



A State Policy Framework for Integrating Health and Social Services

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Abstract Recognizing that health is determined by a variety of interrelated factors, states are looking to connect health care, public health, and social services to help achieve improved population health, better care, and reduced cost of care. This issue brief describes three essential components for integrating health, including physical and behavioral health services and public health, and social services: 1) a coordinating mechanism, 2) quality measurement and data-sharing tools, and 3) aligned financing and payment. It also presents a five-step policy framework to help states move beyond isolated pilot efforts and establish the infrastructure necessary to support ongoing integration of health and social services, particularly for Medicaid beneficiaries.

OVERVIEW

Despite considerable obstacles associated with reengineering the nation's medically oriented health care system, Medicaid agencies are beginning to explore health delivery models that connect patients directly to community-based public health and social services. In doing so, they are looking to take advantage of both new and existing funding strategies and Medicaid policy options to promote more effective service linkages.

To help guide these efforts, this issue brief details three components necessary for an integrated system of health and social services:

1. A coordinating mechanism responsible for managing collaboration across services.
2. Quality measurement and data-sharing tools to track outcomes and exchange information.
3. Payment and financing methods that support and reward effective service integration.

Our five-step framework is intended to help states develop an implementation plan that addresses the infrastructure requirements, incentives, and decision-making authority needed to support health and social services integration. Elements of this brief were gleaned from state officials and health policy experts through interviews and group discussions.

BACKGROUND

There is growing recognition that social factors—such as individual behavior, socioeconomic status, and the physical environment—have a greater impact on health outcomes than medical care.¹ Nevertheless, most health care expenditures are for medical services. Further, the planning, financing, and delivery of health care, public health, and social services often occur in isolation. In response to this misalignment of resources, a new vision for integrating health and social services is emerging. Such a system would coordinate, finance, and assess a wide range of services that impact health, including social supports, housing, economic opportunities, education, public health, and community resources.

Federal and state-level policy environments appear favorable for integrating health and social services for many reasons: 1) the Affordable Care Act (ACA) extends Medicaid to millions of vulnerable individuals primed to benefit from integrated services; 2) the ACA's focus on delivery system and payment reform and the creation of the Center for Medicare and Medicaid Innovation has led to the spread of innovative care models like accountable care organizations (ACOs) that promote more coordinated, patient-centered care; and 3) providers are increasingly supportive of approaches that address patients' unmet social needs.² New efforts to integrate health and social services can draw lessons from existing programs that coordinate physical and behavioral health and social services.

However, policymakers must contend with some challenges. For example, states' health and social services programs often are fragmented because of federal financing streams, poor interagency communication, and insufficient IT capacity. There is also little evidence to support a positive return on investment (ROI) for integrating services.

ADVANCING HEALTH AND SOCIAL SERVICES INTEGRATION: PRINCIPLES FOR STATES AND PARTNERS

- Demonstrate a shared commitment to the integrated vision;
- Increase community accountability for population health outcomes that reflect physical, mental, and social well-being;
- Use financing strategies that foster accountability for outcomes; and
- Use population health data to track performance and refine incentive strategies.

ESSENTIAL COMPONENTS FOR INTEGRATING HEALTH AND SOCIAL SERVICES

State leaders can target planning efforts by focusing on three core components for integrating health and social services: a coordinating mechanism, quality measurement and data-sharing tools, and aligned financing and payment methods. States pursuing integration of health and social services will need to develop each of these components at the state, community, and provider levels (Exhibit 1).*

1. A Coordinating Mechanism

States can identify or develop a statewide “integrator” to assume responsibility for ensuring coordination and communication across state-level services. This coordinating entity—a state agency, task force, or nongovernmental organization—can engage partners, recommend policy and practice changes, promote information exchange, and assess data.³ Maryland's Office of Health Reform, for example, facilitates interagency collaboration on state health initiatives. California created a Health in All Policies Task Force, bringing together 19 state agencies to develop health improvement recommendations.

Coordinating mechanisms are also important at the community level. David Kindig, at the University of Wisconsin–Madison, developed the concept of a “health outcomes trust,” a local entity that receives financial incentives to coordinate services across organizations to address the social determinants of health.⁴ This entity could disseminate health data, establish shared goals and activities, and engage local residents.⁵ Prevention Institute, a national nonprofit,

* Note that this brief focuses on the state and community levels only.

Exhibit 1. Components to Support Health and Social Services Integration by Stakeholder

Level	Coordinating Mechanisms	Quality Measurement and Data-Sharing Tools	Financing and Payment Methods
State	Integrator agencies/entities Formalized interagency arrangements	Population health metrics Integrated claims database/analysis	Braided or blended agency financing Wellness trusts Multipayer coordination
	Health outcomes trusts Accountable care communities	Integrated population health/quality report cards	Communitywide global services payment Community benefit funds Global capitation
Provider	Accountable care organizations Medicaid health homes	E-referrals Integrated patient-level data-sharing	Bundled payments Shared savings Care management per-member per-month Global capitation

Source: Authors' analysis.

has proposed community-centered health homes, in which local health institutions serve as a coordinating entity for collaborative health improvement efforts, like building walking paths, improving food access, and minimizing environmental hazards.⁶ Community-based ACOs and newly emerging accountable care communities serve a coordinating function by taking responsibility for providing and paying for a range of services beyond medical care.⁷

2. Quality Measurement and Data-Sharing Tools

Efforts to meaningfully integrate health and social services should be supported by a robust set of tools to measure health outcomes and costs, as well as the capacity to share data, link services, and evaluate and improve programs.

Quality Measurement

It is important for states to choose metrics that reflect realistic quality and accountability goals, understanding that it may take years or decades to fully influence outcomes. Population health metrics could include: life expectancy from birth, condition-specific life expectancy changes, and self-reported levels of health.⁸ The Institute of Medicine (IOM) recommends establishing population health measures that are usable for assessing various populations, rigorous, and widely accepted.⁹

Some states are collecting and analyzing health data from sources outside clinical settings, then producing report cards on state or community health.¹⁰ For example, Maryland publishes outcomes on 39 health measures, such as healthy social environments and safe physical

STATE-BASED MODELS OF HEALTH AND SOCIAL SERVICES INTEGRATION

Minnesota's Hennepin Health: This health plan integrates health care, public health, community resources, behavioral health, and social services for high-risk, Medicaid-eligible adults. It is financed by an up-front payment for all Medicaid services, with blending of additional county-based social services funds.

Vermont's Support and Services at Home: This program combines supportive housing with medical services to help Medicare beneficiaries remain in their communities. It offers onsite nursing, care coordination, and supportive community activities. It is funded by a per-member per-month fee through a Medicare demonstration program.

Maryland's Health Enterprise Zones: Five geographic areas in Maryland with high health disparities rates receive state funding to test innovative, multisector programs. Examples include establishing a "health care transportation route" to address rural access barriers; a patient-centered medical home in a senior housing complex; and healthy living activities.

environments.¹¹ Connecticut created the Health Equity Index, a community-level electronic tool that measures the social, political, economic, and environmental conditions affecting health.¹²

Data-Sharing Systems

Up-front technology investments are needed to support integration efforts, accurately measure program impact, and inform future investment decisions. These include building an integrated data system and establishing the IT supports necessary for implementation. Ideally, such systems would facilitate cross-agency data-sharing and enable providers and community organizations to input and access patient- and population-level information.

State- and community-level data-sharing tools could include integrated claims databases that link and share information across payers, service sectors, and provider networks. One example is the Predictive Risk Intelligence System—known as PRISM—a decision-support tool developed by Washington State to support care management for high-risk Medicaid patients. PRISM integrates data from health and social services programs and creates patient risk scores, identifying consumers most in need of care coordination.

States also are supporting on-the-ground integration through two-way electronic referrals between providers and social service organizations. Massachusetts' e-referral system, for example, will connect a subset of community health centers with community resources such as tobacco quit lines, YMCAs, senior centers, and visiting nurse services.

3. Aligned Financing and Payment Methods

Sustaining a meaningful level of health and social services integration requires long-term financing sources and payment models with incentives to encourage ongoing integration.

Financing

The appropriate financing formula will depend on many variables and may shift over time. One option during an initiative's early phases is to apply for grant funding or seek state funds. Maryland helped secure \$4 million in the state's 2013 budget for Health Enterprise Zones by projecting a long-term ROI. States also could consider the social impact bond model, in which the state partners with private-sector investors to run small pilots, paying the investors only if the pilot achieves performance targets.

Massachusetts created the Prevention and Wellness Trust Fund, which is allocating almost \$60 million over four years to fund competitive, community-level grants for evidence-based prevention activities. Insurer and hospital assessments paid for the fund, which was the first of its kind.¹³ Another revenue-raising option is to use a small percentage of

COMMUNITY-LEVEL INTEGRATION EFFORTS

The Oregon Health Authority (OHA) is implementing **coordinated care organizations** (CCOs) to assume responsibility for the cost and quality of physical, behavioral, oral, and nontraditional health services. "Innovator agents" coordinate between CCOs and OHA, relaying state-level data to local CCOs and practice-level information about health improvement strategies to OHA.

The **Camden Coalition of Health Care Providers**, as part of its community-based ACO, engages with representatives from local public health, housing, and transportation agencies to facilitate coordination at both the patient and the community level to better serve high-need patients in Camden, New Jersey.

Maryland has created **local health improvement coalitions** to monitor community and population health, identify and respond to hot spots of health needs, and create local plans for health improvement. These coalitions engage a diverse range of stakeholders, including individuals working in housing, education, corrections, and business.

Nemours Health and Prevention Services convenes partners from multiple agencies in Delaware, such as health, education, and child care, to achieve shared children's health goals. Nemours and its partners work to make and sustain policy and practice changes that create healthy environments.

insurance premiums, as Vermont currently does to fund health IT efforts. States also could require nonprofit hospitals to allocate a portion of their community benefits spending to population health improvement.¹⁴

Blended or braided financing—often used in early childhood programs—are strategies for pooling money from different sectors. Blended funding involves commingling funds from different sources into one pot to draw down dollars as needed; costs do not have to be allocated and tracked by funding source. Braided funding coordinates multiple, distinct funding streams to pay for a service package; tracking and accountability for each stream is maintained at the administrative level.

Finally, given that state Medicaid agencies would save money if integrated programs result in improved health, states may examine ways to use these savings to fund nonmedical care. Some states already have been successful at obtaining waivers to use Medicaid dollars to pay for nontraditional health workers, nonmedical services, and local initiatives.¹⁵

Payment

States could reallocate a portion of social services and public health funding and include a “population health” payment to cover nonmedical services in Medicaid managed care capitation rates. Alternatively, capitation payments could be made directly to a fully integrated multipayer entity that purchases health and nonhealth services for patients.

States also could bundle payments to cover clinical, public health, and social services specific to a population. Payers can draw on lessons from how states used Medicaid funding to cover nonmedical services that address children’s needs. For example, Massachusetts Medicaid is running a pediatric asthma bundled payment pilot program that provides nontraditional services and supplies (e.g., mattresses, vacuums, and air conditioners) to mitigate environmental triggers.¹⁶

States also may consider promoting community- or provider-level budgeting or shared-savings approaches. For example, community health budgets could include a blend of public health, Medicaid, and social services funds. Within those budgets, a population-level shared-savings model could distribute savings to entities that contribute to population health improvements.

IMPLEMENTATION PLANNING FRAMEWORK

With the three core program components in mind, states can develop a strategic plan for integration of health and social services. Five key planning steps include:

Step 1: Establish goals. States can create measurable goals based on their current needs, circumstances, and priorities. They can look to existing resources for insights about the types of goals to pursue (see box: Sources to Inform Program Design). States may consider different goals for different patient populations across a spectrum of complexity.

Step 2: Identify gaps and opportunities. States can determine the types of health and social services integration they wish to pursue by identifying current gaps and opportunities. Local governments and consumer organizations can be

SOURCES TO INFORM PROGRAM DESIGN

- Existing [state health improvement plans](#)
- Community health needs assessments and state or communitywide evaluations of the impact of social service, public health, and clinical interventions on health and health care outcomes
- Financial or ROI analysis for statewide or community integration interventions
- The Kaiser Family Foundation’s State Health Facts data
- The National Prevention Strategy and Healthy People 2020 goals
- The Institute of Medicine’s Community Health Development Process
- Proposals for and assessments of payment, delivery reform, and quality improvement initiatives, including the Centers for Medicare and Medicaid Services’ (CMS) Center for Medicare and Medicaid Innovation State Innovation Models Initiative, CMS Health Care Innovation Awards, CMS State Demonstrations to Integrate Care for Dual Eligible Individuals, and the Robert Wood Johnson Foundation’s Aligning Forces for Quality and Roadmaps to Health Community Grants

helpful in identifying areas where needs are not being met. In some cases, communities may be resource-rich but ineffective in linking neighborhoods, patients, and providers to resources. States also can identify existing investments that may be reallocated to support integrated care delivery goals.

Step 3: Prioritize opportunities for integration. States can prioritize efforts based on: opportunities that project a positive ROI, existing strengths, and input from stakeholders. Many experts suggest using an asset-based approach to choosing priorities, which takes a community's unique strengths and resources into consideration.¹⁷ Finally, states may consider pursuing a balanced portfolio of short- and long-term interventions and a range of partnering organizations and population targets.¹⁸

Step 4: Establish an implementation roadmap. An implementation roadmap can guide near- and long-term planning activities and highlight policy considerations. A roadmap would include a developmental stage to pilot new ideas (Phase 1); an expansion stage (Phase 2); and an operational stage (Phase 3) (Exhibit 2).

Exhibit 2. Roadmap for Phased Integration of Health and Social Services: Potential State Activities

	Phase 1 Pilot	Phase 2 Expansion	Phase 3 Fully Operational
Coordination Mechanism	<ul style="list-style-type: none"> • Fund community based pilots • Create state level interagency integration task force 	<ul style="list-style-type: none"> • Choose and staff community entities to lead integration 	<ul style="list-style-type: none"> • Implement statewide community based integrator agencies
Quality Measurement/ Data-Sharing	<ul style="list-style-type: none"> • Fund evaluations • Develop new metrics task force 	<ul style="list-style-type: none"> • Test data sharing and tracking pilots 	<ul style="list-style-type: none"> • Create statewide integrated data exchange
Financing/ Payment	<ul style="list-style-type: none"> • Provide innovation grants • Test payment demonstrations 	<ul style="list-style-type: none"> • Use simplified financing and payment policies 	<ul style="list-style-type: none"> • Implement performance based payments and blended financing

Step 5: Create a measurement strategy. A robust measurement strategy will include key metrics that link outcomes and goals and promote accountability. Assessing the ROI for integration also will be an important objective. Although few tools exist to quantify the returns associated with full health and social services integration, states can begin to think about how to identify, assess, and measure these results.¹⁹

CONCLUSION

While barriers exist for integrating community-based services and health care delivery, states have many policy, financing, and regulatory opportunities available. It is an opportune time for states to work with the federal government, local organizations, and health care professionals to establish meaningful integration of physical and behavioral health, public health, and social services to meet the Medicaid population's complex circumstances and needs.

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