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Addressing the Social Determinants of Health in Medicaid Managed Care

October 30, 2018

Today’s Agenda and Presenters

- Social Determinants of Health – What Are They, Why Do They Matter?
- The Emerging Business Case for SDOH
- Next Generation Approaches to Integrating SDOH into Care Delivery

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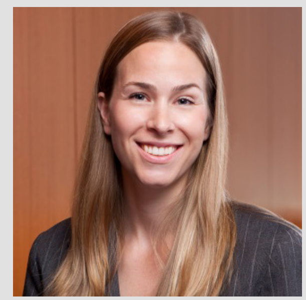

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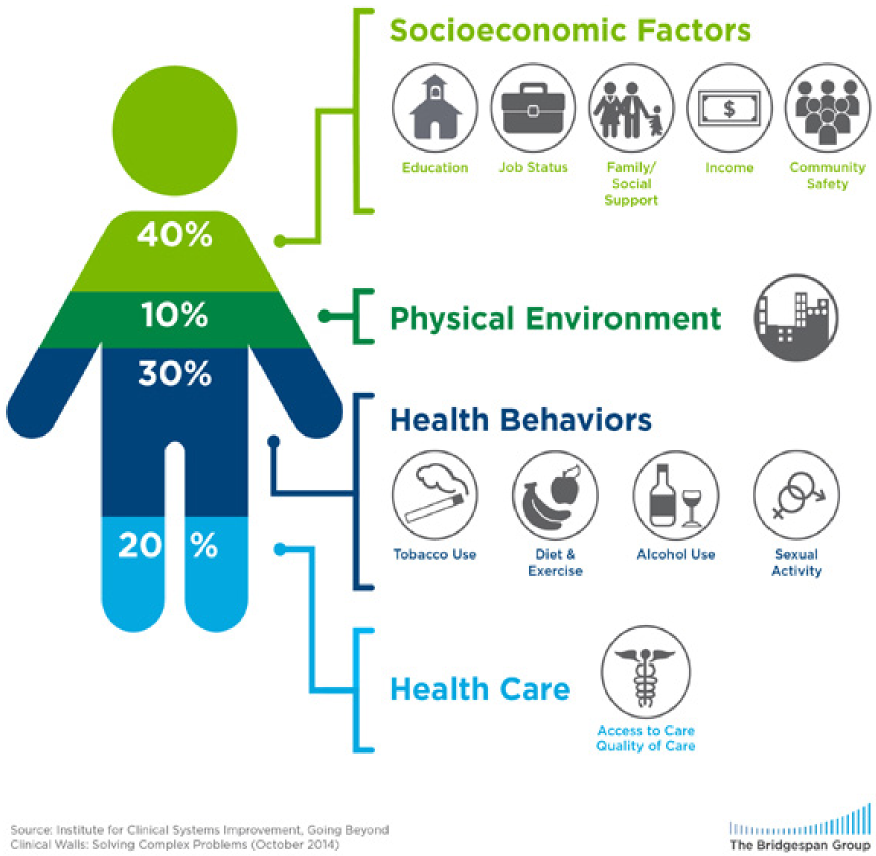
Social Determinants of Health –
What Are They, Why Do They Matter?

Social Determinants of Health: Definition & Impact

Social determinants of health (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



Socioeconomic factors, physical environments, and health behaviors drive health outcomes more than medical care.

Having at least one unmet social need is associated with increased rates of depression, diabetes, hypertension, ED overuse, and clinic "no-shows."

Nearly 80% of physicians believe addressing social needs is as important as medical care, but most do not feel prepared to address them.

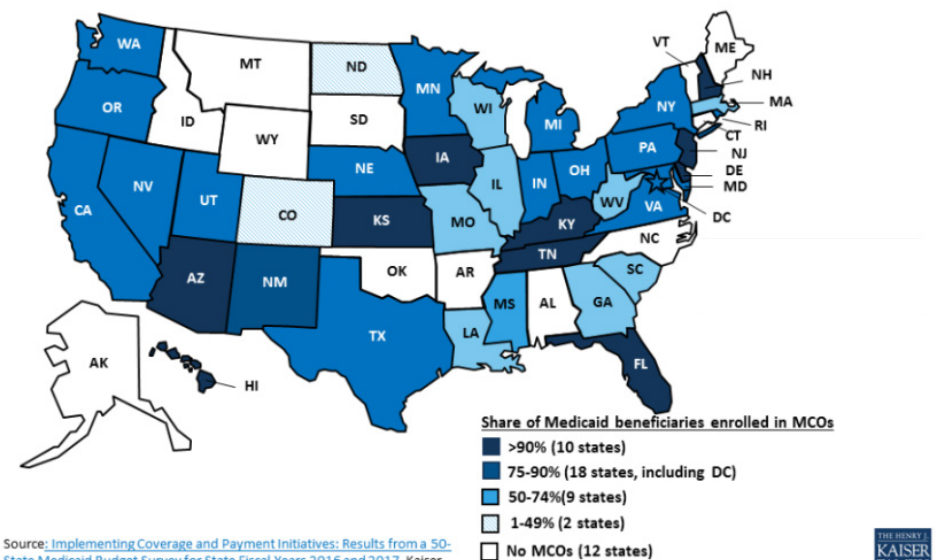
(1) Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010.
(2) Bachrach, D., Pfister, H., Wallis, K. and Lipson, M. Addressing Patients' Social Needs: An Emerging Case for Provider Investment. Commonwealth Fund. May 2014.
(3) Blendon, R.J., Donelan K., Hill C., Scheck A., Carter W., Beatrice D., Altman, D. "Medicaid beneficiaries and health reform." Health Affairs, 12, no.1 (1993): 132-143.

Medicaid as the Vehicle for Addressing SDOH

Medicaid enrollees—low-income by definition—are particularly likely to struggle with basic needs, including food, clothing, and shelter.

Medicaid Managed Care Organizations (MCOs) provide care to 81% of enrollees nationwide and can provide a strong platform for addressing SDOH.

A large share of all Medicaid beneficiaries are enrolled in risk-based MCOs.



Source: Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, Kaiser Family Foundation, October 2016.

(1) Kaiser Family Foundation. Total Medicaid Managed Care Enrollment.
https://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

The Emerging Business Case for SDOH

Emergent: Evidence Base for Addressing SDOH

The SDOH evidence base is largely focused on targeted interventions for discrete populations, pilot programs and small randomized control trials.

- Supportive or permanent housing solutions for homeless individuals as a means to reduce hospital admissions and medical expenditures
- Addressing food insecurity (e.g., through medically tailored meals or enrollment in SNAP) to lower health care spending
- Providing rideshare-based transportation to reduce "no-shows"

Active Marketplace of SDOH Ideas and Players

A diverse group of players have entered the SDOH "marketplace" including: health insurers, health providers, governments, IT organizations and other community-based organizations.

Kaiser Permanente Announces $200 Million Impact Investment, Partners With U.S. Mayors and CEOs to Address Housing Stability *KP Press Release, 5/18/18*

Why UnitedHealthcare is investing millions in affordable housing projects *BizJournal, 2/26/18*

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Regenstrief Institute

SOCIAL DETERMINANTS ARE CORE OF NORTH CAROLINA'S MEDICAID OVERHAUL *Modern Healthcare, 8/3/18*

Camden Coalition of Healthcare Providers

CITYBLOCK

NOWPOW

BOLDGOAL #MOREHEALTHYDAYS

The CEO of a company often called the future of healthcare explains why health insurers want to cover your rent *Business Insider, 9/28/18*

Top Ten Tech Trends 2018: A Social Determinants of Health Technology Market is Slowly Emerging *Healthcare Informatics, 9/4/18*

“Next Generation” Strategies to Integrate SDOH

Medicaid programs and managed care plans are driving the next generation of efforts to address social service needs within an integrated care delivery platform—in pursuit of “whole person care.”

- **Identifying beneficiaries with social needs (as a first step)**
- **Embedding SDOH into care management/care coordination**
- **Building a “provider network” of community-based organizations**
- **Supporting sustainable investments in community-based interventions**
- **Evaluating the effectiveness of SDOH interventions on health outcomes and healthcare costs**

Next Generation Approaches to Integrating SDOH into Care Delivery

Identifying Social Needs

Systematically identifying Medicaid beneficiaries with complex social needs is an important step in addressing the major causes of poor health and health care outcomes.

The Opportunity

States, payers and providers are developing ways to systematically gather information on enrollees' social needs impacting health.

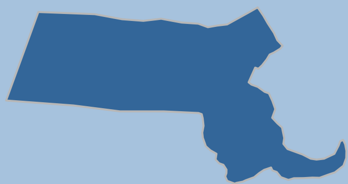
Considerations

- Stakeholders must define their "target population"– whether identifying a broader population that can benefit from social interventions or a more narrow, high-cost subpopulation.
- Successfully assessing individuals for social needs requires careful consideration of the following tactical issues:
  - **Engaging** individuals in the process and **establishing their trust**
  - **Timing**, when to administer screening questions and length of time to complete
  - **Staff or care team member** best-positioned to administer
  - Training in soliciting sensitive information
  - **Infrastructure** for storing collected information, and,
  - Supports and available resources for **addressing identified needs**.
- Data-driven risk stratification may help to expedite identifying beneficiaries with social needs.

Examples: Identifying Social Needs

Assessing for Social Needs

Massachusetts



Medicaid MCOs and ACOs* must include screening questions related to a range of unmet social needs (e.g., housing) during an initial health assessment for all Medicaid enrollees. Plans have flexibility to design the questions.

Identifying Patients through Risk Stratification

Hennepin Health

Hennepin Health, a Minnesota Medicaid ACO, uses a risk identification methodology to target “high-risk” members “most likely to incur high costs” (e.g., homeless or housing insecure) for coordinated care that aims to address medical, behavioral, and social problems.

**ACO – accountable care organization*

Managing the Social Needs of Beneficiaries

Managing social needs through a person-centered process and coordinating among community-based organizations—as is done for physical and behavioral conditions—is critical to improving health.

Actively managing the social needs of beneficiaries

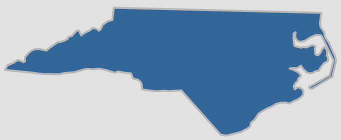
Care management provides the opportunity to embed activities addressing enrollees' social needs into care delivery. Types of care management activities optimally should include:

- **Referral** and **tracking connections** to community-based services;
- Assistance with **securing community-based services**;
- Formation of **"authentic healing relationships"** with enrollees that are secure, genuine, and continuous: enrollees feel seen and heard, and providers maintain this relationship outside of a provider setting. 1
- Development of a **multidisciplinary care management team** to ensure the right mix of expertise—and bandwidth—for addressing integrated physical, behavioral and social needs.
  – For example, care teams may include "Community Health Workers" (CHWs) and those with lived experience

The Core of Care Management. Population Health Management (2016). Available: https://www.liebertpub.com/doi/full/10.1089/pop.2015.0097

State Examples: Managing Enrollees' Social Needs

North Carolina



For **members with high physical, behavioral, or social needs**, MCOs/care managers must provide face to face assistance securing health-related services, and have access to people with expertise on homelessness and medical-legal partnerships.*

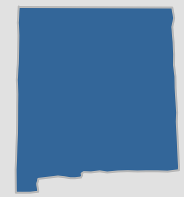
For all members, MCOs will be required to provide linkages to community services, including through the use of a statewide "NC Resource Platform."

Michigan

MCOs are required to:

- Coordinate and help manage social needs to reduce socioeconomic barriers.
- Engage with community-based organizations (CBOs)/CHWs to coordinate population health in their regions.

New Mexico



MCOs must make CHWs available to members for activities related to

- Navigating the health care system—including ensuring receipt of all medically necessary covered services
- Securing culturally appropriate health information, and
- Obtaining information on community resources.

**Subject to availability and capacity of medical-legal assistance providers*

Building a Network of Community Based Organizations to Address SDOH

The Opportunity

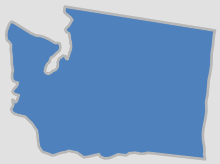
- States, plans and health systems are looking to gain an understanding of community-based resources, needs and workflows.
- Increasing focus on working collaboratively with community-based organizations (CBOs) to develop a robust, multi-disciplinary network.
- Recognition that CBOs bring unique expertise and patient relationships distinct from those found in health care.

Considerations

- Plans and CBOs operate differently with respect to payment processes and IT systems.
- Health plans and CBOs must “bridge the gap” between traditional healthcare and on the ground community-based service delivery to ensure success.

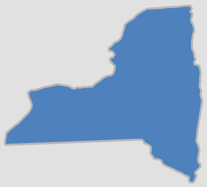
Examples: Efforts to Support CBO Participation

Washington



Washington's Foundational Community Supports program, authorized through the State's 1115 waiver, offers supportive housing and supported employment services to high-need Medicaid enrollees through CBOs overseen by a third-party administrator.

New York



As part of the State's value-based payment (VBP) roadmap, New York requires MCOs with high-level VBP arrangements to contract with at least one non-Medicaid billing CBO.

UnitedHealthcare

UnitedHealthcare myConnections™

To support the delivery of a suite of SDOH-related services for its high-need Medicaid population, UnitedHealthcare has created on-the-ground partnerships with a spectrum of community providers (e.g. faith-based providers and non-profits) as part of its "My Connections" program.

Strategies for Sustainable Investments in Social Interventions

Sustainable financing is essential to spread and scale strategies to address SDOH. Medicaid can be an important part of the equation, but it cannot be the sole source of funding and cannot be used to directly pay for housing and other key social services.

Category	Strategy
Care Coordination under Managed Care	Include **connections to social needs care** into care management responsibilities
Medicaid Benefits	Classify certain **community-based services as covered benefits** under the state's Medicaid plan
	Explore use of **value-added** and **"in lieu of"** services
Quality Improvement	Integrate SDOH measures in **quality improvement** or **performance measurement**
Financing/ Payment Mechanisms	Use managed care rate setting tools to **encourage** effective **plan investments in social interventions** (e.g., incentives, VBP)
	Incorporate SDOH factors into **risk-adjustment methodology**

Guyer, J, Bachrach D. et al. Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund, 2018

State Examples: Sustainable Investments in Social Interventions

Arizona

Arizona's Regional Behavioral Health Authorities (RBHAs) have several strategies to address SDOH including:

- Covering non-clinical services (respite & care management)
- Reinvesting 6% of profit back into community
- Using their equity as credit to invest in low-income housing
- Leveraging state/local funding for housing grants.

Oregon

Oregon permits Care Coordination Organizations (CCOs) to cover "health-related services"—non-covered services offered as supplements to covered benefits—to improve care delivery and community health/well-being.

- **Examples include**: housing supports and helping to establish a farmers market in a "food desert."

The State is also considering mechanisms to reward plans that invest in health-related services and increase quality and efficiency with a higher profit margin.

Evaluating the Effectiveness of SDOH Interventions on Outcomes/Costs

Managing social needs through a person-centered process and coordinating among community-based organizations—as is done for physical and behavioral conditions—is critical to improving health.

Next Generation Issue: Evaluating SDOH Interventions

- Demonstrating the effectiveness of efforts to address SDOH requires:
  - Data and IT systems that collect, store, analyze and transmit necessary data
  - A standardized set of quality and outcome measures
- While interest in evaluation is high, resources to support it is often limited.
- States with SDOH initiatives within their 1115 waivers are responsible for systematically evaluating outcomes
  - States with recently-approved SDOH waivers are actively seeking to identify effective interventions and then integrate them into the state's Medicaid program

States Supporting the Evaluation of SDOH Interventions

MCOs' Monitoring and Reporting of SDOH

Michigan

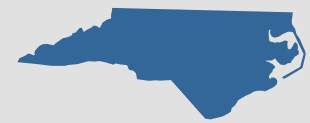
MCOs must develop and submit a multi-year plan to the State on how they intend to incorporate SDOH into their data analysis and population health management strategies, including what SDOH-related measures will be added to the plan's core measure set for reporting.

1115 Waiver Evaluations

California

California's "Whole Person Care" (WPC) Pilots provide a wide spectrum of coordinated physical, behavioral and community-based services to "high-risk, high-cost target populations." Through relationships across sectors, pilot entities are expected to provide coordinated medical and social services and share data.

North Carolina



North Carolina's "Healthy Opportunities Pilots" will be implemented by Medicaid managed care plans, in close partnership with their communities, and offer targeted interventions to address a subset of Medicaid enrollees' needs in: housing, food, transportation, employment and interpersonal safety

CA and NC will evaluate these pilots as part of their 1115 waivers and plan to integrate successful services into their Medicaid managed care programs.

States “Pulling it all Together”

Massachusetts: MassHealth ACO Model

Rhode Island: Medicaid “Accountable Entities”

Washington: Accountable Communities of Health

Closing Thoughts

- Expect SDOH innovation to continue and mature
- Anticipate diversity in the SDOH “marketplace”… and look to Medicaid managed care to lead
- Keep an eye on “whole person care”—to succeed, SDOH must be integrated into the care continuum

Q & A

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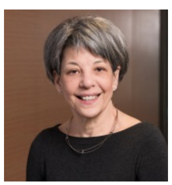

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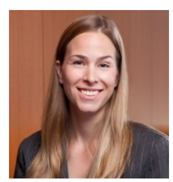

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