2021 Emerging Trends in Public Programs

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Overview: Medicaid and the Health Care System

In a typical year, one of the most significant factors impacting trends in Medicaid and the health care system would be the outcome of the Presidential, Congressional and State elections. However, this past year was not a typical year, as the factor that has most significantly impacted the Medicaid program and the health care system overall has been the COVID-19 pandemic, which shifted trends in both enrollment and spending.

Going into 2020, trends such as slightly decreasing or flat enrollment in Medicaid, increasing total spending in health care overall, and Medicaid spending growth rate that was slowing were anticipated to continue. In 2019, health care spending in the U.S. increased 4.6% to $3.8T—a rate of growth similar to 2018.[1] Medicaid's share was up from just under $600B in 2018 to $613.5B in 2019, or 16% of total spending.[2] A 2020 report from the Office of the Actuary at CMS projected that national health expenditures would grow on average 5.4% annually through 2028 (note that this report did not include COVID-19 pandemic impacts). Health expenditures would account for almost 20% (up from almost 18% in 2019) of Gross Domestic Product (GDP), a measure of our overall economic vitality and growth.[3] Medicaid was specifically projected to increase at an annual rate of 5.5%.

In the second quarter of last year, however, health care spending decreased by almost 10%. Even with a rebound in the summer and fall, overall spending on health care in 2020 was down about 2%.[4] This pendulum swing in spending was driven in large part by utilization shifts in hospital care. A key driver in total health care spending, hospitals saw dramatic decreases in both inpatient and outpatient volume.[5] Despite depressed hospital care and service utilization within Medicaid programs, Medicaid spending dramatically increased in 2020 and projections are for continued growth as total enrollment continues to rise.

According to the Kaiser Family Foundation (KFF), total annual federal Medicaid spending grew by 12% in fiscal year (FY) 2020 to a total of $458B.[6] Together federal and state spending jumped by 6.3% in FY 20 and is expected to increase by 8.4% in FY 21.[7] This is particularly significant given that the spending growth rate in Medicaid was previously slowing due to enrollment declines. State Medicaid directors have indicated that they anticipate pressures on Medicaid spending to continue into FY 21 and even FY 22, due to enrollment increases and continued spending on long-term services and supports and provider rate changes.[8]

Based on the latest figures, Medicaid enrollment is up to ~81M from just under 71M at the start of 2020.[9] Through March 2020, total Medicaid enrollment was declining slightly. However, enrollment numbers changed course due in large part to the Maintenance of Eligibility (MOE) requirement associated with receipt of the Federal Medical Assistance Percentage (FMAP) increase authorized by Congress. State Medicaid directors have reported that they believe Medicaid enrollment will jump by 8.2% in FY 21 due to the MOE requirement.[10]

Even when states begin to officially take action on redeterminations when the MOE requirement ends (anticipated in early 2022) there are some indications that few enrollees overall will have an income or other eligibility change that would cause them to be disenrolled from Medicaid.[11] Populations most sensitive to the changes in economic conditions due to the PHE – children, parents, expansion adults - have seen their enrollment figures increase faster than older adults or people with disabilities, which prior to the pandemic were the primary populations driving increases in Medicaid enrollment. However, given that few states have begun the process of addressing changes in circumstances or overdue renewals in advance of the end to the MOE requirement, concrete data is lacking about where Medicaid enrollment figures will be once the PHE ends. If enrollment numbers stay at their current inflated level but with no additional funding from the enhanced FMAP, states will likely experience cost pressures in Medicaid. With over 75% of the Medicaid population enrolled in Medicaid Managed Care Organizations (MCOs) and over half of the Medicaid spending flowing through managed care programs, the budget pressures will likely result in rate pressure for MCOs and/or state-driven changes to benefit design.[12]

The Medicaid system has been taxed in ways unanticipated going into 2020. The predicted rising health care costs related to the aging of the population and the introduction of higher-acuity enrollees were driving many of the trends in Medicaid at the start of the year. These trends drove the decisions states were making and informed how managed care organizations responded to meet the needs of their state partners and members. Those same cost pressures exist today but have been exacerbated and added to by the pandemic. And though identified as a secondary factor driving current trends, the outcomes of the 2020 November elections will also impact how states emerge from the current PHE and the direction of Medicaid policy and program design moving forward. **Medicaid will continue to be relied upon as a critical social safety net for millions of Americans.**

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[1] CMS
[2] Ibid
[3] CMS
[4] Health System Tracker
[5] Revcycle Intelligence
[6] Kaiser Family Foundation
[7],[8] Kaiser Family Foundation
[9] Medicaid.gov
[10] Kaiser Family Foundation
[11] Kaiser Family Foundation; The Commonwealth Fund
[12] AHIP; Health Management Associates

Macro Trend: Reforming the Delivery of Health Care

Delivery system reform includes a variety of activities designed to change the way care is delivered and paid for to promote more efficient and effective health care. At its core, delivery system reform involves "altering care delivery, payment incentives, or both to stimulate and sustain delivery system changes."[13] Value-based payment (VBP), value-based care, and alternative payment models (APMs) all fall within the broad category of "delivery system reforms." In addition, change to how care is delivered such as using digital platforms to connect providers to members is also a trend in the transformation of health care delivery.

Trend 1: Alternative Payment Models and Value-Based Purchasing

Increasingly, states are encouraging or requiring Medicaid Managed Care Organizations (MCOs) to participate in and support delivery system and payment reforms. Specifically, MCOs are being asked to: 1) enter into diverse value-based arrangements with an increasing number and types of providers, 2) collaborate with other members of the delivery system to increase efficiencies, 3) support providers to take on greater risk for outcomes, and 4) use a variety of other strategies to coordinate care for beneficiaries with complex care needs.

In January 2020, Bailit Health released a report on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC) analyzing Medicaid VBP approaches in five managed care states. These encompassed state-established thresholds for minimum percentage of payments tied to value, quality, and performance withholds, Accountable Care Organizations (ACOs), medical homes, and bundled payments.[14] The report is one of the few reviews of the opportunities and challenges tied to VBP models in Medicaid managed care. Bailit found that although states have multiple tools to promote the use of VBP and that related contract requirements are effective in changing MCO behavior, most providers are not yet ready or willing to engage in downside risk arrangements.

Impact of COVID-19

In the fall of 2020, the Health Care Payment Learning and Action Network (HCP-LAN) released the Healthcare Resiliency Framework, outlining steps for payers, providers, and other health care stakeholders in transitioning to APMs that support system resiliency in a post-COVID-19 environment. Simultaneously, CMS distributed a letter to State Medicaid Directors discussing the role of VBP in the post-COVID-19 health care environment. The letter quoted then-CMS Administrator Seema Verma, saying "...by accepting value-based or capitated payments, providers are better able to weather fluctuations in utilization, and they can focus on keeping patients healthy rather than trying to increase the volume of services to ensure reimbursement... Value-based payments also provide stable, predictable revenue—protecting providers from the financial impact of a pandemic."[15] The COVID-19 pandemic renewed conversations on the potential benefits of VBP arrangements to providers, particularly capitated models, to serve as pathways for financial resiliency. Even with the pandemic further illuminating the challenges of fee-for-service (FFS) reimbursement, providers are still likely to vary in their ability and desire to adopt capitated payment structures and accept financial risk.

APMs to Reduce Health Disparities and Improve Equity

The death of George Floyd in May 2020 and the more than 2,000 protests across U.S. cities that followed fueled growing public acknowledgement of the systemic racial inequalities in America. At the same time, COVID-19 continued to disproportionately affect communities of color in America, with Black, Hispanic, and Native American case and death rates far exceeding rates of White, non-Hispanics.[16] These events combined to accelerate conversations with states on the role of the health care system and APMs in addressing health disparities, including how value-based interventions could be deployed to improve health equity. This topic is particularly relevant to the Medicaid population given that more than half of Medicaid beneficiaries under age 65 are a part of a racial or ethnic minority group.

[13] Commonwealth Fund
[14] MACPAC five states studied were: MN, NM, NY, OH, SC
[15] Medicaid.gov
[16] NPR

State Medicaid agencies' increasing interest in addressing health disparities through APMs has been reflected in both MCO contracts and in recent RFPs.[17]

- **In Michigan,** MCOs are held to plan-specific health equity measures as part of the state's performance withhold program.[18] To score well on these measures, MCOs must reduce the index of disparity between white members and Black and Hispanic members on certain metrics.
- **North Carolina** has also expressed interest in exploring how VBP could be deployed to address health disparities, both through the state's planned managed Medicaid program and through the Integrated Care for Kids (InCK) model.[19]
- **Minnesota's** recent Medicaid managed care RFP asked respondents to elaborate on how their organization uses VBP or other incentive arrangements to "improve racial equity in quality of care and health outcomes."

Model Trends

Multi-Payer Alignment

Given CMS's and HCP-LAN's shared goal of having providers across all market segments shift to APMs with higher total cost of care accountability, it is likely that the recent trend of multi-payer alignment in models will continue. CMS's recent letter to State Medicaid Directors on Medicaid VBP models emphasized the importance of developing models that apply to Medicaid, Medicare, and commercial populations. Multi-payer models can reduce fragmentation in the health care system and provider concerns over the number of VBP models and related quality measures they report on, which may encourage increased provider engagement.

While multi-payer participation in models is one method for easing provider burden during the transition to value-based reimbursement, over the long-term multi-payer initiatives must thoughtfully consider the differences between market segments, including payment and revenue structures and populations of interest. Given the variation between state Medicaid programs and the unique amount of churn within the member population, models that are successful in commercial and Medicare segments are not necessarily transferable to Medicaid. As CMS continues to develop multi-payer models, they must consider the methodological elements necessary to ensure models effectively apply to the Medicaid population as well as other market segments.

State VBP Targets and Shift to Downside Risk[20]

In an October 2020 op-ed, then-CMS Administrator Seema Verma wrote of the importance of incorporating value-based incentives into state Medicaid programs through contractual requirements, and noted that the primary takeaway of CMMI's APMs to date is that "models where providers have downside risk perform better because they have 'skin in the game.'"

Going into 2020, some states, like New York, Rhode Island, and Texas, had already established thresholds for the proportion of MCO payments tied to downside risk arrangements. But states have since had to reconsider such thresholds in light of the COVID-19 pandemic, given its unforeseen consequences on providers and service utilization. Rhode Island, for example, has since revised their 2021 target for 10% of providers engaged

Data Spotlight

Of the 40 states with Medicaid managed care in FY 2019:

53% required MCOs to set targets for payments made through APMs

35% had implemented financial incentives and penalties associated with APM requirements

43% identified "value-based purchasing" as a focus area for MCO performance measures

Source: Kaiser Family Foundation

[17] Kaiser Family Foundation
[18] Michigan.gov
[19] Health Affairs
[20] Downside risk APMs are included as Categories 3B and 4A, 4B, and 4C in the HCPLAN Framework.

in downside risk agreements from mandatory to optional for Medicaid MCOs. As discussed above, the COVID-19 pandemic has prompted conversations on how to adjust VBP methodology and thresholds in response to a disrupted health care system. States will likely continue to alter their VBP programs and expectations this year to account for the pandemic, while keeping the overall intention and direction of their programs focused on increasing the proportion of providers moving to downside risk, even if they do so on a longer timeline.

Bundled Payments in Medicaid Managed Care[21]

Bundled payments have continued to gain traction in Medicaid managed care, including in maternity care, substance use disorder (SUD), asthma episodes, and joint replacement.[22] Given the amount of churn in the Medicaid population, bundles may be an especially promising form of VBP in Medicaid as they are tied to a specific episode of care instead of a specific provider. Still, successful implementation of bundles requires intentional design of the payment model, including multi-payer participation and/or alignment with existing bundles to ensure consistent quality measure use and reduce provider abrasion. Additionally, to capitalize on bundles' discrete nature, included diagnosis codes should be clearly established and guidance should be provided on providers subject to attribution.

Trend 2: Telehealth

As reported by both the American Telemedicine Association (ATA) and the Center for Connected Health Policy, going into 2020, all 50 states and Washington, DC had established policies supporting Medicaid reimbursement for telehealth but there was wide variation in the types of modalities covered, the payment requirements, and the providers eligible to provide services via telehealth.[23] Though considered as a way to increase access to care, adoption by both providers and consumers was limited due to issues with access to needed technology, limited information on outcomes and effectiveness, and patient and provider preferences.[24] However, the PHE significantly accelerated adoption as policymakers and the health care system looked to reduce the exposure and spread of COVID-19 while continuing to deliver needed health care services. This experience has forced policy changes related to some of the noted previous barriers to adoption that will have long-term implications for the Medicaid program.

Impact of COVID-19

In response to the pandemic, federal and state authorities quickly relaxed many regulations (e.g. use of telehealth during first visit with provider, audio only visits, expanded list of eligible providers of services via telehealth) and provided funding to facilitate rapid adoption of telehealth.[25] These actions resulted in a more than 2600% increase in telehealth visits (46.8 million total services) among Medicaid and CHIP members between March and July of 2020, with the highest utilization occurring among working age adults followed by children and older adults.[26]

Telehealth use peaked in April and has since decreased as providers were able to start seeing patients in person (i.e. when safe-at-home/ stay-at-home orders were relaxed or lifted). However, demand has continued at a relatively higher rate than before the pandemic. Recent estimates show telehealth constitutes 8% of outpatient visits, compared to less than 1% pre-pandemic.[27] While both specialty and primary care showed increases in telehealth visits, the largest increase, 56%, was seen for behavioral health services (Figure 1).[28]

Increase in Telemedicine Visits[29]

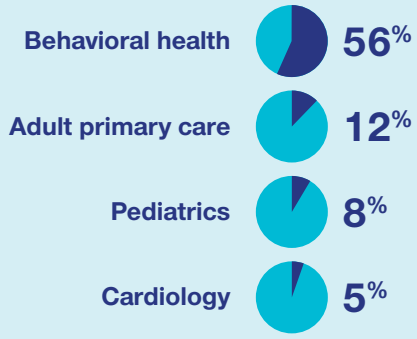

Figure 1

[21] Bundled payment APMs are included as Category 3B in the HCPLAN Framework.
[33] American Medical Association
[23] mHealth Intelligence; Center for Connected Health Policy
[24] MACPAC
[25] Commonwealth Fund
[26] Medicaid.gov
[27] Commonwealth Fund
[28] Commonwealth Fund
[29] Commonwealth Fund

Medicaid agencies and providers have reported seeing several benefits from telehealth during the pandemic, which are spurring interest in permanent regulatory changes to facilitate on-going use. These benefits include:[30,31]

- Reduced no-show rates
- Decreased non-emergent medical transportation costs
- Greater access for individuals with work or childcare concerns
- Increased engagement among new populations
- Increased engagement in new service areas, such as tele nutrition
- Increased member satisfaction

Telehealth Adoption Long-Term

The PHE has created a natural opportunity for states to see what greater utilization of telehealth for the Medicaid population could look like, and the benefits for providers and consumers. Based on the positive impacts to date, states have moved quickly to determine which telehealth policies should and should not continue long term and evaluate whether the policy changes need to be made via state legislation or regulation (including Medicaid and scope of practice/licensure laws). It is important to note that states have significant authority to set telehealth policy. In fact, there are no federal prohibitions on any form of telehealth in Medicaid for state plan services. For example, a state must only seek a state plan amendment specific to telehealth if it wishes to have provider payments differ when a service is provided via telehealth compared to a face-to-face setting.[32]

Policy areas states have or are currently considering for permanent adoption include:

- Expanding where a patient can be located during a telehealth visit (e.g., member's home),
- Expanding the providers and services authorized for reimbursement via telehealth, and
- Expanding which telehealth modalities are reimbursable, including remote patient monitoring, store-and-forward, and audio-only/telephone.

While the telehealth policy landscape will continue to take shape, there are key areas that will need to be addressed more substantively for telehealth to create sustainable, expanded access over the long-term.

Bridging the Digital Divide

Low income and rural Americans are less likely to have access to adequate internet coverage[33] or other technological resources[34] necessary to facilitate a telehealth visit. In fact, people who wanted to but did not use telehealth during the pandemic "cited barriers such as [...] lack of access to or comfort with using the required technology."[35] States are considering permanently covering and paying for audio-only telehealth in a limited scope, such as for rural areas or targeted services like behavioral health, to reduce telehealth barriers for Medicaid members. However, more will need to be done to advance equitable access, including implementing policies and tailored interventions for members who may face additional barriers to accessing services via telehealth (e.g., people with disabilities, limited English proficiency, mental illness).[36]

Data Spotlight

Of adults with annual household incomes below $30,000, around **24%** report not owning a smartphone at all, while **15%** are solely reliant on their smartphone for internet access.

Source: Pew Research Center

Advancing Health Equity

Medicaid covers a diverse group of individuals with unique care needs. Medicaid programs must effectively understand the impact digital care is having on members, paying close attention that telehealth does not unintentionally increase health disparities or negatively affect vulnerable populations (including outcomes and privacy). For example, a greater portion of Hispanic/Latinx adults reported using telehealth during the pandemic than their white counterparts but were less satisfied with the experience.[37]

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[30] Medicaid.gov
[31] Journal of the Academy of Nutrition and Dietetics
[32] Medicaid.gov
[33] Federal Communications Commission
[34] Pew Research
[35] Robert Woods Johnson Foundation
[36] National Governors Association
[37] Robert Woods Johnson Foundation

Balancing Access and Cost

During the pandemic, many states allowed for telehealth visits to be paid at the same rate as in-person visits to stabilize the delivery system. Providers have advocated that payment parity should continue given the costs of technology and implementation, and the incentive it creates for investment in telehealth long-term even if the associated costs decrease over time. Expanded access offered by telehealth is especially valuable for Medicaid members, who have historically faced greater barriers accessing care than individuals covered by other insurance. This uniquely positions Medicaid programs and MCOs to work together to monitor trends and develop payment models and practices that strategically expand telehealth without sacrificing program stability or effective stewardship of public dollars.[38] A growing number of states are interested in seeing value-based payment models used to grow telehealth capacity that promotes effective and appropriate utilization.

Building and Supplementing Local Capacity

States and providers are leery of telehealth programs that simply replace the local delivery system. Rather, as demonstrated in recent RFPs in Hawaii, Minnesota, and Oklahoma, states are interested in solutions that build or augment existing capacity to enhance access.

[38] Health Affairs

Macro Trend: Serving the Whole Person

To serve the whole person, policymakers are advancing policy and program design initiatives that are focused on both access and care coverage and increasingly through the lens of equity. Using the authority granted in the Affordable Care Act (ACA) to expand Medicaid to individuals earning up to 138% of the federal poverty level (FPL) continues as a trend. In addition, access to not only physical and behavioral health services but also non-clinical services continue to be areas where states in particular are refocusing the approach to creating access to those services. Finally, spotlighted by the COVID-19 pandemic, health disparities and inequities in health care outcomes are being prioritized by federal and state policymakers through various actions, including new policies, additional procurement requirements, and new contract obligations.

Trend 3: Medicaid Expansion

In total, 38 states plus Washington, DC have adopted Medicaid Expansion.[39] In just the last year, Idaho, Nebraska, and Utah have implemented Medicaid Expansion (after successful adoption in 2019) and two additional states, Missouri and Oklahoma, saw ballot initiatives pass for Expansion in 2020.[40]

States with previous or current movement and the potential opportunity to expand Medicaid in the next few years include:

- Florida: Advocates attempted to get Expansion on the ballot in 2020 but the Legislature made changes to the ballot process that thwarted their efforts. Advocates restarted their efforts in 2021 and signatures are being collected in order to secure a ballot measure in the 2022 election cycle.
- Mississippi and South Dakota both have signature drive efforts underway to put Expansion on the 2022 ballot. Though the effort continues in South Dakota, advocates in Mississippi paused their effort due to a state Supreme Court ruling that broadly effects all voter-based ballot initiatives.
- The Wyoming House successfully passed legislation that was ultimately rejected by the Senate. However, the Legislature's Joint Revenue Committee revived the proposal setting it up for debate during an upcoming session.
- In Kansas, North Carolina, Wisconsin[41], there has been movement to expand Medicaid, but efforts have run into partisan disagreements that appear insurmountable in the current environment.
- The Georgia legislature enacted legislation allowing the state to seek an 1115 waiver to expand Medicaid in 2019, which the State subsequently submitted and received approval of allowing expansion of Medicaid coverage to individuals earning up to 100% FPL (versus 138% as outlined in the ACA). Though implementation was set to begin July 1, 2021, the effort has been delayed due to push back from the Biden administration.[42]
- There have been no substantive efforts to date to expand Medicaid in Alabama, South Carolina, Tennessee, or Texas.

Data Spotlight

The American Rescue Plan includes a **5%** FMAP increase for a state's non-expansion population to incentivize states that haven't implemented Medicaid Expansion to date.

A total of six states have adopted Medicaid Expansion by ballot initiative that are considered 'red' or conservative (Idaho, Maine, Missouri, Nebraska, Oklahoma, and Utah).[43] The use of ballot initiatives continues to be a trend with advocates using them in a number of the states that have yet to adopt Expansion. However, the Missouri legislature's efforts to block implementation of Medicaid Expansion may serve as a new type of roadblock used in other states to delay or wholly prevent efforts to expand Medicaid.[44] Though there has also been a trend in states tying Expansion coverage to meeting specific community engagement requirements, with the underlying authority for community engagement requirements in Medicaid anticipated to be withdrawn, this trend will likely end. If that occurs, it could have potential implications for states who were considering Expansion but only if they were able to tie the coverage to these requirements.

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[39] Kaiser Family Foundation
[40] Despite successful passage of the ballot measure, Missouri legislature is currently advancing a budget that does not fund the Expansion setting up a potential lawsuit.
[41] Wisconsin is unique as it has a modified Expansion coverage today.
[42] HealthInsurance.org
[43] Bloomberg Law
[44] As of the timing of this publication, the Missouri State Supreme Court has ruled that the state legislature did not need to allocate funding in order to for the state to move forward with implementing Medicaid Expansion as approved by the voters.

Trend 4: Addressing the Social Determinants of Health

Social determinants of health (SDOH)—social, economic, and environmental factors—continue to be primary drivers for health outcomes, health care costs, and quality. The latest estimate attributes approximately 80% of health outcomes to SDOH, including the following domains: housing, nutrition, transportation, employment, and interpersonal violence.[45] The COVID-19 pandemic and accompanying economic impacts have compounded the negative impacts of SDOH, especially for the Medicaid population. Increasing state budget pressures continue to drive interest in addressing the negative impacts of SDOH that significantly impact health care costs.

Impact of COVID-19

COVID-19 has exacerbated the negative impacts of all SDOH domains, especially for Medicaid beneficiaries, and will likely last years beyond the pandemic. As of April 2021, key COVID-19 related impacts prevalent in the Medicaid community included:

- **Housing:** Prior to the pandemic, an average of 3.6 million eviction cases were filed annually in the U.S., but it estimated that the lifting of eviction moratoriums will put an estimated 30-40 million Americans at risk of eviction.[46] This will likely continue the rise in homelessness seen in recent years—a study by the Economic Roundtable estimates homelessness, which sat just under 100,000 pre-pandemic recession, will climb 49% over the next four years, peaking in 2023.[47]
- **Nutrition:** Food insecurity has increased across all states during the COVID-19 pandemic. State rates vary, ranging from 9.7% (North Dakota) to 22.6% (Mississippi) in 2020. Child food insecurity has risen as well, ranging from 15.0% (North Dakota) to 32.3% (Louisiana and Nevada), due in part to increased rates of poverty, but also to the shift from in-person to virtual learning, as low-income children rely heavily on free or reduced-price lunch at school for their primary source of food.[48] Supplemental Nutrition Assistance Program (SNAP) enrollment has increased as a result.
- **Employment:** The unemployment rate rose due to the economic downturn from the COVID-19 pandemic, hitting an all-time high in April 2020 (14.7%). Unemployment has since leveled off (measured 6.2% as of March 5) but remains elevated compared to pre-pandemic times (4.4% in March 2020). Low-wage jobs have been hit the hardest by the pandemic, accounting for 53% of jobs lost from February to November.[49] At the beginning of the pandemic, temporary layoffs, also commonly referred to as "furloughs," increased by over 15 million persons from March to April 2020 to hit 18.1 million persons total, while permanent job losses increased by 544,000 during that same time period. Since then, temporary layoffs have leveled off, accounting for 2.7 million unemployed persons in January 2021, while permanent job losses totaled 3.5 million in January 2021.

Data Spotlight

33% of Black renters and **20%** of Latino renters reported being behind on rent in February and March of 2021, compared to **19%** of all adult renters.

Source: U.S. Census Bureau

The COVID-19 pandemic has heightened the importance of addressing SDOH, increasing the appeal of new value-added services such as food assistance and home delivered meals, personal protective equipment, and pharmacy home deliveries. In total, 27 states reported implementing, expanding, or reforming a program or initiative in response to COVID-19 to address SDOH for Medicaid beneficiaries[50]. To respond to the increase in food insecurity due to COVID-19, states are using the SNAP flexibilities made available through the Families First Coronavirus Response Act (FFCRA) to provide emergency benefit supplements and reduce administrative procedures required to receive benefits.

Federal activity continues to address the COVID-19 impact on SDOH. President Biden signed an Executive Order to expand benefits for low-income families with children to account for meals missed due to COVID-related school and childcare closures. The American Rescue Plan Act includes $26 billion in rental assistance and $5 billion in assistance for individuals experiencing homelessness[51].

[45] Robert Wood Johnson Foundation
[46] Aspen Institute
[47] Economic Roundtable
[48] Feeding America
[49] Center on Budget and Policy Priorities
[50] Kaiser Family Foundation
[51] Center on Budget and Policy Priorities

Use of Procurements, MCO Contracts, & Waivers

State Medicaid programs are increasingly prioritizing SDOH and their effects on health outcomes. States continue to use Medicaid managed care procurements and contracts to push MCOs to develop innovative solutions to address SDOH. In 2020, 35 states (out of 41 total managed care states) used contracts to promote addressing SDOH within the Medicaid program.[52]

The two most prevalent SDOH-related contractual requirements are social service referrals (31 states) and social needs screening (31 states). Social needs screening allows MCOs and providers to capture priority SDOH elements, which can help improve SDOH data. Improving accessibility of this data, even at an aggregate level, allows states to better coordinate programs and linkages across an individual's whole life experience. States are also showing the increased desire to close referral loops through outcome tracking. The progression of SDOH contractual requirements in the last several years began with screening, evolved to include referrals, and are now expanding to include referral loop closure to ensure that social needs are not only identified, but also addressed.

As states place a greater emphasis on closing referral gaps and improving SDOH outcomes, interoperability between data systems and programs continues to grow in appeal, especially alignment at the Health Information Exchange (HIE) level. The increasing use of consistent and accessible data platforms has allowed for the possibility to connect information across all social risk points to better see the entire timeline of an individual.

State Medicaid programs are limited in how they can use federal funding to pay for social services, and as a result, states are finding innovative ways to utilize 1115 demonstration waivers to support SDOH initiatives. Several states have created funding streams through new or existing 1115 waivers including for tenancy supports (HI, MN, WA) and community-based organization direct payments (NC).

Partnerships & Collaboration

Collaboration with community partners is increasingly important in the effort to address and solve for gaps in SDOH. States are encouraging MCOs to invest in collaborations with and between community-based organizations. Specific 2020 procurements that targeted collaboration include:

- **Ohio:** Required MCOs to commit a portion of profits to community re-investments that align with their population health strategy to target SDOH. Procurement criteria emphasized collaborative, community informed, and data-driven initiatives.
- **Oklahoma:** Required MCOs to partner with community-based organizations or social service providers and report on referrals to specific partners.

Even as more states place greater emphasis on closing referral gaps, community capacity is unlikely to meet the demand.

Trend 5: Health Disparities and Inequities

Health disparities, which are defined as a difference in health status that can be linked to social, economic, and/or environmental disadvantages[53] are not a new phenomenon. Driven by longstanding realities in addition to deep roots in U.S. history, traditionally underserved racial and ethnic minority populations continue to be significantly impacted. And while communities struggle to overcome existing challenges, individual, provider, health system, societal, and environmental factors are creating new and widening disparities that need to be addressed.[54] This deeply rooted societal challenge is clearer and more urgent today than ever as minority and other vulnerable populations are disproportionately affected by COVID-19.

Eliminating health disparities would result in a substantial reduction in health care costs, both directly ($230 billion) and indirectly ($1 trillion)[55], demonstrating the additional impact that a focus on health equity can achieve. In addition, states are continuing to explore leveraging payment models to incentivize providers to promote health equity and reduce and eliminate health disparities.

[52] Kaiser Family Foundation
[53] Healthy People.gov
[54] Kaiser Family Foundation
[55] Association of State and Territorial Health Officials

State and Federal Activity

Compared to commercial and employer-based insurances, Medicaid covers a high proportion of underserved groups, meaning Medicaid beneficiaries are more likely to be impacted by health disparities. In 2019, racial and ethnic minorities comprised 58.9% of Medicaid beneficiaries.[56] This has incentivized both the federal government and state Medicaid programs to place an emphasis on reducing health disparities, including the addition of a health disparities component to CMS quality initiatives.[57] Several states, including Nevada, have also begun requiring MCOs to submit annual cultural competency plans to measure progress against health equity goals. The Nevada legislature also encouraged MCOs to align provider networks to meet the diversity of their Medicaid population, a trend likely to emerge nationally in the years to come.

States are increasingly using Medicaid managed care procurements and contractual requirements to target population health and address health disparities for Medicaid populations, with increasing focus on how managed care organizations are addressing disparities and structural racism within their own companies and systems. Most recently this has included:

Kentucky	• Applicants required to provide a detailed plan of how they planned to reduce or eliminate health disparities, including identifying partnerships, using innovative solutions, and data-sharing with providers.
Minnesota	• RFP included questions around managed care organizations' antiracist systems and processes, both where they stand today and how organizations plan to improve upon them. • Awardees will be required to report on specific initiatives that make a meaningful impact on disparities and health equity.
Ohio	• Required MCOs to employ a Health Equity Director within their organization. • Required MCOs to promote and support the use of telehealth services to increase access and health equity across the state. • Required MCOs to integrate health equity efforts into their population health strategy, information and technology infrastructure, and staffing. • Required MCOs to collaborate with each other for a collective impact at reducing health disparities and improving population health.
Oklahoma	• Required applicants to provide an example of an innovative approach they have used to target health disparities and how this approach could be tailored to Oklahoma. • Required applicants to identify and address how they will specifically target perinatal health disparities. • Awardees will be required to use quality and outcome data to target and improve health disparities. • Awardees will be required to participate in the Oklahoma Health Care Authority (OHCA) led effort to reduce health disparities. • Awardees will be required to specifically target Tribal health disparities.
Pennsylvania	• Required MCOs to describe specific policies, procedures, and initiatives implemented to promote health equity in RFPs.

Given the magnification of health disparities by the COVID-19 pandemic, outlined below, it is expected that states will also look to leverage payment models that incentivize providers and MCOs to promote health equity.

[56] Kaiser Family Foundation
[57] Medicaid.gov

Impact of COVID-19

The COVID-19 pandemic has disproportionately affected underserved groups of society, including racial and ethnic minorities, rural populations, and socioeconomically disadvantaged populations, resulting in higher infection rates, hospitalization rates, and death rates. Contributors to this disproportionate impact include:

- **Occupation:** For many in minority communities, adequate social distancing is not possible. Many are considered "essential" in industries such as food processing, manufacturing, transportation and service industry, leading to higher spread given the dynamics of their working environments, e.g. indoors, inability to telecommute. Additionally, given the work hours and lack of benefits typically associated with these occupations, essential workers often delay accessing treatment given an inability to take off work due to lack of sick time/paid time off or fear of losing their job.
- **Housing:** Higher percentages of minority groups live in multigenerational households[58], with many underserved individuals also experiencing crowded living conditions. Both factors can lead to increased risk of transmission and hinder COVID-19 prevention strategies. Further, people who are homeless – who suffer disproportionately from chronic illnesses – are largely unable to maintain social distancing.
- **Access:** Health care costs and the lack of insurance often creates a barrier for underserved groups to seek care and treatment. Additionally, minority groups are often provided with different levels of care than their white counterparts. For example, among diabetes patients, Black Americans are less likely to receive influenza vaccinations, have glycosylated hemoglobin (HbA1c) testing or cholesterol testing.[59] The delay of care can exacerbate conditions and put individuals at a higher risk of serious and/or fatal effects.
- **Systemic Racism:** Even after removal of long-standing rules and policies targeted at populations of color, the impacts continue to reverberate across society. A prominent example is the redlining of Black neighborhoods, which enabled the ability to 'disinvest' in the infrastructure and health of these communities. To this day, neighborhoods with historical 'redlines' see higher rates of pre-term births, cancer and mental illness.[60]
- **Distrust:** Due to historic and persistent systemic racism and mistreatment, underserved groups often have a deep distrust of government and health care systems. The distrust continues to compromise numerous public health efforts, such as vaccine promotion and acceptance, and broadly creates hesitation to seek care.

Data Spotlight

Black Americans and Latinos are **5x** more likely to become sick from COVID-19 compared with whites.

Black Americans are **3.5x** more likely to die from COVID-19 and Latinos are twice as likely to die from the virus compared to white people.

46% of Black Americans and **39%** of Latinos view COVID-19 as a major threat, compared to **20%** of whites.

Source: Centers for Disease Control and Prevention

Partnerships and Collaboration

For Medicaid and managed care organizations, the instilled distrust of government and health care systems makes disparities and health equity an especially difficult trend to tackle. Addressing health disparities cannot happen within siloes; they must be approached in close collaboration and partnership with local leaders, community organizations, members, and providers. Any initiative aimed at addressing health disparities must include thoughtfully and culturally appropriate engagement designed to address the underlying causes. Ensuring that trusted community partners and providers are positioned as key leaders, and supported in their efforts, is critical in order to have meaningful, lasting impacts.

[58] Pew Research
[59] NCBI
[60] New England Journal of Medicine

Conclusion

2021 will continue to be dominated by the COVID-19 pandemic. The full impact on individuals, the U.S. economy, and the broader health care system are yet unknown, but many of the 'temporary' actions taken in response to the PHE appear to have the potential to become long-term trends.

The current landscape in which this report is written makes clear that access to health care, and more specifically, the coverage provided by the Medicaid program, is critical for millions of Americans and has served as a lifeline for many over the past year. Given the prominent role managed care organizations play in the management of Medicaid, there exists a unique opportunity to showcase the value they bring to the members they serve, the providers and organizations they work with, and the states they partner with as the health care system collectively emerges from the pandemic stronger, wiser and more focused than ever on ensuring our most vulnerable have coverage for, and access to, the critical health care, social and behavioral services that will most effectively address their needs.