September 15, 2020

Amy Katzen
Executive Office of Health and Human Services
3 West Road, Virks Building
Cranston, RI 02920
Submitted via email: amy.katzen.ctr@ohhs.ri.gov

Re: HSTP Social Determinants of Health Investment Strategy Proposal

Dear Ms. Katzen,

UnitedHealthcare Community Plan of Rhode Island commends EOHHS on its commitment to further improving health outcomes, coordinating care and social services, and addressing social determinants of health (SDOH). The proposed Health System Transformation Project (HSTP) investments put EOHHS on a track towards building capacity and addressing SDOH to help its beneficiaries achieve healthier and more independent lives.

We value the State's commitment to stakeholder engagement and look forward to continued collaboration. Should you have any questions or seek further information about the feedback provided, please do not hesitate to contact me by phone or email.

Sincerely,

Patrice E. Cooper

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Chief Executive Officer, UnitedHealthcare Community Plan of Rhode Island
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Systems Approach

To address the upstream social determinants of health (SDOH) needs, the proposed Health System Transformation Project (HSTP) investments must go beyond health care at the provider level and take a systems-level approach. We encourage EOHHS to build out its investment strategy further and develop a framework that outlines the various state agencies they intend to coordinate with (i.e., public housing agencies) and expectations of these relationships. As different agencies have different priorities and goals, outlining expectations will be critical to getting stakeholder buy-in for coordinated care. For example, data sharing between key systems and Managed Care Organizations (MCOs) such as public housing agencies and Continuums of Care can help identify shared membership and improve organizational capacity and the ability to address SDOH. Also, EOHHS should consider convening a working group that includes AEs, MCOs, and any other agencies or organizations EOHHS intends to involve to leverage and integrate feedback fully.

Current HSTP funding will only scratch the surface of impacting SDOH. We request EOHHS provide additional guidance on how HSTP funds will be spread across the proposed initiatives, including how they will be split amongst Accountable Entities (AEs) and community-based organizations (CBOs), and how EOHHS intends to fund services long-term once HSTP funds are expended. We are concerned that the limited funding could be spread too thin to have any significant impact. We recommend EOHHS reexamine the proposal and focus on the most meaningful and impactful spread of funding, including limiting the number of funded initiatives.

SDOH Screening and Platform

Screening

EOHHS should work with members, AEs, CBOs, and MCOs to develop a standardized screening tool to capture priority SDOH elements such as housing, transportation, food insecurity, and interpersonal safety. Also, member preferences, including self-identified race and gender, primary language, preferred communication method, and other key factors, should be captured. EOHHS can require AEs, MCOs, and CBOs to use this screening tool to enable a shared understanding of a member's most critical social needs and individual care preferences. Improving SDOH data accessibility will allow for appropriate program coordination and linkages across an individual's whole experience. Targeting state resources to bring consistency to SDOH data collection and storage methods across social service programs and enabling the collection of enough information will allow testing interventions and predictive analytics to target individuals' limited resources based upon combined needs.

There are several standardized SDOH screening tools EOHHS can leverage. These include:

- PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences),
- Health Leads, and
- Accountable Health Communities (AHCs).

We welcome the opportunity to collaborate with EOHHS to identify which screening tool would work best for Rhode Island. Lessons learned from our work in Hawai'i with the Accountable Health Communities program, supported by a Center for Medicare and Medicaid Innovation (CMMI) grant,

will be valuable resources to support the state in developing screening tools and protocols to identify best and address the needs of our communities and families.

Platform

Many stakeholders have likely already made significant technology investments to link social and clinical data and may already use their SDOH platform and/or screening tool (e.g., PRAPARE). EOHHS must ensure that any implemented tools can to plug into existing infrastructure (e.g., CurrentCare) to reduce system redundancy for providers. Implementing a statewide platform, similar to North Carolina's NCCARE360[1], would allow EOHHS to connect to existing systems and would provide the ability to share critical care coordination data (i.e., screenings, assessments, and care plans). Through this connectedness and sharing of information, AEs and CBOs can use information from the platform and standardized screening to make connections to local community partners, enhancing their ability to address and mitigate identified social barriers. We recommend the system be designed to support direct payments to CBOs to allow for immediate functionality should EOHHS pursue that structure in the future. Mechanisms to directly pay CBOs for their services will enhance sustainability, simplify data collection for audits, and improve Medicaid beneficiaries' experience and outcomes.

NCCARE360 is a statewide public-private partnership between the North Carolina Department of Health and Human Services and the Foundation for Health Leadership and Innovation that gives CBOs the ability to simplify communication, referral processes, and payment by centralizing all data sharing through a single source. NCCARE360 uses a closed feedback loop to inform health plans, providers and CBOs that social services and supports have been provided to members. The platform also has the potential to allow for direct service payments to community-based organizations. It creates the IT infrastructure for data collection to build new alternate payment/ value-based payment models for social services and supports.

EOHHS will need a dedicated funding stream to support SDOH technology, CBO technical assistance, and network development. Opportunities to sustain current and future SDOH initiatives should be explored, including 1115 Demonstration waivers. Several states have created SDOH funding streams through new or existing 1115 waivers including:

- Tenancy Supports: Hawai'i, Minnesota, and Washington
- CBO Direct Payments for Services: North Carolina

Improved Capabilities/Long Term Sustainability

Through the development of both a standardized screen and a resource and referral platform, including data on "closing the loop" with CBOs that provide social services, EOHHS, MCOs, AEs, and CBO partners, can use this data, combined with clinical and utilization data, to identify priority areas or domains to support goals aimed at improving health and reducing disparities. At a member or population level, MCOs can use data to determine if members are being connected to and receiving services from local CBOs and its impact on health utilization. For example, if a child with asthma has a history of ED usage due to household asthma triggers, the State and MCOs can measure if mitigating household triggers have a demonstrative impact on health care utilization.

Ongoing evaluation should focus on the utilization and financing effectiveness of addressing the SDOH issue (in this example, mitigating household triggers). Data should be used to drive and

[1] NCCARE360. https://nccare360.org/

influence long-term financing structures and care delivery models. At a community level, this could include identifying areas where demand for services is disproportionate to local supply and developing coordinated and aligned investment strategies across AEs, CBOs, philanthropy and government to address these disparities. As this system continues to mature and evolve, new opportunities should be explored to broaden Medicaid's reach through the use of waivers to pay for an additional suite of non-clinical social services that lower health care costs by addressing and financing interventions tied to the state and local partners overall goals.

Managed Care Organization (MCO) Involvement

An MCOs case management team may be conducting similar or identical services as the CHTs. To limit any possible duplication of services and costs and enhance the effort, MCOs should be included in HSTP planning discussions and related initiatives from the onset. It is important for both entities to understand their respective membership and whether there is overlap. By fully understanding potential areas of overlap, MCOs and CHTs can identify which organization is best suited to perform overlap services and reduce duplication.

MCOs can offer experience from serving the Medicaid population for many years, insights from health and SDOH data, and learnings from similar initiatives conducted in other states. EOHHS indicated that "although managed care organizations... are not a required team member, they are encouraged to participate" in the Rhode to Equity investment. However, we view MCOs as being integral to community teams and SDOH investments. Moving the needle on community health is more likely when it is in synergy with clinical care and vice versa. MCOs collect data related to SDOH from various sources that would benefit the initiative, including enrollment files, ICD-10-CM Health Factors (Z Codes), health risk assessments and questionnaires, and information directly from members and/or providers. This data is critical to identify areas of concern that should be targeted to impact negative SDOH and associated disparities.

Operating Setup

Community Health Teams

Community health workers (CHWs) are an essential piece for providing coordinated care. We recognize the concern on the amount variation that currently exists among CHW programs in Rhode Island, including Community Health Teams (CHTs), but also see the value in this variation and diversity. We recommend that both MCOs and CHTs continue to have flexibility in their use of CHWs and should be encouraged to work together to share care management best practices to strengthen CHW capabilities and improve care coordination. Should EOHHS opt to streamline the CHW process, they must consider any changes in current CHW billing that are reflected in the MCO rate setting to ensure overall program sustainability.

EOHHS states that CHTs will only be funded partially through HSTP funds. We request clarification on how EOHHS intends to fully fund CHTs. Should multiple funding sources be brought in, EOHHS must develop a clear mechanism to hold programs accountable and track funding. Given potential areas for overlap and duplication, EOHHS should require CHTs to work with MCOs to help identify these areas across organizations to lessen the administrative burden on EOHHS, while improving care coordination and lowering overall costs.

Health Equity Zones

We welcome the opportunity to partner with health equity zones (HEZs) to promote and support the work we have seen thus far as they have a strong foundation to improve health outcomes. Still each HEZ has different motivations based on the specific needs of the community they serve. We are concerned that requiring AEs to work with one or more HEZ, combined with multiple HEZ priorities, could be administratively burdensome for AEs and inhibit HSTP initiative success. We recommend focusing HEZs on a select number of priorities, aligned with the Health in Rhode Island outcome measures already in place and selected based on HEZ collaboration and consensus.

Participatory Budgeting

We request clarity from EOHHS on how the participatory budgeting process will operate, including how members will be selected and can participate. While we agree that including the voice of the Medicaid beneficiary is critical, the process will only be successful if it includes a broad array of members. To ensure a broad spectrum of members are included and ensure the process is as authentic as possible, we recommend EOHHS work with CBOs, MCOs, and AEs to develop an operating procedure to ensure consistent member participation and authority.
To expand and amplify community involvement, we encourage EOHHS to consider how participatory budgeting projects could fit the broader HSTP initiatives.

Conclusion

We once again voice our appreciation for the opportunity to provide feedback on the HSTP Investment Strategy. We believe that finetuning and reducing the number of initiatives will allow EOHHS to be most successful. We also believe EOHHS should leverage the SDOH experience and lessons learned of MCOs for HSTP initiatives to best improve both health and social outcomes of Rhode Islanders. We look forward to continued collaboration with EOHHS and are happy to provide additional information or clarification on any of our comments.