RESEARCH REPORT

2019 Medicaid Growth Outlook

Five plan roles to manage social determinants of health services

PUBLISHED BY

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RECOMMENDED FOR

Medicaid leaders, social determinants of health leaders, care management teams

READING TIME

20 min.

Executive summary

There are new growth opportunities for high-performing Medicaid plans with some states expanding Medicaid, more business being shifted to plans that can manage costs, and potential public option plans. While these growth opportunities keep Medicaid managed care a promising business, policy restrictions threaten to decrease Medicaid enrollment and therefore MCO sustainability.

In fact, with new initiatives such as work requirements, immigration rules, and block grants that might affect Medicaid enrollment, **MCOs are likely to lose healthy members, rather than gain sicker members.**

Consequently, more and more Medicaid plans are investing in efforts to address social determinants of health (SDOH) as their principal strategy to bend the cost growth curve. The biggest plan challenge within SDOH is that there are too many possibilities—**both in terms of the array of determinants to address first and in the types of roles plans can play.**

Plans have long since been viewed as the funder but their role can grow beyond the funder to cover convener, expert, advocate, and creator roles.

Introduction

Case studies

A good time for the Medicaid business?

Signs of potential growth for MCOs already excelling in the Medicaid market

State Medicaid programs have two universal goals: to manage spending and to appropriately cover their neediest residents. This continues to hold true in 2019 though Medicaid growth has declined. Despite the fact that national Medicaid enrollment growth has declined from -0.6% growth in total Medicaid enrollment in 2018 to -1.7% growth in 2019, the medium-term prospects for the Medicaid program remain strong.

First, some states are **expanding Medicaid**. Virginia and Maine expanded Medicaid and other states like Idaho, Nebraska, and Utah have approved expansion.

Second, there has been an increase in states trying to change their contracting environment with more business shifting towards **high performing plans** as better quality shows lower cost per beneficiary. Louisiana, Kansas, and Oregon have all replaced some of their Managed Care Organizations (MCOs) in search of better performance. Also, North Carolina is still pushing to shift to managed care, although they have been delayed by local politics. In general, states are raising the bar for MCO performance and rewarding high performers.

Finally, some states are starting to consider a **Medicaid buy-in or public option plans** to offer alternatives for individuals who can't currently find affordable insurance. Though these initiatives are still in their infancy, they could become an opportunity for Medicaid MCOs to capture new members and business. The details for these proposals vary dramatically, with Washington state's public option operating outside the Medicaid space. But other states like New Mexico are exploring having their Medicaid MCOs offer a plan that individual consumers could purchase.

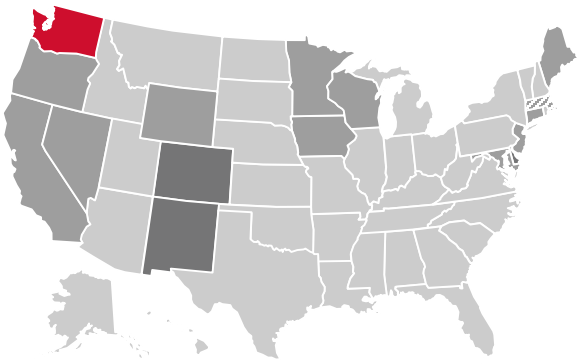
Revived ACA expansion activity

Virginia and **Maine**[1] expanded Medicaid in 2019

Idaho,[1] **Nebraska,** and **Utah** voters approved expansion in 2018

North Carolina actively debating expansion pathways

Several states considering Medicaid buy-in or public option legislation



Source: Meyer H, "States giving public option health plans a hard look," *Modern Healthcare*, June 2019; "Medicaid buy-in and public option: The state of play," *Manatt on Health*, February 2019; Ollove M, "Medicaid 'Buy-In' Could Be a New Health Care Option for the Uninsured," *Pew*, January 2019, Quinn, M. "Medicare For All? How about Medicaid for More". *Governing*. May 2019; "Status of state Medicaid expansion decisions," *Kaiser Family Foundation*, May 13, 2019; Rudowitz et al, "Medicaid Enrollment & Spending Growth: FY 2018 & 2019" *Kaiser Family Foundation*, October 25, 2018, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/; Rudowitz et al, "Medicaid Enrollment & Spending Growth: FY 2019 & 2020" *Kaiser Family Foundation,* October 18, 2019, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2019-2020/; Health Plan Advisory Council research and analysis.

1. Maine and Idaho do not have managed care programs.

Case mix may shift with Medicaid enrollment threats

MCOs are likely to lose healthy members, rather than gain sicker members

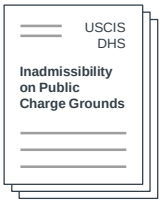
While these potential growth opportunities keep Medicaid managed care a promising business, policy restrictions threaten to decrease Medicaid enrollment and therefore also threaten MCO sustainability. As the Trump administration experiments with policies that might affect Medicaid enrollment, **MCOs are likely to lose healthy members, rather than gain sicker members.**

2019 has been marked by significant state activity to promote eligibility restrictions in the Medicaid population. **Work requirements** have been the most notable one. Despite state interest in these eligibility restrictions, many proposals are going through litigation and their future prospects are unclear. The evidence so far says these initiatives could reduce Medicaid enrollment by up to 18M members, as shown below.

New **immigration rules** may also impact Medicaid enrollees. The new Department of Homeland Security (DHS) public charge regulation updated the immigration policy so that officials can view an immigrant's prolonged use of Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Section 8 housing assistance to be grounds for denying a visa. With many Medicaid members likely living with noncitizens, fear about immigration status could cause members to avoid Medicaid enrollment.

Policy activities affecting Medicaid enrollment

Eligibility restriction	Enrollment deterrence	Limits on spending?
Federal district court rulings D.D.C.[1] rules to set aside work requirements in Arkansas, Kentucky, and New Hampshire	**Trump administration issues immigration rule** Use of Medicaid, SNAP,[2] and Section 8 housing assistance can prevent visa approval	**Tennessee's pending block grant proposal** • Lump sum payment given to state with fixed baseline • Funding rises with inflation and annual projected spend, rather than enrollment • Any savings shared with federal government • Exempts state from service coverage, enrollment, quality, and access requirements
CMS offers waiver support		
Further waiver progress still likely 1 implemented 5 approved 7 pending		
4.1M projected possible coverage losses	13.5M enrollees estimated to be or live with noncitizens	1M TennCare enrollees likely to be affected



Lastly, some states are seeking greater flexibility in managing costs. A handful of states have applied for a waiver to **enact block grants,** and the Centers for Medicare and Medicaid Services (CMS) has said they will offer detailed guidance to states on applying for these waivers.

Tennessee hasn't expanded Medicaid but is requesting a lump sum block grant for their existing Medicaid population. This request is different from a traditional block grant in that there's fluctuation in funding based on projected spending and there's opportunity to share savings with the federal government.

Taken together, these eligibility restrictions will significantly change the composition of beneficiaries. If implemented, the Medicaid program will see a decline in healthy members, leading to a sicker population.

1. United States District Court for the District of Columbia.
2. Supplemental Nutrition Assistance Program.

Source: "Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers?," Kaiser Family Foundation; Japsen, Bruce, "Trump's Medicaid Work Rules Hit States with Costs and Bureaucracy," *Forbes*, July 22, 2018; "Changes to "Public Charge" Inadmissibility Rule: Implications for Health and Health Coverage," Kaiser Family Foundation, August 2019; "1115 Demonstration State Monitoring & Evaluation Resources," CMS, August 2019; Garfield, Rachel et al. "Understanding the Intersection of Medicaid and Work: What Does the Data Say?" Kaiser Family Foundation. August 2019; Collins, S, "Medicaid Work Requirements Increase Coverage Gaps," Commonwealth Fund, February 2019; Rosenbaum S, "Looking Inside Tennessee's Block Grant Proposal," Health Affairs, October 2019; Health Plan Advisory Council interviews and analysis.

MCOs are rightfully increasing efforts to address SDOH

Three market forces make now the right time to invest in SDOH initiatives

Regardless of the Medicaid growth outlook, success seems to be reserved solely for Medicaid plans that excel at maintaining costs. More and more Medicaid plans are investing in efforts to address social determinants of health (SDOH) as their principal strategy to bend the cost growth curve.

As more and more research is released that show the impact of SDOH on the highest risk members' health care spending, Medicaid plans are recognizing the business need for addressing these determinants. For one example, WellCare recently published their findings on the potential cost savings from meeting SDOH needs. They found that members who called Wellcare with SDOH needs, and then had these needs met from plan referrals and services, showed an 11% decrease in health care spending one year later.

Data spotlight

11%

Lower health care spending for members who report that all their social needs are met

There are also three market forces, as shown below, that are pushing the **urgency of addressing SDOH today** more than five or ten years ago.

Drivers of today's SDOH[1] business imperative

New flexibility

CMS authorized plans to offer **supplemental benefits** for specific member segments and has further widened the scope of these benefits for 2020

Required screening

Screening for SDOH increasingly required under **transformation programs** (e.g. CPC+[2], NCQA's[3] new Population Health Accreditation Program, CMMI's Accountable Health Communities model)

35 states require or encourage MCOs to screen for SDOH and refer to appropriate services, becoming increasingly important for **winning Medicaid bids**

Provider interest

Health system executives are increasingly interested in addressing SDOH due to shifting payment, cost, fundraising, and policy imperatives, making them eager to partner on this issue

1. Social determinants of health.
2. Comprehensive Primary Care Plus.
3. National Committee for Quality Assurance.

Source: "Population Health Program Accreditation", *NCQA*, https://www.ncqa.org/employers/ncqa-programs-of-interest-to-employers/population-health-program-accreditation/; Health Plan Advisory Council research and analysis.

SPOTLIGHT

North Carolina Medicaid's Healthy Opportunity Pilot Program

As a part of their shift to managed care, North Carolina received a waiver for their "Healthy Opportunities Pilot Program". This is one of the largest demonstrations to date of a robust SDOH strategy, with $650 million in authorized state funding..

The state will require their MCOs, called Prepaid Health Plans (PHPs), to screen members for both health risk factors and social risk factors. For members that have at least one of each, the plans will be required to refer members to local service organizations and the state will pay for these services—ranging from rental assistance to meals.

They have had to delay the managed care launch due to state budget negotiations, but this pilot is still expected to start in 2020.

Health plan roles in North Carolina Medicaid's Healthy Opportunities Pilot Program

Screen for eligible beneficiaries

At least one…

Health risk factors

- Adults and children with more than two chronic conditions, repeated ER use, hospital admissions
- High-risk pregnant women, infants, children

And at least one…

Social risk factors

- Homelessness, housing, food, or transportation insecurity
- At risk of witnessing or experiencing interpersonal violence

Manage appropriate pilot services

Pilot service organizations to provide:

- Tenancy support; housing quality and safety; legal referrals; security deposit and first month rent; short-term post-hospitalization housing assistance
- Food support and meal delivery
- Non-emergency health-related transportation
- Interpersonal violence-related transportation, legal referrals, and parent-child supports

Plans given access to new NCCARE360 community referral management tool

$650M
Amount authorized for services and capacity building by CMS across the five-year pilot

Source: Hinton E et. al., "A First Look at North Carolina's Section 1115 Medicaid Waiver's Health Opportunities Pilot," Kaiser Family Foundation, May 2019; Health Plan Advisory Council research and analysis.

Too much plans can do for too many determinants

Plans frozen because they don't want to waste efforts on unproven initiatives

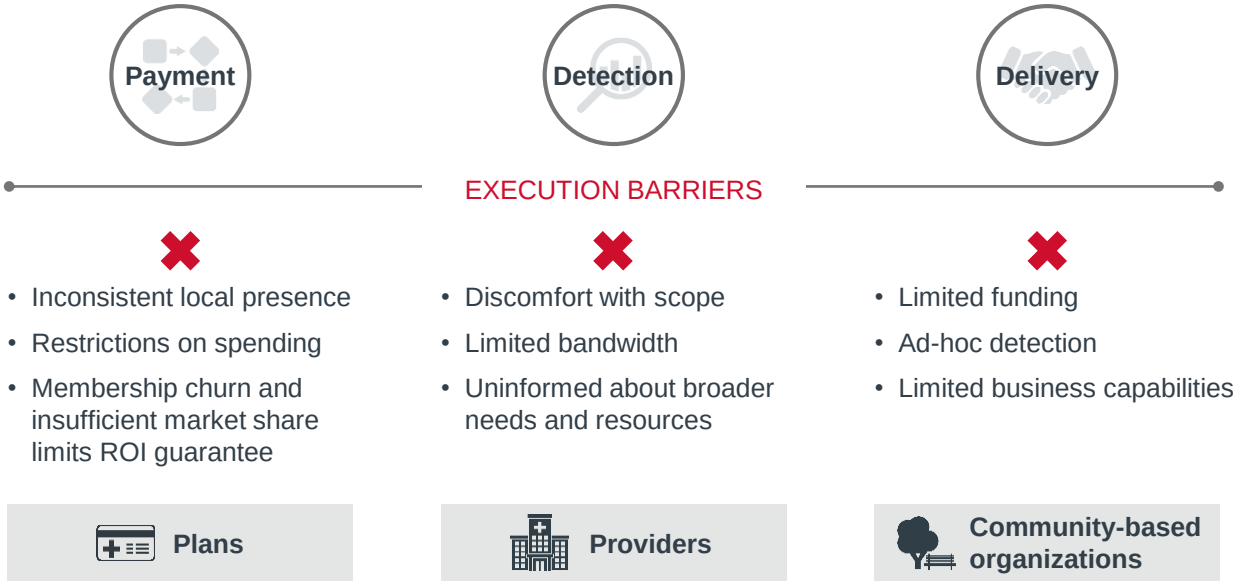
The biggest plan challenge within SDOH is that there are too many possibilities—**both in terms of the array of determinants to address first and in the types of roles plans can play.**

Earlier definitions of social determinants were limited to delivery system reform and then food, housing, and transportation. But as research expands, a much broader definition including determinants such as social integration, economic stability, literacy, and early childhood education is now emerging.

We see plans already making big investments here but the to-do list keeps getting longer and there's no clear sense of where to start. This is frustrating to plans who want to help but **don't want their resources to go to waste on unproven interventions.**

There is an abundance of programs that might not have the outcomes a plan wants. For example, plans are often surprised to find out that ridesharing services don't actually improve the PCP appointment attendance rate. They can still have a great impact on meeting regulatory standards or member satisfaction but it just goes to show that plans have to be judicious with SDOH investments.

Stakeholder barriers to supporting action on social determinants



It's also **difficult to hone in on the role plans should play because these are not simple interventions.** They require a lot of local community input, customization, and careful coordination.

As shown in the chart above, securing funding is a key challenge. Plans have the comparative strength and incentive here. But beyond that, seeking out which members need which services and making sure they're connected to the right services is often challenging. Lastly, providing the service in a way that effectively engages the individual and addresses their real needs from a trusted position requires close relationships with community based organizations.

Source: Health Plan Advisory Council research and analysis.

Five sustainable roles for plans addressing SDOH

Build your value proposition on the role that uniquely plays to your strengths

Plans have long since been viewed as the funder but their role can grow beyond that. There is ample opportunity for plans and other organizations to fill these five, equally-important roles to address SDOH for high-risk members.

These five roles can be filled by the plan, provider, or CBO and some organizations can even fill multiple roles at once.

Review the chart below and the associated case studies for how your plan could choose and act on one or more of these roles. There should be specific roles that stand out to you as ones that your plan is uniquely positioned to take on.

Primary roles for organizations to become an effective SDOH community partner

	Funder	Convener	Expert	Advocate	Creator
ROLES					
TASKS	• Devote staff and resources • Offer RFPs[1], grant-writing support	• Recruit parties for collaboration • Build channels for communication	• Contribute existing knowledge • Conduct studies to build academic evidence base	• Engage policymakers • Publicize system policy positions	• Contract with local businesses • Invest in workforce equity, diversity, and inclusion
GUIDING QUESTIONS	Are there existing high-quality partners who need funding support?	Are there disparate efforts to accomplish the same goal that we could help connect?	Does the industry have all the answers yet?	Would a local, state, or federal policy change reduce barriers to success?	Are there business, workforce, or culture changes I can make to drive equity and economic mobility?
CASE STUDIES	**LA Care's** HIPAA assistance	**UPHP's** health services fair	**IEHP's** member identification help	**UHC's** coding advocacy	**Caremore's** togetherness program

1. Request for proposals.

Source: Health Care Advisory Board interviews and analysis.

L.A. Care's HIPAA assistance for community partners

Fund to increase CBO capacity rather than to cover the entire initiative

CASE EXAMPLE

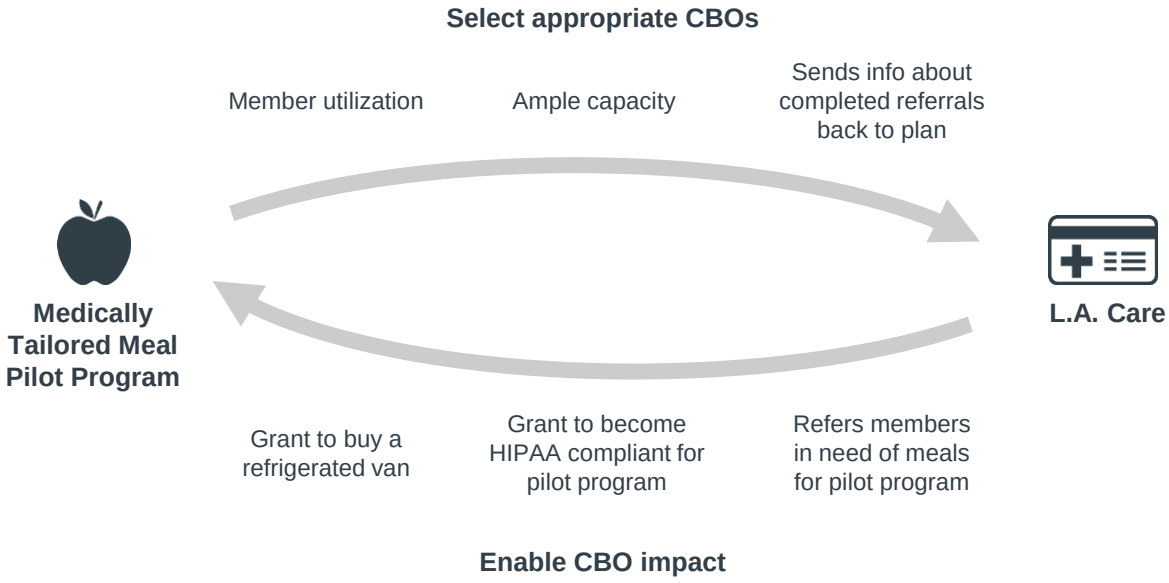
L.A. Care
2M-member public plan focused on Medicaid LOB • Los Angeles, CA

L.A. Care decided to invest in a food insecurity program to address a key challenge affecting their members' health. Before picking food, they conducted a three step process. First, they conducted a literature review on successful social determinants of health initiatives. After doing so, they conducted a gap analysis so they wouldn't duplicate any already established L.A. Care programs. Finally, they convened focus groups with members in their local community about their needs.

This research showed L.A. Care that they didn't need to build up a program from scratch. **They could choose and enable existing CBOs**. So they chose appropriate CBOs based on L.A. Care member utilization, ample capacity, and most importantly—CBOs that were willing to work on sending information about completed referrals back to the plan.

In return, L.A. Care enabled these food organizations to serve their members even better. For example, L.A. Care provides grants for CBOs to hire HIPAA[1] consultants to become HIPAA compliant. Now L.A. Care can share data to help the CBOs identify and outreach to members. This would not be a possible investment for every CBO, so the strict selection process at the outset was crucial.

How L.A. Care chooses effective CBOs to support



1. Health Insurance Portability and Accountability Act.

Source: L.A. Care Health Plan, Los Angeles, CA; Health Plan Advisory Council interviews and analysis.

UPHP's community resource fair

Build on plan's third party role to convene CBOs, members, and providers

CASE EXAMPLE

Upper Peninsula Health Plan
50K-member Medicaid managed care and Medicare plan • Marquette, MI

Upper Peninsula Health Plan (UPHP) added a new spin to the standard community resource fair that many plans have already been putting on for years. They realized the true power in having the community organizations all together in one place was that they can share with providers what the different CBOs each do.

UPHP operates in a small, rural community. Their providers historically relied on outdated state directory information or their own personal relationships to find local services for their patients. To build stronger ties to the community, UPHP gathered CBOs and physicians for a two-part event.

First, a morning session, where CBOs "pitched" their services to an audience of local providers and other CBOs. Each organization had three minutes to give their quick pitch to providers, and a one-slide template that they had to use.

Providers appreciated this information because they now have a comprehensive understanding of what is available to their patients and how they can connect patients to these services. As an example, one of the main reasons providers don't ask about SDOH during regular PCP visits is because they don't feel like they have a resource or solution they could offer the patient. Because UPHP worked as the convener between CBOs and PCPs, more members are now able to receive SDOH services.

During the second part of the day, UPHP convened CBOs with the rest of the community since they had all the organizations together already. Each CBO had a booth, offering services such as free haircuts, care management information, flu shots, and more. UPHP also gave each member a "passport". If members visited five booths and got five stamps in their passport from them, the member could receive a backpack of donated goods on their way out.

Illustrative example of Upper Peninsula Health Plan's (UPHP) template for CBO presentations

Holly's Homes

Holly Holmes, President
(906) 425-0011
holly@hollyhomes.com
www.hollyshomes.com

Services provided: subsidized housing, housing search, temporary shelters, new home creation

Results: 30 new homes built and 500 people placed in homes since we started in 2010

Goals: Build five more homes in 2020 and find housing for 60 more people in need of housing assistance

Coverage area: All 83 counties in Michigan

Referral process: Submit referral to "Holly's Homes" on your EMR system or tell patient to call (906) 111-HOME

Attendee numbers

75
CBO presentations

125
Audience members

1,000
Attendees at the broader community health fair

Source: Upper Peninsula Health Plan, Marquette, MI; Health Plan Advisory Council interviews and analysis.

IEHP's best practice research

Lend plan expertise on members and health care to increase CBO capacity

CASE EXAMPLE

Inland Empire Health Plan
1.2M-member Medicaid managed care plan • Rancho Cucamonga, CA

Inland Empire Health Plan (IEHP) has been addressing social determinants of health (SDOH) with local community based organizations (CBOs) for over two decades.

IEHP created specific metrics for high-performing CBOs and choose to partner with CBOs that meet these metrics or show a commitment to meet these metrics. These CBO partners are privy to the many ways IEHP lends its expertise to increase CBO capacity, as listed in the chart, and a few are detailed below.

IEHP provides expertise to select CBO partners

IEHP partners with CBOs that have shown or show a commitment to addressing specific metrics such as:

- Addressing referrals in a pre-determined amount of time
- Closing communication feedback loops
- Number of members identified and helped
- Number of times members are met
- Number of successful grants

In return, IEHP helps CBO partners increase capacity as a health care expert, by providing:

- Funding, in portions, as metrics are hit
- Grant writing support
- Connections to hospital discharge planners
- Research on evidence based programs
- Meetings with other CBO leaders
- Plan outreach representatives to support CBOs
- Meetings with providers to garner patient referrals
- Member identification help

Research on evidence based programs

IEHP has a robust evaluation department that identifies evidence based programs and recommendations to the plan, providers, and CBOs. Their newest area of research is in the area of ACE[1] assessment and interventions. Most CBOs do not have the bandwidth to conduct this research themselves so they're thankful for the expert help from IEHP that is tailored in response to a CBO's specific proposal to IEHP.

Meetings with other CBO leaders to share best practices

IEHP coordinates quarterly meetings with hundreds of CBO leaders so that they can share best practices and learn from each other. For example, the CBOs learned that it takes about 10 engagements with a member before they actually accept a housing offer. The CBOs enjoy the comradery and the meal and are really appreciative to IEHP for hosting these events.

Plan outreach representatives support CBOs

Plan outreach representatives serve CBOs similar to how plan provider representatives serve providers. They are experts in specific SDOHs such as childhood prevention programs, housing instability, and more. These reps are able to have in-depth and regular conversations about the CBO's specific challenges and how IEHP can support them.

1. Angiotensin converting enzyme.

Source: Inland Empire Health Plan, Rancho Cucamonga, CA; Health Plan Advisory Council interviews and analysis.

UnitedHealthcare's ICD-10 codes for SDOH

Request associations to increase the tracking and payment of SDOH initiatives

CASE EXAMPLE

UnitedHealthcare
115M-member national health plan • Minneapolis, MN

UnitedHealthcare (UHC) recognized that it is difficult to track SDOH requests and refer members appropriately when there are not ICD-10 codes for providers to record for SDOH. UHC therefore worked with the American Medical Association (AMA) to **expand ICD-10 codes to include 23 new codes for SDOH**, on top of the original 11. They are the first payer to request expansion of these codes to the international codes committee. Once approved, the new codes will go into effect in October 2020.

UHC realized that allowing clinicians to use these codes would be the first step in identifying which members have SDOH needs and which specific ones they are struggling with. Also, if clinicians start using these codes, the hope is that plans can eventually start paying for these referrals via claims.

Categories of ICD-10 codes for SDOH

- Contact with an suspected exposure to arsenic, lead or asbestos
- Educational circumstances
- Effects of work environment
- Foster care
- Inadequate material resources
- Homelessness/other housing concerns
- Legal circumstances
- Other social factors
- Parent/child/family issues

Source: Lynch, J, "New developments on ICD-10 codes for SDOH", *Alliance for health equity,* April 2019, https://allhealthequity.org/icd-10-codes-for-sdoh/; Minemyer, Paige, "Why UnitedHealthcare wants to expand diagnostic codes to the social determinants of health", *Fierce Healthcare,* Feb 2019, https://www.fiercehealthcare.com/payer/why-unitedhealthcare-wants-to-expand-diagnostic-codes-to-social-determinants-health; United Healthcare, Minneapolis, MN; Health Plan Advisory Council interviews and analysis.

CareMore's Togetherness Program

Use internal resources to create and scale a program for your members' needs

CASE EXAMPLE

CareMore
160K-member Medicaid and Medicare plan • Cerritos, CA

A study at Harvard University that followed hundreds of people for 75 years identified the quality of people's relationships as the single clearest predictor of their physical health, longevity and quality of life.

CareMore has developed the Togetherness Program to alleviate senior loneliness. As a plan with a primarily Medicare Advantage line of business focus, they have a clear business case to invest here. For CareMore, it was worthwhile to create and scale a program **in-house** because their members were so disproportionately impacted by senior loneliness.

CareMore recruits plan volunteers to call members weekly who have been identified as a senior who suffers from loneliness. Seniors volunteer to participate in the program.

CareMore Togetherness Program's two-pronged outreach process

Plan employee volunteers make weekly calls to lonely seniors

Plan sets up social Health Hubs in PCP clinic waiting rooms

Togetherness patient profile

- Spends majority of day in isolation
- Lives alone
- Self-reported as lonely or isolated
- Newly widowed
- Average age 74
- 40% male 60% female

What is really central to CareMore's Togetherness is the fact that the same person is calling the senior member every time and they begin to develop a relationship with them. They become familiar. CareMore uses *plan* volunteers to make these calls, and they build a bond with the members as they continue to talk with them every week. CareMore is able to increase employee satisfaction and retention while they decrease senior loneliness.

The Togetherness Program also sets up social health hubs in PCP clinic waiting rooms so members can interact with each other. This takes one of the worst parts of a doctor's visit, waiting for the appointment, and turns it into a positive part of the member's day.

Results of CareMore's Togetherness Program

23K	1,800	57%	21%
Calls and visits with seniors	Referrals to resources and programs	Increased participation in exercise programs	Decreased hospital admissions

Source: "CareMore Health Announces New Outcomes Data from First-of-Its-Kind Togetherness Program." *Business Wire*, Dec 18, 2018, www.businesswire.com/news/home/20181218005059/en/CareMore-Health-Announces-New-Outcomes-Data-First-of-its-Kind; Jain, Sachin, and Craig Samitt. "The Growing Imperative to Address Senior Loneliness." *NEJM Catalyst*, Feb. 27, 2018, catalyst.nejm.org/growing-imperative-address-senior-loneliness/; Kasley, Killam, "To Combat Loneliness Promote Social Health" *Scientific American,* 2018, https://www.scientificamerican.com/article/to-combat-loneliness-promote-social-health1/; "Caremore Health", LTC Discussion Group, May 2019, http://www.ltcdiscussiongroup.org/archives_173_2589677649.pdf; Mineo, Liz, "Good genes are nice, but joy is better" *The Harvard Gazette,* April 11, 2017, https://news.harvard.edu/gazette/story/2017/04/over-nearly-80-years-harvard-study-has-been-showing-how-to-live-a-healthy-and-happy-life/; Health Plan Advisory Council interviews and analysis.

Centene's Social Health Bridge

Some organizations can fulfill all five roles

This last case study, we included as a culmination of the five roles. These roles don't exist in their own silos; plans can also merge multiples roles to create a new role altogether.

CASE EXAMPLE

Centene Corporation
15M-member Medicaid and Medicare plan • St. Louis, MO

Centene created a subsidiary called Social Health Bridge (SHB) to bridge the gap between plans and local community organizations. While SHB is still in its early stages, the ideas in their pipeline hit on many of the key roles plans can play in SDOH:

Funder: SHB collects funds from multiple health care industry organizations and distributes funds to vetted community-based organizations.

Convener: SHB is an aggregation model that truly meets people where they are. The model includes SHB, a site partner (in this initial offering a low-income housing community) and health partners (in this case a health plan and an FQHC[1]). SHB uses a community health worker model leveraging resident service coordinators who work at the site location to provide targeted support services including activities such as SDOH screening and intervention, community referrals and care gap closure.

Expert: Centene has a repository of SDOH best practices that have worked for community organizations. Other community organizations can add to and learn from these.

Advocate: SHB wants to standardize data sharing for CBOs to more easily monitor and share outcomes—similar to how Surescripts has standardized EMRs in the clinical care realm.

Creator: Centene is creating a subsidiary to address SDOH more broadly, while Centene Health Plans continue to address SDOH locally in their markets.

How Centene's Social Health Bridge subsidiary benefits health care organizations and CBOs

Health care industry organizations

- Standardized performance and outcomes data for each CBO
- Established partner ready to share savings and risk
- Simplified way of engaging multiple CBOs

Social Health Bridge

Community-based organizations

- Funding from health care organizations
- Single, easy way to engage with fragmented healthcare ecosystem
- Collaboration opportunities with other CBOs

1. Federally Qualified Health Center.

Source: "About Social Health Bridge", Social Health Bridge, www.socialhealthbridge.com/aboutus.html; Health Plan Advisory Council interviews and analysis.

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