Outstanding Design Element 1: Social Determinants of Health (DRAFT)

TASK FORCE FINDINGS AND PROPOSED DRAFT RECOMMENDATION

Unlike the other Outstanding Design Elements prioritized by the Task Force in the extension, SDOH/SDOH-E are not required to be addressed by SB 770. However, the Task Force understands that it occupies a unique position, and thus has an important opportunity, to advocate for policies that support SDOH to improve the health of all Oregonians, particularly those who have been historically marginalized within the health care system.

The Task Force on Universal Health Care finds that addressing SDOH-E is foundational for:

1. Ensuring that Oregon's Health Care for All Oregon Plan (Plan) provides equitable access to care and improves the health status of **ALL** Oregonians.
2. Lowering the overall cost of care and making the Plan financially sustainable and operationally efficient.

Therefore, the Task Force strongly recommends that in implementing the Plan, the Legislative Assembly direct the Health Care for All Oregon Board (Board) to:

1. Review and incorporate lessons from SDOH efforts around the state including, but not limited to, the SHARE initiative and HB 3353.
2. Maximize the current federal flexibilities and allowances that exist to address SDOH-E in the Medicare and Medicaid programs. Where evidence-based opportunities to address SDOH-E are not eligible for federal financial participation, the Board should prioritize seeking federal approval or consider the use of non-federal resources.
3. Prioritize partnering with existing entities, including public health agencies, social service agencies, and community-based organizations (CBOs) that are already addressing SDOH-E in Oregon's communities. Regional Entities shall advise the Board on local partnerships that support the needs of their specific communities.
4. Create reimbursement arrangements to support the delivery of services in ways that both respect and address SDOH-E.
5. Develop systems to continuously collect and analyze data on SDOH-E to ensure investments are focused and effective. Data collection should include feedback from enrollees of the Plan and communities.

BACKGROUND

During the first year of the Task Force's work, the Eligibility, Benefits & Affordability Technical Advisory Group (EBA TAG) and Consumer Advisory Committee (CAC) clearly identified social determinants of health (SDOH) (racism, systemic oppression, poverty, food insecurity, etc.) as factors that influence individual health outcomes and access to care. TAG members felt it was crucial that SDOH be addressed in the design and implementation of the Health Care for All Oregon Plan (Plan) to promote the health of all Oregonians. The complex question of how best to support SDOH was discussed in multiple meetings. Ultimately, the TAG recommended to the

Task Force that addressing SDOH: (1) is paramount to a successful single payer plan; and (2) cannot be accomplished through a traditional benefit structure.

The Task Force's Interim Report reflects the prioritization of developing a recommendation for how the Single Payer should address SDOH as an Outstanding Design Element to be addressed in the SB 428 extension. This brief offers up common language and definitions already in use in Oregon, examples of the work already happening to support SDOH, and an initial proposal for language on this issue that the Task Force may consider including in its final report.

DEVELOPMENT AND IMPLEMENTATION OF SOCIAL DETERMINANTS OF HEALTH AND EQUITY DEFINITIONS IN OREGON

Approved in January 2017, Oregon's extension of its Section 1115 Medicaid Demonstration Waiver (1115 Waiver), , included changes aimed to encourage coordinated care organizations (CCOs) utilization of resources designed to address SDOH by clarifying the permitted use of health-related services (HRS). The waiver hypothesizes that use of HRS will help address SDOH to improve individual and population health outcomes. Consequently, in 2017, Governor Brown outlined expectations that the Oregon Health Authority's (OHA) next round of contracts with CCOs include social determinants of health and equity (SDOH-E) as one of four areas to prioritize in improving Oregon Health Plan (OHP) member health.[1] Simultaneously, OHA identified the need to for more definition and guidance for how CCOs address SDOH-E and sought guidance and recommendations from the state's federally required Medicaid Advisory Committee (MAC). The MAC delivered its recommendations in May 2018, building off of existing definitions from national and international health experts to recommend definitions for "social determinants of health" and "social determinants of health equity."[2]

In 2019, OHA modified the MAC's definitions in adopting a SDOH-E definitions into Oregon Administrative Rule (OAR 410-141-3735) to guide CCO delivery of services for the Oregon Health Plan (OHP) population. The OHA definitions are provided below as a starting point to aid the Task Force in establishing a common vocabulary and shared understanding of these important concepts.

- Social Determinants of Health: The social, economic, and environmental conditions in which people are born, grow, work, live and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.
- Social Determinants of Health Equity: The systemic or structural factors that shape the distribution of the social determinants of health in communities.
- Health-Related Social Needs: An individual's social and economic barriers to health, such as housing instability or food insecurity.
- Health Related Services[3]: Noncovered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care

[1] Governor Brown Letter to Oregon Health Policy Board, September 28, 2017, available at https://www.oregon.gov/oha/OHPB/Documents/Gov.%20Brown%27s%20Letter%20to%20the%20Board.pdf

[2] Oregon Medicaid Advisory Committee, *Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model*, May 2018, available at https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf

[3] OAR 410-141-3500 and OAR 410-141-3845

delivery and overall member and community health and well-being. HRS are intended to address Health-Related Social Needs and are **provided as a supplement to covered health care services.**

Examples of HRS include[4]:

- Healthy food boxes
- Farmers Market vouchers
- Gas vouchers
- Bicycles
- Installation of parks
- Legal assistance for citizenship issues
- Employment support
- Violence intervention services
- Culturally-specific Traditional Health Worker services
- Temporary housing
- Home/utility repair

With Oregon's 1115 waiver set to be renewed in 2022, OHA has indicated that it intends to increase flexibility for spending aimed to address SDOH, including redistributing funds and decision-making power around community investments to the community itself."[5]

Since 2018, the Oregon legislature has also codified CCOs responsibilities for addressing SDOH-E for the OHP members and communities they serve. House Bill 4018 (2018) requires CCOs to expend a portion of their excess annual net income or reserves on "services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan" and the state's 1115 Waiver. Implemented as the Supporting Health for All through Reinvestment (SHARE) Initiative CCOs are required to select SDOH-E spending priorities from among four domains: economic stability, neighborhood & built environment, education and social/community health.[6]

In 2020 and 2021 Oregon Regional Health Equity Coalitions (RHECs) worked together and with several CCOs to develop a proposal to address challenges and ensure a greater focus on health equity. RHECs also worked closely with legislators to help craft and pass House Bill 3353 (2021). This measure requires OHA to seek federal approval of an amendment to the state's 1115 Waiver to require CCOs to spend up to three percent of its global budgets on,: (1) investments in health equity, and (2) enhanced payments to providers and staff that improve community health and aid underserved populations.

FEDERAL GUIDANCE ON SOCIAL DETERMINANTS OF HEALTH IN MEDICARE AND MEDICAID

[4] https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf
[5] Oregon Health Authority, "Oregon's 2022-2027 1115 Medicaid Demonstration Waiver: A Pathway to Health Equity," June 4, 2021, available at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3786a.pdf
[6] OAR 410-141-3735(3)(b)

Medicaid

On January 7, 2021, the Centers for Medicare & Medicaid Services (CMS) issued guidance to state health officials designed to "support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability , and lower overall costs."[7] The guidance focused on services and supports that states can provide under current federal law, including housing-related services and supports, non-medical transportation, home-delivered meals, educational services, and employment supports. CMS also emphasized its continued commitment to accelerating the shift away from traditional fee-for-service payment models to value-based models, noting that adoption of value-based care arrangements can provide better opportunities to address SDOH and other health disparities.

Medicare

Prior to 2018, supplemental benefits offered to Medicare Advantage enrollees were limited to primarily health-related medical services, such as dental, vision, and screening. The Bipartisan Budget Act of 2018 expanded the scope of supplemental benefits that could be provided to chronically ill Medicare Advantage enrollees beginning in 2020 to include non-primarily health-related benefits.[8] This has allowed Medicare Advantage plans to offer services such as pest control, social needs benefits, and indoor air quality equipment and services. For the 2019 plan year, CMS also expanded the definition of supplemental benefits in its general Medicare Advantage rules to allow for better coverage of products and services that address SDOH-E. Under the expanded definitions, a supplemental benefit is permitted if it:

1) Diagnoses, prevents, or treats an illness or injury;
2) Compensates for physical impairments;
3) Acts to ameliorate the functional or psychological impact of injuries or health conditions; or
4) Reduces avoidable emergency and healthcare utilization.

These supplemental benefits still need to be primarily health-related, but the expanded definition allows for coverage of services such as transportation, meal delivery, and adult day care. CMS allowed additional flexibility to offer supplemental benefits for targeted disease states and chronic conditions as long as those conditions are objectively identified by an ICD-10 codes and the benefits are medically-related to the health status or disease state. However, CMS explicitly states that, "[s]ocial determinants may not be used as a means to target benefits, even those benefits related to health (e.g., homelessness, food insecurity)."[9] Thus, the current ability to provide benefits that may address SDOH-E of Medicare enrollees depends heavily on the health status of the individual.

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[7] Centers for Medicare & Medicaid Services, *Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH),* January 7, 2021, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
[8] Public Law No. 115-123
[9] Memorandum from Kathryn A. Coleman, Director of the Medicare Drug and Health Plan Contract Administration Group, CMS to Medicare Advantage Organizations and Section 1876 Cost Plans, "Reinterpretation of the Uniformity Requirement", April 27, 2018.