

Webinar Q&A: Addressing Social Determinants of Health through Medicaid Accountable Care Organizations: Early State Efforts

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1. Rhode Island is currently reviewing applications for the state's Comprehensive AE program. How do AEs plan to coordinate with community-based organizations to address SDOH?

AEs have proposed to coordinate with a wide range of community-based organizations, including those that focus on safety, food security, homelessness, and transportation. From a practical standpoint, examples of coordination strategies from the AE applications include establishing memorandums of understanding that outline specific approaches to referral management, monitoring and evaluation, and scope of work around key deliverables. Another coordination strategy is ensuring that representatives from community-based organizations will be included within an AE's leadership or governance structure.

2. What are some examples of health equity or SDOH-related metrics, and how are they being used in Minnesota's IHP and Rhode Island's AE programs?

Rhode Island plans to measure AEs based on the percent of their attributed population screened for SDOH. The AE's pool of shared savings (or losses) is adjusted based on performance on this (and other) [quality measures](#). In the first year, this measure is pay-for-reporting only, but will ultimately shift to pay-for-performance. Minnesota requires IHPs to [propose at least one health equity measure](#) tied to interventions intended to reduce health disparities among the IHP's population. IHPs must submit an annual report containing a written evaluation of the impact and effectiveness of the IHP's interventions, as well as the IHP's performance on its identified [health equity measure\(s\)](#). The equity measures are tied to unique interventions that IHPs are carrying out based on distinctive issues within their local communities. For example, one IHP has implemented interventions related to addressing the opioid crisis, with a focus on wrap-around services related to substance use disorder (SUD) treatment. This IHP is measuring the number of patients referred to an SUD consultant, and, of those referred, how many received services from an addiction specialist or other treatment provider. Another IHP is addressing food instability and insecurity through a partnership with [Second Harvest](#). The IHP has equity measures focused on the number of people referred for related services; the number of people receiving services, such as Supplemental Nutrition Assistance Program and/or food boxes from Second Harvest. Minnesota's [population-based payments](#)—which are quarterly care coordination payments for each member attributed to the IHP—are impacted, in part, by performance on health equity metrics. While the equity measures are largely process-focused at this point, it is expected that they will evolve over time.

3. How are ACOs in Minnesota and Rhode Island addressing maternal and child health? For example, are there specific initiatives to support children's healthy development in order to "break the cycle" of disparities?

One key method used by both states is to incorporate quality measures related to maternal and child health in the ACO programs. For example, Minnesota assesses IHPs' performance based on a number of pediatric-related [quality measures](#), including childhood and adolescent immunizations; weight assessments and counseling for children and adolescents; annual dental visits for children; and adolescent mental health and depression screening. Rhode Island plans to assess AEs on similar [quality measures](#), such as weight assessment and counseling for children and adolescents and developmental screenings in the first three years of life. Further, Rhode Island's AEs must define a [member contact and engagement approach](#) designed to recognize that: (1) the

roots of many problems are [based in childhood traumas](#); (2) many of the highest-need individuals have a basic mistrust of the health care system; and (3) many members may not be affiliated with a primary care provider.

4. How does social risk adjustment work in Minnesota’s IHP program?

Minnesota adjusts IHPs’ quarterly population-based payments for social risk factors, including homelessness, mental illness, substance use disorder, past incarceration, and child protection involvement. In other words, the base rate for the [population-based payments](#) will vary by the risk and social complexity of each IHP’s attributed population, with additional payments to account for the complexity and difficulty of managing care for those experiencing the identified social risk factors.

5. How does Minnesota’s Medicaid program have access to detailed SDOH data?

The [Minnesota Department of Human Services](#) (DHS) administers a number of health and social services programs, including Medicaid, Child Protective Services, Housing and Homelessness Programs, and the Supplemental Nutrition Assistance Program. This enables the Medicaid agency in Minnesota to access relevant SDOH data through state administrative data. For example, the poverty metric and housing instability metrics use addresses from DHS’ eligibility and enrollment system. DHS analyzes this data, such as whether Medicaid beneficiary addresses are for homeless shelters or whether addresses are changing frequently. Data on SUD and mental health disorders come from Medicaid claims data. In cases where SDOH-related data were not readily available, the state worked with other agencies to access needed information. For example, DHS worked with the Department of Corrections to access data on prior incarcerations, and is currently working to get access to county jail data. It is also currently working with [Second Harvest](#) to obtain data on food insecurity.

6. How are Rhode Island and Minnesota incorporating community health workers into their ACO programs?

[Community health workers](#)— also referred to as *promotores de salud*, health navigators, or liaisons — can play a key role in facilitating connections with community resources and addressing SDOH for patients with complex needs. Community health workers typically have [shared lived experience and a first-hand understanding of the culture and community norms of the population they serve](#), which allows them to intimately understand the socioeconomic and cultural environments in which their patients live, and as a result, build strong, trusting relationships. Rhode Island specifically asked potential AEs in the [AE application](#) to comment on the extent the organization’s care management capacity includes a well-defined set of providers, including community health workers. Minnesota does not have specific requirements related to community health workers, but one of the core principles of the IHP program is to ensure emphasis on primary care, with flexibility to include a role for non-traditional principal care providers. Further, the state allows [eligible providers](#) to [bill](#) for services provided by community health workers.

7. What are examples of some of the SDOH screening tools being used in Rhode Island and Minnesota?

Rhode Island requires that AEs screen their attributed populations for SDOH, but does not mandate use of a specific tool. Examples of the SDOH screening tools that AEs plan to use include the [Health Leads Screening Toolkit](#); the [Accountable Health Communities Health-Related Social Needs Screening Tool](#); and the [Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences \(PRAPARE\)](#). Minnesota does not require IHPs to screen for SDOH nor does it require use of a specific SDOH screening tool.

CHCS recently published a [brief](#) that reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying community resources and tracking referrals.

8. How can community-based organizations be funded to help ACOs meet quality and cost goals? For example, do the ACOs pay them a fee and/or share savings?

In Minnesota, IHPs are exploring various approaches to fund community-based organizations, including in-kind support, sharing a portion of any earned savings, and direct payments tied to shared clients. In Rhode Island, [AEs are eligible to receive incentive funds](#), which help to provide startup funds to support investments in AE capacity. Rhode Island requires that 10 percent of AE performance incentive funds be allocated to establishing partnerships between AEs and community-based organizations. The distribution of AE incentive funds is contingent upon [AEs meeting performance metrics outlined in the Health System Transformation Project Plans](#) and serves as a time-limited opportunity to earn start-up funds in years one through four of the AE program. The expectation is that AE shared savings would ultimately replace the incentive funds.

This is an evolving field, with a growing body of literature exploring partnerships and financial arrangements between health care systems and community-based organizations. For example, the Shared Savings Plan Playbook, developed by the Parkland Center for Clinical Innovation (PCCI), is a resource that can be used to assist in the development of shared savings models that comprise a multitude of service providers, including those in clinical health care, social services, behavioral health, and public health. The [Partnership for Healthy Outcomes](#), a collaborative of Nonprofit Finance Fund, CHCS, and Alliance for Strong Families and Communities, has also created tools and reports that summarize approaches to health care partnerships with community-based organizations. CHCS also recently published a blog post on using [Pay for Success](#), which is a less conventional contracting approach focused on paying for outcomes, not services. This contracting approach could inform financial arrangements between ACOs and community-based organizations.

9. Is Minnesota or Rhode Island considering a future phase that would create accountability at a community/geographic level--perhaps with multiple ACOs working together with other regional stakeholders--to improve total population outcomes?

Medicaid ACO programs in Rhode Island and Minnesota will continue to evolve. However, both states are currently driving toward changes that incentivize accountability for population health. For example, Minnesota had a related initiative, referred to as [Accountable Communities for Health](#) (ACH), which built upon the state's existing delivery system and payments reforms, including the IHP program. ACHs are collaboratives of medical and community providers tasked with addressing clinical and social needs of a defined population through coordinated care across a range of providers: acute and primary care, behavioral health, long term care, local public health, social service and other community-based supports. ACHs were required to include at least one organization participating in or planning to participate in an ACO. While the ACH grant period ended December 31, 2016, [Minnesota's "IHP 2.0" program](#), which officially launched January 2018, mirrors some aspects of the ACH model, such as incentivizing partnerships between medical and non-medical providers to address patient and population health—including community-based organizations, social services agencies, counties, and public health resources—and stressing the importance of non-medical health factors. Similarly, Rhode Island envisioned that AEs would be multi-disciplinary in composition, inter-disciplinary in practice, and focused on population health, with programs tailored to address varying levels and types of needs. All AEs should have a defined, integrated strategic plan for population health that describes how it will organize its resources to impact care and health outcomes for attributed populations.

10. What key lessons would you share with states interested in addressing SDOH via their Medicaid ACOs?

Although the "science" behind social risk and effective SDOH-related interventions is still developing, Minnesota capitalized on existing research projects and activities; good working relationships with health care systems and community-based organizations; and flexibility in the IHP program that allowed for experimentation. Minnesota

took a “good is better than perfect” approach that includes on-going cycles of review, reassessment, and periodic changes as needed. Additional conversations with beneficiaries and community partners are also expected. Finally, what works in one state (or even just one community) may not always work in another – local innovation is needed, and can only occur with a lot of conversations. Minnesota is learning (and re-learning!) with each step of the project.

In Rhode Island, a critical lesson has been the importance of establishing a “top-down” focus on SDOH to ensure that social needs are built into the framework of what AEs are trying to accomplish day-to-day. This includes, for example, having representatives from community-based organizations serving on AEs’ leadership and governance structures. From a practical perspective, the flexibility AEs have to identify how to incorporate SDOH into their organizations has also been important. It allows the AEs to figure out how best to implement new work-flows given their unique organizational characteristics, data systems, and local needs. Similar to Minnesota, Rhode Island is also allowing for a period of testing and learning as AEs determine how best to integrate new tools, referral management processes, and quality and cost outcomes within their day-to-day work.