Green & Healthy Homes Initiative®

Overcoming Barriers to Health Care Investment in Social Determinants of Health

Green & Healthy Homes Initiative

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Introduction

Imagine you are a caregiver of a young child. You bring them to all necessary doctor's appointments, ensure they wash their hands, and take pains to get them to eat their broccoli. At their annual checkup, you find out they have lead poisoning. The source of this life-changing diagnosis? Your home and the lead paint you never knew existed. This diagnosis could lead to delayed development, behavioral changes, and future health complications if not immediately addressed. Unfortunately, while lead poisoning directly impacts health, the causes (e.g. lead paint) are not considered health related and therefore the necessary remediation is not covered by insurance.

Research has shown that the strongest predictor of an individual's health outcomes and, consequently, health care costs, is not genetics or access to medical care, but is overwhelmingly nonmedical factors such as housing.[1] In 2009, 1% of the US population accounted for 20% of total health care expenditures. Given the great cost of these "super utilizers" on the health care system, most notably on public insurance such as Medicaid,[2] it is not surprising that health care is looking to better understand and address nonmedical factors that substantially impact health.

Labeled the social determinants of health (SDOH), these nonmedical factors are defined by the World Health Organization (WHO) as the "conditions in which people are born, grow, live, work and age"[3] and include neighborhood and built environment, economic stability, and education, among others.[4] A report by WHO found that programs that integrate medical and social services can be "ten times more effective than waiting for families to visit health services,"[5] emphasizing the importance of partnerships between health care and social service providers. Furthermore, a 2015 report by the Blue Cross Blue Shield Foundation of Massachusetts found "strong evidence that increased investment in selected social services as well as various models of partnership between health care and social services can confer substantial health benefits and reduce health care costs for targeted populations."[6]

Despite the strong evidence to support addressing SDOH through integration of medical and nonmedical services, many health care organizations and community-based providers have struggled to build sustainable partnerships. The Green & Healthy Homes Initiative (GHHI) has worked with partners across the US, from health plans to providers to community-based organizations, to address this challenge, seeing firsthand the barriers, both perceived and real, that exist. We truly believe that these barriers are surmountable and the benefits to overcoming them are immense.

Our goal in this brief is to provide an overview of the perceived and real barriers to sustainable health care investment in the SDOH, with evidence to combat the former and solutions to overcome the latter. Though much of the information provided can be applied to improve health care outcomes across populations enrolled in commercial insurance or Medicare, the brief will focus on the Medicaid population, which stands to benefit the most from SDOH interventions. This brief will not address the case for investing in SDOH, as other papers from GHHI and external sources have done this thoroughly.[7,8,9]

Perceived Barriers to Sustainable Investment in Social Determinants of Health

What are perceived barriers?

Through GHHI's many conversations with Medicaid Managed Care Organizations (MCO), Accountable Care Organizations (ACO), State Medicaid offices, policymakers, providers, and others we have found an overwhelming interest in providing members and patients with comprehensive, evidence-based services that address the SDOH, improve health outcomes, and reduce costs. While the benefits of these services are often undisputed, there is

deep skepticism about the ability of health care to overcome barriers to pay for them. Many of the barriers that rise to the top during these conversations are perceived and often based on unconfirmed or outdated assumptions. In this section, we will outline some of the most frequently cited perceived barriers and provide information to counter them.

Perceived barrier #1: Government is already paying for these services

It is a common belief that government is already paying for services that address SDOH for members (e.g. through Community Development Block Grants). Understandably, health care payers are reluctant to pay for services that government is already providing. Unfortunately, many services that have been shown to positively impact health are not funded by government and those that are often face instability due to political turnover and budget cuts. A 2018 report found that around 50% of nonprofits in the US have less than one month of operating reserves and 30% have lost money over the last three years.[10] **Sustainable financing, from government or elsewhere, is not a current reality for most of the organizations providing these services.**

For example, comprehensive asthma interventions that address environmental factors have been proven to improve health and dramatically reduce medical utilization among high utilizers,[11] but most states do not have consistent and/or sufficient funding for these programs. Instead, programs cobble together funding from multiple sources, leaving them unable to scale and often leading to temporary service disruptions and even program termination. Further impeding success, without a proper connection to the health care system, many members that need the program due to frequent exacerbations and preventable hospital usage are never referred to the services. Relationships with health care could not only improve the stability of successful programs but could also extend their reach.

Health plans can invest in these services sustainably, allowing for consistent delivery to all members that need them. In turn, the health plan reaps the financial benefit of healthier members. This investment can be made in conjunction with, not instead of, existing funding and in many instances can be used to leverage new money. For example, the Montachusett Opportunity Council's Green & Healthy Homes Program leveraged $3 for every $1 invested, with the leveraged funding coming from a local Housing Authority and utility company.

Perceived barrier #2: Medicaid does not allow for payments to community-based organizations

Medicaid is structured as a partnership between Federal and State government. While states are subject to certain Federal standards, each has the flexibility to define its own program including what health services will be covered for members. Services in the community that address SDOH are not typically considered covered services, leading MCOs to assume that they cannot provide them to members. Even if they are not covered services, there are multiple ways in which Medicaid allows for payments to community-based organizations (CBOs) that address the SDOH. This brief will outline two options: value-based payments and administrative spending.

While most states are still operating Medicaid as a largely fee for service (FFS) program (even for those that have implemented Managed Care, most payments are FFS arrangements), there is a movement toward **value-based payment (VBP)**. VBP arrangements connect "provider payments to improved performance by health care providers" and "hold health care providers accountable for both the cost and quality of care they provide."[12] Given that only 20% of health outcomes are driven by access to and quality of traditional clinical health care services, while 60% are driven by SDOH,[13] it will be difficult for providers to meet cost and quality targets without addressing SDOH.

VBP arrangements allow providers to determine how to improve outcomes and reduce costs, providing flexibility to subcontract with CBOs that address the SDOH. **This does not require additional Medicaid approval.** An example of this relationship can be found in Figure 1 below.

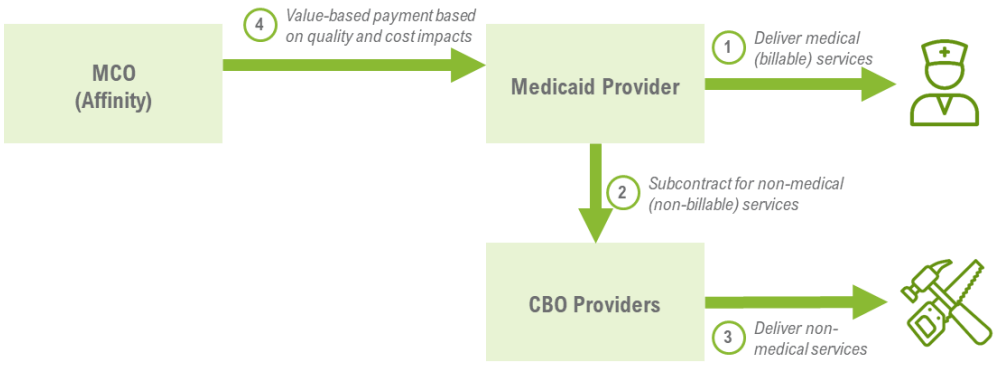

Figure 1: Example value-based contract structure to pay for services that address SDOH

Using the comprehensive asthma intervention above, we provide an illustrative example of a VBP agreement:

1. A hospital (Medicaid Provider) is responsible for lowering the total cost of care for patients for whom it provides billable primary and specialty care; the hospital identifies children with asthma as a subset of patients with high costs and preventable utilization
2. CBOs near the hospital are providing evidence-based asthma services that can reduce hospital utilization and improve health by addressing the root causes of asthma exacerbations (e.g. mold, pests)
3. The hospital subcontracts with the CBOs to deliver non-billable services such as home-based education and asthma trigger remediation that will in turn improve quality and reduce costs
4. As cost savings are realized by the health plan (MCO/ACO), savings are shared with the hospital who can use a portion to pay for the CBOs non-medical services. Health plans can also pay hospitals for outcomes related to quality improvements, which are often tracked by the state (e.g. asthma medication ratio (AMR)).

A second option is for health plans to pay for evidence-based services that address the SDOH through **administrative dollars**. Health plans are required to share data on how much is spent on medical activities (clinical services and quality improvement) versus administrative activities (e.g. salaries, marketing). Medical activities are only those that are considered billable.

Given that many of the community-based services that address the SDOH are currently not billable, health plans can choose to fund these programs for members through administrative dollars. For example, Amerigroup Maryland has partnered with GHHI to provide in-home health services designed to address the environmental triggers of asthma to eligible Medicaid members in Baltimore. Participants receive three in-home care visits, a home environmental assessment, home supplies, integrated pest management, and telephone follow-up support. Amerigroup pays GHHI 75% of the pre-negotiated fee after the first visit, and the remaining 25% after completion of all the home visits, all paid out of Amerigroup's administrative (non-medical) budget.

This may be an attractive option for services that provide a positive return on investment to the health plan, but it is important to note that the Affordable Care Act requires health plans to spend at least 80-85% of premium dollars on medical activities.[14] **Administrative dollars are also an avenue to pilot a partnership with a CBO before entering into a VBP agreement.**

Surmountable Barriers to Sustainable Investment in Social Determinants of Health

What are surmountable barriers?

While some of the barriers identified by health care are perceived, there are very real challenges to creating systems alignment that allows for sustainable health care investment in SDOH services. But just because something is difficult does not mean it cannot and should not be done. These challenges are surmountable and the costs of not overcoming them are high. Without addressing SDOH, it is unlikely that the US will improve health outcomes to meet Healthy People 2020 goals[15] or significantly lower the growth rate of health care spending.

Surmountable barrier #1: SDOH investments will lead to lower future rates

Capitation rates are the most common mechanism used by Medicaid to pay MCOs to provide covered services to members. Capitation rates are a fixed amount, usually in the form of a per-member per-month (PMPM) rate. This fixed amount depends on a few factors, but one of the most influential is the base data, which is historical data that is projected forward to set the following year's rates.

One concern MCOs express when faced with the opportunity to pay for services that address the SDOH for members is that a reduction in total cost of care due to these new services will result in a decreased capitation rate in subsequent years. Simply put, MCOs are concerned that they will invest money in these services and Medicaid will reap the benefits while health plans are essentially penalized. **This does not have to be the case.**

Value-based payments for non-covered services can be counted for rate setting purposes, meaning that the base data will account for investments in SDOH and future rates will not decrease. Since this is not widely done, states should clarify with MCOs that this is possible and encourage them to do it. Special permission from CMS is not needed. In fact, it is already being done in New York State.[16] This small shift opens the door for incentivizing value over volume and moving the needle on health outcomes related to SDOH.

Surmountable barrier #2: Medicaid churn rate is too high to justify investment in SDOH services for population

When individuals transition between different health insurance plans and/or from being insured to uninsured, it is referred to as churn. In discussing investment in services that address SDOH with health plans, many suggest that Medicaid churn rates are so high that the plan will never see the benefit of its investment before members unenroll. Sometimes this is based on the data, sometimes it is an assumption.

In GHHI's analysis of claims data from ten health plans across the US, we have found the average churn rate for high utilizing Medicaid members with an asthma diagnosis to be 12%. Churn rate will depend on the health plan and population, but it may not be as high as some assume and an analysis of historical plan data is worth a look. It is important to note that high utilizers may have a lower churn rate than the average Medicaid member. Given that SDOH services most often target these high utilizers, health plans should identify the churn rate for the program's target population when possible. A cost-benefit analysis of the potential investment can account for churn rate, allowing the health plan to see the full financial picture before moving forward.

Regardless of the plan's Medicaid churn rate, a value-based payment arrangement may still be a worthwhile investment because the health plan will **only pay for outcomes**. For example, if one of the agreed upon outcomes is reduction in total cost of care for members that received services, the health plan will not pay for an individual that left the plan if they are no longer generating cost savings.

Surmountable barrier #3: It is impossible to measure value of services due to attribution issues

Health plans offer access to a diverse set of services that are not available and/or utilized by every member. For example, a health plan may offer chronic disease case management for individuals that meet specific criteria to

help them better manage their condition. While great for members, this variety of service offerings makes measuring attribution of outcomes to any one program less straightforward, but still very feasible. This illustrative example for comprehensive asthma services shows one way to measure outcomes for a program (Figure 2).

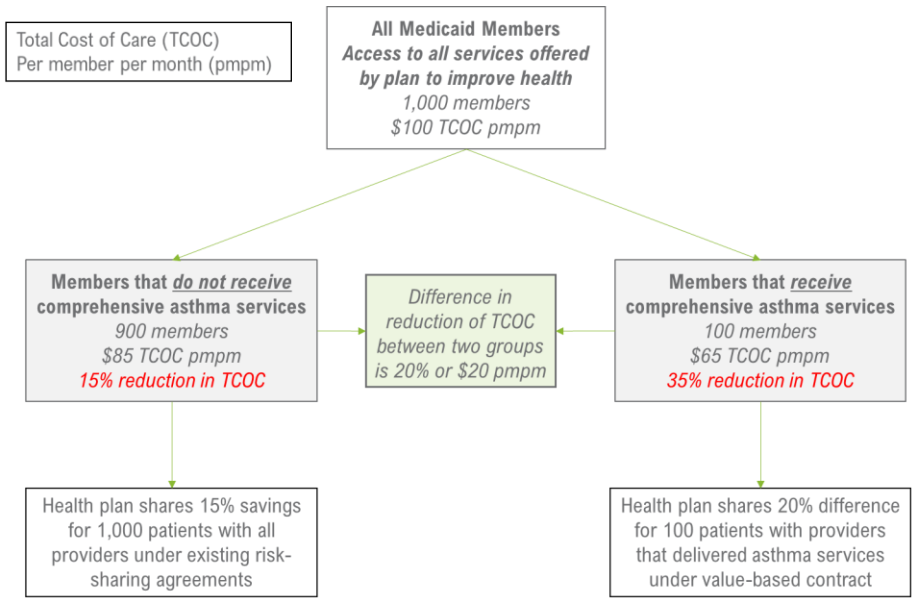

Figure 2: Illustrative examples of simple evaluation design to measure outcomes from one program

In this example, members that receive comprehensive asthma services are evaluated against those who do not. This evaluation design helps parse out the value of asthma services *above and beyond* that of the other services offered. While providers of the other services would be rewarded for positive outcomes achieved for those they serve, the providers implementing asthma interventions would receive additional compensation. Health plans should have no trouble with this evaluation design, especially with the large amount of data available for the comparison group.

Surmountable barrier #4: SDOH services cover a small number of people and have a long payback period

Health plans often think all services that address SDOH will only cover a small number of members and take many years to accrue monetary value, but **services that address SDOH are not all the same.** Some are relevant to a very niche group of individuals; others are needed by many Medicaid members. There are effective services that have a positive return on investment (ROI) with a short payback period and others that have a high ROI that will take decades to accrue. While all of these services are important and beneficial, health plans should look at each individually to analyze the costs and benefits of providing them to members.

Let us first address the concern that SDOH services only cover a small number of people. Of children with asthma, 47.4% are covered by Medicaid and Children's Health Insurance Plan (CHIP).[17] In 2014, Medicaid covered 82% of Neonatal Abstinence Syndrome-related births in the US at a cost of $462M.[18] 11% of the costs for severe obesity in the US are paid for by Medicaid.[19] Asthma, opioid addiction, obesity, and many other conditions/diseases that disproportionately effect Medicaid beneficiaries are directly impacted by the social determinants of health. Historically, scale of services has not been limited by need within Medicaid, but availability of resources to meet that need**. With sustainable financing for these services, the potential for impact in Medicaid is vast**.

Even for those programs that do impact a small number of individuals, but in a very valuable way, multiple partnerships can begin at once to reduce administrative burden and spread initiation costs across a larger cohort. For example, a Community Action Partnership (CAP) may provide Meals on Wheels, transportation services, and asthma home visiting. While the local health plan may only have 100 children eligible for the asthma services, it may have over 500 members that need transportation and nutrition support. One partnership with the CAP agency can provide all three services to over 600 patients.

Next, we turn to the argument that all SDOH services have a long payback period. While each health plan's definition of 'long payback period' varies, many have stated the need to breakeven in one year. This stems from the fact that traditional health care operates on an annualized cycle and entering into multi-year contracts is not the norm.

Overcoming this barrier is largely about systems change within health care. Most programs will not have a payback period of one year or less because services must first be delivered, and then subsequent health care usage must be avoided and measured. This takes time. If health care wants to address SDOH, it will need to meet CBOs in the middle. Contracts can be written to account for discomfort with long-term projects by including interim targets, annual performance evaluations, and the ability to terminate the contract if those targets and performance expectations are not being met. Contracts can also include auto-renewal terms to ensure that successful partnerships do not have the burden of renegotiating annually. Long-term, if health care wants to move from volume to value, it will also have to shift its mindset from short- to long-term investments in health.

Conclusion

With rising costs and poor outcomes, health care in the US must adapt. Sustainable investments in evidence-based services that address SDOH have the potential to not only improve health and quality of care, but also to mitigate rising costs by preventing unnecessary and expensive health care utilization. Partnership between health care and the community is key to ensuring success. While it is important to acknowledge that barriers to collaboration exist, we must move past identification and on to solutions. The work is hard, but the challenges are surmountable, and the benefits are great.

Endnotes

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