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Medicaid Researching Social Determinants of Health

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It should come as no surprise that where we are born, grow, live, work, play, and age can have a dramatic impact on our health. Over the last ten years, creating social and physical environments that promote good health for all has been a top priority for several organizations, including the World Health Organization.

Now, Medicaid officials are looking at how it should address these "social determinants of health" (SDOH) for a broad population of Medicaid enrollees, to achieve better health outcomes.

In this article, we will explain what social determinants of health are; how they affect the elderly and the disabled; how Medicaid and others are getting involved; and what we can expect to see in the near future.

What are Social Determinants of Health?
Social determinants of health are the conditions and environments in which people live that can affect a wide range of health, functioning, and quality-of-life outcomes. These include:

- Resources to meet daily needs, such as safe, affordable housing and access to local food markets;
- Social support, education/literacy, and economic/job opportunities;
- Access to health care and services;
- Safe and clean neighborhoods free of poverty, crime, and life-threatening toxins;
- Transportation options;
- Access to mass media and emerging technologies, such as cell phones and the Internet;
- Good community design with access for people with disabilities, green space (grass and trees), sidewalks, bike lanes, and recreational settings.

How SDOH Affect the Elderly and Disabled
Many of the elderly and disabled have limited income. This often results in inadequate housing (or homelessness) and poor diets, making it difficult for them to even think about securing a job, attending school, or improving their physical and emotional health. Their neighborhoods may be crime-ridden and littered, with no fresh food markets nearby and with limited disability access. They may not have access to transportation to be able to venture out into the community. Social isolation is common. There may be language, literacy, or cultural barriers. An individual with significant social needs, combined with complex health needs, may not have the ability or resources to follow up on a referral for medical care.

How Medicaid is Involved

In recent years, it has become more apparent that SDOH has a great impact on the health status of individuals, especially among health plans serving low-income populations. From fee-for-service to managed care, Medicaid programs are seeking to address SDOH for a broader population of enrollees. Although states have previously addressed these factors for targeted populations, some are starting to expand their efforts as they seek to show cost-effective improvements in health outcomes, instead of just the volume of medical services provided.

In 2016, the Center for Medicare and Medicaid Innovation (CMMI) announced a new Accountable Health Communities model, focused on connecting Medicare and Medicaid beneficiaries with community services to address health-related social needs. The model provides funding to test whether systematically identifying and addressing health-related social needs through screening, referral, and community navigation services will affect health costs and reduce inpatient and outpatient utilization. In 2017, CMMI awarded 32 grants to organizations to participate in the model over a five-year period.

Another CMMI program, State Innovation Models Initiative (SIM), provides financial and technical support to states for the development and testing of state-led multi-payer health care payment and service delivery models that aim to improve health system performance, increase the quality of care, and decrease costs. To date, SIM has awarded nearly $950 million in grants to more than half of all states, to design and test innovative payment and delivery models. As part of the second round of SIM grant awards, states are required to develop a statewide plan to improve population health.

All 11 states that received Round 2 SIM testing grants plan to establish links between primary care and community-based organization and social services. For example:

- *Ohio* uses the funds to support a program in which primary care providers connect patients with needed social services and community-based prevention programs.
- *Connecticut's* SIM model seeks to promote an Advanced Home Model that will address individuals' needs, including environmental and socioeconomic factors that contribute to their ongoing health.
- *Washington* established nine regional Accountable Communities of Health which bring together multiple sectors to determine priorities for and implement regional health improvement projects.
- *Delaware* plans to implement ten Healthy Neighborhoods that will focus on priorities such as healthy lifestyles, maternal and child health, mental health and addiction, and chronic disease prevention and management.
- *Idaho* is creating seven Regional Health Collaboratives that will support local primary care practices and create formal referral and feedback protocols to link medical and social services providers.

Medicaid researchers are also examining the new practices states are implementing to address SDOH using Medicaid 1115 waiver demonstrations and managed care contracts.

A recent report found that many states are moving beyond screenings and instead connect enrollees to social supports. While 35 of 39 states now require or encourage managed care organizations (MCOs) to screen enrollees for social issues and provide referrals to services, they found that simple screenings can be ineffective for many people. As mentioned earlier, some individuals, especially those with significant social needs or complex health issues, may not have the resources or ability to follow up on a referral. Even if they do, it is possible that the agency or organization to which the person has been referred cannot help as anticipated.

Recognizing that screenings and referrals can become a "check-the-box" exercise, some states are adding stronger MCO requirements to connect people to social supports. Some are requiring "closed-loop" referrals, ensuring the plans track the outcomes of referrals that are made and provide additional help as needed.

Several states require that MCOs work with community health workers or contract with locally-based staff for care coordination. The belief is that local staff is likely to have more knowledge of community resources and the members' experiences, as well as being able to meet the individual to assess and address social needs personally. For example, *New Mexico* requires MCOs to make community health workers available to help members navigate the health care system, secure culturally appropriate health information and obtain information

on community resources.

Rather than focusing on enrollees with complex health conditions, programs are now considering the social and economic factors of all members. Some states are addressing social isolation and loneliness, as well as the effects of adverse childhood experiences.

In addition to moving beyond standard screenings and interventions, states are working to build stronger networks of community-based organizations and collaborations with providers. They recognize that addressing social factors via Medicaid requires stronger coordination with and support for community-based social service organizations.

Medicaid agencies are using Section 1115 waivers to strengthen community-based organizations. For example, *New York, North Carolina,* and *Rhode Island* secured 1115 waivers that explicitly require an investment in community-based organizations that provide social services. *Colorado* and *Oregon* are implementing Medicaid payment and delivery models that provide care through regional entities that focus on the integration of physical, behavioral and social services as well as community engagement and collaboration.

Addressing Housing and Homelessness
The link between housing stability and overall health has been widely studied. In 2017, the American Hospital Association reported that almost 1.5 million people experience homelessness each year, and these individuals are much more susceptible to infectious diseases such as HIV/AIDS, pneumonia or tuberculosis.

While states cannot use Medicaid funds to pay for room and board, Medicaid funds *can* support a range of housing-related activities, including referral, support services, and case management services that help connect and retain individuals in stable housing. For example, some states' Medicaid programs are focusing on SDOH through Delivery System Reform Incentive Payment (DSRIP) initiatives that are part of Section 1115 Medicaid demonstration waivers.

In *New York*, providers may implement DSRIP projects aimed at ensuring people have supportive housing. *Louisiana's* Department of Health partnered with the state's Housing Authority to establish a Permanent Supportive Housing (PSH) program with the dual goals of preventing and reducing homelessness and unnecessary institutionalization among people with disabilities. A preliminary analysis shows significant reductions in hospitalization and emergency department utilization after PSH intervention, as well as a 24% reduction in Medicaid acute care costs after a person was housed.

How Other Health Payers are Getting Involved
Other payers besides Medicaid are also starting to realize the benefits and long-term returns for actively addressing SDOH. A recent survey by Change Healthcare found that 80% believe that addressing the SDOH of their members will be a crucial way to improve their health programs. 42% are integrating community programs and resources into their health programs. 34% are combining census and socioeconomic data with clinical data to develop new insights. Over 33% are adding SDOH assessments to their health risk assessments, and 26.6% are adding SDOH into clinical workflows. Less than 19% are not integrating SDOH in any form into their health programs.

In 2017, *The Humana Foundation* announced awards of $750,000 to help *South Florida* nonprofits improve community health. The projects include a community-centered care initiative that uses community health workers to close gaps in care for adults who are pre-diabetic, diabetic and hypertensive. Other programs include a seed-to-table garden program, behavioral healthcare using telehealth, extensive lifestyle interventions for those with chronic diseases, and community-wide self-health-management education for other health conditions. Leaders at Humana expect these grants will result in positive health changes in the following years.

UnitedHealthcare (UHC) recently announced it had invested more than $400 million to address SDOH and increase affordable housing access for people in underserved communities. The healthcare payer has funded more than 80 affordable-housing communities across the U.S., with more than 4,500 homes for people in need. The company has concluded that when homeless people have access to stable housing, they can manage their

health more effectively. Citing its own Medicaid data, UHC noted that in one state, emergency room admissions dropped 60% and total cost of care was cut in half for people who enrolled in a housing program.

As part of UHC's affordable housing initiative, the payer has invested in new communities that include on-site amenities and services such as clinical healthcare service, social support counseling and monitoring, job training, adult education courses, and childcare. One development in Austin, *Texas*, reserves 25% of its units for homeless individuals. Two affordable housing communities in Minneapolis, *Minnesota,* serve military Veterans and their families who are struggling with homelessness and offer on-site supportive services and access to Veteran health and social service programs.

Affordable housing is just one element of UHC's efforts to address SDOH. The company has previously awarded grants to *Arizona* food banks to combat food insecurity, as well as VisionQuest, 20/20, and Brighter Way of Arizona, to offer dental and vision screenings and immunizations.

Support from Non-Health Sectors
Practices and policies in non-health sectors also have impacts on health and health equity. For example, the availability and accessibility of public transportation affect access to employment, affordable healthy foods, health care and other important drivers of health and wellness. Nutrition programs and policies promote health by supporting healthier stores in low-income communities, farm-to-school programs, and community and school gardens. Early childhood education for children in low-income families can help to reduce achievement gaps, improve the health of low-income students and promote health safety.

What to Watch
The Medicaid report concluded that going forward, it will be necessary for both payers and providers to address patients' non-clinical factors to improve health outcomes, and it is anticipated that SDOH interventions will be more closely integrated into the delivery of care.

Using Medicaid dollars for some health-related services that do not fit into a Medicaid benefit category may require a Medicaid 1115 waiver, so we will likely see more Section 1115 waivers modified or granted.

It will also be essential to measure the impact of all such trials, recognizing that some of the benefits of addressing social factors may have a long-term impact on programs and entities outside of Medicaid.

Conclusion
At ElderCounsel, we care deeply about issues that affect the elderly, the disabled and our Veterans. We will continue to watch for future developments on this topic and how they affect our most vulnerable, and we will keep you informed.

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