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

Kelly Cronin, ACL Deputy Administrator, Director, Center for Innovation and Partnership (facilitator)
Paul Sorenson, Interim Co-Director at Community Innovation & Action Center, ACL Challenge Team Captain
Timothy McNeill, Principal, Freedmen’s Health
Ji Im, Senior Director, Community and Population Health, CommonSpirit Health
Jolie Ritzo, Director, Partnerships and Programs, Civitas Networks for Health
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 Maryland Living Well Center of Excellence/MAC, Inc. for Statewide access to a suite of evidence-based falls prevention and health promotion programs
  • 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
<table>
<thead>
<tr>
<th>Healthcare Data</th>
<th>Social Service Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Funding Sources / Billing</td>
<td>Diversity of Funding Sources</td>
</tr>
<tr>
<td>Clinically-Centered Interventions</td>
<td>Person and Community Centered</td>
</tr>
<tr>
<td>Largely Mature Data Systems</td>
<td>Scattered Data / Data Systems</td>
</tr>
<tr>
<td>Interoperability Push / FHIR</td>
<td>Interoperability? (Few Standards)</td>
</tr>
<tr>
<td>Robust Communities of Practice</td>
<td>Data Often as Burden / Afterthought</td>
</tr>
</tbody>
</table>
Missouri Aging Services Data Collaborative