CHCS Center for Health Care Strategies, Inc.

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Addressing Health-Related Social Needs among Medicaid Beneficiaries: Mapping Cross-Sector Partnership Roles

IN BRIEF

Given the significant influence of social needs on the health of Medicaid beneficiaries and their overall cost of care, there is increasing interest in maximizing the impact of social needs interventions and avoiding duplication of services. Cross-sector teams can improve the efficiency of partnership efforts by strategically mapping out complementary activities that support shared goals for improving the health and wellbeing of Medicaid beneficiaries. This framework was developed to support Medicaid agencies, managed care organizations, health care providers and community partners in mapping potential cross-sector partnership roles for addressing health-related social needs based on the relative strengths of each partner.

There is growing recognition among health care stakeholders — states, payers, providers, and community partners — that each has unique and essential capabilities for addressing Medicaid beneficiaries' health-related social needs (HRSN). Given the significant impact of social needs on the health of Medicaid beneficiaries and their overall cost of care, there is increasing interest in maximizing the impact of social needs interventions and avoiding duplication of services. Leading-edge cross-sector teams are seeking to develop partnerships that strategically maximize the strengths of each partner to support shared goals for improving the health and wellbeing of Medicaid beneficiaries. In particular, stakeholders are exploring coordinated efforts around data collection and analysis, shared infrastructure, and community-level investments in upstream preventive services.

To support these efforts, the Center for Health Care Strategies developed a framework *(see next page)* to support cross-sector teams — including Medicaid agencies, managed care organizations (MCOs), and health care providers/community partners — in mapping cross-sector partnership roles for addressing HRSN based on each partner's strengths. Activities included in the framework are organized under five key categories for addressing social integration as outlined in the National Academies of Sciences, Engineering, and Medicine report, ***Integrating Social Care into the Delivery of Health Care***: Awareness, Adjustment, Assistance, Alignment, and Advocacy.

While roles may vary from community to community, this framework is intended to stimulate productive conversations about the roles of each stakeholder in addressing HRSN. Additionally, partners will need to think critically and comprehensively about how to ensure that consumers and communities are effectively engaged.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

A Framework for Mapping Partnership Roles in Addressing Health-Related Social Needs among Medicaid Beneficiaries

NASEM-Identified Activities Supporting Social Integration	State Medicaid Agencies	Medicaid Managed Care Organizations (MCOs)	Health Care Providers / Community Partners
Awareness: *Identify the social risks and assets of defined patients and populations*	▪ Develop managed care contract requirements for MCOs/ providers, with an emphasis on screening for and collecting data on social needs. ▪ Design incentive programs for MCOs to explore HRSN pilots and fund trainings for providers to screen. ▪ Partner with state agencies/public health departments to access, interpret, and share available state-level social needs data and assess the scale of unmet needs. ▪ Encourage adoption of standardized social needs documentation, including the use of ICD-10 Z codes to identify reimbursable HRSN screening and coordination.	▪ Collaborate with and incentivize network providers and other MCOs to standardize screening questions/domains. ▪ Provide screening using MCO infrastructure for beneficiaries not screened by providers. ▪ Support provider outreach and education via trainings that offer continuing education credits, provider bulletins, and other materials.	▪ Implement standardized screening tools or questions for intake, potentially prioritizing high-need subpopulations. ▪ Document screening results in EMR and care plans using ICD-10 Z codes that can be shared with care team/MCO. ▪ Co-lead screening in the community or patient homes. ▪ Promote HRSN services through community organizations, public awareness campaigns, or point-of-care settings. ▪ Partner with other regional stakeholders to complete unified community health needs assessments. ▪ Share HSRN data with MCOs and contracted community service providers.
Adjustment: *Focus on altering clinical care to accommodate identified barriers*	▪ Clarify the role that HSRN activities play within care management program requirements in managed care or payment and delivery reform programs, including health homes.	▪ Adjust existing care management programs to more effectively incorporate HSRN into care planning. ▪ Embed care management staff trained with social needs experience in clinical settings.	▪ Establish clear parameters around roles of staff on inter-professional care teams. ▪ Adjust clinical models to meet social needs that may impact health outcomes, such as offering home-based asthma education, after-hours care, and onsite childcare.
Assistance: *Reduce social risk by providing assistance in connecting patients with relevant resources*	▪ Expand the scope of community health and social workers and related reimbursement to provide care management services that facilitate access to social services. ▪ Invest in/coordinate activities with technology vendors to support screening and navigation infrastructure. ▪ Establish standards for use of electronic platforms to manage social service resources. ▪ Use other state agencies' data sources to inform comprehensive catalogue of available social services.	▪ Risk stratify members based on clinical and social risk and coordinate with provider partners to target further outreach and follow up. ▪ Establish virtual peer-to-peer programs (e.g., call center-based) to help link members to community resources.	▪ Explore specific partnership opportunities with community organizations that have capacity to partner with health care teams and use local community resources. ▪ Initiate assistance with identified social needs and track resolution of need areas in shared care plan. ▪ Support patient engagement approaches based on established community relationships. ▪ Identify where the patient journey could be more person-centered.
Alignment: *Understand existing social care assets in the community, organize them to facilitate synergies, and invest in and deploy them to positively impact health outcomes*	▪ Explore flexibilities with state plan amendment, waiver authority, and rate-setting to enhance funding of social services in health care settings and via managed care. ▪ Leverage/sustain preliminary private equity and federal investments in digitization. ▪ Provide guidance for MCOs and providers/ACOs around permissible social care activities and benefits. ▪ Introduce/adjust policies to allow MCO flexibility in paying for services that address HRSN with capitation dollars. ▪ Incentivize MCO, ACO, and provider HRSN activities and risk adjust payments based on social factors.	▪ Enter into formal contracts/agreements with health care providers and community partners to enhance access to social services. ▪ Invest in upstream services and partner with organizations that can help accommodate beneficiaries with limited access (e.g., housing and transportation) and seek out non-traditional partners like GED providers and landlords. ▪ Evaluate impact of addressing HRSN on outcomes.	▪ Collect direct consumer feedback by administering a community needs and assets survey to inform targets/opportunities for investment in health needs activities and infrastructure. ▪ Invest in specific social services needed by beneficiaries and not otherwise covered. ▪ Where relevant, maximize use of community benefit dollars to fund eligible social support services. ▪ Broker relationships with Community Development Financial Institutions.
Advocacy: *Promote policies to facilitate the creation and redeployment of assets or resources to address HRSN*	▪ Facilitate data collection and aggregation to produce public-facing reports that demonstrate the need for added government investment in social services. ▪ Convene government, health care, and community stakeholders to identify needed investments, support coordination efforts, and pool resources.	▪ Collaborate with providers to advocate for policies that change how social services are provided. ▪ Evaluate the impact of access to community resources. ▪ Use data to seek government and private investment. ▪ Support plan associations' efforts to advance greater federal, state, and local investment in social services.	▪ Work to promote policies that fundamentally change the infrastructure in the community for key social services. ▪ Support provider associations' efforts to advance greater federal, state, and local investment in social services. ▪ Help consumers advocate for their social needs.