

MCOs' Role in Combatting Homelessness in the Wake of COVID-19

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

The changes COVID-19 have forced on our society underscore the importance of both protecting and strengthening core social determinants of health (SDOH). There is increased recognition that improving health and achieving health equity goes beyond addressing individuals' medical concerns—policymakers must also take into account the social, economic, and environmental factors and racial inequities that influence individuals' health and lived experience. Programs and policies that address SDOH and work to align health care and social services play a central role in alleviating the harmful impacts of this virus on the health and well-being of millions of people in the United States. Services and supports for individuals whose needs go beyond the traditional health care landscape are already precarious; lack of access to housing and food has been further exacerbated by social distancing and increased demand coupled with shrinking nonprofit, local, and state budgets as a result of the pandemic. SDOH needs are often interconnected, adding to the complexity of identifying meaningful services and supports.

A key area of SDOH is an individual's neighborhood and built environment, which includes their quality of housing.¹ Individuals experiencing homelessness or inadequate shelter are vulnerable to lack of SDOH services, which can negatively impact their health. Without proper shelter, effective social distancing needed to combat COVID-19 cannot occur. Due to the pandemic, an increasing number of individuals are experiencing homelessness and job loss, and are therefore more vulnerable to negative health outcomes and health inequities. The following overview outlines the impact of homelessness on health outcomes, what state Medicaid programs and managed care organizations (MCOs) have done for this population pre-COVID-19, what they are doing now, and strategies they can consider in the future.

This brief is intended to support the Robert Wood Johnson Foundation, Robert Wood Johnson Foundation funded-organizations, MCOs, and other organizations to advance health equity by presenting timely topics and providing examples of leading organizations and their efforts in these topic areas.

SDOH, Homelessness, and COVID-19

The COVID-19 pandemic has highlighted the need to address social determinants of health (SDOH) to improve health outcomes and achieve health equity throughout the U.S. population. SDOH include the social, economic,

environmental, racial, and ethnic inequities that influence health. SDOH that can negatively affect an individual's health include, but are not limited to, poverty, poor access to education, employment status, as well as unhealthy and unstable housing.² Some researchers estimate that overall health and risk of premature death is determined by individual behavior (40 percent); genetics (30 percent); social circumstance (15 percent); environmental factors

(5 percent); and health care (10 percent).³ Given that social circumstances and environmental factors make up 20 percent of health risk, addressing the nonmedical drivers of health among those with an increased risk of disease and premature death is imperative.

Race and ethnicity are also key aspects of SDOH. Racial and ethnic minority populations experience social and economic inequities that translate to disparities in access to care, quality of care, and health outcomes.⁴ For example, in the United States, heart disease is the number one cause of death for all populations; however, middle-aged Black males **and** females have death rates that are about twice as high as their White counterparts.⁵

SDOH AND HOUSING ISSUES PRIOR TO COVID-19

State Medicaid programs and MCOs have implemented initiatives designed to address social and environmental factors influencing their members' overall health. A contributing factor in implementing these initiatives is that the Medicaid population is more likely to experience SDOH that negatively impact their health, leading to higher health care costs and poorer health outcomes.

Neighborhood and physical environmental factors, including housing, are a major SDOH. Safe and affordable housing enhances quality of life, which can influence health outcomes.⁶ In January 2019, the Department of Housing and Urban Development's (HUD) Annual Point-in-Time Count revealed that an estimated 567,715 people in the United States were experiencing homelessness on a given night.⁷ Many individuals experiencing homelessness have chronic mental or physical health conditions,^{8, 9} creating complex health care needs for those in this population that are enrolled in Medicaid or MCO health plans:

- Compared to the general population, individuals experiencing homelessness have disproportionate rates of chronic conditions such as diabetes, heart disease, and HIV/AIDS.¹⁰
- In 2017, 20 percent of individuals experiencing homelessness reported having a serious mental illness (SMI) and 16 percent reported conditions related to chronic substance use.¹¹
- Individuals experiencing homelessness are more likely to engage in substance use (including needle sharing).¹²

Obtaining adequate housing has also been a longstanding systemic issue for racial and ethnic minority groups, in part due to racial residential segregation instituted by federal policies in the mid-20th century.¹³ For example, the Federal Housing Administrations (FHA), established in 1934,

intensified racial residential segregation through redlining policies that stopped issuance of mortgages in and near Black neighborhoods.¹⁴ While the Fair Housing Act of 1968 made racial residential segregation illegal, the structures of racial residential segregation have largely remained and have been a fundamental cause of racial and ethnic health disparities.¹⁵ Exclusionary zoning, gentrification, and discriminatory lending practices still exist today and pose continued barriers for minority groups in obtaining adequate housing.¹⁶ Minority groups are much more likely to become homeless, illustrated by higher rates of homelessness overall:¹⁷

- Pacific Islanders and Native Americans are the most likely to be homeless in the United States when compared to all other racial and ethnic groups, with 160 out of every 10,000 Pacific Islanders experiencing homelessness and 67 out of every 10,000 Native Americans experiencing homelessness.
- Rates of homelessness are also significant among Black Americans (55 out of every 10,000); multiracial Americans (35 out of every 10,000); and Hispanic/Latinx (22 out of every 10,000).

SDOH AND HOUSING ISSUES IN LIGHT OF COVID-19

Without safe and affordable housing or shelter during the COVID-19 pandemic, individuals experiencing homelessness are even more vulnerable. Additionally, without adequate shelter or space in shelters to allow social distancing, this population is likely more susceptible to the virus than the general population. COVID-19 is not only impacting the nation's physical health, but also precipitating a behavioral health crisis.¹⁸ Given that the experience of acute physical and behavioral health crises may lead to homelessness,¹⁹ it is more important than ever to ensure that individuals experiencing homelessness receive the supports they need.

The following sections review the regulatory landscape that influences MCOs and health plans' ability to address SDOH and homelessness, as well as pre-COVID-19 programming. This background is imperative in understanding what MCOs and health plans can do to assist this population during the COVID-19 pandemic and in the future.

Regulatory Landscape

Federal and state regulations influence how and to what extent health plans can address SDOH and homelessness in particular.²⁰

FEDERAL ACTION

At the federal level, the Centers for Medicare & Medicaid Services (CMS) specifies which housing-related services are reimbursable with Medicaid funds. While Medicaid funds cannot be used to cover room and board, they can be used to cover other housing-related activities falling into the following three categories:²¹

1. **Individual Housing Transition Services** that provide direct support to individuals experiencing chronic homelessness, individuals with disabilities, and those needing long-term services and supports. For example, Medicaid funds can be used to cover assistance with the housing application process, develop an individualized housing support plan, and conduct a tenant screening and housing assessment to understand individuals' preferences and barriers.
2. **Individual Housing and Tenancy Sustaining Services** that support tenancy once individuals secure housing. Examples of covered services include education on tenant rights, assistance with resolving landlord disputes, and advocacy and linkage with community resources.
3. **State-level Housing Related Collaborative Activities** to assist with identifying and securing housing resources. Such activities include developing agreements with housing and community development agencies to facilitate access to housing and assisting these agencies with their planning processes by providing relevant data (e.g., demographic data on the population served).

STATE ACTION

Prior to COVID-19, states used a number of different waiver authorities to fund housing-related services. In particular, states have used mechanisms such as 1915(b) managed care waivers and 1915(c) home- and community-based service (HCBS) waivers to support the transition of individuals from institutional to community-based settings.²² For example, North Carolina offers Medicaid coverage under a 1915(b) waiver for transitional living skills such as housekeeping and shopping for children under 21 years with certain behavioral health diagnoses.²³ In Louisiana, multiple 1915(c) waivers help provide tenancy, tenancy crisis, and tenancy-maintenance services

for individuals with substantial, long-term disability who need housing and tenancy support.²⁴

Additionally, states have used 1115 waivers and contracts to effectuate SDOH interventions:

1. **1115 Waivers:** Section 1115 waiver demonstrations have increasingly included SDOH interventions, including requirements for MCOs to implement these interventions.²⁵ In particular, states continue to rely on these waivers to seek additional flexibilities for the coverage of housing-related services. For example, in 2018 CMS approved a 1115 waiver that finances North Carolina's "Healthy Opportunities Pilots," which includes evidence-based, nonmedical services to address housing instability (e.g., tenancy support, housing quality and safety improvement services, legal assistance, payments to help secure housing such as security deposits) in addition to other SDOH for individuals with certain risk factors.²⁶ When North Carolina's waiver is implemented, health plans operating within certain regions of the state will participate in the waiver by managing pilot budgets, determining enrollee eligibility, authorizing pilot services, and working with "lead pilot entities" who coordinate social service providers and community-based organizations.²⁷ California's Medicaid program also uses a 1115 waiver to test "Whole Person Care" pilots, which includes housing supports (e.g., housing navigation and financial assistance for security deposits and moving fees).^{28, 29}
2. **Contracts:** States are increasingly using their contracts with participating MCOs to address SDOH. While these contracts vary widely, MCOs must pursue primary activities that address SDOH, including screening for members' needs and coordinating the linkage of members to social supports.³⁰ For example, Maryland and Rhode Island require MCOs to link individuals experiencing homelessness with services. In Massachusetts, MCOs must provide services to individuals experiencing homelessness through the Community Support Program for Chronically Homeless Individuals; these include tenancy supports (e.g., landlord negotiation, housing search, crisis intervention), in addition to wrap-around supportive services such as peer supports and service coordination.³¹

State Medicaid programs are also increasingly using value-based payment (VBP) approaches focused on SDOH to incentivize improved health outcomes and provide a mechanism to finance efforts addressing SDOH that are upstream from clinical encounters.^{32, 33, 34} VBP approaches incentivize MCOs and providers to focus on

members' needs more holistically, whether they be medical or nonmedical, to achieve better outcomes.³⁵ An example of this is the Arizona Health Care Cost Containment System that requires MCOs to make 50 percent of their reimbursement to providers through VBP. It has allowed providers to directly finance the cost of supplying housing to homeless beneficiaries instead of paying for their medical bills if they continued to live on the streets.³⁶

Programs Assisting Individuals Experiencing Homelessness Pre-COVID-19

MCOs are implementing housing programs for their members either to fulfill a contractual requirement with their state or because of an understanding that tackling this SDOH leads to healthier members. Many MCOs have honed in on housing as a key SDOH.^{37, 38}

In general, MCOs are pursuing three types of housing activities:

- Risk assessments
- Capital investments
- Housing navigation and transitional services

Risk Assessments: Many MCOs have fielded risk assessment instruments to better understand the social needs of their beneficiary population. This is becoming standard practice, as a survey of Medicaid officials shows that 31 MCO states are requiring MCOs to screen enrollees for social needs as of 2020, including housing needs.³⁹

Capital Investments: Investing capital in affordable housing solutions for beneficiaries is proving to be a promising strategy for mitigating health care costs and utilization. Health care providers have found that providing housing-related services for individuals experiencing homelessness, such as those covered through Medicaid, can reduce medical expenditures for emergency department visits and inpatient care, as individuals experiencing homelessness are three times more likely than the general population to visit emergency rooms.^{40, 41} For example, University of Illinois Health (UI Health) launched the Better Health Through Housing program, a partnership with the Center for Housing and Health. This program identifies individuals experiencing chronic homelessness and places them in permanent supportive

housing. The program tracks participants' mortality, morbidity, cost, and utilization. To date, collected program data illustrate the importance of stable housing and support for a person experiencing homelessness in decreasing emergency room use and lowering costs for this population.⁴²

Some MCOs are also exploring capital investment in housing. Notably, CareOregon partnered with housing and services providers to address the needs of low-income seniors and those with disabilities as part of an LLC.⁴³ They also helped fund an initiative to build 379 new housing units for individuals experiencing homelessness and of low-income.⁴⁴ Central California Alliance for Health similarly provided capital funding in the form of a \$2.5 million one-time grant to a nonprofit housing developer to build 90 mixed-use units.⁴⁵ UnitedHealthcare of Arizona provided a grant to a community development organization in Phoenix to acquire affordable housing units.⁴⁶

Housing Navigation and Transitional Services: Some plans offer housing navigation and transitional services to coordinate affordable and alternative housing for beneficiaries who are homeless and vulnerable. Housing navigation consists of various services that range from financial management to tenants' rights education, while transition services can support an individual's ability to prepare for and transition to housing. A few examples include:

- Health Plan of San Mateo partnered with a nonprofit housing organization and the public housing authority to provide community alternatives to institutional care such as subsidized and low-cost apartments.⁴⁷
- A partnership between Mercy Maricopa Integrated Care (a nonprofit health plan sponsored by Mercy Care Plan and Maricopa Integrated Health System); the city of Phoenix Housing Department; and Valley of the Sun United Way provides housing and navigation services to members with substance abuse and mental health conditions.⁴⁸
- Hennepin Health⁴⁹ and EmblemHealth⁵⁰ offer housing navigator services.
- University of Pittsburgh Medical Center Health Plan offers housing services through intensive case management services.^{51, 52}

Understanding the efforts of MCOs to date is critical for determining how they can build on these efforts to address homelessness amid the COVID-19 pandemic.

The Impact of COVID-19 on Homelessness

Evidence shows that COVID-19 has quickly spread among individuals experiencing homelessness, especially in shelters.⁵³ The risk of homelessness—and issues faced by individuals experiencing homelessness—does not equally impact all social, racial, or ethnic groups. COVID-19 may exacerbate this issue. Almost 20 percent of U.S. counties that are disproportionately Black account for 52 percent of COVID-19 cases and 58 percent of deaths nationally.⁵⁴ Social conditions and structural racism—among other factors—increase risk of COVID-19 infection and death within Black communities.⁵⁵ Already, more than 34 million Americans have lost their jobs due to the economic impacts of the virus, with women, African Americans, and Latin Americans experiencing unemployment at disproportionate rates.^{56, 57}

Individuals experiencing homelessness are at a greater risk for contracting COVID-19 than the general population. This is due to a number of factors that exacerbate the spread of the virus: congregated living settings, such as shelters and encampments; scarce access to basic hygiene needs, such as disinfectants; and a general lack of access to health care, including screenings, testing, and quarantine treatments.⁵⁸ Individuals experiencing homelessness also live transient lifestyles and survival often depends on movement in order to acquire the most basic resources.⁵⁹ The resources that many individuals experiencing homelessness have relied on for shelter, sanitation, and food (e.g., fast food, libraries, etc.) have closed or modified hours and access in response to the pandemic.⁶⁰ Moreover, individuals experiencing homelessness infected by COVID-19 are twice as likely to be hospitalized, two to four times more likely to require critical care after infection, and two to three times more likely to die as a result of infection than the general population.⁶¹

The federal government hopes that increased flexibility for shelters, reduced “bureaucratic” decision-making, and elimination of environmental or habitability review and shelter caps will have positive impacts on this population.⁶² However, it is not clear whether these changes will improve or worsen the problem. Studies have shown higher rates of positive COVID-19 results for both staff and residents—many of whom are asymptomatic—in homeless shelters relative to the general population.^{63, 64} Furthermore, these changes may not be a viable solution. The number of individuals and households experiencing homelessness may potentially increase, as several states near the end of eviction moratoriums established as a

result of the COVID-19 pandemic. This is of particular concern given that unemployment rates between April 2020 and July 2020 have been anywhere from double to triple what they were just prior to the COVID-19 pandemic.⁶⁵

Current Actions: Assisting Individuals Experiencing Homelessness in Response to COVID-19

Due to COVID-19 exacerbating the issue of homelessness and posing particular susceptibility to the virus for individuals experiencing homelessness, action is being taken across the United States. The following text outlines examples of action being taken at federal, state, and local levels, as well as by MCOs and health plans, to assist and protect those experiencing homelessness.

FEDERAL ACTION

One way the federal government has addressed this issue is by releasing \$4 billion in emergency grants from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to state and local governments for shelter, short- and medium-term rent, and supportive services.⁶⁶ This is in addition to the \$12 billion in funding for U.S. HUD programs, health care enhancements, individual payments, small business loans, unemployment insurance enhancements, and state local government support that policymakers hope will mitigate COVID-19's impact on homelessness.⁶⁷ However, results of these programs have demonstrated little ability to prevent or stabilize the housing crisis resulting from COVID-19.⁶⁸

STATE AND LOCAL ACTION

State and local level policies have been implemented “to increase flexibilities, protections, and funding to support individuals experiencing homelessness.”⁶⁹ According to the Center for Health Care Strategies, efforts have largely focused on addressing shelter needs, such as increasing capacity, temporarily halting evictions, or identifying unique temporary housing options.⁷⁰ Some examples include:

- Many states are using Section 1135 waivers to permit payments for services provided to patients with COVID-19 in alternative care settings, such as temporary shelters or mobile testing sites.⁷¹

- California secured Federal Emergency Management Agency (FEMA) approval to provide safe isolation for tens of thousands of people experiencing homelessness by setting a goal of securing up to 15,000 rooms, and county partners have moved at least 869 individuals experiencing homelessness into isolation. The state's effort is known as Project Roomkey.⁷²
- Additionally, several states, such as Arizona, Illinois, and Arkansas, have requested 1115 waivers and are awaiting approval to use Medicaid dollars to pay for housing for individuals experiencing homelessness with COVID-19.
 - Arizona: Requested flexibility to pay for meals for all eligible populations, and for housing for Medicaid enrollees who are experiencing homelessness and who have tested positive for COVID-19.
 - Arkansas: Requested a home delivery benefit for Medically Necessary Non-Emergency Transportation and temporary housing for individuals at high risk of experiencing homelessness.
 - Illinois: Requested to cover housing during the quarantine period for people with COVID-19 who are experiencing homelessness.

WHAT MCOS AND HEALTH PLANS ARE DOING

MCOs and health plans are taking a variety of actions in addressing this challenge. Several health plans across the nation are donating funds to nonprofits that assist the homeless population through the foundation arm of their organizations. Examples include:

- BlueCross BlueShield of North Dakota Caring Foundation giving \$75,000 to nonprofits, including those that service populations experiencing homelessness.⁷³
- Anthem Blue Cross's \$100,000 contribution to United Way's COVID-19 Response Fund supports California's low-income and vulnerable populations by ensuring families stay fed and housed amid the economic shutdown. Contributions are being used to provide food assistance, cash to pay for necessities such as rent and utilities, and even broadband access to help school children continue their education from home.⁷⁴
- MeridianHealth in Illinois gave \$500,000 to Federally Qualified Health Centers (FQHCs) and community mental health centers to help them provide shelter or secure housing for those who have been exposed to COVID-19 and must be quarantined, or those who have tested positive but do not need hospitalization.⁷⁵

Aside from providing funds, MCOs and health plans have used other tactics to assist those experiencing homelessness:

- The health plan MeridianHealth provided 100,000 protective masks to the Westside Homeless COVID-19 Response Workgroup, a newly formed workgroup in the Chicago area.⁷⁶
- Molina Healthcare of Ohio partnered with Make-A-Day Foundation and a former Ohio State University Football coach to provide 20,000 nutritious meals to Ohioans experiencing homelessness or financial distress.⁷⁷
- CareOregon is expediting approvals for temporary housing support for members suspected of having COVID-19, including helping secure hotel and motel stays for members experiencing homelessness who are at risk for virus transmission.⁷⁸

Recommended Actions to Assist Individuals Experiencing Homelessness

While state Medicaid programs and MCOs have been doing a lot for individuals experiencing homelessness, COVID-19 has highlighted an even greater need to help this population now and in the future.

Per recommendations from the National Alliance to End Homelessness, steps MCOs can take to mitigate the impact of COVID-19 on this vulnerable population include:⁷⁹

- Deploying housing navigators to provide logistical support
- Contracting with local Healthcare for the Homeless to use Medicaid to finance outreach services, medical services, and other supports
- Coordinating with FQHCs
- Include medical respite as a billable service, as allowed by the state, to strengthen and expand medical respite capacity
- Reimbursing FQHCs for eligible services provided to Medicaid beneficiaries experiencing homelessness
- Convening stakeholders to create medical respite and other medical transitional housing resources

In addition, MCOs can:

- Assist in expanding COVID-19 testing in homeless shelters, as the Centers for Disease Control and Prevention (CDC) has expressed the need for expanded testing.⁸⁰
 - Boston Healthcare for the Homeless Program, which provides or ensures access to the highest quality health care for all individuals and families experiencing homelessness in the greater Boston area, is taking several actions such as equipping and operating a 16-bed medical tent to care for people who have no safe place to self-isolate while awaiting test results.⁸¹
- Provide resources for populations experiencing homelessness that could address hygiene concerns, such as mobile showers and bathrooms, care kits that include hygiene and sanitation products, in addition to food and clothes.
- Work closely with hotels and motels to house populations experiencing homelessness, as is happening in states requesting Medicaid dollars for this.
- Consider implementation of new initiatives such as supportive housing programs that combine permanent affordable housing with comprehensive and flexible support services.
- Advocate for housing policy to expand on what has already been done at the federal, state, and local levels, whether it be housing policy pre- or post-COVID-19, to assist individuals experiencing homelessness now and in the future, particularly as this population may expand due to downstream effects of COVID-19.
 - Opportunity Starts at Home recommended that Congress include housing resources in the COVID-19 relief package to include (1) \$100 billion for emergency rental assistance, (2) at least \$11.5 billion for homeless assistance, (3) uniform moratorium on evictions, and (4) at least \$4 billion for housing choice vouchers.⁸²
- Consider interventions to address individuals living in multigenerational housing or precarious living situations that impede a healthy lifestyle (e.g., make it challenging to adhere to medication or follow COVID-19 guidelines).⁸³
- Given the role that residential segregation and discriminatory policies played in leading to racial and ethnic disparities in housing access and stability, consider targeting investments to housing in disinvested neighborhoods.

- Carefully consider how to best collect and use race and ethnicity data, in combination with available homelessness data, to tailor and inform MCO programs in assisting racial and ethnic minority groups experiencing homelessness.

This is certainly not an exhaustive list of opportunities for state Medicaid programs and MCOs seeking to help those experiencing homelessness, but rather a starting point that MCO and Medicaid programs can build on to assist this population now and in a post-COVID-19 world.

Facilitators and Barriers to MCOs' Efforts to Address Homelessness

State-managed care contracts and Medicaid coverage flexibility, particularly through Section 1115 waiver demonstrations, have increasingly opened the door for MCOs to address homelessness in innovative and promising ways. In many instances, state MCO contracts provide MCOs with flexibility to implement initiatives based on their members' needs.^{84, 85} As noted above, MCOs seeking to address homelessness typically do so by identifying individuals experiencing homelessness and linking them to services. However, one barrier is the lack of incentives for coding an individual as homeless, which may mean providers are not entering homelessness diagnostic codes and could ultimately result in MCOs not being able to identify these individuals.⁸⁶

The lack of safe and affordable housing stands out as primary challenge to all entities seeking to address homelessness, including MCOs.^{87, 88, 89} As described above, some plans have found ways to increase the availability of housing for individuals experiencing homelessness through capital investments and by forging collaborations with housing developers and community-based organizations. However, building cross-sector partnerships requires leadership investment, time, and familiarity between stakeholders that are not accustomed to partnering with one another.⁹⁰ Affordable housing and managed care plan stakeholders operate under different regulations, funding streams, and timelines that are typically not aligned.

Despite these challenges, the following key considerations can help MCOs seeking to build sustainable cross-sector partnerships around housing:

- Securing commitment from high-level leaders across sectors in addition to mid-level staff who may be positioned to ensure engagement over time.^{91, 92}

- “Learning to speak the same language,” i.e., establishing mutual understanding of goals, timelines, and regulatory environments among stakeholders.^{93, 94} Hosting regional convenings and attending cross sector events and conferences are two potential avenues for achieving this.⁹⁵
- Developing data use agreements and systems that foster the sharing of data for identifying and serving eligible populations.^{96, 97}
 - MCOs can also address data limitation issues with homelessness diagnostic coding by partnering with states and providers to emphasize the importance of this coding.
- Engaging with national advisory or advocacy groups that can help broker these relationships.⁹⁸

ABOUT NORC 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 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

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