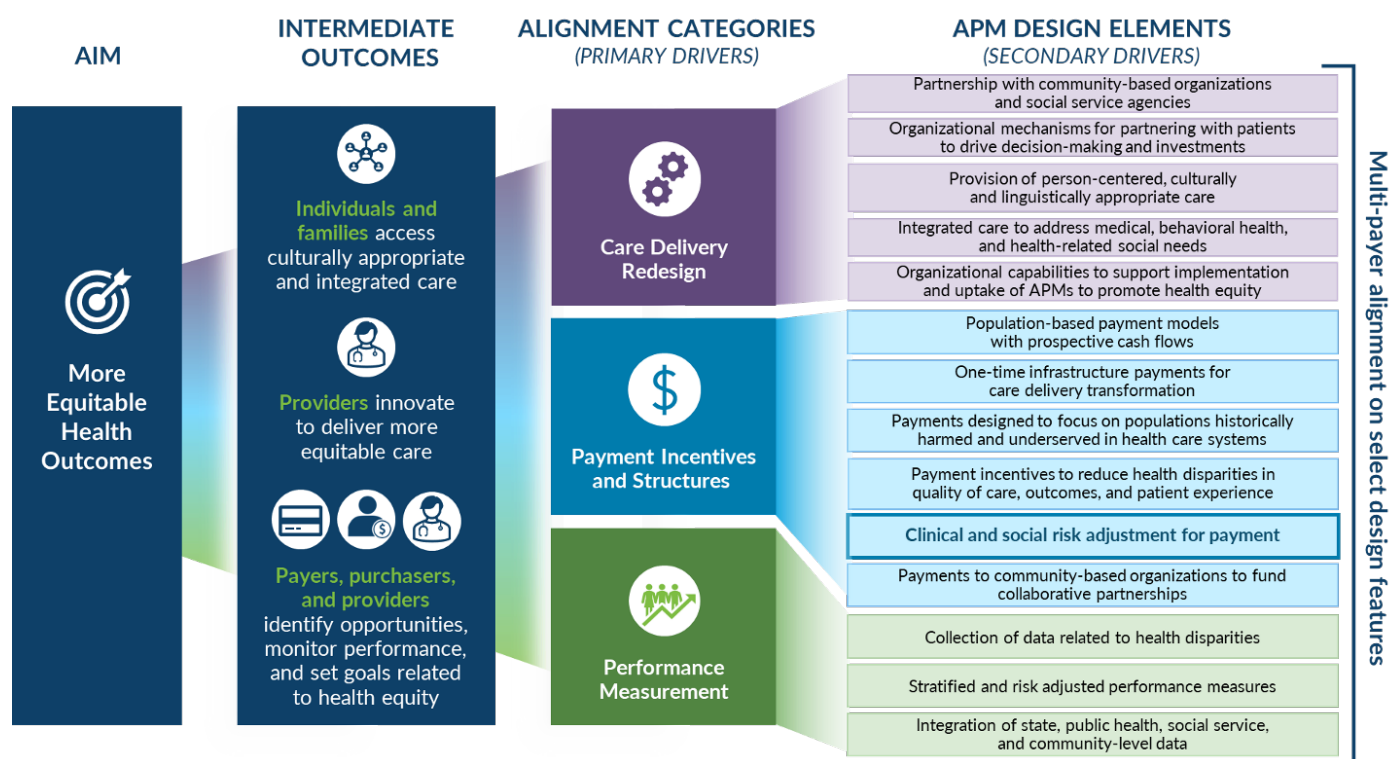
Figure 1: HEAT Theory of Change for How APMs Advance Health Equity

The HEAT's theory of change identifies three interrelated primary drivers for advancing health equity: Care Delivery Redesign, Payment Incentives and Structures, and Performance Measurement (Figure 1). Social risk adjustment for payment is a lever or design element within payment incentives and structures that can be used to incentivize and reward better care and outcomes.

Social risk adjustment functions within a broader constellation of factors that can support or undermine health equity. Therefore, accounting for complementary actions within data collection and care transformation is important for effective implementation. Social risk adjustment and complementary reforms can incentivize and provide organizations with the resources needed to mitigate the negative impact that explicit and implicit biases and structural racism have on historically marginalized communities and the providers that serve them, reducing disparities, and advancing health equity.

Guidance Overview

This document provides stakeholders with a starting point for action by offering guidance on the three core components of social risk adjustment—data collection and tools, payment incentives and mechanisms, and care transformation. The guidance is categorized as:

- "**Essential**" –describing the baseline elements for advancing health equity and
- "**Enhanced**" –providing more advanced approaches for experienced stakeholders.

Essential and enhanced approaches are designed to offer specific meaningful direction that promotes multi-stakeholder alignment and communicates expectations while also having the breadth to allow customization based on local context and the needs of populations being served.

A summary of essential and enhanced guidance across the three core social risk adjustment components are highlighted below:

Data Collection and Tools

Essential Guidance

- Collect and incorporate readily available and/or publicly available social needs, demographic, and population-level data into APMs to predict health-related risks/outcomes and appropriately adjust payments and benchmarks to support related social needs.

Enhanced Guidance

- Improve data for social risk adjustment by collecting data on individuals' social risk factors and/or additional demographic factors.
- Implement a glidepath approach to data collection to work toward the ideal state of self-reported individual-level data.

Payment Incentives and Mechanisms

Essential Guidance

- Identify areas where it is feasible and appropriate to incorporate social risk adjustment into existing payment structures.

Enhanced Guidance

- To supplement social risk adjustment, provide upfront or ongoing payments to providers or plans whose patient population has a high social risk score for care transformation efforts that address patients' social needs.
- Provide performance-based payments tied to quality and equity metrics. The payment should be adjusted using social risk adjustment methodologies as appropriate.

Care Transformation

Essential Guidance

- Develop a health equity plan collaboratively with community partners, payers, and providers to inform effective allocation of upfront payments to care transformation efforts.

- Ensure payments adjusted for social factors (e.g., bonuses, incentives, capitated payments) are allocated to initiatives within the provider organization that address health disparities among its patient population.

Enhanced Guidance

- Develop reporting and accountability measures that address disparities within the identified populations.

- Use outcomes measures to report on impact of care transformation over time.

- Create a local governance structure to assess place-based community needs including social factors and engage with local partners to make decisions about how to meet those needs.

- Activate technical assistance and learning and diffusion resources to solidify processes and outcomes that lead to reduction in disparity.

- Promote an integrated and comprehensive health care system.

Risk Adjustment Overview

Risk adjustment is a statistical methodology used to control for variations in patient populations when comparing factors like performance and health care spend across groups like payers and providers. Risk adjustment methodologies are designed to account for differences in patient attributes which can be clinical (i.e., types, number, or severity of conditions), demographic (i.e., age, gender), and/or socioeconomic (i.e., race, ethnicity, income) in nature (Smith, et al. 2006). In quality measurement, for instance, risk adjustment is used to control for individual risk factors or comorbid conditions that can have an impact on patient outcomes when comparing providers on outcomes such as mortality.

In value-based or managed care settings, risk adjustment is used to determine payment. This is because patient attributes are associated with the overall cost of care for a particular person, both due to direct needs (e.g., costs associated with treating a specific condition) and indirect costs (e.g., older patients are more likely to develop new conditions, need more intensive treatment, or need treatment for age-related incidents such as falls). Failing to account for these attributes can lead to over- or underpayment of providers who are coordinating comprehensive care for a patient. The details of a given risk adjustment methodology may significantly impact providers' ability to profitably provide high-quality care to a given patient. Beyond establishing payment rates, risk adjustment is also used to prevent adverse selection by incentivizing plans and providers to enroll or care for individuals regardless of their complexity or health status.

Well-designed risk adjustment promotes fair comparison across groups like payers and providers. This is important because providers, payers, and health plans are frequently compared against each other when decisions impacting their businesses are made: patients and purchasers leverage related insights to make informed decisions about where to obtain care; payers, health plans, and providers are rewarded or penalized based on how much they spend on health care; and providers and plans often manage reputations that are based on performance or quality of care experienced by patients they serve (National Quality Forum 2017).

Limitations in traditional clinical risk adjustment methodologies have, in some cases, led to the penalization of providers and plans who serve more patients with complex needs and therefore often expend more resources to administer high-quality, high-value care. [2] Moreover, many patients who face socioeconomic barriers to care may have a history of underutilizing preventive care services, which may further reduce predictions and benchmarks that estimate the true cost of their care needs. This underestimation could lead to unintended consequences for these patients who may find it more challenging to access needed services. Providers and plans who serve them may also find it challenging to improve services when reimbursement is reduced due to misaligned value-based care incentives (Joynt Maddox 2018).

This document describes opportunities to implement social risk adjustment in value-based care settings to improve accuracy and fairness of payment in ways that support the advancement of health equity. The document details:

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[2] For further discussion of the limitations of risk adjustment see e.g., The Future of Risk Adjustment: Supporting Equitable, Comprehensive Health Care.

- An explanation of how social risk adjustment accounts for adverse social conditions
- The HEAT's point of view on effective social risk adjustment
- Essential versus enhanced guidance on the core components of social risk adjustment
- Priorities for multi-stakeholder alignment
- Recommended actions for specific stakeholders
- The limitations of risk adjustment

Risk Adjustment in Value-Based Care Settings

In traditional clinical risk adjustment for payment, the risk adjustment methodology or algorithm is used to predict the health care cost of an individual or population. Algorithms use demographic and clinical data from ICD-10 diagnoses codes and/or procedure codes on paid claims to develop a risk score (also known as risk factor) that represents illness burden or acuity (the level of intensity of care needed by a patient). This risk score is then applied to a benchmark (financial dollar amount) to determine the cost of care (Figure 2).

Figure 2: Simplified Risk Adjustment Algorithm for Payment

APMs, particularly those with risk-adjusted payments, present an opportunity to reduce health disparities because they offer reimbursements based on the difference between actual spending and the estimated cost of care calculated by the risk adjustment methodology or algorithm. APMs reward payers and providers that successfully manage patient care; when the actual cost of caring for a patient is less than the estimated cost of care, providers and payers generally share in the savings. Alternatively, if a patient's actual cost of care exceeds the estimated cost of care, the provider and payer may share in the risk, or financial loss, of the patient's care.

Although APMs with risk-adjusted payments have the potential to reduce health disparities, in some cases, they penalize providers caring for underserved populations and people with complex needs, consequently exacerbating health disparities (Rubin 2018). This is because traditional clinical risk adjustment is not comprehensive enough—it does not incorporate broader social factors that influence patients' health outcomes into the risk score. Since estimated cost of care from traditional risk adjustment is based on demographic and clinical factors, the expected cost of care for populations with high social vulnerability and complex needs are often underestimated. As a result, providers that serve populations with complex needs (e.g., safety net providers) are more likely to be penalized than rewarded financially for their patients' health outcomes—the actual cost of care for caring for their patients often exceeds the estimated cost of care. They are also less likely to be adequately funded at a level necessary to address the health issues of their more complex patients.

In addition, providers with limited financial resources are less able to participate in APMs because they lack the means to take on additional financial risk (McCullough, et al. 2019). These constraints, among others, perpetuate limited access to quality care for underserved populations. To reverse these effects,

APMs can adapt their payment structures in multiple ways to deliberately reduce disparities, including by adjusting risk adjustment methodologies and benchmarks to more fully reflect non-clinical drivers of the cost of care for individuals. They could, in some cases, account for historical underutilization of services when setting benchmarks and forecasting health needs, tie incentive payments to the provision of services that address existing disparities, improve access to and uptake of preventive care services, or meet specific equity metrics.

Incorporating social risk adjustment into the payment incentives and structures of APMs can:
1) facilitate more appropriate levels of payment and aid participation opportunities for providers that care for populations experiencing high rates of health disparities; and 2) promote care transformation that advances equitable health outcomes for patients.

Social Risk Adjustment

Unlike traditional clinical risk adjustment, social risk adjustment accounts for adverse social conditions associated with poor health (Crook, et al. February 2021). The algorithm uses demographic, clinical factor, and social risk factor data (i.e., food insecurity) to calculate a risk score and determine the cost of care (Figure 3).

Figure 3: Simplified Social Risk Adjustment Algorithm

Social risk factors are social conditions at the community or individual level that are associated with negative health status or outcomes, such as housing instability and social isolation (State Health Access Data Assistance Center at the University of Minnesota 2020). Accounting for social risk factors is important because there is increasing evidence that social factors affect health status and lead to differential health outcomes across various identity groups (i.e., race, gender, sexual orientation). These differences in health outcomes are meaningful in their impact on value-based care programs. [3] [4] [5]

> *Social risk factors must directly factor in race, ethnicity, language, and other sociodemographic variables to accurately measure and address health inequities.*

There have been various efforts to identify the social risk factors to prioritize for social risk adjustment. For instance, the Centers for Medicare & Medicaid (CMS) has relied on area level measures while some

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[3] (Byrd and Chung 2021).
[4] (Johnston, et al. 2020).
[5] (Harmon 2019) Improving Risk Adjustment in Alternative Payment Models | AMA (ama-assn.org).

state programs have explored the use of individual-level data. [6] Commercial plans and large providers may use a combination of sources and, in some cases, include supplemental data from electronic health records. Different approaches offer benefits and limitations. The National Quality Forum has provided general guidelines for selecting risk factors for adjustment, which include ensuring there is:

- Empirical association between the risk factor and outcome of interest
- Variation in prevalence of the factor across the measured entities
- A process that is resistant to manipulation or gaming
- Accurate data that can be reliably and feasibly captured

Advantages and Limitations of Social Risk Adjustment

Social risk adjustment can help advance health equity by better allocating resources between under-resourced populations and populations with more secure socioeconomic standing to avoid unjust differences that lead to health disparities. However, there are still some limitations and areas where more research is needed to better understand the impact of social risk adjustment on plans, providers, and patients. For example, little is known about how plans and providers change their behavior in response to shifts in risk adjustment methodology with regard to social needs, and some researchers have raised concerns around social risk adjustment potentially reducing visibility into quality of care or potentially reducing incentive for providers to improve the quality and equity of care provided.

Social risk adjustment alone will not reduce health inequities and disparities It is only one element in an effective payment strategy and adjusting payments for social needs does not always need to occur via direct modification to the risk score. Other policy and regulatory mechanisms are needed to complement risk adjustment to advance health equity.

Technical challenges with risk adjustment that need to be addressed include but are not limited to:

- Identifying and prioritizing social factors that are important for accurately assessing risk.
- Understanding the extent to which social risk is correlated with barriers to accessing care which has implications for the technical application of social risk adjustment for payment (e.g., through a regression versus an adjustment to a benchmark).
- Consistency in methodologies for incorporating social risk factors into risk adjustment models.
- Defining disparities and reference groups.
- Standardization of imputation methods.
- Reviewing evidence for using Area Deprivation Index (ADI) versus Social Vulnerability Index (SVI)

Additional limitations to social risk adjustment include:

- Limited evidence, given the novel approach, to draw upon regarding the ability of social risk adjustment methodologies to accurately capture conditions for specific populations.
- Lack of national standards for data collection, which can result in differing views and understanding of how organizations look at their own data.

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[6] See e.g., ASPE report to Congress; National Quality Forum paper on risk adjustment models; State Access Health Access Data Assistance Center.

- For example, patients or beneficiaries describe their racial and intersecting ethnic identities in many ways, but the categories, subcategories, and stratification that an organization uses to collect information about those identities may differ from one entity to the next. These differences are a barrier to alignment, data sharing, and national benchmarking.

- Interoperability, inter-agency data sharing, and aggregation of standardized data related to health-related social needs (HRSNs) and social drivers of health (SDOH) needs to be improved to support aligned social risk adjustment, payment initiatives, care management, and performance monitoring.

- Limited engagement opportunities for commercial payers due to the diversity of commercial health plans and types of contracts within each plan that makes it difficult to negotiate and achieve scaled impact through risk adjustment. Unlike Medicare and Medicaid who have more concentrated market power, commercial plans often have to negotiate various aspects of APMs, making it difficult to find alignment between plans, providers, and employers.

While social risk adjustment has its limitations, it may be used to improve the broader health care delivery and payment system by:

- **Capturing and providing mechanisms to address social factors that affect a patient's health**: Non-clinical factors beyond an individual's medical conditions— e.g., income, food insecurity, lack of stable housing, transportation, health literacy, and personal safety—impact their health outcomes.

- **Allocating health care resources more equitably**: Populations with greater social risk factors face barriers to provider access, and providers serving these populations often do not have sufficient resources (both upfront and ongoing) to care for historically under-resourced populations with clinical and social risk factors.

- **Facilitating increased APM participation by safety net providers:** Underrepresentation of historically underserved groups and providers serving these groups in APMs decreases access to culturally and linguistically appropriate care (Hughes 2022). Historic underinvestment in social infrastructure and SDOH leads to potentially harmful consequences of existing APM requirements such as providers facing financial penalties for increased utilization because they serve populations with high levels of social risk factors. Thus, performance metrics that account for social risk factors could reduce the prospect of financial penalties and facilitate increased APM participation.

- **Advancing a strong ecosystem that supports care transformation:** Without an integrated and comprehensive health care system— a network of resources that work together to support the success of stakeholders who treat underserved populations (i.e., a provider network designed to achieve equity, organizational infrastructure for collecting and sharing data on HRSNs, engaged community-based organizations (CBOs), an available and qualified workforce)—and an effective approach to learning and diffusion, it is likely that payments resulting from social risk adjustment may not be effective. For example, providers and plans adjusting payment for social risk must still sometimes contend with limitations on how funds can be used to support patients and members. A strong ecosystem can help to bridge gaps and support patients and members beyond the limitations of health care funding.

Although social risk adjustment alone will not reduce health inequities and disparities, it can contribute to the advancement of health equity when supplemented with complementary actions on data collection, payment incentives, and care transformation. This could include complementary regulation

and policies that ensure payments that are enhanced due to risk adjustment are used to support the full range of activities that will enable effective care. It is also important to be mindful of the other components that must fit together to form an effective integrated and comprehensive health care system—one that functions as a network of resources that work together to support the success of practices or providers who treat underserved populations. Some of those resources include:

- Technical assistance groups
- Multi-stakeholder learning & diffusion collaboratives
- Health information exchange (HIE) platforms
- Social supports such as transportation services, food banks, and local non-profits focused on housing

An integrated and comprehensive health care system also provides leadership, funding, infrastructure, and sustainability to communities working towards reductions in health disparities.

The HEAT's Point of View on Social Risk Adjustment

Social risk adjustment that is effectively applied or incorporated into the payment incentives and structures of APMs should enable more providers—especially those that provide care to communities that have persistently been underserved by the health care system—to participate in APMs by increasing their financial potential to serve high need populations and reducing the risk of inappropriate penalty attributable to caring for those populations. Payments that result from social risk adjustment can be used to address historic underinvestment in health care needs of underserved populations and should be appropriately allocated to enable care transformation that reduces inequities and ensures quality, accessible, and efficient care for patients. Social risk adjustment can be enhanced with appropriate supplemental policies that address root causes of health disparities and promote population health and longer-term reductions in cost of care. Supplemental policies also can help to ensure social risk adjustment does not result in unintended negative consequences.

The HEAT believes effective social risk adjustment should:

- Increase the availability of payments for providers caring for historically underserved populations
- Increase APM participation by providers in communities with high rates of health disparities
- Increase investment in capabilities that are needed to deliver well-coordinated medical and social support services
- Support aligned payment, care management, and performance monitoring in APMs that are reflective of community need
- Incentivize care transformation that supports long-term health and reduces the cost of care
- Be complemented with other policy and regulatory mechanisms to advance health equity

Collection and use of actionable data, effective payment mechanisms, and evidence-based care transformation initiatives that address patient and provider needs are core elements of effective social risk adjustment. These components, in addition to complementary policies and regulatory mechanisms, facilitate successful implementation of social risk adjustment that advances health equity.

Having the right data and appropriate payment structures tied to the social needs of populations enables care transformation that leads to more equitable care. Consequently, this guidance document discusses the integration of social factors into APM risk adjustment methodologies with the goal of increasing the number of providers (especially safety net providers) that receive adequate resources to successfully participate in APMs. This guidance outlines how data collection, payment incentives, and care transformation work together to facilitate effective social risk adjustment and identify priorities for action for each core element. The guidance does not focus on technical aspects of social risk adjustment (e.g., designing the algorithm) or adjusting quality benchmarks, recognizing that additional research is needed to establish empirical evidence of variables and approaches to social risk adjustment that effectively advance health equity and prevent adverse outcomes.

Guidance for Social Risk Adjustment for Payment

To provide stakeholders with a starting point for action, this section provides essential and enhanced guidance on the three core components of social risk adjustment—data collection and tools, payment incentives and mechanisms, and care transformation. The section also details priorities for multi-stakeholder alignment and recommended actions for specific stakeholders.

This guidance is intended to support flexible approaches to using social risk adjustment to advance health equity, taking into account opportunities for improvement and existing practical implementation challenges. Included alongside the guidance are illustrative examples of how stakeholders can incorporate these approaches into new or existing APMs and risk adjustment methodologies.

Key Stakeholders:

Payers: public and private insurers that negotiate or set rates for provider services, collect revenue through premium payments or tax dollars, process provider claims for service, and pay provider claims using collected premium or tax revenues

Purchasers: public and private entities (i.e.: employers) that pay premiums for a health insurance policy or make direct payments to providers for care services rendered

Providers: clinicians, provider organizations, and public/private health systems that operationalize and deliver health care services to patients and, in many cases, negotiate payment rates and payment models with payers

Community-based organizations: organizations that represent a community or significant segments of a community and provide health or related services to individuals in the community

Regulators: federal and state health and human services agencies

Individuals: members of the population being served by providers, payers, and CBOs

1. Data Collection and Tools for Risk Adjustment and Alternative Payment Model Design

Traditional risk adjustment does not account for social factors that influence patients' health outcomes, as it includes clinical and demographic data but does not include information on social drivers of health, which are significantly predictive of health care costs and outcomes. Moreover, this data is frequently incorporated at an individual level or at a full population level, which does not account for meaningful community variation. For example, individual-level data is often only captured when patients are present for clinical visits and may not contain meaningful information on patients who have historically experienced challenges in accessing care or diagnoses. While detailed information about a person's social risks may be captured in the clinical record, that information is unlikely to be consistently reflected in diagnosis codes captured for risk adjustment. Therefore, the incompleteness and variability of clinical data hinders the accuracy of traditional risk adjustment methodologies in representing the full social and clinical risk profile of a patient or population. Ultimately, traditional risk adjustment, based on diagnosis codes and demographic data, does not account for social factors that influence patients' health outcomes.

Incorporating social risk factors into risk adjustment methodologies generates a more complete social and clinical risk profile of a patient or population. Quality data on clinical and social risk factor data is important for determining benchmarks, articulating outcomes, and measuring the impact of implemented risk adjustment methodologies. Some approaches to social risk adjustment leverage data on food, transportation, and housing insecurity to achieve this level of insight but additional research is needed to build the evidence base around which social factors are relevant and data sources that engender feasible data collection. Individual-level data and publicly available community and population data can create a solid foundation for assessing the social risk factors of a patient population when it is collected in a timely, complete, and accurate way. Unfortunately, while individual data is highly desirable for accurate risk adjustment, it is rarely reliable and complete. It is also important to note that while technology has increased the availability of social needs data, consent and using the data in a way that complies with the latest ethical guidance is necessary.

Supplementing more reliable individual data elements with appropriate community or population-level data can also be effective when developing as accurate a risk profile as possible. Building capacity for feasible data collection and diversifying the types of data (individual-level and community-specific data) used is important for developing effective benchmarking methodologies. The combination of individual, community, and population-level data can be incorporated into the algorithm or methodology for social risk adjustment. A glide path approach can be leveraged to shift from using commonly accepted population-level data to increased use of more predictive individual-level data over time (Figure 4).

Specific individual data points that may provide value in understanding patient social drivers of health include data on social risk factors; race, ethnicity, and language (REL); disability; and sexual orientation and gender identity (SOGI). These data elements could be collected via patient self-report at the point of care, surveys, claims data, and Z codes at the individual level and stratified by each factor. While the data can be supplemented at a community level by using data from publicly available sources such as the ADI and SVI, it is important to note that not all indices include direct measures of the racial and ethnic makeup of a community, nor do they stratify community conditions by other sociodemographic variables. Ideally, data collection should not be burdensome to collect for both providers and patients, and the intended use of the data should be clearly communicated to support reliable collection. An

evolving body of research can provide guidance on both preferred data collection mechanisms for various population groups (e.g., in-person, computer-based), as well as which data points may be most meaningful to predict specific costs and needs.

The guidance on improving data collection for risk adjustment is two-fold: 1) diversifying the use of readily available data in the short term and 2) incorporating self-reported individual-level data in the long term.

Essential APM Design Guidance

Collect and incorporate readily available and/or publicly available social needs, demographic, and population-level data into APMs to predict health-related risks/outcomes and appropriately adjust payments and benchmarks to support related social needs. The use of available data should be in line with evolving expert guidance on ethical use of data to advance equity. Examples of essential data include:

- Demographics (e.g., date of birth, REL, SOGI, disability)
- Neighborhood level variables (e.g., ADI, SVI)
- Z codes that capture SDOH data

Examples of Essential Guidance on Data Collection and Tools:

- Examples from Massachusetts and Minnesota illustrate that there is a path to leverage existing data sources to incorporate socioeconomic data in a predictive way that is not overburdensome to providers.

  - **Massachusetts** uses administrative and claims data, including certain Z codes, prescription data, and extensive data from publicly available sources to adjust for social variables in its population. This method has proven to lessen the burden of data collection on providers and improves the SDOH risk adjustment methodology.

  - **Minnesota** uses several measures of social risk factors, all obtained from administrative and claims data, along with index data from publicly available sources to adjust for social variables in its population.

- CMS' Office of Minority Health and the RAND Corporation collaborated on an improved imputation algorithm—the Medicare Bayesian Improved Surname Geocoding (MBISG)— to improve the accuracy of identifying racial and ethnic minority groups when these data are missing.

In cases where individual-level data is not available, imputed data (a statistical method for inserting estimated values into missing data fields) can be used but has limitations. While imputed data can be leveraged in the short term, it can be imprecise and imputation methods may be more reliable for some groups than others (e.g., existing methods of race and ethnicity imputation are less accurate for American Indian and Alaska Native populations than other groups, which may make it more difficult to assess risk for a group that is already underrepresented in analysis) (Vickie M. Mays 2022). As a result, while imputed data may be helpful for adjusting upfront payments to account for social disadvantage, it

should be used carefully when precise data is needed (e.g., to determine final benchmarks used to perform reconciliations of APMs or to adjudicate pay-for-performance payments).

Plans using imputed data should collaborate with providers to advance the use of individualized social risk data by implementing patient engagement efforts such as multilingual regional surveys, listening sessions, community advisory committees, and regional coordination (e.g., roundtables with key stakeholders such as public health agencies) to supplement and improve the accuracy of available data. Data collection and data sharing can also be supported by investments in standardized HIE platforms, with a growing number of HIEs that are integrating the use of community information exchange (care coordination tools that facilitate data collection and exchange between the health and social services sector) and social needs platforms, along with data governance standards. With appropriate consent, these HIEs can improve access to social needs data including assessments, referrals, and coordination between health care providers and CBOs offering support services. While these investments in data access and accuracy may be costly, they help to make social risk adjustment possible and have benefits for designing and implementing APMs at large.

Whether using imputed data or self-reported data, it is essential to prioritize the collection of social factors that drive cost or worsen outcomes when those factors are not addressed.

Enhanced APM Design Guidance:

Essential guidance, plus:

- **Improve data for social risk adjustment by collecting and reporting data on individuals' social risk factors and/or additional demographic factors.** Examples include:
  - Individual HRSN assessments to screen for factors that may influence a person's ability to seek or consume care and improve health (e.g., transportation, food, housing). The assessments inform treatment plans and referrals to community services.
  - Individual Social Proxy (e.g., dual eligible status collected from insurance intake forms).
- **Implement a glidepath approach to data collection to work toward the ideal state of self-reported individual-level data.** The data collection glidepath approach should be dynamic and allow stakeholders to move between imputed, population-level data collection in the immediate term and implementation of enhanced data collection practices over time (see example below)[7].

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[7] ADI and SVI are listed as imputed data because they are estimated characteristics of an **individual** living in a given geographic area
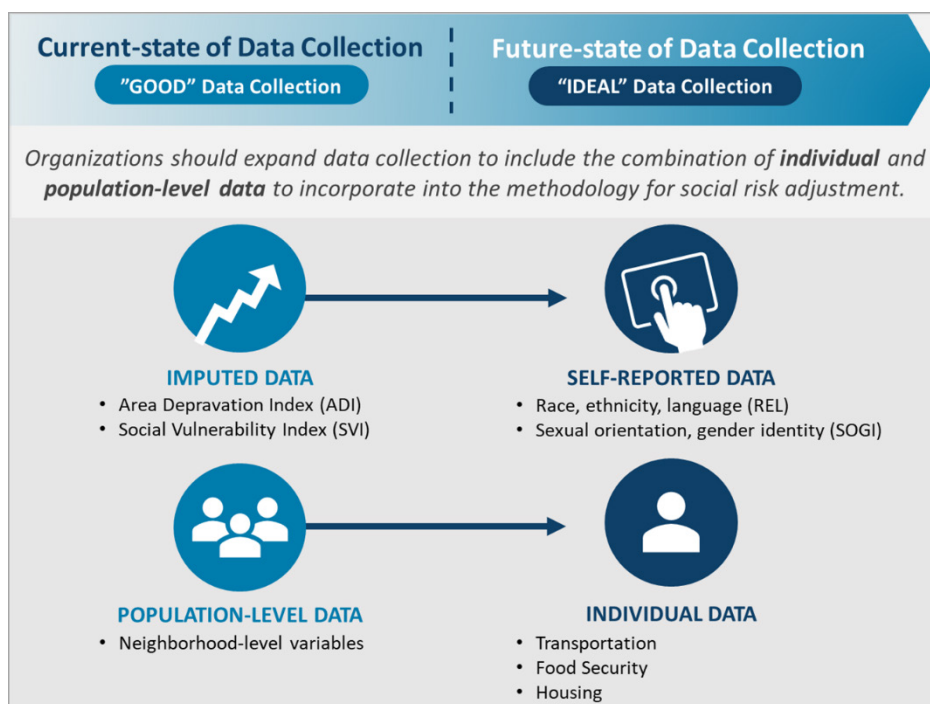
Figure 4: Glidepath for Data Collection of Social Risk Factors

Bias, especially how data bias may contribute to or perpetuate existing disparities, should also be considered. For instance, data bias can stem from lack of representation in the data being collected. Creating a dynamic glidepath for data collection allows stakeholders to prioritize understanding the needs of their patient populations and delivering appropriate care. Employing research methods that are compatible with small racially or ethnically diverse groups, including oversampling and the use of multi-year pooled data is important. There will always be more and better data to collect; thus, data collection processes should be reviewed and improved at least triennially.

Examples of Enhanced Guidance on Data Collection and Tools:

- **Denver Health:** Denver Health recognized the need to improve its collection of self-reported data and focused on improving its collection of select reported REL data. By focusing on REL data, Denver Health improved its collection rate from 70% to 98%. Denver Health continues to improve data collection and look for other ways to collect additional data without increasing burden on providers and patients.

- **Oregon:** The Oregon Health Authority (OHA) piloted using QR codes at point of care to collect self-reported Race, Ethnicity, Language & Disability data from beneficiaries.

- **Oklahoma**: Oklahoma's Route 66 Coalition received a $4.5M grant from CMS to create an Accountable Health Community (AHC) where social issues and needs, and not just medical needs, are addressed to improve health. Led by Oklahoma's non-profit HIE network, MyHealth Access Network, the Route 66 Coalition also includes the Oklahoma City County and Tulsa Health Departments and more than 200 other health care and social service organizations in Oklahoma.

  To accomplish their goals, MyHealth Access set up the ability to have patients complete a social needs assessment as part of a routine encounter (e.g., with their primary care provider). As the patient registers, a text is sent to their phone, or they are handed a device with the text link. The patient gives consent and completes the social needs assessment, which is then scored, and the results made available. The social needs tool also provides information on local resources and CBOs that are responsive to the individual's needs. Large numbers of Oklahomans have completed the assessments and been referred for services.

- **Blue Cross Blue Shield of Massachusetts (BCBS-MA):** BCBS-MA recognizes that imputed data underestimate or overestimate the true magnitude of inequities in some cases, so it is working to collect self-reported race and ethnicity data from members, directly through its member portal and mailed surveys, as part of the effort to incorporate equity measures into its contracts and payment programs with clinicians.

2. Payment Incentives and Mechanisms

Payment incentives and mechanisms that incorporate social factor data for the purposes of risk adjustment can address existing gaps in funding by tightening the connection between the need and acuity of a population or an individual and the financial opportunities available to the providers caring for them. Payment models that adjust for social risk can better address health disparities than traditional fee-for-service arrangement by better matching the distribution of payment to the needs of specific populations. This can happen in two ways:

- First, in some cases, the incorporation of social factor or SDOH risk adjustment into payment methodologies can increase payments made to providers that serve high-risk populations by capturing non-clinical risk factors in a manner that is complementary to clinical risk adjustment. It is important to note that incorporating social factor data into risk adjustment may not always lead to increased payments and additional research is needed to understand which variables are effective risk adjusters and the tradeoffs between the benefits and costs of adding new variables.
- Second, social risk data can be used to identify investment opportunities by using the process of calculating social risk scores to identify patients with high-risk profiles and inform opportunities to support providers in providing expanded services as part of APMs.

Social risk adjustment is a tool for adjusting payments based on social risk factors. To this end, complementary payments or payments tied to social risk can take several forms such as:

- Upfront funding for capacity building (e.g., a grant or loan to support data capacity building or training on relevant screener tools).
- Payments on an ongoing basis through APMs to create flexibility or reimburse for expanded services (e.g., per member per month (PMPM) related to targets or benchmarks).
- Performance-based bonuses.

Figure 5: Glidepath for Payment Mechanisms that Advance Health Equity
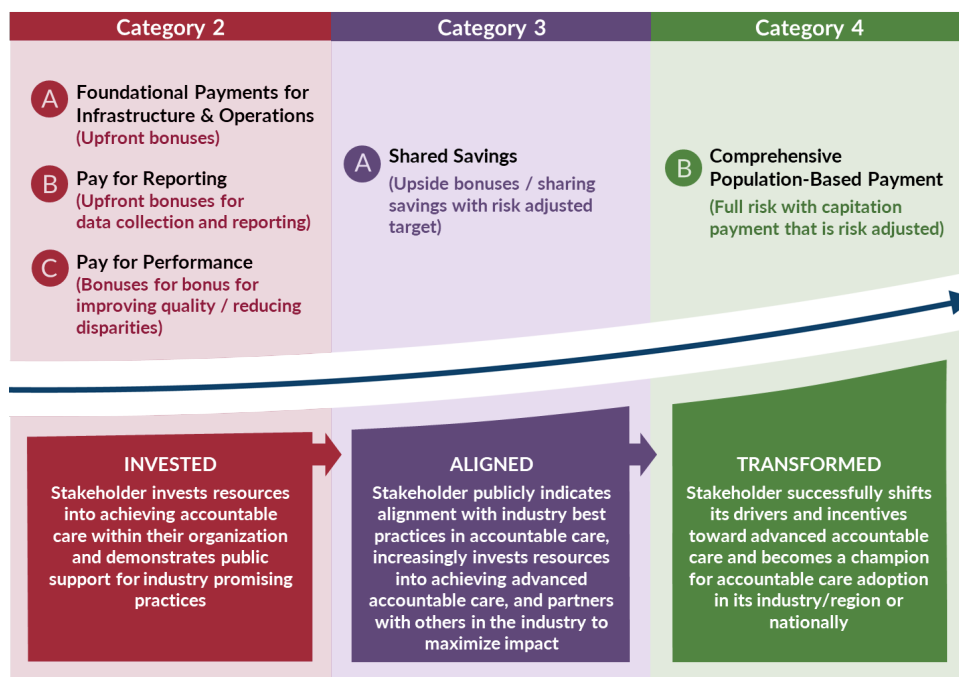
These mechanisms fall under various categories of the LAN's APM framework as indicated in Figure 5. Payment mechanisms that can be used to advance health equity include upfront payments, ongoing payments (e.g.: PMPM related to targets, benchmarks, capitation), and performance-based bonuses.

These mechanisms fall under various

categories of the LAN's APM framework as indicated by the subcategories illustrated in the figure. Organizations can implement different types of payment mechanisms depending on their level of maturity (from "informed" – "transformed" as defined by the Accountable Care Commitment Curve at the bottom of the figure) and existing capabilities. Organizations can also advance from payment mechanisms in Category 2 to Category 4 as they become more mature overtime.

Advancing health equity through social risk adjustment and complementary payment incentives will require:

- Adjusting existing payment models or structures to account for social factors
- Retargeting benchmarks and/or payments or providing additional payments to providers serving populations with high social vulnerability and/or complex needs to help address existing disparities and gaps in care

The following section provides guidance on payment incentives and mechanisms that account for social risk factors.

Essential APM Design Guidance:

- **Identify areas where it is feasible and appropriate to incorporate social risk adjustment into existing payment structures:** Choose a data-based method or formula for quantitatively capturing social risk and use social risk data to adjust benchmarks, targets, and payments in existing payment structures to better account for the acuity of historically under-resourced patients (Figure 6). APMs commonly include risk-adjusted targets/benchmarks (e.g., PMPM, [8] quality/pay-for-performance) or global payments/capitation. These payment structures could benefit from social risk adjustment given they want to ensure providers are compensated appropriately based on the underlying acuity of the populations they serve.

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[8] In this document, the terms *per member per month (PMPM)* and *per beneficiary per month (PBPM)* are used. These terms are the same, but we use *PMPM* generally and *PBPM* within the context of CMMI models.
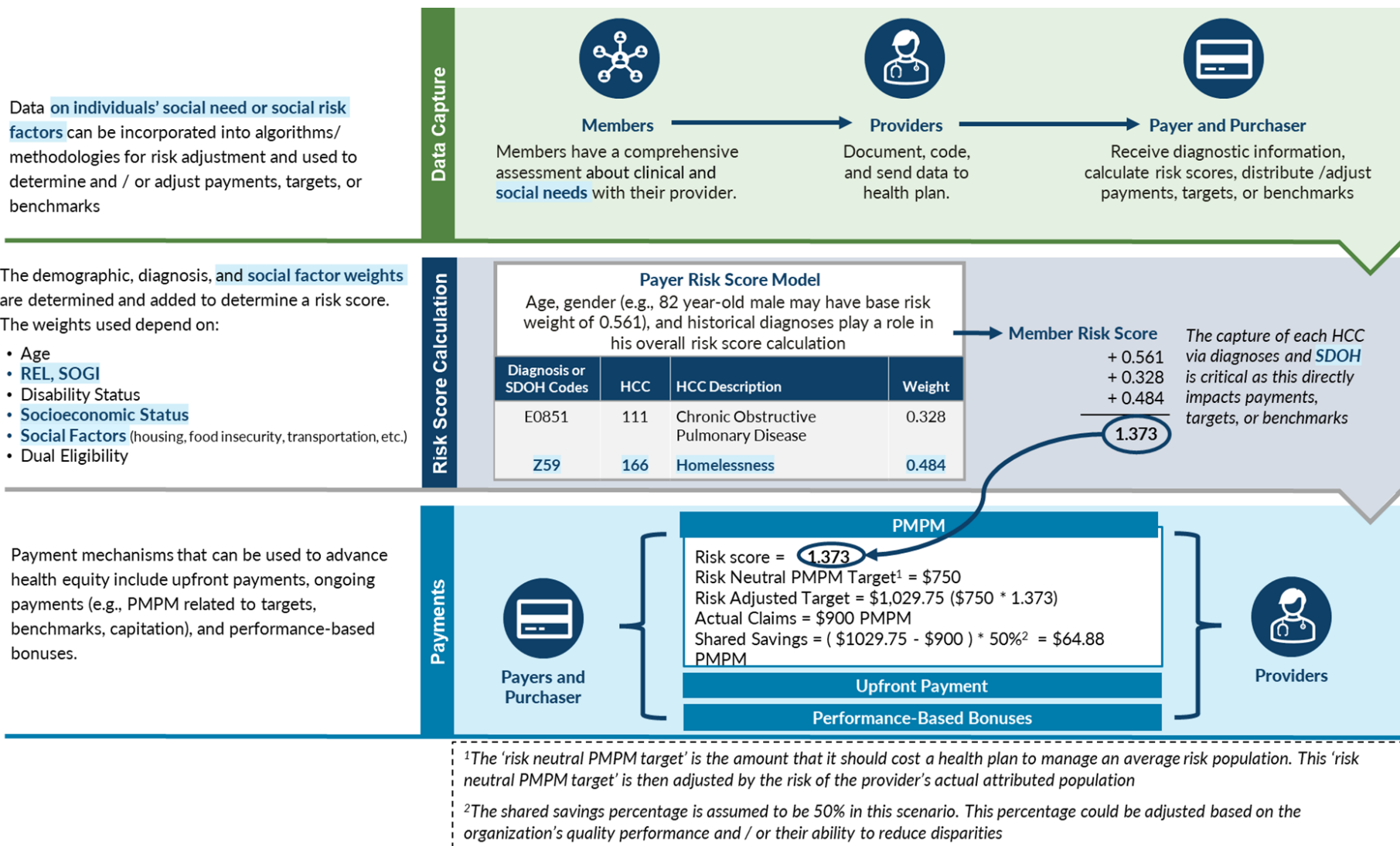
Data on individuals' social need or social risk factors can be incorporated into algorithms/methodologies for risk adjustment and used to determine and / or adjust payments, targets, or benchmarks

Data Capture

Members
Members have a comprehensive assessment about clinical and social needs with their provider.

Providers
Document, code, and send data to health plan.

Payer and Purchaser
Receive diagnostic information, calculate risk scores, distribute /adjust payments, targets, or benchmarks

The demographic, diagnosis, and social factor weights are determined and added to determine a risk score. The weights used depend on:

- Age
- REL, SOGI
- Disability Status
- Socioeconomic Status
- Social Factors (housing, food insecurity, transportation, etc.)
- Dual Eligibility

Risk Score Calculation

Payer Risk Score Model
Age, gender (e.g., 82 year-old male may have base risk weight of 0.561), and historical diagnoses play a role in his overall risk score calculation

Diagnosis or SDOH Codes	HCC	HCC Description	Weight
E0851	111	Chronic Obstructive Pulmonary Disease	0.328
Z59	166	Homelessness	0.484

Member Risk Score
+ 0.561
+ 0.328
+ 0.484
———
1.373

The capture of each HCC via diagnoses and SDOH is critical as this directly impacts payments, targets, or benchmarks

Payment mechanisms that can be used to advance health equity include upfront payments, ongoing payments (e.g., PMPM related to targets, benchmarks, capitation), and performance-based bonuses.

Payments

Payers and Purchaser

PMPM
Risk score = 1.373
Risk Neutral PMPM Target[1] = $750
Risk Adjusted Target = $1,029.75 ($750 * 1.373)
Actual Claims = $900 PMPM
Shared Savings = ($1029.75 - $900) * 50%[2] = $64.88 PMPM

Upfront Payment
Performance-Based Bonuses

Providers

[1]The 'risk neutral PMPM target' is the amount that it should cost a health plan to manage an average risk population. This 'risk neutral PMPM target' is then adjusted by the risk of the provider's actual attributed population

[2]The shared savings percentage is assumed to be 50% in this scenario. This percentage could be adjusted based on the organization's quality performance and / or their ability to reduce disparities

Figure 6: Incorporating Social Risk Factors into Payment Methodologies

Example of Essential Guidance on Payment Incentives and Mechanisms:

- **Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH):** The benchmark adjustment in CMS' ACO REACH model uses the Area Deprivation Index (ADI) to classify the level of social deprivation in geographic areas and then applies flat, per-beneficiary-per-month adjustments for individuals residing in the highest and lowest deprivation areas. This approach represents an effort to mitigate disincentives for providers to participate in ACO REACH and care for historically underserved populations.

  The model includes requirements for intentional planning on how participants will improve health equity, collection of data on individual-level social determinants, and use of financial incentives directly tied to equity.

Enhanced APM Design Guidance:

- **Supplement social risk adjustment by providing upfront or ongoing payments for care transformation efforts that address patients' social needs to providers or plans whose patient population has a high social risk score**. Payments should prioritize capital investment and care transformation funds to providers and provider organizations, especially safety net and federally qualified health center (FQHC) providers, to address existing inequities among patients and historical underinvestment. Payments should provide enough capital to enable safety net providers and FQHCs to make the capital investments needed to move from fee-for-service (FFS) to APMs (see LAN APM Framework category 2A), thereby moving providers into accountable payment frameworks or models. Upfront payments should be linked to accountability measures which can take the form of:
  - A required shift from FFS to APMs
  - Technical assistance that helps providers identify and/or prioritize steps to value-based payments that address social needs and reduce disparities as an integral part of APMs
  - Disbursement that is tied to a health equity plan that is discussed in the Care Transformation Guidance

  Upfront payments should also be based on long-term return on investment (ROI) of implemented health solutions. Evaluating ROI should move beyond a sole or traditional focus on saving money, and equally account for improved beneficiary experience, more equitable access to health care resources, reduced disparities, and improved health outcomes of those who need it the most.

  Predictable and ongoing regular payments can also result in more equitable care delivery, helping providers have confidence to invest in workforce, data infrastructure, and other essential ingredients for a health care ecosystem that serves populations with complex medical and social needs. Upfront or ongoing payments can lead to cost savings in the long-term by reducing emergency department (ED) visits and hospital admissions that are avoidable with better upstream medical and social support services, increasing the likelihood that care will be delivered at the most appropriate site of service with broadly improved health outcomes.

Furthermore, since these providers may be taking on downside risk, it is appropriate that the risk bearing entity (e.g., a managed care organization) move an appropriate amount of capital reserves from their entity to the entity assuming the downside risk.

- **Provide performance-based payments tied to quality [9] and equity metrics. The payment should be adjusted using social risk adjustment methodologies as appropriate.**
  Unlike upfront payments, performance-based payments are tied to provider performance on measures that assess patient outcomes and disparities reduction. Some examples of such metrics include:
    - Quality measures stratified with variables such as race, ethnicity, SOGI, low-income subsidy, dual eligibility, neighborhood disadvantage and poverty status, and disability
    - Increased screening for recommended and preventive care for historically under-screened populations
    - Improving patient experience measures for underserved populations

Critics of social risk adjustment have expressed concerns that it creates an incentive for unnecessary clinical visits where the primary purpose of the visit is to collect social and clinical factors that provide additional payments to the provider. To protect against this type of activity, payments should be stratified by outcomes and disparity reductions for patients with social risk factors.

When targeted appropriately, payments with social risk adjustment have the potential to address existing health disparities and improve health outcomes. Social risk-adjusted payments can also reduce long-term spending due to savings from reduced ED visits, fewer admissions, improved access, and more appropriate site of service usage, among other factors. Payment approaches, such as upfront investment and PMPM, can contribute to addressing disparities by creating financial flexibility for valuable capacity building, staffing, and practice transformation activities such as care coordination. Payments can also be made to fund specific social needs, such as food/nutrition issues, air quality remediation, and/or experiences of homelessness and home modifications.

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[9] There is considerable debate about using social risk factors to adjust quality measures. "Adjusting Quality Measures For Social Risk Factors Can Promote Equity In Health Care" provides additional context on questions that must be addressed to determine whether social risk adjustment is appropriate for a given quality measure.

3. Care Transformation

To enhance health equity through care delivery, providers could reinvest a portion of payments received from APMs to enhance their ability to address patients' social needs and health disparities. Social risk adjustments are intended to result in payments that can support these efforts, and well-designed APMs can give providers flexibility in how investments are made so that programs can be tailored to the needs of their patient populations while still requiring these investments to be meaningful.

Quality data is needed to identify high-risk populations and guide the design, implementation, monitoring, and evaluation of tailored and responsive care transformation initiatives. Other principles to guide care transformation in an APM include 1) care transformation efforts and incentives should be examined for unintended consequences with regards to equity and 2) any changes that may incentivize behavior that increases disparities (e.g., selective inclusion of patients in specific models, reducing flexibility that accounts for patient preferences and needs) should be amended or safeguarded so that APMs do not burden, negatively impact, or perpetuate inequities for patients. APMs should also support organizations to continuously improve and build their capacity to evaluate progress addressing social needs and reducing disparities, using performance measurement to support care transformation goals.

Essential APM Design Guidance:

- **Develop a health equity plan collaboratively with community partners, payers, and providers to inform effective allocation of upfront payments to care transformation efforts.** The equity plan should be monitored by key stakeholders with regular frequency and should:
  a. Identify high-risk or high-priority populations
  b. Specify existing disparities and needs within the population
  c. Detail expected ROI and how additional payments will be used to implement interventions that address and/or reduce identified disparities and needs (e.g., Oregon Medicaid provisions)
  d. Be person-focused and clear about how care transformation will address both medical and social needs
  e. Consider other relevant influences such as exploring upstream approaches to improve health (i.e., how to address SDOH), considering place-based community needs
  f. Be data-driven and establish clear, measurable goals and targets and associated mechanisms to drive change
  g. Encompass advocacy to address unmet social needs (housing, transportation, food security, etc.)

  This framework affords each organization the flexibility to create a tailored equity plan that advances equitable outcomes for the population being served as the interventions are designed by those who know their population best. As an example, organizations could reference the CMS Disparities Impact Statement.

- **Ensure payments adjusted for social factors (e.g., bonuses, incentives, capitated payments) are allocated to initiatives within the provider organization that address health disparities among its patient population.** (i.e., funds flow).

Examples of Essential Guidance on Care Transformation:

- In its new Medicaid contracts, Oregon includes SDOH and health equity-related provisions via Section 1115 waivers. The state encourages Medicaid plans to invest in SDOH initiatives with current-year global budget dollars and past-year revenues.

- The AIM Model provides upfront payments to providers for the purposes of targeted investments in infrastructure and staffing.

Enhanced APM Design Guidance

- **Develop reporting and accountability measures that address disparities within the identified populations.** Examples include:
  - Percentage of the population with unmet addressable social needs (housing, transportation, food security, etc.) stratified by demographic variables.
  - Proportion of the population with adequate access to and utilization of critical preventive care services in areas where the population has been historically underserved.

- **Use outcomes measures to report on impact of care transformation over time.** Payers can support the success of this monitoring through alignment on standardized measure definitions and standardized reporting on reduction of disparities.

- **Create a local governance structure to assess place-based community needs including social factors and engage with local partners to make decisions about how to meet those needs.** Payers, providers, CBOs, public health departments, and advocacy groups can participate in social care network collaboratives that help APM participants understand how to effectively use their investments to address social needs and reduce disparities.

- **Activate technical assistance and learning and diffusion resources to solidify processes and outcomes that lead to reduction in disparity.** This further supports and embeds the health equity plan in the local integrated care system. Technical assistance and learning and diffusion resources must also be activated to help solidify the processes and outcomes that reduce disparity (e.g., Idaho's social needs platform integrated with the HIE and supported by a statewide shared learning collaborative).

- **Promote an integrated and comprehensive health care system.** Improving health outcomes and reducing health disparities will not be solved by social risk adjustment alone. Stakeholders should monitor the broader ecosystem of resources that work together to improve outcomes for traditionally underserved populations. Some of the components of this ecosystem could include specific government policy actions (at both national and local levels) and non-profits and other community-based non-profits focused on topics such as housing and food security. A health equity plan should be cognizant of and reflect the broader ecosystem given unique local conditions and include a plan for monitoring progress on how the ecosystem progresses and improves services to address social needs.

Examples of Enhanced Guidance on Care Transformation:

- **Minnesota**: The Minnesota Integrated Health Partnership (IHP) model has evolved since its start in 2013. Launched in 2018, the IHP 2.0 model contained enhancements that allows the Department of Health Services to continue contracting with innovative health care delivery systems to provide high-quality, efficient care to Minnesota's Medicaid population. The 2.0 model includes a Track 1 and Track 2 option. Track 1 is a non-risk bearing contract intended for smaller organizations. Track 2 involves shared risk where participating providers enter into a risk arrangement with the department by which they are held financially accountable for the costs and quality of care their Medicaid patients receive. Providers showing an overall savings across their population while maintaining or improving the quality of care receive a portion of the savings. Providers who cost more over time may be required to pay back a portion of the losses.

  Additionally, participants in Track 1 and Track 2 receive a population-based payment for care coordination and are required to design an intervention to address specific health care disparities observed in the IHP's population. This equity intervention is an opportunity for IHPs to innovate and advance efforts such as community partnerships, screening, referral, and care coordination for social needs.

- **Idaho**: Idaho's Health Data Exchange (IHDE) partnered with Findhelp, a social needs assessment platform, to provide a safe, secure, and effective platform for IHDE users to connect patients with social services. The platform serves as an extension to care teams, providing connections to over 2,800 community programs in Idaho. Findhelp can be easily accessed by providers through a single sign-on through the IHDE portal, and by patients through a mobile application with built-in consent. The program facilitates referrals; tracks compliance, outcomes, and patient goals; and helps deliver complete SDOH data for outcome-based analytic reporting.

  In addition to health services, resources and community programs available through the platform include food, housing, transit, goods/supplies, emergency services, money, care, education, work, and legal services.

Priorities for Multi-Payer and Multi-Stakeholder Alignment and Stakeholder-Specific Action

Multi-payer alignment on data collection and tools, meaningful quality metrics, effective payment mechanisms (payment structures tied to social need), and care transformation strategies is essential for increasing APM participation opportunities for providers, reducing burden on providers and patients, and promoting care transformation that advances equitable health access and outcomes for patients. Alignment on health equity goals and a health equity performance measure set, stratified by race, ethnicity, language, and other characteristics also strengthens alignment on social risk adjustment over time—particularly on techniques for addressing negative correlations between social risk factors and increased payments.

Beyond payers, multi-stakeholder alignment and collective action at the local level is important to advance health equity and reduce health disparities. Power differentials among key community stakeholders— payers, purchasers, providers, regulators, community-based organizations, individuals and their families— related to payment and infrastructure can act as barriers for alignment. This unequal distribution of power presents a tension between the aspirational goal of effective multi-stakeholder alignment and the current reality of fragmented efforts to advance health equity. Intentional efforts to include a diverse group of stakeholders in decision-making processes is necessary for developing and implementing comprehensive and coordinated efforts on establishing a shared agenda, identifying root causes, and building solutions that strengthen primary care, specialty care, and the overall health system.

Stakeholder alignment strategies should employ bidirectional goal setting to foster true engagement and collaboration among stakeholders. Alignment strategies should also be flexible, reflected in a health equity plan, and allow for stakeholders to use their own levers to solve community capacity constraints and address health equity. Such flexible alignment strategies increase the likelihood that investments available through social risk adjustment are used effectively to reduce health disparities.

Multi-Stakeholder Alignment and Stakeholder-Specific Actions on Data

Data limitations and data collection burden may constrain effective social risk adjustment efforts. The essential and enhanced guidance on data collection calls for effectively incorporating readily available social needs data into APMs in the short term and gradually following a glide path for leveraging self-reported individual-level data as capacity to do so is developed over time. Thus, multi-stakeholder alignment on data should prioritize:

- Standardizing the process for imputing data to reduce bias and heterogeneity in the short term.
- Ensuring consistent collection of standardized core social needs data set across providers and payers that supports alignment. Collected data should include granular community-specific and relevant data that provides meaningful insights at both the community or disaggregated level and population level when aggregated. Data that can be aggregated and disaggregated is important for developing intentional initiatives that eliminate disparities in health outcomes.
  - One method in standardizing data collection processes is to leverage existing policy (e.g., the CMS interoperability rule and HRSA's Uniform Data System reporting standards for FQHCs) to build and foster a consistent data set across payers, settings of care, and geographic areas. Stakeholders can also align on a set of tools for data collection to enable streamlined data sharing.

- Enacting data governance standards at the organizational and community level to ensure consistency in data collection and how that data gets used.

- Developing consistent communication or messaging about the value of collecting and reporting data. This is important for ensuring transparency and building trust with individuals, families, and their communities.

- Creating incentives like pay-for-reporting and contract bonuses to promote data collection and consistency.

- Identifying data and insight sharing opportunities that may inform future best practices and mechanisms to support success for shared APM participants.

The tables below include recommended actions to advance alignment priorities for data in the short, medium, and long term, including considerations for stakeholders that should be engaged in each action (indicated by "✓"). Each collaborative should account for local context when defining roles and developing alignment strategies.

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Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Data**

Short-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Establish a baseline for the percentage of self-reported data collection and reporting, and create a plan with year-over-year targets for ways to improve patient self-reported data collection of individual HRSNs data at the point of care		✓	✓	✓	✓	
Educate or build understanding of the importance of collecting data, how the data will be used, and how the data is protected	✓	✓	✓			
Develop a data governance framework to standardize data collection and foster a consistent data set across payers, providers, settings, and geographic areas		✓	✓	✓	✓	✓
Engage community stakeholders (individuals/families/communities/local public health departments) in data collection efforts	✓	✓	✓	✓	✓	✓
Share needs and preferences with plan and policy decision makers	✓					
Share race, ethnicity, language, and cultural preferences with health and social service practitioners		✓	✓	✓	✓	✓
Develop and disseminate data collection and governance standards and best practices			✓			✓

Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Data**

Medium-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Train coders and staff on collection of universal identifiers (e.g., Z codes) Identify and establish relationships with community partners and non-clinical service provision that could improve patient health outcomes		✓	✓			
Fund infrastructure development that strengthens provider and community capacity to coordinate services and collect data (e.g., creation of a community information exchange)			✓			✓
Accurately report relevant data to providers and payers to support implementation	✓					
Fund infrastructure development that strengthens provider and community capacity to coordinate services and collect and share data (e.g., creation of a community information exchange or HIE)			✓			✓
Adopt and use universal screening metrics (e.g., demographics, SDOH data)	✓	✓	✓	✓	✓	✓
Fund and guide research into impactful social need drivers of cost of care, care outcomes, and barriers to access as well as meaningful interventions			✓			✓
Develop a consistent and transparent social risk adjustment method that can be used by various stakeholders			✓			✓

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Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Data**

Long-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Identify and implement mechanisms to better identify, serve and manage the care of patients who have historically underutilized clinical services		✓				
Adjust quality incentives to providers to promote disparity reduction and provision of culturally competent care			✓	✓		✓
Increase benefits for non-clinical services for patients with health-related social needs			✓	✓		
Fund and guide research into impactful social need drivers of cost of care, care outcomes, and barriers to access as well as meaningful interventions			✓			✓
Develop a consistent social risk adjustment method that can be used by various stakeholders			✓			✓

Multi-Stakeholder Alignment and Stakeholder-Specific Actions on Payment

Fragmentation and heterogeneity in the goals, processes, and components of existing payment models present an opportunity to align on payment mechanisms that leverage social risk adjustment to advance more affordable and higher quality care. The essential and enhanced guidance on payment incentives and mechanisms calls for incorporating social risk adjustment into existing payment structures and supplementing social risk adjustment with upfront or ongoing payments for care transformation efforts that address health disparities. Therefore, multi-stakeholder alignment on payment should prioritize:

- Developing a shared approach for using social risk factor data to determine and adjust payment. This could entail alignment on methodologies for incorporating demographic, social risk factors, population-level data and/or individual-level measures of need into payment models to capture health-related social needs.

- Sharing information, insights and lessons learned from implemented models and methodologies—specifically, their impact on provider and patient behavior and outcomes. CMS' efforts to evaluate existing models and align key aspects of value-based arrangements is an example of current endeavors on this priority.

The tables below include recommended actions to advance alignment priorities for payment in the short, medium, and long term, including considerations for stakeholders that should be engaged in the action (indicated by "✓"). Each collaborative should account for local context when defining roles and developing alignment strategies.

Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Payment**						
Short-term	**Individuals and Families**	**Providers**	**Payers**	**Purchasers**	**Community-Based Organizations**	**Regulators or Regulatory Agencies**
Enroll in APMs with social risk adjustments and propose meaningful equity impact plans with accountability measures to track progress		✓				
Develop APMs using social risk adjustment methodologies and associated supportive payments			✓	✓		
Establish or engage in beneficiary or consumer councils to actively solicit or provide input and feedback on model design	✓	✓	✓	✓	✓	✓
Test and disseminate results from APMs and social risk adjustment pilots			✓			✓

$ Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Payment**

Medium-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Collaborate with payers, providers, and purchasers to develop payment mechanisms that support meaningful change and are not burdensome		✓	✓	✓		
Support participating providers and patient/ family/ caregiver/ community stakeholders in implementing changes aligning with payment incentives (this could entail providing technical assistance, additional payments to support staff, etc.)		✓	✓			
Grant waivers, as appropriate, to promote innovation in payment and service provision						✓

$ Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Payment**

Long-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Assess impact of funding changes and associated changes in care on patient population, share data when appropriate, and identify areas for ongoing improvement		✓				
Publish or otherwise share results, best practices, and limitations of approaches used in achieving goals			✓	✓		
Fund and guide research into best practices and impacts of interventions on health equity						✓

Multi-Stakeholder Alignment and Stakeholder-Specific Actions on Care Transformation

Payments from social risk-adjusted APMs can be reinvested into care transformation efforts that work to reduce health disparities. The essential and enhanced guidance on care transformation calls for collaboratively developing a multi-stakeholder health equity plan with reporting and accountability measures that address disparities and report on impact of care transformation efforts over time. Thus, multi-stakeholder alignment on care transformation should prioritize:

- Developing a shared definition of accountability between providers, payers, regulators, and communities and standardized reporting on reduction of disparities (how performance measures are stratified and metrics for implementation of care transformation).

- Establishing a learning & diffusion platform to share results from various equity-focused initiatives, which could help to inform care transformation areas for future investments and promote further alignment across stakeholders.

The table below provides recommended actions to advance alignment priorities for care transformation in the short, medium, and long term, including considerations for stakeholders that should be engaged in the action (indicated by "✓"). Each collaborative should account for local context when defining roles and developing alignment strategies.

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Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Care Transformation**

Short-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Self-assess to understand current capabilities, the needs of the patient population, and identify health priorities for advancing health equity	✓	✓	✓	✓	✓	✓
Prioritize areas where additional training, capacity building, or community connections may improve outcomes		✓			✓	
Engage providers and CBOs about what resources are available to them and how to improve access to additional resources that address social determinants of health			✓	✓		
Provide providers and patients with educational materials and resources that support desired care transformations			✓	✓		
Provide input on needs, goals, and barriers to optimal outcomes via public comment and other mechanisms on proposed changes	✓					
Develop advocacy or awareness campaigns to improve trust among providers and individuals who have been historically underserved and ultimately, improve patient access to quality care					✓	
Develop quality measurement and equity measurement standards to assess progress						✓
Ensure rulemaking promotes improvements in data sharing and the interoperability of health information						✓
Develop standards related to care provision and care quality			✓			✓
Fund and disseminate research into impactful efforts on care transformation						✓

Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Care Transformation**

Medium-term	Individuals and Families	Providers	Payers	Purchasers	Community-Based Organizations	Regulators or Regulatory Agencies
Implement and test solutions to identify patient needs and assess progress		✓			✓	
Participate in cross collaborative QI initiatives to strengthen leverage APM and other resources to understanding of evidence-based approaches to mitigating e common challenges (i.e.: evidence-based interventions that lower HSRNs and improve health equity)	✓	✓			✓	
Adopt metrics and processes that consider equity, disparities, and provider and patient burden in all care transformation initiatives			✓	✓		✓
Collaborate with Community-Based Organizations (CBOs) to establish referral pathways for social services, appropriate sharing of care plans, and to develop a health equity plan focused on achieving reductions in health disparities		✓	✓			
Establish forums to collect and provide feedback from the community on new initiatives (e.g., focus groups, survey data, community outreach)	✓	✓	✓	✓		
Collaborate with patients and providers to establish initiatives that are responsive to patient preferences and strengthen the provision of social care		✓	✓			
Develop and strengthen relationships with providers to inform and improve service provision	✓				✓	
Test and disseminate results from APMs and social risk adjustment pilots						✓

Stakeholder-Specific Actions for Multi-Stakeholder Alignment on **Care Transformation**						
Long-term	**Individuals and Families**	**Providers**	**Payers**	**Purchasers**	**Community-Based Organizations**	**Regulators or Regulatory Agencies**
Set continuous quality improvement goals and targets, adjusting benchmarks as needed, to assess progress towards equitable			✓	✓		
Offer technical assistance to organizations interested in promoting health equity			✓	✓		
Develop evidence-based APMs whose mechanisms for change promote equitable care outcomes			✓	✓		
Fund and disseminate research into impactful						✓

Some of the most important factors for strong stakeholder alignment are market context (the credibility of stakeholders, the collaboration-competition balance, and market composition), a shared purpose, and trust. Highly aligned stakeholders typically have more extensive histories of collaboration, have established more credibility in the local community, and are more effective at balancing collaborative initiatives against competitive interests (Herald, et al. 2012).

To enable strong multi-stakeholder alignment, stakeholders should:

- Trust each other
- Have a shared purpose and express a shared interest in an issue or topic
- Designate a leader themselves or with the help of a trusted third party such as an HIE, formal convener, or CMS

Examples:

- The Gravity Project is a national public collaborative that develops consensus-based data standards to improve how information on SDOH is used and shared. The collaborative works to create standards for health and social care interoperability and use among multi-stakeholders.

- The Office of the National Coordinator for Health Information Technology established a SDOH Information Exchange Learning Forum that brings together health care providers, community-based organizations, government, payers, health information exchange networks, IT platform developers, innovators, and other partners to share lessons learned, promising practices, and challenges related to exchanging SDOH data.

- The Accelerate Health Equity initiative comprises a group of payers and other stakeholders in Philadelphia aligned around the issue of health equity data collection. They formed a steering group including health systems, payers, and community-based organizations that is led by payers and large health systems who are trusted community leaders.

- The Colorado Multi-Payer Collaborative was formed with a group of payers that is guided by a trusted third party, the Center for Evidence-Based Policy at Oregon Health & Science University. It was organized to address multiple transformation initiatives and is now focused specifically on the central issue of advanced primary care. The collaborative created the Framework for Integration of Whole-Person Care, an example of the shared vision for primary care that the payers have aligned around in Colorado.

- The Colorado Primary Care Payment Reform Collaborative is a state-based collaborative that is led by the Colorado Division of Insurance. The goal of the collaborative is to develop and share best practices to improve primary care delivery.

Conclusion

Social risk adjustment, along with other efforts to improve the health care delivery system, shows promise as a tool to help reduce health disparities across traditionally underserved populations. Transformation efforts that do not take a health equity lens risk perpetuating disparities among traditionally underserved populations. In APMs, risk adjustment methodologies are frequently used to adjust payments to providers based on clinical risk factors. Using clinical risk adjustment factors alone is not enough, because there is substantial empirical evidence that shows individual health outcomes are correlated to social factors. This clinical risk adjustment shortcoming can disincentivize certain providers from participating in APMs because they may be unfairly penalized when serving high-risk social populations. Without fair incentives to compel greater participation, this could further exacerbate health disparities by leaving these providers and patient populations behind from health care delivery transformation efforts.

This guidance is grounded in the perspective that social risk adjustment and APMs must benefit communities that have been historically marginalized and discriminated against and that providers should be rewarded for advancing health equity in ways that strengthen their financial resilience. The LAN recognizes that there is a need for evidence generation on what works when intentionally designing APMs to advance health equity. Identifying effective variables to incorporate into social risk adjustment models will depend on many factors like specific payer or geography, and how much social risk factors correlate with barriers to access. Therefore, it is important to continue investments in other complementary efforts that advance health equity especially when adding variables to a risk adjustment model does not result in increased resources to providers who care for patients with the most complex needs. Over time, appropriately incorporating social risk factors into payment will lead to more participation in APMs, and approaches will evolve to reflect implementation lessons, feedback from the field, and evidence of what works as intended. The LAN looks forward to working with participating stakeholders to support implementation and to generate the lessons and evidence needed to guide future efforts to advance health equity through APM design and implementation.

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Appendix

About the Health Care Payment Learning & Action Network

The Health Care Payment Learning & Action Network (LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system's adoption of alternative payment models (APMs). The LAN mobilizes payers, purchasers, providers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Our Vision	Our Mission
The LAN will advance multi-stakeholder payment reforms to enable coordinated health care that achieves better health, equity, and affordability	Improved and equitable health outcomes, resulting in overall lower total cost of care

About the LAN Health Equity Advisory Team

The LAN established the HEAT to help identify and prioritize opportunities to advance health equity through APMs, to influence design principles and to inform LAN priorities and initiatives. Its goal is person-centered—leveraging APMs to help make needed care more accessible, drive better outcomes, and reduce disparities. Patient experiences, priorities, and perceptions are crucial elements the HEAT explores.

The LAN would like to thank HEAT Members and other stakeholders for sharing their expertise and contributing to the development of this guidance document on social risk adjustment.

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