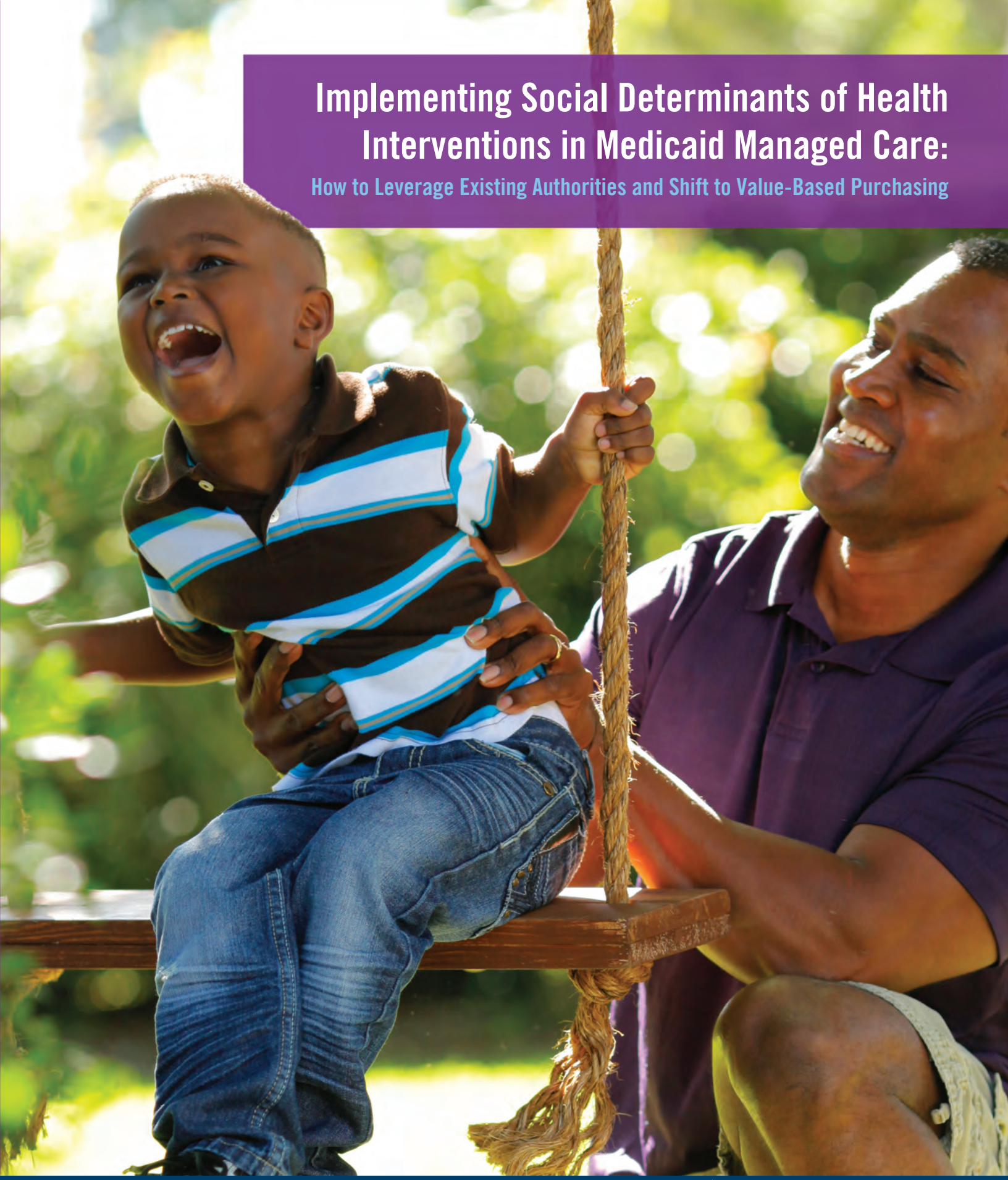
Implementing Social Determinants of Health Interventions in Medicaid Managed Care:

How to Leverage Existing Authorities and Shift to Value-Based Purchasing



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Implementing Social Determinants of Health Interventions in Medicaid Managed Care:

How to Leverage Existing Authorities and Shift to Value Based Purchasing

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Nemours Children's Health System was awarded a one-year grant to help three state Medicaid programs test approaches to financing upstream prevention and population health through AcademyHealth's Payment Reform for Population Health initiative, with funding from the Robert Wood Johnson Foundation. While almost all states have begun Medicaid delivery system reform, initiatives and programs geared toward upstream prevention and population health are in varying stages of development. Nemours provided technical assistance to three states – Maryland, Oregon and Washington – as they developed or implemented upstream prevention strategies using Medicaid funds. This brief is one in a series of six "how to" briefs illustrating how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives. The entire series of briefs can be found at **https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention**. To learn more about AcademyHealth's Payment Reform for Population Health initiative, visit **www.academyhealth.org/p4ph**.

INTRODUCTION

Recognizing that health outcomes are driven by factors other than clinical care, Medicaid and other payers are exploring ways to provide health-related, non-clinical services that can address social determinants of health (SDOH) and cost-effectively improve health outcomes and lower costs. Medicaid agencies are increasingly interested in how to weave SDOH interventions into broader care management strategies and in ways that align with the principles of value-based purchasing (VBP). For states operating the Medicaid program in full or in part under managed care, the Medicaid Managed Care regulations issued in 2016 by the Centers for Medicare and Medicaid Services (CMS) appear to offer targeted options to directly finance such interventions via managed care capitation payments.

In 2017, Nemours Children's Health System contracted with the Center for Health Care Strategies (CHCS) to work with the PacificSource Columbia Gorge Coordinated Care Organization (CCO), a regional Medicaid payer operating as the sole managed care organization in a rural area in Oregon, to identify sustainable financing mechanisms for the Bridges to Health Pathways Hub, which provides community service referrals and care coordination to residents in the Columbia Gorge area. This issue brief draws upon the practical lessons learned through that work and provides advice for state Medicaid agencies and managed care organizations (MCOs) interested in implementing similar SDOH strategies within managed care, by reflecting upon:

- What existing Medicaid Managed Care authorities can be used to cover community care coordination and service delivery activities related to social determinants?
- What incentives do MCOs have to invest in such programs?
- What are innovative ways to pay for these services, in alignment with the broader shifts to VBP?

BACKGROUND

There are a few key trends driving high levels of interest in SDOH strategies in the health care sector: (1) increased understanding of the impact that social determinants have on health outcomes; (2) rapidly growing uptake of VBP to reimburse health care providers; and (3) a mounting evidence base around the impact that specific interventions around housing, food security, home remediation for asthma triggers, and other non-clinical interventions have on health quality, outcomes and costs.[1]

Numerous efforts are underway at national, state and local levels to implement cost-effective SDOH strategies. These include, but are not limited to: using staff like community health workers (CHW) to reach at-risk individuals in the community; accountable communities of health and the Center for Medicare and Medicaid Innovation's (CMMI) Accountable Health Communities Model[2]; the Pathways Community HUB model[3]; and health care organization and community based organization (CBO) partnerships.[4] Several state Medicaid agencies are pursuing a range of these SDOH strategies, including: California, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New York, Oregon, Rhode Island and Washington. A wide range of funding mechanisms are used, including: (1) CMMI funding opportunities; (2) federal §1115 waivers including Delivery System Reform Incentive Payment (DSRIP); (3) managed care capitation payments; (4) foundation funding; (5) social impact investing; and (6) grants and operational funding from health care providers, such as hospital community benefit spending.

In light of the proliferation of Medicaid managed care[5], it is worth exploring how states may and may not leverage managed care programs to fund SDOH strategies. Medicaid managed care offers greater flexibility to support SDOH approaches than exists under Medicaid fee-for-service (FFS) or primary care case management delivery systems. This brief aims to help states and Medicaid managed care plans: (1) understand the existing authorities states have under the Medicaid managed care regulations to cover what we refer to as "value-added services" and the coordination/referral of such services; and (2) align payment approaches for such services with the broader shift to VBP, in which providers are rewarded for improved outcomes and lower costs. While this brief does not explicitly address what types of providers can deliver such services, managed care plans have tremendous flexibility to use a variety of providers for non-medical services, including CHWs.

Defining Social Determinants of Health and Coordination

For the purposes of this issue brief, we define SDOH as the social and economic opportunities and resources available in our homes, neighborhoods, and communities that impact our health. We also define the *coordination* of non-clinical interventions and services intended to address SDOH to include: (1) **identifying** patients who are likely to have multiple health and social needs; (2) **screening** patients for social determinants of health (SDOH) needs and determine appropriate organizations with the resources and knowledge to address their specific needs; (3) **connecting** patients with these community organizations to help address their health-related social needs; (4) **following up** to ensure patients are connected and facilitate completion of the SDOH intervention or activity; and (5) **tracking outcomes** of patients receiving community-based services. (Please see one of the other briefs developed as part of this project, *"Community Care Coordination Systems: Connecting Patients to Community Services,"* for more detail. **https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/community-care-coordination-systems**) This set of coordination activities is distinct from the intervention or services actually delivered, which we refer to as *value-added services,* a term used by CMS. Finally, we define "SDOH interventions or strategies" to encompass both coordination and value-added services.

RELEVANT MEDICAID MANAGED CARE AUTHORITIES

As noted earlier, we delineate two distinct sets of services: (1) community care coordination; and (2) value-added services. Table 1 below summarizes how Medicaid managed care rules treat each set of services. A more detailed discussion follows.

TABLE 1: Existing Medicaid Authorities to Fund Prevention

Type of SDOH Services	Applicable Federal Regulations and Guidelines	Financial Implications
Community Care Coordination Services An MCO's contractual responsibility to identify and coordinate community based, non-medical services that are related to meeting a patient's health needs, with medical services. Examples: ▪ coordinate the transition between settings of care ▪ coordinate services enrollee receives from community and social support providers	"Coordination and Continuity of Care" provision: **42 C.F.R. § 438.208**(b)(2)(iv) Medical loss implications: **42 C.F.R. § 438.8**(e)(1), (e)(2)(i)(A) (referring to direct claims paid to providers for services covered under the contract) **42 C.F.R. § 438.8**(e)(1), (e)(3)(i), (referring to activities that improve health care quality) **45 C.F.R. § 158.150**(b)(2)(i)(A)(1) (listing care coordination as an activity that improves health care quality) Calculation of capitation rate: **42 C.F.R. § 438.4**(b)(3)	May be considered in the numerator of the medical loss ratio for the MCO as a standard contract requirement for all MCOs and an activity that improves health care quality. Must be considered for MCO capitation rate-setting purposes.
Value-Added Services Additional services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.[6] Examples: ▪ assessing the home for asthma triggers ▪ medication compliance initiatives ▪ identifying and addressing ethnic, cultural or racial disparities ▪ mosquito repellant to prevent Zika transmission	"Value-Added Services" provision: **42 C.F.R. § 438.3**(e)(1)(i) Medical loss implications: **42 C.F.R. § 438.8**(e)(1), (e)(2)(i)(A) (referring to incurred claims and services under **42 C.F.R. § 438.3**(e)) Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526 (stating that value-added services may be considered as incurred claims in the numerator for the MLR calculation) **42 C.F.R. § 438.8**(e)(1), (e)(3)(i); **45 C.F.R. § 158.150**(b) (referring to activities that improve health care quality) Calculation of capitation rate: **42 C.F.R. § 438.3**(e)(1)(i)	May be considered in the numerator of the medical loss ratio for the MCO as "incurred claims" or "activities that improve health care quality." May not be considered for MCO capitation rate setting purposes.

Using home remediation of asthma triggers as an example, community care coordination services could consist of the following:

- identifying and screening individuals who may have home-based asthma triggers;
- sharing information about home remediation services;
- obtaining authorization for coverage of home remediation services;
- helping to set up an appointment to receive the services; and
- following up on the results of the assessment and any remediation efforts and communicating those results to a patient's medical services provider.

Value-added services would consist of services such as the in-home assessment for asthma triggers and services related to remediating those triggers, such as mold removal.

This distinction is primarily useful in the context of Medicaid managed care regulations, which treat community care coordination and value-added services as separate services that fall under different sections of the regulations and have distinct implications for managed care capitation in terms of coverage and future rate setting.

Community Care Coordination Services. Under the *Coordination and Continuity of Care* provision of Medicaid managed care regulations, MCOs must coordinate the medical services delivered under managed care with services that enrollees receive in the community and through social supports providers. This provision enables MCOs to use capitation payments to cover such community coordination services. One perceived barrier to covering these services is how these expenditures will be categorized — as administrative or medical expenses. As outlined in the Medicaid managed care regulations, such coordination expenditures "count" towards the numerator of MCOs' Medical Loss Ratio (MLR) as an allowable expense, and help the MCO meet the requirement that 85 percent of capitation expenditures cover certain non-administrative expenditures. This may be financially advantageous to a Medicaid MCO, which may otherwise be penalized if it invests in services that are intended to improve health, but are categorized as administrative expenses and therefore do not count towards the 85 percent MLR requirement.

Further, community care coordination expenditures must be included in MCO capitation rate setting. When states set future capitation rates, these expenditures must be included in that calculation, even if they were not explicitly part of the capitation payment previously. This at least partially mitigates the future financial downside of an MCO providing such services, which may result in lower utilization of medical services and subsequently lower capitation rates.

Value-added Services. Value-added services are "additional services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care."[7] Such services can fall under *Activities that Improve Health Care Quality* within 45 C.F.R. § 158.150. Referring to value-added services in its response to public comments, CMS clarified that services included under this provision may be non-medical in nature; CMS subsequently removed the term "medical" from § 438.8(e)(2)(i)(A).

Activities that improve health care quality must be designed to:

1. improve health quality;
2. increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
3. be directed toward individual or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; and
4. be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

In response to public comments, CMS clarified that such expenditures may also be considered as incurred claims in the numerator of the MLR. This means that such expenditures also "count" towards MCOs' MLR requirements as an allowable expense in the numerator and helps the MCO meet the requirement that 85 percent of capitation expenditures must cover medical expenditures. This may be financially advantageous to a Medicaid MCO, as discussed earlier.

However, value-added services fall outside of Medicaid state plan services and required benefits, and therefore these services may not be included in MCO capitation rate setting. CMS clarified this perspective in the Center for Medicaid and CHIP Services (CMCS) Informational bulletin, *Medicaid Benefits Available for the Prevention, Detection and Response to the Zika Virus, 6-1-16*. In this bulletin, CMS stated that "at their discretion, managed care plans may choose to provide products and/or services beyond what is included in the benefit package under their contracts, provided that such additional services are not included in the capitation rates." The bulletin also says that states may not require, but can encourage, MCOs to cover such services.

Nevertheless, it may be in an MCO's interest to invest in value-added services for a few reasons. First, such investments are intended to achieve measureable improvements in health outcomes and quality rankings, which may be financially beneficial to MCOs under state contracting provisions. Such investments may also result in significantly lower health expenditures for high-cost treatments or conditions, as with the Zika example. Finally, investments in value-added services might also align with the MCO's broader mission to improve the health of enrollees and may enhance the MCO's reputation with state purchasers and enrollees.

IMPLICATIONS FOR STATES AND MEDICAID MCOS

By leveraging both community care coordination and value-added service authorities under Medicaid managed care rules, states operating in a managed care environment can help make the case for MCOs to develop comprehensive approaches to paying for SDOH strategies.

State Actions

States can leverage and evaluate MCO contract language to encourage, incent and, in the case of community care coordination, require MCOs cover such services. For example, Florida requires its MCOs to have procedures for identifying available community support services and facilitating referrals to community support providers; the MCO must also document the referral in the enrollee's case record and follow up on receipt of services.[8] A state could also require its MCOs to adopt a CHW program or other strategy intended to provide community care coordination services, just as it may require MCOs to implement clinical care coordination programs. New Mexico's Medicaid program incorporates the cost of CHWs into the administrative portion of its MCO capitation payment and requires MCOs to not only use CHWs to work with enrollees, but also increase CHW contacts with enrollees by 10 percent in both 2017 and 2018, as compared to the previous year's baseline.[9] As part of its VBP requirements, New York State requires providers participating in certain VBP arrangements to implement at least one SDOH intervention and its MCOs to share in the costs and responsibilities associated with the investment, development and implementation of the intervention.[10]

As specified in 42 C.F.R. § 438.3(e)(1)(i), MCOs voluntarily agree to provide value-added services. Because the services are not state plan benefits (i.e., not covered by Medicaid), states may not require the MCOs to provide specific value-added services, but can encourage MCOs to do so. For example, Oregon requires each CCO to develop a specific plan and associated processes for identifying patients whose health would benefit from a value-added service, such as a nutrition class; after delivering that service, the CCO must report to the state which services were delivered. States can also use their MCO procurement process to pose questions around what approaches MCOs are taking or plan to take to address members' health-related social needs. States could consider rewarding MCOs through auto-assignment rules and MCO incentive programs, such as repayment of withholds associated with quality performance or VBP adoption.

Given limited federal guidance about how value-added services may be defined in MCO contracts, states are encouraged to consult with CMCS. However, states should not need special authority or waivers to provide their own guidance or definitions.

PacificSource Columbia Gorge CCO's Approach to Financing the Bridges to Health Pathways Hub Program

Beginning in 2018, the Bridges to Health Pathways Hub will be able to shift its funding from solely grants to more sustainable revenue from the PacificSource Columbia Gorge CCO. The CCO will use the global budget it receives from Oregon Medicaid (Oregon Health Authority) to finance program services for CCO members as health-related services, as allowed under the Medicaid managed care regulations and the Oregon §1115 demonstration waiver and in accordance with OAR 410-141-3150, 45 C.F.R. § 158.150 or 45 C.F.R. § 158.151. Payments include support for the care coordination services provided by contracted agencies and also the program operating expenses such as provider recruitment and training, but do not include funding for administrative expenses incurred by Columbia Gorge Health Council for health plan duties delegated to the Council such as compliance activities.

MCO Actions

From the MCO's perspective, there are a few implications worth highlighting. Foremost, the MCO has wide latitude and discretion about the types of community care coordination and value-added services it may cover and pay for using the capitation payment. This can include comprehensive SDOH strategies designed to meet the SDOH needs of all enrollees or programs more narrowly targeted to specific populations. In Ohio, most of the Medicaid MCOs reimburse for community care coordination, medical and value-added services provided through the Pathways HUB model, which originated in Mansfield, Ohio.[11] From the MCO financial perspective, community care coordination is on equal footing with other quality and cost improvement strategies and tools, like VBP. Since value-added services are not included in the benefit package and may not be required by states, MCOs have significant flexibility to target and tailor approaches for different patient populations, so long as the services are designed to improve health care quality and meet related standards delineated under 45 C.F.R. § 158.150. MCOs also have flexibility to use different types of providers to provide services, including CHWs.

These provisions also create an opportunity for MCOs to use capitation payments to: (1) provide such community care coordination services directly themselves; or (2) pay for such coordination activities delivered by others in the community. CBOs often have practical expertise and knowledge necessary to deliver these services effectively. Massachusetts is one state that is explicitly pursuing this approach under its DSRIP program, which requires accountable care organizations to partner with community-based entities called Community Partners for care coordination.[12]

Connecting VBP and SDOH Strategies

If MCOs decide to contract directly with non-health care provider organizations like CBOs to deliver community care coordination and value-added services, it is critical to think through not only the financing sources discussed above, but how reimbursement for SDOH interventions will be structured. The underlying financial incentives of the reimbursement model should align with improving health outcomes efficiently. Unfortunately, fee-for-service payment approaches may lead to perverse incentives resulting in overutilization without commensurate quality of care. Therefore, SDOH intervention payment mechanisms could align with the principles of VBP used to reimburse health care providers, where payment is at least partially contingent upon achieving specified levels of quality or outcomes. Using VBP principles, MCOs might consider four basic approaches: (1) pay for performance; (2) shared savings/risk; (3) pay for success; and (4) capitated payments.

It is important to note upfront that regardless of the payment model used to reimburse for community care coordination and value-added services, the Medicaid managed care rules governing such services are still applicable. Specifically, using VBP to pay a CBO to deliver value-added services does not mean that such payments now "count" as VBP, which can be incorporated into capitation rate setting. Regardless of the payment method, value-added services remain non-covered Medicaid services. When structuring a payment model, MCOs will also need to consider how the payment model can support the MCO's ability to separately report payments made for community care coordination and value-added services, since the former can be included in rate setting, but the latter cannot.

In the context of these payment models, how the outcomes are defined is critical. They may be defined in terms of: (1) health outcomes (e.g., healthy birthweight baby); (2) health care cost or utilization outcomes (e.g., reducing the length of a hospitalization or ED visits); and (3) social services outcomes or obtaining the needed value-added service (e.g., securing a Section 8 housing voucher).

Pay for Performance. Under a pay for performance (P4P) approach, the MCO could reward the partner organization for achieving a set of mutually-desired outcomes that are largely within the control of the partnering organization. Such payments could be made in addition to payment for services delivered. One way to create a financial win-win for both organizations may be to thoughtfully pair payment to specific outcomes that cut across two or more of the outcomes categories that are relevant to the project at hand. In the Bridges to Health program, for example, payment for the pregnancy pathway is made upon successful delivery of all recommended prenatal services, as well as a potential bonus for delivery of a healthy birthweight baby.

Shared Savings. MCOs might also consider a shared savings payment model. Just as with health care providers, some portion of the CBO's compensation for SDOH interventions would depend upon the MCO achieving cost savings for the patient population served, while realizing specific health outcomes or quality improvement. If savings are attained, the partner organization would receive a portion of the savings. However, this may only be a viable option if: (1) savings are anticipated to accrue over a one year time frame due to annual managed care rate setting cycles[13]; and (2) the program has sufficient participant volume to measure "actual" cost savings. Additionally, under a shared savings arrangement, a portion of the payment should be tied to deliverables other than cost savings — covering a portion of the services successfully delivered, for example — to ensure that CBOs are not at full financial risk for outcomes that are not entirely under their control.

Pay for Success. Pay for Success (PFS) is an approach to funding SDOH interventions that attaches payment to the desired outcomes rather than the underlying services. The financial vehicle — the "social impact bond" — typically has two components: (1) an outcome-based payment, and (2) upfront working capital for the CBO, usually provided by investors. Each project has expected outcomes; if the project does not achieve its expected outcomes, no payment is made.

With PFS, CBOs can receive upfront working capital and shift the risk of an outcomes-based payment to the investor. Likewise, an MCO may experiment with different SDOH interventions and only pay for "what works." An MCO may not have the resources or the expertise to substantially invest in an SDOH intervention, but as backend payers in a PFS arrangement, it can undertake projects with less financial risk. If the project does not deliver expected results (i.e., improved health outcomes), the payer does not make the outcome-based payment and the investor loses its return. However, the CBO still gets paid for delivering the SDOH interventions. It should be noted that in PFS arrangements, potential investors are only likely to invest in programs with a strong evidence base and potential for a significant return on investment.

Outcomes-based payments in the Bridges to Health Pathways Hub

Beginning in 2018, the Bridges to Health program will use an outcomes-based payment method similar to what the Pathways Community HUB Model uses. Under this model, at least 50 percent of program payment is based upon outcomes achieved, which are defined as a mix of health outcomes and social service outcomes. There are 17 pathways, each of which correspond to a predefined, specific SDOH need (e.g., housing). Clients may be enrolled in more than one pathway, depending upon their needs. Each "pathway" is the primary unit for billing and is considered "complete" when a specific outcome is reached (e.g., Section 8 voucher is obtained).

For the majority of pathways, a fixed outcomes-based payment is made when the pathway is completed. The amount of payment is driven by a fee schedule, which is based upon the average cost per pathway. Payments are adjusted for patient risk as well as for travel time for hard-to-reach clients. Partial payments are made for pathways that are incomplete due to specific factors out of the program's control (e.g., client moves out of the region). For pathways that take a larger amount of time or resources to complete, an interim payment is made once a specified outcome is achieved. For certain pathways, bonus payments are made for achieving a predefined set of health outcomes, such as delivering a healthy birthweight baby.

For example, the Green and Healthy Homes Initiative (GHHI), a provider of home-based asthma interventions, is developing PFS arrangements that reward reductions in the total cost of care for children who have had one or more asthma-related visits to the emergency department. Similar to shared savings models, the methodology behind the outcomes-based payment is reviewed by an actuary.

Capitated or Bundled Payments. Finally, MCOs might consider using capitated or bundled payments to cover a portion of an SDOH intervention. For example, MCOs could pay an upfront per-member, per-month lump sum payment to a CBO to cover community care coordination activities and pair that with fee-for-service reimbursement for delivered value-added services, subject to prior authorization. The partner would be financially accountable if costs exceeded the payment. However, this payment model should also be linked to quality of service delivery or outcomes achieved, in line with the principles of VBP wherein payment is connected to quality or outcomes.

Additional Considerations

There are a couple of additional considerations for MCOs in determining the most effective approach. First, MCOs should consider ways to structure payments so that they balance the need to cover the associated service delivery costs (e.g., delivering asthma remediation services) with the goal to reward partners for delivering services that lead to specific outcomes (e.g., reducing uncontrolled asthma). This is particularly important to consider if partnering with non-profit CBOs, which may not be capable of assuming financial risk for expenses associated with service delivery. In the context of health care VBP, P4P and shared savings are often layered on top of existing FFS payment arrangements, and providers are therefore guaranteed payment for the services delivered. Similarly, payments to CBOs should not be structured so that payment is solely contingent upon achieving health or social service outcomes.

Second, it may be useful for partners to purposefully adapt the payment model over time. For example, the Bridges to Health Pathways Hub in Oregon started as a pilot with a grant from the CCO and other community partners that was structured to cover the anticipated costs of providing program services to a defined population. But participants agreed upfront that the goal was to transition to a to-be-defined outcomes-based payment model after the initial grant ended. It is worth noting that the grant also paid for a program evaluation and data collection infrastructure, which enabled the partners to accurately assess their true costs and track a variety of outcomes, thereby paving the path for developing a sustainable payment model.

CONCLUSION

The findings of this brief demonstrate that state Medicaid agencies and Medicaid MCOs have substantial flexibility in how interventions that address SDOH may be covered and paid for within Medicaid managed care. There are clear opportunities to cover such interventions using MCO capitation payments and to structure funding to take advantage of the different treatments that community care coordination and value-added services receive under the managed care regulations. Furthermore, there are approaches that MCOs can take to structure payments to partners so that the principles of VBP carry over into those contracts and align with the incentives that providers and MCOs face to produce better outcomes at a lower cost. By taking advantage of these opportunities, MCOs can thoughtfully pay for and structure programs that will ultimately improve the health outcomes of beneficiaries while bending the cost curve.

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