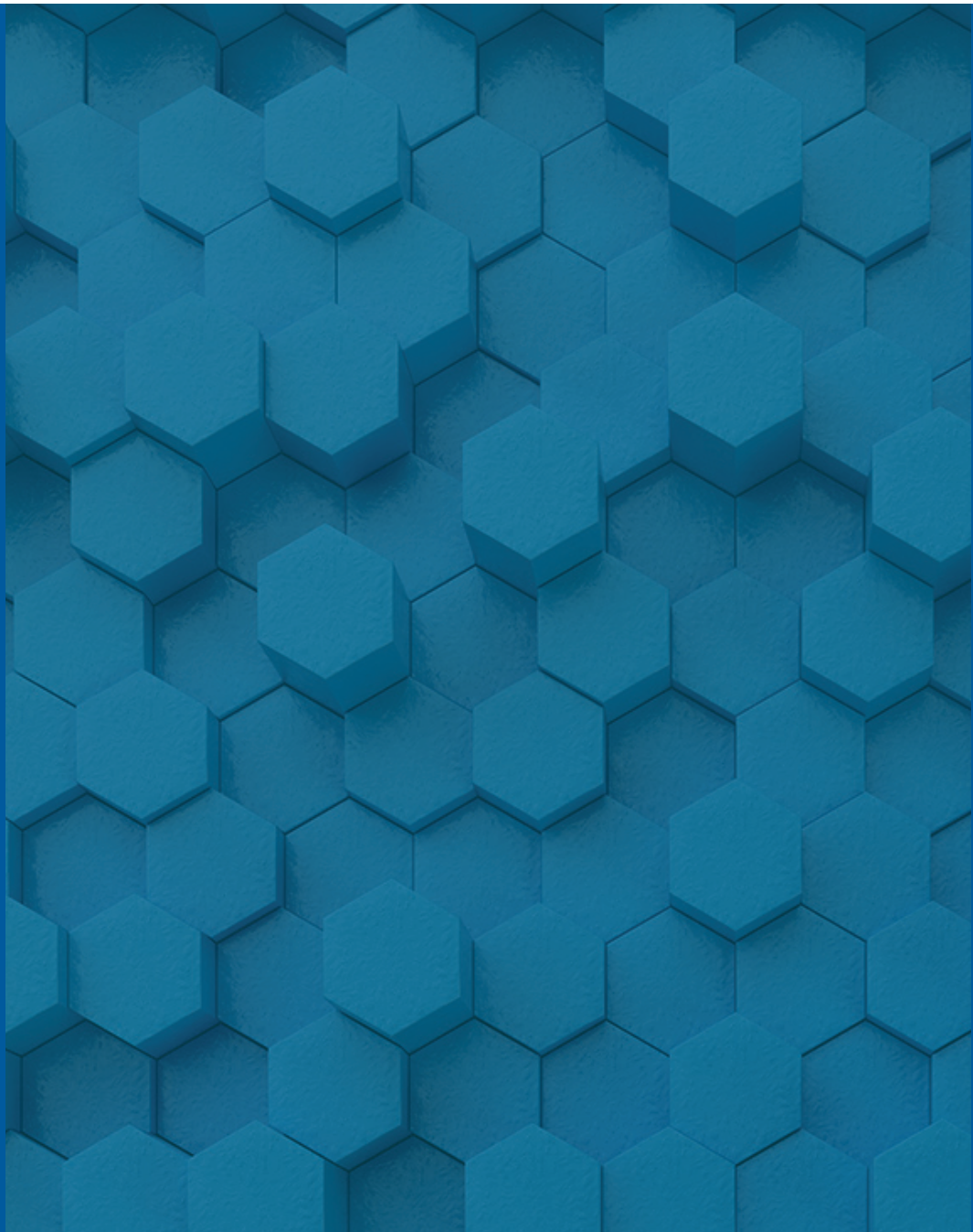
Marrying Value-Based Payment and the Social Determinants of Health through Medicaid ACOs

IMPLICATIONS FOR POLICY AND PRACTICE



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Abstract

State Medicaid programs are experimenting with two vital trends in health policy—value-based payment (VBP) and interventions intended to address social determinants of health (SDOH). We analyzed the policy levers employed by states through their Medicaid accountable care organizations (ACOs) to incorporate requirements and incentives for ACO providers to address SDOH. The policy approaches fall into three main categories: (1) requirements that providers screen for social risks; (2) requirements or incentives for partnering with social service organizations; and (3) requirements or incentives for SDOH-associated quality metrics.

As states marry VBP and SDOH interventions through their Medicaid ACOs, key policy considerations include:

- Integrating social risk screening into practice and achieving health provider buy-in by supporting requirements for screening and social service partnerships with provision of infrastructure funding and technical assistance to both health care and social service partners;
- Designing provider risk sharing and payment to account for social risk on the part of the population served while taking care to protect patients' privacy;
- Defining and measuring outcomes by extending metrics (and payment based on those metrics) beyond screening and referral process data to track patient experiences and outcomes in both the health care and the social service sector;
- Tracking savings across systems outside of health care, such as child welfare, education, and criminal justice; and
- Investing in data platforms that link the health care and social service sectors and inform state policy regarding upstream gaps in the social safety net.

Introduction

In the past decade, we have seen the emergence of two vital movements in health policy: the shift from fee-for-service to value-based payment (VBP) and the emphasis on health care delivery strategies intended to address the social determinants of health (SDOH). An important new report from the National Academies of Sciences, Engineering, and Medicine (NASEM), *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health,* points out that the move toward VBP has facilitated the integration of social care into health care delivery:

> The shift in the health care sector towards value-based payments that incentivize prevention and improved health and health care outcomes for persons and populations rather than service delivery alone has made possible expanded approaches to addressing health-related factors that may be upstream from the clinical encounter.[1]

Building on some of the opportunities and challenges presented in the NASEM report, we will focus on recent state-level initiatives—the development of Medicaid accountable care organizations (ACOs)—designed to tackle a dual goal: payment reform and better integration of social care into clinical care. State Medicaid programs are well poised to test the marriage of VBP and SDOH because they are the largest providers of health care services to patient populations with unmet social needs and are under enormous pressure to reduce state health care spending. Moreover, research continues to demonstrate the oversized role of SDOH as drivers of population health outcomes and health disparities. Addressing unmet social needs has been shown to reduce health care utilization and costs, which are the primary goals of accountable care.[2]

The majority of states utilize managed care to control Medicaid costs,[3] and many have experimented with paying for nonmedical services, including social services.[4] Unlike Medicare ACOs, which are governed by federal rules and models, states have the flexibility to experiment with the design, requirements, and incentives structuring Medicaid ACOs. Hence, states are developing and testing different models. Of these, a subset of state Medicaid ACO programs is experimenting with tying payment to new protocols for providers to identify patients' social needs, develop partnerships with social service organizations, and make appropriate referrals for services. To analyze this trend, we first explore the development of Medicaid ACOs in recent years and the specific incentives and requirements that states are using to drive care transformation and spending related to SDOH in these programs. We then describe some of the challenges confronted by state Medicaid programs that have pioneered the marriage between VBP and SDOH, and offer key questions and considerations for state policymakers and stakeholders planning similar initiatives.

Medicaid and SDOH

Since Medicaid covers a range of socially and medically complex patient populations, including low-income adults and children, the disabled, and dual eligibles, the value of integrating social and medical care for these populations is as important as, if not more important than, for Medicare-only patients. Under the Obama administration, a number of federal funding streams supported the integration of medical and social care, including State Innovation Model (SIM) grants and Delivery System Reform Incentive Payments (DSRIP), through Section 1115 waivers.[5,6] Section 1115 waivers allow states to pilot delivery system and payment reforms outside of federal Medicaid requirements.[7] Many states have used their waivers to experiment with payment for nonmedical services in order to address health-related social needs.

In addition, in 2016, the federal government started down the path of incentivizing health system experimentation by integrating systemic ways to address social needs into health care with the Accountable Health Communities (AHC) pilot program.[8] The AHC program set in motion a role for government in writing criteria for how screening and referral should be accomplished, including the development of a health-related social needs (HRSN) screening tool and requirements for recipients to demonstrate the establishment of partnerships between clinics and communities.

The Centers for Medicare and Medicaid Services (CMS) has encouraged states to integrate medical and social care through their Medicaid managed-care programs. In 2016, CMS updated its Medicaid managed-care regulations for the first time in more than a decade. Among other provisions that support better integration of behavioral health and medical care as well as value-based payment, the new rules incentivize managed care organizations to cover nonmedical services that address social needs by allowing those services to be included when estimating the capitated rate.[9] The services include linkages to social service programs, stable-housing support, assistance in finding and maintaining employment, and peer support.[10] The majority of states that operate Medicaid managed-care programs now require screening and referral for social needs.[11]

A Brief Overview of the Medicaid ACO Landscape

Driven primarily by concerns about cost growth in Medicaid programs, some states began developing Medicaid ACOs as early as 2011, just as implementation of the Affordable Care Act was getting off the ground.[12] States also adopted Medicaid ACOs as a mechanism to promote system delivery reform, something managed care had failed to accomplish. Colorado and New Jersey were early adopters in 2011, followed by Oregon and Minnesota in 2012.[13] As of January 2020, 12 states have adopted Medicaid ACOs (covering roughly 4 million beneficiaries), with 10 more states in the planning stages.[14]

Most of the states with Medicaid ACO programs (9 of the 12) are engaged in activities related to addressing SDOH, though their models vary considerably. By incorporating SDOH strategies into their ACO programs, these states anticipate the cost-containment and equity benefits that have generally been associated with greater integration of social care into the medical system.[15] Based on our analysis of the policy levers being employed by states to incorporate requirements and incentives for ACO providers to address SDOH, the strategies appear to fall into three main categories: (1) requirements that providers screen for social risks; (2) requirements or incentives for partnering with social service organizations; and (3) requirements or incentives for SDOH-associated quality metrics. Table 1 provides an overview of the range of models, including authority, funding streams, governance structure, and payment and risk-sharing mechanisms.

Table 1: Medicaid ACOs—Structure and Funding Sources

State and Program Name	Year Launched	Authority	Federal Funding Sources	Governance Structure	Payment Mechanism
CO; Accountable Care Collaborative	2011	State plan amendment	No federal funding	Care Coordination Entity assigned based on geographic region	Capitation for behavioral health; shared savings with upside only for physical health
CT; Patient Centered Medical Home Plus (PCMH+)	2017	State plan amendment	$15 million SIM grant	Provider-led	Upside shared savings
IA; Iowa Medicaid Enterprise	2014	1115 demonstration waiver	$43 million SIM grant	Provider-led with MCO contracts	Risk-based payments based on quality scores, with variations depending on MCO contract
MA; Accountable Care Organization	2016 (pilot), 2018 (full program)	Chapter 224 of Acts of 2012; 1115 demonstration waiver	$1.8 billion DSRIP; $44 million SIM grant	Provider-led with opportunity for MCO contracts (3 structure options)	Depends on risk track—shared savings/losses from state, shared savings/losses from MCO, or capitation
ME; Accountable Communities (AC) Initiative	2013	State plan amendment	$33 million SIM grant	Provider-led	Shared savings with upside or upside/downside
MN: Integrated Health Partnership (IHP)	2012	State plan amendment; Managed Care Authority authorized under legislation MN Statute 256B	$45 million SIM grant	Provider-led	Shared savings with upside/downside OR risk-adjusted, population-based payment tied to quality metrics

NJ; Medicaid Accountable Care Organization Pilot (no longer operational)	2015 (ended in 2019)	NJ Public Law 2011, Ch. 114 authorized ACO demonstration; upon demonstration completion in 2019, governor decided to cut program in exchange for broader health hub model	$1 million allocated to each ACO by state legislature; supplemented by external resources	Community group–led (geographic organization)	Upside-only shared savings based on MCO and ACO contracts
NY; Accountable Care Organization	2016	NY Law Article 29-E; 1115 demonstration waiver	$6.4 million DSRIP grant	Provider-led	Shared savings only OR shared savings/risk between MCOs and ACOs
OR; Coordinated Care Organization (CCO)	2013	2011 House Bill 3650; 1115 demonstration waiver	$ 1.9 billion DSRIP grant and $45 million SIM grant	Payer-led (geographic organization)	Global budget capitation plus quality bonuses
RI; Accountable Entity (AE)	2016 (pilot), 2018 (full program)	Health System Transformation Project (HSTP), an amendment the state's 1115 demonstration waiver	5-year, $129 million workplace and development grant	Provider-led with state MCO contracts	Shared savings/losses with MCO with full risk forthcoming under future contracts
UT; Accountable Care Organization	2011	Senate Bill 180, Medicaid Reform;1115 demonstration waiver		Payer-led	Capitation with some opportunities for shared savings arrangements
VT; Next-Generation Accountable Care Organization	2016	State plan amendment	$45 million SIM grant	Provider-led	Capitation, plus shared savings/losses with 3% cap

Notes: SIM=State Innovation Model. MCO=managed care organization. DSRIP=Delivery System Reform Incentive Payments.

Screening for Social Risks

States must determine how much flexibility to give ACOs to accommodate local priorities and capacity while at the same time driving practice change through clear guidelines. Only a few states have mandated provider screening for social risks in order to qualify as a Medicaid ACO. Rhode Island and Massachusetts both require that participating providers screen patients for social risks, and both include quality metrics associated with screening. For example, Massachusetts requires that providers demonstrate that they screen attributed patients at least once per measurement year. The state also demands that screening include four domains—housing, transportation, food security, and utility expenses—and one supplemental domain chosen by the ACO.[16] Rhode Island requires that providers use a screening tool approved by the state Executive Office of Health and Human Services.[17]

Requirements and Incentives for Social Service Partnerships

All of the state Medicaid ACO programs that include an SDOH component either require or encourage providers to partner with social service organizations. Again, state models vary considerably. Some states require providers to demonstrate partnerships with social service organizations in order to qualify as an ACO (e.g., Colorado, Connecticut, Maine), while some also require that they contract with these organizations (e.g., Massachusetts, Rhode Island, New York). Minnesota and Oregon incentivize partnerships with social services through payment incentives.[18] Encouraging integration of social care through partnerships facilitates more coordinated, patient-centered care. But the devil is in the details in terms of how effective these partnerships will be in serving patients' needs. As discussed later, the level of integration of services is key; a simple referral network is unlikely to impact outcomes significantly. Furthermore, in many communities, social service organizations are underresourced and are already working to capacity. Failing to invest in social service agency infrastructure could overburden already taxed organizations. Understanding the social service landscape and aligning incentives, payment, and goals across the health care and social service sectors are critical to success.

SDOH-Associated Quality Metrics

To hold providers accountable for instituting practice transformation that incorporates SDOH, some states are requiring collection of SDOH-associated quality metrics (see Table 2). Massachusetts requires that providers report data-associated screening and utilization of social services.[19] Minnesota's recently revamped Integrated Health Partnership (IHP) 2.0 program also launched health equity quality metrics tied to provider payments, with various other states following suit.[20] Important questions remain about which SDOH-related metrics will drive practice transformation and measure meaningful outcomes.

Table 2: SDOH Requirements and Metrics

State and Program	SDOH Requirements	Quality Metrics
CO; Accountable Care Collaborative	2018 Phase II: Requirement for connections to community-based organizations (CBOs); state government has expressed interest in considering service bundles addressing SDOH	No SDOH metrics; however, 2018 updates led to inclusion of behavioral health metrics and social performance metrics like high school graduation rate
CT; Patient Centered Medical Home Plus (PCMH+)	2018 Wave 2: Must implement community partnerships to become authorized as PCMH+	No SDOH metrics as of 2018 Wave 2
MA; Accountable Care Organization (ACO)	2018 Launch: Must contract with community partners for long-term services and supports (LTSS) and behavioral health in application process, have at least one quality metric for social service, and include social factors in rate-setting; as of 2020, some ACOs will offer housing and nutritional support services	Health-related social needs screening and community partner engagement required as care integration quality metrics; flexible social service metrics likely forthcoming
ME; Accountable Communities (AC) Initiative	2014 Launch: ACs tied to health homes program to link most-in-need patients to social services; required relationship with one public health entity, CBO, or social service organization 2019/2020 Updates: Expansion of program eligibility likely, but specific SDOH measures unknown	No SDOH metrics as of 2014 launch
MN; Integrated Health Partnership (IHP)	2018 2.0 Program: Partnerships with community social service programs required under some contracts; population-based payment adjusted for social risk factors	During contract discussions, IHPs required to propose at least one quality measure for interventions that aim to reduce health disparities among beneficiaries
NY; Accountable Care Organization	2018 Value-based Payment Roadmap: Some ACOs must contract with at least one CBO; contractors in certain risk agreements must implement at least one SDOH intervention	No SDOH quality metrics included in VBP Roadmap, but New York Department of Health expressed interest in exploring the feasibility of incorporating SDOH measures into Quality Assurance Reporting Requirements
OR; Coordinated Care Organization (CCO)	2020 2.0 Program: CCOs expected to invest in services that address SDOH and health equity, with a statewide focus in 2020–2022 on housing services; CCOs also required to spend part of year-end surplus on health disparities	Oregon Health Authority intends to begin offering bonus payments for CCOs that meet SDOH and health equity performance measures in 2021 (subject to CMS approval and state budget); quality measures to be developed by November 2020

RI; Accountable Entity (AE)	2018 Launch: Demonstrate capacity to screen for and address SDOH in three focus areas of social need during the application process; at least 10% of pooled incentive funds in year 1 allocated to CBO partners	Quality metric linked to percentage of attributed patients screened for SDOH, based on documented AE screening and results
VT; Next-Generation Accountable Care Organization	2018 SIM Evaluation: Partnerships with health homes and CBOs encouraged, though no firm requirements	No direct SDOH metrics as of 2018

Considerations for State Policymakers and Stakeholders

Based on our analysis of pioneer states' requirements and incentives, we find that state policymakers and stakeholders are likely to encounter a number of challenges as they consider marrying value-based payment to SDOH interventions through Medicaid ACO programs. These challenges include implementing processes for integrating social risk screening and referral into practice; achieving provider buy-in; calculating provider risk when incorporating SDOH; measuring outcomes; and assessing savings.

Integrating Social Risk Screening and Referral into Practice

Social risk screening is now embraced by many professional medical associations,[21] and there has been a proliferation of SDOH screening tools,[22] best-practice guidelines,[23] calls for standardization, and mechanisms for coding within electronic medical records.[24] Yet many questions remain as providers attempt to integrate social risk screening into routine care delivery.[25] Should all patients be screened, or just those deemed high-need, high-cost? Who should conduct the screening and who should be informed of its results? Who is responsible for following up with the patient who indicates a need? Providers are often reluctant to screen without a clear protocol for the action to be taken when a patient screens positive for needing assistance.

One of the questions for states designing SDOH requirements for their Medicaid programs is how narrowly to draw those requirements. If the requirements are too flexible, busy providers may "go through the motions" without accountability for outcomes. On the other hand, if they are too narrow, providers may be set up to fail if they are not equipped to screen for and address multiple social needs. States are employing different approaches to take these concerns into account. New York simply requires that the ACO demonstrate that it is implementing an SDOH intervention, allowing it to choose from a menu of options,[26] while other states are much more prescriptive, requiring that providers demonstrate how they will identify patients' social needs and the protocol they will use for connecting patients to appropriate services to address those needs. Rhode Island, for example, requires screening for certain SDOH deemed most important, such as housing, food, nutrition, and transportation, while allowing ACOs to choose others they wish to screen for depending on the populations they serve.[27] The NASEM report on integrating social care into health care delivery

found that, despite the growing prevalence of social risk screening in health care, there is little evidence as to effectiveness or outcomes.[28]

The NASEM report authors raised important questions about the potential benefits and harms of screening patients for social risk in the absence of follow-up intervention (e.g., at the very least a referral to an appropriate community).[29] Before imposing social risk screening requirements, state policymakers and Medicaid program directors should be careful to assess not only the validity of the tools that will be used (based on available evidence), but, more important, the capacity of ACOs to develop appropriate responses to positive screens. This may require limiting the screening questions, at least initially, to specific issues, such as food insecurity, for which there are known and available resources in the community.

Achieving Provider Buy-in

In asking providers to embrace a role in addressing the complex social needs of Medicaid patients, how should screening requirements and expectations for referral and follow-up be structured so as not to overburden already stressed providers? The literature is rife with discussion about the crisis of physician burnout.[30] Although many providers, especially those serving Medicaid patients, embrace their role in identifying and addressing social needs, structuring the appropriate supports, incentives, and protocols is critical to effectiveness. A study of physicians, social workers, nurses, and pharmacists in an integrated health care system in California found that, although most providers support social needs screening, only about a quarter of those surveyed routinely screen, considering barriers such as lack of confidence about how to address needs, lack of time, and lack of resources.[31]

However, when given the right supports and resources, many providers who serve Medicaid patients may embrace screening and referral for social needs as part of health care delivery and payment. Some studies suggest that primary care provider burnout may actually be mitigated by developing effective clinic capacity to address social needs.[32] VBP can, in fact, provide the flexible funding necessary for building the infrastructure and staff capacity needed to develop screening and referral protocols. VBP enables payment for services not allowable through traditional fee-for-service ICD-10 codes for nonmedical services, supports, and navigation of external social services.[33]

Indeed, many providers serving Medicaid patients have long been frustrated by the inability to bill for integrated behavioral health, social work, or care coordination. Joining a Medicaid ACO has given those providers the opportunity to design care delivery that makes sense for the populations they serve. Yet, this kind of radical delivery system transformation takes time as providers restructure workflow (e.g., who screens for SDOH and who follows up?) and resource allocation (e.g., how does one structure efficient and effective referral protocols and communication loops that track outcomes?). State policymakers and Medicaid directors can support providers who are at the forefront of these system delivery reforms by convening provider organizations to develop best practices for SDOH workflow protocols and by offering realistic time for health care leadership and staff to test, implement, and scale those protocols.

Calculating Provider Risk for the Costs Associated with Social Needs

Since participation in a Medicaid ACO is voluntary, in order to attract providers, state programs must strike the right balance in their shared risk and savings calculations. Most states have adopted a flexible approach to risk sharing at the early stages of program development, allowing providers to opt for one-sided risk (see Table 1). [34,35] In some states, providers were deterred from participating in Medicaid ACOs if they felt that the parent organization was retaining too much of the shared savings, making it hard for them to meet ACO goals. States that have longer-standing programs have adjusted for this issue. For example, in its Medicaid 2.0 program, Minnesota applied a retrospective quarterly payment based on the population served to avoid this problem.[36]

States that have included SDOH mandates for Medicaid ACOs do so with the expectation that holding providers accountable for addressing upstream social needs will lead to downstream cost savings as well as better outcomes. Inherent in this approach is the shifting of costs away from the health care system by utilizing less-costly community-based services, such as housing, food support, and transportation, that may prevent unnecessary health care use such as ER visits for housing-related asthma attacks. But accounting for social risk in the cost of care is a more complicated exercise than meeting the quality measures generally used in Medicare ACOs, such as demonstrating that a certain percentage of patients have received screenings.

Asking providers to take on risk for patients with multiple unmet social needs can be a hard sell. States implementing Medicaid ACOs that incorporate SDOH requirements have had to learn an important lesson from Medicare ACOs: how not to unfairly penalize providers who take on the highest-need, highest-cost patients.[37] The most likely reason Massachusetts has been successful in attracting providers to join Medicaid ACOs is that it was an early adopter of algorithmic risk adjustment for social needs in its Medicaid MCO program.[38] The goal of risk adjustment is to modify payment according to a defined set of risk factors associated with a specific patient population—for example—those with chronic conditions. State Medicaid programs have long used diagnostic medical claims data for risk adjustment, but "[a]ccounting for SDOH in Medicaid payment models creates a better alignment between the risk of the population and the payment amount—that is, payment that better reflects the health and well-being of the population and their likely health care and social service needs." [39] Using variables for housing instability and a neighborhood stress score (a composite measure of financial or economic stress), Massachusetts employs an enhanced payment model to establish total cost of care for its Medicaid ACO program.[40]

Nevertheless, policymakers must take care in designing risk prediction models to ensure that patient social risk information protects patients' privacy and is not inappropriately used to exclude them from care. As the NASEM report suggests, policymakers and health care administrators must take this unintended consequence seriously: "To avoid such discrimination caused by the presence of social risks, new care management guidelines must be thoughtfully designed both to incorporate social risks into personalized care and to provide guardrails against discrimination." [41]

Defining and Measuring SDOH Outcomes

Although growth in the number of Medicaid ACOs has accelerated in recent years, outcome data are relatively scant. Most published research has centered on Medicare ACOs. The few studies of Medicaid ACOs have aimed to calculate potential cost savings and reduced health care utilization. A recent study analyzing cost and quality data from Maine, Massachusetts, Minnesota, and Vermont—all of which used State Innovation Model grants to support the development of their Medicaid ACO programs—generated some promising findings. Three states demonstrated a reduction in ER visits among the ACO population, in contrast to the comparison group, and both Maine and Vermont had slower growth in inpatient admissions. Three states also demonstrated shared savings, with Minnesota distributing to ACO providers $23 million of the $65 million in savings generated to the state.[42]

In a 2019 study of Oregon's coordinated care organizations (CCOs), researchers sought to determine whether Medicaid ACOs affect quality of care by comparing the self-reported experiences, over time, of patients enrolled in fee-for-service Medicaid programs with those of patients enrolled in a CCO. CCO members demonstrated greater improvements in access to care, including having a personal health care provider, than fee-for-service members. They also reported higher-quality care and greater use of primary care, which, as the authors noted, was "linked to cost reduction and population health improvement."[43]

Because Medicaid ACOs with SDOH requirements and incentives are just getting underway, they are collecting primarily process data, such as how many patients are screened for social needs and how many are referred to social services. At the population level, these kinds of metrics may indicate whether SDOH interventions can reduce utilization and clinical care costs over time; however, they do not tell us whether patients are experiencing better health, or even if they successfully accessed the desired service. For example, a patient who screens positive for food insecurity may be referred to the partnering food bank, but when she arrives there the food bank is closed or has run out of food. If there is no way to track successful referrals to ensure that a patient actually accesses the service that was referred, then the process data do not tell us much.

"Closed loop" referrals, which track the outcomes of individuals referred to social services, facilitate more meaningful outcome data about the effectiveness of a social needs referral process.[44] But building a robust closed-loop referral process requires system change, from communication protocols among clinical and social service staff to more complex technology interoperability among clinical and service provider database systems, including (sometimes multiple) electronic medical record (EMR) platforms and case management systems.

Linked clinical and social service data can shine a spotlight on the inadequacy of the social safety net as well as on community-level social determinants and barriers to services, which may otherwise remain invisible. Some states and communities are actively working to centralize resource directories so as to streamline referrals and track referral outcomes in order to collect data on access to social services. For example, North Carolina has invested heavily in developing infrastructure to support coordination between health and social services

and to track outcomes. The state secured 1115 waiver authority to spend up to $650 million in Medicaid funds (federal and state) to create pilot projects aimed at addressing SDOH. Up to $100 million of this amount can be used for capacity building of regional entities charged with establishing and strengthening a network of social service providers. As part of this effort, North Carolina has invested in NCCARE360, "a statewide coordinated care network to electronically connect people with identified needs to community resources and allow for a feedback loop on the outcome of that connection," which will involve both public and private payers and will be a key element of the state's Medicaid managed care program.[45]

Policymakers interested in measuring population health outcomes linked to Medicaid ACO social-needs screening and social service partnerships will need to confront a range of systemic factors affecting how and what type of data is collected. Metrics should extend beyond screening and referral process data to those that track patient experiences and outcomes across health care and social service sectors. Assembling these metrics will, in turn, require state investment in resources that enable linkage of health care and social service system data.

Assessing Savings: Where and When Do They Accrue?

VBP is premised on returning investment to the health care system. In typical ACOs, the return on investment accrues to payers, and with shared savings, to providers. With increasing attention to the potential value of SDOH interventions, scholars and policymakers are exploring how to calculate return on investment. Although Medicaid ACOs that are integrating SDOH interventions are banking on reduced utilization and clinical costs, if they are truly successful in improving broader population health outcomes, savings are also likely to accrue to other systems, including the criminal justice, education, and child welfare systems. Indeed, better health can also render better social outcomes such as reduced untreated substance use disorders and mental health problems, or enhanced early childhood health and development. But the horizon on which these better social outcomes and reduced social spending depend is often distant and difficult to gauge. It also requires that multiple state agency officials sit at the table to develop more systemic approaches to tracking and targeting resources across systems.

Some Medicaid programs are working in close conjunction with other state agencies and community partners to collect data, adjust risk, coordinate access to services, and track savings across systems, not just to the Medicaid program. For example, Minnesota is using cross-agency data on child protection and public benefits, along with other non-Medicaid data, in conjunction with Medicaid enrollment and claims data to determine risk.[46] This type of integrated data collection not only moves the bar on understanding and accounting for the importance of SDOH in population health, but can also drive a broader "health in all policies" agenda at the state level and illuminate the gaps in the social service infrastructure that lead to poor health.

Policy Questions Arising from the Integration of Medical and Social Care

In addition to the practical and systems-related issues generated by marrying payment to SDOH interventions, Medicaid ACOs highlight some of the larger policy questions arising from the integration of medical and social care. Although not unique to Medicaid ACOs, these questions are important for state policymakers to consider as they venture into this new territory.

The "Bridge to Nowhere"?

Clinics are increasingly hiring community health workers and/or social workers tasked with connecting patients to community-based organizations to address social needs. As discussed earlier, Medicaid ACOs in states that include requirements for SDOH interventions are obligated to demonstrate partnerships with community-based organizations. As ACOs have begun to implement these interventions, they have had to confront the realities of a fragmented, underfunded social service system that often cannot meet demand. A prime example is the lack of safe, affordable housing in most communities.[47] Most states have long waiting lists for public and Section 8 housing.[48] As Loel Solomon, vice president of community health at Kaiser Permanente, said:

> We're putting a ton of energy into connecting our members to community-based providers that can address their social needs, but we can't build a bridge to nowhere. The social sector is incredibly fragmented, in many cases under-resourced, and so we need to have a variety of ways to support those organizations.[49]

For Medicaid ACOs, which are hoping for health care cost containment tied to SDOH screening and referrals, the "bridge to nowhere" could prove to be a significant barrier to success. The attention to SDOH has generated a trend among health care payers and systems of demonstrating the ways in which they are addressing social needs. But this trend raises the question, what is the appropriate role for the health care system in addressing unmet social needs? One could argue that shifting the cost of social services to health care makes perfect sense as the United States overspends on health care and underinvests in social care.[50] But medicalizing social needs also has costs. Shifting accountability for social risks to the health care sector will influence the delivery of social services, potentially redefining service delivery goals, strategies, and funding.

Medicalization of Social Needs

The recent movement toward integration of SDOH into clinical care is driving a great deal of discussion about the medicalization of social needs and debate about the appropriate role for the health care system in addressing social problems. Paula Lantz, associate dean for academic affairs and a professor of public policy at the Ford School of Public Policy at the University of Michigan, explains the potential pitfalls of medicalizing social problems:

> Medicalization provides medical professionals the primary authority to "diagnose" and "treat" what are ostensibly social problems within the boundaries of biomedical expertise and clinical practice. And, importantly, medicalization leads to a conflation of "health" and "health care," giving credence to the fallacy that societal problems having to do with health primarily need health care solutions.[51]

Despite widespread use of the term "social determinants of health" in health care reform initiatives (including Medicaid ACOs), there is a distinction between "health-related social needs," which are individual patient needs, and social determinants of health, which are upstream, structural factors that cannot be addressed at the individual patient level.[52] Medicaid ACOs—even those that integrate social care—are focused primarily on improving medical care and reducing health care costs rather than addressing upstream, structural determinants of health.[53]

On the other hand, using payment reform in Medicaid to nudge payers and providers toward patient-centered care that is responsive to health-related social needs is a positive development in health care policy and practice. Providers are on the frontlines: they are key witnesses to the downstream effects of ineffective social policy in the health of their patients every day. Health care staff, including community health workers and social workers, are important allies in identifying systems barriers and policy failures through the experiences of individual patients. The recent NASEM report acknowledges that partnerships between health and social service organizations can create a powerful voice for upstream policy change. As one of the five types of activities central to strengthening integration, it includes "[a]ctivities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs." [54] State policymakers should seek counsel from health and social care advocates to identify priority areas for investment in upstream services.

Nonetheless, the "bridge to nowhere" and medicalization of social problems elevate two critical concerns made even more apparent by Medicaid ACOs' strategy of marrying payment and SDOH: (1) What are the consequences of shifting the costs of social needs to health care payers (in this case, to Medicaid programs)? (2) How much risk and responsibility should providers bear for patient outcomes when confronting a fragmented and under-resourced social service system? The incentives in VBP models, such as ACOs, which are designed to account for return on investment, may ultimately undervalue social services. That is because "summing the benefits accrued only by the health care system delivers an incomplete accounting."[55] Funds that the state intends to dedicate to community-based organizations through health care partnerships may be in danger of never making it out of the health care system. Or, effective social service organizations may experience mission drift if they are beholden to their health care partners and health care system metrics. Funneling money through the health care system to eventually finance social services is an inefficient way to deliver those services; why not just pay for them directly?[56] Would it not be more efficient to move upstream to address the social determinants of health, not just catch them downstream as health-related social needs? Of course, shifting investment away from the health

care system (with all of its entrenched interests) toward more direct investment in social services requires significant political will and thoughtful planning. For now, the conversation seems to be landing in state Medicaid programs as they respond to rising health care costs and attempt to innovate within VBP models.

Conclusion

Given the attention now paid to SDOH in health care policy, it is likely that more states will explore ways to marry VBP to clinical interventions that identify and address social needs. As state policymakers shift responsibility for identifying and addressing social needs toward health care systems and providers, they have to support the infrastructure required to build clinic capacity and effective protocols. At the same time, policymakers must be strategic about aligning extremely fragmented health care and social service systems and collecting data in order to document the "bridge to nowhere." Tracking outcomes across systems like education and criminal justice—not just the health care system—will help policymakers to account fully for the savings and benefits of payment and delivery reforms.

When rolling out value-based payment tied to SDOH interventions, however, policymakers should not rely on these initiatives at the expense of upstream investments. Medicalizing social needs will do little to address the underlying structural deficiencies that are at the root of poor health and runaway health care costs. Utilizing data from Medicaid ACOs that are experimenting with SDOH interventions is one strategy for identifying social service system gaps and barriers experienced by patients on a daily basis. Ultimately, state policy and investments in services should be shaped by this information to move upstream to meet basic needs more efficiently and effectively in order to prevent the downstream social needs that become apparent at the clinic level.

Notes

[1] National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health.* Washington, DC: The National Academies Press; 2019. doi:10.17226/25467.

[2] Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep.* 2014;129(Suppl 2):19–31.

[3] Total Medicaid MCO enrollment. Henry J. Kaiser Family Foundation website. 2017. https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed March 15, 2020.

[4] Hinton E, Rudowitz R, Diaz M, Singer N. 10 Things to Know about Medicaid Managed Care. San Francisco, CA: Henry J. Kaiser Family Foundation; 2019. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/. Accessed March 15, 2020.

[5] State Innovation Models Initiative: general information. Center for Medicaid and Medicare Innovation website. https://innovation.cms.gov/initiatives/state-innovations/. Published 2019. Accessed June 22, 2019.

[6] Gates A, Rudowitz R, Guyer J. An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers. San Francisco, CA: Henry J. Kaiser Family Foundation; 2016. https://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/. Accessed June 22, 2019.

[7] Hinton E, Musumeci MB, Rudowitz R, Antonisse L, Hall C. Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers. The Henry J. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/. Published February 2019. Accessed June 22, 2019.

[8] Centers for Medicare and Medicaid Services. Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm. Accessed June 22, 2019.

[9] Machledt D. Addressing the Social Determinants of Health through Medicaid Managed Care. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicaid-managed. Published November 29, 2017. Accessed June 22, 2019.

[10] Ibid.

[11] Boozang P, Nabet B, Guyer J. Addressing Social Factors That Affect Health: Emerging Trends and Leading Edge Practices in Medicaid. Manatt Health. https://www.shvs.org/resource/addressing-social-factors-that-affect-health-emerging-trends-and-leading-edge-practices-in-medicaid/. Published April 2019. Accessed March 15, 2020.

[12] Medicaid Accountable Care Organization Learning Collaborative. Center for Health Care Strategies. https://www.chcs.org/project/medicaid-accountable-care-organization-learning-collaborative/. Published August 13, 2018. Accessed June 22, 2019.

[13] Matulis R, Lloyd J. The History, Evolution, and Future of Medicaid Accountable Care Organizations. Center for Health Care Strategies. www.chcs.org/media/ACO-Policy-Paper_022718.pdf. Published February 2018. Accessed June 23, 2019.

[14] Medicaid Accountable Care Organizations: State Update. Center for Health Care Strategies. www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf. Published February 2018. Accessed June 23, 2019.

[15] Romm I, Ajayi T. Weaving whole-person health throughout an accountable care framework: the social ACO. *Health Affairs Blog.* January 2017. https://www.healthaffairs.org/do/10.1377/hblog20170125.058419/full/. Accessed June 23, 2019.

[16] Seifert RW, Love KA. What to Know about ACOs: An Introduction to MassHealth Accountable Care Organizations. Blue Cross Blue Shield. https://bluecrossmafoundation.org/sites/default/files/download/publication/ACO_Primer_July2018_Final.pdf. Published July 2018. Accessed June 23, 2019.

[17] Matulis R. Prioritizing Social Determinants of Health in Medicaid ACO Programs: A Conversation with Two Pioneering States. Center for Health Care Strategies. https://www.chcs.org/prioritizing-social-determinants-health-medicaid-aco-programs-conversation-two-pioneering-states/. Published January 7, 2019. Accessed June 23, 2019.

[18] Ibid.

[19] Breslin E, Lambertino A. Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes. July 2017. https://www.healthmanagement.com/wp-content/uploads/SHVS_SocialDeterminants_HMA_July2017.pdf. Published September 2017. Accessed March 10, 2020.

[20] Evaluation of the Minnesota Accountable Health Model. University of Minnesota, School of Public Health. https://www.leg.state.mn.us/docs/2018/other/180336.pdf. Published September 2017. Accessed June 23, 2019.

[21] Characteristics of Social Prescribing Statements by Professional Medical Associations. SIREN. https://sirenetwork.ucsf.edu/PMAstatements. Published 2019. Accessed June 25, 2019.

[22] Ibid.

[23] Andermann A. Screening for Social Determinants of Health in Clinical Care: Moving from the Margins to the Mainstream. *Public Health Rev.* 2018;39(1). doi:10.1186/s40985-018-0094-7.

[24] Olsen D, Oldfield, B, et al. Standardizing social determinants of health assessments. *Health Affairs Blog.* March 2019. doi:10.1377/hblog20190311.823116.

[25] Ibid.

[26] Crumley D, Pierre-Wright M. Addressing Social Determinants of Health through Medicaid Accountable Care Organizations. Center for Health Care Strategies. https://www.chcs.org/addressing-social-determinants-health-medicaid-accountable-care-organizations/. Published January 7, 2019. Accessed June 25, 2019.

[27] Rhode Island Executive Office of Health and Human Services. 2017. EOHHS Medicaid Infrastructure Incentive Program: Attachment L 2: Requirements for Medicaid Certified Accountable Entities." September 29, 2017. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Attachment_L2_Incentive_Program_Requirements_final_092917.pdf. Accessed June 23, 2019.

[28] National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health.* Washington, DC: The National Academies Press; 2019. p. 93. doi:10.17226/25467.

[29] Ibid, p. 40.

[30] Jah A, Iliff A, Chaoui A, Defossez S, Bombaugh M, Miller Y. A Crisis in Health Care: A Call to Action on Physician Burnout. 2018. http://www.massmed.org/News-and-Publications/MMS-News-Releases/Physician-Burnout-Report-2018/. Massachusetts Medical Society. 2019. Accessed March 10, 2010

[31] Schickedanz A, Hamity C, Rogers A, Sharp AL, Jackson A. Clinician Experiences and Attitudes Regarding Screening for Social Determinants of Health in a Large Integrated Health System. *Med Care.* 2019;57:S197–S201.

[32] Marchis ED, Knox M, Hessler D, et al. Physician burnout and higher clinic capacity to address patients' social needs. *J Am Board Fam Med.* 2019;32(1):69–78. doi:10.3122/jabfm.2019.01.180104.

[33] Matulis R. It's Not Just Risk: Why the Shift to Value-Based Payment Is Also about Provider Flexibility. Center for Health Care Strategies. https://www.chcs.org/its-not-just-risk-why-the-shift-to-value-based-payment-is-also-about-provider-flexibility/. Published March 21, 2019. Accessed June 26, 2019.

[34] Houston R, McGinnis T. Program Design Considerations for Medicaid Accountable Care Organizations. Center for Health Care Strategies. http://www.chcs.org/media/Program-Design-Considerations-for-Medicaid-Accountable-Care-Organizations.pdf. Published February 2016. Accessed June 23, 2019.

[35] Matulis R, Lloyd J. The History, Evolution, and Future of Medicaid Accountable Care Organizations. Center for Health Care Strategies. www.chcs.org/media/ACO-Policy-Paper_022718.pdf. Published February 2018. Accessed June 23, 2019.

[36] Rutledge RI, Romaire MA, Hersey CL, Parish WJ, Kissam SM, Lloyd JT. Medicaid accountable care organizations in four states: Implementation and early impacts. *Milbank*. 2019;97(2):583–619. doi:10.1111/1468-0009.12386.

[37] Joynt Maddox KE. Financial incentives and vulnerable populations—will alternative payment models help or hurt? *N Eng J Med.* 2018; 378:977-979. doi:10.1056/NEJMp1715455..

[38] Ash AS, Mick EO, Ellis RP, Kiefe CI, Allison JJ, Clark MA. Social determinants of health in managed care payment formulas. *JAMA Intern Med.* 2017;177(10):1424–1430. doi:10.1001/jamainternmed.2017.3317.

[39] Breslin E, Lambertino A. Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes. Health Management Associates. July 2017. https://www.healthmanagement.com/wp-content/uploads/SHVS_SocialDeterminants_HMA_July2017.pdf. Accessed March 10, 2020.

[40] Ibid.

[41] National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health.* Washington, DC: The National Academies Press; 2019. p, 43. https://doi.org/10.17226/25467. Accessed March 10, 2020.

[42] Rutledge RI, Romaire MA, Hersey CL, Parish WJ, Kissam SM, Lloyd JT. Medicaid accountable care organizations in four states: Implementation and early impacts. *Milbank Quarterly*. 2019;97(2):583–619. doi:10.1111/1468-0009.12386.

[43] Wright BJ, Royal N, Broffman L, Li HF, Dulacki K. Oregon's coordinated care organization experiment: are members' experiences of care actually changing? *J Healthc Q.* 2019-41(4):-e38–e46.

[44] Boozang P, Nabet B, Guyer J. Emerging Trends for Addressing Social Factors in Medicaid. Manatt Health. https://www.manatt.com/Insights/White-Papers/2019/Emerging-Trends-for-Addressing-Social-Factors-in-M. Published April 12, 2019. Accessed June 26, 2019.

[45] National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health.* Washington, DC: The National Academies Press; 2019. p. 99-100. doi.org/10.17226/25467

[46] Breslin E, Lambertino A. Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes. Health Management Associates. July 2017. https://www.healthmanagement.com/wp-content/uploads/SHVS_SocialDeterminants_HMA_July2017.pdf. Accessed March 10, 2020.

[47] Taylor L. Housing and health: An overview of the literature. *Health Aff.* 2018. https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/. Accessed June 26, 2019.

[48] Semuels A. America's shame: How U.S. housing policy is failing the country's poor. *The Atlantic.* https://www.theatlantic.com/business/archive/2015/06/section-8-is-failing/396650/. Published July 13, 2015. Accessed June 26, 2019.

[49] Johnson SR. Hospitals Address Social Determinants of Health Through Community Cooperation and Partnerships. *Modern Healthcare.* https://www.modernhealthcare.com/article/20180602/TRANSFORMATION03/180609978/hospitals-address-social-determinants-of-health-through-community-cooperation-and-partnerships. Published June 2, 2018. Accessed June 26, 2019.

[50] Taylor L, Tan A, Coyle C, Curry L, Bradley E, Ndumele C, Rogan E, Canavan M, Curry L. Leveraging the social determinants of health: What works? *PLoS One.* 11(8): e0160217. doi:10.1371/journal.pone.0160217.

[51] Lantz PM. The medicalization of population health: Who will stay upstream? *Milbank.* 2019;97(March). https://www.milbank.org/quarterly/articles/the-medicalization-of-population-health-who-will-stay-upstream/. Accessed June 26, 2019.

[52] Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. *Health Affairs Blog*. January 2019. https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/. Accessed March 15, 2020.

[53] Jacobson PD, Parmet WE. Public Health and health care: Integration, disintegration, or eclipse. *J Law Med Ethics*. 2019;46(4):940–951.

[54] National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health.* Washington, DC: The National Academies Press; 2019. https://doi.org/10.17226/25467. Accessed March 10, 2020.

[55] Taylor L. How do we fund flourishing? Maybe not through health care. *Hastings Center Report*. 2018;48. doi:10.1002/hast.916.

[56] Ibid.

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