Making Sense of Social Care Referrals: States Role in Herding the Cats

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Value-Based Care Adoption in Maryland



Maryland Total Cost of Care Model

- Partnership between CMS and the State of Maryland
- Geographic Risk-Based Payment Model impacting Hospitals in Maryland
- Hospitals take risk for the total cost of care for a patient risk pool, aligned with their geographic market reach
- Hospitals receive a fixed population-based payment, which creates incentives to reduce utilization and readmissions

Maryland Primary Care Program

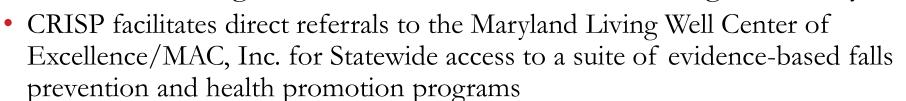
- Program incentivizes primary care providers to offer advanced primary care
- Participants receive an additional per beneficiary per month payment to cover advanced care management
- Performance-based incentive payment to incentivize reductions in hospitalizations
- Track 2 Participants must screen and refer for SDOH interventions



Efforts to address SDOH



- Maryland Primary Care Program Track 2 Participants
 - Must demonstrate adoption of advanced Health Information Technology capabilities and perform advanced care management services
 - Facilitate access to resources that are available in the community for beneficiaries with identified health-related social needs
 - Ensure coordinated referral management for attributed beneficiaries
- CRISP: State Designated Health Information Exchange for Maryland



• CRISP facilitates direct referrals to the Central Foodbank of Maryland to address Food Insecurity





Innovation in Aligning Health Care and Social Services



Maryland Statewide ADRC Network: Maryland Access Points

- Gateway to Long-term Services and Supports and Medicaid Waiver
- Money Follows the Person to support nursing home transitions
- Medicaid Administrative Claiming to support enrollment of Dual-Eligible beneficiaries into one or more Medicaid Waiver programs to reduce utilization of Institutional care

Power of Joining Forces

- Plan: Maryland Access Points will directly integrate with Hospital Discharge planners
- CRISP HIE segments the hospital patient population of admitted Duals
- CRISP exchanges referrals, for dual-eligible beneficiaries at-risk of nursing home placement, with the local ADRC/AAA
- Early intervention to expedite enrollment in a Medicaid Waiver or Money Follows the Person program
- Combined Goal: SNF Diversion and Reduced SNF Length of Stay achieved by Early Implementation of Medicaid-Funded LTSS, prior to hospital discharge
- Innovation: Rapid implementation of Waiver LTSS to achieve SNF Diversion and reduce long-term care expenditures for Duals that are high-risk for long-term nursing home placement

HEALTH IS FREEDOM

Key Differences Between Health and Social Service Data

Healthcare Data	Social Service Data
Common Funding Sources / Billing	Diversity of Funding Sources
Clinically-Centered Interventions	Person and Community Centered
Largely Mature Data Systems	Scattered Data / Data Systems
Interoperability Push / FHIR	Interoperability? (Few Standards)
Robust Communities of Practice	Data Often as Burden / Afterthought

Missouri Aging Services Data Collaborative



Community-Based Organizations (CBOs) / Home and Community Based Services (HCBS)

