

## Cost Containment through Collaboration

Working Across Sectors to Manage Costs and Improve Well-being



**April 2022** Arizona continues to prove itself a national leader in the pursuit of more efficient ways for states to manage costs and improve overall well-being, thanks in large part to one key ingredient: cross-sector collaboration.

# Introduction

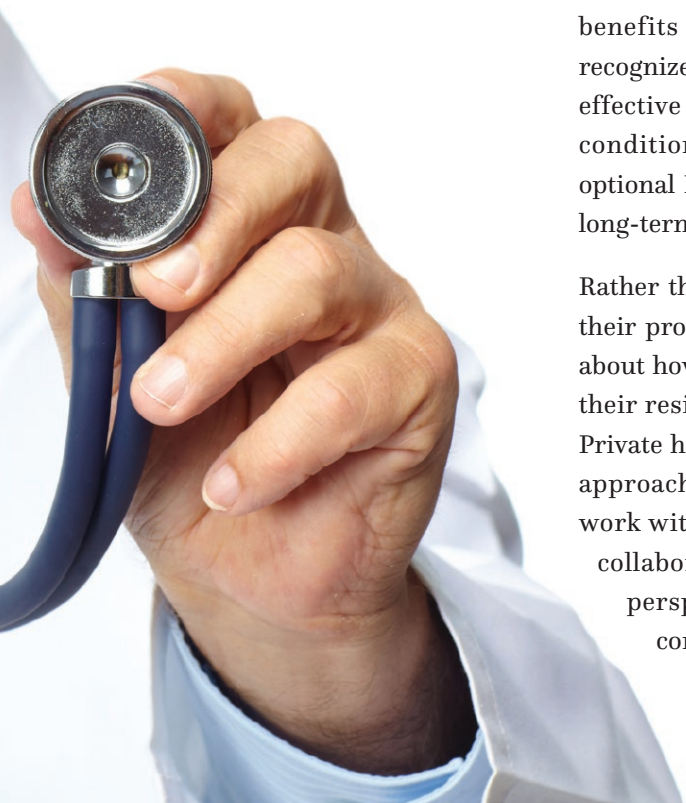
Across Arizona, and the nation as a whole, public and private sector entities are working together to manage the fiscal sustainability of government programs by collaboratively addressing root causes and underlying needs.

BECAUSE MEDICAID IS OFTEN THE SECOND-LARGEST PROGRAM IN MOST STATE BUDGETS, STATES GIVE PARTICULAR ATTENTION TO OPPORTUNITIES TO IMPROVE THE EFFICIENCY AND SUSTAINABILITY OF THE PROGRAM.<sup>1</sup>

In health care, for example, these new partnerships leverage existing community resources such as housing, food security and education to address social and economic needs that, when unmet, contribute to poor health outcomes and further dependence on public resources. By creating strong connections between entities that have historically been siloed (even though they serve similar populations), these efforts are an opportunity to increase the efficiency with which government services are delivered and improve health outcomes, all while reducing costs.

Many states have placed an important focus on developing these innovations in the Medicaid program (known in Arizona as the Arizona Health Care Cost Containment System, or AHCCCS). States are recognizing that traditional levers to manage Medicaid program costs such as reducing provider rates, eliminating coverage, or reducing benefits, have significant unintended economic and human costs. For instance, cutting provider rates is a standard state response to budget pressures, but often results in higher private sector costs for health insurance as providers shift those costs to employers and individuals purchasing insurance. As Arizona learned during the Great Recession, reducing coverage leads to significant uncompensated care losses in hospitals, some of which are also borne by private sector employers and employees in the form of higher rates.<sup>2</sup> Cutting optional benefits often results in the use of other higher costs services. For example, pharmacy benefits are technically optional under the Medicaid program, but all states recognize providing medication to manage chronic disease is much more cost-effective than hospitalization to treat the problems that result from untreated conditions. Similarly, home- and community-based services (HCBS) are an optional Medicaid benefit but much more cost-effective for populations needing long-term services and supports than the mandatory nursing facility benefit.

Rather than relying on similar legacy approaches to the fiscal sustainability of their programs, states instead are looking at opportunities to think differently about how to manage costs while improving the overall health and well-being of their residents. These efforts are not confined to the government-payer space. Private hospital systems, insurers and businesses are also rethinking traditional approaches to service delivery and developing new, creative ways to link and work with entities outside the health care system. Using data to inform those collaborations shows a clear opportunity to address health from a broader perspective and identify new strategies that address underlying needs contributing to poor health outcomes and high health care system costs.



## Social and Economic Drivers of Health

Social and economic factors such as income, employment, education, access to safe and affordable housing and nutritious food, and physical conditions of communities, are sometimes referred to collectively as social drivers (or determinants) of health (SDOH). SDOH are “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks,” and have a significant impact on individual and community health outcomes.<sup>3</sup>

In fact, these drivers have a much greater impact on health than traditional medical care. As shown in Appendix A, which includes a figure from the AHCCCS Housing and Health Opportunities (H2O) Waiver Amendment Request, clinical care accounts for only about 20% of an individual’s health, while social and economic factors account for up to 40%.

It is easy to understand how these factors contribute to health outcomes. For example, an individual discharged from a hospital with an open wound that requires sterile bandages may be more likely to be readmitted to a hospital if they are discharged without a safe place to heal. Parents of children who have diabetes may find it harder to support their children’s health and manage their chronic condition without access to healthy food. An individual in recovery from an opioid disorder who leaves prison without an ongoing supply of medication may be more likely to have additional contact with the justice system or be admitted to the hospital. Even the underlying enrollment in the Medicaid program is linked to the state’s overall economic health. Understanding the interconnected nature of social, economic and health needs opens the pathway to a broader set of strategies to address them.

## Collaborations to Support Whole Person Care

A common theme across many of these partnerships is the interdependence of mental and physical health. Studies show that health care spending is not equally distributed across populations, but concentrated in a small number of individuals with very complex needs. In a national study of both public and private spending, over 50 percent of health care spending was associated with only 5 percent of the population, while about 15 percent of the United States population had no associated health expenditures.<sup>4</sup> A similar distribution was found across Medicaid spending in a report by the federal Government Accountability Office (GAO). In this more detailed analysis, GAO also calculated the distribution of health needs across Medicaid enrollees and found that more than half of the top 5 percent of individuals with the highest expenditures had a mental health condition, and almost 20 percent had a substance use condition.<sup>5\*</sup> Appendix B shows the distribution of conditions by high-expenditure enrollees and all enrollees from the report.

Individuals with multifaceted, complex needs interact with a broad array of other public services. For example, national estimates indicate that individuals with severe mental illness are associated with 1 in 10 calls for police services and 1 in 5 prison and jail beds.<sup>6</sup> There is also a well-documented relationship between children’s mental health and long-term educational success (which also contributes to future economic prospects).<sup>7</sup> Economists at Penn State have estimated that “poor mental health ranks as one of the costliest forms of sickness for U.S. workers,” with an impact of \$53 billion less total income in the U.S. for each extra poor mental health day in a month, on average across the U.S. population.<sup>8</sup>

These figures highlight why many recent innovations and partnerships focus on meeting the needs of the whole person, including their mental health and substance use disorder needs, and are designed to not only improve health outcomes but also the long-term financial stability of the health care system.

\* These figures are significantly higher than the comparable statistics for all Medicaid enrollees which are about 13% (mental health) and 4% (substance use).

# Healthcare Beyond Traditional Medical Care Across the Nation

Across the country, as government and private sector entities increasingly recognize the connection between SDOH and health care costs and the need to approach care holistically, they are finding new and creative ways to partner to build efficiencies, lower costs and improve health outcomes as outlined in Figure 1.

FIGURE 1 Goals of Cross-Sector Collaboration



These strategies include recognizing and reimbursing for new programs and benefits designed to help stabilize growing health care costs by treating underlying unmet needs. This includes partnering with sectors previously siloed from health care delivery such as housing developers, food banks, and the justice system. Arizona has long been at the leading edge of advancing innovative new approaches to these issues, but we are not alone in recognizing the importance of new ways of thinking about health.

## Medicaid as an Early Leader

As discussed in more detail later in this brief, AHCCCS has been a trailblazer in these efforts, but other states have followed suit. Under the Trump Administration, the Centers for Medicare and Medicaid Services (CMS) issued guidance for states to leverage Medicaid opportunities to support SDOH including through housing-related services and supports, employment, food security and education partnerships.<sup>10</sup>

In 2018, North Carolina received CMS approval for a pilot program that used Medicaid funding for services related to housing, food security, transportation and interpersonal safety and toxic stress, all of which impact health outcomes.<sup>11</sup> After several years of development, this program is launching in March 2022.<sup>12</sup>

In addition, Medicaid programs have evolved to deliver more services and supports at home rather than high-cost medical care in facilities. As a primary payer of long-term care, state Medicaid programs have long recognized the cost advantages of providing non-traditional community supports that keep individuals out of nursing homes and in their homes and communities. While these services were not originally part of the Medicaid program, states have used waivers of federal law to provide supports such as home health and personal care to seniors and persons with disabilities. Over time, states have focused a larger percentage of spending on HCBS compared to nursing facility care, saving money and keeping people living independently.

## Medicare's Non-Traditional Supplemental Benefits

Medicare is also recognizing the opportunities to improve the lives of seniors and persons with disabilities through non-traditional supports. Many seniors receive their Medicare through private sector Medicare Advantage (MA) plans which leverage their efficiencies to offer benefits beyond traditional Medicare. These supplemental benefits have historically been specifically defined health-related services such as dental care or hearing aids. However, in response to Congressional Budget Action and the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act passed by Congress in 2018, the Trump Administration allowed MA plans to offer a broader set of benefits including healthy meals or groceries for individuals with heart disease, and rides to health care appointments for individuals who lack transportation.<sup>13</sup> While many plans are still building out these benefits, some MA plans such as Anthem began offering optional benefits including pest control (which could improve asthma), service dog allowances (to reduce social isolation), and home safety devices such as grab bars (allowing members to remain independent at home).<sup>14</sup>

## Private Sector Innovations

Like Medicaid programs, commercial insurers and large hospital systems understand that their own efforts to support improved health outcomes are complicated by factors traditionally considered outside the health care delivery system. Commercial insurers, large health care systems and employers are all investing in new partnerships that support underlying drivers of health and whole-person care.<sup>13</sup>

- **Blue Cross Blue Shield of Kansas City** collects data on member social needs (including incentives for primary care physicians to collect such data) and has built a network of community organizations to whom it can refer members for unmet needs such as food access. Its data driven approach will not only increase efficiencies, streamline access, and avoid duplication across community-based organizations, but also provide data to analyze their impacts.<sup>15</sup>
- **UnitedHealthcare** has been a national leader in supporting housing access for its patients, investing almost \$800 million in affordable housing initiatives across the country over the past decade, including \$21 million for 500 new apartments here in Arizona.<sup>16,17</sup>

- **Texas Health Resources (THR)**, a large faith-based nonprofit health system in North Texas, is funding a variety of community grants to support social drivers of health and improve health outcomes through investment in community resources. THR uses data to identify community needs and brings together stakeholders such as education partners, cities, grassroots organizations, and health providers to work collaboratively on identified issues such as ensuring seniors in the community have access to healthy food, connecting unemployed workers to job resources, and working to increase access to behavioral health services.<sup>18</sup>
- **ProMedica**, a health system in Ohio, is so committed to this work it created a National Social Determinants of Health Institute to “integrate social determinant factors with clinical care.” Not only do their health care providers screen for social needs such as access to food, but they connect them to community partners and resources to help them establish a plan to address their socioeconomic needs. For example, hospital patients are asked about their regular access to food and, when needed, provided basic food at discharge along with a connection to community resources for ongoing assistance. ProMedica also offers free financial coaching to help individuals learn how to budget, save money, and take financial steps necessary to raise their credit scores. These programs set patients up for longer-term economic success which will ultimately reduce reliance on government-funded programs. ProMedica reports that 30% of their financial wellness participants saw increased net income and credit scores. Average monthly income increased by \$432, and patients used fewer health care resources, with a 33% reduction in emergency department visits, and a 14% reduction in inpatient stays (saving on average \$2,000 and \$13,000 respectively).<sup>19</sup>
- **CareSource**, a private nonprofit health plan serving Medicaid, Medicare, and Insurance Marketplace members, is investing \$50 million in affordable housing across Ohio, Indiana, Georgia, Kentucky, and West Virginia.<sup>20</sup> CareSource is also making numerous other strategic investments in SDOH such as job readiness supports, food security and support for individuals experiencing homelessness in Ohio, and mental health supports in Ohio and Indiana.<sup>21,22</sup>

## Arizona Successes

ARIZONA WAS AN EARLY LEADER IN RECOGNIZING HOW GOVERNMENT SILOES CAN DRIVE UP COSTS AND FRAGMENT CARE, AS WELL AS THE INTERPLAY BETWEEN SOCIAL AND ECONOMIC FACTORS AND HEALTH CARE COSTS.

Historically, Arizona Medicaid was administered by multiple state agencies: AHCCCS, the Arizona Department of Health Services (ADHS) and the Department of Economic Security (DES). AHCCCS and ADHS separately oversaw components of the program (physical health and behavioral health, respectively) and individually contracted with managed care organizations to administer benefits for the exact same populations. This led not only to administrative duplication, but challenges for private sector partners who had to deal with two distinct government agencies who often had different approaches and expectations. Recognizing the most basic opportunity for collaboration existed between two agencies performing overlapping functions, AHCCCS and the Division of Behavioral Health Services at ADHS merged, streamlined their functions, and reduced the overall footprint of state government. This also facilitated the integration of the private sector contracts, so the State wasn't holding multiple contracts for services to the same individuals. These efforts set the stage for future collaborations as AHCCCS and ADHS demonstrated clearly how state agencies could overcome internal and external barriers and work collectively toward common goals.<sup>9</sup>

More recently, the Arizona Department of Housing (ADOH), AHCCCS, ADHS, DES, the Governor's Office of Youth Faith and Family, and others have begun collaborating to streamline service delivery and address the underlying factors contributing to poor health outcomes and high health care costs. State agencies are working well together and with community stakeholders to coordinate state, local and federal funding to avoid duplication and efficiently direct resources.<sup>10</sup> For example, ADOH leadership has engaged AHCCCS, ADHS, as well as community funders to discuss how American Rescue Plan Act funds are being distributed for housing and supportive housing services, and where the gaps are so community funders might be involved. AHCCCS, ADHS and Arizona Department of Education (ADE) are also working together to share plans on mental health best practices for schools so they can collaborate on implementing successful strategies.



AHCCCS REPORTS RECENT STRATEGIES HAVE RESULTED IN A \$5,563 REDUCTION IN AVERAGE PER MEMBER PER MONTH COSTS FOR INDIVIDUALS SERVED IN THE AHCCCS HOUSING PROGRAMS, AND AN \$82.5 MILLION REDUCTION IN TOTAL COST OF CARE.

## Housing as a Cross-Sector Issue

A particular focus in Arizona has been the integration of housing and health care. Several complementary initiatives support individuals with serious mental illness (SMI), many of whom face unique and multi-faceted barriers to obtaining and maintaining stable housing, thereby increasing their likelihood of emergency department use, interaction with the justice system and experiencing homelessness. In an Arizona study, individuals with SMI who experienced severe, long-term symptoms and who experienced chronic homelessness had 32% higher health care costs than individuals in permanent supportive housing.<sup>23</sup> The study also found individuals experiencing chronic homelessness had higher criminal justice costs (i.e., police interaction, incarceration, and courts costs) compared to those in permanent supportive housing, \$5,406 per year to \$3,259 per year respectively. Other efforts approach the issue more broadly, recognizing that stable housing supports strong communities, educational outcomes, and safety.

## State Support for Housing for Persons with Behavioral Health Needs

The Arizona Legislature has long appropriated funding for behavioral health services for non-Medicaid populations and benefits. As an increasing number of individuals accessed health care coverage over the past decade, AHCCCS focused a portion of those non-Medicaid state funds on housing and housing supports for persons with behavioral health needs. In recent years, AHCCCS was able to provide rental subsidies for almost 3,000 individuals. AHCCCS reports these strategies have resulted in a \$5,563 reduction in average per member per month costs for individuals served in the AHCCCS housing programs, and an \$82.5 million reduction in total cost of care.<sup>24</sup> Yet data shows there is an even greater need. During the COVID-19 pandemic, AHCCCS was able to pair its own data with data from Maricopa County's Homeless Management Information Service (HMIS) and identified over 30,000 members as lacking housing. AHCCCS reports that one-third of these members had three or more emergency department visits, three-quarters had at least one health care claim related to substance use disorder, and the average annual costs of health care for individuals experiencing homelessness was more than three times higher than the average cost for all AHCCCS enrollees. To build on their existing success in improving health outcomes and stabilizing costs, Arizona has asked the federal government to match its state investment. If approved, this will expand the reach of the program by strengthening outreach services to better identify those in need, providing resources to connect members to housing, and adding services that support members in maintaining stable housing.<sup>25</sup>

In addition to AHCCCS support for housing, Arizona has also separately funded housing for individuals with behavioral health needs through a direct legislative appropriation.<sup>26</sup> The Legislature has historically directed a portion of unclaimed property revenues (up to \$2.5 million annually) to the SMI Housing Trust Fund, which provides housing projects and rental assistance for individuals with SMI. In FY 2020, the Legislature also provided an additional \$6.5 million for housing projects for individuals with SMI. Administered as a partnership between ADOH and AHCCCS, the monies will be used for individuals court-ordered into a residential treatment facility, as well as transitional housing for individuals experiencing homelessness who have an SMI. These projects are underway.

## Private Sector Leadership in Cross-Sector Collaboration

AHCCCS's private sector partners also recognize the benefit of supporting these collaborations and non-traditional interventions. In 2020, the AHCCCS health plans, which traditionally compete against each other in the Medicaid market, banded together to pool their own corporate funds and partnered with local business, community, and education leaders to launch a nation-leading collaboration known as Home Matters to Arizona. The AHCCCS plans recognized that a rental home shortage directly impacts the health of their members if families cannot afford activities and factors that support good health outcomes (such as healthy food) because their rent is unaffordable. In addition, children in stable homes are better positioned to succeed in school, and communities are safer when Arizonans have access to stable housing. The goal of the Home Matters to Arizona Fund is to distribute \$100 million to finance affordable housing projects that support healthy individuals and communities, including a focus on SDOH connections. As of December 2021, the fund included \$6.5 million for grants and \$35 million to support debt, and had distributed \$2.8 million across 8 projects.

## Supporting Arizona Kids

Arizona has also recognized the synergy between health care and improved educational outcomes. Children who are struggling with mental health needs are often not able to perform their best in school and are more likely to engage in risky behaviors both as adolescents and adults.<sup>27</sup> In the same way schools support physical health through physical education, sports teams and health curriculum, schools provide a variety of mental health supports that help students stay engaged and ready to learn. Arizona agencies are partnering on a number of innovative efforts:

- Project A.W.A.R.E. (Advancing Wellness and Resiliency in Education) is a partnership between ADE, AHCCCS and local school districts. Using federal grant funds, the agencies work to improve access and connection to mental health services and resources, as well as conduct trainings for educational staff, families and communities on mental health issues including how to identify and support mental health and wellness in students.



- Arizona provides broad support for students to access behavioral health services in schools. In addition to Medicaid coverage, which offers services directly in schools, the Arizona Legislature appropriated \$8M in FY 2020 for mental health services for children and services not eligible for Medicaid funding. Further, AHCCCS significantly expanded its partnership with schools that leverages Medicaid funding to support the delivery of health care services on school campuses. Finally, ADE and AHCCCS jointly created several resource guides for school leaders, educators, and mental health professionals to understand mental health resources in Arizona and how to navigate the health care delivery system.<sup>28</sup>

## Justice System Partnerships

As noted above, data shows high (and in many cases preventable) justice system engagement for persons with mental illness. In addition, individuals exiting the justice system often have chronic health conditions such as asthma and diabetes that also require ongoing care as they transition to the community. Through creative partnerships and a willingness to think differently and try new approaches, Arizona agencies have developed numerous cross-sector innovations in supporting individuals leaving incarceration in their successful return to the community.

Created in 2017, Arizona's Second Chance Centers started as a partnership between the Arizona Department of Corrections, Rehabilitation and Reentry (ACDRR) and DES and are a prime example of how agencies can work in synergy to comprehensively address whole-person needs. Second Chance Centers were designed to provide job readiness and other supports to individuals nearing release from

incarceration to set them up for success as they transition to the community. In addition to ACDRR and DES, more recent partners include the City of Phoenix, which provides bus passes in the Phoenix area; ADOH, which meets with participants on housing needs; Community organizations that offer post-release resources such as the Home Builders Association of Central Arizona's construction skills training; and the Arizona Department of Administration, which provides surplus cell phones for individuals through the Centers.<sup>29</sup> Both AHCCCS and DES also facilitate applications for Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits, respectively, to ensure individuals are enrolled in these programs upon release.

While federal law prevents the use of Medicaid funding for individuals who are incarcerated, AHCCCS has also developed a number of nation-leading initiatives to facilitate connection and support for individuals exiting incarceration to avoid duplication of spending and prevent poor health outcomes that could lead to high-cost hospitalizations or reincarceration. For example, by suspending Medicaid enrollment upon incarceration rather than terminating it, AHCCCS is easily able to re-instate eligibility when individuals are released. The agency built data feeds with most counties and the ACDRR, which allows individuals to quickly move into coverage and prevents other funding sources from being used to cover what Medicaid should. In addition, these data matches prevent AHCCCS from paying for individuals when they are in a correctional setting, which was estimated to avoid \$42 million in spending in Fiscal Year 2018 (the most recent year for which data was available).<sup>30</sup>

Arizona also requires its health plans to "reach in" to correctional settings to make sure members with chronic conditions like substance use disorder, diabetes, or serious mental illness have appointments and a plan for getting needed medical services as they are released, which averts an escalation of health care needs that might result in higher costs. In addition, it supported the development of 13 clinics co-located with or adjacent to probation and parole offices, designed to make sure individuals can keep needed appointments as they meet their obligations to the justice system.



# Challenges in Advancing Collaboration

## Balancing Future Payoffs with the Needs of Here and Now

The reality of state budgets means that at times exigent needs eclipse investments that have longer-term returns. As a result, at times policymakers must prioritize health spending on more immediate needs (e.g., traditional medical treatment) rather than more prevention-oriented cross-sector activities that save money over a longer time horizon.

## Fostering Collaboration Despite Unique Organizational Objectives

Each individual collaborator comes into a partnership with their own set of goals and objectives to fulfill the mission of their organizations, and each organization may define success in their own way. Aligning efforts to support common goals requires helping organizations see how working together toward those larger aims supports their own organizational endgame and values.

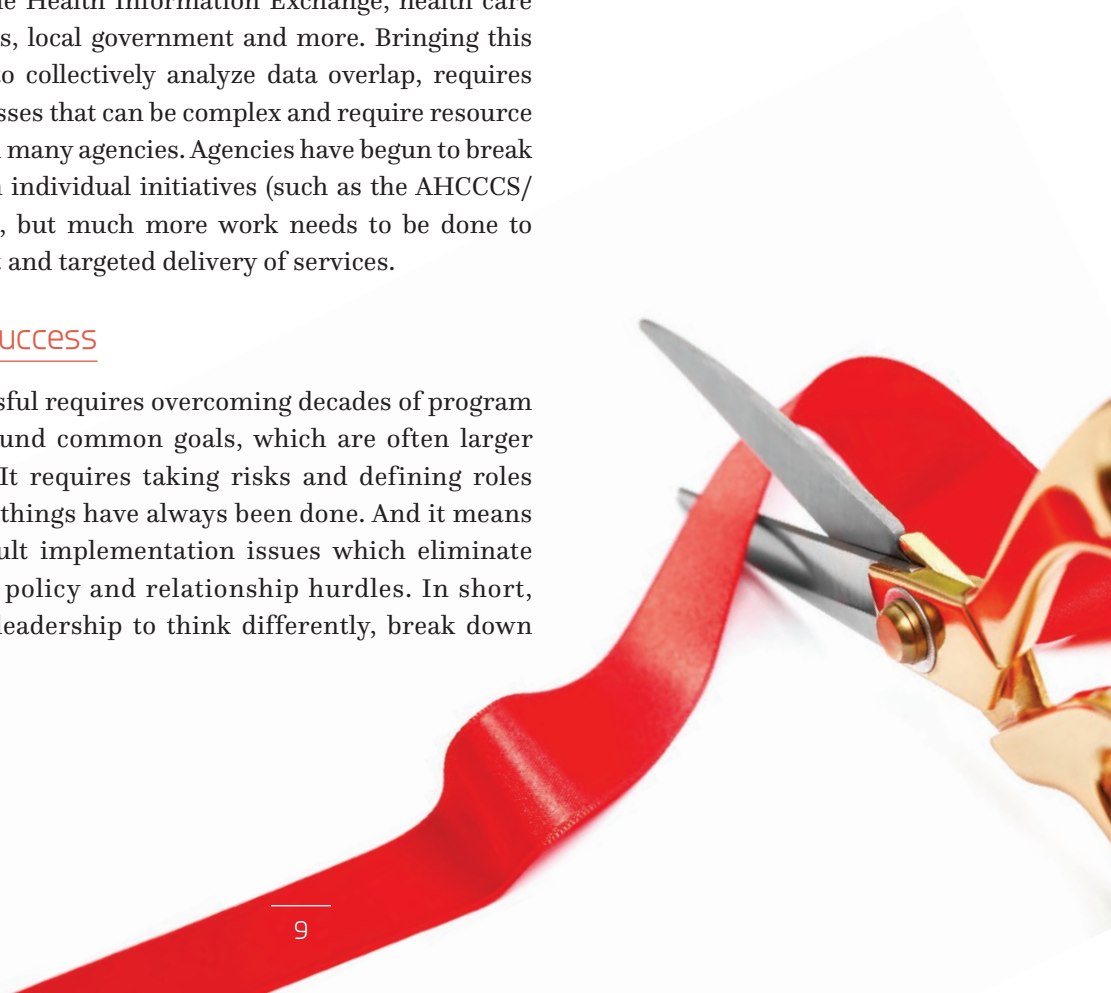
## Navigating Siloed Data and Program Criteria

Historically, agency programs and data have been relatively siloed. Even programs that serve a significantly overlapping population (e.g., AHCCCS and DES SNAP) have different eligibility criteria and data sets. Other related data lives outside the State in private agencies such as the Health Information Exchange, health care providers, community organizations, local government and more. Bringing this data together, or even partnering to collectively analyze data overlap, requires technological, policy and legal processes that can be complex and require resource commitment, which is a challenge in many agencies. Agencies have begun to break down these walls and share data on individual initiatives (such as the AHCCCS/HMIS match-up during COVID-19), but much more work needs to be done to maximize opportunities for efficient and targeted delivery of services.

## Leadership is Required for Success

For any of these efforts to be successful requires overcoming decades of program and policy siloes and aligning around common goals, which are often larger than individual agency missions. It requires taking risks and defining roles that might look different than how things have always been done. And it means working through incredibly difficult implementation issues which eliminate red tape and overcome financial, policy and relationship hurdles. In short, it requires strong and principled leadership to think differently, break down barriers and produce results.

DESPITE BROAD AGREEMENT ON THE BENEFITS OF CROSS-SECTOR COLLABORATION, AND THE SUCCESSES DEMONSTRATED SO FAR IN ARIZONA AND ACROSS THE NATION, POLICYMAKERS STILL FACE NUMEROUS CHALLENGES IN THE DELIVERY OF EFFECTIVE, EFFICIENT, AND WELL-COORDINATED PROGRAMS.



## Key Takeaways

ARIZONA STATE AGENCIES, COMMUNITY GROUPS AND PRIVATE SECTOR PARTNERS HAVE LED THE NATION IN COLLABORATIVE INNOVATIONS THAT THINK BIG AND THINK DIFFERENTLY ABOUT LONG-STANDING ISSUES AND PROBLEMS. KEY TAKEAWAYS FROM THESE EFFORTS ARE LISTED TO THE RIGHT.

- The case for interagency collaboration is strong. Early efforts report great success in lowering costs, improving health outcomes, and positioning Arizonans for long-term economic and educational success.
- Examples include Arizona’s cross-sector housing initiatives, which have saved over \$82 million in health care costs by providing supportive housing to individuals with SMI.
- The most efficient and effective way to manage overall government resources is through creative, interdisciplinary work that breaks down siloes across agencies to address underlying issues and problems.
- Future efforts hinge on bringing together disparate data sources to tell the true and complete story of Arizonans’ needs and using this data to make informed decisions.
- Leveraging taxpayer resources in the most efficient manner possible means solving the right problems and generating real results, which requires committed leadership to overcome historical policy and people barriers.

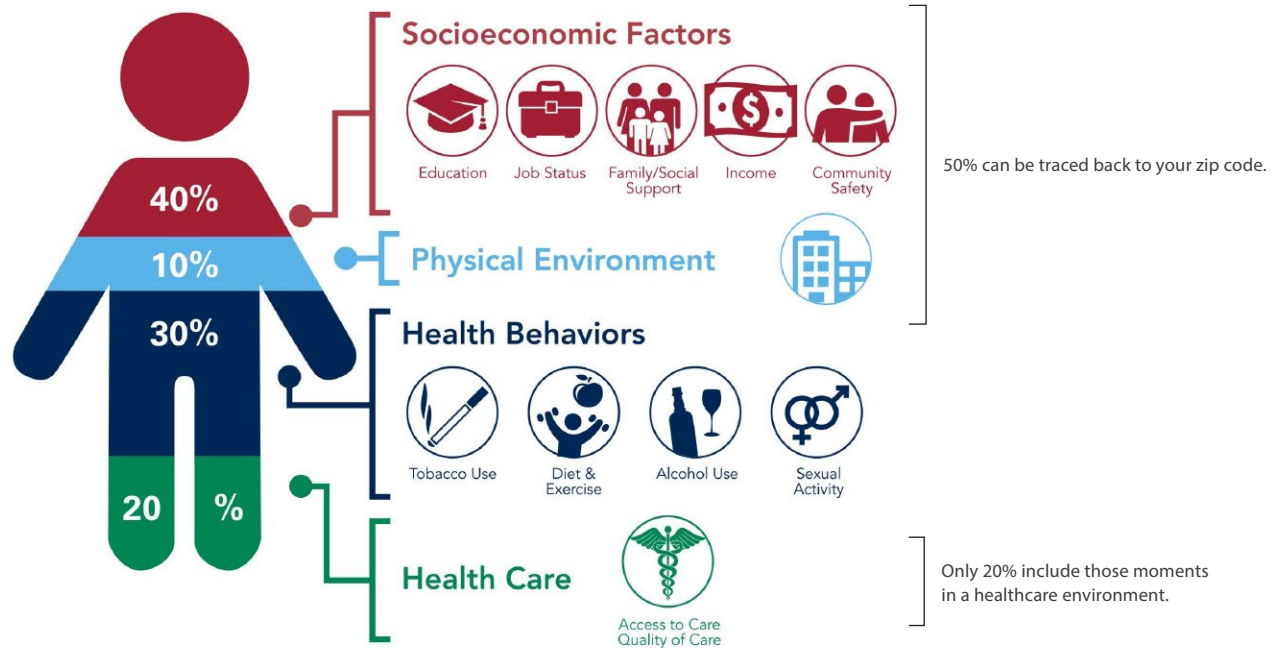
## Resources to Learn More

- Arizona Department of Corrections, Rehabilitation and Reentry  
[corrections.az.gov](http://corrections.az.gov)
- Arizona Department of Economic Security  
[des.az.gov](http://des.az.gov)
- Arizona Department of Education  
[azed.gov](http://azed.gov)
- Arizona Department of Health Services  
[azdhs.gov](http://azdhs.gov)
- Arizona Department of Housing  
[housing.az.gov](http://housing.az.gov)
- Arizona Health Care Cost Containment System  
[azahcccs.gov](http://azahcccs.gov)
- Governor’s Office of Youth, Faith and Family  
[goyff.az.gov](http://goyff.az.gov)
- Kaiser Family Foundation  
[kff.org](http://kff.org)
- National Academy for State Health Policy  
[nashp.org](http://nashp.org)
- National Association of Medicaid Directors  
[medicaiddirectors.org](http://medicaiddirectors.org)



# Appendix A

## Social Determinants of Health Factors Influencing a Person's Health Outcome



Source: AHCCCS Housing and Health Opportunities (H2O) Waiver Amendment request; Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 graphic designed by ProMedica.

# Appendix B

**Table 1: Percentage of High-Expenditure and All Medicaid-Only Enrollees with Certain Conditions or Services, Fiscal Years 2009 through 2011**

Fiscal year	Asthma	Diabetes	HIV/AIDS	Mental health conditions	Substance abuse	Delivery or childbirth	Long-term care residence	None of these conditions or services
<b>Percentage of high-expenditure Medicaid-only enrollees</b>								
2011	14.20	18.79	3.10	52.64	19.87	9.95	8.35	22.23
2010	14.42	18.50	3.27	51.13	19.21	10.45	8.15	22.65
2009	14.08	18.13	3.24	50.13	18.48	10.79	8.48	23.49
<b>Percentage of all Medicaid-only enrollees</b>								
2011	5.74	2.98	0.27	13.61	4.02	6.16	1.01	73.13
2010	5.88	2.86	0.29	12.72	3.72	6.26	0.86	73.88
2009	5.41	2.81	0.29	12.00	3.50	6.52	1.07	74.60

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-15-460

Notes: High-expenditure Medicaid-only enrollees were defined as the 5 percent with the highest expenditures within each state. Data were from all states and the District of Columbia, but excluded Idaho in fiscal year 2010, and Florida and Maine in fiscal year 2011.

Source: GAO-15-460, Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures.

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