Addressing Social Determinants of Health via Medicaid Managed Care Contracts and § 1115 Demonstrations

December 11, 2018
Agenda

- Welcome and Introductions
- About the Report
- Key Findings
- Federal Policy Recommendations
- Perspective from a Medicaid MCO
Today’s Presenters

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About the Report

Research focused on:

» Requirements and incentives for MCOs related to social determinants of health (SDOH)

» Managed care contracts/requests for proposals (RFPs) in 40 states

» 25 approved § 1115 demonstrations
  • Delivery System Reform Demonstrations, including Delivery System Reform Incentive Payment (DSRIP) demonstrations
  • Demonstrations that implemented the following:
    » Healthy behavior incentive programs
    » Work/community engagement requirement
    » A managed care program
Excluded from our inventory:

» Common Medicaid benefits
  • Home and community-based services
  • Non-emergency medical transportation
  • Health homes
  • Targeted case management

» Requirements and incentives not in MCO contracts or § 1115 demonstrations
  • E.g., Minnesota’s Integrated Health Partnership (IHP) RFPs
Overview of Key Findings
Managed Care Contracts: Key Findings

Growing focus on SDOH

Most common references were in care coordination and management requirements

Little detail on how MCOs can use existing authority to invest in SDOH interventions

Few payment incentives explicitly linked to SDOH
Delivery system reform demonstrations focus on:

- Enhancing care coordination
- Building community partnerships to address SDOH
- Payment incentives to advance these projects

Healthy behavior incentives are not typically linked to SDOH

Health plans in two states (Indiana and Arkansas) can help members meet eligibility requirements related to work and community engagement
Overview of Today’s Discussion

- **Systems and Partnerships**
  - Care Coordination and Management
  - Quality Assessment and Performance Improvement

- **Authority and Funding**
  - Additional Services
  - MCO Payment Incentives
  - Value-based Payment
Systems and Partnerships

• Care Coordination and Management
• Quality Assessment and Performance Improvement
Care Coordination and Management: 35 States

KEY
- 1115 Demonstration
- Contract

[Map showing states with various colors indicating participation in care coordination and management programs]
Care Coordination and Management: Overview

- Screening
  - Initial screening for SDOH
  - Comprehensive assessment of those with special health care or long-term services and supports needs
    - Care planning
  - Risk stratification

- Linkages
  - Coordination with community and social support providers
  - Referrals
  - “Closing the loop”
Care Coordination and Management: State Examples

**Contract (Kansas)**

- Focus: “Social Determinants of Health and Independence”
- Requires health risk assessment questions on domestic violence, housing, and employment
- Community service coordinators ensure linkages to community resources and support for education, employment, and housing

**1115 (North Carolina)**

- Opportunities for Health: “Enhanced case management and other services”
- Plan coordinates with Lead Pilot Entities, responsible for contracting with CBOs and social service agencies
- SDOH-related focus areas: housing, food, transportation, interpersonal violence
Quality Assessment and Performance Improvement: 13 States

[key]
- **1115 Demonstration**
- **Contract**
Plan must have an ongoing comprehensive QAPI program

» Performance Improvement Projects (PIPs)
  - Measurement of performance
  - Implementation of interventions
  - Evaluation
  - Planning and initiation of activities increasing or sustaining improvement

» Performance measurement data

» Mechanisms to detect under- and over-utilization
Quality Assessment and Performance Improvement: State Examples

**Contract (California)**
- Requires the MCO to include proposed interventions that address health disparities in its quality improvement plans

**Contract (D.C.)**
- Identify disparities, SDOH, and causes for disparities
- Develop a plan of action and a timeline to remediate identified SDOH and health disparities through targeted interventions and include this plan and timeline in the plan’s QAPI program
Authority and Funding

• Additional Services
• MCO Payment Incentives
• Value-Based Payment
Additional Services: 24 States

KEY
- 1115 Demonstration
- Contract
Value-added services

» MCO may voluntarily provide “any service”
  • Activity that improves health care quality
  • Incurred claims

» Cost not considered in the development of capitation rates

In lieu of services

» Medically appropriate and cost effective substitute for the covered service or setting under the state plan

» Authorized and identified in the contract

» Cost considered in the development of capitation rates
Additional Services: State Examples

**Contract (Texas)**

- Value-added services added by written amendment of the contract
  - Promotion of healthy lifestyles
  - Transportation services
- Case-by-case services at discretion of plan and not required to be part of the contract

**1115 (Massachusetts)**

- Accountable care organizations (ACOs) can pay for traditionally non-reimbursed flexible services to address health-related social needs
  - The state may provide a portion of flexible services funding directly to social service organizations to help them build infrastructure and capacity to better support ACOs in delivering flexible services
MCO Payment Incentives: 3 States

KEY
- 1115 Demonstration
- Contract
MCO Payment Incentives: Overview

- SDOH-related targets in the following:
  - Incentive arrangements
    - MCO receives funds in addition to capitation rate, but may not receive more than 105% of the capitation rate
  - Withhold arrangements
    - Portion of capitation rate withheld and paid back if MCO meets targets in the contract
  - Penalties
    - Portion of capitation rate withheld for non-compliance with "general operational requirements"
MCO Payment Incentives: State Example

Contract (Michigan)

- Pay for performance bonus, tied to a 1% withhold arrangement
- Three SDOH-related bonuses
  - Population health management intervention
  - Low birth weight
  - Emergency department utilization
- Baseline analysis, intervention proposal, and intervention reporting
VBP Initiatives: 10 States

KEY

- 1115 Demonstration
- Contract
**VBP Initiatives: State Examples**

<table>
<thead>
<tr>
<th>Contract (New Mexico)</th>
<th>1115 (Rhode Island)</th>
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<tbody>
<tr>
<td>Care coordination is delegated, or partially delegated, to a specific provider as part of a VBP arrangement</td>
<td>Accountable Entities (AEs) receive infrastructure incentive funds that can be used to develop capacity to address SDOH</td>
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<tr>
<td>The MCO can share care coordination functions related to coordinating referrals and linking members to community services</td>
<td>AEs report on the rate of screening for social needs. This measure factors into AE’s quality score, which determines the AE’s shared savings distribution</td>
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Recommendations for Federal Policymakers
Systems and Partnerships: Recommendations

- Make it easier for vulnerable populations to access needed health services and care coordination
- Enhance agency collaboration at the federal level
Authority and Funding: Recommendations

- Provide additional guidance on addressing SDOH
- Approve § 1115 demonstrations that test strategies to address SDOH
- Support outcomes-based payment for SDOH interventions
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OUR WORK ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Anne Kanyusik Yoakum
Chief Executive Officer
Overview

• State Policy Landscape
• Whom We Serve
• Hennepin Health Structure
• Initiatives Addressing the Social Determinants of Health
State Policy Landscape: Minnesota Department of Human Services (DHS) Procurement

- Prepaid Medical Assistance Plan (PMAP) and MinnesotaCare (BHP) are bid at least every five years

- In the most recent bid (for the 2016 plan year), DHS questions for Managed Care Organizations (MCOs) focused on the Social Determinants of Health

  Sample Question: “Describe how the MCO currently and in the past has maximized the integration of primary health, behavioral health, Public Health, and Social Services. Provide a detailed description (and any data in support) of your current or developing internal infrastructure that helps maximize the integration of primary health, behavioral health, Public Health, and Social Services.”
State Policy Landscape: Minnesota Department of Human Services (DHS) Accountable Health Model

In February 2013 CMMI awarded Minnesota a State Innovation Model (SIM) testing grant of over $45 million

- Joint effort between the Minnesota Department of Health (MDH) and DHS
- Used to test new ways of delivering and paying for health care through the Minnesota Accountable Health Model framework
  - Expand patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services.
  - Build on Minnesota's Integrated Health Partnerships (IHP) demonstration to adopt Accountable Care Organization (ACO)-style contracts with providers to better coordinate care
State Policy Landscape: Minnesota Department of Human Services (DHS) Accountable Health Model

Goals accomplished by July 2017:

- 465,000 Minnesotans receive care through a Medicaid accountable care organization.
- 88 percent of organizations can engage in health information exchange.
- Integrated Health Partnerships surpassed the cost savings goal of $100 million, and as of 2016, have reached a cost savings of $212.8 million.
- 15 Accountable Communities for Health were established by 2015.
- 57 percent of providers are health care home or behavioral health home certified.
Whom We Serve: Hennepin County

- Most populous county with 1.2 million residents (one-fourth of Minnesota’s population)
- Communities ranging from inner city neighborhoods to wealthy suburbs and rural areas
- Increasing poverty levels: 5% of families in 1999, up to 9% in 2010, with significant racial disparities
  - 4% of white families in poverty
  - 36% of black families in poverty
  - 38% of Native American families in poverty
- Well-documented health disparities
Hennepin Health Structure: County System
Levers for Health Improvement

- Hennepin Health members receive care from other (non-County) providers.
- Most County residents are not covered by Medicaid.
- Most County patients do not have Hennepin Health insurance.
- Not all County patients reside in Hennepin County.
Hennepin Health Structure: Accountable Health Model

- Shared electronic health record
- Collaborative decision-making
- Data and service integration
- Measuring impact
- Risk-sharing funding model
- Defining success in community health terms
Initiatives Addressing SDOH: Social Service Navigation

- Social workers and community health workers

- Facilitate access to services across Hennepin County
  - SNAP
  - Housing
  - Chemical Dependency/Withdrawal Management
  - Child Wellbeing and Protection
  - Criminal Justice
  - Emergency Cash Assistance
  - Eligibility and Enrollment Supports

- Opportunities to coordinate with community partners, including health plans
Initiatives Addressing SDOH: Housing

• Development of indicator for persons experiencing homelessness through data analytics

• Individualized work with enrollees to:
  ❖ Identify short- and long-term housing goals
  ❖ Assist with applications for coordinated entry, Section 8, other housing programs
  ❖ Locate and submit required documentation
  ❖ Complete Professional Statement of Need
Initiatives Addressing SDOH: Redesigned Primary Care Clinics

• Multi-disciplinary team-based care
• Access Clinic and other intensive interventions for most complex
• Co-located medical, behavioral health, dental and social services
• Flexible access
• Extensions into the community

Hennepin Health
Initiatives Addressing SDOH: New Enrollee Survey

• A regulatory requirement and an opportunity to connect
• Base survey from DHS, with an opportunity to modify
• Iterative, flexible process to develop future questions with broad input
• Challenges with difficult-to-reach enrollees