HUB ANALYSIS   OCTOBER 2020

Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health

The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences and your feedback on future Medicaid MCO Learning Hub so we can better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

In July and August 2020, the NORC team convened four group discussion meetings with each of its Medicaid MCO Learning Hub partners – Community Catalyst, the Association for Community Affiliated Plans (ACAP), America's Health Insurance Plans (AHIP), Families USA – and their affiliated Medicaid MCOs and advocacy experts. Discussions focused on the social determinants of health (SDOH) needs of their members and how COVID-19 is affecting those needs. After assessing key themes, the team convened a roundtable with representatives from each partner to discuss key findings from the group discussions and insights and opportunities for addressing those key findings.

This brief is the first in a series of group discussion meetings and roundtable discussions detailing findings and insights and opportunities around key issues. The brief will provide the Robert Wood Johnson Foundation, its grantees, MCOs, community-based organizations (CBOs), and other stakeholders with information about key challenges faced by MCOs and CBOs during COVID-19, and local, state, and federal opportunities for addressing those challenges. Forthcoming briefs in this series will focus on complex populations (e.g., behavioral health) and consumer voice and engagement.

Over the years, state Medicaid programs and Medicaid managed care organizations (MCOs) have invested in and implemented initiatives to address the impact of social determinants of health (SDOH) on Medicaid enrollees. The COVID-19 pandemic has further highlighted the need to both protect and strengthen SDOH of Medicaid enrollees. In a series of group discussions and a roundtable discussion with Medicaid MCO Learning Hub partners, we asked Medicaid MCOs and consumer advocacy representatives to provide their perspectives on changes in SDOH needs, and how those needs depend on health care services that have been disrupted due to COVID-19. This brief highlights key findings from these discussions about the role of MCOs in addressing social needs, facilitators, or barriers to MCOs' efforts to address social needs, and issues regarding how services that address MCOs' member social needs should be financed.

Key Findings from the Group Discussions

This section presents key findings from the group discussion meetings on Medicaid members' SDOH needs, how COVID-19 has affected these needs, and organizational and contextual factors affecting MCOs' ability to address these needs.

I. SOCIAL NEEDS: HOUSING, FOOD, AND TRANSPORTATION

Housing, food, and transportation are the greatest social needs among the Medicaid population, though the need for mental health services is rising due to COVID-19.

Consistently across the four group discussions, participants noted that the greatest Medicaid member needs are housing stability, food security, and transportation. Both MCOs and member advocates identified housing in particular as one of the biggest challenges for Medicaid members. They noted that, while housing has not been a huge issue during the pandemic due to a federally backed moratorium on evictions, the expiration of this moratorium will be extremely detrimental to Medicaid members, many of whom will face evictions or increased housing uncertainty.

> "The biggest needs right now are food, transportation, then housing…and social integration due to social isolation." — *Advocacy Representative*

The COVID-19 pandemic exacerbated the need for housing, food, and transportation, and highlighted additional needs such as mental health and substance use support as a result of social isolation and increased substance use, and technology needs for basics such as schooling, telemedicine, and social interaction. Multiple MCOs noted growing issues related to domestic violence as a result of social isolation due to shelter-in-place requirements. Participants also noted challenges connecting members to employment services. Advocates highlighted needs for COVID-19 testing—to ensure not only equitable access but also faster results, as certain decisions (e.g., ability to go to work) often depend on test results.

MCOs reported conducting enhanced outreach to members given the growth of needed SDOH-related services during COVID-19. Also, several plans are proactively identifying individuals at increased risk for severity of disease due to chronic conditions, and those in certain high-risk zip codes for additional SDOH support.

Advocates also highlighted the importance of intersectionality. For example, racism is an SDOH that intersects with other biases such as socioeconomic or sexual orientation. This is important because Medicaid members have multiple identities across race, ethnicity, class, and sexuality, all of which play an important role in SDOH. Each identity and the intersection of their identities impact how they engage with the health care system and/or with providers, so they are likely to have overlapping needs across multiple issue areas.

Future MCO SDOH initiatives likely will focus on housing and food insecurity.

MCOs noted that they will continue to invest in programs that alleviate food and housing insecurity to support their Medicaid members. As mentioned, MCOs focused on these two areas pre-COVID, and see these as two important SDOH factors to continue addressing for the long term, although COVID-19 has exacerbated need in these areas. In addition, MCOs mentioned partnering with community-based organizations (CBOs) to create community gardens, deliver food boxes, and develop neighborhood-level food pantries, which also address the concurrent need of transportation.

> "Affordable housing is a challenge across all the populations we serve. We are talking about ways to proactively augment some of the housing resources already in place. To date, we have allocated close to $25 million toward this." – *Medicaid MCO Representative*

II. RISE OF TELEHEALTH

The rise in telehealth during COVID-19 has the potential to be a catalyst for improving access, while at the same time Possibly worsening disparities.

There are differing perspectives on how telehealth or virtual visits are impacting members. Advocates noted "a big digital divide" between members with access to technology, such as smartphones, Wi-Fi, and computers for telehealth visits, and those either without access or with access but lacking the ability to use the technology. As more information is provided online rather than on paper, the divide between those who are technology literate and technology sufficient and those who are not grows.

> **"Many people of color are the very people who don't have the bandwidth and technology to really take advantage of services like telemedicine. The biggest thing I hear is that people don't get any information—they don't know what's going on; if it's online and you're not, you're not going to get that information."** — *Advocacy Representative*

In contrast, some MCOs noted that "virtual care is a great catalyst and equalizer," as it can reduce transportation and language access issues, which have impeded Medicaid members' ability to receive timely health care services. Advocates noted that promoting access to universal broadband would be one step in helping members more easily access health and social services.

III. MEMBER CHALLENGES

Members experience challenges in receiving, understanding, and using MCO and provider information due to communication barriers.

Both MCOs and advocates noted a variety of challenges meeting member needs. For example, many MCOs and advocates highlighted that the transient nature of the Medicaid population, where some members must regularly change home addresses or phone numbers, and members' challenges in finding time to focus on the information they receive, can lead to difficulty in communicating and coordinating services, and ultimately meeting members' basic needs.

> **"Trying to continuously get member buy-in and engagement with our plan is very challenging."** — *Medicaid MCO Representative*

This has been especially evident during COVID-19. Advocates noted a lack of COVID-19-related health information sent to members and, when members do receive letters or guidance, their difficulties reading, understanding, and using the information. Advocates also highlighted the importance of heeding and fully addressing language barriers, be it for immigrant groups, individuals with disabilities, or other populations with special language requirements. One advocate noted that providing more services around health literacy and navigation can help empower MCO members in their own decision-making and ability to self-manage their conditions.

> **"The overriding imperative is to provide better communication, simpler communication, and multiple means of communication out there [to members]. When you get a letter that you can't understand, what do you do? Who do you reach out to?"** — *Advocacy Representative*

Advocates also noted that increased MCO COVID-19 or SDOH-related communication with members via primary care providers (PCPs) or other trusted intermediaries, like faith-based organizations or community health workers, is helpful. While PCPs may not have the capacity to fully take on this additional role, they are trusted sources of information and could address members' questions and/or concerns. An advocate noted the potential to foster relationships between community-based PCPs, who have stable and long-lasting relationships in the community, and advocates; they could work together and share data and resources to meet members' needs. Advocates also noted that community health workers are high-value providers who can play this intermediary role in the community.

> **"Figuring out how to effectively use PCPs who are often [people] patients trust the most to help with communication...that is important. I am hesitant to add more to a PCP's plate, but that is going to be the person they listen to compared to a letter from the state or an insurance company."** — *Advocacy Representative*

Advocates noted, however, that it is important to distinguish between health-related social needs, which are members' social needs at the individual and clinical level, and broader SDOH needs that require systemic responses. It is easier for health care providers and clinicians to address health-related social needs, though MCOs can play broader roles in helping address more systemic issues of employment, education, and racism that affect the health needs of their members.

IV. SDOH AND RACE AND ETHNICITY DATA: COLLECTION, ACCURACY, AND SHARING

Collecting accurate SDOH and Race and Ethnicity data and sharing it have the potential to help MCOs better meet the needs of their members, but data challenges have limited MCOs' ability to tailor SDOH programs, including by race and ethnicity.

Many MCOs noted challenges to consistently collecting race and ethnicity data that would help them better tailor their SDOH initiatives. Some MCO SDOH initiatives make accommodations to bring services to their members in terms of cultural appropriateness—e.g., tailoring programs and linking to CBOs based on member zip code. However, while most MCOs typically include race and ethnicity questions during the enrollment process, one MCO representative noted that only 30 to 40 percent of their members select a race or ethnicity in their application, which makes it difficult to appropriately customize programming.

In addition, one MCO representative noted that there are too often inconsistencies in SDOH or race and ethnicity indicators for the same individual depending on the data source. MCOs generally agreed that they have been collecting SDOH and race and ethnicity data across several different domains and data sources, but need to improve the efficiency of the collection processes and integrate the data so that they are available in one place. One MCO noted that it has "27 data sources" related to SDOH and demographic indicators, which were not organized in a way that would allow case managers to see the full picture of an individual's SDOH needs alongside demographic data, such as race and ethnicity. MCOs noted that they are "still figuring out how to use the data to better target their programs."

> "I'm thinking about all of the SDOH data we collect across 12 domains and how we need to find a way to meld that data together to better inform our work. I think we can be more efficient and impactful with our SDOH initiatives if we combined all these data elements…" — *Medicaid MCO Representative*

Advocates highlighted the role community needs assessments can play in helping MCOs, in addition to conducting these with health departments and other key stakeholders, better understand the needs of their community and members. For example, if community needs assessments are patient- or beneficiary-centric, then they can directly provide insight into what is most important to the community. Paired with patient-centered, comprehensive individual-health assessments, these datasets can help MCOs understand community deficits (such as the unavailability of grocery stores within a community) and identify both short- and long-term strategies. In addition, risk stratification and using clinical risk groups to understand the needs of all members, not just individuals using a higher level of services, can help MCOs better determine outreach and intervention efforts. Advocates and MCOs also highlighted a need for more evaluation of the interventions, so they can understand what is and is not working and to create more sustainable, measurable improvements.

In addition, data sharing across organizations (such as MCOs, clinicians, CBOs, etc.) can improve coordination of services for members. Participants noted this is a persistent gap. MCOs observed, in particular, the challenge of sharing data across organizations and highlighted the important role of the federal government in enabling this exchange. One plan noted, "What CMS [Centers for Medicare & Medicaid Services] can help with is supporting interoperability; efficient data exchange is key." An advocate noted that MCOs can potentially play a role in working with providers and CBOs to make data more transparent. Since CBOs often have limited data on members' social needs, and clinical providers often have only clinical and individual-level data, MCOs, which have more robust member data, are in a good position to leverage data exchange across these partners for better coordination of services to individual members.

V. COLLABORATION BETWEEN MCOS AND CBOS

Opportunities exist for further strengthening relationships between MCOs and CBOs to address members' SDOH needs.

MCOs and advocates uniformly agree that MCOs alone cannot address SDOH; there needs to be a holistic, coordinated approach among the state, managed care plans, CBOs, and other key partners.

> "No one entity has the resources to solve all of the community's problems. We are talking about complex systems, and people's lives. It is a public-private partnership. We should be a conduit for the state…is there a way for us to do that with community-based networks to provide resources for our members." — *Medicaid MCO Representative*

Participants agreed that CBOs, in particular, are critical partners for MCOs seeking to address a variety of SDOH-related member needs. MCOs reported using Medicaid SDOH data and member self-reported needs to identify needed CBOs with whom to partner. However, challenges exist with CBO capacity. MCOs reported that they are reaching out to CBOs, but fear at times they are "overrunning" them, as CBOs are often "overburdened and underequipped" to meet the high level of member need. In rural areas, both MCO and advocacy representatives also noted challenges with CBOs that may be unable to provide the same services as those in urban areas, or a lack of CBO presence altogether.

However, participants agreed that opportunities exist to further strengthen existing relationships and build new ones between MCOs and community organizations. MCOs noted a need for a "network" and proper "organizing" of MCOs with CBOs to promote greater matching of resources and relationship building to meet Medicaid member needs. Advocates highlighted that states can promote these partnerships using financial incentives, such as value-based purchasing (VBP) with providers. Advocates also noted that MCOs can play a role in building community capacity; partnerships between states, MCOs, and CBOs can identify community needs and fill identified gaps. Participants noted the role of community development organizations and trusted intermediaries, such as faith-based institutions, in these partnerships.

VI. MCOS' FINANCING OF SDOH

MCOs are financing SDOH initiatives using multiple funding sources, and note a positive return on investment from funding them.

MCOs report using their reserves, grant funding, and/or profit margins to fund SDOH initiatives.

> **"Right now, most of our [SDOH-related] resources come from our reserves or grant funding. They are not part of the rate received from the state and I think that's one of the challenges in this country—we don't connect health and social services together. It's also a maldistribution of health care and social services in terms of dollars spent per GDP." — Medicaid MCO Representative**

Several MCOs noted that funding certain SDOH programs has led to a reduction in unnecessary utilization. Multiple plans noted that they track or are evaluating the impact certain SDOH initiatives have on health care utilization.

> **"The biggest investment we've made is on housing. Our year one results were really promising. We saw a large reduction in health care spending, leading to an increase in housing financing in year two. We are going to continue to invest in the housing side as our biggest SDOH expenditure. Hopefully, we can turn to more private investors and make a case for investment on their behalf." — Medicaid MCO Representative**

One MCO noted, however, the high upfront cost of identifying and coordinating SDOH-related services, such as supportive housing, particularly if a member disengages or leaves the plan altogether. In addition, there are also financial limitations to what services MCOs can provide to their members. As one MCO representative noted, most of their resources come from reserves or grant funding.

For example, MCOs described challenges in funding transportation initiatives; many said they cannot offer nonemergency medical transportation or transportation for daily needs, such as to the grocery store, for all of their members. Some MCOs invest in other higher-priority services such as housing, because these investments correlate with a reduction in health care spending. MCOs reported that they rely on their case managers to identify the critical transportation needs among their members and direct targeted transportation services as needed.

VII. LEVERS OF CHANGE

Blending and braiding state and federal funds, along with MCO Funding and other resources via public-private partnerships, can help align financial incentives across organizations to meet the complex needs of the Medicaid population.

There was a general consensus among MCO and advocacy representatives that state agencies should be doing more to organize efforts and create a multifund stream with MCOs to avoid duplicative administration costs and services to meet the comprehensive needs of members. One MCO noted that they have experience pooling state agency dollars with their care management resources to meet members' needs, and they are working with government relations staff to break down state social service agency silos to pool resources. At the same time, one MCO reported challenges in understanding all of the eligibility and funding requirements for state and federal assistance programs, which can make these cross-agency relationships very difficult to navigate.

> "We see opportunities to work at state levels to…blend the case management and administrative dollars of those different state programs into comprehensive care delivery systems. We have had success receiving Head Start, Department of Labor, and USDA SNAP dollars, and being able to bring resources together alongside Medicaid case management and behavioral health care and see that the comprehensive [funding] approach not only helps state departments hit their targets but reduces the MCO's medical costs as well." – *Medicaid MCO Representative*

Crucial to establishing these relationships for blended funding is aligning financial incentives across agencies and organizations. One MCO noted that incentives across organizations and sectors are not aligned. One MCO noted that the number of hospital beds has increased due to an increase in utilization, which must now be supported with stable revenue. At the same time, CBOs compete with one another and other non-CBO organizations for scarce funding. The participant noted, "We've created this competitive environment that makes it counterproductive to problem solving." Pooling funding across state and federal agencies, along with MCO resources and public-private partnerships that align financial incentives, was viewed as a comprehensive approach to meeting the complex needs of the Medicaid population.[1]

Medicaid contracts with MCOs could include more prescriptive value-based payment approaches with the right financial incentives to advance SDOH services and benefits for members.

Advocates noted that while some states are adept at using their Medicaid contracts with MCOs to require or advance SDOH services, many states struggle with how to best include these requirements and incentives. Many states want to provide MCOs with flexibility to provide innovative SDOH-related services to members, but a lack of clear guidance or requirements, both from states to plans and the federal government to states, can also impede progress.

> "So much starts at the state level. Many states are not very good at [using MCO contracts]; they want to be doing this and feel like they want to address SDOH and use it as a buzzword. I see it in a lot of [state] contracts, a requirement around SDOH assessments or something really broad; it's great to have that flexibility because we want MCOs to innovate and accomplish what they need to accomplish, but if that goal isn't really clear, it is hard for everything else to follow suit." — *Advocacy Representative*

MCOs also said that while they hoped that Section 1115 waivers could provide more flexibility for states to address SDOH at a level that would allow plans to integrate SDOH components into their systems, they have not experienced this flexibility to date.

With that said, an advocate reported that Oregon has been a leader in devising creative ways to fund SDOH initiatives. The state has leveraged funding from Section 1115 demonstrations and State Innovation Model grants, and has also worked with CMS to issue clearer guidance on which social services, like housing, can be provided under Medicaid. In addition, because Oregon's coordinated care organizations are nonprofit entities, they are able to use the state's 1115 Medicaid demonstration waiver to invest in SDOH through a community benefit initiative.[2]

MCOs have the potential to leverage their status as state partners For Medicaid experts to better advocate for the needs of their members at the community level.

Advocates noted that MCOs have additional levers that they can use to more broadly support the needs of their members. For example, MCOs can leverage their lobbying arms to advocate for communities' social needs, e.g., education, housing, zoning, etc. In addition, MCOs can work more closely with CBOs, including community development organizations and other key partners, to advocate for investment in underserved communities.

> *"MCOs can become an advocate for those community deficiencies and systematic issues that are leading to problems that we are trying to address. So [more MCO] advocacy would allow a rising tide to lift all of the boats, so even if you're concentrating on the high utilizers or children in foster care or substance use, mental health intersections — [MCOs would be] lifting the boat for the entire community and making it easier for MCOs to do the work with the high utilizers or whoever they're focusing on." — Advocacy Representative*

Some advocates highlighted the potential for MCOs to build community power by investing in grassroots organizations that are leading work to create social services capacity. Doing so would help with the sustainability of cross-cutting collective impact. MCOs can also host listening sessions with their members to understand their service needs.

> *"We have a lot of issue-specific collective impacts: food collective impact, housing collective impact — it misses the point of the collective impact a little. Medicaid MCOs have a chance to seed consistent overarching community engagement that helps prioritize what matters most to more broadly influence transformational change." – Advocacy Representative*

Advocates also suggested that MCOs look internally at their own organizations and providers to see how they can better address the diverse needs of members and their communities. An advocate noted that people of color, and Black people in particular, often experience racism within the medical system. The participant noted the potential for "MCOs to make a difference by helping to increase the cultural competency and reducing the unconscious bias of provider networks in caring for the Medicaid population."

INSIGHTS AND OPPORTUNITIES FOR IMPROVING SDOH NEEDS FOR MEDICAID MEMBERS — HIGHLIGHTS FROM A ROUNDTABLE DISCUSSION

Leveraging Medicaid to address SDOH-related activities is a growing area of importance and relevance to MCOs and the broader policy and advocacy community. As such, there are opportunities to further define and strengthen the role of MCOs, states, and other key stakeholders—

including CBOs—in addressing health-related social needs and broader systematic SDOH-related barriers for Medicaid members.

After the group discussions with Medicaid MCOs and advocate representatives, the MCO Learning Hub convened a roundtable with representatives from all four partner organizations: Community Catalyst, the Association for Community Affiliated Plans, America's Health Insurance Plans, and Families USA. They focused on key takeaways from the group discussions and potential opportunities for addressing the challenges described in these meetings. Here, we describe insights and opportunities proposed by roundtable participants for addressing these key challenges.

I. BREAK DOWN SILOS AMONG STATES, MCOS, AND CBOS

Breaking down existing silos among States, MCOs, and CBOs has the potential to reduce administrative and funding inefficiencies across organizations and increase resources available for and effectiveness of SDOH initiatives for Medicaid members.

Between MCOs and CBOs. Group discussion participants described how silos between MCOs and CBOs are challenging to overcome for several reasons, including the difficulty of exchanging data; CBOs lacking sufficient capacity, exacerbated by challenges during the pandemic like underfunding, a lack of staff, and high demand; and administrative complexity and contracting issues like legal contracts, HIPAA-compliance concerns, whether CBOs are considered eligible providers under Medicaid, etc.

> *"What we heard from CBOs — it's challenging to contract with MCOs. They are challenged by compliance issues and legal contracts. It would help to bring CBOs together in a larger umbrella to contract with MCOs." — Advocacy Representative, Roundtable*

In addition, MCOs noted difficulty assessing the quality of CBO services and knowing which CBOs are available to support SDOH efforts. Roundtable participants gave examples of potential models, including CommunityRx in Chicago, which employs youth to go door-to-door to find lesser-known CBOs and identify other potential community resources[3]; NowPow, a digital health platform that has partnered with MCOs to match members with SDOH services[4]; and North Carolina's 1115 Waiver demonstration that authorizes $650 million in Medicaid dollars to pay for nonmedical interventions. These dollars will come from the state through MCOs to Lead Pilot

Entities who will manage a network of CBOs that will be paid to deliver select services to specific members.[5]

Insights and Opportunities:

- Provide technical assistance for CBOs on administrative and contracting issues (e.g., HIPAA, legal contracts, etc.) to navigate legalities that could delay select servicing to members

- Lift up delivery system models or funding that can help scale CBO capacity, promote greater matching of and relationship building between CBOs and MCOs, and provide more streamlined avenues for contracting with MCOs

Between States and MCOs. Group discussion participants noted existing siloes between various state agencies and funding streams. Among the group discussion participants, there was a general consensus that state agencies could do more to organize efforts and create a multifund stream with MCOs to avoid duplicative administrative costs and services to meet the comprehensive needs of the Medicaid population. Crucial to successful coordination of resources is aligning financial incentives across agencies and MCOs. Roundtable participants described Washington State's Accountable Communities of Health[6] and Massachusetts's ACO model[7] and payment system as ways in which states have led efforts to bring agencies and organizations together towards a common goal.

Insights and Opportunities:

- Work toward a collective impact model,[8] where all relevant stakeholders work towards the same goals to improve outcomes

- Develop comprehensive financing models for SDOH services that rely on braided/blended funding streams across organizations and state agencies

II. CLARIFY STATE AND FEDERAL GUIDANCE ON FUNDING SDOH

MCOs are seeking additional guidance from states and the federal government on how they can better address SDOH with Medicaid funds.

Group participants described the lack of state and federal clarity around SDOH funding. A lot of MCOs use their reserves to fund significant activities in SDOH. In roundtable discussions, MCO representatives noted the lack of direction at both the state and federal level on allowances for SDOH funding using the portion of the MCO rate designated for medical costs. Participants observed that MCO investment in SDOH programs would seek to improve member health and reduce utilization rates. Yet, in

turn, reduced utilization could lower future plan capitation rates, resulting in decreasing rates to the MCO over time. Both MCOs and advocates noted that state Medicaid contracts with MCOs could include more prescriptive VBP approaches with the right incentives to advance SDOH services and benefits for members, while not negatively affecting MCO rates and the dollars that are critical to supporting these interventions.

> "I worry about setting requirements for plans to invest in SDOH and not providing financial support for such investments. I know there is some movement to allow SDOH to be funded as part of the administrative portion of the rate…But if [MCOs] do the right investments, and health care costs decrease, plans receive less money in their rates and don't have money to invest again, resulting in less money being available in the system to support the needs of Medicaid members…We want people to be healthier, but we don't want to lose money out of the system; it's a catch-22." — *Medicaid MCO Representative, Roundtable*

Attendees also discussed how the use of 1915(c) and 1115 waivers in 1981 allowed Medicaid coverage of home and community-based services (as opposed to providing long-term services and supports in nursing homes). That use of waivers may offer a conceptual framework for tapping Medicaid funding to target support to members requiring SDOH, to avoid unnecessary health care utilization.

Insights and Opportunities:

- Explore how state governments and MCOs can leverage policy flexibilities provided during the COVID-19 pandemic over the long term (e.g., continuous eligibility requirement in Medicaid to reduce churn[9])

- Advocate for CMS and the federal government to provide additional guidance on how to use Medicaid dollars to address SDOH and potential allowances for the medical portion of the Medical Loss Ratio

- Encourage states to provide MCOs with specific guidance around establishing VBP approaches related to SDOH initiatives that tie financial incentives to SDOH improvements

III. CLARIFY THE ROLE OF MCOS IN ADDRESSING SDOH

Roundtable participants highlighted the need to distinguish the role of MCOs in addressing health-related social needs from states and the federal government's roles in addressing broader, structural SDOH issues.

Group discussion and roundtable participants agree that MCOs have a role to play in addressing SDOH, but that "MCOs can't do it all." Participants noted that MCOs have opportunities to address the health-related social needs at the individual level, e.g., housing, food, and employment. However, they note that addressing the more systemic and structural issues regarding SDOH requires the focus of policy efforts at the state and federal level. With that said, participants acknowledged that the current COVID-19 pandemic has reduced state budgets and may pose challenges on the state role in funding or advancing these issues over the next several years.

> "MCOs are good advocates and partners but, ultimately, they are witnessing the health impacts of SDOH, not the root cause. But what can we do more at the systemic policy level?" — *Medicaid MCO Representative, Roundtable*

Insights and Opportunities:

- Explore other levers (e.g., advocacy, public-private partnerships) that MCOs can use to promote improved population health. MCOs may more fully utilize advocacy efforts and other levers to advance public-private partnerships and improve population health.

IV. IMPROVING SDOH AND RACE AND ETHNICITY DATA CAPTURE AND QUALITY

Achieving consensus on key SDOH metrics and improving data collection on race and ethnic status can help MCOs better tailor initiatives for key populations.

In group discussions, participants identified the need to improve the collection, quality, and synthesis of SDOH and race and ethnicity data to better identify community and member needs, increase consistency and accuracy of data, and enhance data analyses to inform efforts around health equity and reduce racial and ethnic disparities. Roundtable participants described opportunities for states or the federal government to identify a consensus on SDOH impact measures. This includes identifying immediate, intermediate, and long-term outcomes and metrics that CBOs and MCOs can work towards.

Insights and Opportunities:

- Work to achieve consensus around standard SDOH quality and impact measures

- Develop pilots on community-based priority setting and alignment on impact measures

- Identify SDOH return on investments and outcomes from SDOH initiatives to date

- Promote and incentivize infrastructure for interoperability and data exchange between agencies/organizations working with Medicaid members

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

We want to hear from you. Please contact us at MCOLearningHub@norc.org to start the conversation or join our distribution list.

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

Acknowledgements

NORC'S PARTNERS

References

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[3] More information at: https://www.uchicagomedicine.org/forefront/prevention-and-screening-articles/uchicagos-communityrx-intervention-helps-patients-find-community-resources.

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