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

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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.

Over the past decade, policy makers and industry leaders have pursued significant changes in the way we deliver and pay for health care, moving away from incentivizing volume and high-cost interventions, and linking payment more closely to "value." Yet improvement in *health care* is not enough to improve *health*. An estimated 20 percent of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors—such as homelessness, food insecurity, exposure to intimate partner violence (IPV), adverse childhood experiences and racism—collectively referred to as *drivers of health (DOH)*.

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. Across race, class, politics and geography, voters agree that there is a need to invest in what we all need in order to be healthy—safe homes, healthy food, a stable income. The economic devastation of the pandemic and the stark racial inequities it has brought to the fore have broadened this consensus, creating new urgency and alignment among state and federal policy makers and a growing chorus of providers, payors and public health experts.

Efforts to address DOH are growing—the Centers for Medicare & Medicaid Services (CMS) recently released new guidance to support state efforts to address DOH in Medicaid and the Children's Health Insurance Program (CHIP), several states are offering food or housing supports to prevent the spread of COVID-19, 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. States control a large share of the health care spend within their geographic markets. On average, one in five people are covered under Medicaid—making up 16 percent of national health expenditures. States regulate health providers and payors, and control state employee health benefits and, in some states, marketplace coverage. Finally, states implement federal and state social service programs designed to ensure access to healthy foods, housing stability, community and personal safety, education and early childhood development programs, job training, and cash assistance. Aligning state health and social services goals is a first, significant step toward *Investing in Health*.

The following seven strategies can help states bring scalable, sustainable integration of DOH into their state health care systems—creating greater alignment of financial incentives, seeding shared assets and resources needed to identify and address DOH, and setting new expectations for health care providers and payors as anchor institutions in their communities and stewards of public funds. 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.** COVID-19 has laid bare the inextricable link between economic, social and environmental factors, health outcomes, and health equity. 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. As the country begins to emerge from the pandemic, states have an opportunity to ensure these investments are sustained.
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 to 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. The Minnesota Integrated Health Partnerships social risk adjustment methodology includes a set of social risk factor measures for children and for adults. 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. Additional examples include "lead entities" in the California Whole Person Care Pilots, Washington State's Accountable Communities of Health model and North Carolina's Lead Pilot Entities program. 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. *Investing in Health* also entails taking advantage of the federal option to expand eligibility in Medicaid and eliminating bureaucratic barriers that cause people to lose coverage, given that continuity of health coverage is a prerequisite to efforts to manage care and control costs and has well-documented positive impacts on the health of those enrolled.
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 are powerful laboratories for testing and learning, and DOH can be integral to their innovation efforts. To yield the greatest impact, states should 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. Working with their partners, states can identify DOH domains and interventions that are ready with appropriately aligned incentives and structural supports. 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 accounting 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. Over time, as experience and evidence grow, the number and diversity of priority domains and interventions can expand, with an eye to testing interventions addressing the unique needs of additional subpopulations and inclusive of a broader set of domains.

Table 1: Examples of High-Value Services Approved by CMS in North Carolina's 1115 Waiver

Housing Services	Food/Nutrition Services	Services to Address ACEs/Toxic Stress
• Housing navigation, support and sustaining services • Essential utility setup • Home remediation services • Short-term post-hospitalization housing • One-time payment for security deposit and first month's rent	• Food and nutrition access case management services • Evidence-based group nutrition classes • Healthy food boxes • Fruit and vegetable prescription • Medically tailored home-delivered meals	• Dyadic therapy • Evidence-based parenting curriculum • Home visiting services • Violence intervention services • IPV case management services

7. **Incentivize community accountability and stewardship.** Health care makes up nearly a fifth of our nation's economy—and health providers and payors are often among the largest employers in their communities. 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. Through its managed care contracting process, California requires an MCO serving Imperial County to make a per member per month payment into a local Wellness Fund intended to pool, manage and align funds from various sources (including from the California Accountable Communities for Health Initiative) to address community health priorities.

Each of the seven strategies above must be viewed through the lens of **health equity**. The link between racial disparities and DOH is clear and is only becoming more acute given COVID-19. The Affordable Care Act requires population health surveys in federal health programs, including Medicaid, to collect and report race, ethnicity, language and other data in order to understand and help reduce health and health care disparities. Nonetheless, recent studies confirm that Medicare, Medicaid and commercial plans have largely incomplete data on race and ethnicity, though some positive outliers exist. Requiring the collection, use and application of race and ethnicity data is essential to identifying and improving disparities.

Case Study: North Carolina

Recognizing the impacts of unmet health-related needs on health outcomes and costs, North Carolina has developed multiple shared assets to address DOH across all populations and payors while developing targeted requirements within Medicaid. These efforts have focused on four priority domains—food insecurity, housing instability, lack of transportation and intimate partner violence—based on evidence linking them to health outcomes. For example, intimate partner violence, experienced by 47 percent of North Carolina women, is linked to many long-term health problems, including mental health issues and poor maternal outcomes, and is a major cause of homelessness and housing instability among women. To identify and address these needs, North Carolina has developed a standardized screening tool; built a statewide coordinated care network to connect people with needs identified through screening with community resources; and created an interactive statewide map of DOH indicators to guide community investment. North Carolina will launch statewide managed care this summer and has built DOH requirements into the state's Medicaid managed care contracts. The state has also secured a Medicaid 1115 waiver allowing the creation of Healthy Opportunities Pilots, which provide select evidence-based, nonmedical interventions to Medicaid managed care enrollees. When COVID-19 hit, the state leveraged the statewide coordinated care network and the social service fee schedule developed for the pilots in order to provide supportive services for individuals isolating or quarantining due to COVID-19 and in need of food, relief payments or access to primary medical care to do so. This approach—often described as "buying health, not just health care"—has spurred broad support as an effective use of taxpayer dollars, galvanized private payors and physicians, and leveraged existing federal and state dollars to improve health.

Case Study: Indiana

Since 2017, Indiana's Family and Social Services Administration (FSSA) has committed to investing in health as a core element of its mission and operations. To this end, FSSA created a Healthy Opportunities office to drive integration across various state agencies impacting health, including the Departments of Transportation, Housing and Community Development, and Workforce Development. FSSA now screens all SNAP, Medicaid and Temporary Assistance for Needy Families (TANF) applicants for drivers of health (e.g., housing, food insecurity, utilities); this data is aggregated into the Hoosier Health & Well-Being Atlas, which state agencies and Indiana communities can use to identify and prioritize emerging social needs and target services to address those needs. To support Hoosiers with unmet social needs, FSSA has assumed responsibility for the statewide 211 community resource navigation system, reimbursed community health workers via Medicaid and committed to agencywide trauma-informed training. FSSA has also sought to mitigate the "cliff effect" for public eligibility programs through its Bridge program. Finally, it has also built requirements into the state's managed care contracts incentivizing plans to increase enrollment for SNAP-eligible members, with the goal of addressing members' food insecurity and reducing health care costs. These assets have played an essential role in enabling Indiana to tackle COVID-19's health and economic crises.

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*. At the same time, states should engage their federal partner, CMS, to leverage its regulatory authority and purchasing power as outlined in the federal action plan to support state efforts to *Invest in Health*.


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