HUB ANALYSIS NOVEMBER 2020

Spotlight Series

Karin VanZant, Vice President Integrated Community Partnerships, CareSource

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 with us and welcome your 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 has forced on our society underscore that core social determinants of health (SDOH) need to be both protected and strengthened. There is increased recognition that improving health and achieving health equity goes beyond just addressing an individual's medical concerns and should take into account the social, economic, and environmental factors and racial inequities that influence their health and lived experience.

The Medicaid MCO Learning Hub "Spotlight Series" highlights key initiatives addressing SDOH and health equity that are driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation and its grantees. In addition, the series provides MCOs, community-based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

We recently spoke with Karin VanZant, Vice President Integrated Community Partnerships, to discuss racial and ethnic disparities in health care exposed by COVID-19, as well as methods to advance Social Determinants of Health (SDOH) initiatives among Medicaid MCOs.

Q: What do you think are the various challenges MCOs face in using race and ethnicity data to identify and address member needs?

When looking at SDOH from a disparity or equity lens, equal access to various health care systems is necessary to have a high quality of life. With the recent movements, we're further recognizing how most systems are not structured to address inequity when it comes to minority populations. As a managed care leader, our goal is to rebalance the system to address these longstanding inequities.

Our plan collects racial and ethnic data and we are currently going through a new exercise around COVID-19. We're examining the data from an equity perspective to understand how COVID-19 has impacted minority populations.

The challenges with equity as a component of SDOH is that the majority of decision-makers tend to be from the dominant culture. A focus on education, personal connection, and effort will be required to build the systems that can work for minority populations in a different way. These critical changes will require intentionality among the decision-makers to ensure that the health care system is appropriately structured to meet the needs of minority populations.

Q: How can you use data to change the delivery system for minority populations?

This year we've been looking at health equity with a very different lens, due to both COVID-19 and the BLM movement.

We reviewed CareSource's JobConnect™ program, which reaches out to minority populations and was built by bringing in staff who have community development backgrounds and perspectives. Fifty-six percent of those enrolled in JobConnect™ are Black, with most living in urban areas. We also saw how successful this is in rural areas as well. In terms of collecting the necessary ethnic and racial information, it is being collected on the 834 enrollment file, SDOH assessments, and regionally based staff were on the ground collecting this information via face-to-face meetings before COVID-19.

For example, right now we are working with the Ohio Department of Medicaid for COVID-19 testing in nursing homes and assisted living facilities. But do we know the racial makeup within Medicaid in each of the facilities? We looked at the information we had and we dedicated outreach to the facilities that have higher minority populations. It doesn't have to be a big project; asking the right questions and using the right lens when conducting outreach to minority populations increases attention to these issues.

Q: What do you see as the role for the federal government?

Most of the activities related to SDOH occur at the local level. We have to ask: What is the private or public partnership in this conversation? Where do social and faith-based organizations fit with what we are trying to achieve?

From there we have to partner with the right groups. We're experiencing new dynamics regarding the equity issue; corporations have made significant statements on issues related to equity, which allows us to tackle policy issues together.

Q: Breaking down silos among state agencies and leaders, MCOs, CBOs, and advocates through improving communication and partnerships may reduce administrative and funding inefficiencies across the organizations, and increase the resources available for and effectiveness of SDOH initiatives for Medicaid members. What are your thoughts on this?

My experience, having initially worked on the community side and now managed care for the last five years, has altered my opinion on how SDOH can be most effective for the Medicaid population. We understand services are delivered at the local and individual level, but it's about scalability. What can we appropriately scale and gain traction on, document, and prove that a particular SDOH is improving health outcomes because of the intervention? SDOH and community-based partner networks are important; however, we need to work with community-based organizations (CBOs) that have at least a similar-sized footprint to the market in which we're operating, in order to adequately scale the services we are providing.

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For example, we decided to partner with the foodbank associations within our market footprint. Part of that is linking with the Supplemental Nutrition Assistance Program (SNAP) benefit and the food subsidy benefit, which closely align with the eligibility perspective. We believe that we must work with members' communities where they are most likely to be engaged and then streamline services with CBOs, to support the member in a holistic way.

Our plan must ensure we're meeting the SDOH, clinical, and behavioral health needs of members. We're thinking about scalability for foodbanks, for example, and the

number of families using them and the volume they serve. It is the structure and reach of the CBOs that makes this approach more appropriatecompared to working with the small church pantry that is only open two days a month.

Q: Are there other examples besides foodbanks where you have a similar approach?

It's a new and innovative approach so we're looking at several different groups that align with our SDOH areas. We're looking at workforce development and a strategic partner in each SDOH pillar to see what we might be able to do.

Q: For the foodbanks, what agencies are involved?

80 different federal programs cover the areas of SDOH. Depending on the state, the majority of funding for food security comes from the United States Department of Agriculture, which provides SNAP, commodity benefits that help fuel the pantries, summer feeding locations, and is now working with school districts, particularly those that went into virtual learning or are closed.

There are a lot of complexities regarding the coordination of SDOH services, but the state could define some common outcomes and could pool those resources rather than delivering them separately. Many state programs have case management embedded within and this creates unneeded complexity. For example, CareSource runs into these silos all of the time, when an individual that has a case management relationship with us is also in a case management relationship with the housing provider and then separately with the workforce case manager. Case management is loosely defined and not consistently applied nor coordinated across safety-net programs.

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Q: Do you think MCOs have a community role in pushing for improved coordination of these services? Do all of these community leaders get together and figure out how to better coordinate case management across different programs?

Absolutely. For hospitals, housing, and so forth the community plays a critical role.

Community leaders can collaborate together. What is working against them, especially from the plan perspective, is that funding streams have not adapted to make them work together to allow communities to join together to solveoverarching problems.

Q: Would you say that the various CBOs and other organizations running programs understand the need for better coordination?

That's part of the conversation. For the most part, people understand certain regulations exist within the different funding streams keep us siloed. There is some movement among thought leaders, but the government is facing challenges in adapting to what communities need to work together. As safety net programs have rolled out, there have been very few changes to these programs to encourage coordination among the organizations serving the Medicaid population in our communities.

The Affordable Care Act changed Medicaid in significant ways. While funding for housing has decreased, the cost of housing has increased across the country. Unfortunately, there has been no widespread change to increase support and address the needs of low-income individuals. This isn't to say this is impossible, as there are some communities are doing this, but can national leadership scale it to the level required to meet the need? One of the best opportunities is around SDOH; many of these approaches and resources have been available for decades, but how do we create a bridge so there are the right type and level of needed funding? We need to create the right connection points among the funding streams, recognizing health care cost is a significant portion of the total spending required to address the needs of low-income individuals.

We're also interested in becoming more consumer-friendly. For some CBOs, their infrastructure may be lacking, but they do so much more than what a health plan would ever be able to do and can navigate community-level engagement.

To help meet the SDOH needs of members we're going to need to demonstrate how to work across multiple streams of funding to move the needle. CareSource is a small national plan and we have great aspirations of serving more members and is committed to finding solutions to scale SDOH effort.

Q: Are there any other groups you've been involved with to address SDOH needs more broadly?

There are a few different groups we've been involved with:

- Aligning for Health has developed legislation that has been submitted in the U.S. House of Representatives and the U.S. Senate, which provides funding and a coordinated strategy to meet the SDOH needs of Medicaid members.[1]
- The Root Cause Coalition brings together industry leaders to help address health inequities through cross-sector partnerships. This work brings advocates and health plans together as well and there is a movement to examine grassroots initiatives.[2]
- We're also paying attention to some of the discussions coming out of Leavitt partners.

Q: Ohio Medicaid was closing in on a plan to address SDOH needs for Medicaid beneficiaries and then COVID-19 happened. How has this affected your work?

Ohio Medicaid has been a great partner and is letting us try some different strategies, some of which we're funding ourselves. For example, COVID-19 led us to adapt non-emergency transportation to meet the needs arising from the pandemic. We have developed many interesting partnerships around the housing realm, for example, with metro housing authorities and the U.S. Department of Housing and Urban Development that access housing resources for special populations; we're making a positive impact there.

Q: What other levers can MCOs use to promote population health and address public/private partnerships to address population health? Is there a stronger role for the federal government in this area?

There are some additional ways in which Medicaid funding can fill the gap in need; there are resources that could be organized in a better way to deliver on value. Intuitively, we all know that for the pregnant mom in a shelter, finding housing will benefit her and improve the child's health outcomes. We're looking specifically at how partnering with housing voucher programs for pregnant women can have an impact on birth outcomes. I'm not sure Medicaid should be extensively engaged in paying for housing; Medicaid cannot, nor should not pay for everything. Food and housing programs certainly have more SDOH dollars than plans currently have.

Q: Can you draw a line for where Medicaid dollars should stop in supporting SDOH services?

When health partners shut down for COVID-19, and when members had transportation problems, it allowed us to respond. It will be interesting over the next year as the science catches up with understanding the virus and the economy opens up, what role MCOs should play in terms of health and quality of life. Stress is a big part of well-being, so there is a lot for us to still figure out. Some things need to be piloted and we need to see why other resources aren't being leveraged to their capacity.

Conclusion

As MCOs seek to meet the SDOH needs of Medicaid members, there are various considerations:

- MCOs can use their program data to assess racial and ethnic disparities in access to or receipt of health care. This is an important aspect of reducing health inequities.
- Improving outreach to and engagement of minority populations in health access and SDOH programs is critical to improving health outcomes.
- While many CBOs may serve small groups of Medicaid members and lack robust infrastructure, CBO

partnerships, large and small, are key to community and neighborhood-level engagement with members.

- Siloed food and housing programs at the federal and state level have led to inefficiencies in coordinating funding and resources to meet member needs. MCOs can partner with ongoing efforts to improve the coordination of these funding streams at the federal level.

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. To start the conversation, please contact the senior staff listed here:

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

Acknowledgments

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OUR PARTNERS

References

[1] For more information, visit:
http://aligningforhealth.org/social-determinants-legislation/

[2] For more information, visit:
https://www.rootcausecoalition.org/