Creating a Seamless Accountable Health Community that addresses Food Security in DC

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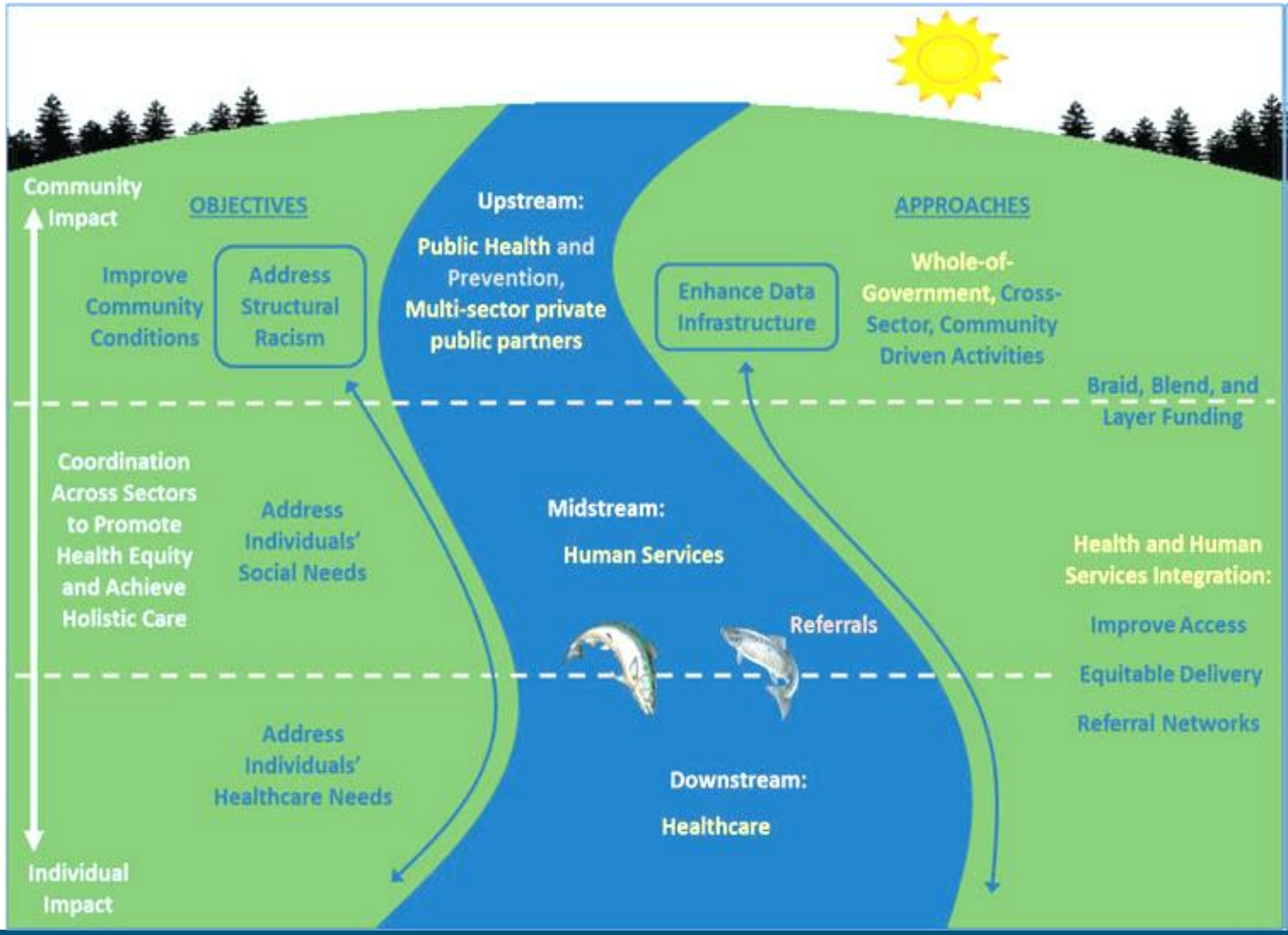
Upstream and Downstream Social Drivers of Health (SDOH)

- Some health-related social needs (HRSNs) must be addressed via services directly to individuals
  - Some are already being approved for federal financing via Medicaid waivers
- Other health-related social needs are best addressed via community structural interventions available to everyone



Elderly and Persons with Disabilities (EPD) Waiver: independent, supportive care at home

- Who is this program for?
  - DC residents aged 65+ or 18+ with a disability who can qualify for Medicaid, need assistance with activities of daily living like dressing, grooming, preparing meals and housing cleaning, and who would otherwise need to live in an assisted living community
- Services available may include:
  - Case Management,
  - Chore and Personal Care Aides or Participant-Directed Services (such as hiring an authorized rep/family member to provide services),
  - Environmental/Accessibility Adaptation,
  - Other Respite/Day/Therapy programs
- The EPD Waiver is part of the national Home & Community Based Services (HCBS) program in Medicaid, one of several waiver authorities allowing states to provide services that demonstrate comparable quality and superior cost effectiveness to institutionalization
  - States are authorized to use ‘savings’ from hypothetical institutional care to pay for HCBS services and keep the remainder
  - Expanding available services to home-delivered meals, nutritional supplements and medical nutrition therapy would be evaluated on similar lines

Medicaid Section 1115 Waiver and service-based investments

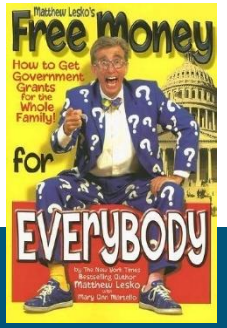
- What is it?
  - Section 1115 waivers provide states the broadest avenue possible to test new approaches in Medicaid, subject to strict evaluation for inclusion in benefit package
- Why is it important?
  - Biden administration has encouraged states to propose waivers that expand coverage, reduce disparities, and/or advance whole-person care, including by addressing health-related social needs (HRSNs)
- What could we do?
  - Fall 2022 approval of 1115 waivers in four states (AR, AZ, MA and OR) signals CMS support for new state HRSN model, followed by 2023 HRSN approvals in CA, WA, IL, and others in progress (NY) or using similar authorities (RI, NC), all of which are worth exploring for implementation in DC. Scope and eligibility can vary by focus, as well as implementation models varying by geographic health care market structures

Link: Kaiser Health News - Section 1115 Issue Brief

Link: Folder with CMS 1115 waiver approvals for selected states (maintained by DCPCA)

Common language among 2022 HRSN 1115 Waivers – Demonstration Scope

- HRSN services must be evidence-based, tying upstream service to preventing downstream health impact
- Medically appropriate for the beneficiary (not a blanket benefit for all)
- Evaluation hypotheses: "Broadening the availability of certain HRSN services is expected to promote coverage, access to and quality of care, improve health outcomes, reduce health disparities, and create long-term, more cost-effective alternatives or supplements to traditional medical services."
  - This set of criteria applies to inclusion of nutrition services in other waivers as well, such as the EPD waiver
- Provided states propose HRSN investment plans that meet this criteria, the federal government is just giving money away!*
  - *see terms and conditions (State Health & Value Strategy brief)



1115 Waiver Renewal is Opportunity to Expand Beyond Behavioral Health to Address the 'Whole Person'

Renewal broadens focus from behavioral health transformation to whole person transformation

Waiver Goals (Current)

- Increase Medicaid's service array to improve coverage of a broader continuum of behavioral health treatment for individuals with SMI/SED/SUD.
- Advance the District's goals for reducing opioid use, misuse, and deaths outlined in the District's Opioid Strategic Plan, Live.Long.DC.
- Support the District Medicaid program's movement toward a more integrated health care experience that facilitates coordinated treatment of behavioral and physical health needs.

Proposed Additional Waiver Renewal Goals to Achieve Whole Person Transformation

- Incorporate social care as an integral part of addressing the whole person
- Advance health equity and drive sustainable transformation
- Tailor programs to individuals and communities, resulting in improved access to care and services
- Implement effective technologies and solutions that expand data collection, improve reporting capabilities, and enable analysis to support person-centered decision-making

Recent CMS Guidance and State Approvals Provide New Opportunities for 1115 Waiver Renewal

Health-Related Social Needs (HRSN) Opportunities

Housing:

- Rent/temporary housing for up to 6 months, specifically for:
  - Individuals transitioning out of institutional care or congregate settings
  - Individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter
  - Youth transitioning out of the child welfare system including foster care
- Utility costs, including activation expenses and back payments to secure utilities, limited to individuals receiving rent/temporary housing benefits
- Pre-tenancy and tenancy sustaining services
- Housing transition navigation services
- One-time transition and moving costs
- Housing deposits to secure housing
- Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention
- Medically necessary home accessibility modifications and remediation services

Nutrition:

- Nutrition counseling and education
- Medically tailored meals, up to 3 meals a day, for up to 6 months
- Meals or pantry stocking, up to 3 meals a day, for up to 6 months
- Food prescriptions, for up to 6 months
- Cooking supplies

Case Management, Outreach, and Education:

Including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees

HRSN Infrastructure:

- Technology
- Development of business or operational practices
- Workforce development
- Outreach, education, and stakeholder convening

Justice-Involved Reentry:

Allows states to waive the "inmate exclusion" to provide a limited set of Medicaid services for up to a 90-day period prior to an individual's release from a state and/or local jail, prison, and/or youth correctional facility

2022 HRSN 1115 Waivers - Eligibility

Massachusetts	Oregon	Arkansas	Arizona
ACO-enrolled members age 0-64 who meet at least one health needs-based criteria: • Behavioral Health • Complex physical health needs • Assistance needed with one or more activities of daily living • Repeated ED use • Pregnant individuals and one social risk factor: • Experiencing homelessness • At risk of homelessness • At risk for nutritional deficiency/imbalance	**Populations eligible for HRSN services are experiencing major life transitions**. • youth with special health care needs (YSHCN); • adults and youth discharged from IMDs; • adults and youth released from incarceration; • youth involved in child welfare system; • individuals transitioning from Medicaid-only to dual eligibility status; • individuals who are homeless or at risk of becoming homeless; • and individuals with high-risk clinical needs residing in regions experiencing extreme weather events.	3 types of health homes are created for: • Rural individuals with SMI/SUD diagnosis, • Individuals with high-risk pregnancies/2 years postpartum, • and young adults at high risk for long term poverty	Enrollees who are homeless or at risk of becoming homeless and who meet at least one of a list of specified clinical and social risk criteria (e.g., SMI designation, high- cost high needs chronic health conditions or co-morbidities, or enrolled in AZ's Long Term Care System)

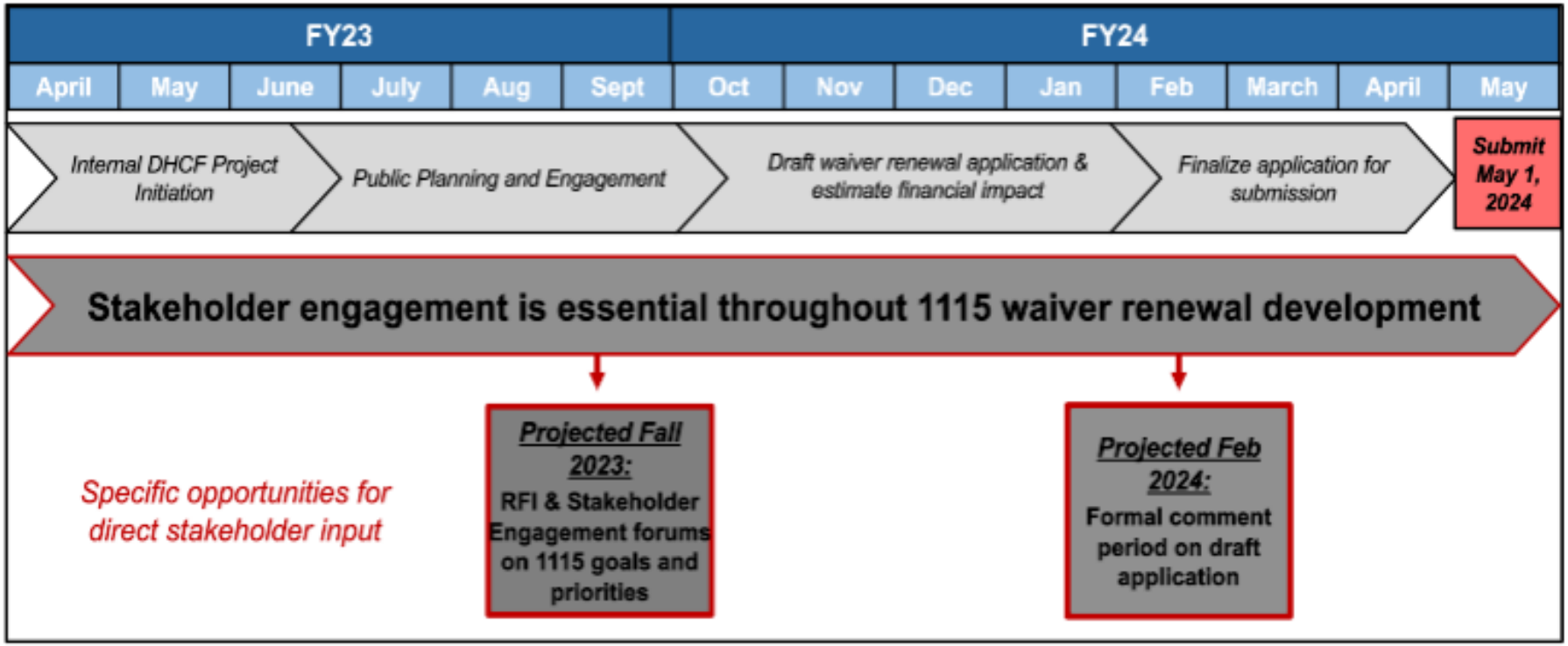
Another Example: California Enhanced Care Management

Who Is Eligible for ECM?

ECM is available to MCP Members who meet criteria for ECM "Populations of Focus" (POFs), which are launching in phases from January 2022 to January 2024.

	ECM Population of Focus	Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

DHCF's Proposed 1115 Waiver Renewal Workplan Reflects Commitment To Stakeholder Engagement



Kiszla, Jordan (DHCF)

Cautionary Note: individual interventions should be complementary to structural ones, not either/or

Medicaid for food draws mixed reviews

Ayurella Horn-Muller

"The bottom line: Medicaid funds used for food programs may bolster nutrition "in a way that's important, but [it's] not the same way as giving people their own purchasing power," Gilkesson tells Axios."

KFF Health News

DONATE

'Separate and Unequal': Critics Say Newsom's Pricey Medicaid Reforms Leave Most Patients Behind

By Angela Hart
OCTOBER 12, 2022

REPUBLISH THIS STORY

"CalAIM has the potential to dramatically improve the health of patients who are lucky enough to receive new benefits, Baackes said. But he isn't convinced it will save the health care system money and believes it will leave behind millions of other patients…"

HEALTH AFFAIRS FOREFRONT

RELATED TOPICS:
SOCIAL DETERMINANTS OF HEALTH | ACCESS TO CARE | COSTS AND SPENDING | SYSTEMS OF CARE

Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health

Brian C. Castrucci, John Auerbach

JANUARY 16, 2019 10.1377/forefront.20190115.234942

"We often discuss health using the metaphor of a stream, with upstream factors bringing downstream effects. Social needs interventions create a middle stream. They are further upstream than medical interventions, but not yet far enough. Social needs are the downstream manifestations of the impact of the social determinants of health on the community. Improvements in our nation's health can be achieved only when we have the commitment to move even further upstream to change the community conditions that make people sick. The demand for social needs interventions won't stop until the true root causes are addressed."

DC PACT BACKGROUND

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

DC PACT (Positive Accountable Community Transformation) is a Collective Impact coalition effort of community providers

PROBLEM DEFINITION	Racism and the lack of accountability, alignment and investment has led to inequitable social conditions, and inequitable health and well-being outcomes	VISION	DC functions as a seamless accountable health community that provides care and the social conditions for racial equity, health equity, and community well-being	MISSION	Build the movement to create a seamless accountable health community that achieves equitable individual and community well-being in the District of Columbia through community leadership, policy change, infrastructure development, and care improvement

DC P★A★C★T
POSITIVE ACCOUNTABLE COMMUNITY TRANSFORMATION

DC P★A★C★T
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DC P★A★C★T
POSITIVE ACCOUNTABLE COMMUNITY TRANSFORMATION

DC PACT Strategic Goals

#1: By December 2024, guide investment of health system resources to address social and structural determinants of health via Medicaid quality improvement and payment, social risk management, care model flexibility, community benefit, and/or Wellness Funds.

#2: By December 2024, implement DC PACT communication strategies to promote and sustain health system dialogue and action on the social determinants of health

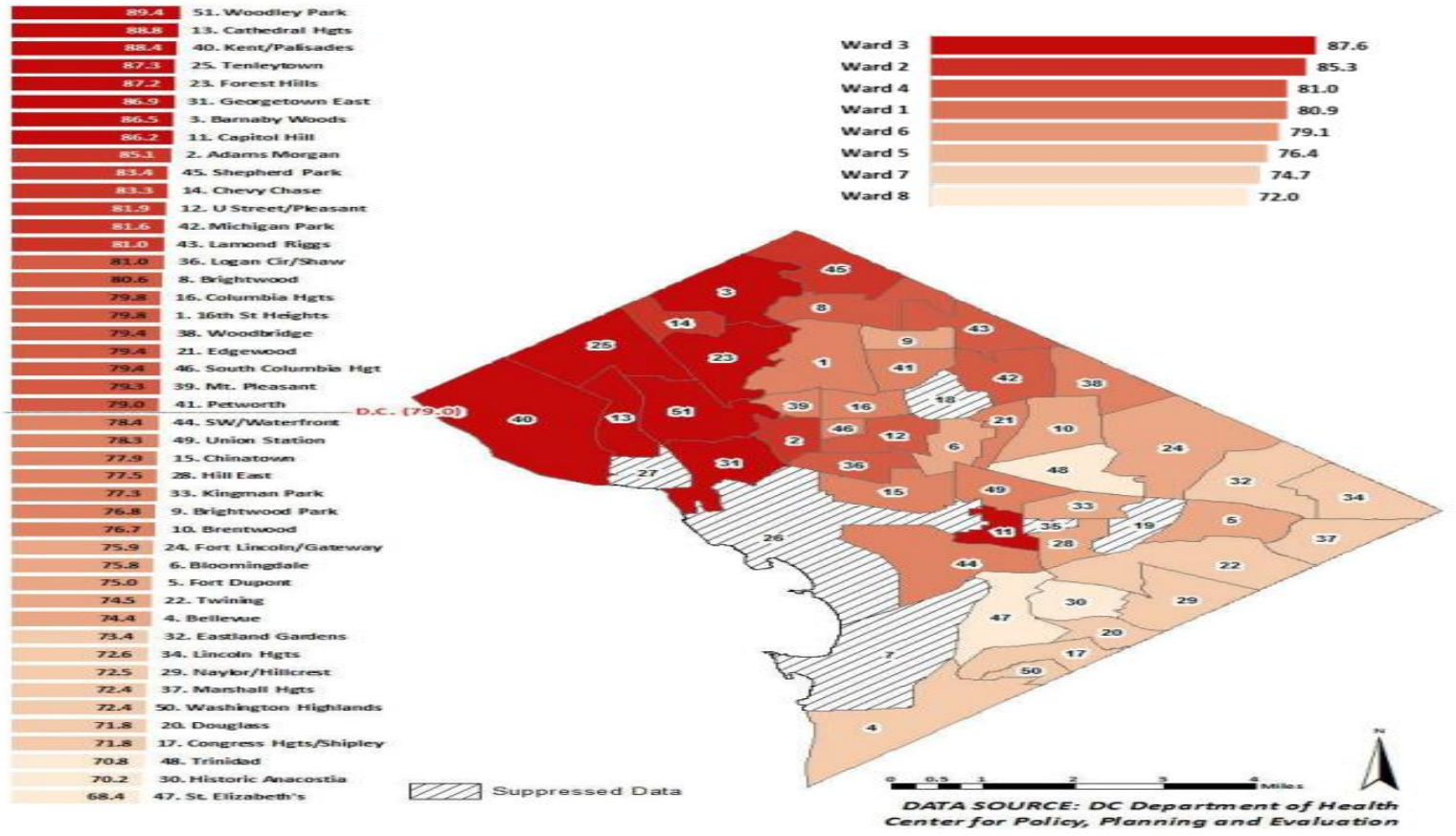
#3: By December 2024, ensure all relevant DC PACT partner staff are using DC HIE-connected technology solutions for social risk assessment and analytics, resource location, and care team coordination

#4: By December 2024, leverage citywide well-being assessment to drive health system accountability to community-defined progress measures on the social determinants of health

DC PACT Problem Definition Key Metric: Life Expectancy

POPULATION HEALTH OUTCOMES by Neighborhood Group

Figure 2: Life Expectancy at Birth (2011-2015) Years



The DC PACT origin story

Partners:
AmeriGroup DC
AmeriHealth Caritas DC
Bread for the City
Capital Area Food Bank
Capitol Hill Group Ministry
CareMore Health
Children's National Medical System
Children's Law Center
Community Connections
Community of Hope
DC Behavioral Health Association
DC Greens
DC Hospital Association
DC Primary Care Association
Family & Medical Counseling Services
Food & Friends
George Washington Hospital
Health Services for Children with Special Needs
Hillcrest Children & Family Center
Howard University Hospital
Institute for Public Health Innovation
La Clinica del Pueblo
Leadership Council for Healthy Communities
Mary's Center
MedStar Hospitals
Providence Health System
Regional Primary Care Association
So Others Might Eat
Trusted Health Plan
Unity Health
Vitas HealthCare
Whitman Walker Health

Government Partners:
Department of Behavioral Health
Department of Disability Services
Department of Energy & the Environment
Department of Health
Department of Health Care Finance
Department of Human Services
Interagency Council on Homelessness
Fire and Emergency Management Services

2016: Came together to apply for CMS's Accountable Health Community pilot project

2017: Commitment to work together without CMS support through Collective Impact Model

2018: Completed a Common Agenda to define where we are and begin engaging more broadly

2019: Received DHCF Community Resource Inventory and Exchange (CoRIE) planning grant

2020: CoRIE technical development phase commenced, led by CRISP and DCPCA

2021: Updated our Common Agenda again

2022: Completed baseline data collection in Ward 8 (over 1000 residents surveyed) for community well-being assessment to drive health system accountability to community-defined priorities on health and social equity

2023: Began Social Care working group to advocate for best practice health system investment in social and structural determinants of health