



BETTER MEDICARE ALLIANCE  
MINI SPOTLIGHT ON INNOVATION

# Social Determinants of Health

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UnitedHealthcare Leverages Data  
to Address Medicare Advantage  
Beneficiaries Social Determinants  
of Health

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## Overview

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Social determinants of health are the conditions in which people live, work, and age that shape the conditions of daily life and contribute to health status.<sup>1</sup> They include factors such as income, literacy, access to health services, and the social and physical environment.<sup>2</sup> Increasingly health plans and providers are partnering with community-based organizations and private companies to address social and economic barriers to care that can include the high cost of care, unsafe housing, food insecurity, and a lack of access to social services and supports. Medicare Advantage health plans are increasingly developing innovative ways to address social barriers to care to improve patients' quality of life and health outcomes.

The Centers for Medicare & Medicaid Services (CMS) and the Bipartisan Budget Act (BBA) have provided Medicare Advantage health plans with benefit flexibilities to better integrate medical and non-medical care, particularly for chronically ill beneficiaries.<sup>3 4 5</sup> However, health care stakeholders still lack comprehensive data to measure the impact of social risk factors on the cost and quality of care. UnitedHealthcare (UHC) is working address this challenge through a national initiative to capture, code, and refer beneficiaries to social services. Standardizing the collection of social determinants of health data will provide more information to policymakers, payers and providers to better meet patient's needs.

## Background

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Medicare Advantage health plans are in a unique position to collect and utilize data on social determinants of health to identify gaps in care. Capitated (monthly) payments put health plans in the unique position of being at-risk for the whole person's care. UHC, the largest health care company in the U.S., has developed new International Classification of Disease (ICD) Diagnosis Codes to better capture social determinants of health. Systematically diagnosing and collecting data on Medicare Advantage beneficiaries' social risk factors would improve the accuracy of Star Ratings quality measures and risk adjustment, while assisting health plans in the delivery of support services to improve patients' health outcomes.

ICD Diagnosis Codes were originally designed to collect, process, and classify diseases to obtain internationally comparable mortality statistics. Today, patient diagnoses are assigned ICD Diagnosis Codes for the purposes of reimbursement. CMS groups individual diagnosis codes into broader diagnosis groups, which are then refined into Hierarchical Condition Categories (HCCs) associated with the most severe manifestation of a disease. HCCs, together with demographic factors such as age and Medicaid eligibility, are used to predict beneficiaries' total care costs and pay Medicare Advantage health plans a capitated payment rate through a process called risk adjustment. The accuracy of this process is critical to ensure Medicare Advantage health plans are accurately paid for the expected cost of caring for a beneficiary.<sup>6</sup>



# Innovation to Address Social Determinants of Health

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Since reliable data to ensure adequate payment is required for Medicare Advantage health plans to attend to beneficiaries' social determinants of health, UHC conducted a nearly two-year pilot using non-traditional ICD-10 Diagnosis Codes to address beneficiaries' social determinants of health. These new codes capture beneficiaries' self-identified social barriers to care to address measurement gaps and connect patients with additional social services.

The social determinant of health data was captured in a standardized file layout, matched to diagnosis codes, and integrated with traditional clinical data to provide a more holistic picture of beneficiaries' care needs. The expanded diagnosis codes set the stage for the standardized measurement of social determinant of health data by identifying when beneficiaries face social risk factors such as social isolation, food insecurity, or lack access to transportation to obtain necessary health care services.<sup>7</sup> The new ICD-10 Diagnosis Codes fell into the following categories:

- Counseling
- Economic stability
- Education
- Employment
- Health/health care
- Personal care
- Respite care
- Social/community

**The UHC pilot was designed to capture social barriers to care and referral data from every beneficiary touchpoint, including health risk assessments (HRAs), care managers, and providers' electronic medical records.**

Then UHC cross walked the data into diagnosis codes to increase providers ability to assess beneficiaries' health status and health care needs. For example, if a Nurse Practitioner (NP) learned a senior lacked access to nutritious food through an HRA, the NP would refer the beneficiary to a local food bank. The information was then added to a portal for the beneficiary's provider to obtain a more complete picture of potential barriers to care. UHC is using existing diagnosis tools and community resources to identify beneficiaries' social risk factors to connect them with assistance programs, social services, and national and local resources. Despite the fact that data to help address social determinants of health is collected, the health care system lacks standardized codes to improve the coordination of non-health and medical and behavioral health services.

# Outcomes of Innovation to Address Social Determinants of Health

In the pilot, conducted from January 2016 to May 2018, UHC collected over 600,000 Medicare Advantage beneficiaries self-identified social barriers to care. UHC has provided over 560,000 referrals to for nearly 100,000 individuals to critically important social services valued at nearly one-quarter-of-a-billion-dollars for these individuals. The most prevalent barrier was beneficiaries' inability to pay for care. In summary UHC found:



**133,000 or 22.1%** were unable to pay for their prescriptions



**50,000 or 8.3%** were unable to get or pay for transportation unrelated to health care



**75,000 or 12.5%** were unable to pay for utilities



**39,000 or 6.5%** were unable to obtain transportation for medical appointments or prescriptions



**70,000 or 11.7%** were unable to deal with stress



**28,000 or 4.7%** reported having inadequate housing



**65,000 or 10.8%** were unable to pay for medical care



**24,000 or 4%** were unable to count on family and friends in times of trouble



**60,000 or 10%** reported inadequate social interaction



**17,000 or 2.8%** could not afford a telephone



**53,000 or 8.8%** reported a lack of adequate food and safe drinking water



**14,000 or 2.3%** felt unsafe in their current location

## Conclusion

The UHC data clearly show the dimensions of care that fall outside the traditional health care system, and the importance of addressing these barriers to care. It is critical that resources are leveraged across the health care system, and in every community to assist beneficiaries unable to afford care, experiencing social isolation, and lacking adequate nutrition. The additional social risk factor data coupled with clinical data has helped UHC connect nearly 100,000 patients with resources to address barriers to care, resulting in millions of dollars in social value.

Diagnosis codes identifying barriers to care would better equip Medicare Advantage with the tools to address social determinants of health. These non-traditional measures would also help spur Medicare Advantage stakeholders to take on risk, coordinate care, and innovate to address beneficiaries' social barriers to care. Clinical outcomes are increasingly tied to cost in the delivery of value-based care. Social determinants of health have significant implications for the success of value-based arrangements. Therefore, standardized ICD-10 codes could not only increase available resources to address barriers to care, but also expand value-based contracts that incentivize addressing beneficiaries' social determinants of health to improve health outcomes and contain the cost of care.

## References

- <sup>1</sup> [http://www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/)
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