Addressing Social Determinants of Health through Medicaid ACOs

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Addressing Social Determinants of Health through Medicaid ACOs

I. Welcome and Introductions

II. Early State Efforts to Address SDOH via Medicaid ACOs

III. Addressing SDOH in Two Leading-Edge ACO States

   » Minnesota’s Integrated Health Partnerships

   » Rhode Island’s Accountable Entities

IV. Panel Discussion and Wrap Up
Today’s Speakers

Tricia McGinnis, Senior Vice President, Programs, Center for Health Care Strategies

Pamela Riley, Vice President, Delivery System Reform, The Commonwealth Fund

Mathew Spaan, Manager, Care Delivery and Payment Reform, Minnesota Department of Human Services

Rachael Matulis, Senior Program Officer, Center for Health Care Strategies

Deborah Faulkner, President, Faulkner Consulting Group

Deborah Correia Morales, Senior Consulting Manager, Conduent at Rhode Island Executive Office of Health & Human Services
Welcome & Opening Remarks

Tricia McGinnis, Senior Vice President, Center for Health Care Strategies
About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans
The Medicaid ACO Learning Collaborative

- National initiative designed to help states plan and launch Medicaid ACO programs
  - Offer peer-to-peer learning and technical assistance
  - Have helped 16 states develop/design their ACO programs and 10 of those states launch ACOs

- Medicaid ACO Resource Center
  - Practical resource to help states interested in designing a Medicaid ACO program
Pamela Riley
Vice President, Delivery System Reform
commmonwealthfund.org
Medicaid ACOs & Social Determinants of Health

Rachael Matulis, Senior Program Officer, Center for Health Care Strategies
Agenda

- Current Medicaid ACO landscape
- Overview of social determinants of health
- State approaches to addressing social determinants of health via Medicaid ACOs
Accountable care organization (ACOs) are designated entities held accountable for the financial and quality outcomes of a defined population.

ACOs were developed to move the U.S. health care system toward the goals of the Triple Aim.

ACOs were first adopted in Medicare under the Affordable Care Act of 2010.

First Medicaid ACO Program launched in 2011.

ACOs have since become a leading payment and delivery reform model across all payers.

What is an Accountable Care Organization?

- Improve patient care experience
- Improve health of populations
- Reduce per capita costs
What Impacts Health?

- Health care is a relatively small component of what influences health outcomes.
- Because most ACOs are accountable for total cost of care and quality, ACOs have a business case to address SDOH.

Determinants of Health and Their Contribution to Premature Death

- Behavioral Patterns: 40%
- Genetic Predisposition: 30%
- Social Circumstances: 15%
- Health Care: 10%
- Environmental Exposure: 5%

# Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
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<td>Community engagement</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
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<td>Discrimination</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
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<td>Social integration</td>
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<tr>
<td>Support</td>
<td>Walkability</td>
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<td>Support systems</td>
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## Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

State Policy Levers for Addressing SDOH via Medicaid ACOs

Medicaid ACO programs offer several key leverage points for addressing disparities and social determinants, including:

1. Partnership requirements
2. Care management requirements
3. Scope of services
4. Quality metrics
5. Financial incentives
## Innovative State Examples

<table>
<thead>
<tr>
<th>Partnership Requirements</th>
<th><strong>Colorado</strong> requires contractors to establish relationships with community-based organizations</th>
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</thead>
<tbody>
<tr>
<td>Care Management</td>
<td><strong>Rhode Island</strong> requires screening for and addressing social determinants of health</td>
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<tr>
<td>Scope of Services</td>
<td><strong>Oregon</strong> encourages contractors to provide services to address SDOH, such as a member’s living environment</td>
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<td>Quality Metrics</td>
<td><strong>Massachusetts</strong> plans to measure ACOs on social service screenings, as well as use of state certified “community partners”</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td><strong>Massachusetts</strong> will risk adjust ACOs’ rates and cost targets based on stability of housing status and “neighborhood stress score”</td>
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</tbody>
</table>
Notable Resources

- A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability, National Quality Forum, December 2017.
- B. Frieda, D. Kozick, A. Spencer, Partnerships for Health: Lessons for Bridging Community-Based Organizations and Health Care Organizations, Center for Health Care Strategies, January 2018.
- R. Mahadevan, R. Houston, Supporting Social Service Delivery through Medicaid Accountable Care Organizations: Early State Efforts, Center for Health Care Strategies, February 2015.
Integrated Health Partnerships and Social Determinants of Health

Mathew Spaan | Manager, Care Delivery & Payment Reform
Integrated Health Partnership Program - History

- MN’s Medicaid Accountable Care Organization (ACO) model
- Enhance accountability for patients’ care, create incentives for innovative care models that meet IHI triple aim
- First six (6) IHPs started in 2013, covering ~100,000 Medicaid beneficiaries
- We now have 24 IHPs, covering over 460,000 beneficiaries, with wide diversity and spread
- In 2018, we launched our “IHP 2.0” model
Current Impact of IHP

- Cost savings: $213 million
- People served: 460,000+
- Emergency room visits: Down 7%
- Hospital stays: Down 14%
Core Concepts and Accountability

- Medicaid and MinnesotaCare; FFS and Managed Care
- Primary care centric, but with built-in flexibility
- IHP system is responsible for:
  - Defined core set of health care services
  - Population-based payment to support innovate care delivery, care coordination, and infrastructure (Tracks 1 and 2)
  - Potential Total Cost of Care (TCOC) shared risk (savings and losses) (Track 2 only)
  - Robust quality metrics – clinical, utilization, and health equity
- DHS acts as facilitative partner, providing detailed data analytics and reports
IHP 2.0 – Critical Enhancements

- Multiple opportunities for a **wide variety of provider participants**
- Enhanced focus on **social determinants of health** and **meaningful partnerships**
  - Accountable Care Partnerships
  - Population-based payment
  - Health equity metrics
  - “Social risk” adjustment
- **Sustainability** of innovations, interventions, and partnerships
Integration of Social Determinants into IHP Model

Better Care, Healthier Populations, Lower Costs

Requirements

Direct and Indirect Incentives

Facilitation and Support
Integration of Social Determinants - Require

- PCMH, ACO or similar certification
- Demonstrated partnerships
- Meaningfully engage patients & families
Integration of Social Determinants - Incent

Population-based Payment

Risk Arrangement and Terms

Health equity metrics
Clinical performance & utilization
Success in targeted interventions
Accountable Care Partnerships
Sustainability of partnerships
Integration of Social Determinants - Facilitate

Population-based Payment Amount (PMPM) = Clinical / Medical Risk (ACG) + Individual Social Risk Factors

- Substance use disorder
- Serious mental illness (SMI & SPMI)
- Housing instability
- Prior incarceration
- Deep poverty
- Child protection involvement

Social risk data

Aggregate level / demographics

Individual level (*when available*)
Thank you!

Mathew Spaan
Manager, Care Delivery & Payment Reform
mathew.spaan@state.mn.us
Agenda

❖ Background and Context: RI Accountable Entities

❖ Integration of Social Determinants of Health
✓ **Target:** high/rising risk population
   Top 6% of Medicaid users accounting for 65% of cost, especially:
   - Populations receiving institutional and residential services
   - Populations with integrated physical and behavioral health care needs

✓ **Alignment of financial incentives (State, MCO, AE)**
   Shared responsibility for reduced cost, increased quality

✓ **Transition to risk**
   Using HSTP incentives to encourage/require increased AE financial risk and responsibility
Medicaid Accountable Entities: Goals

- Substantially transition away from fee-for-service models
- Define Medicaid-wide population health targets (consistent with SIM), and link any incentive payments to performance
- Deliver coordinated, accountable care for all, with targeted support for high-cost/high-need populations
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings as appropriate
Timeline

- **June 2015**: Reinventing Medicaid
- **August 2015**: EOHHS Request for Information (RFI)
- **January 2016**: Phase 0: AE Pilot implementation
- **October 2016**: CMS Approves Waiver Amendment
- **April-July 2018**: Phase 1: AE Program Implementation
Managed Care Partnership

New infrastructure *within and in partnership with* the existing MCO structure

- building on the existing strengths of the current MCO model
- enhancing its capacity to serve high-risk populations by
  - increasing delivery system integration and
  - improving information exchange, clinical integration
Medicaid Accountable Entities: Approach

Program Approach: Three Legged Stool

1. Certification
   Define expectations for Accountable Entities: capacity, structure, processes

2. Payment
   Require transition from fee based to value based payment model (APM Requirements)

3. Incentives
   Targeted Financial incentives to encourage/support for Infrastructure Development (HSTP)
Three Legged Stool: 1. Certification

1. Breadth and Characteristics of Participating Providers
   1.1. Provider base
   1.2. Relationship of Providers to the AE
   1.3. Ability to Coordinate for all levels of need for attributed pop
   1.4. Defined methods to care for people with complex needs
   1.5. Ability to ensure timely access to care

2. Corporate Structure and Governance
   2.1. Multiple entity applicant: Distinct Corporation
   2.2. Single Entity Applicant
   2.3. Governing board or Governing Committee: Interdisciplinary
   2.4. Compliance
   2.5. Required: an executed contract with an MMCO

3. Leadership & Management
   3.1. Leader: CEO or program manager
   3.2. Management structure/staffing profile
   3.3. Prepared for TCOC

4. IT Infrastructure: Data Analytic Capacity & Deployment
   4.1. Core data infrastructure and provider & patient portals
   4.2. Provider and care manager access to information
   4.3. Using data analytics for population segmentation, risk stratification, predictive modeling
   4.4. Reshaping workflows by deploying analytic tools
   4.5. Integrating analytic work with clinical care & care mgt processes
   4.6. Staff Development - Training

5. Commitment to Population Health & System Transformation
   5.1. Key Population Health Elements
   5.2. Social Determinants of Health
   5.3. System Transformation and the Healthcare Workforce

6. Integrated Care Management
   6.1. Systematic Processes to Identify Patients for Care Mgt
   6.2. Defined Care Mgt Team with Specialized Expertise Pertinent to Characteristics of Target Population
   6.3. Individualized Person Centered Care Plan for High Risk Members

7. Member Engagement & Access
   7.1. Defined Strategies to Maximize Effective Member Contact and Engagement
   7.2. Implementation, Use of New Technologies for Member Engagement, Health Status

8. Quality Management
   8.1. Quality Committee and Quality Program
   8.2. Methodology for the Integration of Medical, Behavioral, and Social Supports
   8.3. Clinical Pathways, Care Management Pathways, and Evidence Based Practice
   8.4. Quality Performance Measures
Three Legged Stool: 3. Incentives (HSTP)

- **Partnership with Institutions of Higher Education (DSHP)**
  - Community College of Rhode Island
  - University of Rhode Island
  - Rhode Island College

- **Health System Transformation Project (HSTP)**
  - Transitional Program for Hospitals & Nursing Facilities
  - Reinventing Medicaid Phase II: Accountable Entities
  - Health Workforce Partnerships

**EOHHS**

**One-year transitional funding to support the transition to new Accountable Entity structures.**

**System Transformation, including capacity building toward mature, broad based Accountable Entities (AEs), and new specialized provider partnerships.**

**Development of a healthcare workforce that is congruent with the goals of Medicaid reinvention and melds with the Governor’s Jobs Plan.**
The AE Program has grown considerably since inception; first year financial performance is encouraging.

AE Pilot Program Attributed Lives

As of Q3 2017, over half (51%) of Managed Care Enrollment is attributed to Accountable Entities.

PMPM AE Savings per Contract
SFY 2017*

- 4 of 7 AE contracts accomplished shared savings in SFY 17.
- There are 6 Certified Pilot AEs, of which 5 AEs are currently participating in shared savings contracts
- Participating AEs include: Blackstone Valley Community Health Center, CHC ACO, Integra, Prospect CharterCARE, and Providence Community Health Center
- The 5 participating AEs have a total of 7 AE contracts - 5 AEs have contracts with NHP; 2 with UHC

Source Data: AE Attributed Lives: MCO Quarterly Attributed Lives Snapshot Reports
Medicaid Managed Care Enrollment: Q3 2017, RI Medicaid Monthly Managed Care Report as of 9/30/17 (Aug, Sept. Average)

Source Data: MCO Shared Savings Reports
*Note: UHC Shared Savings results are reported for the period July 2016 – September 2017
Key Challenges

- Three way relationship: State, MCO, AE
- Flexibility and innovation vs. standardization
- CMS partnership
- State budget
- Administrative resources
- Sustainability
Sustainability

Incentive funding provides unique opportunity for startup funds to support investments in critical AE capacity and infrastructure....

- **AE Operations**
  Building, maintaining new provider capacity and infrastructure

- **AE Incentives**
  Interim support for AE Operations

- **Shared Savings**
  Source of ongoing funding to support AE operations

....Sustainability depends upon AE Savings replacing AE Incentives as source of funding
Agenda

- Background and Context: RI Accountable Entities
- Integration of Social Determinants of Health
SDOH: Considerations

Goal: Advance the systematic integration of social determinants of health into an individuals’ total care

❖ **Enhance capabilities**
  - Screening & Identification
  - Referral Management & Support
  - Follow up & Outcome
  - Tracking & Reporting

❖ **Enhance capacity**
  - Push beyond minimal in-house capacity for SDOH
  - Encourage AEs to leverage existing community capacity

❖ **Key Considerations**
  - Recognize variable starting points of participating AEs (Independent assessment)
  - Flexibility vs. Standardization
  - Build or buy?
  - Funds to community partners, where to start, resources
Integration of SDOH: Approach

**Approach:** Build expectations around integration of SDOH into each of component of the “three legged stool”

1. **Certification**
   - Capacity & Provision of Service Arrangements
   - Priority Areas/Domains
   - Screening & Referral Management Processes

2. **Payment**
   - APM/TCOC Quality Measure: SDOH
   - Screening tool guidelines
   - MCO/AE partnership & Strategy

3. **Incentives**
   - 10% of AE performance incentive funds must be allocated to establishing AE - CBO partnership
Integration of SDOH: 1. Certification

EOHHS has established certification requirements for participating Accountable Entities to demonstrate capacity and capabilities in addressing SDOH

- **Priority Domains**
  The Applicant is expected to identify three key domains of social need for each population for which certification is being sought (children, adults) and identify arrangements in place for the provision of pertinent services.

- **Capacity**
  Applicant must demonstrate clear evidence of capacity for the three priority domains
  - defined relationships with community-based organizations
  - in-house social supports capacity within a single entity AE, or
  - an Associate Provider agreement with a separate social supports agency.

- **Screening and Referral Management Process**
  Methods for Arranging Supports in high stress areas of SDOH such as:
  - Housing stabilization & support services;
  - Housing search and placement;
  - Food security
  - Safety and domestic violence
  - Need for utility assistance;
  - Physical activity and nutrition;
  - Education and literacy,
  - Employment,
  - Transportation,
  - Legal assistance
  - Criminal justice involvement
  - Other
Integration of SDOH: 2. Payment

- The Total Cost of Care (TCOC) Methodology must incorporate a quality multiplier
- Quality multiplier must be based on EOHHS Quality Scorecard
- EOHHS Quality Scorecard includes 10 required measures, one of which is a SDOH Measure
- SDOH Measure
  The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS approved screening tool, where the AE has documented the screening and results.
Integration of SDOH: 3. Incentives

SDOH Incentive Milestone: 10% of AE Incentive Pool is tied to the execution of Compliant Agreement w/SDOH, BH, SUD Service Provider

• Such agreement(s) must demonstrate that at least 10% of Program Year 1 Incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.

• These agreement(s) shall minimally include three core components:

  1) Protocols that enable the identification of social, behavioral and/or SUD service needs;
  2) Protocols for the referral of attributed members to participating SDOH, BH and/or SUD provider; and
  3) Reporting requirements that include referral tracking.
For Your Reference

Links to key documents, go to:

http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx

Accountable Entity Program
• Background/Context
• RI Vision, Goals, and Objectives
• Approach
• Progress to Data

Accountable Entity Stakeholder Meetings & Public Comments

Accountable Entity Program Requirements (CMS Deliverables)
• AE Roadmap:
• Certification Standards
• Attribution Requirements
• Incentive Requirement
• APM/Total Cost of Care & Quality Requirements
Panel Discussion
Questions?

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