NASDOH

SDOH-RELATED CMMI MODELS

NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

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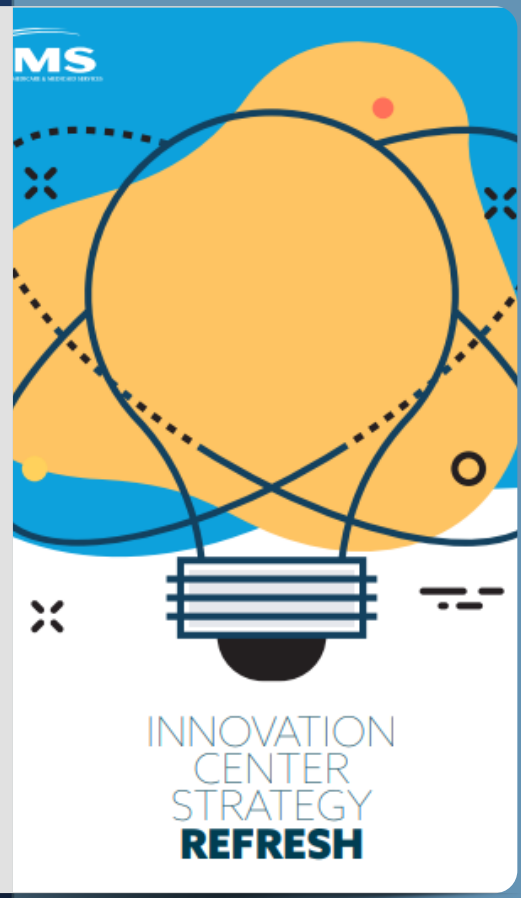
CMS Innovation Center Strategy Refresh



CMS Innovation Center Strategy Refresh (2022)

Source: INNOVATION CENTER STRATEGY REFRESH (cms.gov)

CMMI Strategy Refresh: Health Equity Objective

Innovation Center Strategic Objective 2: Advance Health Equity

Aim:
Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Measuring Progress:

- All new models will require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health. *
- All new models will include patients from historically underserved populations and safety net providers, such as community health centers and disproportionate share hospitals.
- Identify areas for reducing inequities at the population level, such as avoidable admissions, and set targets for reducing those inequities.

*Data would be collected in a manner in which PHI complies with HIPAA and other applicable laws.

Source: CMMI

CMMI Strategy Refresh: Health Equity Actions

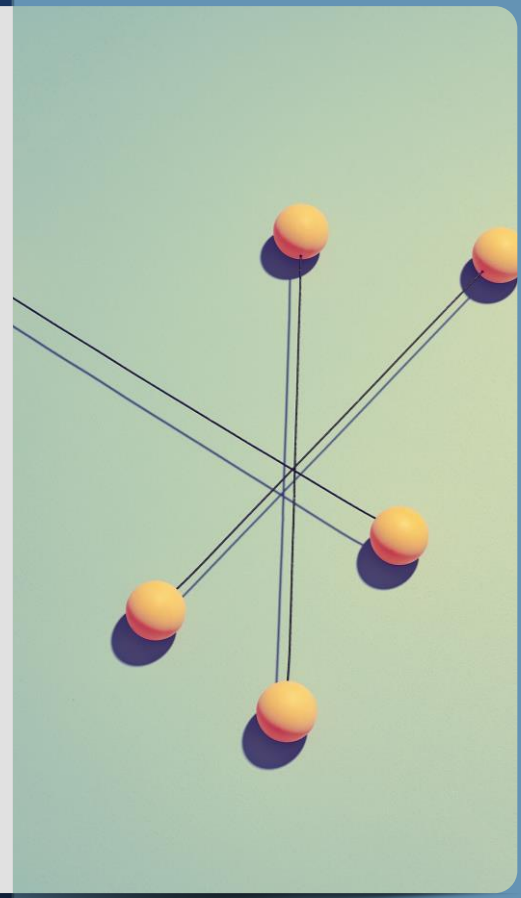
1. "Develop new models and modify existing models to address health equity *and social determinants of health*."

2. "Increase the number of beneficiaries from underserved communities that receive care through value-based payment models by increasing the participation of Medicare and Medicaid providers who serve them."

3. "Evaluate models specifically for their impact on health equity and share data and "lessons learned" to inform future work."

4. "Strengthen data collection and intersectional analyses for populations defined by demographic factors such as race, ethnicity, language, geography, and disability—in order to identify gaps in care and develop interventions to address them (in a manner that PHI complies with HIPAA and other applicable laws)."

SDOH-Related CMMI Models



Methodology

- NASDOH reviewed existing CMMI models and selected models that include a focus on addressing health-related social needs (HRSN) or SDOH.
  - Models that were selected generally included an intention in CMS' description of the model that participants will screen for and address HRSN, receive payments that are adjusted to reflect social risk, or connect beneficiaries to community services.
  - NASDOH did not review the activities of individual model participants to determine the extent to which participants are involved in SDOH-related activities beyond the model activities described by CMS.
- This slide deck is intended to be a resource for better understanding which CMMI models are focused on addressing HRSNs and SDOH, as well as how these models are carrying out this work. It is not intended to describe all of the work of CMMI model participants to address HRSNs and SDOH.
- If you have any questions about this resource, please reach out to NASDOH@LeavittPartners.com.

Overview of SDOH-Related CMMI Models

Model	Description	SDOH-Related Activities and Impact
Accountable Health Communities Model **Stage:** Not Active (Completed) **Participants**: Community Bridge organizations	Over a five-year period, the model provided support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their HRSNs: **Assistance Track** – Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services to address health-related social needs **Alignment Track** – Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of the beneficiaries	• **Screen** beneficiaries to determine unmet HRSNs and **refer** beneficiaries to community services. • Provide **navigation services** for high-risk beneficiaries to help access community services. • **Align clinical and community services** to assure availability and responsiveness to needs.
Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model **Stage:** Active (Performance Year 2023 Applications Closed) **Participants:** Providers (i.e., primary care physicians, specialty care physicians)	The model requires all participating ACOs to have a robust plan describing how they will meet the needs of people with Traditional Medicare in underserved communities and make measurable changes to address health disparities. Additionally, the model uses an innovative payment approach to better support care delivery and coordination for people in underserved communities.	• Trial an innovative payment method to **enhance care delivery and coordination** for underserved patients. • Create and execute a **health equity plan** targeting underserved communities, • Implement initiatives to **measurably decrease health disparities** within their beneficiaries.

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model **Stage:** Announced **Participants:** States, hospitals, and primary care practices	AHEAD will test state accountability for controlling overall growth in health care expenditures while increasing investment in primary care and improving population health outcomes within a participating state or region within a state. Through AHEAD, CMS aims to strengthen primary care, improve care coordination, and increase screening and referrals to community resources like housing and transportation to address social drivers of health.	• Requires participating states to **develop a Statewide Health Equity Plan**, and participating hospitals to **develop aligned hospital health equity plans**. • The hospital global budget and Primary Care AHEAD **payment methodologies adjust for social risk** and provide bonus eligibility for hospitals' performance improvement on disparity-focused measures. • **Increase demographic data collection and health-related social needs screenings**, subsequently addressing social needs via **connection to community resources**.
Maryland Total Cost of Care Model (TCOC) **Stage:** Active (Year 6) **Participants:** State of Maryland, certain Maryland hospitals, primary care practices, and Federally Qualified Health Centers	The Maryland TCOC Model sets a per capita limit on Medicare total cost of care by establishing the pricing of medical services provided by hospitals, primary care doctors and specialists across all payers. The model aims to incentivize greater coordination between health care providers, promote patient-centered care, improve the overall health of Marylanders, reduce avoidable hospital readmissions and emergency department visits, and improve the patient experience in health care settings.	• The Maryland Primary Care Program, a component of the Maryland TCOC Model, offers a "Health Equity Advancement Resource and Transformation (HEART)" payment to support participating primary care providers and federally qualified health centers in the delivery of **enhanced care management services** for socioeconomically disadvantaged and medically complex patients with high clinical risk, particularly in counties with elevated Area Deprivation Index (ADI) scores compared to other counties in the state.

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
Medicare Advantage Value-Based Insurance Design Model (MA VBP) **Stage:** Announced – Applications Under Review **Participants:** Medicare Advantage plans	The VBID Model allows MAOs to further target benefit design to enrollees based on chronic condition, socioeconomic characteristics and/or place of residence and/or incentivize the use of Part D prescription drug benefits through rewards and incentives. MAOs may also offer the Medicare hospice benefit to its enrollees as part of the VBID Model.	• Allows Medicare Advantage Organizations to further **target benefit design to enrollees based on chronic condition, socioeconomic characteristics** (i.e., Low Income Subsidy eligibility, dual eligibility, underserved area deprivation index). • Participating MA plans may provide patients with **tailored supplemental benefits** (e.g., lower costs for prescription drugs, grocery assistance, transportation services, support managing chronic health conditions), reduced copayments).
Making Care Primary (MCP) Model **Stage:** Announced – Applications Under Review **Participants:** Primary care organizations	The MCP Model will provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care. The model will attempt to strengthen coordination between patients' primary care clinicians, specialists, social service providers, and behavioral health clinicians,	• **Adjusts payments** by clinical indicators and **social risk**. • Requires **strategic plans** for the identification and reduction of disparities. • Allows **cost-sharing reductions** for patients in need. • CMS **measures** the percentage of **patients screened for HRSNs**. • CMS will **collect demographic data and HRSNs** to assess health disparities.

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
ACO Primary Care Flex Model **Stage:** Announced (Applications to be released Q2 2024) **Participants:** Accountable Care Organizations	The ACO Primary Care Flex Model (ACO PC Flex Model) is a voluntary model that will focus on primary care delivery in the Medicare Shared Savings Program (Shared Savings Program). It will test how prospective payments and increased funding for primary care in Accountable Care Organizations (ACOs) impact health outcomes, quality, and costs of care. The flexible payment design will empower participating ACOs and their primary care providers to use more innovative, team-based, person-centered and proactive approaches to care.	• **Increase access** to high-quality, primary care. • **Promote and incentivize equitable care** through the development of new ACOs, especially in underserved communities.
Community Health Access and Rural Transformation (CHART) Model **Stage:** Withdrawn (due to lack of hospital participation) **Participants:** Lead Organizations representing a rural community	Through the CHART Model, CMS aimed to continue addressing disparities by providing a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities.	• Use sustainable financial and reimbursement models to **promote the provision of additional services that address SDOH** such as food and housing.

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
Maternal Opioid Misuse (MOM) **Stage:** Active (Year 5) **Participants:** States	In addition to providing integrated physical and behavioral health, MOM Model programs provide care coordination, and other supports to alleviate common barriers to care such as: transportation, childcare, and stigma around seeking treatment for opioid use disorder.	• **Address issues of opioid use disorder**, a specific concern to underserved populations, in pregnant and postpartum Medicaid beneficiaries. • **Increase care coordination** and **integrate care delivery** of physical and behavior health care, as well as other critical services.
Transforming Maternal Health (TMaH) Model Stage: Announced (NOFO will be released Spring 2024; Applications will be due Summer 2024) **Participants:** State Medicaid Agencies	TMaH will support relationship building and education to help participating states address barriers that limit access to midwives, doulas, and perinatal Community Health Workers (CHW). Individuals will be screened during their initial prenatal visit to determine what, if any, additional supports they may need for health-related social needs, mental health, or substance use disorder. Based on their physical, social, and mental health needs, a care plan will be developed in collaboration with the mother.	• Partners with providers in high-need areas (e.g., Federally Qualified Health Centers, rural health centers) to **provide customized technical assistance**. ○ The technical assistance will focus on: (1) providers' **screening for HRSNs**, (2) **referrals** to community-based and social services, and (3) **monitoring** of how needs are addressed. • Participating states are required to **develop and implement a Health Equity Plan** with consideration for language support, access to transportation services, and addressing gaps in care.

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
Innovation in Behavioral Health (IBH) Model **Stage:** Announced (NOFO will be released Spring 2024; Model will launch Fall 2024) **Participants:** Practice participants (community-based behavioral health organizations and providers)	The Innovation in Behavioral Health (IBH) Model supports behavioral health practices to coordinate care across different types of providers to address Medicaid and Medicare patients' behavioral and physical health and health-related social needs. States selected to participate in the voluntary model are responsible for ensuring delivery of integrated care, with comprehensive care coordination and care management, to fully support an individual's care needs.	• Requires practice participants to **develop a Health Equity Plan**, with detailed steps on how they will address population needs and disparities. • **Require annual screenings and monitoring** of patients with HRSNs. • **Refer** patients to other providers or local safety-net services. • Require **care management** and ensure beneficiaries' HRSNs are addressed. • Invest in health IT to **enhance quality reporting and data sharing**.
Integrated Care for Kids (InCK) Model **Stage:** Active (Year 4) **Participants:** Lead organizations, State Medicaid Agencies, and partnership councils	The InCK Model is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs.	• "Early identification and treatment of children with multiple physical, behavioral, or other **health-related needs and risk factors** through **population-level engagement** in assessment and risk stratification. • **Integrated care coordination and case management** across physical health, behavioral health, and other local service providers for children with health needs impacting their functioning in their schools, communities, and homes. • Development of state-specific Alternative Payment Models to align payment with care quality and supporting accountability for improved child health outcomes and long-term health system sustainability."

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
Million Hearts: Cardiovascular Disease Risk Reduction Model **Stage:** Not Active (Completed) **Participants:** Primary care practices, specialty practices, health centers, and hospital outpatient departments	The Million Hearts®: CVD Risk Reduction Model proposed an innovative way of lowering CVD risks across the population. Currently, health care practitioners are paid to screen for blood pressure, cholesterol, or other risk factors individually. In a new approach, the Million Hearts® CVD Risk Reduction Model used data-driven, widely accepted predictive modeling approaches to generate individualized risk scores and mitigation plans for eligible Medicare fee-for-service beneficiaries.	• Systematically implement **risk calculation and stratification** for all Medicare FFS beneficiaries aged 40-79 years without previous history of heart attack, stroke, or transient ischemic attack, in hospice, or have End Stage Renal Disease. The risk calculator included variables such as age, race, and diabetes status. • Implemented interventions and policies utilizing **prevention and population health management** strategies.
Enhancing Oncology Model **Stage:** Active (Performance Period Year 1) **Participants:** BlueCross BlueShield of South Carolina, BlueCross BlueShield of Tennessee, CVS Health/Aetna	The EOM aims to drive transformation and improve care coordination in oncology care by preserving and enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service. Under EOM, participating oncology practices will take on financial and performance accountability for episodes of care surrounding systemic chemotherapy administration to patients with common cancer types.	• Requires participants to **collect sociodemographic information**. • Conduct **screenings for health-related social needs** among beneficiaries. • **Create health equity** plans to use data for ongoing quality improvement efforts.

Overview of SDOH-Related CMMI Models Cont.

Model	Description	SDOH-Related Activities and Impact
State Innovation Models (SIM) **Stage:** Round Two Test & Design Awards Chosen **Participants:** States	The State Innovation Models (SIM) initiative partnered with states to advance multi-payer health care payment and delivery system reform models. Each state-led model aimed to achieve better quality of care, lower costs, and improved health for the population of the participating states or territory. The initiative tested the ability of state governments to utilize policy and regulatory levers to accelerate health system transformation to meet these aims.	• Develop and **improve referral networks addressing social needs** for individuals at risk of diabetes. • Invest in a **standardized health risk assessment tool to identify SDOH**. • **Share data** for clinicians and patients to collaboratively **review and address social needs**.

CMMI Model Comparisons

Categorization

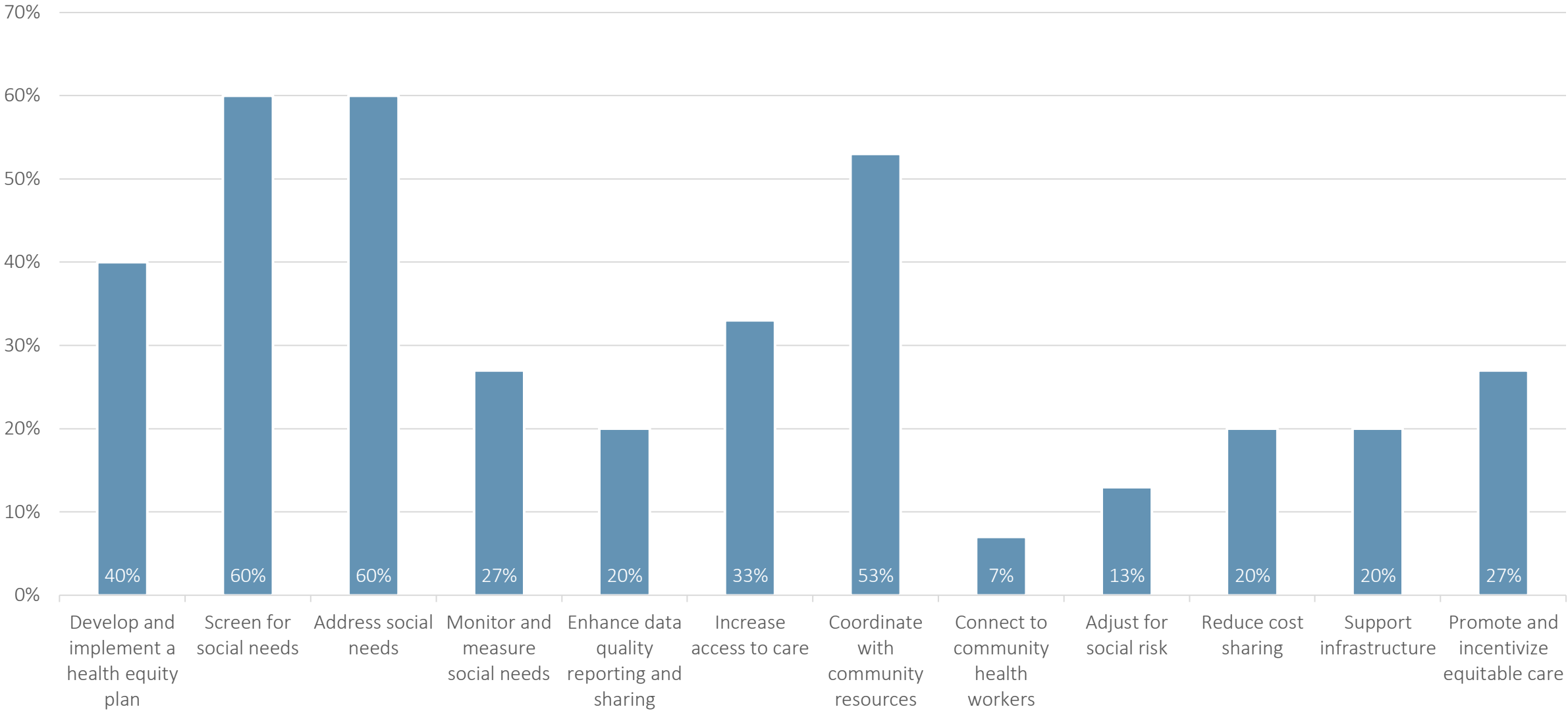
NASDOH categorized SDOH-related activities within CMMI models to facilitate comparisons. The following are the descriptions of each category NASDOH developed and used:

Activity	Description
Develop and implement a health equity plan	Establish and execute a comprehensive strategy aimed at eliminating health disparities and ensuring equitable access to care.
Screen for individual social needs	Assess and identify the specific social needs (e.g., housing, transportation, nutrition) affecting an individual.
Address social needs	Provide social care (e.g., housing, transportation, nutrition) to an individual.
Monitor and evaluate population social needs	Aggregate data (e.g., prevalence) on social needs affecting a group or population.
Enhance data quality reporting and sharing	Improve the accuracy and accessibility of data pertaining to social determinants.
Increase access to health care	Expand opportunities for individuals to receive timely and appropriate healthcare services.
Coordinate with community resources	Forge partnerships with local organizations and agencies to leverage community resources.
Connect to community health workers	Facilitate engagement with trained community health workers.
Adjust for social risk	Integrate social risk into payment methodology.
Reduce cost sharing	Implement policies or programs aimed at alleviating financial burdens.
Support social services infrastructure	Invest in the development and sustainability of robust social service networks.
Promote and incentivize equitable care	Implement incentives and rewards that encourage healthcare providers and organizations to prioritize equitable care delivery.

CMMI Model Comparisons — SDOH-related Activities

	Develop and implement a health equity plan	Screen for individual social needs	Address social needs	Monitor and evaluate population social needs	Enhance data quality reporting and sharing	Increase access to health care	Coordinate with community resources	Connect to community health workers	Adjust for social risk	Reduce cost sharing	Support social services infrastructure	Promote and incentivize equitable care
AHC		X	X				X				X	
ACO REACH	X	X	X	X			X					
AHEAD	X	X	X				X		X			
TCOC										X		X
MA VBP		X	X							X		X
MCP	X	X	X	X		X	X		X	X	X	
ACO PC Flex						X						X
CHART						X						
MOM						X	X					
TMaH	X	X	X				X	X				
IBH	X	X	X	X	X		X					
InCK		X	X			X	X					
Million Hearts												
EOM	X	X	X	X	X							X
SIM					X						X	

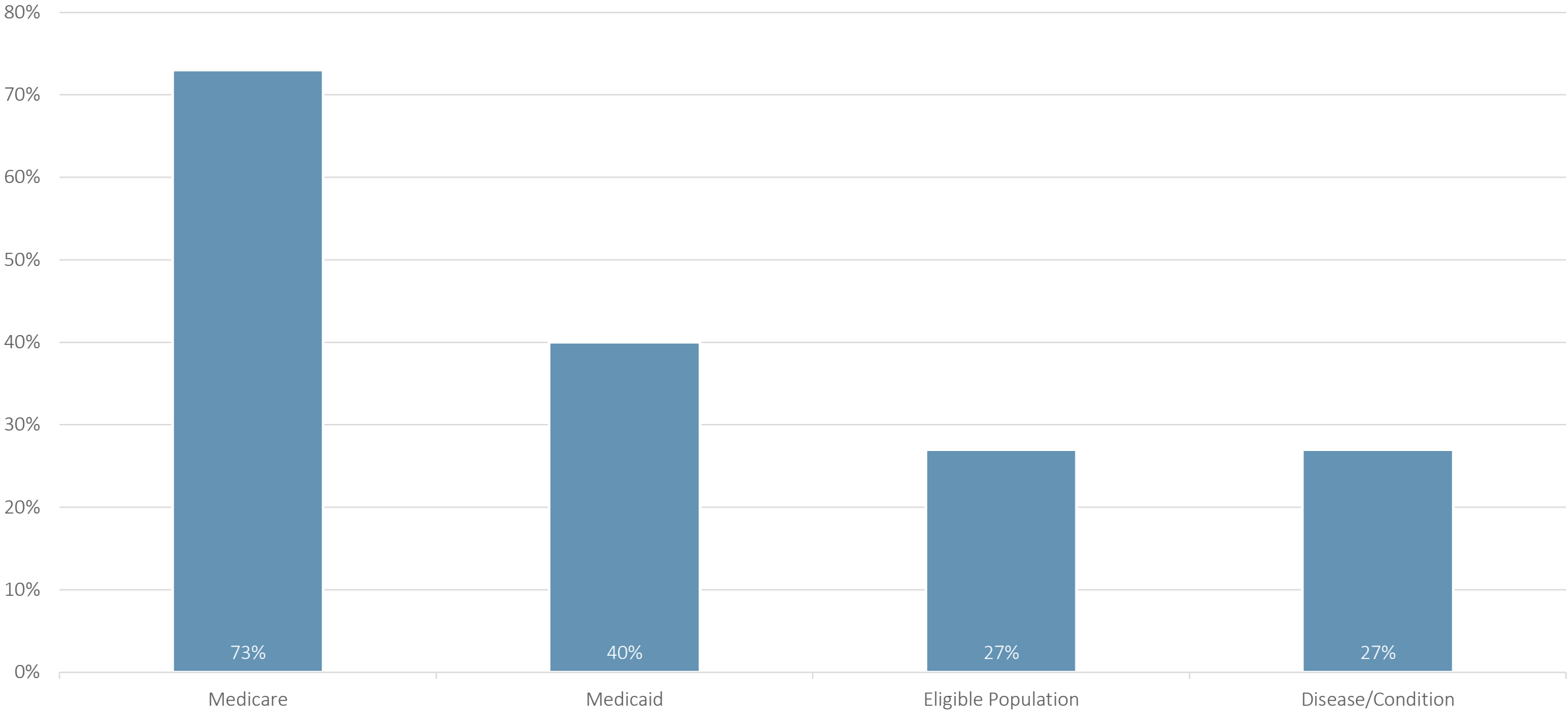
Percentage of Evaluated CMMI Models Utilizing Specific SDOH Components



CMMI Model Comparisons — Targeted Populations

	Medicare	Medicaid	Eligible Population	Disease/Condition
Accountable Health Communities	X	X		
ACO REACH	X			
AHEAD	X	X		
TCOC	X			
MA VBP	X			
MCP	X			
ACO PC Flex	X			
CHART			rural communities	
MOM		X	pregnant and postpartum Medicaid beneficiaries	opioid use disorder
TMaH		X	pregnant and postpartum women	
IBH	X	X		moderate to severe mental health conditions and substance use disorder
InCK		X	children under 21 years of age	
Million Hearts	X			Cardiovascular disease
EOM	X			cancer
SIM	X			

Percentage of Evaluated CMMI Models Targeting Specific Populations



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