Medicaid's Role in Addressing Social Determinants of Health

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Overview

- Discuss a framework for Medicaid programs to address food insecurity and other social determinants of health
- Discuss using Medicaid and other state resources to pay for health related supportive services
Our mission is to lead national collaboration to **improve health and healthcare quality** through measurement.

NQF is a non-profit, nonpartisan, **membership-based** organization that works to catalyze improvement in healthcare.
What We Do

NQF achieves its mission through projects that:

- Set standards by endorsing measures through the Consensus Development Process (CDP)
- Recommend measures for use in payment and public reporting programs, such as Medicaid and Medicare
- Accelerate the development of measures in areas where measurement is inadequate or lacking
- Provide information and tools to help healthcare leaders make evidence-driven decisions
Project Scope

- In collaboration with the Centers for Medicare & Medicaid Services (CMS), the National Quality Forum (NQF) developed a framework to guide Medicaid programs in addressing social determinants of health.

To support NQF:
- Convened an expert panel with expertise in social determinants of health and health care.
- Conducted key informant interviews.
- Proposed measure concepts that can be translated into performance measures to assess the extent to which Medicaid programs are supporting the integration of health and social services.
Food Insecurity

- 12.3 percent (15.6 million) of U.S. households were food insecure at some time during 2016.
  - Essentially unchanged from 12.7 percent in 2015

- Among U.S. households with children under age 18, 83.5 percent were food secure in 2016.

- In 2016: 41.2 million people lived in food-insecure households.

Food Insecurity and Negative Health Outcomes

- Many studies have documented the impact of food insecurity on health outcomes using the Current Population Survey FSS.

- Most studies have focused on children:
  - Associated with increased risks of birth defects, anemia, lower nutrient intakes, cognitive problems, and aggression and anxiety.
  - Higher risks of being hospitalized, asthma, behavioral problems, depression, and poorer general health.

- Less research on the impacts of food insecurity among non-senior adults:
  - Associated with decreased nutrient intakes, increased mental health problems, hypertension, and worse outcomes on health exams.

- Little work on food insecurity and health among seniors:
  - Associated with lower nutrient intakes, depression, limitations in activities of daily living.

Gundersen, Craig. “Food Insecurity And Health Outcomes.” Health Affairs, Health Affairs, 1 Nov. 2015, content.healthaffairs.org/content/34/11/1830.
FIGURE 12.
Impact of SNAP participation on food insecurity and other financial hardships

SNAP reduces food insecurity and diminishes other financial hardships.

Source: Shaefer and Gutierrez 2013.
Note: Sample includes low-income households with children. Medical hardship is measured as whether the interviewee reported that in the past 12 months someone in the household chose not to see a doctor or go to the hospital when needed because of cost.
Framework for Addressing Social Determinants of Health through Medicaid

- Individuals often have to make trade-offs between spending money on food, housing, transportation and other needs
  - Targeting insecurity in one area can lead to reductions in insecurity in other areas
  - There is a need for a holistic approach to addressing social determinants of health

- Medicaid programs are uniquely suited to bridge the gap between health care and non-health services (health related services)
  - Leverage existing infrastructure for assessing eligibility for services
  - State-federal partnership
  - Already connected to many of the individuals who can benefit the most from non-health services that can address SDOH
  - Strong business case
Using SDOH Data in Clinical Care

SDOH Targeted Care

- Using information on social needs in clinical decision making for Medicaid beneficiaries

SDOH Coordinated Care

- Connecting individuals to non-health services that can address SDOH
Recommendations from Expert Panel

- **Community and Health care System Linkages**
  - Acknowledge that Medicaid has a role in addressing social determinants of health
  - Create a comprehensive, accessible, routinely updated list of community resources

- **Information Sharing and Measurement**
  - Harmonize tools that can assess social determinants of health
  - Create standards for inputting and extracting social needs data from electronic health records

- **Payment Methods and Innovative Use of Resources**
  - Increase information sharing between government agencies
  - Expand the use of waivers and demonstration projects to learn what works best for screening and addressing social determinants of health
Where does the money come from and how is it dispersed?
Financing Integration Programs

- Trust fund or Pool
  - States can establish a trust fund or funding pool by setting aside a port of money for health and social service integration

- Medicaid Waivers
  - Medicaid waivers can serve as vehicles to test new or existing ways to deliver and pay for health services in Medicaid and CHIP
    - 1115 Research and Demonstration Waivers
    - 1915c Home and Community-Based Services Waivers
## Example State Supported Service Payment Strategies

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<tr>
<th>Program</th>
<th>Payment Model</th>
<th>Examples of Services Offered</th>
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<td>Oregon Coordinated Care Organizations</td>
<td>• Global payment</td>
<td>• Education/training&lt;br&gt;• Self-help/support groups&lt;br&gt;• Home remediation</td>
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<tr>
<td>Utah Accountable Care Organizations</td>
<td>• Risk adjusted, capitated model with annual increase of no more than 2 %</td>
<td>• Home remediation&lt;br&gt;• Housing assistance</td>
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<tr>
<td>Vermont Blueprint for Health/SASH</td>
<td>• Per beneficiary, per month payment&lt;br&gt;• Capacity payment to community health teams</td>
<td>• Nutritional education&lt;br&gt;• Self-help/support group</td>
</tr>
<tr>
<td>New York Supportive Housing Services</td>
<td>• State-only Medicaid funds</td>
<td>• Rental subsidy assistance&lt;br&gt;• Job training&lt;br&gt;• Tenancy support/mediation</td>
</tr>
<tr>
<td>Boston Massachusetts Children's High Risk Asthma Bundled P payment</td>
<td>• Bundled payment</td>
<td>• Home visits from CHWs&lt;br&gt;• Environmental mitigation supplies</td>
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## Continuum of Financing Options for Social Service Integration

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<th>Fully Operational Integration programs</th>
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<td>• Small-scale federal grants</td>
<td>• Dedicated state pools of trusts</td>
<td>• Blending or braided local, state, and federal financing</td>
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<td>• Social impact financing</td>
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<td>• Philanthropic funding</td>
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Financing Fully Operational Integration Programs

- **Braided funding**
  - Supports coordinated multi-agency funding, but keeps difference funding mechanisms in separate and distinguishable strands

- **Blended funding**
  - Combines money from different sources into a single pool, minimizing administrative burden and maximizes spending flexibility
Supporting Pilot Programs

- Small-Scale federal grants
  - *Time-limited federal grants are available for integration efforts happening within a state. State Medicaid programs can help:*
    - Address regulatory hurdles that may slow implementation
    - Align resources and funding streams
    - Provide data

- Social Impact Funding
  - *State agencies can agree to pay a third party (usually private) to conduct an intervention to reduce food insecurity in an affected area*

- Philanthropic funding
  - *State agencies can collaborate with local and national foundations to fund small-scale pilot programs*
Example Food Insecurity Measures

- **Screening tools:**
  - *Hunger Vital Sign (2-item)*
  - *Accountable Health Communities Screening Tool*
  - *Health Leads Social Needs Screening Toolkit*

- **Surveys:**
  - *U.S. Household Food Security Survey Module (6 to 18 items)*
  - *Food Insecurity Household Access Scale (18-item)*
  - *BRFSS*

- **Toolkits:**
  - *Implementing Food Security Screening and Referral for Older Patients in Primary Care: A Resource Guide and Toolkit*
  - *Addressing Food Insecurity: A Toolkit for Pediatricians*
  - *WellRx ToolKit*
Questions