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Social Determinants of Health

June 12, 2019

Agenda

- **Introduction to Social Determinants of Health**
- **New York's Efforts to Address Social Determinants of Health**
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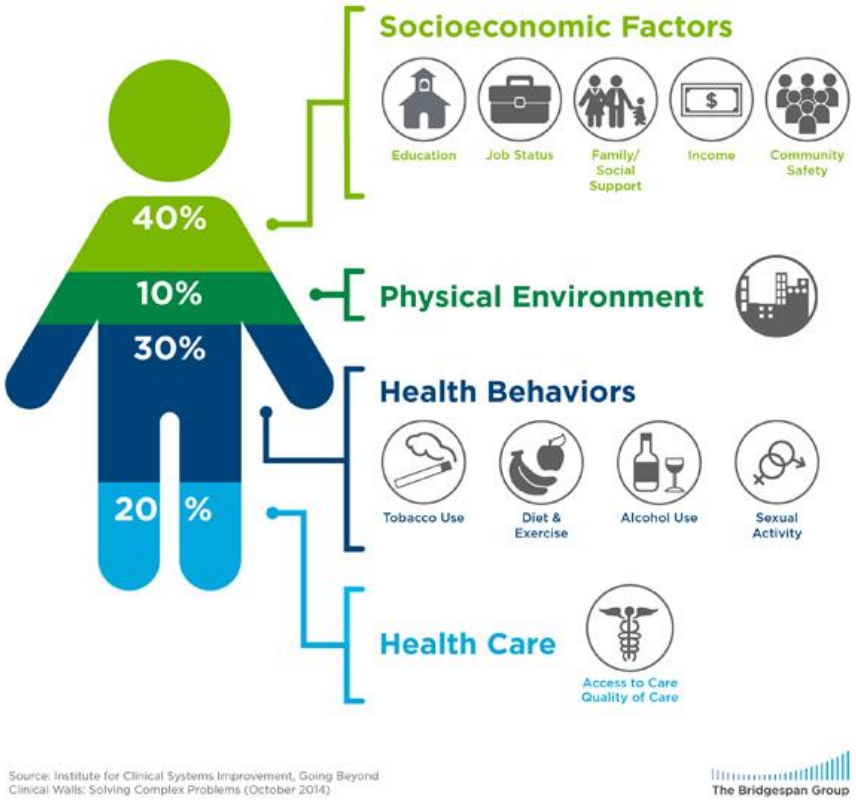
- **Social Determinants of Health and the I/DD Field**
- **Q&A**

Introduction to Social Determinants of Health

Social Determinants of Health: Definition & Impact

Social determinants of health (SDH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



Socioeconomic factors, physical environments, and health behaviors drive health outcomes more than medical care.

Having at least one unmet social need is associated with increased rates of depression, diabetes, hypertension, ED overuse, and clinic "no-shows."

Nearly 80% of physicians believe addressing social needs is as important as medical care, but most do not feel prepared to address them.

(1) Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010.
(2) Bachrach, D., Pfister, H., Wallis, K. and Lipson, M. Addressing Patients' Social Needs: An Emerging Case for Provider Investment. Commonwealth Fund. May 2014.
(3) Blendon, R.J., Donelan K., Hill C., Scheck A., Carter W., Beatrice D., Altman, D. "Medicaid beneficiaries and health reform." Health Affairs, 12, no.1 (1993): 132-143.

Examples of SDH Services

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Medically-tailored meal delivery
- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals

Transportation

- Linkages to existing transportation resources
- Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

SDH Intervention Example: *Medical Respite Care*

Goal: To shorten hospital stays and decrease readmission rates and unnecessary emergency department visits

- Intervention includes providing emergency shelter to homeless adults who are discharged from inpatient hospitalization and have ongoing medical needs
- Intervention allows individuals who are homeless or "housing insecure" to recover, while also working with a care manager to secure permanent housing
- Average cost of respite bed is $140/night; this represents *6%* of the average cost per night for a hospital admission
- Intervention also linked to reducing new and unnecessary hospitalizations
- Return on investment has been measured as high as 300%

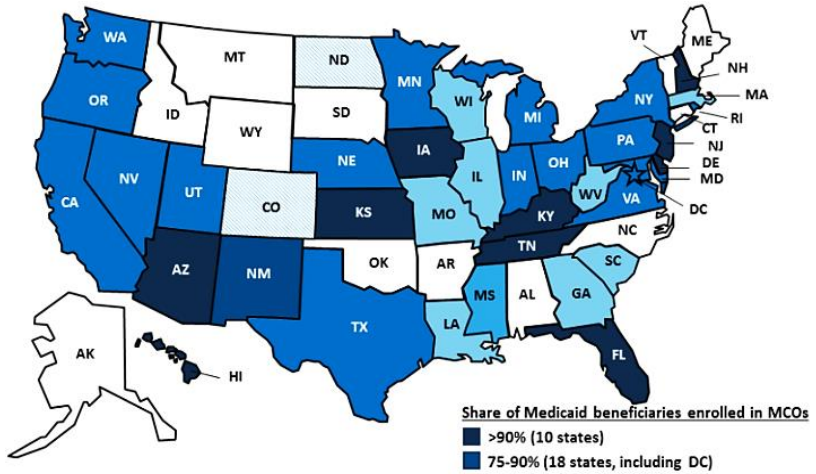
Source: New York State Department of Health (DOH), https://www.health.ny.gov/health_care/medicaid/redesign/sdh/docs/2019-03-08_sdh_cbo_requirements_mltc.pdf

Medicaid as a Primary Vehicle for Addressing SDH

Medicaid enrollees—low-income by definition—are particularly likely to struggle with basic needs, including food, clothing, and shelter.

Medicaid Managed Care Organizations (MCOs) provide care to 81% of enrollees nationwide and can provide a strong platform for addressing SDH.

A large share of all Medicaid beneficiaries are enrolled in risk-based MCOs.



Source: Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, Kaiser Family Foundation, October 2016.

Kaiser Family Foundation. Total Medicaid Managed Care Enrollment. https://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Medicaid's Growing Role in Addressing SDH

States are seeking to leverage federal Medicaid funding to invest in SDH interventions.

Many states are *incentivizing* or *requiring* Medicaid MCO investment by:

- Classifying certain social services as covered benefits under the Medicaid state plan
- Using value-based payment requirements to drive provider investment in social interventions
- Using incentives or withholds to encourage MCO investment in social interventions
- Integrating SDH measures in quality improvement or performance measurement
- Rewarding MCOs through higher rates for effective investments in social interventions
- Exploring use of value-added and "in lieu of" services (e.g., medically appropriate, cost-effective substitutes for state plan services)

Some states have established SDH-related pilot programs through Section 1115 Medicaid waivers, including:

- North Carolina's "Healthy Opportunities" pilots on housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress
- Washington's "Foundational Community Supports" housing and employment services pilots
- Maryland's "Community Health Pilot Programs" on housing and evidence-based home visiting services
- Illinois' "Home Visiting Services" Pilot and "Community Integration" (Housing) Pilot

Source: Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 2018. http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicaid-managed-care-rate-setting;

States Increasingly Including SDH Strategies in Medicaid MCO Procurement/Contracts

SDH Provisions in Medicaid Managed Care Contracts																
	AZ	CO	IL	LA	MA	MI	MN	NV	NM	NY	NC	RI	TN	VA	WA	WI
Screening	●		●	●			●		●	●	●	●	●	●	●	●
Care Management Services	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●
Partnerships with Community Health Workers, CBOs, etc.		●	●	●	●	●	●	●	●	●	●	●		●	●	●
Quality Metrics, Strategy, or Screening; Items related to withholds		●	●	●		●			●	●	●		●	●		●
SDH Interventions and Initiatives; Reporting Requirements		●		●	●	●		●	●	●	●	●		●	●	●
Data Development, Collection, Evaluation						●					●				●	●
SDH Definition		●			●	●					●			●	●	●

Bright Spots: Evidence Base for Addressing SDH

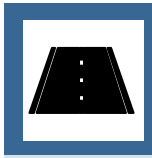
The SDH evidence base is largely focused on targeted interventions for discrete populations, pilot programs and small randomized control trials, but highlights the potential impact of addressing SDH.

Housing as a means to reduce medical expenditures

- For homeless individuals in Los Angeles county identified as the top 10% highest-cost, highest-need individuals, providing supportive housing and intensive case and care management **reduced ER and inpatient hospital admission net costs by approximately $37,000 per enrollee per year.**[1]
- A pilot program offering a permanent housing solution to 30 homeless adults with medical illnesses and high prior acute-care use resulted in a **reduction in healthcare and sobering center costs of more than $36,000 per person per year.**[2]

Addressing food insecurity to lower spending

- Receipt of both medically-tailored meals and non-medically tailored meals (e.g., Meals on Wheels) **reduced the use of select healthcare services and reduced average monthly medical spending by nearly $600** among adults dually eligible for Medicare and Medicaid.[3]
- Enrollment in SNAP was associated with **lower healthcare expenditures by approximately $1,400 per year** for low-income adults.[4]



Providing transportation to reduce "no-shows"

- A pilot program in West Philadelphia demonstrated that offering "rideshare"-based transportation (e.g., Uber or Lyft) to Medicaid beneficiaries to general internal medicine practices **increased the appointment "show rate" from 54% to 68%.**[5]

1) 10th Decile Project. CSH and NHCHC. 2015.
2) Srebnik, D. et al. A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services. American Journal of Public Health. 2013.
3) Berkowitz S. et al. Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. JAMA, 2018.
4) Berkowitz S. et al. Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults. JAMA Internal Medicine, 2017
5) Chaiyachati, KH et al. Rideshare-Based Medical Transportation for Medicaid Patients and Primary Care Show Rates: A Difference-in-Difference Analysis of a Pilot Program. Journal of General Medicine. 2018.

Active Marketplace of SDH Ideas and Players

A diverse group of players have entered the SDH "marketplace" including: health insurers, health providers, governments, IT organizations and other community-based organizations.

Kaiser Permanente Announces $200 Million Impact Investment, Partners With U.S. Mayors and CEOs to Address Housing Stability *KP Press Release, 5/18/18*

Why UnitedHealthcare is investing millions in affordable housing projects *BizJournal, 2/26/18*

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SOCIAL DETERMINANTS ARE CORE OF NORTH CAROLINA'S MEDICAID OVERHAUL *Modern Healthcare, 8/3/18*

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The CEO of a company often called the future of healthcare explains why health insurers want to cover your rent *Business Insider, 9/28/18*

City Health DASHBOARD

Top Ten Tech Trends 2018: A Social Determinants of Health Technology Market is Slowly Emerging *Healthcare Informatics, 9/4/18*

Strategies for Integrating SDH into Healthcare Delivery

In pursuit of "whole person care" and as part of broader delivery system reforms, Medicaid programs and MCOs are driving efforts to address social service needs within an integrated care delivery platform.

Identifying beneficiaries with social needs (as a first step)

Embedding SDH into care management/care coordination

Building a "provider network" of community-based organizations

Identifying and pursuing sustainable financing of community-based interventions

Evaluating the effectiveness of SDH interventions on health outcomes and healthcare costs

New York State Medicaid Efforts to Address the Social Determinants of Health

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New York's Efforts to Address Social Determinants of Health

The State's strategy for addressing the social needs of its Medicaid population has been primarily advanced under its DSRIP program.

About DSRIP

- Federal Delivery System Reform Incentive Payment (DSRIP) initiatives provide states with (sometimes significant) funding that can be used to finance changes in how the healthcare industry provides care to Medicaid beneficiaries. NY is eligible to receive up to **$6.42 billion** over the course of its 5-year DSRIP waiver.
- NY designed its DSRIP program with **provider-led entities (called "Performing Provider Systems") at the center**, eligible to receive funds for implementing certain delivery system reform projects in their communities—with the **overarching goal of reducing avoidable hospital use by 25% over 5 years**.
- The PPSs, generally led by hospitals, must involve downstream providers and community partners as well.

Strategies for Addressing SDH

1. **Performing Provider Systems (PPSs)**
2. **Value-Based Payment (VBP)**
3. **Department of Health (DOH) Bureau of Social Determinants of Health**

NY's current DSRIP waiver is set to sunset on March 31, 2020, but the State has made public its intent to extend, in some capacity, its DSRIP program if possible.

1. Performing Provider Systems (PPS)

What are PPSs?

- **PPSs are providers that form partnerships and collaborate to develop and implement defined DSRIP projects in their communities (for a defined ("attributed") population).**
  - *Examples of DSRIP projects include*: Create Integrated Delivery Systems, Implement Care Coordination and Transitional Care Programs, Improve Behavioral Health, Improve Health Status and Reduce Disparities
- **PPSs include both major public hospitals and safety net providers, with a designated lead provider for the group.**
- **DSRIP payments to PPSs are based on three types of metrics:** process measures, pay-for-reporting ("P4R"), and pay-for-performance ("P4P").

As part of their charge, PPSs partner with community-based organizations (CBOs) to identify and develop strategies to address the social needs of their attributed population.

But importantly, PPS funding is tied to measures that are not explicitly tied to SDH services *(though such services should help improve outcomes and could impact some P4P measures, e.g., potentially avoidable ER visits).*

2. Value-Based Payment

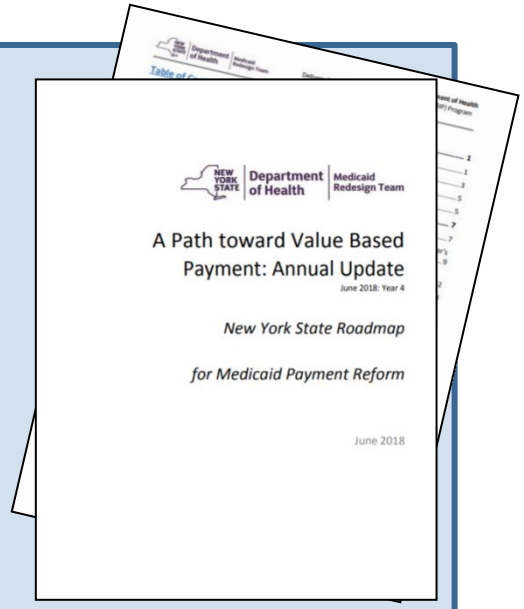
NYS envisions that the delivery system reforms funded by DSRIP over the course of the 5-year waiver will be sustained through VBP.

What is VBP?

- **VBP refers to arrangements between MCOs and providers that tie payment to *value* (e.g., outcomes, performance against certain measures), rather than *volume*.**
- **In many (but not all) VBP arrangements, providers are taking on risk—unlike in traditional fee-for-service arrangements.**
- **Example VBP arrangements include:**
  - Total Care for the General Population (population-based arrangement)
  - Total Care for Special Needs Subpopulations (*population-based arrangement*)
  - Integrated Primary Care (*bundle/episode-based arrangement*)
  - Maternity Care (*bundle/episode-based arrangement*)
- **NYS defined varying "Levels" of VBP, where Level 1 VBP generally refers to upside-only arrangements and Level 3 refers to maximum risk-sharing (e.g., capitation, prospective bundles)**

While the State has identified individuals with I/DD as a Special Needs Subpopulation, the design and quality measures are still under development.

2. Value-Based Payment (VBP), cont.



- **The State has issued (and updates annually) a "VBP Roadmap" that outlines its VBP strategy.**
- **The strategy requires MCOs to implement VBP arrangements with providers and meet certain VBP targets over the course of the waiver:**
  - By 4/1/2018: ≥ 10% of MCO expenditures must be captured in Level 1 or higher contracts
  - By 4/1/2019: ≥ 50% of MCO expenditures must be captured in Level 1 or higher contracts; ≥ 15% of MCO expenditures must be captured in Level 2 or 3 contracts
  - By 4/1/2020: ≥ 80% of MCO expenditures must be captured in Level 1 or higher contracts; ≥ 35% of MCO expenditures must be captured in Level 2 or 3 contracts

  Note: DOH has established less aggressive VBP targets for MLTC plans.

- **In order to be considered a Level 2 or 3 VBP arrangement, the MCO-provider contract must include a "Tier 1 CBO" that implements an "SDH intervention."**
- **A portion of MCOs' revenue is now tied to meeting the above targets.**

What Will VBP Look Like for I/DD?

The VBP design for the I/DD population is currently under development.

The I/DD Clinical Advisory Group met several times throughout 2016 to discuss quality measures and VBP design and recommended several measures. It is now reconvening to build upon its earlier work and further advise the State on quality metrics.

People Choose Where and With Whom they Live	The Council on Quality and Leadership (CQL) Personal Outcome Measures (POMs©)
People Choose Where they Work	
People Use their Environments	
People Participate in the Life of the Community	
People have the Best Possible Health	
People Interact with Other Members of the Community	
People Perform Different Social Roles	

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS
Proportion of Adults who had blood pressure screened in past 2 years	
Diabetes Composite: Aspirin Use	
Emergent Care for Improper Medication Administration or Medication Side Effects	

Annual Dental Visit (ADV)	National Committee for Quality Assurance (NCQA)
Colorectal Cancer Screening	
Diabetes Composite: Hemoglobin A1c Control (HbA1c) (<8.0%)	
Statin Therapy for Patients With Cardiovascular Disease	
Diabetes Composite: Blood Pressure (BP) < 140/90	
Diabetes Composite: Tobacco Non-Use	

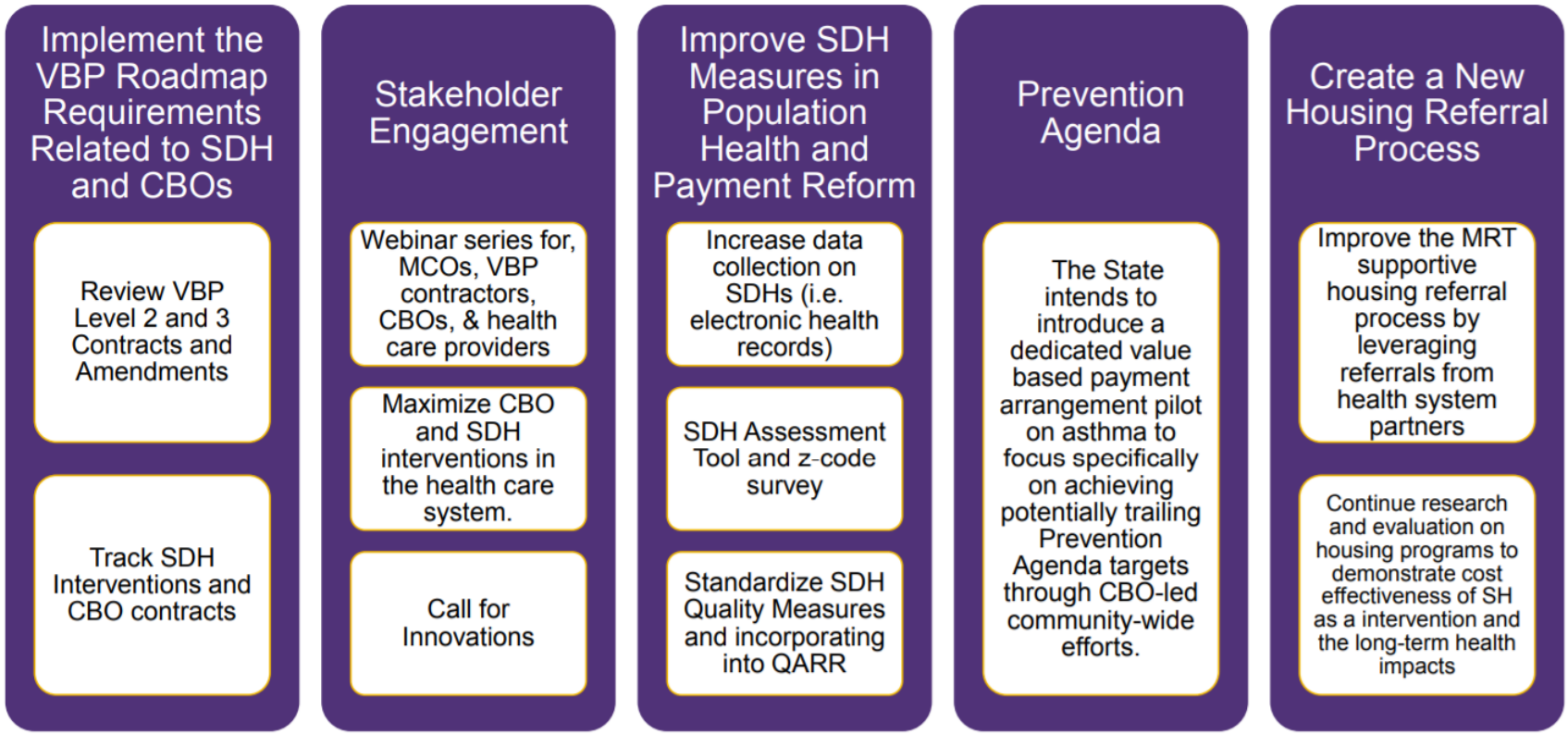
To date, there have been few conversations on how SDH interventions might be deployed for the I/DD population.

3. DOH Bureau of Social Determinants of Health

In January 2018, DOH established the Bureau of Social Determinants of Health (BSDH) to implement VBP Roadmap requirements relating to SDH and CBOs.

BSDH Charge: To facilitate integration of health and human/social services to improve the quality of care and outcomes of NY's "most vulnerable populations."

Bureau's 2019 Goals



Source: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/docs/sdh_bureauslides.pdf

Takeaways from NY's SDH Experience To Date

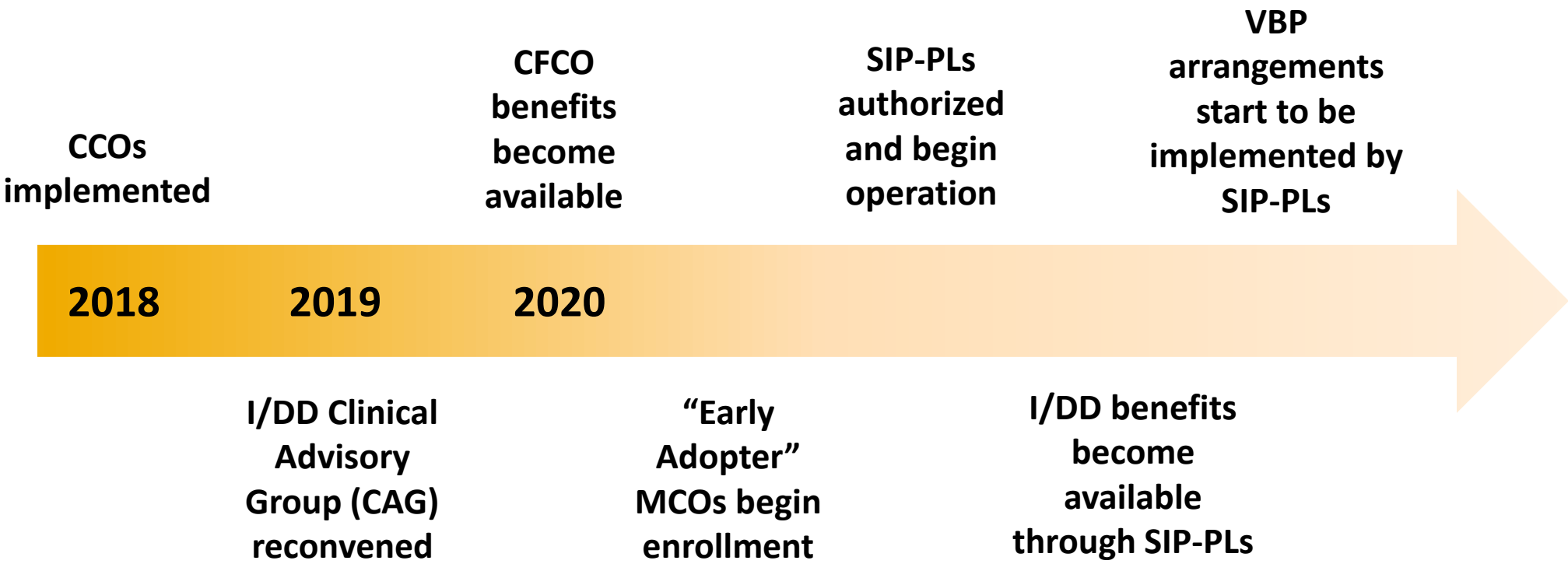
There's a steep learning curve to true integration of health and social services and special considerations are needed for special populations.

- **While PPSs, MCOs and VBP contractors (providers) may be focused on securing contracts with CBOs delivering SDH services (e.g., to meet VBP Level 2/3 criteria), much of the contracting to date seems to "check the box"** – it is unclear how many referrals are actually being made or SDH services actually being delivered
- **Confusion remains around financing of SDH services** – who's responsible for paying for what?
- **Tier 1 CBOs are still learning how to work with MCOs/providers** – new territory for most of them
- **MCOs and providers are still learning how to fit SDH services into their existing service delivery models and process flows** – lack of meaningful guidance from the State
- **MCOs, providers and CBOs alike are still trying to figure out how to share information (in a compliant manner), how to track referrals, service delivery, outcomes, etc., and how to evaluate performance**
- **Things get more complicated for the dual-eligible population, as there is no way to "capture" the savings that accrue to Medicare**

SDH for the I/DD Population

Why Does All This Matter?

We know that the I/DD field is headed toward Medicaid managed care and, ultimately, VBP.



Health Outcomes for the I/DD Population

We know that individuals with I/DD experience poorer health outcomes than the general population.

This population is *more* likely to:

- Live with complex health conditions
- Have poorly managed chronic conditions, such as epilepsy
- Be obese
- Have undetected poor vision
- Have mental health problems

This population is *less* likely to:

- Have cancer screenings
- Visit dentist regularly
- Get eye and hearing tests
- Receive timely vaccines

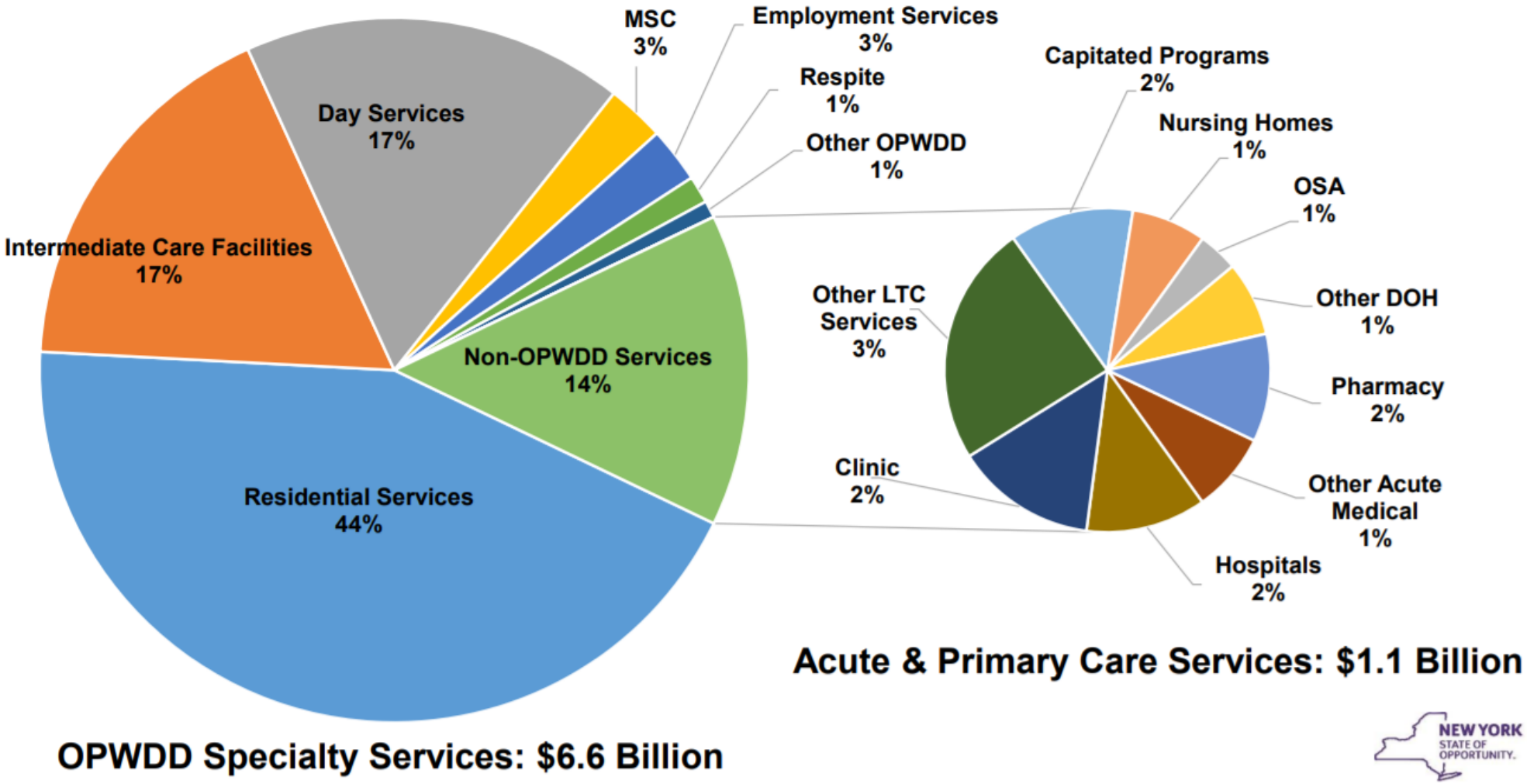
An individual's residential setting also plays a key role in access to preventative and primary care: individuals living in residences are more likely to have access to preventative screenings and vaccinations than those living in the community.

Healthcare Costs for the I/DD Population

- **The I/DD population utilizes inpatient treatment at a much higher rate than the general population**
  - Nearly twice as likely to use the ER and to be admitted for an inpatient stay
  - An estimated 1 in 21 hospitalizations in the State involves individuals with I/DD
- **A significant portion of inpatient stays involve mental health treatment**
- **Individuals with I/DD in a hospital setting require increased staffing, are difficult to diagnose and have longer lengths of stay and increased recidivism**

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-11-04_opwdd_comb_webinar.pdf

Total Medicaid Spend for Individuals with I/DD



Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-11-04_opwdd_comb_webinar.pdf

Key Takeaways: SDH and the I/DD Field

- **Conversations around SDH for this population should be tailored and different from conversations pertaining to the "mainstream" population—*i.e. this not a "medical model"***
  - The goal of addressing SDH for individuals with I/DD is not just to improve health outcomes and reduce costs, but also to improve functioning and quality of life
  - In this regard, providers of I/DD services have longstanding experience addressing SDH
- **Further, funded HCBS often overlap with more traditional SDH interventions**
  - Employment supports and services, housing and food and nutrition services have been provided through Medicaid in New York and other states for several years
  - Models need to leverage existing services that address SDH, while going further to address needs that remain unmet

Questions?

Thank You!

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