VBPQIAC Workgroup 3 – Social Drivers of Health

Policy Issue:

Positive health outcomes are driven by more than health care alone. What happens in homes and communities matters at least as much. The best available evidence indicates that for many low-income individuals, addressing significant non-clinical needs can lead to real savings for the medical system and improvements in health.

Successful value-based payment (VBP) models that improve outcomes while lowering total cost of care connect people to the most appropriate services for their circumstances, whether clinical or nonclinical. Value-based care is increasingly including strategies to address social determinants/drivers of health (SDOH). Texas is engaged with exploring value-based care strategies considering SDOH from multiple perspectives.

The COVID-19 pandemic has exacerbated the effects of SDOH on health inequities. For example, many social determinants of health such as poverty, physical environment (e.g., smoke exposure, homelessness), and race or ethnicity—can have a considerable effect on COVID-19 outcomes.[1] The Centers for Disease Control and Prevention (CDC) recognizes the disparate impact that COVID-19 has on racial and ethnic minority groups and encourages learning more about SDOH and how to improve conditions in communities experiencing these disparities.[2]

The following recommendations support addressing SDOH needs for individuals, including during the pandemic and following the acute response to the pandemic through "lessons learned." Recommendations are focused both on a statewide organization framework to support SDOH activities and on the development of alternative payment models (APMs).

Recommendations:

The VBPQI Committee supports alignment of SDOH activities with quality and value-based improvement goals, including promoting learning and identification of best practices within Medicaid managed care through the following:

- The Committee recommends a landscape analysis of which SDOH assessment tools and electronic referral platforms are currently being utilized in Texas Medicaid, and also review strong models throughout the US. Working with Medicaid managed care organizations (MCOs), providers, and other stakeholders, HHSC should assess whether a state-level or regional tool(s) and/or platform(s) would better enable Texas Medicaid to address SDOH.

- Based on the landscape analysis, the Committee recommends that HHSC work with Medicaid MCOs to implement an assessment tool and electronic

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234789/
[2] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html

referral platform strategy that can be used to better facilitate the ability to address SDOH needs.

- The Committee recommends that HHSC work with stakeholders to explore how initiatives to address SDOH that drive healthcare costs and poor health outcomes are/could be supported through APMs, including:
    - Promoting better reporting of ICD-10 Z codes for social needs. The information could be useful for eventually identifying areas for improvement or intervention.
    - Developing accountability metrics in the Medicaid program related to SDOH/health equity.
    - Looking at pilot/study/proof of concept opportunities with MCOs to develop evidence to inform future HHSC policy or waiver applications.
    - Reviewing opportunities in 1115 waivers, such as the DSRIP transition.

Discussion:

Assessment Tools and Referral Platforms

In order to effectively manage SDOH interventions, health care organizations are increasingly utilizing technology platforms for screening/assessment and to identify and refer patients to social service organizations. This is an area of focus of Texas Medicaid. Texas Medicaid is working with stakeholders, including managed care organizations, to consider what screening and referral platforms would be good models to use for a statewide strategy.

Screening Tool Examples

Accountable Health Communities Health Related Social Needs Screening Tool

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. They are testing to see if "systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better."[3]

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

PRAPARE is a national effort to help community health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. "As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social determinants of health, health centers and

[3] https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

other providers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers."[4]

Referral Platform Examples

Specific to Texas, the Episcopal Health Foundation (EHF) invited Methodist Health Ministries of South Texas and Saint David's Foundation to support a comprehensive study of community resource referral platforms. The purpose was to continue learning about how healthcare organizations screen their patients for SDOH and the tools that are available to providers to effectively refer and link patients to appropriate community-based resources and social services. Social Interventions Research & Evaluation Network (SIREN) at the University of California, San Francisco (UCSF) were commissioned to answer critical questions about the referral platforms that are currently available. The study focused on "the unique capabilities of the tools, how the tools differ from each other, and details about the actual experiences of healthcare organizations who have invested in and used these tools." The following are the tools included:

- Aunt Bertha
- CharityTracker
- CrossTx
- Healthify
- NowPow
- One Degree
- Pieces Iris
- TAVConnect (TAVHealth)
- Unite Us[5]

Example of a statewide approach

North Carolina is a state that has focused on SDOH and has a Medicaid 1115 Waiver to test SDOH interventions. North Carolina uses NCCARE360, a statewide coordinated care network connecting individuals to local services and resources. Through NCCARE360, community partners have access to a statewide resource data repository that will include a call center with dedicated navigators and a shared technology platform that enables healthcare and human service providers to send and receive secure electronic referrals, communicate in real-time, securely share client information, and track outcomes. This solution ensures accountability around services delivered, provides a "no wrong door" approach, and closes the

[4] http://www.nachc.org/research-and-data/prapare/

[5] https://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf

loop on every referral made, according to the state. NCCARE360 started in January 2019 and plans to be available in every county in North Carolina by end of 2020.[6]

Advancing Alternative Payment Models

The Committee has focused on promoting value-based care given limited public dollars and the capitated financing model used in Texas Medicaid through managed care. An issue is how to align health plan and provider incentives with improving health outcomes and reducing costs in a largely fee-for-service capitation model. Strategies for addressing this key issue of containing costs while supporting quality is one of the key concerns of the State, health plans, and providers, including with SDOH strategies.

As outlined in the VBPQIAC report submitted to the Texas Legislature in 2018, federal regulation (45 CFR Sec. 158.150-151) allows certain quality-related costs to be treated as medical expenses. This provision recognizes the increasing evidence that targeted non-clinical interventions can have a substantial impact on improving health outcomes and lowering medical spending, particularly for low income populations and individuals with serious mental illness and other complex health risks. Oregon explicitly uses this regulation to enable their Medicaid Coordinated Care Organizations to cover SDOH.[7]

Effective strategies to reduce the incidence of preventable events and conditions for complex patients require partnerships between health care, community-based, and public health organizations to identify and address root causes for poor outcomes; promote evidence based wellness education and activities focused on modifying risk factors for tobacco use, poor nutrition, low physical activity, and substance use; and improve access within communities to best practices for healthy living. Leveraging federal law to expand navigation to community based, non-clinical services, especially for patients with high medical utilization, is one such promising strategy for MCOs.

For example, improvements in health literacy could be an area of focus. Health literacy is defined as the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information which promote and maintain good health.[8] Peer support specialists and community health workers (CHWs) could be employed to assist with health literacy efforts as a quality initiative. Community pharmacies should be explored as a novel access point for CHWs and/or patient navigation services. Pharmacy teams are uniquely positioned to document SDOH findings and assist with appropriate interventions because they have local trusted relationships, knowledge of local community resources, trained

[6] https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360
[7] https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf

[8] https://www.who.int/healthpromotion/conferences/7gchp/track2/en/

home delivery personnel, walk-in accessibility, abundant patient touchpoints, and medication use expertise.

Along with quality-related costs, some states are also using provisions such as value-added services and in-lieu of services. There are a number of potential financing strategies that are possible to use for SDOH-related services. The Center for Healthcare Strategies outlines potential MCO strategies and also the complexities:

"In their contracts, states often require managed care organizations (MCOs) to screen for social needs and link members to needed community resources, but do not often establish specific expectations around the direct provision of services that address those needs. Nonetheless, states do have some flexibility under existing law, and CHCS' review of managed care contracts suggests that states have, for the most part, not taken full advantage of this flexibility."[9]

California engaged Manatt for a study to review California Medicaid's capitation rate-setting strategy. This report shows the complexities for capitation rate setting for incentivizing health plans and the role the state plays for activities that improve quality of care, including SDOH.[10]

Promoting better reporting of ICD-10 Z codes

As Texas Medicaid works to identify and address SDOH, one tool available on the social needs of patients is the ICD-10 Z codes, which identify non-medical factors that may affect health status. Codes Z55-Z65 may be used to capture social factors related to housing, employment, education and literacy, and family circumstances, among others.

So far, use of Z codes has been limited, but is increasing. HHSC's Center for Analytics and Decision Support (CADS) did a data review for STAR+PLUS from October 1, 2015 through December 31, 2018. The review found that while Z codes were documented for under 2 percent of STAR+PLUS enrollees, the use of Z codes increased 37% between 2016 and 2018. During that time, the most commonly documented code was homelessness (Z590). Housing/economic problems were by far the most commonly reported, followed by other psychosocial and employment problems.

<u>Delivery System Reform Incentive Payment Program Transition Plan</u>

DSRIP has been implemented in Texas as locally driven and based on community needs. It is an incentive payment program and offers flexibility to: 1) innovate to deliver better care and improve health outcomes; and 2) deliver services not traditionally billable to insurance but that can improve health. The DSRIP program has included the opportunity to address social drivers of health, such as through care navigation for individuals with complex conditions, housing supports, and

[9] https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf
[10] https://www.manatt.com/Manatt/media/Documents/Articles/MediCalRateSetting_v3.pdf

transportation assistance. An increased knowledge base nationally, along with the early work in DSRIP, offers opportunities for next steps. The milestones included in the transition plan lay the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. One of the milestones specifically focuses on SDOH. This transition planning is another area of focus for review for the development of APMs.

Cross-Focus Area Milestone: HHSC completes an assessment of which social factors are correlated with Texas Medicaid health outcomes, including pediatric health outcomes. In DY9-10, providers will begin reporting on which Related Strategies they're deploying to improve the health of their DSRIP target population and associated outcome measures, of which nine strategies specifically indicate whether providers have already implemented or are planning to implement strategies focused on SDOH (e.g., assistance with food insecurity, housing, transportation). Analysis of this data will help inform HHSC strategies for continuing to advance alternative payment models and further develop delivery system reform post waiver. [March 31, 2021]

Deliverable: HHSC submits to CMS the assessment of social factors.[11]

As Texas has been planning for the DSRIP transition, HHSC has convened a Best Practices Workgroup. One of the activities of the group was to prioritize practices from DSRIP that have been key for driving improvements in the health status of clients within focus areas and populations for continued delivery system reform and quality improvement.

From the Best Practices Workgroup, the following are the top key practices implemented in the DSRIP program to assist in SDOH:

- Screening patients for transportation needs
- Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
- Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
- Screening patients for housing needs
- Culturally and linguistically appropriate care planning for patients

[11] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/draft-revised-dsrip-transition-plan.pdf