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Strengthening Medicaid as a Critical Lever in Building a Culture of Health

State Opportunities and Innovations

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JANUARY 26, 2017

Innovation Demonstrations: Oregon and Washington

Oregon's Coordinated Care Organizations (CCOs)

- *Comprehensive managed care, combines health care and social needs*
- *Promote access to social, housing, nutrition, and environmental services*

Washington's Accountable Communities of Health

- *Partnerships among local organizations to coordinate activities and investments and improve health*
- *Focus on prevention, primary care / behavioral health integration, and workforce development*
- *Local organizations include: health care providers, health plans, public health agencies, local government, and social service agencies*

- Both currently funded through Section 1115 demonstrations

Administrative Option: Innovation Demonstrations

A1. Develop health improvement demonstrations that employ a longer-term savings time frame, focus on the social determinants of health, recognize health-related expenditures as qualified for federal funding, and count a broader range of estimated cost offsets when calculating budget neutrality.

- *Recognize improving the health of Medicaid beneficiaries as a specific objective of 1115*
- *Recognize state expenditures on evidence-based social services as qualifying for federal financing*
- *Allow state cost savings to include reduced spending on non-medical services*
- *Utilize a longer time frame (e.g., a 10-year budgeting period)*

Pay-for-Success: South Carolina

Nurse-Family Partnership

- *Jointly funded by philanthropic organizations and a Medicaid 1915(b) waiver*
- *Evidenced-based program*
- *Pairs vulnerable first-time parents with trained nurses through home visiting*
- *Will be evaluated based on its ability to achieve the program's objectives:*
  - *Reduce preterm births*
  - *Reduce child hospitalization and emergency department usage due to injury*
  - *Increase healthy spacing between births*

Administrative Option: Disseminate and Expedite Successful Models

A2. Develop a fast-track approval process, a clear implementation roadmap, and a series of definable outcome measures for promising service delivery transformation models.

- *HHS could create a series of evidence-based, specified health innovation models*
- *Subject to fast-track approval process*
- *Would address the challenge of the lengthy approval process for transformation efforts*

Coordinated Care: Minnesota

Accountable Communities for Health (ACH): State Innovation Models (SIM) Initiative

- *15 entities across the state of Minnesota granted ACH status*
- *Engaged with multiple community partners: public health, LTSS, behavioral health, social services, etc.*
- *State aims to incorporate more patient-specific measures*
- *Regional-level data efforts are underway to bridge these gaps and integrate data from insurers, clinical and behavioral health providers, and social service providers*
- *Data analytics sub-group has identified six priority areas and data sources focused on social determinants of health:*
  - *mental health and substance use*
  - *race, ethnicity and language*
  - *access to reliable transportation*
  - *social services*
  - *housing status*
  - *food security*

Administrative Options: Coordinated Care

A5. Improve data sharing between physical health, mental health, and substance use disorder services and providers to enhance care coordination.

- *May prevent health care providers from sharing information across the range of programs and services involved in treatment*
- *Substance use treatment providers still excluded from electronic health record systems*
- *Making behavioral health privacy regulations consistent with other medical privacy regulations will go a long way toward treatment of the whole person*
- *Caveat: must be cautious, protect unnecessary sharing / misuse of sensitive information*

Administrative Options: Coordinated Care

A9. Disseminate social determinants screening tools for utilization in managed care and integrated delivery systems, and adopt payment methods that foster comprehensive care and the integration of health and social services.

- *Accountable Health Communities aim to address the gap between clinical care and social services*
- *Need for screening tools that not only identify problems, but also mobilize resources to address those problems*
- *CMS could institutionalize and incentivize screening for the social determinants – when paired with service integration that connects patients to community resources – either as part of health care visits or through co-located services through non-medical professionals*