BRIEF

RESOURCES FOR INTEGRATED CARE
Resources for Plans & Providers for Medicare-Medicaid Integration

Key Considerations for Health Plans: Partnering with Community-Based Organizations to Address Social Determinants of Health

People dually eligible for Medicare and Medicaid often experience more complex health issues and worse health outcomes than people eligible only for Medicare.[1] These health disparities are often related to factors outside the health care system—including access to nutritious food, transportation, secure housing, social inclusion, and other social determinants. Social determinants of health (SDOH) – the conditions in which people are born, grow, live, work and age– are intricately connected to individuals' health status.[2] Health care providers, however, typically do not offer services that address SDOH, nor do health care payers generally reimburse for these services.

Over the last several years, however, the health care sector has been developing partnerships with community-based organizations (CBOs) to address SDOH, with the aim of improving quality of life and reducing utilization of health care. Many health plans have partnered with or are seeking to partner with CBOs to provide additional services—such as meal delivery, social engagement activities, and transportation—to further support their members' health and wellbeing. CBOs are ideal partners because of their natural familiarity with their communities, established relationships and trust with community members, networks across geographic areas with existing delivery mechanisms in place, and experience delivering services, including within clients' homes. Health plan and CBO partnerships, therefore, have tremendous potential to provide coordinated, quality services for plan members to address SDOH and improve members' health status.

Addressing SDOH through Supplemental Benefits

In 2020, 267 Medicare-contracting health plans, including plans serving dually eligible individuals, began offering special supplemental benefits for chronically-ill members (SSBCI). In 2021, the number of plans offering SSBCI has greatly expanded, with 942 plans offering these benefits. Many of these benefits address SDOH.[3]

Food and Produce: 347 plans

Meals (beyond a limited basis): 387 plans

Non-medical Transportation: 177 plans

Social Needs Benefit: 227 plans

Pest Control: 208 plans

Indoor Air Quality Equipment and Services: 140 plans

A number of Medicare-Medicaid plans (MMPs) already work with CBOs to provide important additional services to their members. Plan partnerships with CBOs are likely to accelerate as Medicare

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2016). *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.* Retrieved from https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf

[2] Artiga, S. & Hinton, E. (2018). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. *Kaiser Family Foundation.* Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[3] ATI Advisory. (2021). *Data Insight: Special Supplemental Benefits for the Chronically Ill in Plan Year 2021*. Retrieved from https://atiadvisory.com/wp-content/uploads/2021/01/ATI-Advisory-Data-Insight_Special-Supplemental-Benefits-for-the-Chronically-Ill-in-Plan-Year-2021.pdf

Advantage (MA) plans, including Dual-Eligible Special Needs Plans (D-SNPs), expand their coverage of additional services in the wake of the CHRONIC Care Act, which authorized plans to offer Special Supplemental Benefits (SSBCI) that contribute to the health or overall function of their chronically-ill members.[4] This brief, developed in partnership with The SCAN Foundation, provides considerations for plans in partnering with CBOs to address the social needs of their dually eligible members.

Organizational Readiness Assessment

Plans considering a partnership with CBOs will first want to consider whether they – and their potential partners – are ready for this high-effort, high-reward endeavor. Critical considerations for plans include internal support – including from leadership – and capacity to implement change. Plans will want to identify the SDOH they seek to address and what services address those needs, as well as whether they need a partner to bring those services to their members. Plans may wish to consider the following set of questions as they conduct readiness assessment and planning.

What is the problem being targeted and what are potential solutions?

A number of factors may contribute to the problem at the system, provider, or individual member levels. After understanding these factors, plans can begin to explore solutions, identify which members are most likely to benefit from these approaches, and determine how to engage these members. After identifying a likely solution, plans will need to determine whether to create a new program to operate ("build"), or contract with a vendor ("buy") such as a CBO, or a combination of both, to provide this service or services.

What is the business case?

Understanding the cost of the program and how it will contribute to solving the problem is important – without a return on investment (ROI), health plan leadership may not approve the proposed solution. In some instances, plans may consider a pilot test prior to building the new program. If planning a pilot, plans should allow enough time to implement the intervention and obtain measurable results; this could take 12 – 24 months. While building the business case, plans should consider how to best target the new program – remembering that not every member may benefit from the identified solution.

How will internal processes change?

Whether the plan decides to build or buy the new program, it will change existing processes. Plans need to consider new contracting arrangements, changes in workflow, and training staff so they know how to effectively implement the solution. These changes will incur costs and will require organizational buy-in.

How will success be defined?

There are a number of factors plans can use to define success. These include an improvement in a person's quality of life, improved clinical outcomes, reduced utilization, improved provider satisfaction, quality ratings, or savings. At the onset, identifying what the markers of success will be and collecting the data to evaluate those factors will help plans determine if the results warrant a sustained effort. If working with a partner, data sharing is critical. The data plans are often retrospective, telling the story of what has happened. As a result, it might take some time for the impact of the intervention to be reflected in the data. However, sharing data on utilization, claims, and quality with the partner allows them to see trends in the data and know where and how they are having an impact. Asking the partner to share their data, which will often be real time and tell the story

[4] Anne Tumlinson Innovations & Long-Term Quality Alliance. (2019). *A Turning Point in Medicare Policy: Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill*. Retrieved from https://atiadvisory.com/a-turning-point-in-medicare-policy/

of the current need, will allow plans to make informed decisions and possibly mid-course changes as part of continuous quality improvement.

How will the plan track any savings the intervention generates?

The specific data a plan needs may depend on the intervention and if and how it is expected to generate savings. To ensure that savings from avoiding readmission, for example, are available to reinvest in the intervention, plans need data detailed enough to identify members in full-risk contracts, track utilization, and draw comparisons to expected utilization and spending at six or 12 months.

Case Example: Home Meal Delivery

Leadership at *Excellence Health Plan* has made addressing SDOH for dually eligible members an organizational priority. You have been tasked with designing and implementing an initial intervention. The following questions outline questions and factors to consider.

What is the problem?

Many of your high-cost, high-need members live in the community, because maintaining independence and social connections are important to them – but some of these members need frequent inpatient care. Your data shows that members who live alone are more likely to be readmitted following surgery or other hospitalizations. With further analysis, you identify that some of these members either had chronic conditions that require specific diets or were unable to obtain or prepare food for themselves when they returned home. You determine that one strategy may be to deliver prepared meals once members return home.

Build or buy?

Should you build or buy your home meal delivery program? You determine that the meal preparation and delivery infrastructure, licensing issues, and other considerations are too complex and costly for *Excellence* to start its own program. You therefore decide to contract with a meal delivery provider.

What is the business case?

Based on your research on meal delivery providers, you estimate the cost per participating member for seven days of meals after discharge. You anticipate this investment will reduce readmissions, because you know from recent research that sustained medically-tailored meal programs and non-tailored food interventions can reduce costs associated with emergency department use and hospital admissions.[5] You decide to test the business case through a 12-month pilot project, providing a shorter intervention that targets members with chronic conditions who live alone in two large counties in your service area. Through this pilot, you will learn if the program's ROI warrants a larger roll-out or whether you need to change the program parameters.

How will your internal processes change?

When you launch the home meal delivery pilot, you will want network clinicians, hospital discharge planners, and care coordinators to know that your plan offers this service for targeted members. You will need to market the pilot program to these stakeholders and provide them with a process for referring or enrolling members in this service.

How will you know you are successful?

To determine whether your home meal delivery pilot is successful, you decide to track:

- Initial and subsequent referral and participation rates for the program
- Participant satisfaction with the program
- Readmission rates for program participants vs. non-participants

[5] Berkowitz, S. et. al. (2018). Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries. *Health Affairs, 37*(4), 535-542. Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0999

- Costs per program participant
- Utilization data pre- and post-program participation

Choosing a Partner

There are a number of factors to consider when identifying a partner. Plans may want a "one-stop-shop," or may want to create a curated set of partners to serve specific populations or needs. Plans may want to ensure that a partner is deeply embedded within the community and is viewed as a trusted source by members.

To choose a partner, plans will want to know how the CBOs in the local area operate, their reach, and expertise. There are a number of ways to learn more about potential partners. One approach is to put out a call for proposals. In the proposal, plans can share information about the problem and the solution under consideration. They can ask for information about the CBOs, their geographic reach, profile or reputation within the target community, services provided, accreditation, capacity and response time from referral, and any prior experience partnering with other health plans providing a similar service.

Depending on community resources, plans may also want to consider whether a local partner or a national provider would best meet identified needs. Local partners know their community and may have a rich history of providing services to people in their homes and the community. In contrast, national partners often have the infrastructure in place to provide efficient services, but may operate at a greater distance from the members and their specific needs.

Case Example: Home Meal Delivery

Choosing a National or Local Partner

You have concluded that *Excellence Health Plan* members would benefit from seven days of home-delivered meals following hospitalization. A national partner may ship a week of frozen meals directly to the member. A local partner, on the other hand, may have staff who can deliver a hot meal in person and interact with your member in their home. During those interactions, they can assess the member's status and report if they have concerns or observe any increased needs the member may have. In both cases, *Excellence* members will receive meals; the national partner may be able to reach more members, while the local partner may provide a more comprehensive service. Given your interest in reducing readmissions, you decide to work with a local partner that can check on members' health status and needs at the same time that they deliver hot meals to members recently discharged from the hospital.

Partnerships in Action

Health Plan of San Mateo—Community Care Settings Program

Health Plan of San Mateo (HPSM), a Medicare-Medicaid Plan serving San Mateo County in the San Francisco Bay Area, launched their Community Care Settings Program (CCSP) in 2014 to support members moving from nursing facilities to the community with the supports and services they need to accomplish this significant transition. In order to provide these services, HPSM issued a request for proposals to identify and contract with CBOs. Through this process, HPSM selected the Institute on

Aging and Brilliant Corners – both organizations with significant previous experience in care transitions programs – to work closely with them to support their members' needs.

Through CCSP, the Institute on Aging provides intensive transitional case management and oversight of services, including eligibility assessment, care management, and identification of housing options for HPSM members residing in nursing homes. Institute on Aging also coordinates long-term services and supports covered through multiple service providers such as California's In-Home Supports and Services program, nutrition services, and transportation. Brilliant Corners provides additional supports by managing independent housing and related issues, including landlord disputes and home modifications for members' safety and accessibility. HPSM has successfully reduced average per-member per-month costs through CCSP. For members participating in CCSP who transitioned from institutional living to living in the community, average costs six months after transition were 35 percent lower than costs six months before transition.

As CCSP has evolved, HPSM continues to gather and respond to member feedback on the program design, supports offered, and service delivery. For example, HPSM learned that many members who transitioned to independent living felt isolated in their new home, so HPSM expanded CCSP through a partnership with Wider Circle, a small San Mateo nonprofit, to provide social programs and connections in the community.

Health Plan of San Mateo Tips for Success:

- Be flexible in approach and open to changes to fit emerging needs or challenges
- Work cooperatively with community partners to identify gaps and challenges
- Start with pilot programs to test what works and expand on successes
- Be open to engaging multiple organizations to provide all the desired services

Addressing SDOH through Partnerships during COVID-19

The current COVID-19 public health emergency has only increased the value of strong partnerships with CBOs, as plans seek to address increased social needs and service interruptions. Preliminary data show increases in social needs for older adults, including assistance with grocery and meal deliveries, accessing protective equipment, staying socially connected, and affording food and prescription medicines.[6,7] To address these increased needs during COVID-19, health plans may seek to identify new partnerships with CBOs to deliver targeted inventions. The following examples highlight particular SDOH needs and strategies plans can implement in the COVID-19 environment:

- **Nutrition/meal delivery:** While in-person congregate meals may be challenging in the COVID-19 environment, some CBOs are offering additional home-delivered and take-home meals. Plans may seek to partner with CBOs who are shifting to home-delivered/take-home meals and may need to work closely with local partners as circumstances shift.

[6] National Council on Aging. (2020). Community-Based Organizations Struggle to Meet the Shifting Needs of Older Adults During COVID-19. Retrieved from https://www.ncoa.org/news/press-releases/community-based-organizations-struggle-to-meet-shifting-needs-of-older-adults-during-covid-19/

[7] Brewster, A.L., Wilson, T.L., Kunkel, S. R., Markwood, S., & Shah, T.B. (2020). To Support Older Adults Amidst the COVID-19 Pandemic, Look to Area Agencies on Aging. *Health Affairs*. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20200408.928642/full/

- **Transportation:** Some health plans are expanding their transportation benefits to include trips to the grocery store, in addition to non-emergency medical transportation.
- **Access to telehealth:** With increased need for telehealth, access to technology devices and the internet have become increasingly important factors in accessing care and services. Some plans are addressing this need by providing or lending devices, such as tablets (e.g., iPads), or providing them with WiFi devices that will allow them to connect to the internet.
    - Some internet providers are offering discounted internet services and may also sell refurbished equipment.[8] The Family Caregiver Alliance has published two tip sheets on technology and internet with additional information.
- **Social isolation:** Social isolation is a serious concern that has been further exacerbated by the COVID-19 public health emergency. Plans may consider implementing additional outreach and services to address social isolation for their members, such as partnering with CBOs who can conduct virtual wellness check calls and connect members to needed services.
- **Caregiver supports:** With pandemic-related disruptions to some long-term services and supports and related changes to health care delivery, many caregivers are taking on additional responsibilities. In addition, some friends and family members are taking on new caregiving roles. To help support caregivers, plans can partner with CBOs that are offering virtual caregiver support groups, caregiver education, or training classes.

Additional Resources

Aging and Disability Business Institute Success

These resources from the Aging and Disability Business Institute offer success stories from CBOs who have formed successful health care collaborations. Stories provide best practices, new approaches, and inspiring innovations in the field.

Facilitating Community Transitions for Dually Eligible Beneficiaries

This case study from the Center for Health Care Strategies (CHCS) highlights Health Plan of San Mateo's (HPSM) Community Care Settings Program (CCSP) and Inland Empire Health Plan's Housing Initiative.

Community Care Settings Program (CCSP) Member stories

This resource from HPSM shares information on the CCSP, including member stories from individuals in the program.

[8] Family Caregiver Alliance. (2020). Tip Sheet: Low-Cost Equipment for Seniors. Retrieved from https://www.caregiver.org/tip-sheet-low-cost-equipment-seniors

Blueprint for Health Plans: Integration of CBOs to Provide Social Services and Supports

This report from the SCAN Foundation highlights successful partnerships for delivering social services and helps identify future opportunities for health plans to better meet the needs of older adults with complex medical and social needs.

The SCAN Foundation: Resources & Tools

This webpage from The SCAN Foundation offers a list of resources and tools that may be helpful for plans looking to partner with CBOs. Listed resources and tools include return on investment (ROI) calculators, training modules, and other resources related to CBO-health care partnerships.

The Commonwealth Fund: ROI Calculator

This ROI calculator from the Commonwealth Fund is designed to help CBOs and their health system partners plan sustainable financial arrangements to fund the delivery of social services to high-need, high-cost populations to address social determinants of health.

What is the Financial 'Tipping Point' for Provider Groups to Implement Person-Centered Care?

This report explores and provides insights on reasons why provider groups may find it financially advantageous to offer person-centered care to their high-need, high-cost populations.

Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill

This report offers guiding principles developed by a workgroup of stakeholders from across the health care and social services sectors, including health plans and national policy and advocacy associations. The guiding principles offer insights to help guide implementation of the new flexibilities under Special Supplemental Benefits for the Chronically Ill.

Aging Today: Local CBO Learns to Balance its Mission with Business Acumen

This article included in Aging Today, the bimonthly newspaper of the American Society on Aging, discusses the partnership between Institute on Aging and Health Plan of San Mateo.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com. The list of resources in this guide is not exhaustive. Please submit feedback to RIC@lewin.com.