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State Payment and Financing Models to Promote Health and Social Service Integration

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IN BRIEF

States are realizing the potential benefits associated with integrating medical care and social services, and are beginning to take the first steps toward developing financing and payment models that encourage this connection. This brief, made possible by The Commonwealth Fund, reviews potential financing mechanisms to facilitate integration, with a particular focus on Medicaid. Drawing from interviews with experts across the country, it offers models ranging from one-time seed funding for pilot projects to blended or braided financing arrangements that support comprehensive integration. The brief also highlights payment methodologies designed to influence providers to incorporate social services into their care efforts, with a focus on moving away from fee-for-service and toward value-based payment strategies like global budgets.

Research suggests that providing health care and social services in a seamless fashion has the potential to improve health outcomes and reduce associated costs.[1,2] Integrating services may also lead to easier and faster access to personalized support services, higher patient satisfaction, and less demand for crisis-oriented services.[3] While models for integrating health and social services have not yet been fully tested, states are eager to develop new programs and expand existing small-scale efforts to reap the potential health and cost benefits of integration and build a more effective and sustainable health care system.

A previous Center for Health Care Strategies-authored brief for The Commonwealth Fund, *A State Policy Framework for Integrating Health and Social Services*, described the initial building blocks states need to integrate health and non-health services: (1) a coordinating mechanism; (2) quality measurement and data-sharing tools; and (3) aligned financing and payment.[4] This brief focuses specifically on the third component—financing and payment—offering a menu of options for states to create financial incentives for integration, particularly for Medicaid populations. It outlines ideas for paying for health and social service integration, including examples of financing mechanisms and sources (*where the money comes from*) and payment methodologies (*how the money is disbursed to providers).* Much of this brief was informed by interviews with Medicaid and public health officials and health policy experts across the country.

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Background on Health and Social Service Integration

A person's health is not determined solely—or even primarily—by the medical care he or she receives, but rather by a host of factors, including genetics, behavior, and access to non-medical resources such as housing, employment, education, healthy food, and community/ environmental development opportunities (see sidebar below for a sample list of non-medical services used in Oregon).[5,6] Evidence suggests a clear link between social advantage and health status; as income and educational attainment increase, health outcomes improve.[7] While it may be impossible to pinpoint exactly which combinations of factors associated with social disadvantage most strongly affect health, researchers have demonstrated that the negative health outcomes associated with low economic resources may be mitigated by increasing access to other resources and opportunities.[8]

This brief addresses the issue of health and social service integration from a state perspective, with particular attention paid to Medicaid's role, given that Medicaid provides health care to many individuals likely to significantly benefit from integrated health and social services. This includes individuals who lack access to basic supports and resources and have complex medical needs (61 percent of adult Medicaid enrollees have a chronic or disabling condition).[9] In addition to providing clinical services, Medicaid is also required to provide "enabling services" that link beneficiaries to necessary care, such as case management, interpretation, and transportation.[10] However, Medicaid is limited in the types of non-clinical services it can fund, so at this time, Medicaid dollars must be combined with other funding sources to pay for comprehensive integration efforts. Finally, Medicaid is the second largest line item in state budgets, accounting for about 16 percent of all state funds.[11] This means that Medicaid, and the state as a whole, could reap a sizable share of any cost savings associated with integration efforts.

For this brief, the term "integration" is used broadly to denote meaningful ties between medical and social services, both financially and organizationally. It incorporates a spectrum of approaches, including both "low touch" connections relatively common in today's health care settings—like referrals, basic case management programs, and the Health Leads program, which trains college students to connect patients to basic health-promoting resources[12]—and more ambitious "high touch" integration models. Examples of more thorough or sophisticated integration models include team-based care (health and social service providers working on the same care team to address patients' wide-ranging needs) and the creation of integrated entities that offer a wide range of services. States may need to establish new financing streams and payment models to support the creation and expansion of such "high touch" programs.

Non-Medical Services Recognized by Oregon's Coordinating Care Organizations

- Training and education for health improvement or management;
- Self-help or support group activities;
- Care coordination, navigation, or case management;
- Home and living environment items or improvements;
- Transportation not covered under State Plan benefits;
- Programs to improve general community health;
- Housing supports related to social determinates of health; and
- Assistance with food or social resources.

Financing Mechanisms

One of the fundamental questions states face when seeking to integrate health and social services is: how will this be paid for? There is no right answer; each state is unique and must capitalize on available resources. Many states will pursue a gradual transformation toward financing integration, characterized by three phases: (1) pilot or demonstration; (2) intermediate ramp-up/expansion; and (3) advanced, fully operational (see Exhibit 1). During this process, states will move from small-scale, local demonstration projects—likely funded by one-time grants or seed money—to statewide efforts, paid for with a combination of Medicaid dollars and other state or federal resources.

This section describes funding strategies that can be targeted for each phase of the integration process. However, just because a particular strategy is highlighted under one phase does not mean it cannot also be used in another phase (e.g., a state pool/trust fund could be an effective financing strategy during the pilot and fully operational phases, in addition to the expansion phase).

EXHIBIT 1: A Continuum of Financing Options for Social Service Integration

PHASE 1: PILOT	PHASE 2: EXPANSION	PHASE 3: FULLY OPERATIONAL
• Small-scale federal grants • Social impact financing • Philanthropic funding	• Dedicated state pools or trust funds • Medicaid waivers • Social impact financing	• Blended or braided local, state, and federal financing.

Phase 1: Financing Pilot Integration Programs

During the early stages of an integration initiative, states can use short-term start-up funding, like federal grants, social impact financing, and/or philanthropic funding to finance pilots.

Small-Scale Federal Grants

Time-limited federal grants are well-matched to funding pilot integration efforts, as these grants are low-risk and provide a guaranteed amount of money over a pre-determined (generally short) time period to test whether a particular model is effective. States can support local or county-based entities applying for one-time federal grant funding by providing a letter of support for the pilot program, as well as offering strategic guidance around how to best design and implement the initiative. Once a grant has been awarded to fund a local pilot program, states can offer to play a role in: (1) addressing regulatory hurdles that may slow implementation; (2) aligning resources and funding streams; and (3) providing data. Examples of recent Center for Medicare and Medicaid Innovation grant programs providing such funding include Health Care Innovation Awards—which test new payment and service delivery models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)—and Transforming Clinical Practice Initiative grants, which support teams of providers to invest in value-based, patient-centered, and coordinated health care services.[13,14]

Social Impact Financing

Social impact financing (SIF), also known as pay-for-success financing, is emerging as another early financing option. Under SIF, a state government agrees to pay a third party to conduct an intervention, but only if that intervention is able to produce a prompt return on investment and meet other goals. Upfront financing is provided by an investor or group of investors that assumes financial risk in exchange for the opportunity to receive full repayment and a financial return if the intervention is successful. Programs can also be designed for investors to receive a percentage of the intervention's savings, with the remaining savings going back to the state.[15] For SIF to be successful, a number of elements must be in place, including: (1) the potential for a substantial impact (otherwise both the investor and the taxpayer lose money); (2) measurable outcomes; (3) a distinct population served; and (4) a high quality evaluation.[16] SIF may therefore only be appropriate for new initiatives that have significant stakeholder support and involvement, are rigorously designed, and are evidence-based.[17] It may also be a financing option for states looking to expand existing pilots that have already demonstrated outcomes.

Some of the earliest SIF models in the U.S. were used to reduce recidivism among jail-involved populations. More recently, SIF pilots are emerging to increase investment in addressing the social determinants of health. For example, the city of Fresno, California is designing a SIF-based project to reduce asthma emergencies among children through asthma trigger remediation; South Carolina is looking to use SIF to expand its Nurse-Family Partnership program; and New York State is considering SIF to offer a diabetes prevention program to at-risk patients.[18]

Philanthropic Funding

States can also look to local and national foundations to fund small-scale pilot programs. Such proposals may be made by the organization that is managing the pilot, or by the state itself. While philanthropic funding is certainly not sustainable over the course of a long-term, large-scale program, it may be the only seed funding available to a new initiative—and can help a program get started and develop the infrastructure to apply for additional funding sources.

Phase 2: Financing Expanding Integration Programs

After a program has shown some promising (though likely preliminary) results and demonstrated the potential to grow, a state can consider how to financially support program expansion. Two potential funding options during this stage include: (1) establishing a state-based trust fund or funding pool; and (2) obtaining Medicaid funding authority via waivers. These financing mechanisms are well-suited to this intermediate phase of program development because they: (1) are likely to have a longer duration than one-time grants, but may still be time-limited; and (2) are geared toward supporting programs that have already demonstrated initial positive results, as opposed to completely untested programs.

Trust Fund or Pool

A state-operated trust fund or funding pool—where the state sets aside a pot of money for health and social service integration—may be appropriate for an initiative's expansion phase because it can encourage growth, innovation, and sustainability planning, but is unlikely to support a project in perpetuity. An example of an existing trust fund is Massachusetts'

Prevention and Wellness Trust Fund, established in 2012 to reduce health care costs by preventing chronic conditions in local communities. The fund, established by the legislature as a four-year, $60 million initiative, is administered by the Massachusetts Department of Public Health and financed by an assessment on insurance and hospital revenue. In January 2014, the state announced more than $40 million in competitive grants to nine community-based partnerships working on prevention-based health initiatives.[19] Illinois is also considering a similar type of trust fund to be financed by a tax on sugar-sweetened beverages.[20]

Medicaid Waivers

Another opportunity to fund initiatives in development are Medicaid waivers, which serve as vehicles to test new or existing ways to deliver and pay for health services in Medicaid and CHIP.[21] As referenced later in the brief, Medicaid dollars cannot be used to pay for some non-health services, so states must be sure that waivers align with Medicaid funding protocols.

1115 Research and Demonstration Waivers: 1115 waivers provide states the flexibility to test and evaluate innovative program components that fall outside Medicaid's traditional requirements, as long as the changes are budget neutral for the federal government. States can use 1115 waivers to offer services not usually covered by Medicaid and test delivery system changes that have the potential to improve care and reduce costs. For example, under an 1115 waiver, a state can receive Medicaid funding at the standard federal matching rate for services delivered by non-traditional health providers or in non-traditional health settings.

1915(c) Home and Community-Based Services Waivers: 1915(c) waivers allow states to provide home- and community-based long-term care services to eligible Medicaid beneficiaries instead of institutional care. Programs can include certain non-medical services, including case management, home health aides, homemaker services, and respite care. States can propose additional non-medical services, so long as they help divert individuals from institutional care to home- and community-based locations.

STATES USING 1115 WAIVERS TO INTEGRATE HEALTH AND SOCIAL SERVICES

- ***Oregon***: Oregon used an 1115 wavier to establish regional Coordinated Care Organizations (CCOs), which pay for the total cost of Medicaid beneficiaries' physical, mental, and oral health care under a global budget. The waiver allows CCOs to use non-traditional health providers, including community health workers, patient navigators, and "health resilience specialists," who help patients address non-medical factors impacting health. The waiver allows the state to include "flexible" or non-State Plan services in the CCO capitation payment, to fund health-related social services.
- ***Texas***: Under an 1115 waiver, Texas established the Delivery System Reform Incentive Payment (DSRIP) Pool, a statewide funding pool for prevention and improvement projects. Under DSRIP, the San Antonio Metropolitan Health District is investing in ways to address obesity through nutrition, physical activity, and environmental improvements like new sidewalks. New York, California, and a few other states are also pursuing DSRIP programs.
- ***Vermont***: Under Vermont's Global Commitment to Health 1115 waiver, the state essentially operates as its own managed care organization, investing excess funding beyond per-member per-month limits in innovative programs, including respite services for families of children with disabilities, substance abuse treatment services, and tuition support for health professionals.

Phase 3: Financing Fully Operational Integration Programs

After a program has consistently demonstrated positive results related to beneficiary health outcomes and/or cost savings (for example, through a cost/benefit or return on investment analysis), states can develop financing models that are sustainable over the long term. Programs can combine Medicaid funding with other state and/or federal funding sources to pay for relevant social services. States can accomplish this goal via a braided or blended funding strategy.

Braided and Blended Funding

Despite the promise of using Medicaid funds to pay for state-based health and social service integration, Medicaid programs generally do not have the regulatory authority to pay for non-clinical services. This is especially true under Medicaid fee-for-service (FFS), as FFS billing codes only cover clinical care. Non-clinical services are more likely to be offered under a value-based or per-member per-month (PMPM) reimbursement system. However, these services must still be approved as "medically necessary" by the state, meaning they must have a direct link to a beneficiary's health. Services like care coordination or intensive case management often qualify as medically necessary, but housing supports, food assistance, or employment services generally do not (though states can use state-only Medicaid dollars to pay for such services; for example, New York is dedicating $100 million in state Medicaid funds to pay for supportive housing in State Fiscal Year 2014-2015).[22] As a result, a state looking to integrate health and social services with joint federal-state Medicaid funding will need to consider how it can combine these funds with other funding sources through the process of braiding or blending:

- *Braided funding:* A braided funding strategy supports coordinated multi-agency funding, but keeps different funding streams in separate and distinguishable strands, so each can be tracked at the administrative level. This strategy allows resources to be closely tracked and accounted for by each contributing agency. An Administrative Services Organization (ASO) or other coordinating entity could assume responsibility for tracking funds' movement and allocation. See the sidebar on the next page for examples of programs paying for health and social services through a braided funding model.
- *Blended funding:* A blended funding approach combines money from different sources into a single pool, making one dollar indistinguishable from another. This approach minimizes administrative work at the back end and maximizes spending flexibility, as providers may be accountable to a single entity, not the many entities contributing to the pool.

Both braiding and blending funding streams can enhance flexibility for the types of services offered and allow for more efficient access to funds.[23,24,25] Overall, however, a blended funding stream is likely to generate more flexibility, seamlessness, and administrative ease than braided funding. It can also spur collaboration and joint strategic planning at the agency and state leadership levels and promote optimal resource allocation. However, blended funding strategies are difficult to implement because of federal/state requirements for tracking and reporting on how funds are spent.

Given this, blended funding is not commonly used in health and social service integration models today, though some systems serving children with special needs have successfully utilized this strategy. Such programs pay for high-need children's physical health, mental health, and social services using a combined pool of two or more sources. Wraparound Milwaukee, for example, pools funds across child-serving systems to establish an all-inclusive case rate to cover care coordination and necessary services. Funding streams include: Medicaid capitation; child welfare funds; juvenile justice funds for residential treatment and corrections placements; education funds; and mental health funds.[26]

PROGRAMS PAYING FOR HEALTH AND SOCIAL SERVICE INTEGRATION THROUGH BRAIDED FINANCING

- **Boston Health Care for the Homeless Program** (BHCHP) provides primary care, behavioral health services, oral health, and other supportive services—including housing assistance and case management—to thousands of homeless individuals each year. It is funded through a braided financing model, in which different funding sources cover different program components: (1) FQHC Medicaid reimbursement covers medical care provided in clinical settings; (2) Massachusetts Medicaid's Massachusetts Behavioral Health Partnership funds a program for individuals with behavioral health and substance use conditions; (3) a Health Resources and Services Administration grant covers street and home-based clinical team services; and (4) foundation grants and philanthropic contributions pay for specialty dental and medical respite services.
- **Vermont's Support and Services at Home (SASH)** program offers Medicare beneficiaries a range of medical services (such as onsite nursing) and non-medical services (such as care coordination and self-management education) to help them safely live at home. Multidisciplinary health teams partner with community organizations to ensure that beneficiaries receive a full range of services. SASH receives Medicare funding through the Multi-Payer Advanced Primary Care Practice demonstration, as well as private philanthropic and public state funding.
- **Minnesota's Hennepin Health Program** is a county-based integrated health care delivery network that provides services to high-need Medicaid-eligible adults. It is working to integrate physical health, behavioral health, and social services (including permanent supportive housing and job support services) to address patients' social determinants of health. It operates under a braided financing strategy, receiving a fixed PMPM payment for the total cost of Medicaid health services (excluding long-term care) and using grants from the county to cover the cost of some program staff.

Funding Streams to Incorporate Under a Braided/Blended Model

The funding streams noted below can all be included in a blended or braided financing model to fund health and social service integration. The options listed are not exhaustive, but rather a sampling of the variety of sources that could be combined.

Medicaid Funding through a State Plan Amendment: Unlike waivers, Medicaid State Plan Amendments (SPAs)—which propose a change to a state's Medicaid plan—are permanent and have no cost or budget requirements, promoting the long-term viability of programs. Two SPAs that can promote health and social service integration are the health home SPA and the 1915(i) home and community-based services SPA. The health home SPA, authorized under Section 2703 of the Affordable Care Act, enables states to better coordinate care for Medicaid beneficiaries with chronic conditions. Referrals to social services are one of six services covered under the SPA and are reimbursed via a PMPM payment, which could be a first step in seeking more complete integration with social services.[27] Washington State's health home program, for example, uses care coordinators to: (1) actively manage referrals to social service programs; (2) assist

beneficiaries in advocating for access to care; and (3) document health and social service goals in an integrated care plan.[28]

Under the 1915(i) SPA option, states can propose home- and community-based services similar to those under the 1915(c) waiver, but are able to target the benefit to one or more specific groups and are not subject to cost neutrality requirements.[29] 1915(i) programs are a particularly promising financing strategy for establishing supported employment programs, which help people with disabilities obtain and maintain employment, instead of participating in expensive and often unfulfilling day treatment programs. Much like supported housing, supported employment programs have been shown to reduce individuals' use of health services and hospitalizations—saving money for Medicaid and state governments.[30]

MEDICAID FINANCING FOR PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing (PSH) is an evidence-based intervention that provides housing and social services to people with serious disabilities who are experiencing, or at risk of experiencing, chronic homelessness. Numerous studies have demonstrated that PSH programs produce a positive return-on-investment and can reduce costs associated with hospitalizations, emergency department visits, and nursing home stays.[31]

While Medicaid cannot currently use federal funding for direct housing costs, Medicaid funding can cover health, behavioral health, and non-clinical services that help disabled individuals obtain and retain housing, such as care coordination, case management linked to housing assistance, and diversionary services to reduce avoidable hospitalizations. Options for covering PSH under Medicaid include: (1) using the Medicaid Rehabilitation Option (an optional Medicaid coverage category for community-based mental and physical health services); (2) providing Medicaid reimbursement to FQHCs that provide PSH services; (3) using the Medicaid Personal Care Option; or (4) using authority granted from a 1915(c) home and community-based services or an 1115 waiver. Examples of PSH Medicaid financing models include:

- In Illinois, Louisiana, and Washington, DC, Medicaid pays for Community Support Teams, which reach out to individuals with serious mental illness to provide ongoing housing supports as needed.
- In Massachusetts, Medicaid pays for "diversionary services" for at-risk individuals participating in the Community Support Program for People Experiencing Chronic Homelessness. Medicaid pays a daily rate for each individual, enabling the service team to respond immediately to beneficiary needs.
- Illinois Medicaid has created an incentive-based bonus pool to encourage health plans to invest in housing supports. Payments are made to plans that demonstrate housing stability for members with serious mental illness or substance use disorders.[32]

Dedicated Federal Funding: States can consider ways to secure regular funding from federal agencies such as the Health Resources and Services Administration (HRSA) and the Department of Housing and Urban Development (HUD). HRSA funds could be used to pay for some services for patients who receive care at federally qualified health centers and health care for the homeless facilities, while HUD funds could be blended with Medicaid funding to provide brick-and-mortar housing to homeless individuals with serious and persistent mental illnesses or other chronic health conditions. Integrated health and social service programs may also utilize funding from the Centers for Disease Control and Prevention, which funds state and local health departments. Finally, programs that target individuals with substance use or mental health conditions could explore funding opportunities from the Substance Abuse and Mental Health Services Administration.

Block Grant Programs: States and local initiatives could also use federal block grant funds to support programs that combine health and social services. The Community Services Block Grant, overseen by the Administration for Children and Families (ACF), provides funds to community action agencies and other entities that address community members' social needs. The ACF also distributes Social Services Block Grants to fund a variety of social service and health care programs. HUD's Community Development Block Grant program provides economic and affordable housing support to low-income individuals.

Non-Profit Hospital Community Benefit Programs: Another opportunity for obtaining local funds to support health and social service integration is through alignment with non-profit hospitals' community benefit programs. State entities can encourage local hospitals to develop community benefit programs that align with the state's goal to better integrate social services into care delivery, or the state could establish initiatives that build on existing hospital programs that may already promote integration. One example of a program leveraging community benefit funds is the Michigan Pathways to Better Health initiative (a Health Care Innovation Award grantee), which trains and deploys community health workers to assist adult Medicaid and Medicare beneficiaries with health and social service needs.[33]

State or Local Budgeting Process: States could use the budgeting process to allocate funding from different state agencies for integration efforts, potentially raising new tax revenue. West Palm Beach, Florida, for example, has a special tax district to raise funding for early childhood programs, using the tax revenue to provide medical and social services for children.[34]

Payment Mechanisms

To effectively integrate social services with health services, providers must receive appropriate payment incentives that encourage or facilitate a connection between sectors. Under current FFS payment models, provider organizations reap no financial benefit, and often lose revenue, when connecting patients with critical social services. As a result, these providers have a perverse financial incentive not to assist patients with non-medical needs, even if addressing these needs could improve overall health. Conversely, payment models that implicitly or explicitly reward providers for linking social services to medical care can promote more meaningful connections. A continuum of payment options is presented in Exhibit 2, encompassing three levels of payment that provide increasing motivation to meaningfully link health and social services.

EXHIBIT 2: A Continuum of Payment Options for Social Service Integration

LEVEL 1: MAKING CONNECTIONS	LEVEL 2: INCORPORATING RISK	LEVEL 3: SUPPORTING COMPREHENSIVE INTEGRATION
• Social service care coordination payments	• Shared savings • Bundled payments • Direct payment to social service entities • Payment tied to social service metrics through shared savings or quality withholds/clawbacks	• Global community health budget

Level 1: Making Connections: Social Service Coordination Payments

One of the most direct ways to align financial incentives to the integration of social services with physical health care is to distribute PMPM care coordination payments to providers or care teams that are positioned to make these connections. Such payments can take the form of an independent payment specifically for social services or can factor the social services payment into an enhanced PMPM for a care coordination payment the provider already receives. The most widespread uses of this payment form is through patient-centered medical home and health home programs, which provide a PMPM payment for a range of care coordination activities, including facilitating connections and referrals to social service agencies and community-based organizations. While social service coordination payments do not incorporate provider risk, they can provide a solid financial foundation on which to build greater accountability at a later time.

Level 2: Incorporating Risk

Once providers have gained experience facilitating connections to social services, states may consider increasing financial accountability and fostering a deeper connection between health and social service entities via risk-based payments, including shared savings models, bundled payments, direct payments for social services through managed care organizations, and quality withholds or clawbacks.

Shared Savings Models

Many states are currently considering ways to incorporate social services into their accountable care organization (ACO) models, and one of the most discussed methods is shared savings payments. Under a shared savings arrangement, ACOs or other entities have an inherent financial incentive to connect patients who could benefit from social and community-based supports to entities that provide these services. Since social services are not often included in the ACO's total cost of care calculation (from which savings are benchmarked and calculated), providing effective non-medical services is an easy way to reap shared savings.

States could also go a step further and tie shared savings to social service metrics. While social services would likely not be included in an ACO's total cost of care, ACOs could stipulate that shared savings would not be distributed unless social service metrics are satisfactorily met, thereby creating a stronger incentive for providers to facilitate connections to relevant social service organizations. Currently, Vermont's Medicaid ACO program tracks school completion rates and unemployment, while Oregon's CCO program measures out-of-home placement for children and adults. These metrics are not currently tied to provider payment, but doing so in the future would help promote medical-social service integration.

Shared savings can also be used to create incentives for community-based organizations to become involved in ACO activities. ACOs could offer community-based organizations a portion of any shared savings achieved, financially tying these organizations to the care of ACO members. While states generally have not dictated how Medicaid ACOs should distribute their shared savings, the states could insert language in ACO program regulations requiring social service and community-based organizations to be part of the ACO and/or its leadership.

Bundled Payments

States can also promote the integration of health and social services via bundled payments, which provide a standard payment for an episode of care or management of a specific condition over a defined period of time. Not all bundled payments need to include a social service component, but some episodes of care/conditions, such as maternity or prenatal care, may benefit from these connections.

Under bundled payment reimbursement, the lead provider has the incentive to work within a budget to achieve a successful health outcome, which may include connecting a patient to relevant social services. For example, if a bundled payment is provided for treating individuals with congestive heart failure, the lead provider may connect the individual with a smoking cessation program and/or a community-based nutrition program to reduce the risk of readmission.

States could take further steps to link social services within bundled payment structures by tying provision of the bundled payment to social service quality metrics. By including quality metrics that are tied to social service factors, either directly (housing status) or indirectly (30-day readmissions), states can ensure that providers remain mindful of the opportunity to refer patients to social services. A stronger link could be created if providers receive funds to distribute to social service or community-based agencies as part of the bundle. Such services could include non-emergency transportation or supportive housing.

Payments for Social Services through Medicaid Managed Care Organizations

Medicaid managed care organizations (MCOs) are at risk for total patient spending, and may see benefits in promoting connections between medical providers and social service/community-based organizations, if doing so could improve patient care and lower costs. If MCOs are given flexibility to pay for social services through an 1115 waiver or other federal authority, they can explore opportunities to provide beneficiaries with enhanced care coordination or supporting services such as transportation or temporary housing. Assuming these services are not provided by physicians or staff directly under an MCO contract, MCOs may be able to pay for these services via direct payments to social service entities.

States wishing to pursue this strategy can include language in MCO contracts requiring MCOs to pay for particular social services or partner with certain social service organizations. States must be mindful, however, that provision of non-Medicaid services may impact actuarially sound rate-setting processes and result in additional federal scrutiny. Further, medical loss ratio regulations—requiring insurers to spend 80 to 85 percent of all premium revenue on medical care—may make MCOs wary of providing funding for social services if they are classified as administrative expenses.

Some MCOs have already begun to address social services using PMPM payment incentives. An Illinois Medicaid managed care organization, IlliniCare/Cenpatico, is paying a mental health and housing services provider a PMPM fee for its services for high-cost homeless individuals.[35] Under Arizona's Integrated Care Management Pilot, a partnership between Care1st Health Plan Arizona and the regional Area Agency on Aging (AAA), Care1st pays the AAA an hourly rate for social case

management services, estimated on what it would cost the health plan to employ case managers for the same services.[36]

Quality Withholds or Clawbacks

States could also make provider organizations and MCOs accountable for outcomes related to non-medical services by employing quality withholds or clawbacks tied to social service quality metrics. Under a quality withhold arrangement, a percentage of service payments are automatically held from payment until performance metrics are achieved. For example, Kansas' Medicaid program withholds five percent of its MCO's PMPM payments contingent on their performance on a set of 15 equally weighted quality metrics. The MCO only receives the full five percent back if it meets or exceeds quality benchmarks on all 15 metrics, which increase on a yearly basis.[37] Alternatively, the full amount of service payment could be paid up front, but could be subject to being "clawed back" or repaid if quality performance metrics are not achieved.

Level 3: Supporting Comprehensive Social Service Integration

A fixed budget offers medical providers the strongest incentive to link patients with social services, as it encourages providers to utilize social service and community-based entities as partners—or eventually, to offer co-funded or embedded social service case managers as part of care teams—in order to keep costs under budget.

A Global "Community Health" Budget

Global budgets are perhaps the most accountable and flexible model of payment for social services, and many providers and payers believe this model holds the most promise for supporting sustainable service delivery integration. Under this model, an entity is given a capitated payment to cover a comprehensive range of services over a fixed amount of time. Even if states do not include social services in the global budget, providers still have a powerful incentive to collaborate with these entities to keep costs down (as it is assumed better access to social services leads to healthier patients, and therefore, to lower costs). If states decide to include social services—like supportive housing or nutrition counseling—in the organization's total cost of care or quality metrics, the incentive would be even stronger.

Examples of health care organizations that currently use global budgets are Minnesota's Hennepin Health, a county-based Medicaid health plan serving high-need, high-cost patients, and Oregon's Medicaid Coordinated Care Organizations (CCOs).[38] These two programs are early in their implementation and are looking to place a greater emphasis on incorporating social services and community-based organizations into their programs in the future, but have laid a successful groundwork for such integration under a global budget.

Hennepin Health, which includes a payer and providers, manages its own capitated budget and reconciles any savings through a year-end settlement process. While providers are still paid via FFS, the budgeted amounts in excess of payments made are distributed through a pre-arranged formula with a certain percentage going to partnering social service organizations, and the remaining percentage going to reinvestment. The reinvestment funds are flexible, and have been targeted to future projects likely to yield the highest returns, such as leased transitional housing

units for complex patients and vocational services for high-cost behavioral health patients.[39] The transitional housing effort has been particularly successful: inpatient utilization among the 100 newly housed individuals dropped 29 percent and inpatient costs fell 72 percent. These patients' ED visits also decreased by 55 percent, and associated ED costs were down 52 percent.[40]

Oregon's CCOs receive a global budget from the state to provide physical health, behavioral health, and dental services for the state's Medicaid enrollees. CCOs' global budgets include payments for social services, and many CCOs have seen the value of actively coordinating with social service agencies and community organizations. For example, CCOs have the flexibility to pay for non-emergency medical transportation and non-medical items deemed medically necessary for certain individuals, such as air conditioners for individuals with asthma.

Regardless of the global budgeting mechanism used, states will likely face challenges in setting appropriate capitation rates, particularly if the budget incorporates multiple funding sources. Global rate setting is largely uncharted territory, so some trial and error may be necessary in determining rates that adequately fund all parties and drive continued improvement. Additionally, states must ensure that plans producing savings through better health and social service integration are not penalized by future rate cuts. Instead, both the state and the capitated entity should benefit from the cost savings, and a mutually agreeable arrangement must be reached to sustain the incentive.

Implementation Challenges

While integrating social services and physical health care is an intriguing and potentially highly rewarding objective for states, many challenges must be addressed. First, as noted above, federal regulations do not generally allow Medicaid funds to pay for social services directly, so unless states use a braided or blended financing strategy that employs multiple funding streams, they will likely need to gain federal approval for payment strategies incorporating Medicaid dollars—which could entail a lengthy approval process. State laws and regulations must also be considered. Depending on how a state organizes its health care, public health, and social service programs and constructs its budget, legislative or regulatory modifications may be needed at the state level to institute these strategies.

States will also need to find ways to coordinate efforts between traditionally separate sectors. While state Medicaid agencies may want to better coordinate with their social service counterparts and community-based organizations, it will take time for new partnerships to develop. Within states there may be resistance to share funding across agencies, as each agency may worry that its budget will be negatively affected. Data sharing—particularly the exchange of beneficiaries' health data—will also be difficult, given: (1) the strict privacy safeguards in place for sharing personal health information; and (2) the fact that medical and social service agencies and providers often have very different information in their records and different systems and software to manage the data.[41]

States face another challenge related to the acceptance and uptake of integration projects by providers, MCOs, and social service organizations. While states could mandate participation in an integrated program, it may make more sense to transition into such models gradually. States

must convince participating parties that the new way of doing business holds merit, and may choose to provide guidance or other supports to help these entities build capacity for collaborative work.

Recommendations

States have an opportunity to integrate social and community-based services into new or existing health care reforms to help address the social determinants of health and achieve the Triple Aim of better patient satisfaction, improved population health, and lower costs. While efforts in this area are in very early stages, states can move toward this goal by ensuring that stable financing and payment mechanisms support such integration. In developing a financial strategy to integrate medical and social services, states may want to consider the following:

1. **Flexibility is an asset.** Blended financing and global payments—often seen as the end goal of many social service integration efforts—allow for the most flexible uses of the dollars across different functions. Having such flexibility allows state administrators to develop programs across departments and use funds more effectively.

2. **Managed care organizations and accountable care organizations can be effective partners.** State-based financing and payment mechanisms (such as FFS Medicaid) are restricted by a variety of federal and state laws. MCOs and ACOs, on the other hand, have much more flexibility as to how their funds are distributed for health improvement purposes, and therefore, can more easily allocate funds to where they are needed (such as social services and supports). If financial incentives are properly aligned, MCOs and ACOs will seek to take advantage of social and community-based services to keep their patients healthy. MCOs and ACOs are also more likely than other players in this space to have the data and management infrastructure in place needed to handle upside/downside risk issues.

3. **Reinvestment can help sustain a program.** No matter how states decide to link social and medical services, reinvestment in the program is crucial for sustainability and continued impact. Instead of simply rewarding providers with excess savings from capitated payments or shared savings arrangements, organizations can require reinvestment of a percentage of these funds back into the program to help fund new initiatives and ensure sustainability.

4. **Geographic- or population-based models may have a bigger impact.** A geographic- or population-based model may lend itself more toward a population health mindset and encourage the use of creative solutions that work across agencies. Such models may also be better suited to using more accountable and flexible models like blended financing and global payments, due to their ability to manage care for a large number of people and services, thus mitigating risk in the patient pool.

Conclusion

There is increasing evidence that the social determinants of health have a profound effect on patient health and health outcomes. In fact, 80 percent of physicians believe that addressing patients' social needs is as critical as addressing their medical needs.[42] Many states have already started to pursue new ways to integrate medical and social services through targeted financing mechanisms and payment methodologies. By strategically employing key components—including multiple, flexible funding streams; value-based payment models that reward social service use or health outcomes; and targeted reinvestment goals—these pioneering state efforts will forge new and more effective relationships between health and social services and transform how patient needs are met. Although financial incentives are not sufficient in and of themselves to ensure lasting change in care delivery, they are a critical piece of an effective integration effort.

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The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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