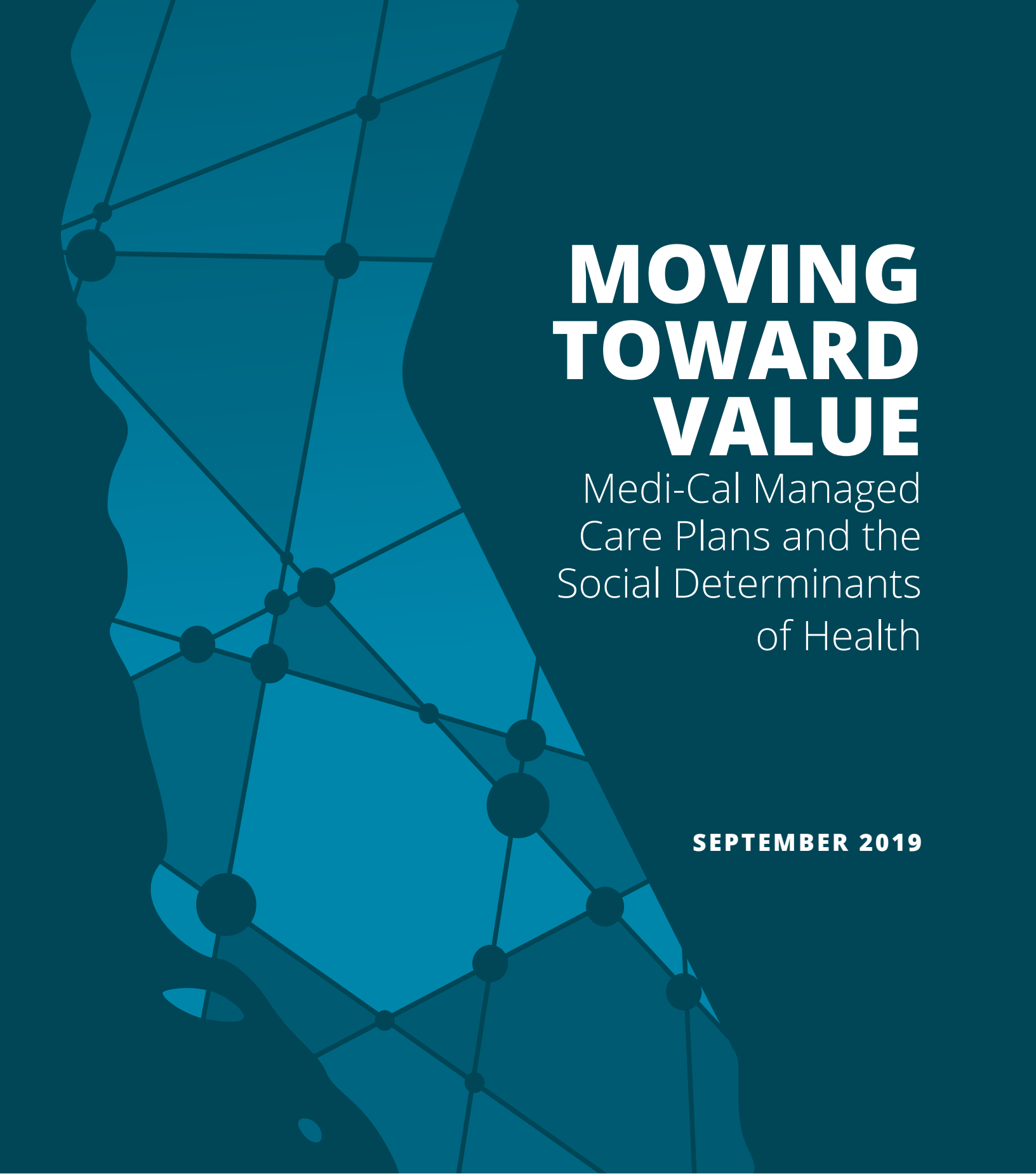


MOVING TOWARD VALUE

Medi-Cal Managed Care Plans and the Social Determinants of Health

SEPTEMBER 2019

JSI

This report was made possible with support from Blue Shield of California Foundation.

JSI Research & Training Institute, Inc. (JSI) is a public health research and consulting organization dedicated to improving the health of individuals and communities. JSI partners with clients to develop flexible, innovative approaches that solve complex public health problems. For over 35 years, JSI has worked at local, county, state, national, and international levels toward more efficient, effective, and equitable health systems.

AUTHORED BY:

Nicole Giron, MS
Tracey Kirui, BA
Rachel Tobey, MPA
Jeremy Cantor, MPH

Table of Contents

Executive Summary

In California, four in five Medicaid beneficiaries are enrolled in Medi-Cal managed care plans – the dominant model for the delivery of Medicaid benefits in California. The implementation of the Affordable Care Act and subsequent expansion of Medicaid in California led to dramatic increases in the Medi-Cal population, especially among individuals who have more complex needs (such as housing insecurity, mental health conditions, and substance use disorders) compared to pre-expansion enrollees. Medi-Cal expansion has led California's managed care plans to move toward value by considering the impacts that social determinants of health have on their members.

About This Report

This report explores the experience and perspective of Medi-Cal managed care plans regarding social determinants of health. In total, 83% of all Medi-Cal managed care plans took part in a survey and follow-up interviews to better understand their recent investments focused on social determinants, associated challenges, and existing opportunities related to these efforts.

KEY FINDINGS

This report presents six key findings about the **current Medi-Cal Managed Care investment landscape**:

FINDING 1. Most investments focus on identifying and addressing individual social needs of plan members.

FINDING 2. Community-level investments focused on social determinants are emerging, although perspectives on what characterizes such investments vary widely.

FINDING 3. Housing instability, lack of transportation, and food insecurity are priority issues among current investments.

FINDING 4. High-utilizing members are the focus of most investments focused on social determinants.

FINDING 5. Current investments are largely dependent on reserve funding.

FINDING 6. Investment decisions are driven by mission to serve the community, quality considerations, and financial positions.

CENTRAL CHALLENGES

Four **central challenges to making investments** focused on social determinants also emerged:

CHALLENGE 1. A lack of consistent, sustainable, and upfront funding limits the maintenance or initiation of investments.

CHALLENGE 2. A lack of clarity around health care entities' roles and responsibilities regarding social determinants stymies willingness to invest.

CHALLENGE 3. There is limited evidence on effective investment strategies.

CHALLENGE 4. Community partnerships are important to scale investments, but they are difficult to establish.

OPPORTUNITIES

Finally, this report details **timely policy, practice, and funding opportunities for Medi-Cal managed care plans and state government** to leverage the current momentum around social determinants. As Medi-Cal Managed Care continues to expand, investments that focus on social determinants can be vital to increasing health care value and addressing underlying issues shaping health spending and outcomes.

PLAN OPPORTUNITIES

- Define shared expectations for a rate-adjustment proposal that would include social determinants-focused investments in future rate setting.
- Evaluate promising practices related to social determinants.
- Leverage leadership role to foster community partnerships.
- Develop a community of practice to help propel the field forward.

STATE OPPORTUNITIES

- Implement a rate adjustment to encourage plan investments in strategies that can generate long-term savings.
- Expand plan authority to pay for historically non-billable providers and supplemental activities to respond to social needs.
- Incentivize investments via value-based performance measures.
- Incorporate best practices from housing-related pilots into managed care contracts.
- Clarify health plan expectations and allowed areas for flexibility and innovation.

Introduction

> "Our philosophy is that health is no longer just the doctor."

Fifty-five million Americans are enrolled in Medicaid managed care plans, approximately 20% of whom live in California.[1,2] In California, 4 in 5 Medicaid beneficiaries are enrolled in Medi-Cal managed care plans – the dominant model for the delivery of Medicaid benefits in California.[3]

The implementation of the Affordable Care Act and subsequent expansion of Medicaid in California led to dramatic changes within the Medi-Cal program. Medi-Cal membership has grown by 45% since the January 2014 implementation of Medicaid expansion, while Medi-Cal managed care enrollment has grown by 75% during the same period (Fig. 1).[4,5,6] Medicaid expansion boosted Medi-Cal managed care plans' financial health and flexibility by generating growth in reserves over historical levels.[7] Research has consistently shown that social determinants of health – "the conditions in which people are born, grow, work, live, and age," such as housing availability, access to education, and economic opportunity – play a larger role in determining health outcomes than health care access and services.[8,9,10] Medi-Cal recipients have historically had more challenging economic, behavioral, and social circumstances than populations ensured through their employers or the individual market.[11] Newly eligible Medicaid beneficiaries across the country have been shown to have more complex needs (such as housing insecurity, mental health conditions, and substance use disorders) than pre-expansion enrollees,[12,13,14] and enrollment of individuals with complex needs has driven up costs as a result of the additional services and expanded provider networks required to care for these new members.[15]

As the health care system strives to move toward value, there is also growing interest in the relationship between social determinants of health and Medicaid funding and policy among policymakers, payers, and providers.[16,17,18,19] Despite this interest, the experience and perspective of California's managed care plans regarding social determinants of health has not been explored systematically. This report presents findings regarding recent and current investments, associated challenges, and existing opportunities related to social determinants that emerged from a survey and interviews conducted with leaders from Medi-Cal managed care plans.

FIGURE 1. Growth in Medi-Cal Managed Care Membership Since Medicaid Expansion[20]

Methodology

In 2018, Blue Shield of California Foundation (BSCF) engaged JSI Research & Training Institute, Inc. (JSI) to better understand the perspectives of Medi-Cal managed care plans (herein referred to as "plans") on social determinants of health.

As part of this work, JSI designed and delivered a survey exploring plans' recent investments focused on social determinants and then conducted follow-up interviews with local public plans and commercial plans across the state (quotes from these interviews are included throughout this report). Surveys and interviews took place between July and December 2018. During this process, The Children's Partnership (TCP), a California-based non-profit advocacy organization committed to improving the health and well-being of children, was simultaneously exploring plan activities focused on children. To minimize burden on plan leaders and maximize potential learnings, JSI and TCP partnered to conduct interviews. TCP continues to explore questions around plan approaches to address children's social needs and their work is available at **childrenspartnership.org**.

The survey and interviews explored recent plan investments focused on social determinants, the decision-making processes behind such investments, related challenges to making these types of investments, and opportunities to encourage future investments. The interviews also explored plan opinions on a specific rate-adjustment proposal designed to incentivize health-related investments that fall outside of traditional Medicaid benefits. The proposal is outlined in ***Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs***, a white paper commissioned by the California Health Care Foundation (CHCF) that is based on discussions by a workgroup comprised of six Medi-Cal managed care plan leaders led by Manatt Health and Optumas Health care and guided by advice and insights from California's Medi-Cal Director. With CHCF's support, JSI included additional questions about the design of a potential rate adjustment in interviews. A detailed synthesis of plan leaders' opinions on this rate-adjustment approach is available in the JSI report ***A Signal of Support: Exploring Medi-Cal Managed Care Plans' Perspectives on a Proposed Rate Adjustment***.

In total, 19 of a possible 23 plans participated in JSI's survey (83%) and 14 agreed to be interviewed (61%). JSI conducted approximately hour-long, phone-based interviews with 26 individuals representing the 14 plans. A complete list of interviewees is available in Appendix I.

The Current Medi-Cal Managed Care Investment Landscape

All plans and their leaders reported making significant investments focused on social determinants. While the specifics of those investments, and the rationale for making them, varied considerably, six key findings emerged regarding plans' approaches to social determinants.

FINDING 1

Most investments focus on identifying and addressing individual social needs

Based on a review of the literature, practice in the field, and conversations with experts and plan leaders, it is clear that there is a continuum of strategies being implemented by health plans in response to the role that the social determinants of health play in shaping health outcomes.[21,22] However, the purpose of this inquiry was not to create an extensive typology of strategies. For simplicity, this inquiry focused on two broad categories of strategies: a) initiatives focused on identifying and addressing individual social needs (e.g. providing members with meals or non-medical transportation) and b) efforts to address social conditions at a community level (e.g. increasing the availability of permanent supportive housing). Examples of investments that range from individual to community focus are included in Figure 2 for illustrative purposes.

FIGURE 2. Continuum of Strategies to Respond to Social Determinants of Health

Survey results suggest that, while a variety of strategies are taking place across all plans to address members' social needs, most plans are implementing similar strategies: screening members, using referral systems, hiring staff, and investing in community organizations (Fig. 3).

FIGURE 3. Plan-Implemented Strategies to Address Social Needs (N=19)

Screening members

A majority of plans (79%) reported investing in screening specifically to identify individual social needs among their members. While conversations with plan leaders did not focus on the details of screening efforts, some leaders did mention several tools currently in use (Box A).

BOX A

Screening Tools to Identify Individual Social Needs

Staying Healthy Assessment (SHA):[23] Primary care providers must administer an age-appropriate SHA to all Medi-Cal members within 120 days of enrollment as part of their Initial Health Assessment (IHA). While neither the IHA nor SHA focus on social determinants explicitly, they include social history questions that plans could use to better understand their members' social needs.

Bright Futures:[24] Bright Futures is a federally-supported prevention initiative geared at assessing children's needs. Since 2017, it has explicitly recommended providers conduct family-centered assessments that include questions about social determinants. California adopted the Bright Futures Guidelines as standard of care in 2014. Bright Futures can be implemented as an alternative to SHA.

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE):[25] PRAPARE is a standardized risk-assessment tool that is specifically designed to capture information related to social determinants. PRAPARE includes a set of national core measures in addition to a set of optional measures specific to community priorities.

Your Current Life Situation (YCLS):[26] Kaiser Permanente Care Management Institute created a screening tool to identify a range of social needs, such as housing, childcare, and transportation. Once needs are identified, members are connected with information and referred to patient navigators. Kaiser is currently working to develop an enterprise-wide services locator that will focus on social determinants and enable both plan staff and community-based organizations to create and track referrals.

Referral systems

Almost all plans (95%) indicated that they are using referral systems to connect members to external resources and social services (Fig. 3). Some plans have developed resource databases and plan leaders described making this investment because they "didn't have a comprehensive view of community-based organizations in [their] geography" for staff to expediently connect members to available resources.

> "We had a really diverse set of stakeholders come together [to figure out] how we can get real-time information that is accurate and at point-of-care to health care and social service organizations…"

> "I think one of the biggest investments that we've made is…in a platform [that] can confirm that these agencies exist, [and includes] commentary about who best to connect to and how best to connect with that agency…[making our staff's] work easier so that they spend less time searching and more time actually engaging with our members."

"We're in the process of making [an investment] in community health workers...the idea is how do you have a workforce that's oriented around going upstream and making those linkages and connections and helping address those issues for the community and the membership?"

Hiring staff

Many plan leaders also discussed the importance of embedding staff with a focus on social needs into their teams to better connect members with available community resources. Over three-quarters of plans (79%) indicated that they are hiring community health workers (CHWs) and navigators. Plan leaders described hiring CHWs, social workers, care coordinators, and even administrative staff responsible for leading community engagement efforts focused on the needs of homeless and other high-need members. Leaders from several plans discussed the role that CHWs can play as integrated members of a care team. However, leaders reported concern and a lack of clarity around reimbursement for CHWs and other historically non-billable providers. While leaders described these staff roles as focused primarily on identifying and responding to individual social needs, a few mentioned that these roles had an "upstream lens" with a focus on policy and environmental change within communities (Box B).

BOX B

Health Net's Investment in a Generation of Community Health Workers [27,28]

Research has shown the effectiveness of CHWs in reducing costs and improving care.[29] As strong facilitators in the work of connecting patients to their care teams, CHWs have also emerged as an important way to ensure that social needs are heard and accounted for within the health care setting.

In their work to understand what factors influence membership, health plan leaders from Health Net, a subsidiary of Centene, described maintaining an internal CHW program for the past five years. Realizing the importance of this work, the plan also partnered with Sacramento City College, the Greater Sacramento Urban League, and Wellspace Health to offer a Community Health Worker Certificate Program through the Greater Sacramento Urban League. This program provides job training for Sacramento residents to become CHWs, opening up new career pathways, as well as building workforce support for the plan and community at large.

"For a health plan to go out on its own and develop anything is lower yield. So we've really been relying a lot on our collaborative venues and relationships to try and figure out where there is momentum."

Investments in community organizations

While plans reported adding staff roles with a focus on social needs to their teams, leaders acknowledged that their plans often do not have the expertise or internal capacity to adequately address the social needs of their members. In response, nearly all plans (95%) indicated that they were investing in community-based organizations to address members' social needs (Fig. 3).

FINDING 2

Community-level investments are emerging

Two-thirds of plans indicated that they have also made social determinants-focused investments at the community level (Fig. 4). However, plan leaders expressed a wide range of perspectives about what characterizes such investments. Most plan leaders reported wanting their investments to focus on members who, at the end of the day, drive plan costs. When examined closely, many investments described as operating at the "community level" actually focused on extending clinical services into community settings, providing community resources directly to plan members, or offering community members secondary benefits that might accrue from quality improvement activities. For example, when asked to describe a community-level investment, leaders from one plan spoke of training providers and explained that, while these trained providers were contracted with the plan, they also served non-members who would then benefit from this investment. Leaders from two plans described creating grant programs to expand supportive housing and clinic capacity in their service areas; both plans clarified that while the investment would benefit the broader community, the main incentive for making the investments was to earmark a certain percentage of beds or housing units for their members.

A few plans described making investments focused on all residents of a community or on changing policies and systems. Plans operating in counties where a large share of the overall population is eligible for Medi-Cal acknowledged that they have a strong incentive to make such investments. For example, leaders from three plans described investing in resource centers that can offer a range of resources to all community members, with an estimated investment of approximately $12 million coming from two of these plans alone (Box C). Leaders from two plans detailed investments that provided education and employment opportunities by funding college education grants for local residents interested in pursuing careers in health care within their communities. Plan leaders confirmed that most of the funding for investments at this level came from plan reserves.

FIGURE 4. Percentage of Plans That Reported Making Community-Level Investments (N=19)

> "I think we have to look holistically at health care… [health plans] realize that although we would want to provide every single service and provide every possible avenue for our members to have better health, we have to partner with our communities."

BOX C

Social Needs Investment at the Community Level: Inland Empire Health Plan's Community Resource Centers[30]

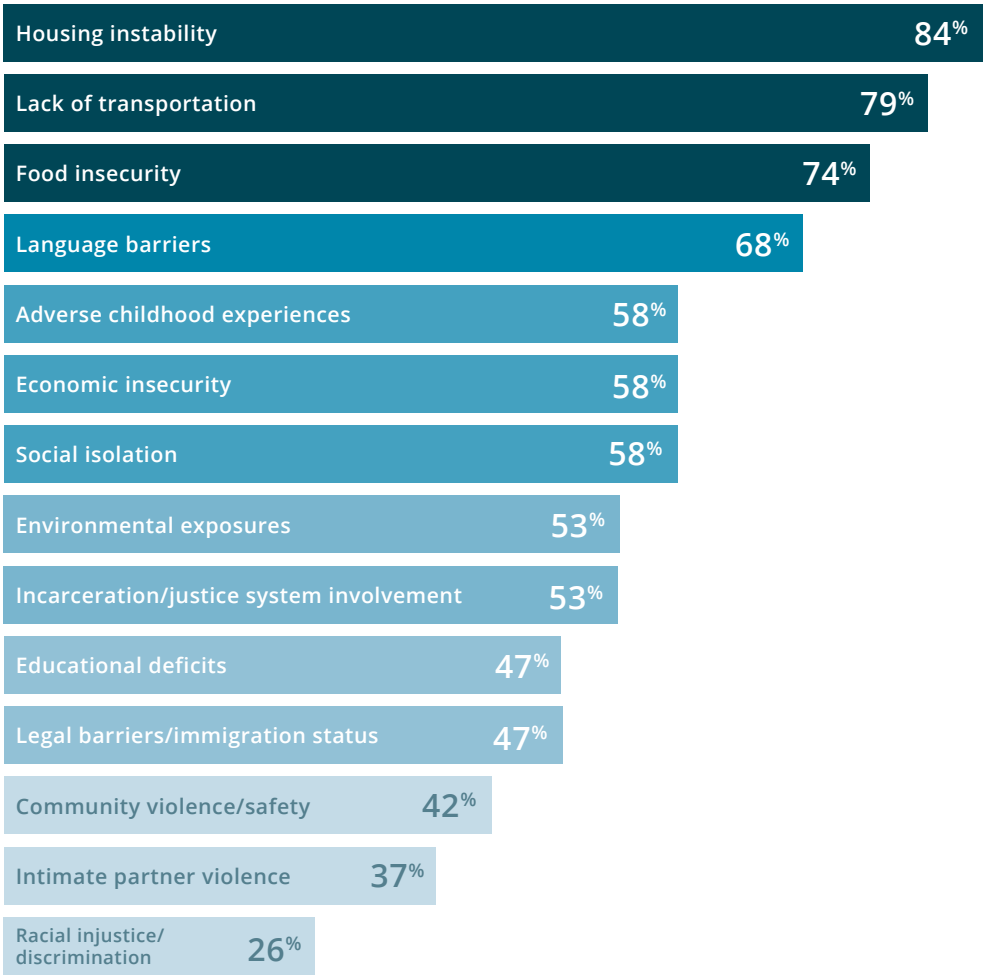
Leaders from Inland Empire Health Plan (IEHP) described plan investments between $5 to $7 million dollars in developing and supporting three Community Resource Centers (CRCs) open to both plan members and the general community. CRCs are staffed by bilingual staff and serve as local hubs for access to health care and community resources, wellness education, fitness classes, trainings, and various workshops such as tax preparation and prenatal workshops – all free of charge. Leaders explained that while most of their investments focus on addressing social needs at the member level, one in every four community members is an IEHP member. Therefore, they acknowledged the importance of investing in initiatives focused on social determinants at the community level in addition to member-specific efforts.

FINDING 3

Housing instability, lack of transportation, and food insecurity are priority issues

Plans indicated making investments to address a wide range of issues among their membership (Fig. 5). Survey results and subsequent interviews revealed that housing instability, lack of transportation, and food insecurity are top priorities. Language barriers also stood out as a priority in survey results but was rarely mentioned during interviews. This is interpreted to mean that most plans are addressing language barriers (and likely have been doing so for an extended period of time through required translation and interpretation services), but have not made significant new investments. A complete list of recent social determinants-focused investments that emerged through conversations with plan leaders is available in Appendix II.

FIGURE 5. Focus of Recent Plan Investments (N=19)



Housing instability

Most plans reported that they are currently investing in strategies to address housing instability (84%). These investments often took the form of grant funding for the development and expansion of supportive housing and recuperative care capacity to address both the housing and behavioral health needs of members (Table A). Leaders from just six plans that were able to estimate the size of their investments described committing a collective $144 million dollars to housing-related efforts (Box D). Leaders also discussed leveraging demonstration programs that emphasize coordinated cross-sector responses to address the needs of complex individuals, such as Whole Person Care and Health Homes, to maximize the impact of their plan investments. For example, one plan reported investing in the expansion of local respite centers that the county Whole Person Care pilot is providing per-bed-per-night funding for on an ongoing basis.

TABLE A. Housing-Related Services That Plans Are Commonly Providing Members

SERVICE	DEFINITION
Recuperative/ Respite Care	Offers health care providers a safe place to discharge homeless patients when they no longer require hospitalization but still need to heal from an illness or injury.[31]
Wraparound Services	A care coordination strategy designed to improve patient outcomes by providing patients additional services that address social needs (e.g. nutrition, social work, and/or patient navigation) in conjunction with primary care.[32]
Permanent Supportive Housing	A housing model that combines low-barrier affordable housing, health care, and supportive services to help individuals and families lead more stable lives. This model typically targets people who are homeless or otherwise unstably housed, experience multiple barriers to housing, and are unable to maintain housing stability without supportive services.[33]

BOX D

Maximizing County Efforts: LA Care's Investment in Supportive Housing[34, 35]

The homelessness rate in Los Angeles has increased significantly in recent years. Between 2015 and 2016 alone, the population of homeless residents in Los Angeles County rose by 6%. The number of L.A. Care members who experience homelessness has also risen significantly as a result of Medi-Cal expansion. In 2017, the plan established a $20 million Community Health Investment Fund to address the needs of the homeless population. This investment will expand the reach of L.A. County's Whole Person Care Initiative by allowing the county to redirect general funds to the social service needs of this population.

L.A. Care is distributing this grant over five years to Brilliant Corners, a non-profit supportive housing agency and partner in the L.A. County's Department of Health Services' Housing for Health Program. L.A. Care's grant funding will cover costs associated with interim and permanent housing through the county's Flexible Housing Subsidy Pool, while Housing for Health will provide necessary wraparound services, including social support and move-in assistance. This partnership aims to smooth transitions from homelessness to housing and improve housing retention rates in the county.

> **"If you can do something to improve conditions in the homeless, behavioral health, and substance use populations, you could do so much to save money because they are high utilizers."**

> "We've expanded our [transportation] benefit [for] housing-related needs...Going to view the apartment doesn't seem like a medical necessity, but if you or I were going to rent a new place, we'd want to go see it first...our members should have that right as well."

Lack of transportation

A majority of plans (79%) also indicated that they are addressing lack of transportation among their membership. Since 2017, the California Department of Health Care Services (DHCS) has permitted all Medi-Cal managed care plans to provide non-emergency medical transportation (e.g. an ambulance or wheelchair van service) and non-medical transportation (e.g. a passenger car or taxi) to members who need assistance getting to and from appointments to receive Medi-Cal services.[36] Most plan leaders did not describe employing strategies to address transportation outside of what Medi-Cal currently allows. However, several leaders mentioned that their plans are exploring ways to expand transportation benefits to members even further, such as paying for transportation so that members can complete a housing application process.

Food insecurity

Nearly three quarters (74%) of plans indicated making investments to address food insecurity. Plan leaders described using grant programs to establish partnerships with local organizations to provide members with food-related services, such as meal delivery, nutrition, and cooking programs. For example, one leader described a plan investment of $300,000 made over three years to organizations that provide nutrition services for senior members. Leaders from a different plan spoke of creating a multi-million-dollar grant program to form partnerships between community-based organizations and health providers to address food insecurity through a variety of methods (Box E).

BOX E

Partners for Healthy Food Access Investment [37]

A 2016 survey found that over half of Central California Alliance for Health (CCAH) members are living in food insecure households. Food insecurity is defined as lack of access to enough affordable, nutritious food for an active healthy life.

To address this need, CCAH made a $4 million investment to award grants (up to $200,000 each) through their Partners for Healthy Food Access program. This program supports innovative partnerships between health care providers, community-based organizations, and government agencies to decrease food insecurity through screening, onsite or easily accessible food distribution, and connections to long-term food sources such as CalFresh.

CCAH leaders shared that, so far, applications recommended for funding have proposed:

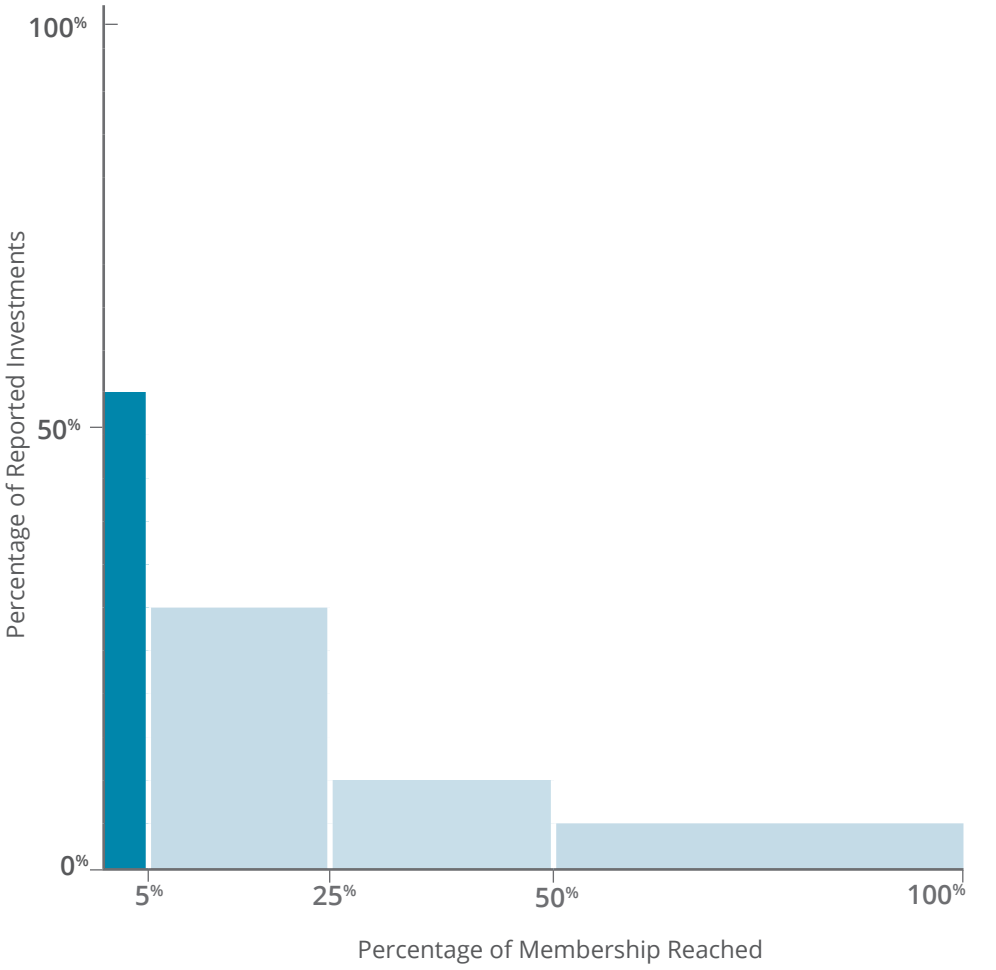
- Increasing local access to nutrition education
- Strengthening connections to CHWs
- Establishing a food prescription program that will enable providers to refer members to nutrition education and food vendors available on site

FINDING 4

High-utilizing members are a focus

Survey results suggest that plans are making investments reaching varying levels of their membership. However, most investments appear to reach only a small subset of plans' membership. Only a tenth of reported investments reached half of plan membership or more, whereas just over half (56%) of investments reached five percent of membership or less (Figure 6). Plan leaders explained that most investments focus on addressing the needs of members who utilize services at high rates and drive short-term outcomes. By contrast, language barriers and lack of transportation were the focus of the majority of reported investments that covered at least 30% of membership, likely due to plans' ability to address these needs through covered services.

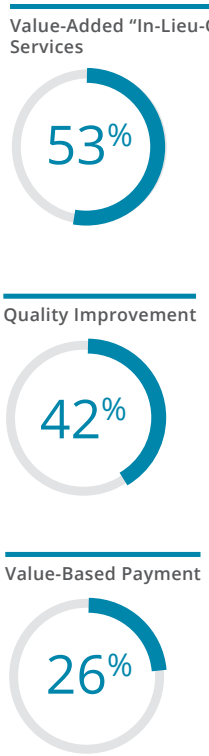
FIGURE 6. Percentage of Plan Membership Reached by Reported Investments



> "[Foundations] are more suited for these types of things that have long-term curves, whereas we're more set up to figure out where we can have the most bang for our buck..."

> "As we look to do more interventions around food insecurity or housing or anything else, there is this big issue now that a lot of that comes out of our administrative costs and doesn't trickle down into our rate-setting process. We're doing it because there is this recognition that this is the right thing to do and this is really the best way to address the member as a whole and prevent these other medical costs that we would normally incur…"

FIGURE 7. Non-Reserve Strategies Used to Support Social Needs Work (N=19)



FINDING 5

Social determinants-focused investments are dependent on reserve funding

The State Plan governing Medi-Cal managed care benefits does not include many services that could improve cost and quality outcomes by focusing on social needs and community resources. As a result, plan leaders reported that reserves were the primary funding source for social determinants-focused investments. Leaders from only nine plans estimated making a combined commitment of $350 million from reserves to initiatives focused on social determinants in California within the last five years.

Plans are also pursuing strategies to leverage currently allowable expenses and encourage changes to the State Plan. For example, approximately half of plans (53%) reported using "value-added" or "in-lieu-of" services as a strategy to help finance their efforts to address social needs (Fig. 7). Plans have been negotiating with the state to approve some services, such as "Tenancy Support and Stability Services" and long-term care alternatives, as "in-lieu-of" services for the Cal MediConnect (dually eligible) population.[38] Plans also reported implementing quality improvement activities and value-based payments to providers (both of which can be counted in future rate setting) to address social needs (Fig. 7).

TABLE B. Reported Non-Reserve Financing Strategies

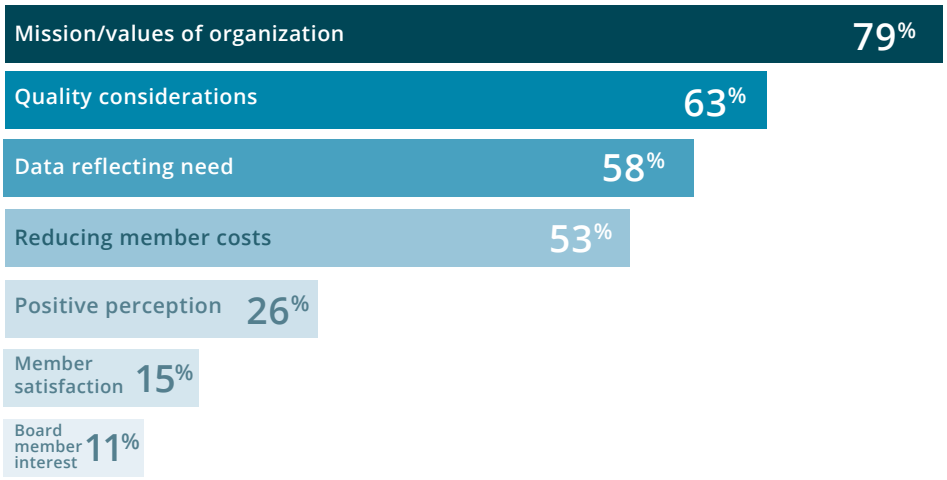
SERVICE	DEFINITION
Value-Added Services	Services plans can choose to provide to members that are not included in the State Plan. The costs of these services can be counted toward the medical-loss ratio but not future rate setting.
"In-Lieu-Of" Services	Cost-effective alternatives to services or settings covered in the State Plan that plans may choose to offer members. The costs of these services can be counted toward both the medical-loss ratio and future rate setting.
Quality Improvement Activities	Systematic actions that can lead to measurable improvements in delivery and quality of health care services and health outcomes of targeted members. [39]
Value-Based Payment (VBP)	A model where purchasers of health care and payers hold the health care delivery system responsible for both quality and cost of care.[40] VBP comes in a variety of forms (e.g. paying for high-value services/providers not currently reimbursed and attaching financial rewards and/or penalties to achieving outcomes).

FINDING 6

Mission to serve the community, quality considerations, and financial position drive investment decisions

Most plans (79%) rated mission or values of their organizations as the top factor influencing decisions around how to spend reserves (Fig. 8). Plan leaders acknowledged that they would like to see a shift from the status quo and that "these efforts outpace the government's ability to recognize the costs." Plan leaders also expressed a sentiment that responding to social determinants is essential to improving quality outcomes and serving their members well. A majority of plans (63%) identified quality considerations as an important factor influencing investment decisions (Fig. 8). Accordingly, nearly all plan leaders expressed commitment to continuing investments as long as financially possible.

FIGURE 8. Leading Factors Influencing Investment Decisions (N=19)



Many plan leaders (58%) weighed community needs as part of their decision-making process when considering new investments. Multiple leaders highlighted homelessness in their communities as key drivers for their plans' investments in housing. One plan leader described investing in a package of housing-related services because of nursing home closures in the region. For many plans, leveraging community partners, listening to community members, and engaging other stakeholders were critical steps for establishing both internal and external buy-in for their investments.

Furthermore, plans have recently experienced a unique period of strong financial performance, which many leaders do not foresee continuing. Interviewed plan leaders pointed to the expansion of Medicaid and the increased flow of federal and state dollars as reasons for the growth in their reserves over historical levels. Leaders explained that the growth in reserve dollars in particular has allowed plans increased flexibility to undertake activities that fall outside of managed care contracts to address the individual non-medical needs and broader community environments that affect beneficiaries' health outcomes.[41]

> "Because of the mission we have, we would always have some kind of community benefits — either resources or program — available to the community at large."

> "Like many health plans in California, we were able to build up significant reserves from the Affordable Care Act revenue that we received…We felt like we had a unique and rare opportunity to make some significant, focused investments."

Understanding Challenges to Social Determinants–Focused Investments

While Medi-Cal managed care plan leaders confirmed that their plans are committed to continuing to respond to the social needs of their members, they identified four central challenges to continuing current investments and implementing new – and potentially more expansive – strategies.

CHALLENGE 1

Lack of consistent, sustainable funding

While plans are currently experiencing a period of financial stability, plan leadership is cognizant that this likely will not last. Consequently, there is caution about the amount, quantity, and size of investments made from reserves. Leaders from smaller plans also noted that Medi-Cal expansion did not result in a large increase in reserves for all plans. Plan leaders pointed out that support is missing for the up-front expenditures associated with social determinants-focused investments and/or mechanisms for reward if investments are successful. There is also some sense of urgency to leverage reserve investments into strategies that can be sustained over a longer term through state-level policy changes that specifically address challenges inherent to the current rate-setting process and its time horizon.

> "I've been at this for a long time and I'm well aware that we're in the good times, but money is going to tighten up soon. We were a plan that once had economic difficulties, so we're always going to be very specific and make our choices carefully in terms of how we invest our dollars."

Rate-setting process

Most plan leaders identified tension between what the state actuaries acknowledge in the rate-setting process and the growing recognition that Medi-Cal has both financial and mission-related reasons to address individual social needs and community-level social conditions. Not reflecting these or other potential cost-saving investments in the rate-setting process can lead to "premium slide,"[42] a phenomenon that occurs when future rates are set based on lower utilization patterns and costs without accounting for the investments that drove those improvements.

Interviewees acknowledged that the risk of premium slide is a significant factor limiting willingness to start initiatives focused on social determinants. Several plans also described limiting investments to those that are "directly related to health" in hopes that they might be counted in the rate-setting process. For example, one plan specified they would not make an investment in education for members or local workforce for fear that it was not likely to be counted in rate setting even if the state were to incorporate the costs of interventions that target social needs.

Plan leaders did express a willingness to share with the state the potential risks and rewards associated with social determinants-focused investments that contain costs and improve quality. For example, expanding the list of approved "in-lieu-of" services or quality improvement activities would allow some up-front costs to be included in plan benefits and considered in rate setting. Additional details on strategies for sharing risk with the state for health-related investments can be found in JSI's companion report, ***A Signal of Support***.

> "By the time we can actually measure the impact, it's going to take a couple of years. So we have to make sure people are comfortable that…these are the right investments, the organizations are solid, and research shows that this will really improve the health of our members…"

Misaligned time horizons

Plans leaders acknowledged that the current rate-setting structure and their associated business models disincentivize long-term investments even if they may be of high value. Social determinants-focused investments that could produce significant impacts on health care utilization and associated costs are not pursued if the benefits are likely to take a longer time to manifest than the

one-year time horizon that DHCS employs when planning and setting rates.[43] Membership churn further disincentivizes plans from making long-term investments since the financial benefits may accrue to Medi-Cal competitors in Two-Plan and Geographic Managed Care counties or to other payers such as Medicare or commercial insurance (between 5,000 and 10,000 Californians transition between Medi-Cal and Covered California on a monthly basis[44]). Plans reflected that short-term bias is particularly problematic when considering children, for whom investments today could create significant impacts over their lifetimes (see Box F).

> "One of the awakenings we've had is that...about 50% of our members are children. If you think about that and the opportunity to prevent chronic illness in that population, it's a big opportunity to create impact for those people and for the system...if we could shift focus to kids, we could help those kids not become adults with complex chronic conditions."

BOX F

Addressing Social Needs Among Children

Children Represent Nearly Half of All Medi-Cal Managed Care Members

2 in 5
California children are Medi-Cal beneficiaries [45]

Medi-Cal provides coverage for 40% of all children in the state, nearly all of whom are enrolled in managed care.[46,47] Among surveyed plans, 79% reported that children represent 40% or more of their membership. Investing in this population presents an opportunity to create positive outcomes beyond health care while containing costs in the long run.[48] Most plan leaders acknowledged the importance of investing in this population.

While children make up a significant portion of membership for a majority of plans, few leaders spoke of making investments focused on their young members outside of services already covered in plan contracts (e.g. care coordination under the Whole Child Model or screening with tools like Bright Futures that include a focus on social determinants). Leaders from three plans described making investments in local community or family resource centers that — while they did not focus solely on children — would benefit their younger members. Several leaders also described current or upcoming partnerships with local First 5 chapters to promote literacy and education among children. One plan leader shared that his plan created an $8 million grant program open to school-based health centers and community-based organizations to increase access to youth mental health services.

Since the initiation of this research, California has experienced a shift in administration that has begun spurring changes in health care delivery at the state level. Medi-Cal has incorporated the entire Centers for Medicare and Medicaid Services (CMS) Child Core Set as health plan performance standards and increased the level of that standard. California's governor has also proposed several Medi-Cal child health incentive payments as part of his budget. In addition, DHCS will be issuing greater clarity for plans on their Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) responsibilities and is increasing oversight and outreach capacity for children's well-child care. In this new environment, plans will likely be shifting even greater focus to the delivery of care to their child members.

CHALLENGE 2

Lack of clarity on roles and responsibilities

All plan leaders acknowledged that their plans can play a role in helping to meet the social needs of individual members, but there is uncertainty around what role(s) health care entities should play and where responsibility for social determinants should fall between plans, county health agencies, other public agencies, and community-based organizations. Specifically, some plans expressed concerns about making investments that would only duplicate ongoing community efforts.

Relatedly, plan leaders reported a lack of clarity around what plans should be held accountable for and what is the responsibility of other institutions, such as philanthropy or county providers. For example, it takes a coordinated effort of county, plan, provider, and community-based organization staff to successfully move homeless individuals with complex needs into permanent supportive housing. The severity of individuals' complex needs may repeatedly change over time, potentially changing what entity is responsible for providing services to address those needs; Medi-Cal managed care plans, fee-for-service mental health providers, and county mental health plans are each responsible for providing mental health services within a single county, where the responsibility of service provision will shift based on Medi-Cal beneficiaries' changing conditions.[49] Beneficiaries may also lose Medi-Cal coverage entirely. These shifts in eligibility, coverage, and provider responsibilities can create gaps in service coverage and exacerbate existing ambiguity around responsibilities and efforts at care coordination.

Therefore it becomes important – but complicated – to clarify who will pay for, be held accountable for, and execute the different roles required in identifying housing needs, providing navigation, offering tenancy supports, identifying and building units, and providing wraparound services.

> "We sort of shied away from [community-level investments] because I don't see that as our role. I know some of my fellow plans made investments in other community efforts, but this is a service-rich community… it's not our charge to do general community wellness."

> "If you assign responsibility to the county or the health plan, it doesn't mean they're going to work together…but, yes, it would help and it would maybe address some of those questions around whether a health plan builds in or contracts for a service."

CHALLENGE 3

Limited evidence on effective strategies

There is a lack of conclusive evidence about cost-effective strategies that respond to social needs and social conditions. While the evidence base is expanding rapidly with increased interest and funding, gaps remain. For instance, evidence around the applicability of specific interventions to different populations and community contexts is not always available. Plans are consequently struggling to determine how to use their resources for their members and within their communities. Leaders emphasized the importance of generating more data around the effectiveness and impact of social determinants-focused interventions in order to galvanize leadership and financial support.

> "It is a challenge to decide how to make strategic investments with such great need…To do it at the depth many of us would like is profoundly difficult. Trying to figure out how to take finite resources and spread them in ways that are meaningful and don't dilute the work being done [is a challenge]."

CHALLENGE 4

Partnerships are difficult to establish

Multiple plans described wanting to collaborate more with community partners — beyond strengthening referral systems — as a way to meaningfully meet their members' social needs as well as address the social conditions affecting communities.

However, there are numerous challenges to establishing partnerships with local community-based organizations, non-health service providers, or government agencies.

> "Most of the time, if we offer financial incentives to our community, they're willing to come onboard. There are times where we would want to have relationships with different entities and they just don't have the bandwidth to take on the role that we're trying to have them fill."

While plan funds may be available, community organizations may not be able to partner

Not all community organizations have the interest, capacity, or resources necessary to partner with plans. At a most basic level, the community organization has to be able to provide the service or program that the plan desires. The organization also has to agree to the financial terms, be able to enter into such a contracting relationship, and meet reporting requirements. Plans leaders explained that potential partners often did not have the bandwidth to dedicate the necessary thought and staff time to developing and implementing all facets of a partnership. Lastly, some community partners have a mission to serve anyone in need and are unwilling to focus attention only on plan members.

> "When we make these community-wide investments, the biggest barrier is for these agencies to share results. While some communities have been able to figure this out, every time we try to bring it up with partners, it's always a sticking point."

Systems that enable secure information exchange are critical but missing

Multiple plan leaders emphasized the need to establish systems that share information and simultaneously protect data privacy, facilitate up-front referrals and case management, and measure the impact of services and partnership activities. Across health care and behavioral health organizations, there are significant interoperability and HIPAA-related privacy concerns. Community partners may need to invest in additional hardware and software in order to handle up-front referrals, information sharing, and back-end monitoring and reporting. Additionally, measuring impact is especially difficult when outcomes from a health care-led investment accumulate in other sectors, such as the criminal justice or education systems.

Opportunities for California

Numerous opportunities exist for both Medi-Cal managed care plans and the state of California to leverage the momentum around linking health care services and social interventions.

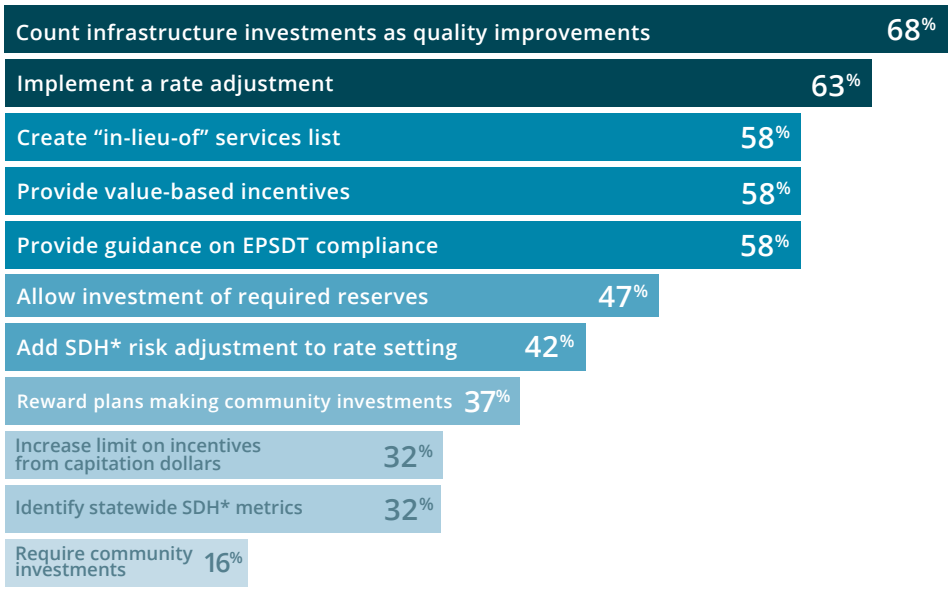
Opportunities for Medi-Cal Managed Care Plans

Conversations with plan leaders surfaced various shared priorities between plans around investments that focus on social determinants. The following plan-specific opportunities are based on the insights that emerged from JSI's engagement with plans through this research.

1 | Define expectations for a rate-adjustment proposal in a shared policy platform.

When asked to prioritize potential state-level policies that would encourage more investments focused on social determinants, two-thirds of plans prioritized implementing a rate adjustment that would allow successful social determinants-focused investments to be counted in future rate setting (Fig. 9). Changes in state leadership, paired with the current momentum around social determinants, have opened a window of opportunity for policy change. Plan associations have an opportunity to facilitate consensus building around expectations for a rate-adjustment policy proposal and advance such a proposal with DHCS. A companion paper, ***A Signal of Support***, synthesizes plan reactions to a potential rate adjustment and areas of existing consensus.

Figure 9. Priority State-Level Policy Changes (N=19)



* SDH—Social determinants of health

> "[It's important] to demonstrate that these projects have already worked in terms of improving members' quality of life, cost of care, and outcomes."

2 | Evaluate promising practices.

More systematic evaluation of initiatives related to social determinants is needed. At the same time, individual plans are already identifying ways to evaluate their own investments. Plans and related stakeholders (e.g. health care foundations) have an opportunity to share emerging evidence around what current investments are working. As evaluations are conducted, evidence should be shared widely to ensure the scaling up and dissemination of effective practices. This could be facilitated through virtual and in-person convenings led by plan associations and through dissemination platforms such as the Social Interventions Research & Evaluation Network (SIREN), an initiative based at the University of California, San Francisco.

3 | Leverage leadership role to foster community partnerships.

Plan leaders repeatedly discussed the importance of diverse partnerships to comprehensively and effectively address social conditions, especially at the community level. Plans have high profiles as authoritative voices on health issues and large employers and purchasers within their communities. Consequently, there are opportunities to lead and encourage partners to "come to the table." Plans have the opportunity to play the "convener" when it comes to community-level strategies and data system developments that require cooperation from multiple entities and affect populations beyond their members.

4 | Develop a community of practice.

Plans are working across the state to address housing instability, lack of transportation, and other social needs in multiple ways. Plan leaders pointed to a need to more regularly share information and learnings across health care entities and within communities. Documenting learnings, identifying common barriers, and generating policy-change ideas through formal and informal venues, such as association-led convenings, are important steps to help propel the field forward.

> "If we're pushing so hard to get this [social determinant] philosophy and screening in primary care, we have to have a way to look into resources that are accessible in real time, are of value, and work."

Opportunities for the State of California

Many opportunities exist for DHCS to engage, guide, and incent plans to make social determinants–focused investments. The opportunities outlined below bring together findings rooted in JSI's engagement with plans as well as JSI's experience in the field. The majority of these opportunities relate to funding, given the state's role as regulator and funder of the Medi-Cal program. However, a number of the potential shifts in funding would also serve to clarify roles and responsibilities, build the evidence base, and facilitate partnership development among plans and within communities.

1 | Implement a rate adjustment.

Plans recognize that while they are currently bearing the risks associated with social determinants-focused investments, the state potentially benefits from the cost savings associated with such investments. Plans are willing to continue bearing risk and making these types of investments if they can share some of the risks and benefits with the state. DHCS should consider implementing a rate adjustment that would encourage plan investments in services and strategies that are not currently reimbursable but that can generate long-term state savings.

> "It's about time — the state needs to move toward this direction — there has to be a way to reduce costs. This new approach benefits the state as well as the health plans."

> "I'm not advocating for more regulatory rules, but when CMS came out with Medicare Advantage's ability to put social needs in their bids, that allowed us to think about what we want to consider organizationally… anytime something gets mandated from our payers, we think about the things we need to be doing."

2 | Expand plan authority to pay for historically non-billable providers and supplemental activities.

Plans are interested not only in receiving greater flexibility to respond to social needs and conditions, but also additional clarity around their role(s) in this effort – specifically, what activities they are allowed to pay for. This clarity could take the form of an explicit statement delineating plan authority to pay for historically non-billable providers (e.g. CHWs, care coordinators, or peer recovery specialists) and how discrete services focused on social determinants could qualify as quality improvement or "in-lieu-of" services for the purposes of rate setting. Alternately, the state could provide a definition or criteria for such investments instead of a prescriptive list. For instance, in 2018, CMS expanded its definition of "health-related supplemental benefits" to allow Medicare Advantage plans to include a wider range of care and services in their benefit packages so long as they "compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization." [50] In its most recent 1115 waiver, the state of Oregon expanded risk-bearing Coordinated Care Organizations' flexibility to offer health-related services by laying out criteria these services must meet to be included in rate setting. Eligible services must lead to outcomes that can be objectively measured, emphasize priorities such as health disparities and patient safety, and "be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-members." [51]

3 | Incentivize or require investments via value-based performance measures.

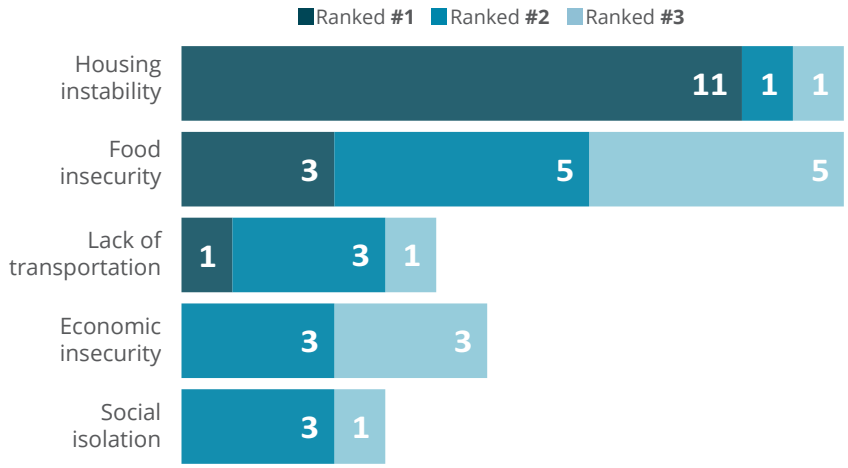
Fifty-eight percent of plans highlighted "providing novel value-based incentives for plans working to improve social determinants" as a high-priority opportunity for the state (Fig. 9). The current state administration has indicated that they intend to expand value-based payments and performance incentives. DHCS could use the opportunity to create incentives that go beyond existing measures such as Health care Effectiveness Data and Information Set (HEDIS). For example, DHCS could implement measures that target community-focused health improvements rather than provision of recommended services (giving plans some flexibility on how to achieve the improvements). Other potential incentive mechanisms include: tying value-based payment to population health metrics such as community-level body-mass index (BMI) or tobacco use to provide flexibility and encourage partnerships that work at the community level; pairing measures of follow-up on referrals to community resources with funding for social needs screening to encourage comprehensive responses; and introducing novel metrics such as kindergarten readiness (being considered in other states[52]) to support investments in long-term and upstream strategies that support population health.

While plans did not express strong interest in increased regulation from the state in the form of required community-level investments (Fig.9), it should be noted that several examples of such requirements exist nationally, such as in Arizona[53] and Oregon.[54] Requiring investments could be examined in future policy discussions, especially those around supporting population health initiatives and efforts to address social conditions at the community level.

4 | Incorporate best practices from housing-related pilots into managed care contracts.

Housing instability is a top-of-mind issue across the state. Accordingly, plans are investing in recuperative and respite programs, participating in statewide Whole Person Care and Health Homes demonstrations, and strengthening supportive housing capacity in their communities. Additionally, most plans indicated that they would continue to prioritize addressing housing instability in future investments (Fig. 10). There is growing federal support for addressing housing through health care. In 2018, United States Secretary of Health and Human Services Alex Azar acknowledged that the Center for Medicare and Medicaid Innovation (CMMI) is thinking critically about serving Medicaid beneficiaries by addressing certain social needs – in particular, housing instability.

FIGURE 10. Focus Area of Future Plan Investments, Priority Ranked (N=19)



DHCS could also leverage learnings and best practices emerging from Whole Person Care pilots.[56] Specifically, DHCS could allow effective Whole Person Care practices – including the building and supporting of infrastructure (data systems, staff training, etc.), housing navigation, stabilization services, and tenancy support – into managed care contracts. DHCS could also expand eligibility criteria for such services, allowing more Medi-Cal members to benefit from the added flexibility provided under the current Whole Person Care demonstration.

> "But what if we went beyond connections and referrals? [...] What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing, or make sure that a diabetic had access to and could afford nutritious food? If that sounds like an exciting idea... I want you to stay tuned to what CMMI is up to."
>
> – ALEX AZAR
> UNITED STATES SECRETARY
> OF HEALTH AND HUMAN SERVICES[55]

5 | Clarify expectations and allowed areas for flexibility and innovation.

Plan leaders explained that limited guidance from DHCS was a challenge to their work because their plans hesitate to make investments that may fall outside of their designated authority and put them at greater financial risk. Some plan leaders also reflected that receiving clearer guidance around the use of their resources overall could encourage additional investments.

> "If there was some explicit guidance – for example... something that explicitly laid out that plans can use reserve dollars [for social determinants-focused investments]...it would certainly help plans a lot."

Conclusion

California's Medi-Cal managed care plans understand that strategies focused on social determinants of health are critical tools to improve outcomes for their members and across their communities. However, the financing, evidence base, partnerships, and data systems are not in place to fully scale and sustain such strategic investments. Plans, the state, and California's health foundations have opportunities to leverage current momentum, investments, and plans' relative financial stability to expand effective strategies, document and share successes, and structure sustainable financing. As Medi-Cal Managed Care continues to expand, investments that focus on social determinants can be vital to increasing health care value and addressing underlying issues that shape health spending and outcomes.

Appendices

APPENDIX I:

List of Interviewees

The authors are grateful to the interviewees listed below who contributed their expertise and insights. In addition, the Local Health Plans of California, California Association of Health Plans, and The Children's Partnership provided essential support and review.

Anthem, Inc.
Beau Hennemann
Director, Special Programs

Blue Shield/Care 1st
Dr. Chris Esguerra
Senior Medical Director

CalOptima
Cheryl Meronk
Director of Strategic Development
Arif Shaikh
Director of Government Affairs

CenCal Health
Bob Freeman
CEO

Centene/CA Health & Wellness/ HealthNet
Sandra Rose
Director of Health Programs

Dr. Eva Williams
Director of Public Programs and LTSS

Kellie Todd Griffin
Director of Strategic Giving and Community Engagement

Chelsey Leasure
Manager, Public Programs

April Canetto
Manager, Cultural and Linguistic Services

Central California Alliance for Health
Lisa Ba
CFO

Stephanie Sonnenshine
CEO

Suzanne Skerness
CHSO

Kathleen McCarty
Strategic Development Director

Health Plan of San Joaquin
Dr. Lakshmi Dhanvanthari
CMO

Jose Michel
Manager of Social Services

Maria Aguglia
Director UM/CM

Inland Empire Health Plan
Dr. Brad Gilbert
CEO

Dr. Jennifer Sayles
CMO

Kaiser Permanente
Dr. Sarita Mohanty
Vice President for Medicaid and VulnerablePopulations, National Medicaid

Kern Health Systems
Deborah Murr, RN
Senior Director of Health Services

Michael Pitts, RN
Director of Case and Disease Management

LA Care Health Plan
Nai Kaisick
Senior Director Health Services

Partnership HealthPlan of California
Liz Gibboney
CEO

San Mateo Health Plan
Maya Altman
CEO

Khoa Nguyen
Director of Government Affairs

Santa Clara Family Health Plan
Lori Anderson
Director of Long Term Services and Supports

APPENDIX II:

Recent Investments by Medi-Cal Managed Care Plans

Plan leaders identified the following investments when asked to describe recent significant investments by their plans. Several investments focused on multiple areas and/or populations but have been categorized according to their central focus for added clarity.

INVESTMENT DETAILS	AMOUNT
HOUSING	
GENERAL GRANT PROGRAMS	
Created grant program for counties to apply for capital or coordination grants	$25M over 2-3 years
Providing housing development capital that is matched by the plan's city and offers wraparound services for members and non-members	$20M over previous 4 years
HOUSING-RELATED SUPPORTS	
Implemented Community Care Pilot that sets up independent housing to transition elderly members out of nursing homes and patients out of acute care; plan pays for "social determinants–related" package of services while the beneficiary pays rent out of social security	None provided
Partnering with local organizations for case management, tenancy services, and recuperative care; focusing on 2 populations: • Long-term care – partnering with national organizations (e.g. Institute of Aging and Bright Corners) to transition members in long-term care that do not require skilled care to other levels of housing such as assisted living • High-utilizers – internal program to get members to supportive housing, e.g. recuperative housing, hotels/motel vouchers; plan is also contributing capital investment and collaborating with National Core, an affordable housing non-profit organization, to develop 15 units for low-income members that will be available for 30 years	$10 M/year via flexible housing subsidy pool
Created recuperative care program with local hospitals that offers a care management/coordination component for houseless members	Up to $1M for one year
Coordinating community-wide collaborative effort of housing services that will include a respite program; partnering with local organizations to provide case management services	Between $5-10M (includes Health Homes investment and provider programs)
Built Thriving Communities Fund to support the homeless/unstably housed in community; will focus on 1) preventing displacement or homelessness of lower- and middle-income households in rapidly changing communities, 2) reducing homelessness by ensuring access to supportive housing, and 3) making affordable homes healthier and more environmentally sound	$200M (national investment)
BEHAVIORAL HEALTH AND HOUSING	
Expanding respite center capacity (includes transportation and counseling) for behavioral health and substance use for the community	$80K (frequency/duration not specified)
Established Coordinated Care Initiative[57] – state-level initiative that includes 7 health plans; seeks to integrate behavioral health and long-term services and supports into medical services for seniors and persons with disabilities who have significant social needs	None provided

Established Behavioral Health Integration and Complex Care Initiative; created a flexible subsidy pool that increased staffing for care management, care coordination, and behavioral health integration	$30M over 3 years via flexible subsidy pool
Created capital grant program that allows local partners to apply for one-time grants of up to $2.5M to expand their behavioral health capacity; partners can apply for two types of grants: 1) planning grants for development and 2) implementation grants for construction	$88M (part of overall $206M commitment for Medi-Cal Capacity Grant Program)
LEVERAGING DEMONSTRATION PROGRAMS	
Participating in Health Homes program to address housing and behavioral health needs for Cal MediConnect members[58]; contracting with federally qualified health centers to provide them with case management services with an emphasis on social determinants	None provided
Investing in recuperative care for homeless members over the course of the county's Whole Person Care pilot	$10M over course of Whole Person Care pilot
Investing in county's Whole Person Care pilot; emphasis on providing supportive housing and case management for members leaving long-term care	$2M (frequency/duration not specified)
NUTRITION	
Created subsidy for senior nutrition programs that provide meals in community centers and Meals on Wheels	$200K/year for 3 years
Partnering with local community organizations on a bundle of interventions to address food insecurity and obesity (e.g. subsidizing mobile farmers' markets that accept EBT in food deserts, providing access to cooking classes and education around healthy eating, and hosting the Diabetes Prevention Program for members)	Part of $35M spread across 4 focus areas (food insecurity, resource platform, housing, coordination, community health workers)
Established dedicated partnerships with local organizations that provide 90 days of medically tailored meals for members with congestive heart failure	None provided
PLAN STAFF AND INTERNAL RESOURCES	
Established community health worker staff program with a focus on social determinants and community health worker training and certification program through the local National Urban League Chapter	None provided
Hired in-house social workers that provide field interventions and work with members to address social needs; created dedicated social worker position to connect with members via phone communication to identify and address social needs	None provided
Created personnel dedicated to building community relationships with homeless service providers, food service providers, employment providers, and education providers	None provided
Invested in collaboration to build a community resource platform and working closely with 211 and California Health Information Exchange Equipping community health workers with skills and responsibilities similar to those that work with Health Homes; building a care team that would include a behavioral health clinician, nurse, case manager, and community health worker; building a local workforce of community health workers	Part of $35M spread across 4 focus areas (food insecurity, resource platform, housing, coordination, community health workers)
Created resource platform to assess and address members' social needs called Your Current Life Situation (YCLS), deployed as part of onboarding for some Medi-Cal members; platform asks about social needs and plan working to follow up to address identified needs	None provided

APPENDIX III:

References

1. Mathematica Policy Institute. *Medicaid Managed Care Enrollment and Program Characteristics, 2016.* Centers for Medicare & Medicaid Services. Spring 2018. Accessed January 2019 at: https://www.medicaid.gov/medicaid/managed-care/ downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf
2. California Department of Health Care Services. *Medi-Cal Managed Care.* Accessed December 2018. Accessed January 2019 at: https://www.dhcs.ca.gov/services/pages/medi-calmanagedcare.aspx
3. Manatt Health and Optumas Health care. *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs.* California Health Care Foundation. March 2018. https://www.chcf.org/wp-content/uploads/2018/03/IntendedConsequencesMediCalRateSetting.pdf
4. Norris L. *California and the ACA's Medicaid Expansion.* healthinsurance.org. November 29, 2018. Accessed January 2019 at: https://www.healthinsurance.org/california-medicaid/
5. California Department of Health Services. *Medi-Cal Managed Care Report - December 2013.* Accessed April 2019.
6. California Department of Health Services. *Medi-Cal Managed Care Report - December 2018.* Accessed April 2019.
7. Dutt P, et al. *Financial Summary of Medi-Cal Managed Care Health Plans: Quarter Ending December 31, 2017.* Department of Managed Health Care. April 12, 2018. https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSB%20April2018/Agenda%20Item%207_Financial%20Summary%20of%20Medi-Cal%20Managed%20Care%20Plans%20Report.pdf
8. World Health Organization. *About Social Determinants of Health.* Accessed January 2019 at: https://www.who.int/social_determinants/sdh_definition/en/
9. Hood C, et al. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. American Journal of Preventive Medicine. 2016;50(2):129-135.
10. Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports.* 2014;129:19-31.
11. Tatar M, Chapman A. *The Medi-Cal Program: An Overview.* California Health Care Foundation. February 2019. https://www.chcf.org/wp-content/uploads/2019/03/MediCalExplainedProgramOverview.pdf
12. Rosenbaum S, et al. *Medicaid Payment and Delivery Reform: Insights from Managed Care Plan Leaders in Medicaid Expansion States.* The Commonwealth Fund. March 7, 2018. Accessed January 2019 at: https://www.commonwealthfund.org/publications/issue-briefs/2018/mar/medicaid-payment-and-delivery-reform-insights-managed-care-plan
13. Shippee N, Vickery K. *The Complex Needs of Medicaid Expansion Enrollees with Very Low Incomes.* The Commonwealth Fund. May 31, 2018. Accessed January 2019 at: https://www.commonwealthfund.org/publications/issue-briefs/2018/may/complex-needs-medicaid-expansion-enrollees-very-low-incomes
14. Winkelman T, et al. The Affordable Care Act, Insurance Coverage, and Health Care Utilization of Previously Incarcerated Young Men: 2008-2015. *American Journal of Public Health.* 2017;107(5):807-811.

15. Tatar M, Paradise J, and Garfield R. *Medi-Cal Managed Care: An Overview and Key Issues.* Kaiser Family Foundation, March 2, 2016. http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues

16. Garfield R, et al. *Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans* Kaiser Family Foundation. March 5, 2018. http://files.kff.org/attachment/Report-Medicaid-Managed-Care-March-Plans-and-Access-to-Care

17. Gottlieb L, et al. *Addressing Social Determinants of Health in Medicaid Populations: Findings from Interviews with Managed Care Leaders.* UCSF Center for Health and Community and Health Begins. January 2016.

18. Manchanda R, Ackerman S, Gottlieb L. *Building Medicaid Managed Care Systems that Address Social Determinants of Health: A Case Study Synthesis.* UCSF Center for Health and Community and HealthBegins. February 2016.

19. Bachrach D, et al. *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools.* The Commonwealth Fund. January 31, 2018. Accessed January 2019: https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review

20. California Department of Health Services. *Medi-Cal Managed Care Reports. December 2011 – December 2018 Reports.* Accessed April 2019.

21. Castrucci B, Auerbach J. *Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health.* Health Affairs Blog. January 16, 2019. Accessed April 2019 at: https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

22. Braveman P, Gottlieb L. 2014.

23. California Department of Health Care Services. *Staying Healthy Assessment.* Accessed April 2019 at: https://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

24. American Academy of Pediatrics. *Bright Futures.* Accessed April 2019 at: https://brightfutures.aap.org/Pages/default.aspx

25. National Association of Community Health Centers. *PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences.* Accessed April 2019 at: https://brightfutures.aap.org/Pages/default.aspx

26. Gold R. *Addressing Social Needs to Improve Health at Kaiser Permanente – and Beyond.* Kaiser Permanente Center for Health Research. December 13, 2017. Accessed April 2019 at: https://research.kpchr.org/News/CHR-Stories/Addressing-Social-Needs-to-Improve-Health-at-Kaiser-Permanenteand-Beyond

27. Health Net. *Newsroom: Sacramento Residents Can Build a Career in Health care with New Community Health Worker Pathway Program Partnership between Health Net, Sacramento City College, Greater Sacramento Urban League and WellSpace Health.* November 8, 2018. Accessed June 2019 at: https://newsroom.healthnet.com/press-release/sacramento-residents-can-build-career-health care-new-community-health-worker-pathway-p

28. Sacramento City College. *Community Health Worker Program.* Accessed June 2019 at: https://www.scc.losrios.edu/sah/chw/

29. Johnson D, et al. Community Health Workers and Medicaid Managed Care in New Mexico. *Journal of Community Health.* 2012; 37(3):563-571.

30. Inland Empire Health Plan. *Community Resource Centers.* Accessed April 2019 at: https://www.iehp.org/en/community/community-resource-centers

31. National Health Foundation. *What is Recuperative Care.* Accessed February 2019 at: https://nationalhealthfoundation.org/recuperative-care/

32. Vest J, Harris L. *Indianapolis Provider's Use of Wraparound Services Associated with Reduced Hospitalizations and Emergency Department Visits.* Health Affairs. October 2018. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0075

33. National Health Care for the Homeless Council, Inc. *Permanent Supportive Housing.* Accessed February 2019 at: https://www.nhchc.org/policy-advocacy/issue/permanent-supportive-housing/

34. L.A. Care Health Plan. L.A. *Care Commits $20 Million to End Homelessness in Los Angeles County.* http://www.lacare.org/sites/default/files/housing-for-health-fact-sheet.pdf

35. L.A. Care Health Plan. L.A. *Care Commits Unprecedented $20 Million to Tackle Homelessness Crisis.* April 13, 2017. Accessed February 2019 at: http://www.lacare.org/news/la-care-commits-unprecedented-20-million-to-tackle-homelessness-crisis

36. California Department of Health Care Services. *All Plan Letter 17-010.* State of California Health and Human Services Agency. May 31, 2017. https://www.calhospital.org/sites/main/files/file-attachments/apl_17-010_transportation_final.pdf

37. Central California Alliance for Health. *Medi-Cal Capacity Grant Program.* Accessed June 2019 at: https://www.ccah-alliance.org/foodaccess.html

38. JSI Research & Training Institute, Inc. and Center for Health Care Strategies. *Opportunities for Medi-Cal to Support Community Health Initiatives.* May 2018. https://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=21605&lid=3

39. U.S. Department of Health and Human Services Health Resources and Services Administration. *Quality Improvement.* April 2011. https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf

40. American Academy of Family Physicians. *Value-Based Payment.* 2016. Accessed July 2019 at: https://www.aafp.org/about/policies/all/value-based-payment.html

41. Dutt P, et al. April 12, 2018.

42. Manatt Health and Optumas Health care. March 2018.

43. California Department of Health Care Services. *Medi-Cal Managed Care Rate Development Overview.* June 2015. https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/meetings/20150617/MediCal.pdf

44. Covered California. *Reports and Research Board Meeting.* October 27, 2016. https://board.coveredca.com/meetings/2016/10-27/Reports%20and%20Research%20Final.pdf

45. Finocchio L, Newman M, Roh E. *Medi-Cal Facts and Figures: Crucial Coverage for Low-Income Californians.* California Health Care Foundation. February 2019. https://www.chcf.org/wp-content/uploads/2019/02/MediCalFactsFiguresAlmanac2019.pdf

46. Ibid.

47. California Department of Health Care Services. *Medi-Cal Children's Health Dashboard.* March 2019.

https://www.dhcs.ca.gov/services/Documents/Mar2019PedDashboard.pdf

48. Wagnerman K, Chester A, Alker J. *Medicaid Is A Smart Investment in Children.* Georgetown University Center for Children and Families. March 2017. https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf
49. Tatar M, Chambers R. *Med-Cal Fact Sheet: Medi-Cal and Behavioral Health Services.* California Health Care Foundation. February 2019. https://www.chcf.org/wp-content/uploads/2019/02/MediCalExplainedBehavioralHealth.pdf
50. U.S. Centers for Medicare & Medicaid Services. *CMS Proposes Medicare Advantage and Part D Payment and Policy Updates to Provide New Benefits for Enrollees, New Protections to Combat Opioid Crisis.* February 1, 2018. Accessed March 2019 at: https://www.cms.gov/newsroom/press-releases/cms-proposes-medicare-advantage-and-part-d-payment-and-policy-updates-provide-new-benefits-enrollees
51. Oregon Health Authority. *Health-Related Services Frequently Asked Questions.* August 2018. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-FAQ.pdf
52. Health Aspects of Kindergarten Readiness Technical Workgroup. *Health Aspects of Kindergarten Readiness Technical Workgroup: Report and Recommendations.* Metrics and Scoring Committee. March 2019. https://childinst.org/wp-content/uploads/2018/09/HAKR_Technical_Workgroup_Report_2019_Final-with-Cover-Letter.pdf
53. Bachrach D, et al. January 31, 2018.
54. Crumley D, Houston R. *Refining Oregon's Medicaid Transformation Strategy through CCO 2.0: A Q&A with the Oregon Health Authority.* April 16, 2019. Accessed June 2019 at: https://www.chcs.org/refining-oregons-medicaid-transformation-strategy-through-cco-2-0-a-qa-with-the-oregon-health-authority/
55. Azar A. *The Root of the Problem: America's Social Determinants of Health. Hatch Foundation for Civility and Solutions.* November 14, 2018. Accessed February 2019 at: https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html
56. Alderwick H, Hood-Ronick C, Gottlieb L. *Medicaid Investments to Address Social Needs in Oregon and California.* Health Affairs. May 6, 2019. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05171
57. California Department of Health Care Services. *Coordinated Care Initiative Overview.* Accessed February 2019 at: https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx
58. California Department of Health Care Services. *Health Homes Program.* Accessed February 2019 at: https://www.dhcs.ca.gov/services/pages/healthhomesprogram.aspx

An electronic version of this report can be accessed at:
www.jsi.com/movingtowardvalue

Recommended Citation: Giron N, Kirui T, Tobey R, Cantor J. *Moving Toward Value: Medi-Cal Managed Care Plans and the Social Determinants of Health*. JSI Research & Training Institute, Inc. September 2019. **www.jsi.com/movingtowardvalue**