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Medicaid Investments To Address Social Needs In Oregon And California

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ABSTRACT Health care organizations across the US are developing new approaches to addressing patients' social needs. Medicaid programs are uniquely placed to support these activities, given their central role in supporting low-income Americans. Yet little evidence is available to guide Medicaid initiatives in this area. We used qualitative methods to examine how Medicaid funding was used to support social interventions in sites involved in payment reforms in Oregon and California. Investments were made in direct services—including care coordination, housing services, food insecurity programs, and legal supports—as well as capacity-building programs for health care and community-based organizations. A mix of Medicaid funding sources was used to support these initiatives, including alternative models and savings. We identified several factors that influenced program implementation, including the local health system context and wider community factors. Our findings offer insights to health care leaders and policy makers as they develop new approaches to improving population health.

Health care organizations across the US are increasingly experimenting with ways to address patients' social needs, such as housing and food insecurity, in an attempt to improve health and control costs.¹ This reflects growing awareness of the social determinants of health and the major role they play in shaping health outcomes.²⁻⁴ At the same time, the growth of accountable care organizations and other value-based payment models has created new opportunities to use health care funding flexibly to improve population health.⁵

State Medicaid programs are uniquely positioned to support activities that address patients' social needs. Medicaid is the largest health insurer for low-income Americans, who disproportionately experience socioeconomic barriers to health.² The Affordable Care Act extended Medicaid coverage to previously ineligible populations, such as childless adults, with high rates

of housing instability and other social needs.⁶ These social needs can increase health care use and costs.^{7,8}

Under current Medicaid regulations, all states have the option to pay health care organizations to connect patients with basic social supports, such as food or housing resources. For example, state plan amendments can be used to cover case management services, including assessing patients' social needs and making referrals to nonmedical services.⁹ Medicaid managed care organizations may also provide additional social supports not covered under state contracts—for example, “in-lieu-of” services (cost-effective alternatives to covered services) or value-added services (extra supports that will improve care quality or reduce costs).¹⁰

Policy makers in several states—including California, Colorado, and Oregon—have also used Section 1115 waivers to extend Medicaid's role in addressing patients' social needs beyond

the level of support in many other states, including by supporting health and social service partnerships and providing greater flexibility to fund social interventions.¹¹ The long-term benefits of these efforts could be significant, given evidence that greater investment in social services at the state and county levels is associated with better health outcomes.^{12,13} Early evaluations of Medicaid reforms in Oregon and Colorado have pointed to some successes in improving quality, controlling costs, and reducing disparities.^{14,15} Yet these studies have not focused specifically on the social needs–related components of each state’s reform programs. Under these and related initiatives, little is known about how Medicaid dollars are used in practice to fund social interventions and the service models developed to implement them. The same is true across the US health system: Data on the funding, structure, and impact of health care interventions to address social needs are limited.^{1,16}

To provide new insights in this area, we conducted qualitative research with communities involved in Medicaid payment and delivery system reforms in California and Oregon to understand how Medicaid funding was used to address patients’ social needs. We selected California and Oregon because both states have introduced reforms that offer new flexibility to address social needs—including paying for social supports not usually covered under Medicaid. In Oregon, coordinated care organizations (CCOs) were established under a Medicaid waiver in 2012 to purchase and provide health care for Medicaid patients, with flexibility to direct funding toward health-related social services.^{17,18} For example, CCOs may use their capitation payments to cover more extensive care coordination supports than would otherwise be covered under state plan benefits, as well as one-time nonmedical expenses that could improve patients’ health (such as air conditioners for asthma patients). At the same time, an alternative payment methodology was introduced for federally qualified health centers that shifted reimbursement from the per visit prospective payment system to a per member per month rate.¹⁹ In California, Whole Person Care Pilots—partnerships of county health departments, managed care plans, hospitals, and community partners—were created in 2016 (also under a Section 1115 waiver) to coordinate health care and behavioral health and social services for California’s most vulnerable Medicaid beneficiaries, and the pilots were provided with up to \$1.5 billion federal funding through 2021.²⁰ This funding could cover new infrastructure or interventions to improve care for high-risk groups, such as data sharing systems or housing-related supports.

Study Data And Methods

DESIGN AND SAMPLE We conducted qualitative research with communities involved in Medicaid reforms in California and Oregon to understand how social interventions were funded and delivered. Our sample included fifty-five representatives from Medicaid payers, provider organizations, local governments, and community-based organizations in six regions across the two states.

We identified a purposive sample of communities involved in each state’s reforms. In Oregon we focused on CCO areas with community health centers that used the state’s alternative payment methodology. In California we focused on counties involved in the Whole Person Care Pilots program. We reviewed publicly available documents and contacted relevant organizations to identify a smaller number of those communities that used Medicaid funding flexibility to support social interventions. We selected three CCOs in Oregon and three counties in California to be involved in the study, chosen to ensure diversity of geographical region, rural versus urban areas, and population size. We undertook site visits and conducted in-depth interviews with representatives from Medicaid payers (including CCOs and managed care organizations), provider organizations (such as federally qualified health centers), local government agencies (particularly in California, given their role in Medicaid reforms), and community-based organizations (such as housing agencies). Interviewees were typically organization leaders and managers of relevant initiatives, but they also included clinicians and community health workers. Participants were identified through web-based research and recommendations from state experts, followed by snowball sampling.²¹

We defined social needs as patients’ social and economic barriers to health, such as housing instability or food insecurity. We focused on the range of ways each region used Medicaid dollars to address social needs—including state reform initiatives but also any other relevant efforts by Medicaid payers and providers.

DATA COLLECTION AND ANALYSIS We used a semistructured interview guide with questions about the content of social interventions, how they were structured and funded, and the contextual factors that influenced implementation (see online appendix 1).²² Interviews were typically carried out in person at the participant’s place of work, lasted about 45–60 minutes, and took place in March–May 2018. All interviews were recorded and professionally transcribed. We asked interviewees to share relevant documents (such as project reports) when they referred to them in their responses.

We analyzed the data using the constant comparative method of qualitative analysis.²¹ We reviewed interview transcripts line by line to identify key themes. Two of the authors (Hugh Alderwick and Laura Gottlieb) reviewed all transcripts and worked collaboratively to develop the code structure. We conducted our analysis in parallel with site visits and revised the code structure as new themes emerged. We used an integrated approach to develop the code structure²³ based on themes identified in the data and the domains covered in our interview guide. After a coding structure was stabilized, one author (Alderwick) coded the remaining transcripts. We used Dedoose, version 8.0.44, to facilitate the analysis of the data.

LIMITATIONS Our study had three important limitations. First, our sampling strategy involved selecting communities that were involved in Medicaid reforms to address social needs. Our findings are not representative of all efforts to do so across California and Oregon. Instead, our findings show how advanced communities in each state used Medicaid funding to address social needs.

Second, our unit of analysis—counties in California and CCOs in Oregon—was too large for us to interview representatives from every organization involved in delivering Medicaid-supported services in each site. Rather, we interviewed organization representatives who could provide an overview of relevant initiatives and others involved in program implementation. As a result, our data do not provide an exhaustive account of all efforts to address social needs under Medicaid in each region.

Third, our data were from professionals involved in designing and delivering services—not from patients. Though we conducted interviews with community-based organizations to understand programs from a social services perspective, this work did not incorporate patients' views on the interventions delivered. This could weaken the interpretation of our findings.

Study Results

All sites used Medicaid funding to invest in social interventions. We describe the content of these interventions, followed by how Medicaid dollars were used to support them. We then describe the contextual factors influencing their implementation.

INTERVENTIONS TO ADDRESS SOCIAL NEEDS Medicaid funding was used to support two categories of interventions to address social needs: direct services and capacity building. Service interventions focused on identifying and responding to patients' social needs by providing direct

services—for example, screening patients for unmet needs and helping them access resources. Capacity-building activities focused on strengthening health care and social services' ability to collaborate and deliver social interventions—for example, investment in data sharing or new team members.

DIRECT SERVICES

► **CARE COORDINATION FOR MULTIPLE SOCIAL NEEDS:** The most common intervention across both states was care coordination to help patients access social services, such as housing, legal supports, and income assistance. The approach and target population for care coordination varied from general, low-intensity supports to intensive case management for target populations. In Oregon, for example, community health workers coordinated health and social services for patients in clinics and community settings. In one federally qualified health center, the workers—funded through the clinic's alternative payment methodology—worked with patients to access, as a clinic supervisor told us, “money for their food, resources for child care, bus passes—you name it.” The workers could also apply to the CCO for flexible services funds (described below) to make one-time payments for nonmedical items, such as heaters and temporary accommodation for homeless patients after treatment.

More intensive care coordination had been established for specific groups, such as homeless patients and people leaving jails. In California, all sites used Section 1115 waiver funding to implement care coordination for homeless patients. In one county, housing navigators connected with homeless patients daily to explore housing options, communicate with landlords, access income support, and find employment. Across all sites, care coordination typically began with an assessment of patients' social needs (approaches varied) and regularly involved referrals to targeted social interventions.

► **HOUSING:** A range of targeted housing interventions had been developed in both states. In Oregon, one rural CCO invested a proportion of Medicaid savings in a project to develop around twenty tiny homes for homeless people. In California, counties used Section 1115 waiver funding to invest in medical respite facilities for homeless patients, on-site supportive housing services, and tenancy-sustaining services—such as helping residents manage their money and shop for groceries. In one county, waiver dollars were used to pay formerly homeless patients' first and last months' rent. In another, housing coordinators had access to flexible funds that could cover patients' utility bills or other housing expenses—“you know, to replace the screen

door that you kicked your foot through so your sister won't let you come back," as the program director told us. Two counties in California also reinvested local savings from Section 1115 waiver programs in flexible housing pools, used to fund rental subsidies for supportive housing and new housing units.

► **FOOD INSECURITY:** All sites described food insecurity as a barrier to patients' health and had developed various approaches to address it. In one site in Oregon, the CCO invested in a vegetable prescription program delivered by a community health center and community-based organization. Patients were screened for food insecurity during clinic visits and offered available resources. This included a \$20 token, funded by the CCO and renewed monthly, to spend at the community-based organization's on-site food stand or local farmers markets.

► **LEGAL NEEDS:** Some care coordination programs included referrals to legal services, but several sites also supported legal services directly through Medicaid. One county in California established a clinic-based medical-legal partnership and remote legal services under its Section 1115 waiver. After a referral from community health workers or other staff members, attorneys helped patients prevent evictions, appeal benefits denials, expunge criminal records, and more.

► **TARGET POPULATIONS:** The target population for these interventions varied based on program requirements and focuses. Common target populations included high health care utilizers, high utilizers of multiple services, homeless clients, and behavioral health patients.

CAPACITY BUILDING As mentioned above, capacity-building activities focused on strengthening health care and social services' ability to collaborate and deliver social interventions to specific populations. Here we describe a variety of these activities carried out in California and Oregon.

► **STAFF TRAINING:** Staff training was a key area for investment in both states. In California, one county was investing \$2.4 million of Section 1115 waiver funding in each year of the pilot to train staff members from health care and social services in information sharing, teamwork, and coordinated entry (a process used to determine and provide access to housing supports and assistance for people experiencing homelessness). Another hired and trained peer navigators to work with vulnerable patients. In Oregon, one CCO used savings to fund training for community health workers and health equity workshops for clinicians.

► **COMMUNITY-BASED ORGANIZATIONS:** Health care organizations also invested in

strengthening the capacity of community-based organizations that delivered social services. In some cases, this involved contributing to operating costs or existing programs. In Oregon, for example, one CCO supported a homeless shelter and family relief nursery. Other interventions focused on building community-based organizations' capabilities. As part of its Section 1115 waiver, one county in California worked with landlords to improve accommodation standards for low-income patients and created an operators association for owners of board and care homes. Another provided administrative support to help community-based organizations manage grants and contracts.

► **COMMUNITY ENGAGEMENT:** Medicaid reforms since 2012 in Oregon had created several opportunities for community engagement—for example, requiring CCOs to conduct community health assessments. In one site, the CCO established a health council responsible for reinvesting CCO savings in community health projects—many focused on influencing social determinants. Sites in California also focused on improved understanding of community needs. One county used Section 1115 waiver funding to establish a community engagement unit, which hired eight full-time advocates—"hardcore advocates[,]...not government people," in the words of a program director—to work with local communities to understand upstream health issues, identify gaps in services, and support health care and community-based organizations to help fill them.

► **DATA AND TECHNOLOGY:** Finally, sites in California invested Section 1115 waiver funding in data and information technology infrastructure to improve their ability to identify patients who required support, coordinate care, and track the use of services between sectors. One county invested in a data repository that combined information from health care, criminal justice, social services, and housing. The system was used to identify high users of multiple systems to be targeted for care coordination.

MEDICAID FUNDING OPTIONS Sources of Medicaid funding used to support these interventions fell into three categories: conventional options, alternative models, and savings (exhibit 1). Funding from multiple categories was often combined and added to other federal and local dollars to cover additional costs or intervention components restricted under Medicaid.

► **CONVENTIONAL OPTIONS:** Some interventions were supported using funding traditionally available under Medicaid (for example, through managed care or fee-for-service contracts). Examples include Medicaid payments for case management and care coordination (benefits under

EXHIBIT 1

Medicaid funding for social needs interventions in Oregon and California, by funding category

Examples of funding sources	Examples of social needs interventions
CONVENTIONAL OPTIONS	
Covered services such as care coordination and case management Medicaid administrative claiming such as Medicaid administrative activities	Medical transportation services and referrals to social services Connecting behavioral health patients with housing, employment, or income support On-site legal supports in FQHCs
FQHC rate adjustments to incorporate social interventions	
ALTERNATIVE MODELS	
Alternative payment methodology for FQHCs in Oregon CCO flexible service spending for individual patients Incentive payments—Section 1115 waiver funding in California Bundled payments—Section 1115 waiver dollars in California	Community health workers supporting patients with social needs Clothes, heaters, shoes, air filters, and temporary accommodation Care coordination for successful transitions from jail to the community Intensive case management for homeless patients, and data and analytics infrastructure development
SAVINGS	
Savings from CCOs and managed care contracts	On-site food bank and vouchers for low-income patients and contributing to family relief nursery operating costs
Savings from Section 1115 waiver contracts in California	Reinvestment in flexible housing pool, used to cover rental subsidies and supportive housing development

SOURCE Authors' analysis of study data. **NOTES** FQHC is federally qualified health center. CCO is coordinated care organization.

managed care), Medicaid administrative claiming dollars (used to fund administrative activities such as care coordination), and funding for defined social supports covered under state plans (such as medical transportation). Some sites used nontraditional organizations to deliver these services. In Oregon, one CCO helped community-based organizations—including a family relief nursery and housing provider—obtain National Provider Identifiers from the Centers for Medicare and Medicaid Services (CMS) to enable Medicaid reimbursement for care coordination. Others were exploring how the costs of social interventions could be covered through rate adjustments. For example, one federally qualified health center in California was seeking to include legal costs (to help homeless patients access benefits) within their prospective payment system rate. While these conventional options were constrained by Medicaid regulations and sometimes involved high administrative burden, they offered a relatively stable route to fund limited social interventions for patients.

► **ALTERNATIVE MODELS:** Sites in both states also used alternative models for funding to support social interventions. In California, county health departments received Section 1115 waiver funding from the state, which they used to construct per member per month bundled payments for defined social interventions covered under the waiver (such as housing-related supports). One county also used incentive payments to support care coordination in settings usually excluded by Medicaid. The county created a payment model that rewarded successful transitions to

community settings for patients leaving jails and institutions for mental disease. To achieve successful transitions—including by connecting patients with social supports—teams must coordinate care before patients' discharge or release. But since Medicaid payments are not allowed while patients are institutionalized, the county receives payments only when patients are enrolled in Medicaid after they leave those settings.

In Oregon, three main alternative funding sources could be used to support social interventions. First, alternative payment models freed up funding for provider organizations to invest in social supports. For example, federally qualified health centers in our Oregon sites operated under the state's alternative payment methodology—a capitated payment covering Medicaid primary care medical services. The centers submit claims data to the state, including on care touches (such as social needs screening) outside the scope of traditional medical visits, and receive additional payments if their revenue falls below prospective payment system rates. Some centers used this new flexibility to expand their nonmedical services—for example, increasing the number of community health workers who supported patients with social needs. Second, the state's Section 1115 waiver in 2012 introduced flexible services spending, which allowed CCOs to purchase one-time, noncovered services on the basis that they would improve members' health. Flexible services target individual patients, must be related to medical diagnoses, and are generally small sums of money (as little as \$20). CCOs described challenges in freeing up funding for flexible services when these

expenditures were treated as administration costs for rate setting. (Flexible services recently became allowable as medical expenses in CCOs' medical loss ratios, and they now fall under a broader category of health-related services spending.) Third, annual quality payments from the state to CCOs provided additional opportunities for investment in social interventions. In practice, however, these investments often focused on achieving state quality measures around clinical priorities.

► **SAVINGS:** A final approach to translating Medicaid dollars into investment in social interventions was through savings. In both states, CCOs and managed care organizations invested a proportion of savings from Medicaid contracts (such as CCOs' global budgets) in programs to address social needs. In California, county health departments also shared a proportion of savings from Section 1115 waiver programs—for example, savings made within prospectively defined bundled payments for services. Savings became county funds and not subject to Medicaid rules. In one site, several million dollars of local savings were being invested in a flexible housing pool, used to pay rental subsidies for patients in supportive housing. In another, savings were combined with other local funding to invest in permanent supportive housing units. While savings were typically seen as the most flexible source of funding for social interventions, health care leaders were uncertain about their ability to accrue them in the future.

CONTEXTUAL FACTORS INFLUENCING IMPLEMENTATION While each state's reforms had made it possible to use Medicaid funding for an array of social interventions, the implementation of these programs was heavily shaped by local context. This included factors relating to health care system context, community context, and interactions between the two (see appendix 2).²²

Within the health care system, growing awareness of the impact of social determinants of health, the backing of senior leaders, and the mission and culture of organizations serving low-income patients all encouraged investment in social interventions. Simultaneously, efforts were constrained by underdeveloped systems and processes for identifying and addressing social needs, ambiguity around what could be covered by Medicaid (and how costs would be treated in rate setting and medical loss ratio rules), and professional opposition to new interventions (for example, clinicians feeling uncomfortable asking patients about social needs without having a solution to address them). Outside the health care system, the political context, extent of collaboration between health care and community-based organizations, and communi-

ty attitudes toward social interventions all influenced program implementation. For example, in California the commitment to address homelessness from county boards of supervisors created a supportive political context for the Whole Person Care Pilots program.

Above all, however, interviewees described how implementation depended on the availability of services in the community to address social needs. In all sites, the scale of Medicaid patients' unmet social needs—for housing, food, income, and more—outstripped the resources available to address them. Interviewees described how additional Medicaid investments in social supports, while welcome, could reach only a small number of high-risk patients and were insufficient compared with the scale of unmet social needs in their communities. One interviewee noted, "If we spent our entire Medicaid budget on housing, we still wouldn't have enough."

Discussion

Interest in health care interventions to address patients' social needs has outpaced the sector's knowledge of what works, when, and for whom. Our study provides new insights into how social interventions have been funded and delivered under Medicaid reforms in Oregon and California, as well as the contextual factors shaping their implementation. While previous work^{9,10} has described options for states to use Medicaid funding to support social services, little evidence is available on how the funding is used in practice. When organizations were given greater flexibility over spending, we found that health care leaders made investments in a range of services to address housing, food, legal, and other social needs, as well as capacity-building interventions to strengthen health care and community-based organizations' ability to respond to these needs. Sites used a mix of Medicaid funding to support social interventions, including conventional options, alternative models, and savings.

Our findings have several implications. First, Medicaid reforms in both states have blurred traditional funding boundaries between health care and social services, raising questions about whether current Medicaid rules make sense in the context of providing care to patients with significant socioeconomic barriers to health. The clearest example is housing, where Medicaid can cover some housing-related services but not direct housing costs or rent. Under the Section 1115 waiver in California, however, Medicaid dollars were used to cover patients' first month's rent and other housing expenses, and local savings from waiver programs contributed to rental

subsidies and new housing units.

Should these kinds of investments become the norm for Medicaid? Some health care leaders in our study hoped that data from their reform efforts could make the case for redrawing some Medicaid funding boundaries in the future—for example, expanding the scope of housing-related services covered under state plans. Others, however, worried about the risk of medicalizing social needs and the health care sector's lack of skills and resources to solve complex social issues, such as homelessness, that face low-income communities. An alternative approach, of course, would be for policy makers to invest in housing and other social services directly, instead of channeling funding through Medicaid—particularly given the imbalance of spending between health care and social services in the US compared to other countries in the Organization for Economic Cooperation and Development.²⁴ Given the paucity of evidence on the impacts of health care interventions to address social needs,¹ targeted evaluation of the initiatives currently under way in California and Oregon—if focused on the specific social needs components of each state's reforms—would at least help policy makers better understand the outcomes and costs associated with Medicaid spending on social supports. Evaluation of the social needs components of these programs could also help local leaders better target their diverse investments in this area.

Second, leaders in both states were concerned about their ability to sustain Medicaid investments in social supports. Funding for California's Whole Person Care Pilots expires in 2021. And in both states, savings from Medicaid revenue—currently used flexibly by CCOs, managed care organizations, and counties to invest in social supports—are not guaranteed in the future, particularly given current efforts to reduce federal Medicaid spending. The recently expanded definition of *supplemental benefits* in Medicare Advantage²⁵ suggests that CMS may allow greater spending on social services over time. But even under more flexible payment models, investment in social interventions ultimately depends on the choices of health care leaders about the proportion of Medicaid revenue they are willing to direct toward nonmedical services. Our study did not assess levels of spending on social services in each site. One recent analysis²⁶ suggested that in 2015, CCOs in Oregon documented spending less than 0.1 percent of their total annual budgets on flexible services, which includes health-related social supports (but excludes spending on social supports using savings)—though documentation of this spending is variable. Recontracting for CCOs is cur-

rently under way, and policy options for new contracts under review include requirements for increased spending on social determinants and new financial incentives to address targeted social needs.²⁷ It is worth noting, however, that CCO spending is only one component of health care financing for social needs in Oregon. Federally qualified health centers, for example, have long invested in social supports for vulnerable populations using a mix of local, state, and federal funding sources.

Finally, our findings illustrate the central role played by community-based organizations in delivering social interventions. In both states, health care organizations had developed partnerships with community-based organizations to deliver care coordination, housing supports, food programs, and more. Positive relationships between health care and community-based organizations were commonly identified as a supportive factor that shaped program implementation. Yet we also uncovered challenges for community-based organizations when partnering with health care, including differences in language and approaches to supporting low-income patients, limited capacity and capabilities to manage large service contracts, and challenges recruiting and retaining staff.

Given that many health care interventions to address social needs rely on referrals to community-based organizations and other social services,¹⁶ our findings suggest that health care leaders should consider the potential tensions and unintended consequences of these partnerships for community-based organizations and how to mitigate them. For example, health care organizations in our study made capacity-building investments in community-based organizations. These considerations are particularly important given the growth of multisector partnerships focused on population health in the US.²⁸

Conclusion

Health care organizations across the US are experimenting with interventions to address patients' social needs. Policy makers are testing new approaches to incentivize these activities. In California and Oregon, sites involved in Medicaid reforms invested in service interventions to respond to patients' social needs directly and in capacity-building activities to strengthen health care and community-based organizations' ability to collaborate and deliver social interventions. These investments blur traditional boundaries between the funding and delivery of health care and social services. ■

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