Agenda

- Introductions
- Objectives for this call
- Updates from ASTHO
- Presentation on the social determinants of health and Medicaid
- Lightening round robin
- Wrap up and next steps
Background and Objectives

• The ASTHO Senior Deputies Medicaid Innovations group originated from interest in discussing how state and territorial health agencies could work with Medicaid on improving population health in a small group.
• This group is intended to provide a venue for peer-to-peer learning and sharing on issues related to Medicaid innovations and health systems transformation activities.
• ASTHO hosted three calls (January, March, and June) with this group and is planning to continue these calls on a quarterly basis.
ASTHO Center for Population Health Strategies
Center for Population Health Strategies

Chief, Center for Population Health Strategies
Mary Ann Cooney

Coordinator
Beth Gambrone

Senior Director, Clinical and Community Connections
Deborah Fournier (10/16)

Director, Health Integration
VACANT

Analyst, Health Systems Transformation
Anna Bartels

Senior Analyst, Health Transformation
Emily Moore

Senior Director, Health Data Analytics & Informatics
Timothy Carmey

Director
VACANT

Director, Health Equity
Melissa Lewis
Center for Population Health Strategies

The Chief Health Strategist and the 3 Pillars

- **Clinical to Community Connections**
  Promote through policy and practice strategic alliances of public health with health care payers and providers

- **Health Data Analytics**
  Use technology and informatics to develop state capacity and leadership for integrated and informative systems technology solution that use health care, human services and public health data

- **Health Equity and Determinants of Health**
  Assure health equity through state health agency’s strategic partnerships with capacity to lead change and commit to promote health in all policies

Leadership - Policy and Advocacy - Capacity Building
Governance

Integration Forum = Population Health Forum

- Population Health Advisory Committee

Population Health Leaders Council

- Health equity and Determinants of Health Policy Team
- Clinical to Community Connections Policy Team

ASTHO Population Health Tactical Team

- Data Analytics
- Research and Evaluation
- Prevention and Promotion
- Infrastructure and Workforce
Examples

- Funding and Actuarial Modeling for Prevention
- Policy and Operations Templates and Examples
- Data Analyses and Visualization
Snapshot of Upcoming Work

• Launch of several learning communities in the coming months:
  • Community health workers
  • Primary care
  • Telehealth
• Hosting a Medicaid-Public Health Leadership Group with NASHP (January 2018)
• Hosting Population Health Summit with NACCHO, NASHP, and NCSL (Spring 2018)
• Continuing technical activities on payment and delivery reform and through the 6|18 Initiative
• Continuing work with the Integration Forum, now the Population Health Forum
• Development of additional tools and TA requests related to payment and delivery reform and population health.
Questions and Feedback?
Medicaid and the Social Determinants of Health

Emily Moore, MPH
Association of State and Territorial Health Officials
Nov. 20, 2017
Objectives

• Discuss opportunities for state and territorial health agencies (S/THAs) to partner with Medicaid on incorporating programs and policies that address the social determinants of health (SDOH) into health transformation.
• Share innovative approaches that are being tested by states related to SDOH.
Social Determinants of Health

- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Built Environment
- Social and Community Context
There is broad recognition of the interplay between SDOH and health care outcomes...

What can S/THAs what to do about it?

How can S/THAs partner with Medicaid on SDOH?
Current Opportunities for State Innovation

- Federal administration is supportive of state and local innovation – encouraging states to consider Section 1115 or 1332 waivers to advance health transformation goals.
- CMS in early November invited states to propose demonstrations that: “Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals.”
- Many states have already begun work on SDOH as part of the State Innovation Model (SIM) Initiative, Medicaid Health Homes, Accountable Health Communities (AHC), or other payment and delivery reform efforts.
Addressing SDOH

Gathering & Utilizing SDOH Data for Medicaid

• Ways to use SDOH data:
  • Adjusting payment rates for MCOs.
  • Structuring performance metrics.
  • Improving healthcare disparities for certain population groups.
  • Determining if additional community supports, benefits and care coordinating are needed.

• Collection methods:
  • Extract elements from claims data.
  • Extract elements from EHR using natural language programming.
  • Use state and federal databases to assess SDOH at population level.
  • Obtain via patient self-reported instruments.

"If you can't measure it, you can't improve it."
SDOH Data Processes

- Integrating SDOH into existing data collection can be a lengthy process and involves a range of key stakeholders (e.g., healthcare providers, health systems, and IT).

Levers to support collection:
- Managed care organization contracting and risk adjustment.
- Incentives for new payment models (AHC or Medicaid waiver demonstrations).
- Collection by community organizations or CHWs using standard templates.

- Some state legislatures (e.g., WA and OR) have specified the creation of common measures for SDOH as part of reform efforts.
Data Collection on Common SDOH Domains in Select States*

<table>
<thead>
<tr>
<th>SDOH Domains</th>
<th>KS</th>
<th>MA</th>
<th>MI</th>
<th>NY</th>
<th>OR</th>
<th>TN</th>
<th>VT</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Family and Social Support</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Education and/or Literacy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Food Security</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Employment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Criminal Justice Involvement</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data collected from Medicaid beneficiaries at the individual and/or population level

♦ Data not systematically collected on the entire Medicaid population

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable Health Communities Screening Tool</strong></td>
<td>Housing instability, food insecurity, transportation, utility, interpersonal safety. Optional: family and social supports, child care, education, employment and financial strain, health behaviors, mental health, and disabilities.</td>
</tr>
<tr>
<td><strong>Health Leads</strong></td>
<td>Food insecurity, housing instability, utility, financial resources, transportation, exposure to violence. Optional: childcare, education, employment, health behaviors, social isolation, behavior/mental health.</td>
</tr>
<tr>
<td><strong>Patient Centered Assessment Method (PCAM)</strong></td>
<td>Health status, mental well-being, lifestyle behaviors, social environment, health literacy, service coordination.</td>
</tr>
<tr>
<td><strong>Patient-reported Outcomes Quality of Life (PROQOL)</strong></td>
<td>Personal relationships, monitoring health, emotional health, money, health behaviors, medicine, getting health care, work, physical health.</td>
</tr>
<tr>
<td><strong>Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences</strong></td>
<td>Demographics, SDOH, including family dynamics social and emotional health, socioeconomic status.</td>
</tr>
</tbody>
</table>

Protocol for Responding to and Assessing Patients’ Assets, Risks, & Experiences (PRAPARE)

- Developed by the National Association of Community Health Centers and others

<table>
<thead>
<tr>
<th>PRAPARE Core Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Language</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Material Security</td>
</tr>
<tr>
<td>Migrant and/or Seasonal Farm Work</td>
</tr>
<tr>
<td>Insurance</td>
</tr>
<tr>
<td>Housing Status and Housing Stability</td>
</tr>
<tr>
<td>Veteran Status</td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Address/Neighborhood</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Social Integration and Support</td>
</tr>
<tr>
<td>Stress</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRAPARE Optional Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incarceration History</td>
</tr>
<tr>
<td>Safety</td>
</tr>
<tr>
<td>Domestic Violence</td>
</tr>
<tr>
<td>Refugee Status</td>
</tr>
</tbody>
</table>

- **PRAPARE** tool aligns with measures proposed for next stage of Meaningful Use, clinical coding under ICD-10, and HRSA’s Uniform Data System for health centers.

CMS AHC Screening Tool

• In Spring 2017, the Innovation Center released a standardized screening tool for health-related needs in clinical settings as part of the AHC initiative.
• This 10-question screening tool identifies unmet needs across five core domains:
  • Housing instability
  • Food insecurity
  • Transportation needs
  • Utility needs
  • Interpersonal safety
• Integrates some measures from PRAPARE and other sources.

Other Measures Available

• **Vermont Social Vulnerability Index**: Tool for identifying the relative social vulnerability of populations across the state and can help for emergency preparedness or infectious disease control.

• MassHealth developed a Risk Adjustment Model for Delivery Reform for MCO rate setting that included a “neighborhood stress” measure summarizing 7 census variables related to income, public assistance, car ownership, family structure, and education.
Key Takeaways on Actionable Data Sharing

• Play a leadership role in mobilizing partners around a specific issue and drive a coordinated response.
• Look for the data that is unique to your agency that may be underutilized or unrecognized.
• Tailor your data analysis and visualization to your partners.
• Under your leadership, create a governance structure to lead data collection and analysis that is empowered with decision-making authority.
• Consider how to restructure your organization to facilitate communication among program staff.
• Formalize greater participation in and use of data from local community health needs assessments.
• Use Medicaid waiver discussions as an opportunity to engage CMS.
• Begin with a single priority area that can serve as a relatively easy “win.”

Source: Integration Forum.  
http://www.astho.org/Integration/Integration-Forum-Actionable-Data-Sharing/
Coordinating Services – Integrated Eligibility and Information Systems

• No Wrong Door strategies and integrated eligibility and enrollment (E&E) systems can be a start to strengthening connections between health and human services programs.

• In 2016, HHS found that about two-thirds of states currently have integrated E&E systems shared by Medicaid and at least one human services program.

• Challenges to integration:
  • Lack of alignment of policies and rules.
  • Limited funding for systems improvements.
  • Outdated, inflexible, or multiple legacy systems.
  • Federal or state rules limiting data sharing (e.g., HIPAA and 42 CFR Part 2 for substance misuse).
Facilitators for Integrated E&E Systems

- Importance of executive-level leadership and collaboration across health and human services agencies to provide governance.
- Critical role of business process reengineering as a driver for technology projects.
- Use blended of funding streams and take advantage of federal funding opportunities (extended through 2018).
Express Lane Eligibility for CHIP and Other Services

• The Children’s Health Insurance Program Reauthorization Act of 2009 provided states with important new avenues to ensure that children eligible for Medicaid or CHIP have a fast and simplified process for having their eligibility determined or renewed.

• Other programs designated as Express Lane agencies can help determine CHIP or Medicaid eligibility, such as Supplemental Nutrition Assistance Program (SNAP), School Lunch, TANF, Head Start, and WIC, among others.
Food Security & Eligibility

States are using coordinated eligibility systems to improve enrollment in both programs:

- **Idaho’s eligibility system uses SNAP data to perform Medicaid ex parte renewals**
  - Eligibility system automatically checks SNAP data when attempting an ex parte Medicaid renewal. For households enrolled in both programs, the SNAP data is used to determine ongoing eligibility for Medicaid.

- **Alabama eligibility workers consult SNAP data to perform Medicaid ex parte renewals for parents**
  - Alabama has a express lane eligibility for children, but workers manually use data to determine Medicaid renewal status.

- **Illinois uses Medicaid to drive the join renewal process for Medicaid and SNAP**
  - Illinois has an integrated eligibility system and integrated workforce. Approximately 2 mos. before the end of the certification period for a household receiving Medicaid and SNAP, the system will attempt an automated ex parte review for Medicaid.
Food Security Interventions for MCOs or Duals

• Managed care organizations have incentives to help members address broader needs with some plans adopting specific interventions targeted at food security.

• CareSource, Ohio’s largest MCO, identified food security as a concern for its high-risk members
  • They created a portable, diabetic food bank, which the case managers use in their quarterly visits as part of their patient education efforts.

• Maryland Medicaid and human services agency found healthcare savings for dual eligibles utilizing SNAP
  • Integrating data from Medicaid and human services they found that food assistance may help older dual eligible avoid hospitalizations. They estimated that, on average, SNAP participation results in approximately $2,120 per year in medical cost savings among income-eligible seniors (age 65 and older).
Medicaid & Housing

• 2015 CMS memo defines the housing-related activities and services which Medicaid can cover:
  • Individual Housing Transition Services
  • Individual Housing & Tenancy Sustaining
  • State-level Housing Related Collaborative Activities

Opportunities for States
• CMS Accountable Health Communities Initiative
• CMS Money Follows the Person Demonstration
• Medicaid Accountable Care Organizations
• 1915(b) and 1915(c) waivers
• Section 1115 Research and Demonstration Programs

Homelessness ⇔ Poor Health
State Examples

• **Colorado Regional Care Collaborative Organizations**
  - Contract with primary care providers to offer care coordination and connect beneficiaries to wrap-around services, including housing assistance.

• **Wisconsin Money Follows the Person**
  - Provided extensive counseling services (e.g., rental assistance, home financing, credit, and homeless and eviction prevention counseling) and property evaluations.

• **Washington State 1115 Demonstration Waiver: Foundational Community Supports Program**
  - Provides services to help Medicaid beneficiaries achieve stable housing, particularly those who are chronically homeless.
Housing & Health Resources

• CMS:
  • Coverage of Housing-Related Activities and Services for Individuals with Disabilities.
  • Homeless Initiatives.
• HHS: A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing.
• ASTHO: ASTHO-CDC-HUD Convening: Cross-Sector Partnership Models to Improve Health and Housing Outcomes, November 2016.
• HealthAffairs Blog: “Medicaid and Permanent Supportive Housing.”
Employment Services

- States can use flexibility in Medicaid or targeted case management services to connect individuals to employment resources.
- States have used 1915(i) and Home & Community Based Services waivers to provide the following services for those with disabilities or major barriers to work:
  - Prevocational services
  - Supported employment services
- **State example:** Maryland used their state’s HCBS waiver for children and adults with developmental disabilities to provide “employment discovery and customization” and “supported employment,” including job coaching, training, monitoring and evaluating performance at the workplace.
Collaborating with Community Organizations

• Partnering with community organizations and local health systems is important to help address SDOH and create linkages between clinics and the community.

• Many S/THAs have partnered with the community to:
  • Develop community health needs assessments (CHNAs)
  • Implement national CLAS standards
  • Engage in different public health programs or specific interventions

• Engagement should go beyond networking and cooperation → ongoing collaborative relationships.

• S/THAs can lend expertise with engaging community to Medicaid demonstrations and other reforms.
Tools on Engaging the Community

- **Partnership for Healthy Outcomes** is a tool for assessing CBOs and health care organizations partnerships to identify areas for improvement.
- ASTHO **issue brief** on CHNAs and partnering with rural hospitals
- ASTHO’s **Integration Forum**
- Robert Wood Johnson Foundation’s [Culture of Health](#) webpage and [Sentinel Communities](#) on current community partnerships
Unique Value of CHWs to Address SDOH

• CHWs can:
  • Provide context to team members on “whole picture” of patient’s life.
  • Serve as “SDOH expert” on the team.
  • Assist patient/family in dealing with non-medical issues affecting health status and access.
  • Mobilize community to deal with macro-level issues.

• Opportunities:
  • States can designate non-licensed providers to provide preventive services as part of the Affordable Care Act.
  • Case management services, including integrating into managed care contracting.
  • State Medicaid programs can create “health homes” for beneficiaries living with chronic disease that could incorporate CHWs.
  • Waiver programs and SIM in some states have included programs utilizing CHWs.
CHWs and 1115 Waivers

• Arkansas’ 1115 Waiver included “Community Connectors” in home and community-based long term care.
  • Private foundation funding used for non-federal match (separate approval).
  • Showed 3:1 net return in total cost of care.
  • State is expanding as part of regular Medicaid operations.

• Texas DSRIP program included CHWs for care coordination and neighborhood engagement.
  • DSRIP grants financed delivery system reforms in safety net systems in exchange for sustained support for uncompensated care.
  • Created a Community Care Collaborative as integrated system for low-income in central TX.
  • CHWs employed in over 300 local grants: navigation for ER users, care coordination and care transfers, and chronic disease self-management support, “neighborhood engagement” in San Antonio.
Conclusions

• State and territorial health agencies have expertise in addressing the social determinants of health that can inform the efforts of state Medicaid agencies.
• There are many opportunities to integrate a SDOH-lens through use and integration of data, leveraging interventions that address these upstream factors, and using care coordination as the lever to link services between the community and healthcare.
Additional Resources

• ASTHO: Cross-Sector Partnerships Webpage
  • Social Determinants of Health: A Quick Reference Guide for State Offices of Rural Health and State and Territorial Health Officials

• Center for Health Care Strategies: Social Determinants of Health Webpage
  • Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons
  • Bridging Community-Based Human Services and Health Care: Case Study Series
  • Using Medicaid Levers to Support Health Care Partnerships with Community-Based Organizations

• Community Tool Box: Addressing the Social Determinants of Health and Development

• RWJF State Network:
  • Shared Measurement and Joint Accountability Across Health Care and Non-Health Care Sectors: State Opportunities to Address Population Health Goals
  • Medicaid and Social Determinants of Health: Adjusting Payments and Measuring Health Outcomes

• Manatt: Medicaid Coverage of Social Interventions: A Roadmap for States
Food for Thought & Discussion

• How have you worked with your state Medicaid agency and health system to address the SDOH?
• What opportunities are you most excited about?
• What are the “low hanging fruit” for these collaborations?
• What technical assistance and infrastructure is needed for S/THAs and their partners?
Lightening Round Robin with States
Thank You!!

Deborah H. Fournier, JD
Senior Director, Clinical to Community Connections, ASTHO
dfournier@astho.org

Emily Moore, MPH
Senior Analyst, Health Transformation, ASTHO
emoore@astho.org

This work was generously supported by the CDC Office of State, Tribal, Local, and Territorial Support (5U38OT000161-04).