

## Health & Health Equity

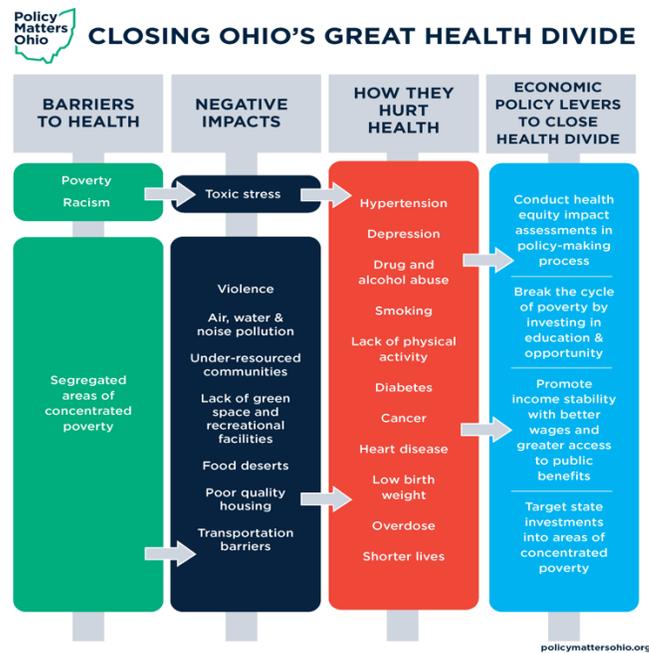
### Response to Ohio Department of Medicaid’s Request for Information Amanda Woodrum

On June 13, 2019, the Ohio Department of Medicaid issued a request for ideas and information related to Ohio’s Medicaid Managed Care Program. Policy Matters Ohio is grateful for the opportunity to share ideas and information with the Department of Medicaid to improve member and provider experience, service quality and system accountability. Policy Matters Ohio is a nonprofit, nonpartisan research group focused on making Ohio more vibrant, sustainable, equitable, and inclusive. In a recent report, Building a Healthy Ohio: Overcoming Barriers to Health from Poverty, Segregation and Racism, we noted Ohio ranks 44<sup>th</sup> among states for overall well-being, according to the Gallup Sharecare Well-Being Index.<sup>1</sup> High rates of disease and chronic conditions contribute to low well-being in Ohio, as does financial insecurity, poor community health, low social support and lack of life purpose.

Ohio’s poor health relates in part to a divide between lower- and upper-income Ohioans. In its “disparity index,” the 2018 Commonwealth Scorecard on State Health System Performance ranked Ohio 47th in the nation for how poorly the health of our lower-income residents compared to that of our higher-income residents.”<sup>2</sup> Low-income Ohioans are far more likely to report having fair or poor health, losing teeth, smoking, and being obese than wealthier residents. Access to health care for low-income households is an important piece of solving the health divide puzzle, but it is not the whole picture.

Poverty is a barrier to health. Poverty is stressful. Chronic poverty is toxic. In 2017, nearly 1.6 million Ohioans lived in poverty, more than 700,000 of them in deep poverty (with incomes less than 50 percent of the federal poverty level, or \$10,210 for a family of three in 2017). Frequent or prolonged adversity from poverty often creates “toxic stress.”

Living in an area of concentrated poverty is a roadblock to health. Housing segregation in Ohio, by race and income status, exacerbates the



<sup>1</sup> <https://bit.ly/2CJyrXJ>

<sup>2</sup> Commonwealth Fund Scorecard on State Health System Performance, 2018, at <https://bit.ly/2P6RFMN>.

health divide by creating areas of concentrated poverty. Roughly 10 percent of Ohio neighborhoods are in areas of concentrated poverty (more than double the share in 2000).<sup>3</sup> Impoverished communities tend to feel less safe, residents are more likely to be exposed to air, water, noise pollution and highway dangers, housing is lower quality, there is less green space, and access to healthy foods is more limited. Poor communities also have fewer resources to counteract health-damaging conditions.

Ohio's Medicaid Managed Care Program has a role to play in knocking down barriers to health stemming from poverty and race. A "whole person" approach to health care means tackling health-related social needs. This not only leads to better health outcomes for individuals, families and communities, but also lower health care costs. Medicaid patients are, by definition, low-income. They are likely to struggle with basic needs such as food, transportation and shelter, leading to preventable health care conditions and unnecessary health care costs.

The Ohio Department of Medicaid can build into its new contracts with Managed Care Organizations requirements for enhanced case management services—screening for health-related social needs, helping patients enroll in and retain needed public benefits, and tracking related outcomes. The Department can also require Managed Care Organizations to invest a percentage of their profits into their local community based on the results of screening for health-related social needs (as Arizona has done).<sup>4</sup> Ohio can also incentivize MCOs to provide wrap-around services through use of bonus payments for related improvements in health outcomes. Much can be done within the existing confines of Medicaid rules and regulations, according to Mannatt Health, without need for a section 1115 demonstration waiver, through State Plan Amendments as part of Medicaid's "optional benefits".<sup>5</sup>

1. **Case management and targeted case management.** States can use Medicaid to pay for the costs associated with helping Medicaid patients gain access to needed medical, social, and educational services, as well as to other services such as housing and transportation.
2. **Medical Home.** States have the option to establish "health homes" for better care coordination for patients. Health Homes are a one-stop shop providing personal and family-centered care for social, emotional, physical, and behavioral needs. The Affordable Care Act provides 90 percent federal match funding to establish health homes for enrollees with two or more chronic conditions, a risk of developing a second chronic condition, or one very serious mental health condition. Health homes provide comprehensive case management services.
3. **"Preventive" and "rehabilitative" services.** States have the option to broadly define "preventive" and "rehabilitative" services in their benefit packages, covering an array of services, including wrap-around services such as housing assistance.
4. **Home and community-based services.** A provision of the Social Security Act allows states to provide "habilitation services" in home and community-based settings rather than institutional settings, to targeted populations such as homeless people with mental illness. Programs can mesh standard medical and non-medical services like group housing for homeless people suffering mental illness, combined with regular access to health care.

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<sup>3</sup> 2016 American Community Survey, Ratio of income to poverty level in the past 12 months.

<sup>4</sup> The Commonwealth Fund, Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Rate-Setting Tools (2018) at <https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review>.

<sup>5</sup> Manatt Health, Medicaid Coverage of Social Interventions: A Roadmap for States (2016) at <https://www.milbank.org/wp-content/uploads/2016/09/MMF-NYS-Health-Issue-Brief-FINAL.pdf>

Below is a series of recommendations, made in response to specific questions from the Department of Medicaid that related to the creation of a statewide 2-1-1 Benefit Bank system, with individual units located within health homes across the state. This Benefit Bank system, would expand United Way's 2-1-1 Help Center model, which provide free, 24-hour help for social service needs.<sup>6</sup> These Benefit Bank centers, staffed by Community Resource Navigators, would tackle health-related social needs starting with enhanced screening requirements based on a community's known risks such as environmental hazards, domestic abuse, food insecurity, housing instability and other common risks in areas of concentrated poverty. We also make recommendations related to addressing major transportation barriers to health.

### ***Communication and Engagement with Individuals Enrolled in Managed Care Plans***

#### ***Access to care***

- 2. What kinds of difficulties do individuals enrolled in managed care plans have in being able to access health care? What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?*

In part due to transportation policies that favor highway development over public transportation, Ohioans rely heavily on cars to get where they need to go.<sup>7</sup> These policies limit access for people of color and low-income families to jobs, education, health care, grocery stores, and other social and economic opportunities. Ultimately, these limitations hurt health.

Numerous studies demonstrate existence of transportation barriers to health care and medication, particularly for lower-income people and people with chronic conditions.<sup>8</sup> Households without regular access to a vehicle use less health care, are more likely to delay care, and miss appointments. This is true for both urban and rural patients and for children whose caretakers faced transportation barriers. Ultimately, these transportation barriers result in patients receiving less timely care, worse outcomes and more expensive treatment in emergency rooms once they can no longer delay or avoid care.

In order to help overcome this recognized barrier to good health, Medicaid allows for state spending on non-emergency medical transportation. It is one of many agency-specific forms of transportation spending designed to help people access public services. Unfortunately, funds allocated for these purposes across agencies are spent in silos, lack coordination at the highest levels, are implemented differently county by county, creating both gaps in services and duplicative services. Even implementation of non-emergency medical transportation varies from community to community, and is sometimes the responsibility of Managed Care Organizations.

Some 2-1-1 outlets are better than others, and with leadership from the state, all programs could better serve Ohioans who need it. 2-1-1 programs could play important roles in connecting Medicaid patients not only to health care-related transportation needs, but also to a wide range of public benefits (as we will discuss later in this document). Managed Care Organizations can help

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<sup>6</sup> United Way 2-1-1 <https://www.211oh.org/who-we-are/mission-and-vision>

<sup>7</sup> Thomas W. Sanchez, Rich Stolz, & Jacinta S. Ma, a joint report of The Civil Rights Project & Center for Community Change, *Moving to Equity: Addressing Inequitable Effects of Transportation Policies on Minorities* (2003).

<sup>8</sup> Samina T. Syed, Ben S. Gerber, Lisa K. Sharp, *Traveling Towards Disease: Transportation Barriers to Health Care Access*, *Journal of Community Health* (October, 2013).

the state to build an efficient, well run and statewide 2-1-1 program for case management purposes that also provides transportation dispatch services, among other things.

In a 2018 report, the Ohio Department of Transportation issued a well-thought out “[Justification for ODOT Human Service Transportation Coordination Regions](#)” creating smart regions that address transportation barriers to accessing health care providers outside a person’s home county. Similarly, 2-1-1 organizations could operate within the same regional boundaries and could contract with public transit systems and other transportation providers in their region to coordinate transportation services efficiently (for non-emergency medical transportation purposes as well as to access other public benefits, jobs, education, training, etc.).

**Communication**

4. *How do you think communication with individuals enrolled in managed care plans could be improved?*
  - a. *Please provide any specific feedback for the following groups:*
    - i. *Individuals who primarily speak a non-English language*
    - ii. *Individuals with cognitive or intellectual disabilities*
    - iii. *Individuals with physical disabilities*
    - iv. *Individuals who may not understand health care terminology*
  - b. *How could managed care plans use technology (such as web-based applications and mobile phones) to assist individuals with their health care needs?*
  - c. *How could managed care plans improve communication with individuals who do not have a mobile phone or computer or do not have reliable internet service?*

A one-stop 2-1-1 shop that Medicaid patients can call directly, visit on-site at their medical home or access online, could dramatically improve access information. Community Resource Navigators, employed at 2-1-1 Benefit Bank sites, with resources from the state and Managed Care Organizations, can be trained to provide extensive case management services for Medicaid patients, including those who have cognitive or physical disabilities, are non-native speakers and others.

The Ohio Benefit Bank, now shuttered, provides an excellent model to address health-related social needs. Similar to the Benefit Bank, the state and Managed Care Organizations should invest in a software model that uses patient information to determine eligibility for public services like housing vouchers, low-income home weatherization to reduce energy bills, food assistance, child care assistance, etc. This same software could also enable Community Resource Navigators to help Medicaid recipients apply for these additional public benefits and promote greater financial well-being and stability. This in turn will reduce toxic stress connected with numerous chronic conditions and help close the health divide between rich and poor Ohioans. By having on-site, online and phone presence, 2-1-1 can be made to be uniquely accessible to Medicaid recipients via their preferred method of communication.

### Case Management and targeted case management:<sup>9</sup>

Case management services and targeted case management services are optional benefits in Medicaid. They allow states to use Medicaid to pay for the associated costs with helping enrollees access medical, social, and educational services, including transportation and housing. Case managers assess an individual's needs, develop a care plan to access the needed supports, and can help connect people to and enroll them in specific services. They also help schedule appointments, fill out paperwork, and provide follow-up support.

5. *What could ODM and managed care plans do to communicate with individuals enrolled in managed care plans and their families to regularly provide input and feedback?*

As an independent nonprofit entity working with but not for Managed Care Organization, 2-1-1 Community Resource Navigators could be an important resource for Medicaid recipients to air their grievances, with these case managers being seen as “on their side.” As is being done in the Cleveland area, these 2-1-1 organizations can be organized as extensions of the medical-legal partnership model to incorporate access to public benefits as well (a medical-legal-public benefit partnership).<sup>10</sup>

### ***Engagement***

6. *What are some ways that managed care plans and providers could encourage or assist individuals to be involved in their health care and promote healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?*

Individual behaviors whether healthy or not are often the result of the less visible systems we live within. For instance, toxic stress may drive an individual to smoke, drink excessively or use drugs. A lack of green space, recreational facilities or even safe communities to walk, bicycle and play in may reduce an individual's ability to engage in healthy physical activity. An area inundated with fast food operations but without access to a grocery store promotes unhealthy eating habits.

Managed care organizations, health care providers and case managers for health-related social needs are in a unique position to recognize these systemic barriers to health, gather and report data, and educate policy makers on these issues.

Evidence does not support the use of incentives or behavioral economics in health care. Instead, the state should improve access to appropriate health services, offer better care coordination and increase integration of health and social services.

Rather than investing scarce financial and administrative resources in offering rewards or imposing penalties to encourage individuals to make healthy choices, Ohio would be better served by investing in improved access to appropriate health services, better care coordination, and increased integration of health and social services. Providing transportation, for example, can enable more beneficiaries to keep appointments.

<sup>9</sup> Manatt Health, Medicaid Coverage of Social Interventions: A Roadmap for States (2016) at <https://www.milbank.org/wp-content/uploads/2016/09/MMF-NYS-Health-Issue-Brief-FINAL.pdf>

<sup>10</sup> <https://www.craigslist.com/article/20170407/NEWS/170409859/united-way-of-greater-cleveland-receives-4-5-million-grant-to>

### ***Provider search***

7. *How could managed care plans make it easier for individuals to search for providers? In particular:*
  - a. *What tools and resources would be most helpful (e.g., calling member services, online provider directory, hard copy provider directory, mobile application)?*
  - b. *Within those resources, what type of information should be provided to help an individual choose a provider?*
  - c. *Are there ways to make these resources more accessible and easier to use?*

2-1-1, with the proper resources and support, could serve as a provider directory via online presence, over-the-phone, and in person services.

### ***Grievances and Appeals***

9. *How can managed care plans and the state obtain feedback and be accountable for addressing member concerns over time? Is there a proactive approach (as opposed to a complaint-based system) that should be explored?*

By developing an independent system of case managers, via 2-1-1 Community Resource Navigators or their equivalent, the state would create a natural conduit for identifying issues and collecting feedback that could provide a foundation for creating a systemic approach to accountability. If the Department of health were to publish high-level data required to be collected and aggregated by Managed Care Organizations, another layer of accountability would be created, enabling outside organizations to analyze indicators and progress towards goals.

### ***Provider Support***

#### ***Data sharing***

17. *How could data sharing between the state, managed care plans and providers be improved? In particular:*
  - i. *What data do providers want access to that they do not have access to today; how would providers use that data?*
  - ii. *What is the most effective way of providing data to providers?*
  - iii. *Are there barriers to providing the requested data; how could those barriers be overcome?*
  - iv. *How could data be shared and used by providers that have limited resources and technology?*

The Ohio Department of Health should host a comprehensive and public database of population health indicators, aggregated for purposes of anonymity but organized by zip code, race, gender and income status. California's Department of Public Health provides a useful example <https://letsgethealthy.ca.gov/5828-2/>. Managed Care Organizations should be required to collect and aggregate relevant data, and share with the Ohio Department of Health.

This endeavor would enable researchers and analysts to compare and contrast health disparities between sub-populations, consider the relationship between health outcomes and possible community-level risk factors, and to track progress on closing Ohio's health divide.

Data on case closures should be made public, by county, enabling an overview of organizations problems that create barriers to care that could be addressed by better delivery of services, smoother redeterminations, and coordination of services between MCOs and external partners.

#### ***Supporting primary care providers***

18. *Describe how managed care plans could support primary care providers in integrating care for individuals enrolled with them. In particular:*
- i. What kind of primary care infrastructure may be needed?*
  - ii. What kind of training or coaching may be needed?*
  - iii. How could the state/managed care plans incentivize primary care providers to improve access to care?*
  - iv. What kind of primary care models should be encouraged by the state/managed care plan?*

The creation of a statewide 2-1-1 Benefit Bank, located across the state within health homes, would require development of a universal software model for eligibility determinations and enrollment applications as well as the training of Community Resource Navigators to work in needed communities, and learn to navigate a new software system designed to identify eligibility for public benefits and programs and help Medicaid patients enroll in them.

#### ***Workforce development***

19. *How could the state/managed care plans support workforce development for different types of providers, including dentists, pediatric psychiatrists, primary care providers, in-home providers and licensed or unlicensed behavioral health providers?*

The health care workforce should reflect the diversity of the community it serves. This is an important step towards addressing racism, sexism, gender bias and other forms of discrimination that permeate not just the health care sector but Ohio's workforce more generally. Given the recognized role poverty and racism play in promoting toxic stress and poor health outcomes, the health care sector should lead by example in this effort, and the state should include a local hire requirement in its Management Care contracts—a percentage of the workforce should come from the community served. Public funding can be a great tool for increasing diversity in hiring practices. Managed care funds could also be set aside to build a diverse pipeline into health care career opportunities. Diversity should also be reflected at the board and management levels of health care entities serving Medicaid patients.

#### ***Payment innovation***

20. *What are some ways the state/managed care plans could prepare and assist providers to move through the continuum of shared accountability models that reward providers for quality and improved health care outcomes? In particular:*
- i. How could the state or managed care plans support and increase the establishment of comprehensive primary care practices and/or accountable care organizations?*
  - ii. Are there other payment innovations that the state should consider incorporating into the Medicaid managed care program?*

Managed Care Organizations can be both required and/or incentivized to provide health-related social services. Payments can be withheld unless a plan meets certain metrics, such as providing enhanced screening and case management programs. Michigan, for instance, requires managed care organizations to use community health workers (similar to Community Resource Navigators).<sup>11</sup> Incentive payments can reward MCOs that succeed in linking a high percentage of patients to the social supports they need.

Incentive payments are made over and above per person (capitation) rates for meeting targets in the contract, and can be up to 5 percent of a plan's capitation revenue.<sup>12</sup> States can also withhold a portion of a plan's capitation payments unless a plan meets certain targets. Both mechanisms can and should be employed.

### ***Benefits and Delivery System***

#### ***Value-added services***

*22. Managed care plans can provide services not included in the managed care benefit package as "value-added" or "extra" services, such as dental or vision services for adults. What "extra" services do you think are the most valuable to individuals enrolled in managed care plans and why?*

If patients' needs are not met even with enhanced case management services, MCOs could enter into agreements with community-based providers of those social needs. "Wrap-around" services could be supported through a requirement of Managed Care Organizations to spend 6% of their profits in the local community it serves (as Arizona requires).<sup>13</sup> Spending would need to be evidence-based, relying on the results of patient screening for health-related social needs. Incentive payments could also be provided for Managed Care Organizations who perform well, successfully fulfilling identified patient needs (as determined through ongoing tracking by case managers).

For instance, Ohio's funding of food and shelter does not fully meet the state's needs. The Ohio Association of Foodbanks requested an additional \$10 million from the General Assembly, but only got \$5 million. Ohio's affordable Housing Trust Fund started out with a request for \$20 million, but received \$2.5 million. Not everyone who needs these services will be able to get them. Nationally, just one in four eligible families get housing assistance. Insufficient assistance for those who lack food and decent shelter has a direct bearing on health. In these instances, managed care organizations could contract with local housing entities or food pantries to help serve those needs.

#### ***Integration of behavioral health and physical health services***

*26. The state understands that coordination and integration of service delivery improves the experience and overall health of individuals enrolled in managed care plans, yet providing well-coordinated and holistic health care can be challenging to individuals*

<sup>11</sup> Manatt Health, Medicaid Coverage of Social Interventions: A Roadmap for States (2016) at <https://www.milbank.org/wp-content/uploads/2016/09/MMF-NYS-Health-Issue-Brief-FINAL.pdf>

<sup>12</sup> The Commonwealth Fund, Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Rate-Setting Tools (2018) at <https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review>.

<sup>13</sup> The Commonwealth Fund, Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Rate-Setting Tools (2018) at <https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review>.

*and providers alike. Discuss any suggestions you have for improving the integration of services, particularly the delivery of behavioral health and physical health care. Include your ideas about:*

- a. Improving communication and consultation across providers*
- b. Shared assessment and service planning*
- c. Data and information exchanges*

On-site case management services should be made available to ensure coordinate of behavioral and physical health care. Case managers should also be trained to assist Medicaid patients with their health-related social needs. Computer software should be developed that can feed patient information into a program that identifies public benefits patients for which patients are eligible, while also allowing the patient to apply for benefits with the assistance of the case manager. As noted, the now-shuttered Ohio Benefit Bank can serve as an excellent model. However, in this setting, case managers would not be volunteers, but Community Resource Navigators employed on-site by a community-based organization (as noted early 2-1-1 could be built out to serve in this function, as is being done to some degree in Cleveland).

*27. How can managed care plans provide better access to evidence-based behavioral health practices, such as medication assisted treatment for opioid use disorder, multi-systemic therapy, supportive housing, and supported employment?*

As noted previously, Community Resource Navigators acting as case managers, employed by a community-based organization but located on site, such as 2-1-1, that is armed with new benefit-bank like software that feeds relevant information about a Medicaid patient into an eligibility-determination system to identify public benefits the patient may also be eligible for, while also enabling application completion within the system, with the assistance of the case manager.

### **Care Coordination/Care Management**

#### **Cross-system collaboration**

*28. How could coordination of services/programs managed by partner state agencies be improved? Include your recommendations for the role of the state agency, state agency case manager, managed care plan, provider, and individual enrolled in a managed care plan.*

Transportation is a major barrier to health care access and positive health outcomes. This is not only true for older adults and people with disabilities, but also low-income households. Driving a car is expensive, often prohibitively so. For older adults and people with disabilities, driving may not be an option at all. Numerous agencies and streams of federal dollars address transportation barriers, but they do so in silos, inefficiently and with both service gaps and redundancies. The largest of the transportation funding sources is Medicaid non-emergency medical transportation. The [2015 Transit Needs Study](#), completed for the Ohio Department of Transportation, estimates transportation funding across agencies amounts to \$250 million annually.<sup>14</sup>

<sup>14</sup> <http://www.dot.state.oh.us/Divisions/Planning/Transit/TransitNeedsStudy/Pages/StudyHome.aspx>

Currently, a number of mobility managers employed locally are working to encourage coordination of services, but the problem runs deep and is difficult to solve at the local level. The Ohio Department of Medicaid could advocate for a state-level interagency taskforce to address the issue.

Ohioans unable to access transportation options due to age, income, disability or other barriers, often rely on specialized transportation services. With service options ranging from non-profit, for-profit, and government agencies, there are many organizations operating in a complex web of services. State level transportation coordinating councils help streamline these various services, improve communication among groups, increase efficiencies and access to populations in need. These councils are generally made up of a group of voting members who create reports detailing plans for improved transportation coordination. In some states, councils have legal authority throughout the state, and receive funding.

#### Exemplary State Councils:

Certain states' coordinating councils can serve as a model for Ohio. Frequent reporting, consistent funding, and comprehensive membership requirements ensure coordinating councils fulfill their mission of mitigating inefficiencies and barriers to transportation access.

Oklahoma and West Virginia have **comprehensive membership requirements** that include state departments who provide services for transport disadvantaged populations such as veterans, people with disabilities, people with mental health or substance abuse problems. In addition to state agency members, Oklahoma requires four members representing the transport disadvantaged population, three members from community organizations, and at least one member from an Oklahoma nation or tribe. West Virginia also requires representatives from state departments that represent the transport disadvantaged, as well as public health, and education; representatives from several advocacy organizations; and two direct members from the community. This direct representation ensures the coordination council is responding to the needs of its users.

Other states, like Colorado and Florida, are great examples of **funding for transportation coordinating councils**. Both Colorado and Florida councils benefit from consistent funding to their various projects. Colorado's council received initial funding of \$105,000 from United We Ride and the Colorado Department of Transportation. They receive ongoing funding of \$160,000 a year from the Department of Transportation, \$110,000 of which is allocated for funding grants of local and regional councils. Rather than rely on a particular department for funding, the Florida council, has their own way of generating revenue. The council established a trust fund which receives revenues from a nonrefundable fee of \$1.50 on car and light truck registrations and registration renewals.

Other councils have particularly **robust reporting requirements**. The South Carolina council must submit quarterly progress reports, in addition to an annual report, and 5-year plan to the state.

Better funding and support for public transit, and for Transportation Coordinating Councils will improve access to health care, and therefore improve health outcomes for those without reliable car access including low-income households, the elderly, and the veteran and disabled populations.

### **Population Health Considerations**

*32. What population health measures (e.g., infant mortality, smoking, cardiovascular disease) could the state target in its procurement to have the greatest impact?*

Important population health indicators include rates of obesity, asthma, hypertension, lead poisoning, diabetes, cancer, low birth weight, overdose, longevity, heart disease, drug overdose, smoking and lack of physical activity. These factors should be tracked by race, income, age and zip code. Comparisons across these populations should be made and evaluated.

Health-related social factors should also be tracked. Managed Care Organizations can screen Medicaid patients for barriers to health such as access to healthy food, stable and healthy housing, public transit, green space, and safe neighborhoods. Evidence-based health risk factors, at the geographic level (i.e. zip code), can be compiled such as the ratio of homes in an area built pre-1978, and areas of concentrated poverty.

*33. Which entity or entities (e.g., managed care plan, primary care provider, other providers) are best suited to work on improving performance on population health measures? Does it vary by measure?*

There is an important role for managed care organizations to track, organize and aggregate this data for analytical purposes within their own regions and over time. However, anonymous-level aggregated data should also be required to be shared with the state's Department of Health to be further aggregated and made publicly available, for the state's own analytical purposes as well as outside and independent entities to use and assess. California's Department of Public Health provides a useful example <https://letsgethealthy.ca.gov/5828-2/>.

Community Resource Navigators, or case managers, could play an important role in compiling evidence-based health risk factors for communities and neighborhoods, and implementing screening of health-related social needs and barriers to health.