

Date: September 16, 2020

To: Amy Katzen, Executive Office of Health & Human Services
Via E-Mail: Amy.Katzen.ctr@ohhs.ri.gov

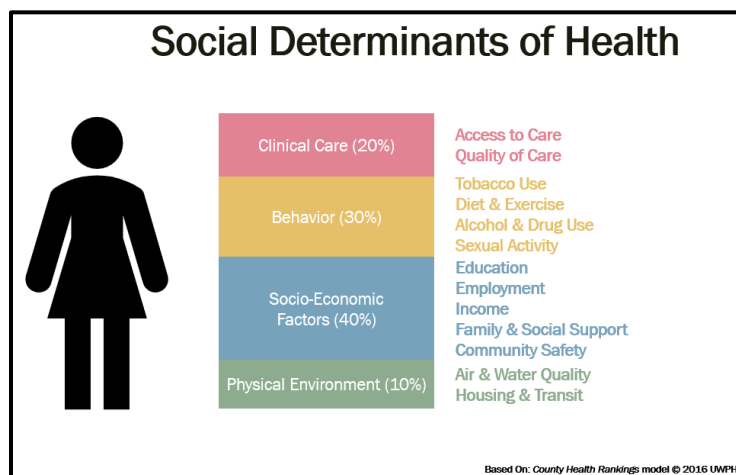
From: Garry Bliss, Program Director
PHSRI-AE

Re: HSTP Social Determinants of Health Investment Strategy Proposal

The following comments are provided in response to the HSTP Social Determinants of Health Investment Strategy Proposal ([LINK](#)) circulated and posted for public comment August 17, 2020.

To begin with, we commend EOHHS and Medicaid for their commitment to developing a robust policy and plan for addressing Social Determinants of Health (SDOH). As your document states, social determinants of health have a greater impact on individual health than clinical care.

Internally, the PHSRI-AE uses the following graphic to make this point:



The SDOH Strategy proposes five ways to encourage, support, and foster effective partnerships between AEs, CBOs, and the communities in which our patients live:

1. *Rhode to Equity – Midstream to Upstream*
2. *Sustain Community Health Teams – Midstream*
3. *Invest in IT Systems to Support Coordination: Community Information and Referral Platform (CIRP) – Midstream*
4. *Accountable Entity Engagement with Health Equity Zones – Upstream*
5. *Participatory Budgeting – Upstream*

(Page 8)

These strategies are informed by the following vision:

*Our vision for an HSTP social determinants of health investment strategy is to enable stakeholders **to address individual health-related social needs and address upstream social determinants of health and racial inequities.** [Emphasis added]*

(Page 1)

The document outlines the ways in which EOHHS and Rhode Island Department of Health (RIDOH) are investing in this vision.

EOHHS and RIDOH envision that HSTP investments in a social determinants of health strategy will generate:

- *Robust coordination between healthcare providers and community-based organizations so that both parties are well-equipped to collaboratively address individual health-related social needs; and*
- *Active engagement by health system participants in community-led processes focused on addressing upstream social determinants of health and inequities.*

(Page 3)

The strategies outlined by the SDOH plan seek to address health-related social needs on an individual, patient-level basis – how healthcare systems traditionally engage – as well as addressing the “underlying root causes of racial injustice and socio-economic disparities at the community level.”

Our comments below address this dual goal of EOHHS. We believe these recommendations will help EOHHS move closer to the truly ambitious goals set for the AE initiative.

Fundament Delivery and Payment Transformation is Necessary

While each of the individual elements of the SDOH strategy have tremendous merit, the fact remains that without a fundamental change away from the fragmented fee-for-service payment system we have today to a **population-based payment system**, the goals of the AE program – including the ambitious SDOH goals – cannot be achieved.

The COVID crisis has revealed many fundamental weaknesses in the current health care and social service system. In addition to highlighting health inequities and barriers to care experienced by the most vulnerable in society, this crisis has also demonstrated the ways that fee-for-service payment is fundamentally incompatible with population health goals. Providers have been severely restricted in their ability to meet the needs of their patients in the middle of a pandemic because they have been, largely, operating within a billing and coding system unsuited to the moment.

This should not be surprising. Fee-for-service was not effective in a pre-pandemic environment. COVID has only served to heighten our awareness of the shortcomings of the current financial and incentive structure.

The overall strategy proposed here continues to be built on a fee-for-service foundation when it is necessary to move to an **accountable, population-based payment system** (capitation) to accomplish the goals that are outlined in the plan and elsewhere.

And this system must be one where investment and activity are driven by goals centered around improving quality, achieving payment effectiveness, and addressing health-related social needs in the population being served by an accountable system of care, or Accountable Entity. To be clear, PCP capitation is not population-based payment and will not in any way fundamentally transform the accountability and cost structure for the AE systems of care in Rhode Island.

Additionally, it is important to acknowledge there are very real limits to what can be achieved in even the highest performing, integrated healthcare/community system of care under a population based

payment system without significant new government investments to address basic needs like housing and food insecurity.

Without a fundamental change in the payment system, there will never be sufficient resources for Accountable Entity systems of care to do what they can do directly, or in partnership with others, to serve their **population** under management and improve their outcomes both on clinical measures (which we have documented) and on SDOH measures, which have largely not been developed. Additionally, the AE systems of care will not have the operational flexibility they need. This is why transformation of the underlying accountability and payment system – aligned with the goals of the accountable entity initiative – is essential. This is the only way to achieve the significant reallocation of resources from medical services – too often high-cost, unnecessary and inefficient services – to interventions that will fundamentally improve population health—clinical, behavioral and socially determined – in an accountable way.

Therefore, we urge EOHHS to put provider accountability and payment system reform back at the top of the Medicaid transformation agenda and timeline, with the clear acknowledgement and understanding that real improvements in SDOH will need to be paid for within the current, increasingly constrained resource environment.

At the same time, launch the significant, necessary and meaningful work to identify and define the SDOH outcomes with as much specificity and detail as the clinical quality and provider efficiency outcomes for the AE systems of care so that there is a comprehensive and evolving set of outcomes required of the AEs.

And immediately implement an **accountable, population-based payment system** that will provide the resources to begin to achieve all of those outcomes. Without that fundamental component of health delivery and financing reform, achieving equitable access for all to healthcare, behavioral and SDOH services will remain a laudable destination without a definable pathway to get there.

Having outlined that context, we do believe that the elements of SDOH that EOHHS has outlined have individual merit and we will comment on them within that context.

The Benefits of an Intermediary

Developing a robust, statewide capacity for addressing social determinants of health will require all stakeholders to find new ways of working and of working together. The state's ambitious SDOH goals will be greatly enhanced by standing up or designating an intermediary. This intermediary could take on the essential task of developing the overall structure to coordinate the collaborative work of healthcare systems, healthcare providers, community-based organizations, payers, funders, government, and more.

The individual components in the draft strategy all have value but building a unified approach to SDOH will require an intermediary to align and coordinate these activities into something that will work across the state and across all social determinants.

For example, while the proposed AE/HEZ projects will pilot and improve how AE/HEZ collaboration, they will do so on specific projects. They will not, necessarily, result in a structure crossing all domains (housing, food, transportation, utilities, IPV, job training, care giver support, etc.). They will also be unique to the community in which each HEZ works, when what is needed is a way for effective partnerships across all communities in Rhode Island.

These projects can and should inform how to structure collaboration beyond these projects but bringing collaboration to scale will not occur naturally and would benefit from an organization charged with driving that kind of change.

Similarly, the Community Information and Referral Platform (CIRP) is a prerequisite for effective healthcare/CBO collaboration, but more than a referral platform is needed. A framework and structure for collaboration needs to be defined, created, and implemented.

An intermediary could take the lead on the following essential activities:

- Convening stakeholders to create a forum and process for collectively identifying and addressing challenges and opportunities – long-term, short-term, strategic, and operational.
- Setting standards for care/services – while recognizing that social services are not the same as medical services, procedures, etc.
- Creating standards for communication and information sharing that meet the needs of all stakeholders.
- Capacity building across the social service sector – with training and new resources.
- Capacity building and training for medical practices and providers
- Creating a consensus framework and process for transferring funds within an accountable healthcare/social service/community service ecosystem.

An intermediary has the advantage of being *the* stakeholder with the vested interest of developing the overall system that will make this work possible. The intermediary operates as a neutral third party, advancing the common goals while respecting the unique needs of individual stakeholders.

The United Way of Rhode Island is uniquely well-positioned to play this role, with experience as a convener of collaborations and a track-record of strong relationships with CBOs large and small as well as healthcare systems, payers, and the state. Additionally, the United Way has the experience of maintaining the only statewide database of CBOs and CBO programs, 2-1-1.

Given the fact success depends upon medical practices and providers changing the way they approach care, there could be a key role for the Care Transformation Collaborative (CTC-RI) which has experience advancing transformation/innovation at the practice – and health system – level.

An intermediary would also have greater procurement and contracting flexibility than the state, something very important when it comes to contracting for complex IT systems in a dynamic, rapidly changing field.

Enabling & Supporting Upstream Investments

The state's SDOH strategy draws an important distinction between "upstream" and "downstream" interventions.

Healthcare providers and CBOs can develop the most efficient SDOH screening and referral systems in the world, but without additional resources for expanded services and without upstream investment in things like housing, the state's goals will remain elusive.

The SDOH plan should include a leadership role for the state identify and advancing new funding – particularly funding that can address costly, large-scale upstream needs like housing.

This leadership role could be supported and facilitated by the intermediary discussed above. A robust intermediary could research, develop, and promote ways to increase investment in upstream solutions such as affordable housing, supportive housing, and housing development/rehabilitation projects with specific health-related goals.

With state leadership, and support from an intermediary, new investment mechanisms and/or payment models (i.e. pay-for-success/value-based payment) could be created to attract new resources such as healthcare system and payor funds in anticipation of TCOC savings, healthcare system and non-profit endowment funds in anticipation of an investment return, and social investors.

These resources could then be invested in community development corporations to create new housing – affordable, supportive, aging-in-place, etc. – tied to specific health care system transformation goals.

Again, this kind of complex, multi-sector partnership will not happen naturally. It needs to be actively promoted, and an intermediary could play that role supporting the advancement of the state’s goals.

Sustain Community Health Teams

We support the state’s decision to continue funding the Community Health Teams (CHTs). We believe that the CHTs, coupled with Community Health Worker (CHW) capacity within each AE, will help meet an array of needs, particularly those of the hardest-to-engage patients.

We urge all partners to find ways to ensure the activity of CHTs are tied to goals of improving quality, achieving payment effectiveness, and addressing health-related social needs in the population being served by an accountable system of care, or Accountable Entity.

This dual approach offers a good balance of providing a common service/benefit across all AEs through a proven outside resource (CTC-RI) while ensuring that each AE also has the “in-house” capacity to implement projects and address needs distinctive to that AE.

At the same time, we are concerned the sustainability plan is essentially grounded in the fee for service payment model. This contradicts the direction the state is working to drive the healthcare system. As we have stated before, we believe capitation holds the most promise for advancing innovative services like the CHT.

Rhode to Equity/AE-HEZ Collaboration

As stated above, we support this component of the plan and believe many worthwhile projects will develop from this.

However, it is likely the AEs will seek to work with a small number of HEZ. It is likely that most, if not all AEs, have a concentration of members in the same geographic areas.

There might be a role for the state to play coordinating AE/HEZ partnerships to ensure this project proceeds efficiently and effectively.

Community Information and Referral Platform (CIRP)

As state above, we believe that a CIRP is essential for a robust, high-functioning SDOH program uniting healthcare providers and community-based organizations.

Given how essential this platform/function will be, procuring and contracting for this might be best performed by an intermediary.

Additionally, given the ambitious goals this plan has for a statewide, multi-sector referral platform, any platform/partner should be one with experience offering a statewide, multi-sector platform.

The effectiveness of the CIRP will only be realized with the kind of fundamental payment reform we discuss at the opening of this memo. Without a change from the current model, this platform runs the risk of being a very high-functioning waiting list. Without new mechanisms for additional investment and resources, the CIRP will be reduced to identify need when what we want is to close needs.

Conclusion

We commend EOHHS for sharing this vision for comment.

We share your belief that it is essential for healthcare providers to identify and to address the health-related social needs of their patients. In short, social needs *are* healthcare needs. And, as stated above, we believe the individual components of this plan have great merit and will make a positive impact on the lives of AE members.

However, without fundamental reform of the payment system the ambitious goals we all share will not be realized. For that reason, we recommend that EOHHS put payment reform at the top of the SDOH and the AE agenda. An **accountable, population-based payment system** is the essential prerequisite for building a robust clinical/community system to address health-related social needs and meet the other goals of the AE program in quality and efficiency.