NEW YORK STATE | Department of Health | Office of Health Insurance Programs

2018 ACL Management Symposium
Social Determinants of Health

May 2018

Agenda

- Social Determinants of Health
- New Opportunities: VBP and SDH/CBOs
- Beginning: MRT Supportive Housing
- Bureau of Social Determinants Of Health: Purpose and Goals

What Are Social Determinants of Health and Why Are They Important?

Social determinants of health are the structural **conditions** in which people are **born, grow, live, work and age**

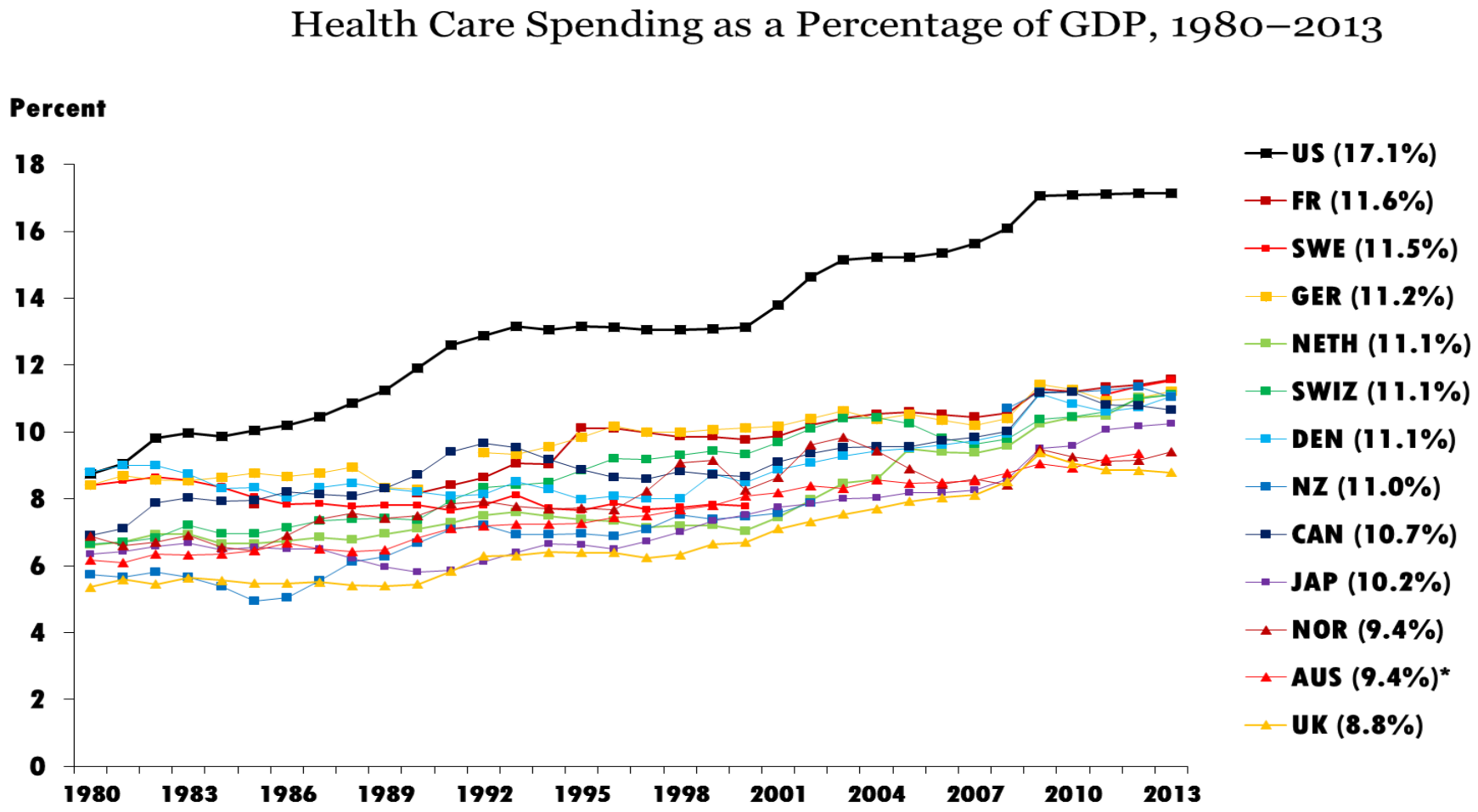
Addressing social determinants can have a significant **impact on health outcomes**

SDH Interventions can be **less costly** than traditional medical interventions

Under VBP, VBP contractors aim to **realize cost savings** while achieving **high quality outcomes**

- The VBP program design **incentivizes** VBP contractors to **focus on** the core underlying drivers of poor health outcomes—**the Social Determinants of Health**

Health Care Spending in US & Other Countries



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

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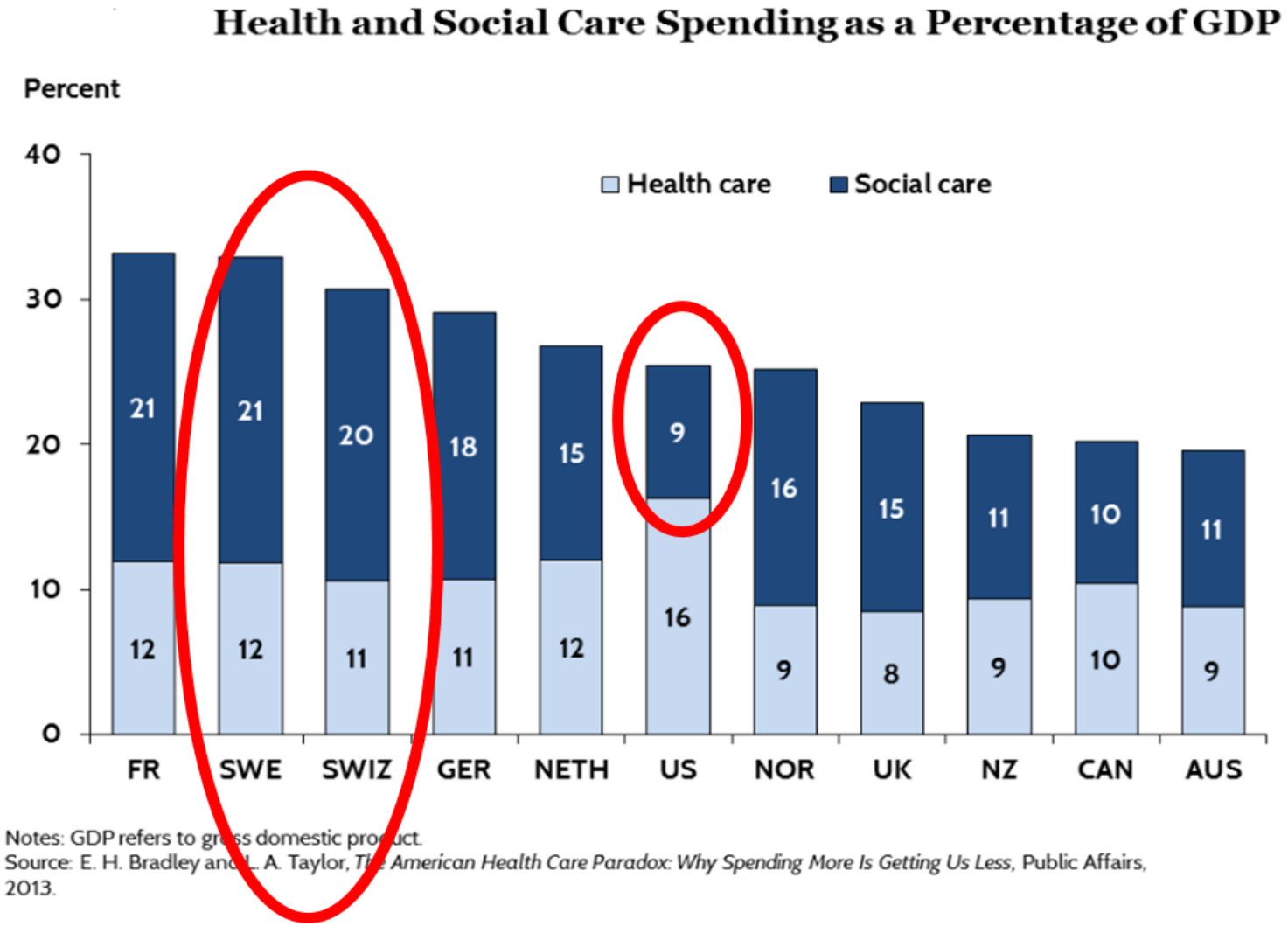
Health Care and Social/SDH Spending



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Health Care Quality, Health Care Spending, and Social/SDH Spending

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

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Rethinking Care for Medicaid's Highest-Need, Highest-Cost Populations

*Experts estimate that **medical care accounts for only 10% of overall health**, with biological, social, environmental, and behavioral factors accounting for the rest. **Lack of** upstream **investment in social determinants of health** probably **contributes to exorbitant** downstream **spending on medical care** in the US.*

The New England Journal of Medicine (NEJM)

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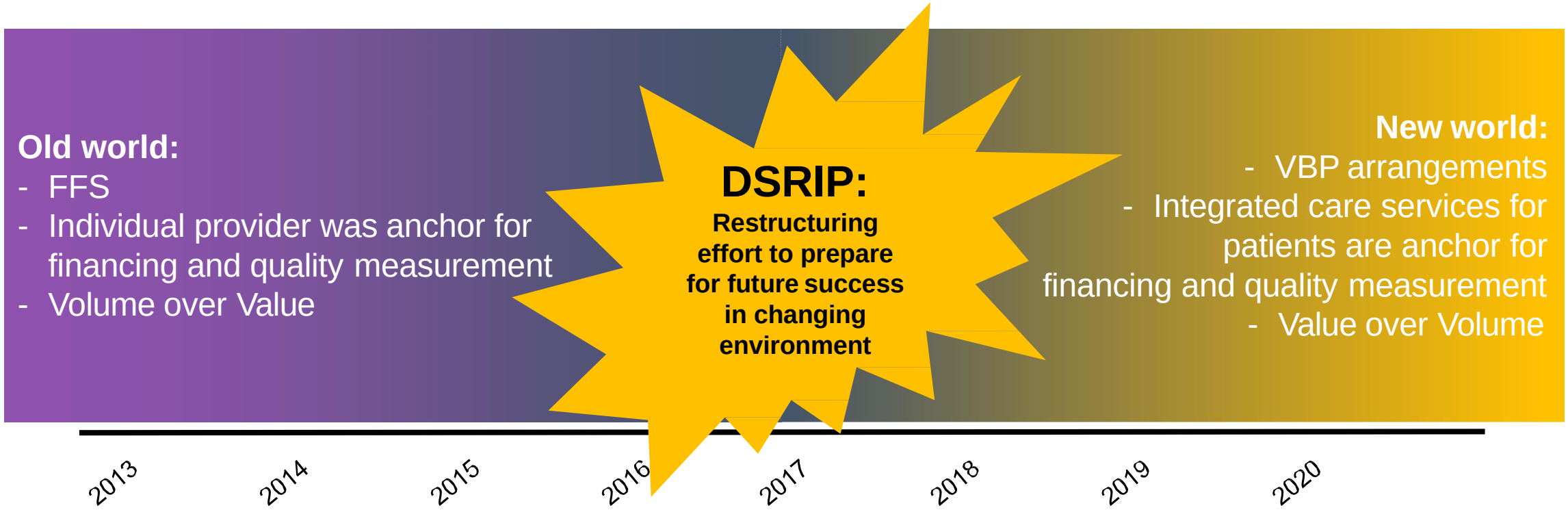
Transition to Value Based Payment

Value Based Payment is the Future



By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80 % of their provider payments.

Value Based Payments

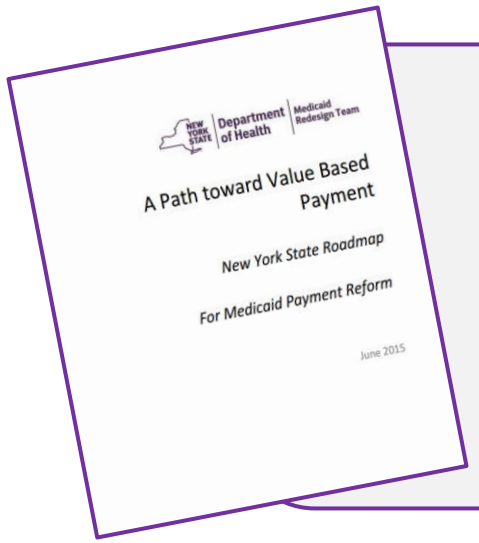
- By DSRIP Year 5 (2020), all Managed Care Organizations (MCOs) must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments.

Value Based Payments (VBP)

An approach to Medicaid reimbursement that rewards value over volume	An approach to incentivize providers through shared savings and financial risk	A method to directly tie payment to providers with quality of care and health outcomes	A component of DSRIP that is key to the sustainability of the program

Value Based Payment Roadmap

Standard: Implementation of SDH Intervention



*"To stimulate VBP contractors to venture into this crucial domain, VBP **contractors in Level 2 or Level 3 agreements** will be **required**, as a statewide standard, **to implement** at least **one social determinant of health intervention**. Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk." (VBP Roadmap, p. 41)*

Description:

VBP contractors in Level 2 or 3 arrangement must implement at least one social determinant of health intervention.

Guideline: SDH Intervention Selection

*"The **contractors will have the flexibility to decide on the type of intervention** (from size to level of investment) that they implement…The guidelines recommend that selection be based on information including (but not limited to): SDH screening of individual members, member health goals, impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (VBP Roadmap, p. 42)*

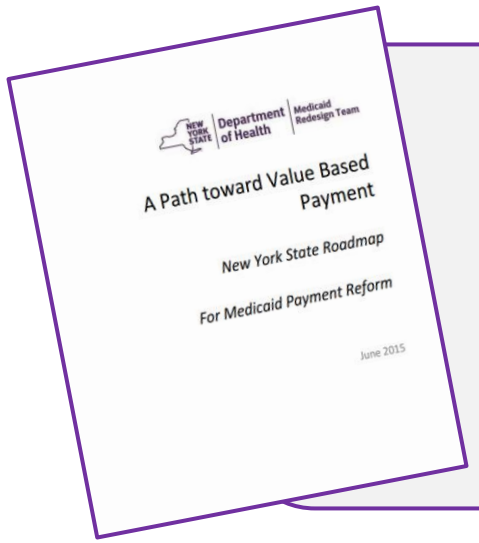
Description:

VBP contractors may decide on their own SDH intervention. Interventions should be measurable and able to be tracked and reported to the State. SDH Interventions must align with the five key areas of SDH outlined in the *SDH Intervention Menu Tool,* which includes:

1) Education, 2) Social, Family and Community Context, 3) Health and Healthcare 4) Neighborhood & Environment and 5) Economic Stability

The SDH Intervention Menu Tool was developed through the NYS VBP SDH Subcommittee and is available here:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/

Standard: Inclusion of Tier 1 CBOs



"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a ***requirement*** *that* ***starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO****." (VBP Roadmap, p. 42)*

Description:

Starting January 2018, VBP contractors in a Level 2 or 3 arrangement **MUST contract with at least one Tier 1 CBO**. Language describing this standard must be included in the contract submission to count as an "on-menu" VBP arrangement.

This requirement **does not preclude VBP contractors from including Tier 2 and 3 CBOs in an arrangement** to address one or more social determinants of health. In fact, **VBP Contractors and Payers are encouraged to include Tier 2 and 3 CBOs in their arrangements.**

Tier 1, Tier 2, and Tier 3 CBO Definitions

01

Tier 1 CBO

- Non-profit, non-Medicaid billing, community based social and human service organizations
  - e.g. housing, social services, religious organizations, food banks
- *All or nothing*: All business units of a CBO must be non-Medicaid billing; an organization cannot have one component that bills Medicaid and one component that does not and still meet the Tier 1 definition

02

Tier 2 CBO

- Non-profit, Medicaid billing, non-clinical service providers
  - e.g. transportation provider, care coordination provider

03

Tier 3 CBO

- Non-profit, Medicaid billing, clinical and clinical support service providers
- Licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

Use the **CBO list** on **DOH's VBP website** to find CBOs in your area

CBO Engagement and Integration

CBO Survey was released earlier this year. The survey is used to understand CBO integration with the NYS VBP program and use information provided to build a public inventory of Tier 1, 2 and 3 CBOs that can be used to facilitate VBP contracting.

- **Total Responses:**
  - 369 Respondents to date

- **CBO Tier Designation:**
  - Tier 1: 29%
  - Tier 2: 14%
  - Tier 3: 48%

- **Have you met with a MCO/VBP Contractor to determine your role in VBP?**
  - 45%- Have met with an MCO and VBP Contractor
  - 12%- Currently participating in an SDH Intervention to support a VBP arrangement

- CBO Directory is posted on the VBP Resource Library under Social Determinants of Health and Community Based Organizations. Directory is updated bi-weekly.

Existing Resources for CBOs

I. Community Based Organization (CBO) Planning Grants

1. Grants support CBOs with contracting and administrative resources
2. Grantees:
   - ➢Arthur Ashe Institute for Urban Health (New York City)
   - ➢The Health and Welfare Council of Long Island (Long Island/Mid-Hudson Region)

II. New York Performing Provider System (PPS) Innovation Fund Awards

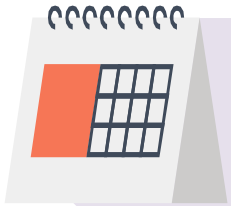
Approximately half of the PPS are using “Innovation Funds” to support the efforts of CBOs and other partners to implement innovative approaches to achieve DSRIP and VBP performance goals.

III. Negotiating for Stimulus Adjustment Dollars

- Managed Care Organizations (MCOs) receive, in aggregate, $85 million in guaranteed VBP stimulus funding for State Fiscal Years (SFYs) 2016-17 and 2017-18
- CBOs can negotiate with MCOs to receive a share of these dollars to facilitate investment in SDH Interventions
- Since providers (including CBOs) who successfully address SDH at both member and community levels may not see savings in the short term, they will be incentivized by MCOs upfront to identify one (or multiple) social determinant(s) and be financially rewarded for addressing them.

MCO Contracting Compliance Tracker

To track progress towards compliance for VBP Level 2 and 3 contracts, DOH developed SDH-CBO Contracting Tracker



MCOs are asked to submit monthly status updates on CBO contracting progress and the SDH interventions being implemented

Nine major MCOs responded and have had discussions with over 200 CBOs as part of VBP contracting

MCOs have executed contracts with CBOs in NYC, Suffolk, Nassau, and Erie counties to implement SDH interventions.

Interventions include: Transportation; Isolation and Lack of Community Support; Health Education on Asthma Management; Home Environment Assessment; Nutritional Case Management; Food Insecurity (food farmacy initiative, fresh box program); Access to Health Care.

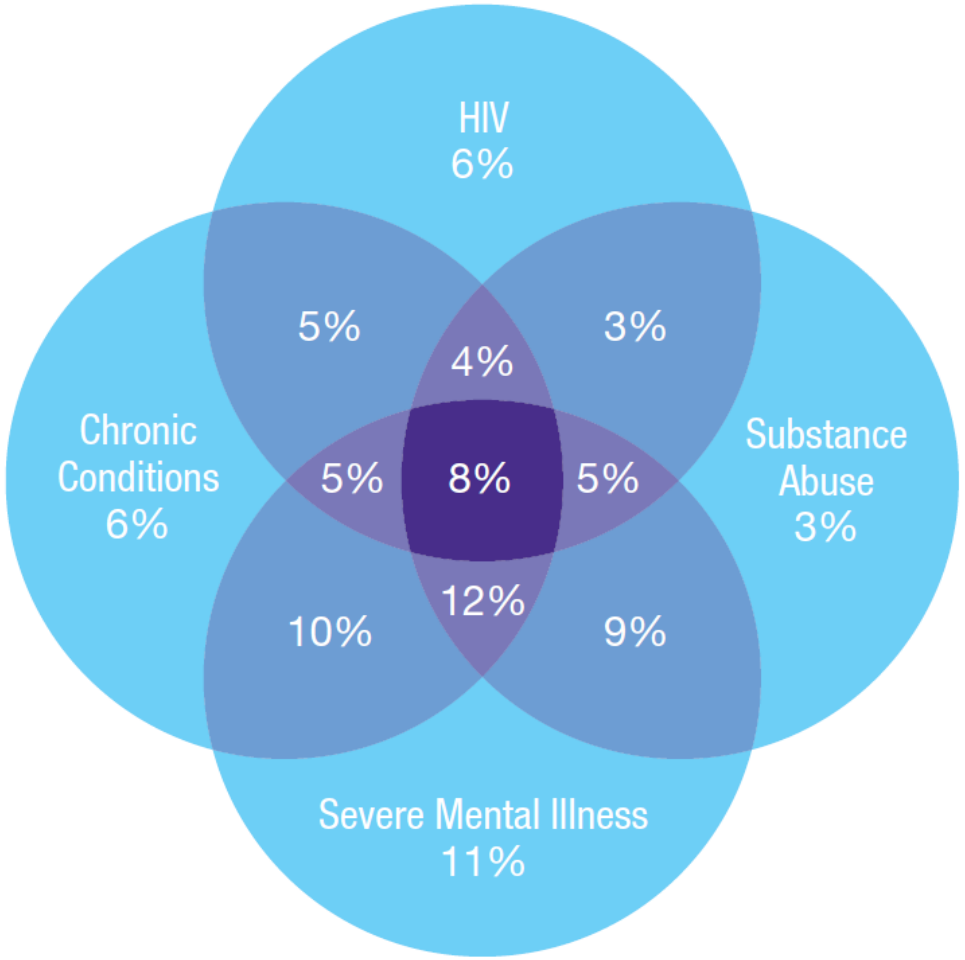
MRT Supportive Housing Initiative

MRT Supportive Housing

- Medicaid Redesign Investment: **$641 Million over 7 years.**
- Funding is targeted to **high-cost Medicaid members.**
- MRT Supportive Housing investment targets **capital construction, rental subsidies and supports, and operating dollars.**
- **Outcomes, measures, research and evaluation are key components.**

3361 Third Avenue in the Morrisania neighborhood of the South Bronx.

MRT SH Clinical Characteristics



- 66% have a serious mental illness
- 46% have a substance use disorder
- 40% are HIV+
- 53% have one or more other chronic medical conditions
- 26% have at least three of these diagnosis types

Source: McGinnis et al, "Medicaid Redesign Team Supportive Housing Evaluation: Utilization Report 1," prepared by the SUNY Research Foundation for NYS DOH, May 2017.
Note: Not shown are substance use + chronic medical condition (3%) and severe mental illness + HIV (4%). Note: To obtain total percentage of participants with a given diagnosis, sum all percentages that fall into the relevant circle (but may not exactly match text due to rounding). Circles are not sized proportionately.

Housing Security: Outcomes of MRT Supportive Housing

Number of high-need Medicaid recipients served to date: **11,656**

Objective

- Medicaid Redesign Team Supportive Housing invests in the social determinants of health to reduce avoidable hospital utilization for high-cost, high-need Medicaid recipients

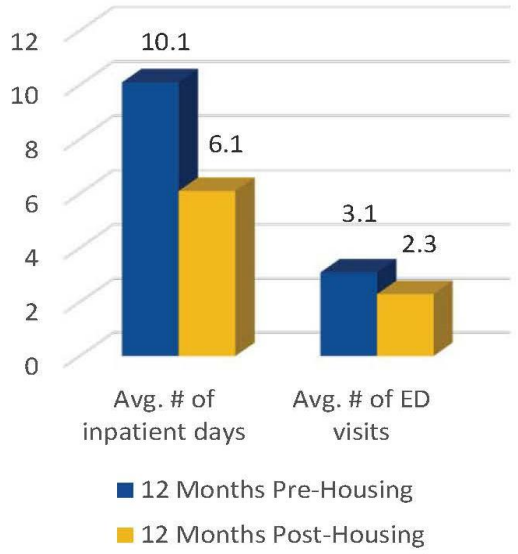
Accomplishments

- 40% reduction in inpatient days
- 26% reduction in emergency department visits
- 44% reduction in patients with inpatient rehab admissions
- 27% reduction in patients with inpatient psychiatric admissions
- Medicaid health expenditures reduced by 15% in one year (average decrease of $6,130 per person)
- Through strategic prioritization, the top decile of enrollees had average Medicaid savings of $23,000-$52,000 per person per year (varied by program)
- 29% increase in care coordination after housing enrollment
- MRT houses extremely vulnerable populations
  - 66% have a serious mental illness
  - 46% of a substance use disorder
  - 40% are HIV+
  - 53% have one or more other chronic medical conditions
  - 26% have at least three of these diagnosis types

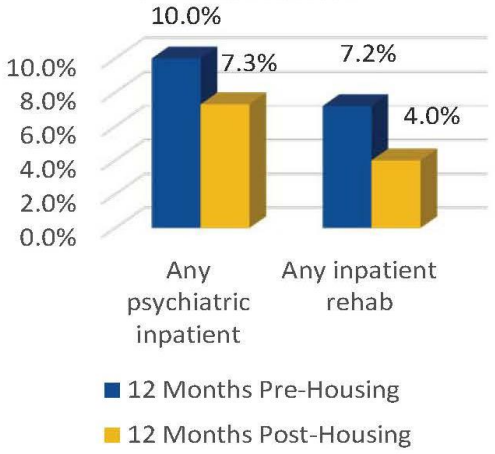
Benefits

- Reduce Medicaid health expenditures
- Improved participant health outcomes and quality of life
- Increased Olmstead compliance statewide

Decreased Inpatient, ED Use



Decreased Percentage of Recipients with Behavioral Health Admissions



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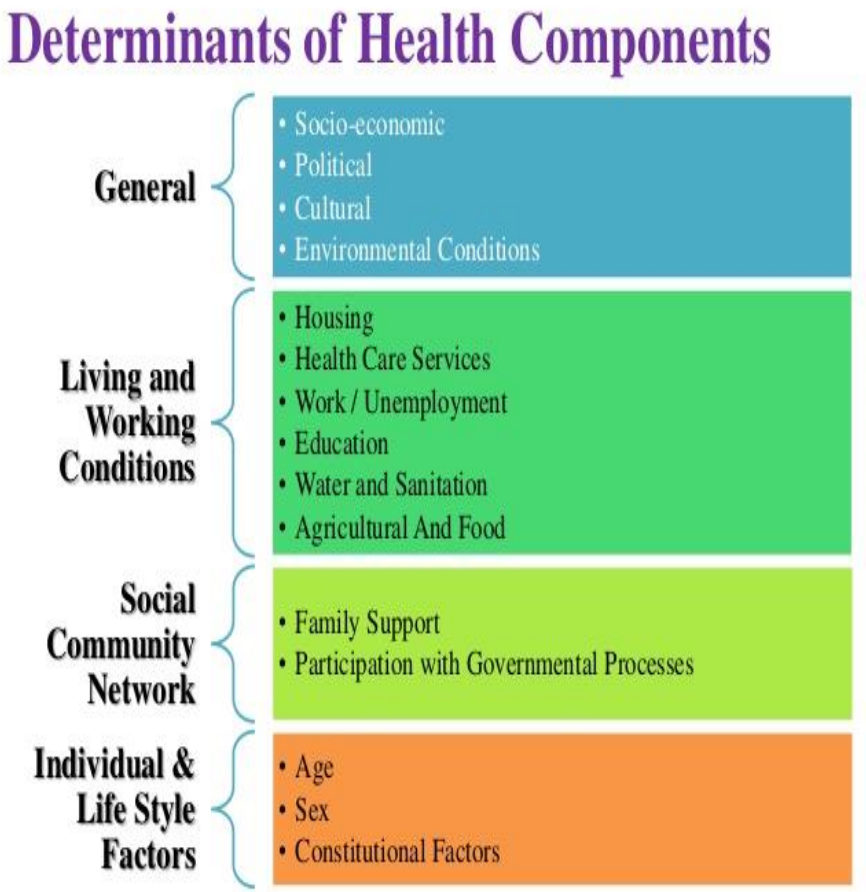
From Housing to all Social Determinants

- Medicaid (state only) invested in housing for over 5 years for high-cost Medicaid members.
- With the move to Value Based Payment, OHIP decided to create a bureau to address the social determinants of health, including housing.
- **Goal:** To engage all CBOs in SDH work and to foster collaborations with CBOs in the health care sector.



Food Security: Outcomes of Medically Tailored Meals (MTM)

God's Love We Deliver Nutrition Intervention Outcomes

- Low-cost/High-impact intervention: Feed someone for half a year by saving one night in a hospital
- Reduce overall healthcare costs by up to 28% (all diagnoses compared to similar patients not on MTM)
- Reduce hospitalizations by up to 50% (all diagnoses compared to similar patients not on MTM)
- Reduce emergency room visits by up to 58% (pre-post MTM intervention)
- Increase the likelihood that patients receiving meals will be discharged to their home, rather than a long term facility (23%) (all diagnoses compared to similar patients not on MTM)
- Increase medication adherence by 50% (pre-post MTM intervention)

Bureau of SDH: 2018 Goals

Implement the VBP Roadmap Requirements Related to SDH and CBOs	• Review VBP Level 2 and 3 Contracts and Amendments • Track SDH Interventions and CBO • Provide support and technical assistance
Begin CBO SDH Regional Meetings	• Regional meetings with MCOs, VBP contractors, CBOs, & health care providers • Maximize CBO and SDH interventions in the health care system.
Improve SDH Measures in Population Health and Payment Reform	• Increase data collection on SDHs (i.e. electronic health records) • Standardize SDH Quality Measures and incorporating into QARR • Risk Adjustment MMC Plans for SDH
Create a New Housing Referral Process	• Integrate MRT SH with PPSs, VBP Contractors, and Health Systems • Create a plan to expand to families to align with the First 1,000 Days

Upcoming MRT Capital Projects

Greenport – 33 Units

- Population Served: Single adults with a mental health diagnosis.
- TCO Completion- April 1, 2018. Hudson Valley Region (Columbia)

Webster Green – 41 Units

- Population Served: Homeless single adults living with HIV/AIDS and who suffer from a co-occurring serious and persistent mental illness, and/or a substance abuse disorder.
- TCO Completion- April 26, 2018. NYC (Bronx)

294 East 162nd St. Court – 37 Units

- Population Served: Formerly homeless families
- TCO Completion- May 1, 2018. NYC (Bronx)

Marion Avenue – 65 Units

- Population Served: Homeless single adults living with a serious mental illness exiting state psychiatric facilities and programs
- TCO Completion- June 4, 2018. NYC (Bronx)

St. Augustine Apartments – 35 Units

- Population Served: Chronically homeless single adults who suffer from a serious and persistent mental illness (SPMI) or who are diagnosed as mentally ill and chemically addicted (MICA)
- TCO Completion- August 1, 2018. NYC (Bronx)

Thank you!

Contact Us:

Bureau of Social Determinants of Health

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