Building on the Movement from Value to Health: Essential Infrastructure to Sustainably Address DOH

Investing in Health Topic #3

Pre-Read Materials for November 5, 2021 Meeting

With generous support from the Commonwealth Fund and the Blue Shield of California Foundation

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Meeting Agenda, Objectives, and Expectations

Agenda for the October 15 Meeting

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Investing in Health Convening Objectives and Expectations

Objectives for Our Convening Series

- Identify **high value policy changes** to invest in health that could be launched or implemented in the next year
- **Chart a pathway** to action within existing federal authority
- Define next steps to leapfrog barriers and **achieve meaningful change**

Vegas Rules: To foster candid conversation, no quotes or attribution without explicit consent.

Where We are in the Meeting Series

Topic Area #1: Integrating DOH into Medicaid and Medicare Payment

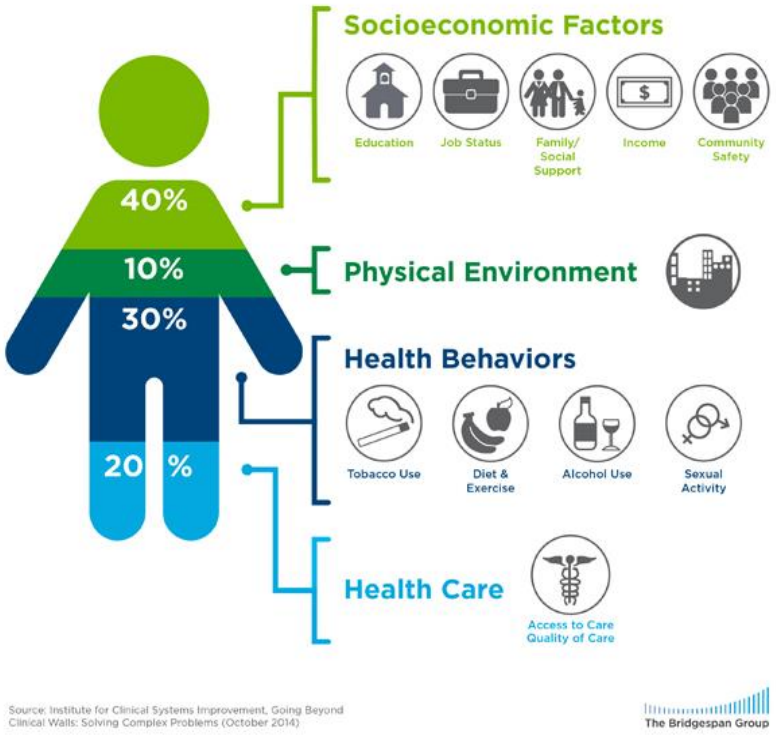
Topic Area #2: Integrating DOH into Systems of Measurement and Accountability

Topic Area #3: Seeding DOH Infrastructure and Shared Assets

Why are we here?
Investing in Health

Improvement in *Health Care* Is Not Enough to Improve *Health*

Drivers of health (DOH) – sometimes called social determinants of health – are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



Socioeconomic factors, physical environments, and health behaviors drive health outcomes more than medical care

Having at least one unmet social need is associated with increased rates of depression, diabetes, hypertension, ED overuse, clinic "no-shows" and higher overall health care costs

States and countries with higher ratios of social-to-health spending have statistically better health outcomes

*Sources: Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010; Bachrach, D., Pfister, H., Wallis, K. and Lipson, M. Addressing Patients' Social Needs: An Emerging Case for Provider Investment. Commonwealth Fund. May 201*health care*4; Blendon, R.J., Donelan K., Hill C., Scheck A., Carter W., Beatrice D., Altman, D. "Medicaid beneficiaries and health reform." Health Affairs, 12, no.1 (1993): 132-143;* Berkowitz, Seth A., et al. "Food insecurity and expenditures in the United States, 2011–2013." *Health services research* 53.3 (2018): 1600-1620.

Health Equity and Drivers of Health

Health disparities exist independently from, but are substantially compounded by, drivers of health.

People of color experience health disparities even after controlling for economic and environmental factors.

Example: Maternal Mortality

The maternal mortality rate for "black women with at least a college degree was five times as high as white women with a similar education."

People of color are disproportionately impacted by the social and economic factors that affect health outcomes.

Example: COVID-19

People of color have been disproportionately impacted by both the economic and health effects of COVID-19.

Example: Accountable Health Communities

Early Results from the Accountable Health Communities Model demonstrate wide-spread social needs, with 33% of Medicare and Medicaid beneficiaries screened having at least one health-related social need. Racial and ethnic minorities were overrepresented in the navigation-eligible population.

Addressing DOH is central to efforts to advance health equity

What it Means to Invest in Health

Investing in Health requires that we leverage our country's significant public and private resources to achieve health, not just deliver health care.

It requires direct investment in the drivers of health—decent wages, healthy food, safe housing—and it requires unlocking the approximately $11 billion we spend every day on health care to maximize health.

When brought to scale, Investing in Health is good for people, good for business and good for government.

Investing in Health: A Federal Action Plan

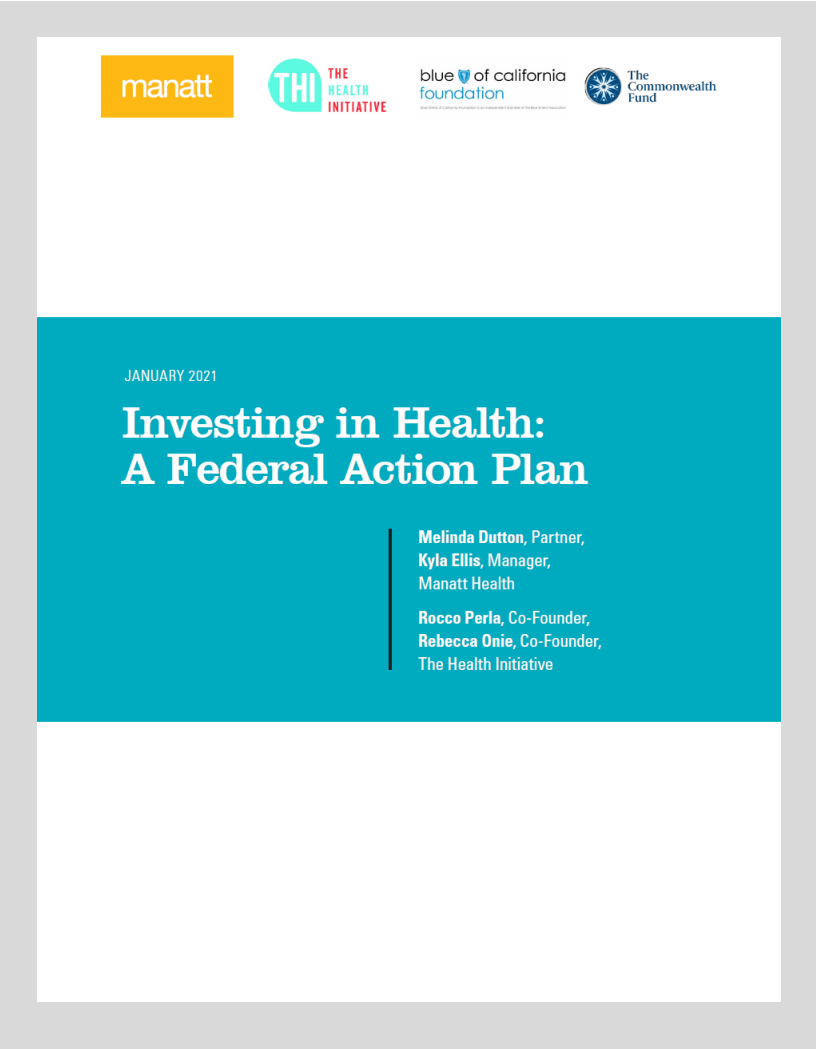
- ***Rethink the role of federal leadership in creating a healthier America.***

- ***Make Investing in Health CMS's central organizing principle*** *- administers programs serving more than 145 million people and operates with a budget of approximately $1 trillion –* ***changing the paradigm of what the health system can and should achieve.***

7 *Federal strategies to maximize health and address inequities;*

45 *Associated policy/program changes for Medicaid, Medicare, the ACA Marketplace, and CMMI; and*

129 *Specific actions to implement these changes under CMS's existing legislative authority.*



Federal Strategies to Address Drivers of Health: Focus of October 15 Meeting

- Address Drivers of Health in Combating COVID-19
- Integrate Drivers of Health into Payment Policy for Providers and Payors
- **Develop Shared Assets to Enable Interventions Addressing Drivers of Health**
- Maximize Participation in Public Programs that Address Drivers of Health
- Create New Standards for DOH Quality, Utilization, and Outcome Measurement
- **Make Drivers of Health Central to CMMI's Innovation Agenda**
- Incentivize Community Accountability and Stewardship

Criteria Used for Selecting Strategies and Policy Change

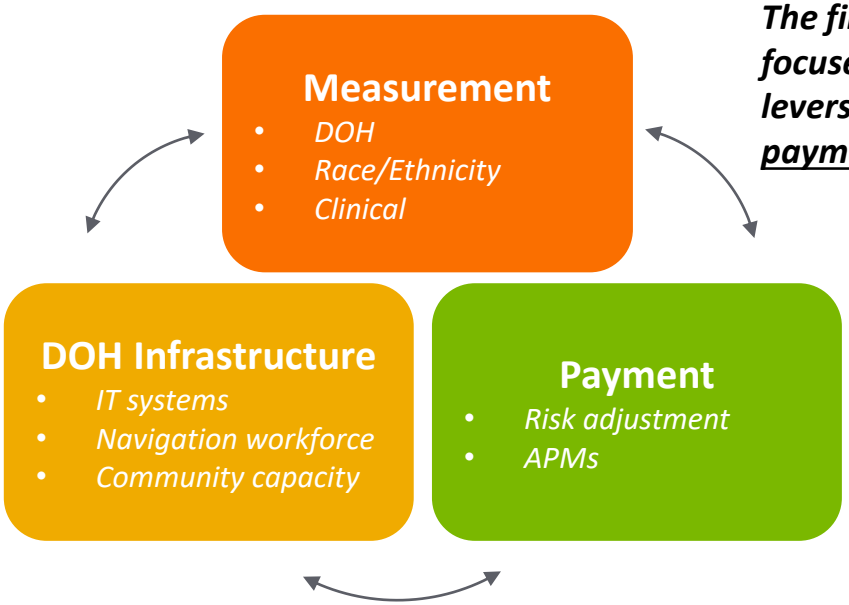
- Actionable through the executive branch
- Feasible within existing program and agency infrastructure
- Advances a commitment to Investing in Health
- Advances health equity

Reaching the “Last Mile”

What's Needed to Sustainably Address DOH

Scalable, sustainable efforts to address DOH require integration of DOH into payment models and measurement systems *and* the infrastructure to bridge the gap between the health care and social services sectors.

Today's convening will identify CMS-specific levers but also broaden the focus to key partnerships that should be leveraged to build DOH infrastructure



The first two convenings focused on CMS' policy levers to integrate DOH into payment and measurement

CMS/CMMI Strategic Priorities

CMS and CMMI leadership articulated their vision for the next decade – "a health system that achieves equitable outcomes through high quality, affordable, person-centered care."

CMMI's Strategic Objectives

1. **Drive Accountable Care.** "*Accountable care means less fragmentation for patients by rewarding providers when they deliver high-quality, coordinated, team-based care that proactively promotes health.*"
2. **Advance Health Equity.** "*CMS is committed to developing a health system that attains the highest level of health for all people and eliminates health disparities.*"
3. **Support Innovation.** "*CMS must support innovations in care delivery to drive optimal health outcomes.*"
4. **Address Affordability.** "*While the Innovation Center's purpose is to test innovative payment and service delivery models to reduce program expenditures for Medicare, Medicaid, and CHIP, we can ensure this goal is met while also focusing on lowering patients' out-of-pocket costs.*"
5. **Partner to achieve system transformation.** "*While Medicare can be an important driver for health system change, Medicare cannot achieve health transformation alone. CMS must continue to work with state Medicaid agencies, but the need for partnerships does not end there.*"

Achieving CMMI's strategic objectives requires a focus on health, not just health care.

The Integration Gap Between Health Care and Social Services Sectors

There is widespread consensus that integration between health care and social services sectors is essential to sustainably address DOH, reduce costs, improve outcomes, and advance health equity. However, the health and social services sectors continue to largely operate in silos.

Health care providers and payers struggle to connect patients to needed DOH resources due to limitations in workforce to support DOH efforts and IT capacity to initiate and track referrals, lack of formal relationships with community-based organizations, and inadequate community resources to address patients' DOH needs.

CBOs are challenged by workforce shortages (exacerbated by COVID-19), lack of capacity and funds to stand up IT systems and administrative capabilities needed to collaborate with health care providers/payers, and limited sustainable funding streams for delivering DOH services.

Federal action is needed to address current challenges across health care and social services sectors to accelerate their integration in addressing DOH.

The "Last Mile" Problem of Addressing DOH

Health care providers and payers are increasingly screening patients for DOH needs using standardized social needs screening tools and navigating them to resources, but are up against the "last mile" problem – lack of sufficient infrastructure to address DOH needs.

- It is **now the norm for states to require Medicaid managed care plans to screen members for DOH and refer them to services**.
- A 2019 cross-sectional study of U.S hospitals and physician practices found:
  - **Most U.S. hospitals and physician practices are screening patients for at least one** CMMI's Accountable Health Communities (AHC) Model health-related social needs (HRSNs).
  - **Nearly one-third of federally qualified health centers screen patients for all five** AHC HRSNs.
- **A number of CMMI models and participating entities have functionally incorporated DOH screening and navigation data** into their quality frameworks and care management plans for beneficiaries *(see next slide)*

And yet, investments in DOH infrastructure are lagging behind

"Current approaches to addressing social needs among patients with low socioeconomic status are likely undermined in many communities by limited capacity in the social services system. This may be especially problematic for certain high-prevalence needs, including many related to housing and transportation."

"Assessing The Capacity Of Local Social Services Agencies To Respond To Referrals From Health Care Providers," Health Affairs, April 2020.

DOH "Adoption" by Multiple CMMI Models

Many CMMI models & participating entities have functionally incorporated DOH screening & navigation data into quality frameworks & care management plans for beneficiaries – but largely without standard tools or measures.

	Does CMMI Model Include DOH (Formally or Functionally)?				
Model (link to evaluation)	**Screen**	**Navigate**	**Required to Screen/Navigate**	**DOH Measures**	**Key Findings**
Accountable Health Communities (AHC)	Yes	Yes	Yes	Yes	• 33% screen positive rate *(p. 31)* • Racial/ethnic minorities overrepresented in the navigation-eligible population *(p. ES-10)*
Comprehensive Primary Care Plus	Yes	Yes	Yes (Track 2)	No	• 99% Track 2 practices screening for DOH *(p.64)* • 86% Track 1 practices screening for DOH *(p.64)*
Maryland Total Cost of Care Model	Yes	Yes	Yes (Track 2)	No	• Track 2 Practices required to use standardized screening for HRSN using a screening tool *(p.21)* • 88% of all practices screened patients for HRSN *(p.65)*
State Innovation Models (SIM) Round 2	Yes	Yes	Yes (varies by state)	No	• IA & MI using DOH as key strategy for VBP *(p.138)* • Community resources were not always sufficient to meet the HRSNs of all patients *(p. 137)*
Next Generation ACO	Yes	Yes	No	No	• Some ACOs building DOH into EHR *(p. 41)* • Some ACOs building DOH into care management *(p.116)*
Comprehensive End-Stage Renal Disease (ESRD) Care Model	Yes	Yes	No	No	• Many pts are food insecure/protein malnourished *(p. 42)* • ESCO piloted program with food bank in PY4 *(p.42)*

AHC Model Evaluation Reaffirms the "Last Mile" Problem

The AHC Model intends to test whether connecting Medicare and Medicaid beneficiaries to community resources can improve health outcomes and reduce costs by addressing health related social needs (HRSN). Entities known as bridge organizations collaborate with clinical delivery sites, community service providers (CSPs), and other stakeholders to implement the AHC Model. The AHC evaluation underscores the need for infrastructure investments to address DOH.

AHC Model

The "Last Mile"

Screening for HRSNs

750,000 beneficiaries screened, with 33% reporting at least one core HRSN

Food insecurity was highest reported need (69% of navigation-eligible beneficiaries), followed by housing & transportation

Navigation to Services

Out of ~500,000 screened, ~75,000 eligible for navigation

High acceptance of navigation (74%) among the navigation-eligible population

Access to Services

*While **74%** of eligible beneficiaries **accepted navigation**, **only 14%** of those who completed a year of navigation **had any HRSNs documented as resolved***

This finding underscores the limitations of models such as AHC in realizing cost-savings without the infrastructure necessary to resolve DOH needs.

AHC Model Evaluation: Barriers to Successful Resource Connections

"Most navigation-eligible beneficiaries whose navigation case were closed had not been connected with a CSP for any HRSNs and did not have any HRSNs documented as resolved." – AHC Evaluation Report

- **Limited Support for Bidirectional Communication and Maintenance of Up-to-Date Information**
  - Limited systems for bidirectional communication between health care providers and CSPs to improve coordination and resolution or HRSNs
  - Bridge organizations lack capacity to update community resource inventory (CRI), given rapidly changing resource landscape
- **Workforce Challenges, including Turnover and Burnout**
  - Turnover required bridge organizations to dedicate resources to "perpetual" recruitment and training and rely on a less experienced workforce to resolve beneficiaries' HRSNs
- **Insufficient Community Resources for Referrals**
  - Lack of CSPs that provide the needed service and limited resources in rural settings
  - Shortages or long waiting lists for community resources
  - Community resources available but not adequate (e.g., for some chronically ill beneficiaries, the challenge is not access to food but access to healthy and medically appropriate food)
  - CSPs with limited business hours or restrictive access
- **Limits to Paid Services**
  - AHC funds cannot be used to pay for services and supports (e.g., food cards, transportation vouchers, rental assistance)
  - Medicaid transportation funds limited to getting to and from medical appointments—not to and from CSPs offering nonmedical services

Reaching the "Last Mile"

Stakeholders have identified a number of barriers to advancing collaboration between health care and social services sectors to sustainably address DOH needs.

Key Challenges to Advancing Integration

- **Limited Data Sharing:** Access to data and information sharing needed to identify and track population health outcomes is challenging and limited; for many social services organizations, underinvestment has greatly hindered development of IT infrastructure.
- **Separate Funding Streams, Inadequate Payment**: Health care and social services sectors traditionally funded through separate systems, with different payment models, administrative expectations, and reporting requirements. Efforts to pay for social interventions have not covered the full cost of improved outcomes.
- **Lack of Investments in Infrastructure and Capacity Building:** Lack of capacity-building funds and ongoing support to advance integration can stall and complicate efforts.
- **Uncertainty in Policy Environment**: Leaves providers in both sectors "torn between investing in tomorrow's promising innovations or continuing to maintain the essential safety net for today."
- **Structural Inequities:** CBOs, particular those led by BIPOC, currently don't have the power to redesign systems or change the structural inequities that result in health disparities.

Funding for DOH Infrastructure

Literature identifies potential funding streams to support core DOH infrastructure elements that will enable partnerships between health care and social services sectors.

Funding Options for DOH Infrastructure Activities

- **Public Health and Social Services Programs,** including programs authorized by the Public Health Service Act or the Social Security Act and administered by HHS agencies.
- **Public Insurance Programs**, including Medicaid, CHIP, Medicare, and Marketplaces.
- **Private and Philanthropic Initiatives**, including foundation grants and public-private partnerships.

"Emerging evidence suggests that a robust ACH infrastructure that provides core support for a wide range of operational, nonprogrammatic functions is critical for long-term success."

Dora L. Hughes and Cindy Mann, "Financing The Infrastructure Of Accountable Communities For Health Is Key To Long-Term Sustainability" Health Affairs, April 2020.

INTEGRATING SOCIAL SERVICES & HEALTH

By Dora L. Hughes and Cindy Mann

ANALYSIS

Financing The Infrastructure Of Accountable Communities For Health Is Key To Long-Term Sustainability

ABSTRACT Accountable Communities for Health (ACHs) are collaborative partnerships spanning health, public health, and social services that seek to improve the health of individuals and communities by addressing social determinants of health such as housing, food security, employment, and transportation. ACHs require funding not only for programs and services but also for core infrastructure functions. We conducted a legal and policy review to identify potential funding streams specifically for ACH infrastructure activities. We found multiple and credible options at the federal and state levels and in the public health, health insurance, and philanthropic and private sectors. Such options could support ACH infrastructure directly or through reimbursement for administrative costs associated with programmatic work. Yet we also found that there is no dedicated or explicit source of funding for these critical functions. For sustainable and long-term ACH support, policy makers and program administrators should clarify and define ACH infrastructure functions and, where appropriate, explicitly recognize supporting these functions as an allowable use of funds and facilitate their coordination across program funding streams.

Accelerating Health Care and Social Services Sectors Integration

Investment in DOH infrastructure – IT, workforce, and community capacity -- is necessary to advance the integration of health care and social services sectors required to address DOH, advance health equity, lower health costs, and improve health outcomes.

- ✓ **Technical capacity and IT infrastructure** to support seamless and secure data sharing needed to address DOH across health care and CBOs.
- ✓ **A workforce capable of navigating both health care and social services sectors** with a unique understanding of the experience and socioeconomic reality of the communities that they serve when working to address DOH.
- ✓ **Upfront investments in community capacity building *and* sustained sources of funding for CBOs** to enable effective, equitable integration of health care and social services sectors.

Topic #1: Building DOH IT Infrastructure

Policy Recommendation:

Seed Development of Standardized DOH IT Infrastructure

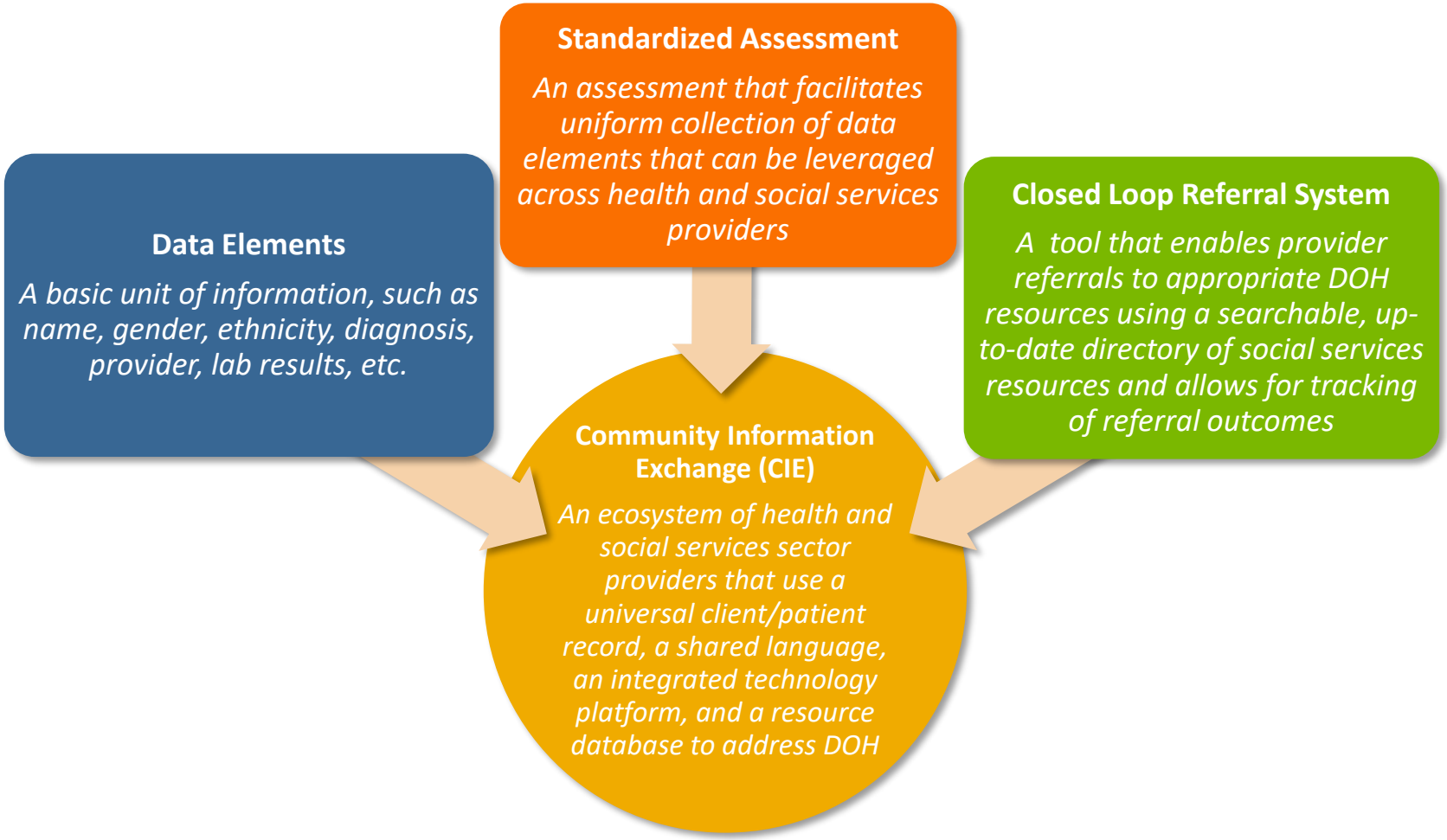
State of Play: Adoption of Community Information Exchanges (CIE) Is Increasing

Efforts to integrate health and social services through CIEs are emerging across the country, drawing upon a patchwork of funding.

SAN DIEGO, CALIFORNIA	KING COUNTY, WASHINGTON	NEBRASKA
CIE San Diego launched in 2012 using grant funding. In 2016, CIE San Diego integrated with 2-1-1 San Diego, the region's central source of information for community, health and disaster services, to enhance care coordination and service delivery through a network of organizations across social services, health and government sectors. 211/CIE San Diego continues to receive grant funding to support its work.	A coalition of 75+ local health and social service organizations is developing Connect2 Community Network, a regional CIE in partnership with Unite Us. The Connect2 technology hub is set to launch in early 2022 to support care coordination between health, behavioral health, tribal, community and social service organizations in King County. HealthierHere, a Connect2 Community partner and a local nonprofit organization provides catalyst funding to support organizations interested in joining the CIE via Unite Us.	In September 2020, Nebraska's statewide health information exchange partnered with Unite Us to launch the Unite Nebraska, a platform that offers a closed-loop referral system and assists users in coordinating housing, nutrition services, employment services and benefits, and community-based resources. Unite Nebraska is sponsored by CyncHealth, a nonprofit with a public/private governance model.

To date, Medicaid has not been a significant funding source for CIE efforts.

State of Play: CIEs Have Common Functions to Enable DOH Data Sharing and Integration



Limited financing/payment opportunities and lack of national standards and remain significant barriers to scaling of CIEs.

State of Play: Medicaid Can Provide IT Funding for DOH

- **Existing Authority for Federal Funding of Medicaid IT.** Under the current statutory and regulatory framework, state Medicaid agencies are authorized to receive federal funding for Medicaid IT and associated activities, and much of it at an enhanced federal matching level (75% or 90% federal match). Activities eligible for support comprise the development, implementation and operations of states' vast Medicaid program management and administrative systems and state Medicaid agency activities to facilitate adoption of electronic health records (EHR) and exchange of health information by health care providers.
- **Leveraging Existing Authority for SDOH.** In January 2021 guidance CMS highlighted availability of federal Medicaid IT funding for data integration and sharing to identify individuals with DOH needs and link them to appropriate medical and social support services in.

"Integrated information systems and data sharing capabilities at the state level are critical to supporting the evolving role of states in assuring appropriate, accessible, and cost-effective care for individuals with complex social needs. Medicaid offers a variety of pathways to support the design and development of statewide data and analytic infrastructure to address SDOH."

- CMS SHO# 21-001, 1/7/21

State of Play: While HIE Funding is Expiring, Federal Authority for MES Funding Continues

Topic	Highlighted Examples	Federal Match	Federal Authority
Medicaid Enterprise Systems (MES)			
Support Mechanized Claims Process and Information Retrieval Systems, including eligibility and enrollment systems and administration management	▪ Medicaid Management Information Systems (MMIS) ▪ Encounter data ▪ Care management	▪ 90% for design, development, installation, and enhancement of the systems ▪ 75% maintenance and operation	▪ Section 1903(a)(3) of the Social Security Act (SSA)
Support health information exchanges (HIEs)	Portal between a state MMIS and clinical data repository		
Health Information Exchange (HIE) – *concludes in 2021*			
Administer the Medicaid electronic health record (EHR) incentive program	▪ Secure messaging gateways ▪ Provider directories ▪ All-payer clinical/claims data warehouses	▪ 90% for design, development, and implementation	▪ Section 1903(a)(3) of the SSA ▪ The American Recovery and Reinvestment Act

State of Play: Medicaid IT Funding Comes with Conditions

To receive enhanced federal funding, states must demonstrate that their proposed or operational systems satisfy a series of conditions and standards outlined in regulation.

Cost Allocated	Benefitting state and local governmental programs to pay their "fair share" (in accordance with benefits received) of costs
Modularity	Use of a modular, flexible approach to systems development (e.g., open application programming interfaces, business rules in both human and machine readable formats)
Alignment with Medicaid IT Architecture (MITA)	Align to and advance MITA maturity for business, architecture, and data
Compliance with National Standards	Align to federal and industry standards and safeguards, including ONC, Rehab Act Sec. 508, ACA Sec. 1104 and 1561
Reusability	Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states

Business Results	Support efficient, economical, and effective administration of Medicaid
Reporting	Produce transaction data, reports, and performance information that contribute to program evaluation, continuous improvement in business operations, and transparency and accountability
Interoperability	Support coordination and integration with the Marketplace, the Federal Data Services Hub, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance as applicable
CMS Oversight	Meet CMS requirements, standards and condition; CMS has begun transitioning to evaluating how well Medicaid IT supports desired business outcomes.

State of Play: Medicaid Funding Requires Cost Allocation

CMS has discretion to define Medicaid's fair share of IT costs.

CMS Discretion in Medicaid "Fair Share."

- While there are federal guidelines**,** CMS has substantial discretion in what it determines to be Medicaid's "fair share" in allocating Medicaid IT costs.
- CMS has commonly relied on the proportion of Medicaid eligible or enrolled as compared to a state's general population.
- However, with HITECH, CMS also considered alternative approaches like Medicaid providers as compared to a state's total providers that allowed for Medicaid to serve as a catalyst and finance the principal share initially, with additional funding partners engaged over time. CMS could take a similar approach for Medicaid funding DOH IT.

State of Play: DOH Data Sharing Requires Interoperability

Alignment across DOH sharing and infrastructure requires interoperability to enable cross-sector integration. Significant progress has been made over the past few years to develop DOH data standards to advance interoperability.

- **The Gravity Project**, a collaborative of 1,800+ stakeholders, has been identifying, developing and validating **national standards** to support the electronic capture and **exchange DOH data across a variety of systems and settings of care and social services**.
- In 2021, the Gravity Project published codes via standards such as ICD-10, LOINC, and SNOMED in the following domains:
  - Food Insecurity
  - Housing Instability
  - Financial Insecurity
  - Material Hardship
  - Employment Status
  - Educational Attainment
  - Veteran Status
  - Stress
  - Social Connection
  - Intimate Partner Violence

"… a concerted, urgent strategy to achieve consensus-based, comprehensive coding standards for SDOH data…"

gravity PROJECT

- The Gravity Project led the effort for inclusion of DOH data elements into the Office of the National Coordinator for Health Information Technology (ONC) interoperability standards.

State of Play: Federal Efforts are Underway to Advance Interoperability in DOH Data Sharing

- ONC maintains a Health IT Certification program, which incudes the United States Core Data for Interoperability (USCDI), a standardized dataset developed to advance interoperability in health information exchange nationwide.
- In July 2021, **ONC updated USCDI v2 to support the standardized electronic exchange of DOH data classes,** which enables the exchange of the standards advanced by the Gravity Project.
- While electronic health records are currently the predominant use case for USCDI**, adherence to the standards will be key to exchange DOH data across a variety of health and social services systems and settings**
- **ONC intends for its standards "be broadly reused across use cases, including outside of patient care and patient access"** and CMS is supportive of this goal.

> *"CMS supports a broader vision for the USCDI, where the standard serves as the central mechanism for exposing usable, standardized interoperable data for multiple use cases…"*

As ONC's interoperability standards mature and are adopted more broadly across sectors, linking Medicaid IT funding to use of ONC's standards can accelerate adoption and interoperability in electronic exchange of DOH data.

Policy Recommendation: Seed Development of DOH IT Infrastructure & Capacity Aligned with National Standards

CMS should provide guidance and resources on Medicaid IT enhanced funding to support DOH technology, such as the development of shared platforms and standards for data exchange to support care management, DOH screening and navigation, oversight and evaluation, and payment. Guidance should reference data standards designated by ONC in consultation with CMS, as part of programmatic requirements.

Policy Tactic	*Authority/Vehicle*	*Estimated Timing*
Issue sub-regulatory guidance for states	Technical implementation guidance, informational bulletins, State Medicaid Director (SMD) letters	6-12 months

Topic #2: Bolstering DOH Workforce

Policy Recommendation:

Elevate Opportunities to Support and Reimburse for Community Health Worker Services

State of Play: Community Health Workers

Community health worker (CHW) is an umbrella term that encompasses a number of job titles, such as health navigators, community outreach workers, and promotoras.

- The American Public Health Association adopted the following definition of a CHW:

  *"**A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."***

- In 2010, the U.S. Bureau of Labor Statistics assigned an occupational code to Community Health Workers; about 60,000 CHWs were employed across the country as of May 2020.

- Demand for CHWs is projected to grow by 14% by the year 2030, and the Administration is investing in hiring and training of CHWs to support response to the COVID-19 pandemic.

State of Play: Community Health Workers Bridge the Gap Between Health and Social Services Sectors

CHWs are trusted members of their community who know how to navigate the health and social services sectors. CHW interventions have shown to:

Reduce Hospitalizations

- Analysis of three randomized clinical trials of CHW interventions found that a standardized CHW intervention **reduced days of hospitalization by two-thirds primarily by addressing patients' underlying socioeconomic and behavioral barriers to health and connecting them with long-term medical and social support**.
- In a randomized clinical trial, CHW intervention ACO patients were **significantly less likely to experience 30-day hospital readmissions** than control participants (12.6% vs. 24.5%). CHWs provided health coaching and **connected patients to specific low and no-cost resources (e.g., food, transportation, housing)** contributing to gaps in care.

Generate Cost-Savings

- A CMMI Health Care Innovations Awards evaluation found that out of six types of innovation system delivery components assessed, **innovations using CHWs was the only type associated with substantial savings** ($138 per beneficiary per quarter).
- Analysis of a standardized CHW intervention that **addresses unmet social needs** for individuals living in high-poverty neighborhoods found that **every dollar invested in the intervention would return $2.47 to an average Medicaid payer within the fiscal year.**

To date, there are no national-level training, certification, or licensure requirements for CHWs, although some states have sought to standardize training and certification requirements. In partnership with the Penn Center for Community Health Workers, NCQA is developing national standards for CHW hiring, training supervision, and work practice.

State of Play: Community Health Workers Have Been Instrumental to COVID-19 Response

Federal and state partners recognize the unique position of CHWs to reach and support communities hit hardest by the pandemic.

- In March 2020, the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency identified CHWs as "essential critical infrastructure workers who are imperative" to the COVID-19 response.
- CDC is making $332 million available to jurisdictions for CHW services to support response to the pandemic. CDC is providing funding and technical assistance to deploy trained CHWs to communities disproportionally impacted by COVID-19.
- Several states are engaging CHWs to support response to COVID-19, including with coordination of access to food, housing, and other community services and contact tracing capacity.

The CHW workforce could be redeployed post COVID-19 to address DOH needs across the health system.

State of Play: CMMI Has Supported Multiple Demonstration Projects with Community Health Workers

State Innovation Models (SIM)	Health Care Innovation Awards	Accountable Health Communities (AHC)
• A number of states have included CHWs in their SIM strategies for health care delivery system transformation (e.g., CO, CT, DE, HI, IA, IL, MD, ME, MI, MN, OH, OR, and PA).	• Health Care Innovation awardees used CHWs as a project component, including to bridge gaps between patients and providers and increase integration with community services.	• AHC participants have deployed CHWs to screen for DOH needs and connect patients to DOH services in their communities.

State of Play: Medicaid Can Play a Key Role in Supporting Community Health Workers

Several Medicaid authorities support coverage and reimbursement of CHW services. States have used one or a combination of these authorities to-date.

Managed Care Contract

- Cover CHWs as part of managed care plan care coordination responsibilities
- Encourage or require managed care plan investment in CHWs

Medicaid State Plan (SPA)

- Cover services provided by a community health worker as part of the Medicaid benefit package

1115 Waiver

- Fund CHW services through targeted programs

- **New Mexico** allows MCOs to share or delegate care coordination to a variety of entities or individuals, including CHWs and leverages its "Delivery System Improvement Performance Target" framework, which imposes financial penalties for failure to meet defined targets of the MCO's enrolled members being served by CHWs annually, and increase in MCO's enrolled members being served over the 5-year period.
- **Michigan** requires MCOs to "support the design and implementation of community health worker interventions delivered by community-based organizations which address social determinants of health and promote prevention and health education."
- **Oregon** secured a Preventive Services SPA to cover "traditional health workers", such as CHWs, supervised by a licensed practitioner who can bill for the services and are responsible for their work, delegation, and supervision. Oregon's managed care organizations – Coordinated Care Organizations (CCOs) – are required to implement and annually update a plan that details how the CCO will integrate traditional health workers into the delivery of services, measure baseline utilization and performance, and increase member utilization of traditional health workers through member and provider communication and contracting with CBOs.
- **Massachusetts** received CMS approval to pilot the Children's High-risk Asthma Bundled Payment Demonstration Program through its 1115 waiver. As part of the pilot, CHWs make home visits to provide education and conduct environmental assessments of potential asthma triggers in the home.

Despite availability of options to reimburse for CHW services through Medicaid, state uptake has been limited.

Policy Recommendation: Elevate Medicaid Opportunities to Support and Reimburse for CHW Services

CMS should issue new guidance detailing all available vehicles for states to support coverage and reimbursement of CHW services related to addressing DOH needs through Medicaid.

Policy Tactic	*Authority/Vehicle*	*Estimated Timing*
Issue guidance for states	State Medicaid Director (SMD) and State Health Official (SHO) letters, implementation toolkits	6-9 months

Policy Recommendation: Elevate Medicaid Opportunities to Support and Reimburse for CHW Services, cont.

Action	Timing
Issue new guidance, building off the January 2021 State Health Official Letter (SHO) titled "Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)," ***detailing all available vehicles for states to support coverage and reimbursement of CHW services related to addressing DOH needs*** through Medicaid.	6 months to issue clarifying guidance
To support use of CHWs in addressing DOH needs, provide states with ***models for implementation, tools and templates:*** • Examples of state approaches (including CHW training guidelines, CHW scope and responsibilities, CHW reimbursement approaches and levels) • Successful models for integration of CHWs into care team • Approved SPAs • Managed care contract language	9 months to identify models and develop a toolkit/guidance for states

Topic #3: Investing in DOH Infrastructure (IT, workforce, & community capacity) via CMMI & Inter/Intra-Departmental Partnerships

Both, And

Investing in DOH infrastructure requires a "both, and" approach – both immediate, unilateral action by CMS, and inter/intra departmental collaboration.

- To date, these convenings have focused on policy recommendations that are entirely within the purview of CMS to implement.
- CMS has the ability to support and accelerate DOH infrastructure investments (including community capacity) – and in Slides 47-35 we will focus on specific opportunities available though CMMI.
- At the same time, CMS's efforts (and CMMI's specifically) could be substantially magnified by wrapping around these DOH infrastructure investments supports available from other divisions within HHS and other federal departments.
- Such efforts to align across programs, divisions and agencies have been effective in the past and can provide a blueprint for the work ahead – and in Slides 54-59 we will focus on opportunities to align intra- and inter-departmental resources around DOH infrastructure.

Case Study: CMMI-Led Million Hearts Model (2017-2021)

The Million Hearts Cardiovascular Disease (CVD) Risk Reduction Model is an example of a "both, and" approach with unilateral action by CMS as well as inter/intra departmental collaboration to achieve a common aim.

The Million Hearts CVD Risk Reduction Model is a randomized controlled trial that seeks to bridge a gap in cardiovascular care by providing targeted incentives for health care practitioners to engage in beneficiary CVD risk calculation and population-level risk management.

Instead of focusing on the individual components of risk, participating organizations will engage in risk stratification across a beneficiary panel to identify those at highest risk for atherosclerotic cardiovascular disease (ASCVD).

Million Hearts: Cardiovascular Disease Risk Reduction Model Participants

Case Study: Intra/Inter-Departmental Partnership on Million Hearts

Goal: Million Hearts 2022 is a national initiative co-led by CDC and CMS to prevent 1 million heart attacks and strokes within 5 years.

HHS Agency/Office or Other Dept.	Funding Provided	Contributions (Examples)
HHS - CMMI/CMS (Million Hearts Cardiovascular Disease Reduction Model)	Yes	• Launched Million Hearts CVD Reduction Model • CMS pays provider organizations $10/eligible Medicare FFS beneficiary (risk stratify) • Year 1 (2017): CMS also paid $10/high-risk beneficiary/month for cardiovascular care management • Year 2 (2018): CMS paid $0 - $10/high-risk beneficiary/month depending success in reducing average risk score for all of its high-risk beneficiaries assessed during relevant period. • Total 30-month payment = $23,303 (93% organizations earned risk reduction payments in 1+ performance period) • Data screening done for CVD
HHS - CDC (Div. for Heart Disease and Stroke Prevention)	Yes	• Funded short-term projects focused on improving hypertension control. • Funded National Association of Community Health Centers (NACHC) to work with primary care associations and health center–controlled networks to improve performance in hypertension control. • Funded National Association of City and County Health Officials (NACCHO) to support the implementation of BP/stroke best practices from five municipalities across the United States • Conducted national coverage and reimbursement analysis on SMBP • Investment in data support via CDC WONDER database.
HHS - ONC	Yes	• Investment in Million Hearts IT Regional Extension Centers to build capacity • Investments in Million Hearts EHR optimization.
HHS - SAMHSA (Million Hearts® Initiative)	Yes	• Added funding to existing wellness initiative to broaden reach of Million Hearts® Initiative so state & local organizations can increase awareness, reduce risk, improve the management of heart disease, and promote one of the eight dimensions of wellness.
Department of Veteran Affairs	Yes	• Funded studies on BP management in veterans • Invested in nutritional support services and medication management programs related to hypertension. • Invested in telehealth & home-based primary care initiatives allow home blood pressure monitoring Invested in diverse outreach strategies to support the veteran populations to achieve better heart health and blood pressure control.

Policy Recommendation #1: Integrate DOH Elements into All CMMI Models

State of Play: Achieving CMMI's Strategic Objectives Requires a Focus on Health, Not Just Health Care

CMS and CMMI leadership have articulated their vision for the next decade, including key strategic objectives to (1) drive accountable care; (2) advance health equity; and (3) partner to achieve system transformation.

- Achieving CMMI's strategic objectives requires broadening the Total Cost of Care (TCOC) frame, which defined the first decade of CMMI, to **focus on *Total Cost of Health* (TCOH).**
- A TCOH frame explicitly addresses the impact of **both clinical factors and the drivers of health** (ex. access to healthy food, safe housing) on health cost and outcomes, through the lens of racial equity.
- As only ~20% of health outcomes and associated costs are linked to clinical care, any CMMI model that does not address the drivers of health (DOH) leaves **potentially significant savings off the table**.
- As a result, a TCOH approach – which integrates DOH and stratifies by race/ethnicity – is more likely to reduce racial/ethnic disparities; enable future CMMI models to achieve actuarial certification; and contribute to the longevity of the Medicare Trust Fund.

Recent studies demonstrate that DOH were associated with **37.7% of variation in price-adjusted Medicare per beneficiary spending** between counties in the highest and lowest quintiles of spending in 2017.

Further, given that DOH disproportionately impact racial/ethnic minorities, traditional TCOC models that do not include these factors will not adequately **identify and address health disparities**.

State of Play: CMMI is Not Starting from Scratch in Creating a TCOH Approach

CMMI has two sets of assets and learning that it can bring to bear in building on TCOC to enact a TCOH approach consistent with its commitment to integrate DOH into its models going forward.

1. **CMS and CMMI's TCOC and Alternative Payment Models have included tools and mechanisms that could be leveraged not only for clinical care, but also to address DOH.**

2. **Current CMS programs and CMMI models have implemented and tested TCOH elements. The challenge is that these elements are scattered across programs/models; the opportunity now exists to integrate them.**

- Since 2015, the Health Care Payment Learning & Action Network (LAN) has leveraged a strong public-private partnership in the shift from FFS to APMs. LAN population-based payments (Category 4 APMs) can be used to cover a range of preventive health, care coordination, and wellness services, in addition to standard medical procedures typically paid through claims. If the LAN framework were to include payment for (and partnerships with) community-based organizations to address DOH, it could further accelerate improved outcomes, lower cost, and health equity.
- Likewise, currently, all ACOs screen for and measure diabetes in a TCOC frame. Under a TCOH frame, ACOs would also screen and measure diabetics for food insecurity (recognizing that food insecure diabetics cost ~ $4,500 more PMPM than diabetics with access to healthy food). This approach also recognizes racial inequities, with Black Americans facing the highest rates of both food insecurity and diabetes. Collected systematically, this member-level DOH data would be critical inputs for actuarial cost projection and risk-adjustment for APMs.

State of Play: CMMI's Models to Date Reveal Four Key Elements to Bridge from TCOC to TCOH in Future Models

	Screening & Data Collection	Navigation	Payment	Capacity
Total Cost of Care	**Identify clinical needs** • *Standardized clinical screens* • *Risk-stratified care plans* • *Stratify by race/ethnicity (& other demographics)*	**Connect to clinical resources** • *Standardized clinical screens* • *Risk-stratified care plans*	**Pay for clinical resources** • *Enhanced care mgmt. fee*	**Investments to enable APM participation** • *Ex. Up-front investments in IT & data/accounting systems for rural ACOs*
Total Cost of Health	**Identify DOH needs** • *Standard screening tool* • *Standard DOH screening measures* • *Stratify by race/ethnicity (& other demographics)*	**Connect to community resources** • *IT infrastructure (ex. closed loop resource database)* • *Navigation workforce (ex. CHWs)*	**Pay for community resources/services** • *In lieu of services* • *CBO fee schedule*	**Investments to enable community capacity** • *Ex. Up-front funding to CBOs for IT & data/accounting systems*

State of Play: CMMI's Recently Published Innovation Center Strategy Refresh Aligns with the *Total Cost of Health* Approach

CMMI's strategy refresh highlights a focus on developing new models and modifying existing models to address health equity and drivers of health. The document specifically highlights action in the following areas:

Screening & Data Collection	Navigation	Payment	Capacity
CMMI identifies the need to "incorporate screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data in standardized formats."	CMMI is considering ways to improve "coordination between community-based organizations and health care entities"	CMMI is examining how to better address DOH in models, including "identifying incentives to address SDoH in health care settings."	CMMI highlights potential ways to encourage greater participation of safety net providers in models, including "upfront investments" for reducing disparities and coordinating with community-based organizations to address social needs.

State of Play: Learning from Maryland TCOC & AHC Models

Element	DOH	What MD TCOC Model *Is* Doing to Address DOH	What MD TCOC Model Is *Not* Doing to Address DOH
Screening & Data Collection	Identify DOH Needs	• Track 2 Practices required to implement a standardized screening for HRSN using a screening tool *(p. 21)* • By Q4 2019, 88% of all practices screened patients for HRSN, up from 64% in Q1 *(p. 65)*	• Not clear if practices are using a standard screening tool • No standard DOH screening/navigation measures
Navigation	Connect to Community Resources	• Track 2 Practices are required to (1) strengthen referral relationships with community & social services & (2) inventory community resources to meet HRSNs *(p. 17)* • CMS pays for Care Transformation Organizations (CTO) to deploy interdisciplinary care management teams, incl. referrals to social services via health educators/CHWs *(p. 6)* • MDH provides a health information exchange (CRISP) enabling data sharing among hospitals, practices, & community organizations *(p. 12)* & is making ongoing improvements to CRISP to enable referrals to CBOs (ex. food insecurity) (*p. 75)*	• ~25% practices reported having no established relationship with social service resources supports *(p. 65)*
Payment	Pay for Community Resources/ Services	• Diabetes-focused Regional Partnerships can bill Medicare for DPP enrollment; increased enrollment due to up-front capacity investments (see below) will support sustainability of programs over time *(p. 75)*	• No ongoing payments for DOH-related services or TA (beyond DPP)
Capacity	Investments to Enable Community Capacity	• To achieve MD's diabetes pop health goal (reduce mean BMI), MD provides Regional Partnership Catalyst Grants; $165M to hospitals & community partners to build DPP capacity *(p. 75)* • Community partners incl. local health improvement coalitions, CBOs, faith-based CBOs, private companies (ride share companies, grocery stores, and pharmacies) *(p. 75)*	• Community capacity investments limited to DPP; doesn't address overall adequacy of resource landscape

Policy Recommendation: Integrate DOH Elements Across CMMI Models

Element	Key Changes	Experience to Date (Examples)	Where to Begin (Examples)*
Screening & Data Collection	Identify DOH Needs	• Accountable Health Communities • Medicaid state plan services/MCOs	• Implement standard, validated HRSN screening tool • Implement standard DOH measures, stratified by race/ethnicity (*note:* DOH measures on 2021 MUC list)

Navigation	Connect to Community Resources	• Accountable Health Communities
		• Comprehensive Primary Care Plus
		• Maryland TCOC
		• State Innovation Model
		• Medicaid state plan services/MCOs/Waivers
			• Pay for ***CHWs/navigation support*** via:
			  • Medicare enhanced care management fees
			  • Medicaid care coordination funding
			• Pay for ***up-to-date, closed loop referral platform*** via:
			  • Pooled/braided resources from enrollee partners (ex. Medicaid MCOs, community benefit dollars, philanthropy)
			  • Requiring platform as standard element of coordinated care management in state-based & multi-payer models (*e.g.*, SIM design states)

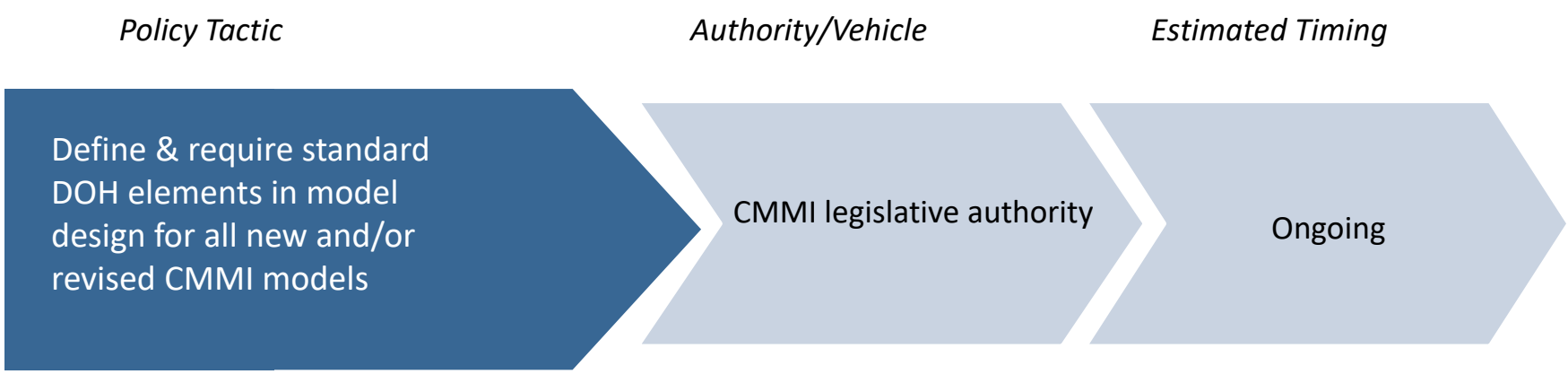
Payment	Pay for Community Resources/Services	• LAN (Category 4)
		• Medicare Advantage
		• Next Gen ACO
		• Comprehensive ESRD Care (CEC)
		• Bundled Payments for Care Improvement (BPCI)
		• Medicaid state plan services/MCOs/Waivers (NC)
			• Pay for ***CBO services/supports*** (ex. healthy food) in model/program budgets via:
			  • MA Supplemental benefits
			  • Medicaid In lieu of services
			  • Prospective population-based payments

Capacity	Investments to Enable Community Capacity	• LAN (Category 4)
		• ACO Investment Model
		• State Innovation Model
		• Maryland TCOC
		• Medicaid MCOs/1115 Waiver
		• Healthy Equity Zones (RI)
			• Invest in ***CBO capacity*** via:
			  • "Advanced payments" to CBOs for infrastructure investments (e.g., IT & data/accounting systems)
			  • Pooled/braided resources from enrollee partners (ex. Medicaid MCOs, enhanced Medicaid IT funding, community benefit dollars, philanthropy)

DOH model elements already being implemented and/or clinical model elements that could be applied to DOH.

Policy Recommendation: Integrate DOH Elements Across CMMI Models

CMMI should integrate DOH elements – including screening and data collection, navigation, payment, and community capacity investments – across CMMI models.



Policy Recommendation #2: CMS Should Formally Partner with other HHS Divisions & Other Federal Departments to Align Investments in DOH Infrastructure

Significant Opportunity Exists to Align Existing Intra/Inter Departmental Investments in DOH Infrastructure

			HHS										
Investment Needs	**Upfront (U) *or* Ongoing (O)**	**Notes/Examples**	**CMS/ CMMI**	**CMS/ Programs**	**CDC**	**ONC**	**HRSA**	**SAMHSA**	**ACF**	**ACL**	**HUD**	**USDA**	**OMB**	**DPC**
Community Serving Organizations/ Networks Capacity Building	U	For CBOs to add/adapt service offerings and acquire administrative capabilities to enter partnerships with providers/payers	X	X	X		X	X	X	X	X	X		X
Community Collaboration/ Convening	U/O	To develop multisector collaborative forums to align around health priorities, deploy community interventions, support continuous learning and identify public and private funding sources to advance common goals	X	X	X		X	X	X	X	X			X
IT/Data Systems Linking Health and Human Services Providers	U/O	To develop/deploy interoperable systems, data governance and privacy/trust frameworks, data standardization and training	X	X	X	X	X	X	X	X	X		X	X
Workforce Capacity	U/O	To invest in training, hiring and deploying a new kind of workforce to bridge health and human services	X	X	X		X	X				X		X
Payment for DOH Services/ Interventions	O	To provide sustainable reimbursement for evidence-based interventions/services	X	X			X	X	X		X	X	X	X
Measurement and Reporting	U/O	To develop/deploy standardized approaches for identifying DOH needs and measuring the impact of interventions on health outcomes	X	X		X	X	X	X	X	X	X		X

Note: Chart is illustrative.

Intra/Inter Departmental Partnerships Could Dramatically Accelerate Efforts to Build DOH Infrastructure

Policy Recommendation: **CMS Should Formally Partner with Other HHS Offices & Other Federal Departments to Align Investments in DOH Infrastructure**

		HHS										
Actions	**Notes/Examples**	**CMS/ CMMI**	**CMS/ Programs**	**CDC**	**ONC**	**HRSA**	**SAMHSA**	**ACF**	**ACL**	**HUD**	**USDA**	**OMB**	**DPC**
Provide grant or ongoing funding, including for indirect/admin costs	For CBOs to add/adapt service offerings and acquire administrative capabilities to enter partnerships with providers/payers	X	X	X	X	X	X	X	X	X	X		X
Align funding criteria across program areas	OMB could lead development of special criteria for entities that want to braid/blend funding streams	X	X	X	X	X	X	X	X	X	X		X
Coordinate/simplify procurement processes to create consistency across programs	Institutionalize learning from COVID rapid-response procurement	X	X	X		X	X	X	X	X	X		X
Streamline/align reporting requirements across programs	Reporting criteria should minimize burden, cost and risk across systems	X	X	X	X	X	X	X	X	X	X	X	X
Streamline/align program eligibility	Alignment across programs like SNAP, WIC and Medicaid would increase participation and directly impact DOH		X					X		X	X		X
Create common standards for data gathering and reporting	ONC could take the lead in designating standards, but deployment requires adoption/integration across all federal programs	X	X	X	X	X	X	X	X	X	X		X

Note: Chart is illustrative.

Additional Examples of Intra/Inter Departmental Alignment

Rhode Island Health Equity Zones

Rhode Island's initiative called Health Equity Zones – where the state funds community proposals to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods – uses braided funding, relying on federal funds from HRSA's Maternal and Child Health Bureau, SAMHSA, the Preventive Health and Health Services Block Grant, and two different chronic disease grants from CDC.

Area Agencies on Aging DOH Hubs

ACL is working with Area Agencies on Aging (AAAs) become hubs for addressing DOH through No Wrong Door Community Infrastructure Grants. While these grants will provide funding to support the AAAs in building their capacity as DOH hubs, AAAs will need to build financial support for specific program areas separately (e.g., NEMT through the Department of Transportation, SNAP enrollment through USDA).

Ryan White HIV/AIDS Program

HRSA's Ryan White HIV/AIDS Program provides a system of HIV primary care, medications, and essential support services to those living with HIV. Ryan White is the payer of last resort, closely coordinating with state Medicaid programs. Ryan White Planning Councils further coordinate other HIV-related funding streams (e.g., HUD's Housing Opportunities for Persons With AIDS program, CDC's HIV prevention funds), ensuring a comprehensive system for addressing the health-related social needs of people with HIV.

Policy Recommendation #2: CMS Should Formally Partner with Other HHS Divisions & Other Federal Departments to Align Investments in DOH Infrastructure

Launch inter-governmental initiative (co-led by CMS) to deploy resources & take necessary actions to create aligned investment in DOH infrastructure.

Key Steps

- **Designate specific government entity co-leads**
- **Define a clear, time-bound aim & strategic framework**
- **Recruit other office/agency/department partners (see Slide 56)**
- **Clarify roles & responsibilities for partner entities**
- **Identify specific actions to be taken & resources deployed, consistent with Administration's priorities (see Slide 57)**

How will we make change?

Discussion and Next Steps

Discussion

- **Stepping back:** Looking at these recommendations, what is the most important signal CMS could send around DOH and infrastructure in the next year?
- **Drilling down:** Are these the right recommendations? Which should be prioritized? Are any crucial policy changes missing? Which could be fast-tracked?
- **Looking ahead:** Who are the actors needed to move these changes forward? How can we leapfrog potential barriers? What can be done in the next 2 weeks; 6 months; 2 years to move these changes forward?