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Investing in Health: Seven Strategies for States Looking to Buy Health, Not Just Health Care

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Editor's Note: In a new issue brief supported by the Blue Shield of California Foundation and the Commonwealth Fund, Manatt Health—in partnership with The Health Initiative—presents strategies for how states can buy health, not just health care. The issue brief presents seven strategies for addressing drivers of health (DOH), defined as socioeconomic, environmental and behavioral factors (e.g., homelessness, food insecurity, exposure to intimate partner violence (IPV), adverse childhood experiences (ACEs), racism and discrimination) that impact health. Click here to download a free copy of the full issue brief. To download a free copy of our recently published Investing in Health: A Federal Action PlanInvesting in Health: A Federal Action Plan—outlining 44 specific federal policy changes for addressing DOH via Medicaid, Medicare, the Marketplace and the Center for Medicare and Medicaid Innovation (CMMI)—click here.

In the wake of a pandemic that has pummeled our public health and health care delivery systems, crippled the economy, and brought into stark relief long-standing racial inequities, states are faced with both the opportunity and the imperative to rethink their role in protecting and improving health.

A growing evidence base has established that addressing DOH can improve health outcomes and do so more cost-effectively and equitably than medical interventions alone. At the same time, focusing on traditional measures of value-based care without addressing DOH and health equity may exacerbate access barriers and worsen racial disparities.

Efforts to address DOH are growing—the Centers for Medicare & Medicaid Services (CMS) released new guidance in January 2021 to support state efforts to address DOH in Medicaid and the Children's Health Insurance Program (CHIP), and virtually all states in the nation include at least one requirement related to DOH in their Medicaid managed care contracts. Yet these and other efforts to address DOH remain diffuse, episodic and grossly underfunded, lacking clear expectations of the appropriate role of health care payors, providers and regulators. By making Investing in Health a central organizing principle, states can leverage their purchasing power, regulatory authority, interagency partnerships and bully pulpit to help change the paradigm of what the health system can and should achieve.

Seven Strategies for Integrating DOH Into State Health Care Systems

The following strategies can help states bring scalable, sustainable integration of DOH into their state health care systems. These strategies, which align with a recently published federal action plan, chart a path forward for states to Invest in Health.

1. Address DOH in combating COVID-19. DOH can create barriers to achieving successful isolation and quarantine, critical to containing disease spread. Lack of transportation or inability to take time off work can prevent those willing from receiving a vaccination. Multiple states (including Michigan, Oregon and North Carolina) have prioritized the use of federal relief funds or implemented Medicaid policy changes to provide for DOH-related supports—including housing supports and meal delivery—filling gaps in social supports as the economy flounders.

2. Integrate DOH into payment policy for providers and payors. States have a variety of tools to integrate DOH into payment policy for providers and payors, including DOH interventions as a Medicaid covered service, integrating DOH into care management requirements and quality incentives, and encouraging Medicaid managed care plans to provide value-added or in-lieu-of services that address DOH, among others. In addition, incorporating social risk factors into risk adjustment models can more accurately predict cost and utilization, enable better care for beneficiaries, and establish more precise cost benchmarks for advanced payment models. Select states have pursued risk adjustment models that include social risk factors: Massachusetts' Medicaid model includes data elements such as transportation, employment status and housing instability. Finally, incentivizing the use of ICD-10 Z-codes across payors will enable changes in provider reimbursement, support DOH data collection, inform future research on DOH impacts and strengthen the case for increased payment for DOH services as a value driver.

3. Develop shared assets and resources to enable interventions addressing DOH. Integration of DOH into the health care system requires new capabilities and tools and the engagement of a different kind of workforce to meet a more diverse set of health-related needs. States can avoid duplication of efforts and create momentum by creating shared assets and resources that can be supported and leveraged across payors and providers, including standardized screening tools, resource maps and common platforms for closed-loop referrals. Another high-value strategy is to support the development of networks of community-based organizations with the expertise and authentic community relationships required to help bring DOH interventions to scale. New Jersey recently created Regional Health Hubs with this purpose in mind, providing health care data infrastructure and analysis, supporting care management, and convening community stakeholders in close coordination with the state's Office of Medicaid Innovation. For the workforce, both Michigan and New Mexico require the use of community health workers (CHWs) as part of integrated care teams to support DOH interventions. Finally, states can leverage enhanced federal Medicaid funding to seed efforts to support standardized data exchange across health and human services providers.

4. Maximize participation in public programs that address DOH. Patients eligible for, but not enrolled in, the Supplemental Nutrition Assistance Program (SNAP) have higher health care costs than those enrolled. When states maximize enrollment in public programs—such as SNAP, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Low Income Home Energy Assistance Program (LIHEAP)—they reduce the DOH that lead to poorer health outcomes and higher health care costs. Cross-agency collaborations that streamline enrollment across health and human services programs, Medicaid managed care contract requirements that integrate screening and enrollment for public programs into care management responsibilities, and outreach efforts to support program participation are all tactics to invest in health.

5. Create new standards for DOH quality, utilization and outcomes measurement. States can build DOH into quality, utilization and outcomes measurement across Medicaid/CHIP. For example, states could leverage their Medicaid managed care contracts to integrate and prioritize DOH into the managed care quality measure set, criteria for quality initiatives and performance improvement plans, and through financial incentives such as withholds linked to process, utilization and/or costs outcomes. More broadly, states can begin incorporating DOH measurement into their state health assessment and improvement plans.

6. Make DOH central to states' innovation agendas. States can focus initially on a defined set of DOH domains and interventions that address the most prevalent individual and community DOH needs (especially in light of COVID-19), promote health equity, and have a strong track record for efficacy. Priority DOH interventions should have a strong or emerging evidence base for improved health outcomes and/or reduced costs and increased cost-effectiveness; be inclusive of populations disproportionately impacted by DOH; and allow for longer time horizons, as well as account for "wrong pocket" savings that might otherwise disincentivize investment. States could leverage the CMS-approved social service fee schedule developed in North Carolina for specific populations.

7. Incentivize community accountability and stewardship. States can work with their partners to create new expectations of health care providers and payors to address upstream DOH, including reducing wage differentials, addressing structural racism and contributing to multigenerational community wealth creation. For example, states can integrate expectations into Medicaid managed care contracts and supplemental payment arrangements for payors and providers to pay a healthy living wage. Several states currently incentivize Medicaid managed care organizations (MCOs) to make broader investments in community collaboration and development. Arizona requires MCOs to contribute 6 percent of their annual profits to community reinvestment and produce an annual Community Reinvestment Report. Beginning in 2021, Oregon's coordinated care organizations are required to participate in the Supporting Health for All through REinvestment (SHARE) initiative by reinvesting a portion of the prior year's excess net income or reserves to address DOH and health disparities.

Conclusion

To ensure this vision is sustained, states can build these seven strategies into annual objectives and multiyear strategic planning processes; create messaging to ensure the vision is disseminated and internalized within their agencies and among their partners; define specific goals around market and agency progress and provide transparent tracking against those goals; establish targeted work groups to foster interagency and public/private collaboration; and use the state's bully pulpit with providers, plans and patients to align the market around Investing in Health.