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SDOH Reimbursement and Value Based Payment Opportunities

Acknowledgements

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Learning Objectives

1. Understand how value-based models are key to addressing SDOH and unmet social needs and promoting health equity.

2. Engage effectively with payers and policy makers on value-based payment models.

3. Discuss policies and systems-level enablers to support health centers with value-based payment models that include reimbursement for assessing and addressing social needs..

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SDOH Screening in North Carolina's COVID-19 Isolation & Quarantine Supports Program

E. Benjamin Money, MPH
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NACHC Policy & Issues Forum

February 15, 2022

Background

- The North Carolina 1115 Medicaid Transformation Waiver will progressively shift Medicaid value-based payments over a 5-year period.
- NC received approval from CMS to pilot paying for non-medical services that impact health as part of the waiver (Healthy Opportunities Pilots)
- SDOH screening and referral is required of Managed Care Organizations
- NCCARE360 – a closed looped electronic SDOH screening and referral platform was developed as a required tool
- NCARE360 was launched in 2019
- COVID-19 pandemic created the opportunity to test the Health Opportunities concept ahead of the launch of Managed Care and the Pilots

NC Medicaid Established Value-based Payment Targets for Managed Care Contractors (aka Pre-paid Health Plans)

Table 1. VBP Targets for Contract Years 1-5

Year 1	Year 2	Year 3	Year 4	Year 5
PHP submits VBP assessment to establish baseline level of value-based contracting	Percentage of PHP's expenditures in VBP (Category 2A+) must: • Increase by 20 percentage points or • Represent at least 50% of total medical expenditures	**Overall[7] (Category 2C+)** • At least 60% of total medical expenditures **Sub-Target[8] Category 3A+** • At least 15% of total medical expenditures	**Overall (Category 2C+)** • At least 75% of total medical expenditures **Sub-Target Category 3A+** • At least 30% of total medical expenditures	**Overall (Category 2C+)** • At least 90% of total medical expenditures **Sub-Target Category 3A+** • At least 45% of total medical expenditures **Sub-Target Category 3B+** • At least 15% of total medical expenditures

NC Medicaid Healthy Opportunity Pilots

- The Healthy Opportunities Pilots test the impact of providing selected evidence-based interventions to Medicaid enrollees.
- five years, up to $650 million in Medicaid funding to cover the cost of select services related to:
  - housing
  - food
  - transportation
  - interpersonal safety

that directly impact the health outcomes and health care costs of enrollees in two to four geographic areas of the state.

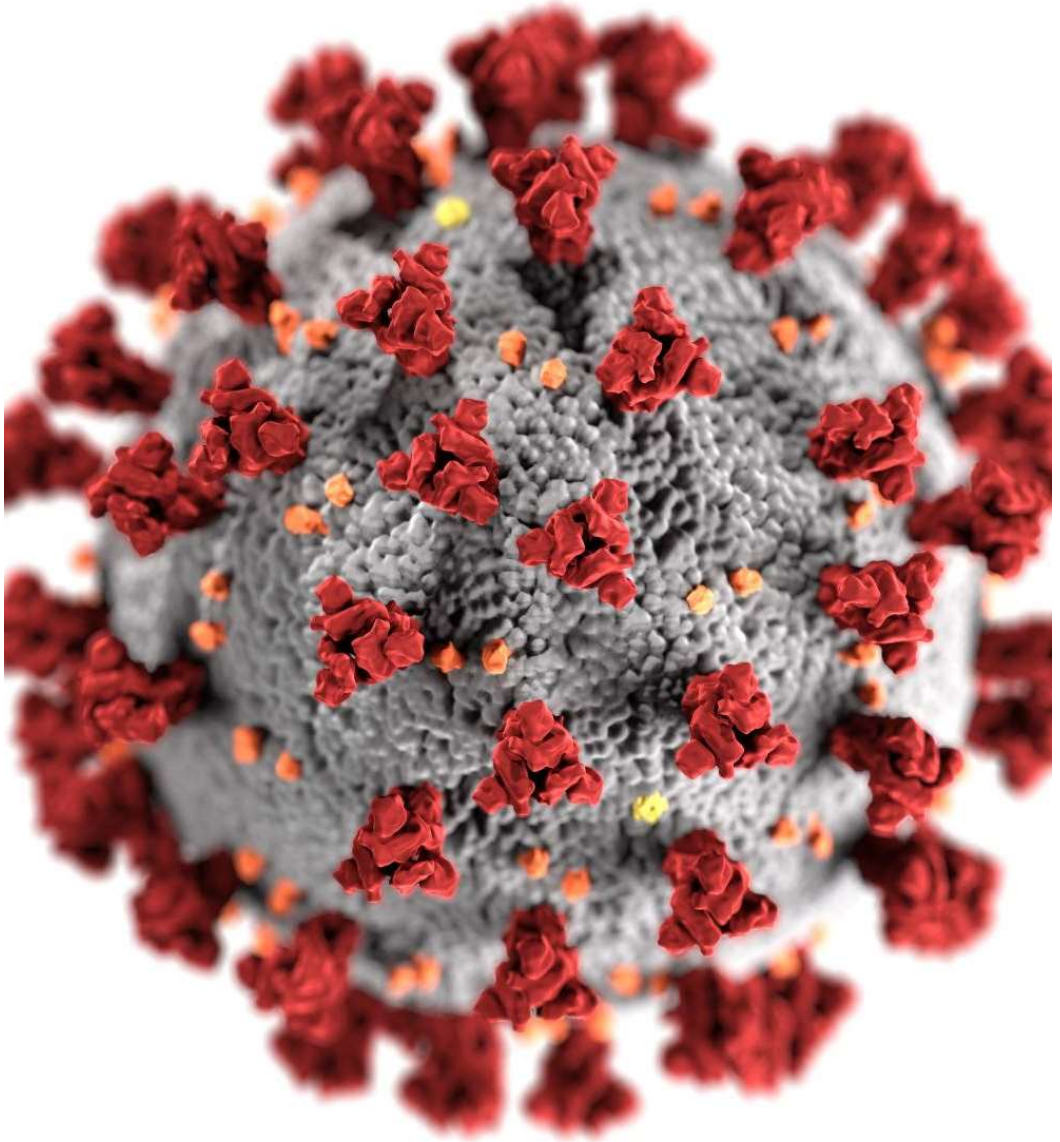
NC DHHS Healthy Opportunities SDOH Screening Questions

- **Food:** The two questions under this core domain were modified from the validated Hunger Vital sign and are intended to identify food insecurity.
- **Housing/Utilities:** The first and second questions under this core domain are modified from the Protocol for Responding to Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment tool. The three questions in this domain are intended to identify individuals who are experiencing homelessness or at risk of losing their housing.
- **Transportation:** The one question under this domain was adapted from the PRAPARE assessment tool.
- **Interpersonal Safety:** The first question in this domain was adapted from the PRAPARE assessment tool. The second and third questions were modified from the Humiliation, Afraid, Rape, and Kick (HARK) questionnaire. The questions are related to the exposure of intimate partner violence, elder abuse, and child abuse

NCCARE360 https://nccare360.org/about/

- NCCARE360 is the first statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina.
- NCCARE360 helps providers electronically connect those with identified needs to community resources and allow for feedback and follow up.
- This solution ensures:
  - accountability for services delivered,
  - provides a “no wrong door” approach,
  - closes the loop on every referral made, and
  - reports outcomes of that connection
- NCCARE360 is available in all 100 counties across North Carolina.

Public Health Response to COVID-19 Created a Unique Opportunity to Test Healthy Opportunities Interventions Prior to Launch of Managed Care



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NCDHHS Overall Strategy

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Goals

- Protect ourselves, our loved ones, and our neighbors from getting seriously ill
- Restore our economy and get North Carolinians back to work safely
- Get our children back to school so they can learn, play, and thrive
- Address the disproportionate impact of COVID-19 on historically marginalized populations

Strategy to Combat COVID-19	What the State is Doing	What the Public Can Do
Slow the Spread: Prevention	• Phase reopening of sectors/activities to minimize spread of COVID-19 • Require face coverings that cover the nose and mouth (indoors and outdoors) when physical distancing of 6 feet is not possible • Promote the 3Ws (Wear, Wait, Wash)	• Practice the 3Ws and encourage friends and family to do the same • Employers should follow NCDHSS guidance for specific settings
Know Who Has COVID-19 and Who Has Been Exposed: Testing and Tracing	• Build a statewide testing and contract tracing infrastructure • Surge resources in hardest hit communities and populations	• Get tested if symptomatic or if you think you are exposed to COVID-19 • Answer the call from the contact tracing team
Support People to Stay Home: Quarantine and Isolation	• Ensure access to non-congregate shelters for people who need to isolate • Enact policies to enable people to stay at home, leverage NCCARE360 to connect to supports	• Stay home when you can, especially when sick • Support employees to stay home when sick to minimize the spread of COVID-19

CHW and Support Services vendors connect the public to vital resources and services helping the state achieve its COVID-19 goals

Support Services Program Overview

An innovative program to provide five key support services in target counties to help people safely quarantine or isolate

Overview

- Innovative new program funded by the CARES Act to assist individuals in targeted counties who need access to primary medical care and support services
- Frontline workers may be unable physically distance or may be unable to take paid sick leave, leading to higher rates of infection
- Targeted service areas are segmented into four regions: Region 1 (Mecklenburg, Gaston), Region 2 (Rowan, Stanly, Montgomery, Randolph, Chatham, Lee), Region 3 (Durham, Granville, Vance, Wake, Franklin, Warren, Nash), and Region 4 (Robeson, Columbus, Bladen, Sampson, Duplin, Wayne, Johnston, Wilson, Greene, Lenoir, Pitt, Craven, Scotland, Hoke)

Eligibility

Individuals must first be identified by a health professional because the individual:

1. Tested positive for COVID-19
2. Is waiting for the results of a COVID-19 test
3. Was exposed to someone who has tested positive for COVID-19
4. Needs to do so as a precautionary measure since they are in a high-risk group

Individuals must also attest to certain criteria, such as needing the services to successfully isolate or quarantine and not having another means to obtain these services.

Process

Individuals who need access to primary medical care and support services to successfully quarantine or isolate due to COVID-19 will follow this process:

1. A health care worker will identify an individual who should quarantine or isolate. If the individual may require support services to do so effectively, the health care worker refers the individual to a Community Health Worker (CHW) or LHD.
2. The CHW or LHD team member will be responsible for supporting the individual through the quarantine or isolation process. The CHW or LHD will perform a needs assessment, determine eligibility for support services, make a support plan, and connect individuals to organizations that can provide support services.
3. The support services vendor will directly provide, or subcontract with local Community Based Organizations (CBOs) to provide, the needed support services:
   - Home delivered meals or groceries
   - A one-time COVID relief payment
   - Private transportation (to allow isolation/quarantine)
   - Medication delivery
   - COVID-related over-the-counter supplies, such as face masks and hand sanitizer

CHWs will serve as the individual's point of contact throughout isolation or quarantine

Performance Period: August 2020 through March 2021

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How Support For Quarantine and Isolation Works

Individual need is identified in a variety of ways:

- Individual tests positive for COVID-19 and receives instructions from the testing center
- Individual is contacted by a Contact Tracer about possible COVID-19 exposure/next steps
- Individual has recommendation to isolate as a high-risk individual
- Individual is a first-responder or frontline healthcare worker
- Individual reaches out to their Local Health Department (LHD) about COVID-19 needs
- Individual is referred to Q&I supports by their doctor or nurse
- Individual sees information online and believes they might qualify for services
- Individual is waiting on test results to come in

CHW will perform a needs assessment, determine eligibility for support services, make a support plan, and connect individuals to organizations that can provide support

CHW primarily utilizes NCCARE360 for all coordination and referral efforts; CHW points individual to access point spreadsheet on NCDHHS website

Community Health Worker (CHW)

LHDs, PCPs, and Contact Tracers

Support Services 2.0

Federally funded food assistance program for individuals who are advised to quarantine or isolate by a healthcare professional.

Food assistance will be delivered to the individual.

Food assistance includes:

1. Food boxes – groceries for individual or family
2. Individual meals for individuals or families that are nutritionally and medically tailored

Non-Congregate Shelter

Collaborative effort between the State, counties and local partners to secure **non-congregate shelter** for individuals with no other safe place to quarantine, isolate, or social distance due to COVID-19.

Two options for reimbursement:

1. Local partners desiring state-centric coverage through NCEM (required MOA)
2. Local partners seeking direct reimbursement from FEMA

Healthcare

Innovative program to assist individuals in targeted counties who need access to general services and primary medical care to successfully quarantine or isolate due to COVID-19.

1. Connect individuals to needed resources and services in their community/region
2. Support COVID-19 testing and contact tracing
3. Connect individuals to primary care and related support services through face-to-face and/or telehealth encounters as appropriate

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CHW core skills and competencies

CHWs are trained on these core skills and competencies to better serve their communities

Communication

Be an **effective listener** to learn about client's needs; Be well versed in **group communication skills** to provide health education and community advocacy to groups served

Interpersonal

Work with diverse groups and **develop relationships** with clients and community members to **improve the lives of their communities and meet the needs of others**

Service

Coordinate the care of their clients; **Create plans to follow for improving health for their client or community** that will require the coordination of services

Capacity Building

Support their clients and communities through **building skills and promoting confidence in their own health**, such as building upon communication skills, **reducing of risk behaviors**, community organization, and advocacy

Advocacy

Advocate for their clients and communities among agencies, service providers, and support changes to public policies; **Speak up to create change** that would improve the health and well-being of their clients and communities

Education

Educate their clients and communities on **how to prevent and manage health conditions**, provide support in developing healthy behaviors, and advocate for social change

Outreach

Provide outreach to individuals and communities about services that are available and encourage enrollment of those services

Knowledge

Know and recognize social determinants of health and health topics that impact their clients and communities, to be able to give support and provide information on these topics

Personal

Have personal skills to be more effective in promoting and advocating for their clients and communities

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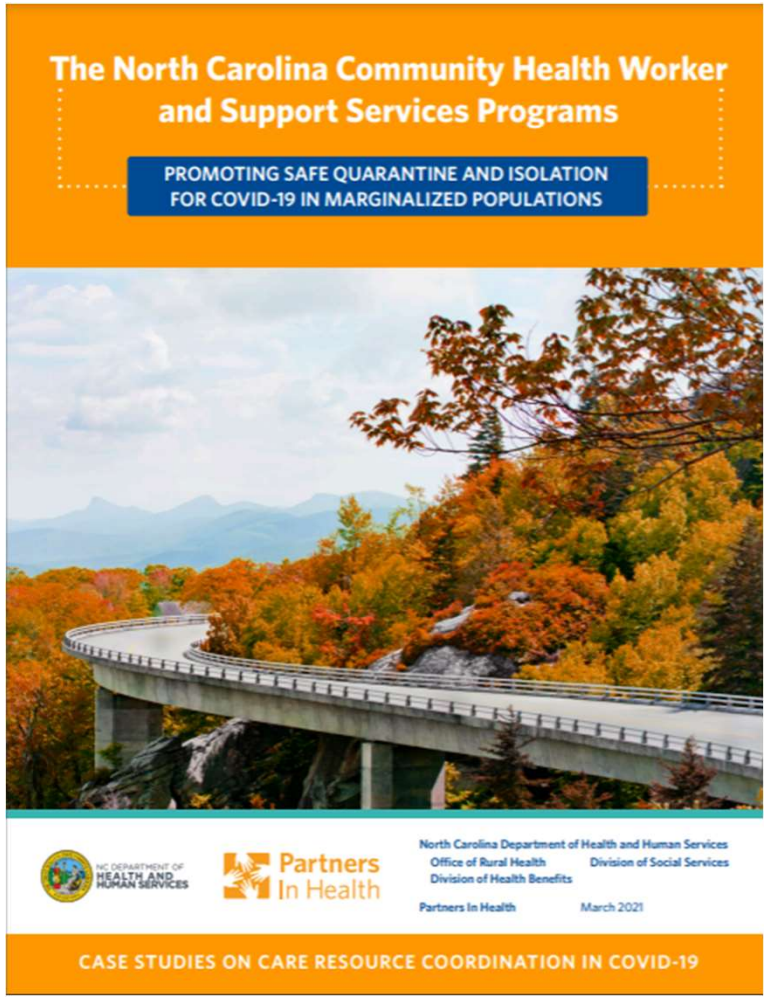
CHWs have been trained on the following tools and capabilities

CHWs are trained through the Standard Core Competency Training (SCCT) on these core tools and capabilities to better serve their communities

- **NCCARE360**
- **Vaccine site support experience**
- **COVID-19 Vaccine Management System** (CVMS - statewide location managers)
- **CHW training** (Through AHEC and a 96-hour Core Competency training at Community Colleges)
- **Vaccine 101 education** (monthly)
- **COVID-19 Community Team Outreach** (CCTO - Contact Tracing)
- **Testing site support** experience
- **Support Services Program 2.0 Referrals** (food insecurity)



Partners In Health Case Study

Outreach workers at a community food distribution event hosted by La Semilla, a non-profit organization serving the Hispanic/Latinx community working with CHW vendor Curamericas Global in Durham, North Carolina and the surrounding area. *Photo courtesy of Curamericas*

Program Overview

CONTACT TRACING: Decentralized; done by Local Health Departments (LHDs) and the Carolina Community Tracing Collaborative (CCTC)

CCTC CONTACT TRACERS: 850 (October 2020) – 1,600 (January 2021)

CARE RESOURCE COORDINATION MODEL: 435 CHWs employed in a CBO/healthcare organization-based model with 7 vendors in 55 counties; not directly linked to contact tracing but with multiple points of entry. Also includes **direct supports** delivered by the Support Services Program (SSP) through 4 vendors in 29 of the 55 CHW counties

IT PLATFORM: NCCARE360

PROGRAM FUNDING:

- CHW: Aug-Dec 2020 $14.7M CARES Act, Jan–June 2021 $16.0M State and CDC funds
- SSP: Sept-Dec 2020 $22.7M CARES Act, Jan–March 2021 $15.5M State funds

TOP 3 SERVICE NEEDS: Food assistance (34%), financial relief (29%), housing and shelter (10%)

PROGRAM IMPACT: As of March 2021:

- the CHW program served over **385,000 individuals** and made **121,000 referrals** to short- and long-term resource supports
- the Support Services Program delivered over **171,000 services** to **38,000 households**
- almost all of these households received food assistance, PPE, and cleaning supplies and 70% received financial relief payments
- of 236 surveyed SSP recipients, **88%** reported that they were **able to fully quarantine and isolate** because of the services provided through SSP

https://www.pih.org/sites/default/files/lc/LT-CRC_case_study_NC_march_2021_Final.pdf

Timeline and evolution of the CHW Program

The timeline shows the evolution of the CHW program and projected milestones of the program.

1. Prevention-Q&I

August 2020

CHW program used to promote prevention via Quarantin and Isolation (Q&I) support.

2. Pivot to Vaccination Outreach

January 2021 - current

As vaccination availability increases, CHW re-prioritizes efforts to vaccination outreach and support.

3. Statewide expansion RFP

March 2021

CHW Expansion RFP Released.

4.Expansion Awarded

July 2021

NC DHHS evaluation completed and contract awarded to 8 CHW vendors to cover all 100 counties.

5.Expansion Launch

August 2021

Statewide CHW expansion launch with continued pandemic response and eye towards pandemic recovery

6. Community Health Worker Initiative

September 2021

CHW Program became foundation for CHW Initiative (CDC CCR 2109) activities including standardized training, certification, and practice integration.

7. "Whole Patient Care"

TBD

Expand focus of CHW program to look beyond COVID-19 emergency response to new pressing community health priorities.

Communicate

How Are Payment Reforms Addressing Social Needs & Social Determinants of Health? Policy Implications and Next Steps

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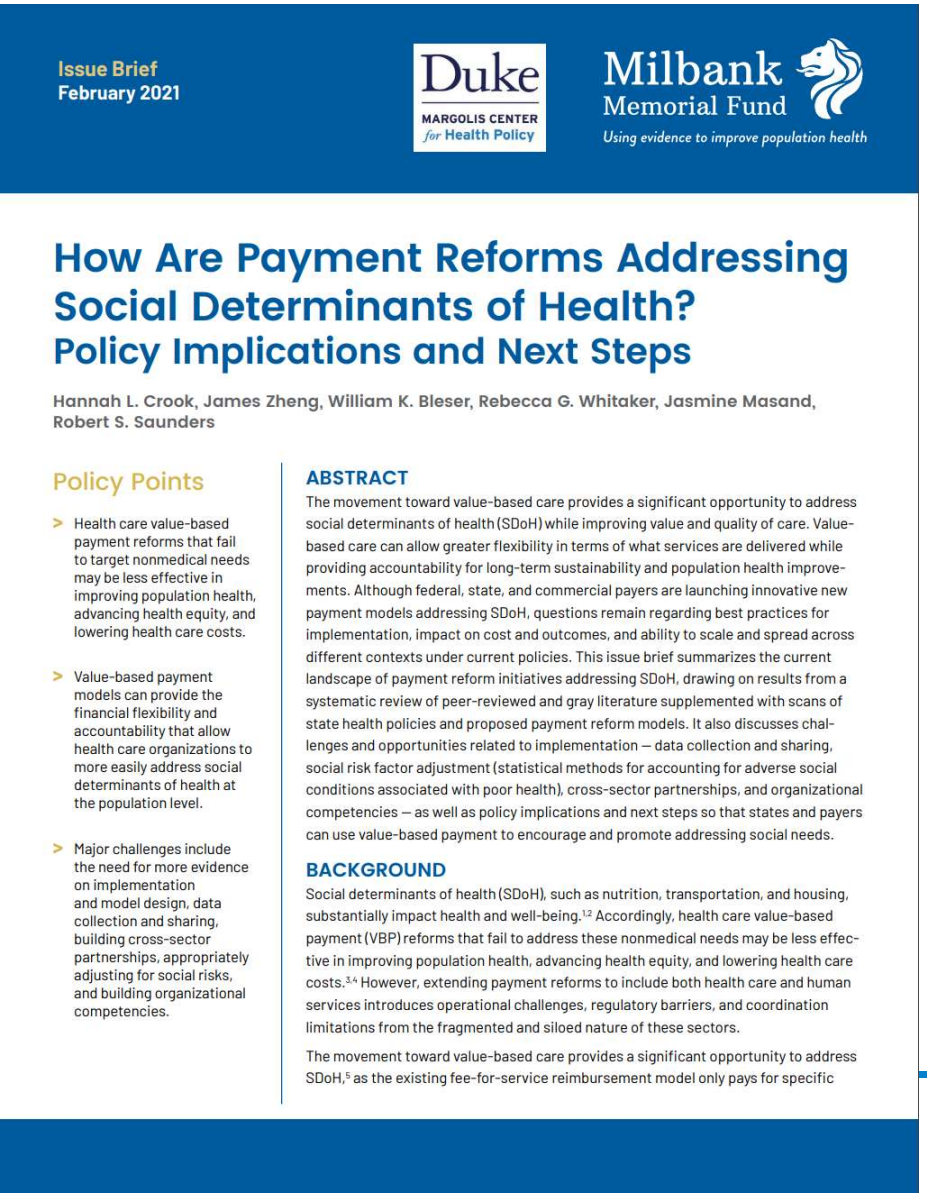


Issue Brief
February 2021

Duke MARGOLIS CENTER for Health Policy

Milbank Memorial Fund
Using evidence to improve population health

How Are Payment Reforms Addressing Social Determinants of Health?
Policy Implications and Next Steps

Hannah L. Crook, James Zheng, William K. Bleser, Rebecca G. Whitaker, Jasmine Masand, Robert S. Saunders

Policy Points

- Health care value-based payment reforms that fail to target nonmedical needs may be less effective in improving population health, advancing health equity, and lowering health care costs.
- Value-based payment models can provide the financial flexibility and accountability that allow health care organizations to more easily address social determinants of health at the population level.
- Major challenges include the need for more evidence on implementation and model design, data collection and sharing, building cross-sector partnerships, appropriately adjusting for social risks, and building organizational competencies.

ABSTRACT

The movement toward value-based care provides a significant opportunity to address social determinants of health (SDoH) while improving value and quality of care. Value-based care can allow greater flexibility in terms of what services are delivered while providing accountability for long-term sustainability and population health improvements. Although federal, state, and commercial payers are launching innovative new payment models addressing SDoH, questions remain regarding best practices for implementation, impact on cost and outcomes, and ability to scale and spread across different contexts under current policies. This issue brief summarizes the current landscape of payment reform initiatives addressing SDoH, drawing on results from a systematic review of peer-reviewed and gray literature supplemented with scans of state health policies and proposed payment reform models. It also discusses challenges and opportunities related to implementation — data collection and sharing, social risk factor adjustment (statistical methods for accounting for adverse social conditions associated with poor health), cross-sector partnerships, and organizational competencies — as well as policy implications and next steps so that states and payers can use value-based payment to encourage and promote addressing social needs.

BACKGROUND

Social determinants of health (SDoH), such as nutrition, transportation, and housing, substantially impact health and well-being.[1,2] Accordingly, health care value-based payment (VBP) reforms that fail to address these nonmedical needs may be less effective in improving population health, advancing health equity, and lowering health care costs.[3,4] However, extending payment reforms to include both health care and human services introduces operational challenges, regulatory barriers, and coordination limitations from the fragmented and siloed nature of these sectors.

The movement toward value-based care provides a significant opportunity to address SDoH,[5] as the existing fee-for-service reimbursement model only pays for specific

Background

- Value-based payment (VBP) models
  - How they work
  - Progress in system transformation
- Social determinants of health and social needs
- Addressing social needs through VBP?
  - Some great evidence, some mixed evidence
  - Time-limited interventions
  - Implementation knowledge?

Issue brief available at: https://www.milbank.org/wp-content/uploads/2021/02/Duke-SDOH-and-VBP-Issue-Brief_v3-1.pdf

Landscape of VBP Models Addressing SDoH

VBP models provide greater flexibility to address SDoH than fee-for-service, but different payers have stronger or weaker structural avenues to pay for SDoH.

Different Opportunities by Payer to Address SDoH

Payer	Opportunities to Address SDOH
Traditional Medicare	Modified payment approaches (e.g. Accountable Health Communities, Accountable Care Organizations)
Medicare Advantage	Supplemental benefits, with many newly allowable benefits related to SDoH
Commercial plans	Great flexibility in what can be covered, but limited by what counts as "medical expenses"
State Medicaid programs	Various structural avenues to cover social supports; level of activity highly depends on the State (As of 2021, 18 states plus DC have taken at least foundational steps)

Add citations here

State Medicaid Programs are Active in Using VBP Models to Address SDoH

State Medicaid programs have the most structural avenues to cover social supports, have been active in using VBP to address SDoH.

Commonly Used Medicaid Mechanisms to Address SDoH

Mechanism	State Examples
Section 1115 Waivers	• North Carolina's Healthy Opportunity Pilots • New York's DSRIP program
Medicaid Managed Care Organization Contracts	• New York, North Carolina's VBP targets for MCOs • Massachusetts' adjusted reimbursement model for MCOs, based on neighborhood stress scores
Medicaid Accountable Care Organizations (and ACO-like entities)	• Massachusetts ACOs and MassUP program • Rhode Island Accountable entities • Oregon's Coordinated Care Organizations

Add citations here

Model Design Considerations

SDoH can be addressed under many payment models (including ACOs, bundles, global budgets, and others), but models with prospective payment tend to allow for more flexibility to cover social services.

Savings produced through improved SDoH may not follow a payer's standard timeline for savings

- SDoH interventions can have high overhead investments, and improvements in SDoH may take years to translate into improvements in health and utilization

Challenges and Strategies for Success to Address SDoH Under VBP

Domain	Challenges	Strategies for Success
Data Collection and Sharing	• Screening and referral tools not standardized across programs/clinicians • Legal and regulatory obstacles to data exchange	• Use existing standardized screening tools • Standardize SDoH data collection; maintain robust data exchange infrastructure
Social Risk Factor Adjustment	• Social risk adjustment remains controversial • Data and methods challenges operationalizing social risk adjustment	• Stratify measures by sociodemographic characteristics to identify areas of disparities

Challenges and Strategies for Success to Address SDoH Under VBP

Domain	Challenges	Strategies for Success
Building Partnerships	• Health and social service sectors have different power dynamics, cultures, histories, processes, and language	• Build partnerships early, establish regular communication channels • Build infrastructure and human capital together to ensure sustainable collaboration
Organizational Competencies	• Many health care organizations need support to build VBP organizational competencies, especially VBP focused on SDoH.	• Provide upfront capital and technical assistance to help build needed competencies

Add citations here

FQHCs and Value-Based Payment Models

Advancing Mission through VBP Models

Flexibility of VBP funding allow for innovative and patient-centered care delivery, with opportunities for community linkages.

Collaborating with States on Aligned Metrics & Goals

Medicaid is the primary payer for most FQHCs, and there are opportunities for strategic collaboration on VBP goals and outcomes.

Opportunities and Challenges for Implementing FQHC-VBP Models

Opportunities

- Momentum for health transformation and promoting health equity
  - Medicaid expansion
- Aligning quality metrics and goals among payers
  - Medicaid as main player
- Providing up-front capital to help FQHCs build infrastructure and VBP competencies

Challenges

No “one size fits all” solution

Patient Attribution

Behavioral health and social risk adjustments

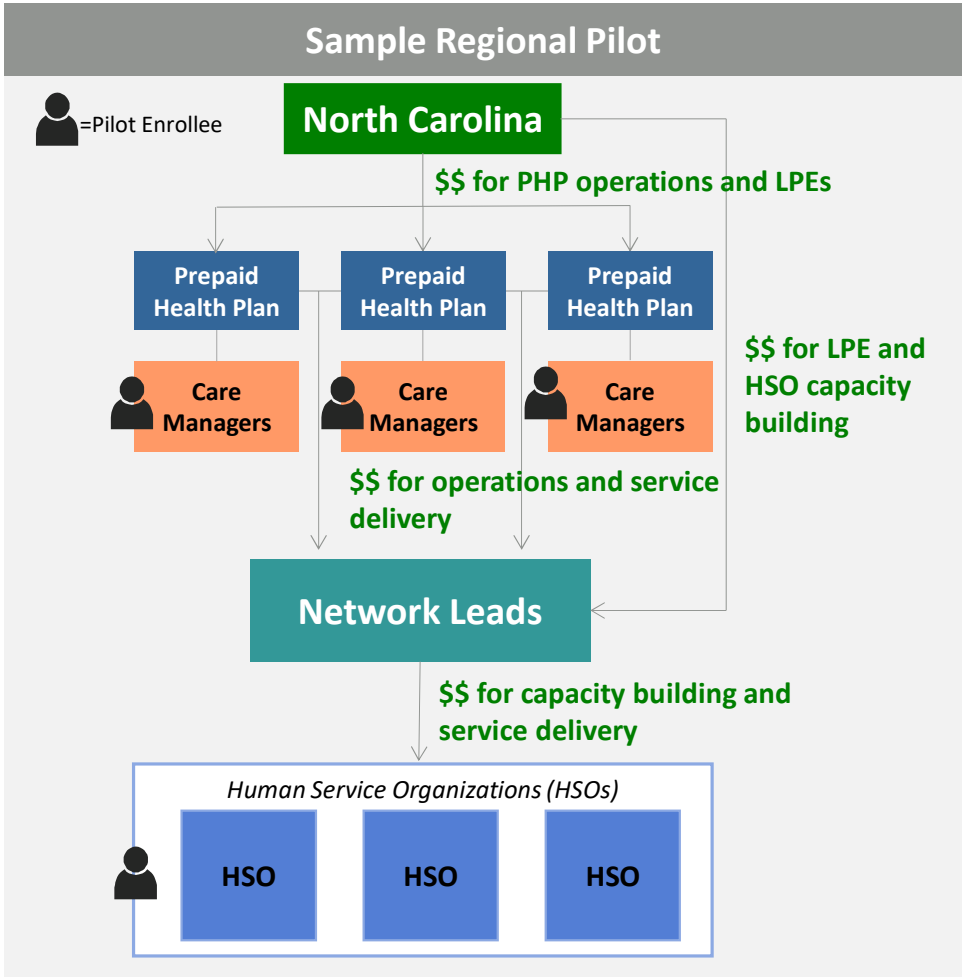
Confusion around whether FQHCs can legally take on downside risk

- All payments must remain above PPS rates

North Carolina's *Healthy Opportunities Pilots*

- The *Healthy Opportunity Pilots* will deliver SDOH-related services in four key domains: interpersonal violence, nutrition, housing, and transportation.

- Services will be coordinated by organizations called Network Leads. Medicaid Managed Care Plans—called Prepaid Health Plans—will be required to contract with the Lead Pilot Entities for operations and service delivery



Example Services Covered in the *Healthy Opportunities Pilots*

SDoH Domain	Covered Services	
Interpersonal Violence/Toxic Stress	• Interpersonal violence case management • Violence services • Dyadic therapy	• Parenting curriculum • Home visiting services
Food	• Food access case management • Group nutrition class • Diabetes prevention class • Medically-tailored meal delivery	• Fruit/vegetable prescription • Healthy food boxes • Healthy meals
Housing	• Housing navigation • Inspections • Home remediation • Home goods	• Move-in support • Utility set-up • Accessibility & safety mods • Post-hospitalization housing • Security deposit, 1st month's rent
Transportation	• Reimburse public or private medically-related transport • Reimburse transport for SDoH case management	

COVID-19 Example: North Carolina's Support Services Program (SSP)

North Carolina developed the COVID-19 Support Services Program to deliver needed social supports to those in isolation of quarantine for COVID-19.

Services delivered included:

- Financial relief payments
- Home-delivered groceries/meals
- Non-Emergency Medical Transportation
- Medication delivery
- COVID-19 supplies delivery (e.g. face masks, hand sanitizer)

Recommendations from studying the NC SSP

Findings from interviews with 17 experts, including program administrators and frontline providers

Theme	Recommendations for other states' & payers' health policy programs for social needs	
Supporting HSO capacity	• Upfront funding before service delivery (takes more time than anticipated)	• Reserve some capacity-building funds to use for demand surges
Bolstering program adaptability	• Specific yet flexible service definitions, payments (and pathways to adjust)	• Accessible, direct communication with all participating providers
Leveraging CHWs	• Maximize CHWs by integrating into care delivery model, pt engagement, outreach	• Develop CHW credentialing programs that include several levels of roles
Partnering with community leaders	• Partner with trusted community leaders • Hold community "meet and greet" events	• Incentivize contracting with local HSOs run by, serving HMPs
Optimizing technology	• Near-real time support capacity • Provide substantial training on technology (and opportunities for user feedback)	• Streamlines critical program functions • Multi-lingual support
Providing technical assistance	• Multiple SDoH domains=multiple TA needs • Real-time TA needed for emergent issues	• TA must be accessible to managers *and* frontline providers

Thank You!

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The Landscape of SDOH in a Federally Qualified Health Center

Courtney Riggle-van Schagen, MSW, LCSW

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Neighborhood Health: Portrait of a Health Center

Total Patients CY 2021 39, 634		
Adult	29,188	74%
Pediatric	10,466	26%
FPL (of those responding)		
<100%		52%
<200%		97%
Prefer Services in Language other than English		
	25,367	64%

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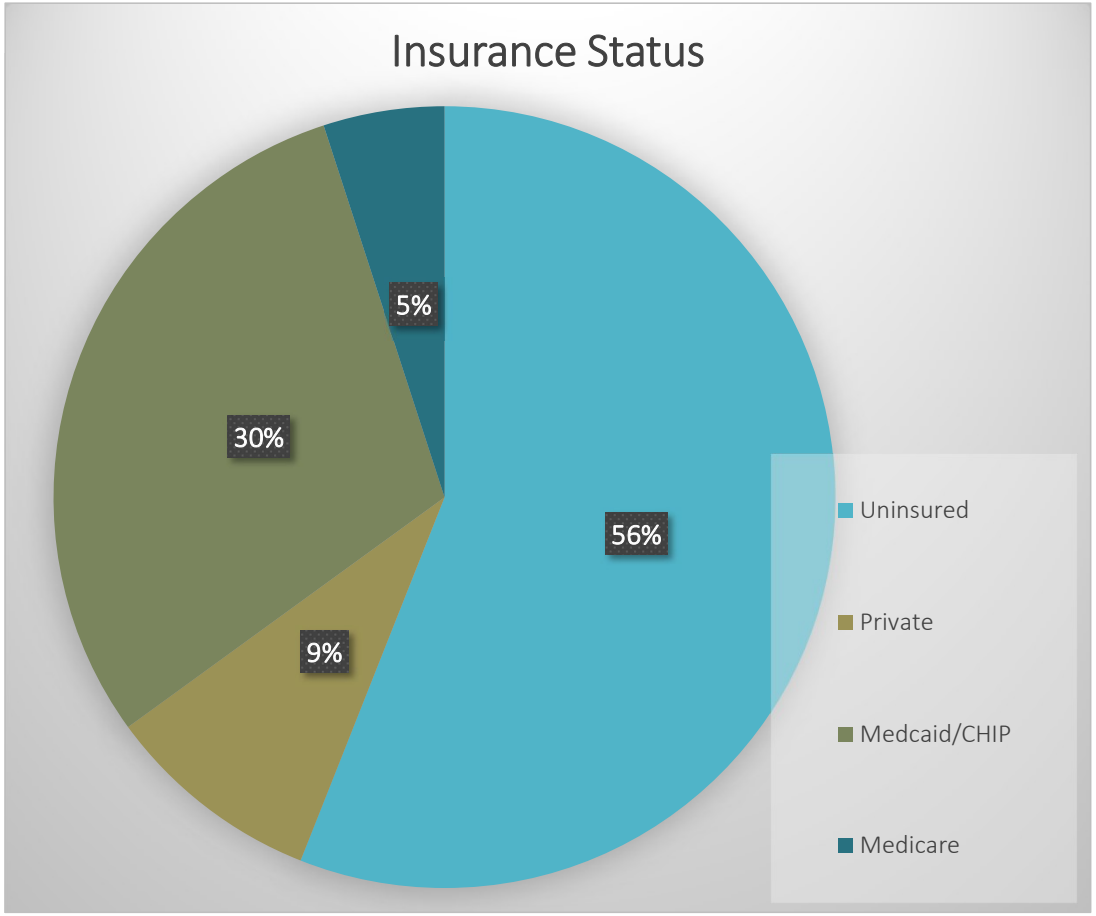
Neighborhood Health: Portrait of a Health Center



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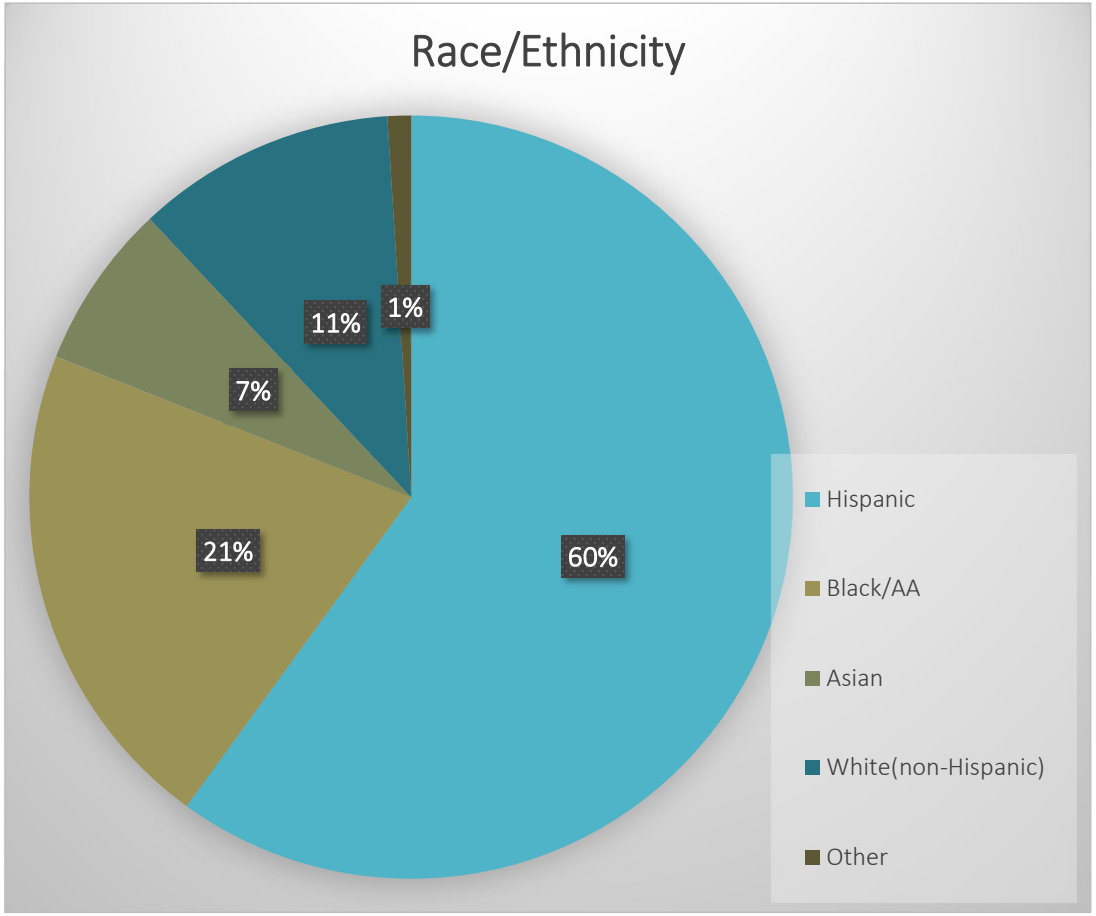

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SDOH and under-resourced populations

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Characteristic	Total Percentage (95% CI)
Race-ethnicity	
American Indian/Alaska Native	14.5 (14.5–14.6)
Asian, non-Hispanic, overall	9.5 (8.2–10.9)
Black, non-Hispanic	12.1 (11.3–13.0)
Hispanic, overall	11.8 (10.8–12.8)
White, non-Hispanic	7.4 (7.1–7.7)
Education	
Less than high school	13.4 (12.5–14.4)
High school	9.2 (8.7–9.6)
More than high school	7.1 (6.8–7.5)

Appendix | Diabetes | CDC

Public Charge

- Drafted in 1882, enforced in 2019
- Part of immigration law, used as an inadmissibility test
- Is an individual applying to live or visit the US likely to depend on certain US benefits?

  Become a “public charge”

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Public Charge

Benefits Included in Analysis

- SSI
  - *TANF*
  - *Grant/Cash Assistance*
- Medicaid
- SNAP
- Section 8 Housing

Additional Factors

- Age
- Health
- Skills
- Work/Educational History
- Income
- Insurance Status
- Financial History

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Impact of Public Charge

- Chilling Effect
- Decrease in new Medicaid enrollment
- 2019, healthcare and social service agencies see families requesting to disenroll from SNAP
- 1 example of existing barriers to accessing systems

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Addressing Barriers:

Thought Question: Where are many systems that address SDOH offered?

- Build partnerships with community-based organizations and government agencies that address SDOH
- Co-locate in facilities, including government offices, that address SDOH
- Share staff through partnership agreements to facilitate addressing SDOH needs of health center patients
- Streamline eligibility requirements across multiple systems of care so that patients are not required to present the same documentation repeatedly**

Screening Tools in FQHC's: Pros and Cons

Pros	Cons
Easily identify needs that impact patient health	Often lengthy
Broaden the conversation about what contributes to health	Requires timing
Invites new partners into healthcare arena	Requires dedicated staffing
	Requires thoughtful decisions

Neighborhood Health
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How can Value-Based Payment Help?

How can it help improve quality?

Access to ancillary services?

Increase connections between CBPs and CHCs?

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Reference

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Medicaid Managed Care's Role in Addressing Social Determinants of Health

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Background

- Medicaid managed care as an entry point into access to services aimed at addressing underlying social determinants of health (SDoH).
- Approximately 7 in 10 Medicaid beneficiaries are enrolled in managed care
- COVID pandemic highlighted significant needs to address and incorporate SDoH into services for low-income and racial/ethnic minority beneficiaries.
- In early 2021, the CMS published clarifying guidance in support of state Medicaid agencies' coverage and payment of SDoH activities.

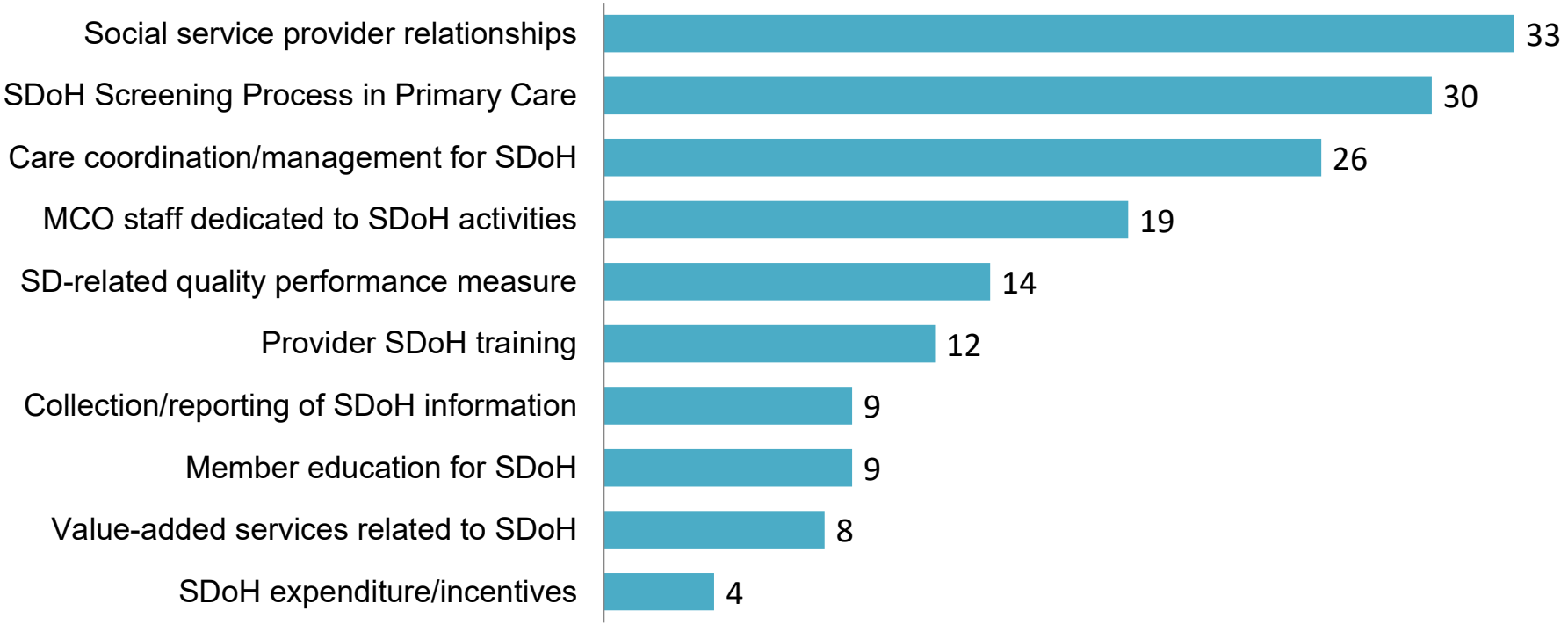
Two-Phase Research Project

Phase 1: Contract Review

- MC contract 39 states and the District of Columbia publicly available as of October 1, 2019
- The review instrument focused on ten major domains:

1) a formal SDoH screening process
2) discretionary value-added SDoH services
3) data collection and reporting of SDoH information
4) social services provider relationships
5) SDoH expenditure requirements or incentives
6) provider training in SDoH
7) MCO staff dedicated to SDoH activities
8) SDoH quality measures
9) SDoH care coordination or management
10) member education for SDoH

Number of States that Reference Select SDoH Terms



Source: George Washington University analysis of 39 state and DC Medicaid managed care contracts publicly available as of October 2019.

SDoH contract language

- SDOH language provides significant flexibility (non-specificity)

Following the first year of the contract, the Department will include a public health measure as a KPI, reflecting the RAE's role in the Health Neighborhood and Community addressing social determinants of health. (Exhibit B-3, p. 108, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

Social Determinants of Health and Health Equity a. Contractor shall spend a portion of annual net income or reserves on services designed to address health disparities and the social determinants of health, according to requirements in Oregon Administrative Rule and ORS 414.625(1)(b)(C).

Phase 1 conclusions (Medicaid)

- Significant discretion for contractors to specify terms and approaches (with agencies and other organizations)
- SDoH efforts target high-risk populations such as beneficiaries with behavioral health disorders or multiple comorbidities.
  - With limited resources to address a wide range of SDoH needs
  - No sustainable funding for SDoH services or process for accounting for those expenditures in their payment methodology.
- The lack of specificity and early setting of SDoH requirements likely reflect limited understanding of health-related social needs and costs.

Phase 2 project

- Interviews with Medicaid agency officials, Medicaid MCOs, community health centers, Primary Care Associations (PCAs), and community-based organizations in 5 case study states (CA, CO, GA, IL, and PA)
- The 5 states were selected for inclusion in the case study based on having a significant number of the SDOH domains incorporated into their contract, community health centers in the state reporting relatively significant capitated Medicaid managed care revenue, and to provide diversity in geography and Medicaid expansion status
- Interviews were conducted between January and May 2021

Phase 2 key findings

(1) Medicaid managed care contract language reflects an increasing, but still flexible, focus on SDoH that is in early stages

"…we have been very conscientious about moving our agreements forward in a manner that encourages and requires that our MCOs focus on those issues that really contribute to individuals' overall health, particularly food insecurity, workforce training, and housing. That's been our overarching philosophy."—State Medicaid

"Before, [our health plan] was either [focused on] medical or behavioral health, but it couldn't be both. I feel like there is a lot more focus now that it all goes hand-in-hand as whole-person care. If a person is hungry or has no place to sleep, it's more of a whole-person approach. The state recognizes now that this is a whole-[person] issue where medical and behavioral health needs to work together."— MCO

(2) The lack of direct Medicaid coverage of SDoH services requires providers to find alternative means of funding

"Right now, SDoH screening is not reimbursable, but it is incentivized. There are indirect ways it's supported... a lot of FQHCs [CHCs] use PRAPARE, but that's incentivized by HRSA."—State Medicaid official

"From the financial side, it [SDoH screening] is funded through operations, so we pay for that and we absorb all of that…so it's not funded but I don't want this to be a barrier."—CHC

- States can require MCOs to portion part of health plan reserves and profits to address SDoH.
- Restructuring payment approaches requires a good understanding of the expenditures and performance.

(3) Push for more and greater integration, coordination, and reinvestment…

For a long time, the way they [Medicaid] addressed this [SDoH] was through care coordination. There is not much else from the state around SDoH, with the exception of some scattered stuff like MCOs working on a housing initiative to fund housing for some Medicaid members. On care management side, [the state] has been pretty prescriptive on how the MCOs had to do this, like staffing ratios, and I think MCOs have by and large met the requirements in name but it's not particularly meaningful work – CHC

We are seeing a greater emphasis on true healthcare integration. Not just taking an assessment of needs but connecting them with services.— PCA

- What does this new structure and financial stability plan look like?

(4) Inconsistent SDoH screening tools limit data cohesiveness across organizations

(5) CHCs and MCOs address SDoH in their own space

- MCO and CHC relationships with local community-based organizations (CBOs) are frequently informal

(6) SDoH coverage is needed but requires flexibility

- *No recommendations for specifying contract language but…*

"*We're still stuck in volume-based care…So I think payment reform, shifting to PMPM model, and a capitated model with gain-share attached to it. If the state Medicaid department paid us a gain-share, 90% of the time health centers will invest that money back into those [SDoH] services*."— CHC

(7) the COVID-19 pandemic enhanced the need for strong relationships with local CBOs

"Especially housing and food insecurity has been exacerbated with COVID. Food insecurity is easier to stay on top of because there are many community partnerships. Before the pandemic, housing was a nightmare so I can't imagine what it's like now. Years-long waiting lists etc. are harder to deal with than getting people groceries."— PCA

- Medicaid and its providers have a clear role in bridging local resources but cannot overcome the limits of those resources.

Conclusions and recommendations

- Safety care access to SDoH services fragmented.
- State payment remodel challenges:
  - standardization of SDoH screening tools,
  - interoperable data collection systems (and “closed loop”),
  - better information regarding health-related social services spending,
  - measures of effectiveness and impact
- Larger care delivery organizations likely more ready to participate in VBP.
- Challenges with balancing flexibility and faithful payment structure for SDoH

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