Blueprint For Health Plans

Integration of Community-Based Organizations to Provide Social Services and Supports ▶

Overview

The current health care system does not adequately meet the needs of older adults with complex medical and social needs, which are intimately related. Despite mounting evidence that supports the integration of the medical and social models of care, the transition to a more comprehensive delivery system has not been simple or intuitive for health plans or social service providers. The result is that care often remains uncoordinated and fragmented for older adults, specifically for those eligible for both Medicare and Medicaid (referred to as dual eligible). Following is an examination of the challenges and opportunities that health plans serving the dual eligible population face and a roadmap for how plans can develop networks that reflect both the social and medical needs of members. However, it is important to recognize that plans are only one part of the system that serves the dual eligible population, and coordination efforts by all the organizations and entities that serve this population is necessary to achieve a more person-centered system of care.

The Valuable Role of Community-Based Organizations in Health Care

Community-based organizations (CBOs) are a largely untapped resource that could be leveraged by health plans to increase access to social service and supports. CBOs are trusted organizations within the community that have access to health plan members outside of the medical office setting and can identify non-medical member needs, such as home modifications or a recuperative care placement. Health plans could strategically invest time and resources into the development of partnerships that provide access to social services and supports for the subset of members, including many older adults and dual eligibles, that would otherwise suffer from preventable adverse health outcomes. When structured appropriately, and focused on the most vulnerable members, partnerships with CBOs can help members avoid more costly medical treatments (such as an unnecessary hospitalization or nursing facility stays) and will result in more person-centered care and better health outcomes.

Successful Partnerships to Date

Health plans in California have successfully developed contractual relationships with CBOs to provide the following services:

- Medically tailored food delivery
- Intensive case management for behavioral health/homelessness
- Home modifications
- Transitional recuperative care
- Nursing home diversions and repatriation
- Community-based alternatives to long-term care placement
- Care Transitions

Under the current system, where most social services are not covered Medi-Cal benefits, and therefore those costs are not accounted for in the rate development process, it is more difficult to finance CBO partnerships. However, health plans can pay CBOs to provide social services and supports under a global case management fee, which is a payment arrangement where the CBO is paid a monthly fee that provides maximum flexibility to address the member's needs in the community.

Two examples of contractual relationships with plans include, *Partners in Care Foundation*[i], through funding from the John A Hartford Foundation, built on its relationships with health plans and developed a network that allows a health plan to contract with a single entity that can provide access to a network of local and regional CBOs. The network offers health plan members access to the social services and supports necessary to provide person-centered care.

Second, Institute on Aging (IOA)[ii] used the resources provided by TSF to develop successful contractual partnerships with both the *Health Plan of San Mateo*[iii] and *Inland Empire Health Plan*[iv]. IOA and its contracted health plans use the case management model to provide access to social services and supports via a local CBO network that can assist in the transition of members back into the community and prevent unnecessary nursing facility placements. These models can be replicated across the state within the current regulatory framework.

Another potential approach health plans could consider under the current system would be to partner with delegated provider groups. Providers and health plans could develop value-based payment models that focus on improved outcomes and lower costs for the most expensive and vulnerable members. This would create an incentive for delegated providers to offer a wider range of home and community based social services and supports. Direct partnerships between provider groups and CBOs would provide access at the point of service and allow the health plan to reduce some of its administrative burden.

Providers and health plans could develop value-based payment models that focus on improved outcomes and lower costs for the most expensive and vulnerable members. ▶

How to Implement Sustainable Health Plan and CBO Partnerships

Integrating social services and supports and contacting or partnering with CBOs is complex and requires action on the part of many stakeholders. However, there are opportunities for health plans to establish a framework that will demonstrate the value of these relationships and lead to structural system changes that will create a more person-centered system of care.

Commitment from Health Plan Leadership

Any initiative to partner with CBOs must start with a commitment from health plan leadership that it is a priority. Health plans have many competing priorities and it must be acknowledged that the Return on Investment (ROI) is part of a longer-term strategy to drive real system change that improve outcomes and lower costs. Health plans have resources such as the *ROI calculator* developed by The SCAN Foundation that can help build the internal case for strong CBO partnerships.

Identify a Discrete Set of Services

Health plans could identify specific unmet social service needs that a CBO might provide for its members and explicitly solicit for that discrete set of services. This step will allow a health plan to determine if the relationship requires the CBO to be part of the formal network, or if an informal network arrangement can meet the needs of members. It will also help the plan better identify the financing options for the identified services given the limitations in the current rate structure.

Communicate Expectations Upfront

A Request for Proposal (RFP) is an opportunity to be clear about the requirements for reporting, oversight, and access standards that the health plan will require. This step will also allow the health plan to identify CBO's that are aligned with the health plans mission and can potentially serve as a conduit to other social services providers in the community. The development of a Request for Information (RFI) can help a health plan identify which CBO(s) can meet that need and what elements will be necessary in a full RFP. Then a health plan can structure the RFP to recognize that CBOs have varying degrees of sophistication and make the requirements specific so that it can identify the type and size CBO that will work best within the health plan's model.

Address Infrastructure Costs & Consider Pilot Projects

CBOs and health plans must be able to share data, invoice and pay for services, and build internal organizational and referral processes. Developing this infrastructure can be cost prohibitive for CBOs and health plans do not have dedicated funding available to defray these costs, which often prevents relationships from being formally established.

However, there are several models that health plans could consider to effectively manage the initial implementation costs to both sides:

- The development of a hub and spoke model where a more sophisticated CBO that has the basic infrastructure contracts or partners directly with the health plan and provides the data/systems integration on behalf of a network of additional CBOs
- Health plans could provide grants to CBOs to help with some of the infrastructure development to increase access and reduce the administrative burdens and cost that come with a formal contract
- Value-Based Payments could be made to a CBO for a very limited population focused on specific outcomes, such as reduced reentries, which would not require the same level of infrastructure development
- Start with a small pilot to reduce the initial risk to both sides and to test out various strategies that can be scaled up as the partnership evolves
- As part of a longer-term strategy health plans could invest resources to support local CBOs, which would result in an indirect impact to the health of their membership as access to social services and supports would be increased through an informal network

Integrated models offer the potential to spread the infrastructure and start-up costs across multiple payers (the county, the state, the federal government, the health plans), which makes building a comprehensive system more feasible than if one payer has the burden of the entire cost. Over time this should result in cost savings to all the participating entities, along with better outcomes for the members.

Another solution that could be considered by health plans, CBOs, and other stakeholders is to create a central utility for CBOs, health plans, and providers that is similar to the *Manifest MedEx* model. While this is an ambitious long-term goal that would require significant commitment of time and resources from all stakeholders, it has the potential to address many of the barriers noted above and create a standardized process for the delivery of social services and supports through health plan partnerships.

Design Mutually Beneficial Payment Arrangements

Once the services are defined and the RFI/RFP process has identified the appropriate CBOs it is important that health plans design payment arrangements that reflect the needs of both parties. CBOs will likely play a role in both the formal and informal network, which means that some of the benefits to the member and the health plan may be indirect and so it may be beneficial to avoid the default immediately to full risk relationships and acknowledge that there is a learning curve on both sides. The payment structure should reflect the cost projections based on the best available data at the time of implementation, and there can also be an opportunity built into the process to re-evaluate the rates based on post implementation data. This approach will help better inform both parties, reduce the up-front financial risk if the rates do not reflect actual costs, and allow the plan to develop a sustainable payment arrangement that provides benefit to the member, the plan, and the CBO.

Develop Organizational Structure to Promote Coordination

Health plans that want to contract with CBOs should consider the development of an on-boarding process for these providers that is like what new medical providers receive. CBOs need to understand how the health plan works and what the expectations are, or the relationship will be set up to fail. Additionally, health plans must work with the CBO to build the capacity to share data and coordinate care. Building in a process that includes regular check-ins with CBO staff on how the process is working is also a good strategy to identify problems with coordination and communication and avoid long-term negative impacts of not addressing these issues.

Build in Referral Capacity

Referrals are the key to a successful relationship and health plans must create CBO referral workflows in the internal case management system or identify other internal processes that will promote integration and coordination with the CBO. If health plan staff are not aware of the services available or the pathway to refer members is too cumbersome then it will result in few to no referrals, which is a waste of the investment of time and resources used to establish the relationship.

Use Data to Drive Internal and External Change

Health plans and CBOs should allow for an iterative process, recognizing that this is a new and complicated partnership. Collecting data on both success and challenges of the relationships with CBOs is a tool that can be used to better inform advocacy with state and federal regulators, improve current and future partnerships, and provide evidence for best practices that will increase access to social services and supports through health plan referral, coordination, and contracting.

Barriers to CBO and Health Plan Partnerships

Rate Structure

Medicare has signaled its intent to allow health plans to cover some non-medical needs through the implementation of the *CHRONIC Care Act*[v] and Medi-Cal has the authority under the final *Medicaid Managed Care Rule*[vi] to use shared savings models or in-lieu of services to build in the costs for certain social services and supports into health plan rates[vii]. However, neither program currently applies these opportunities broadly into the rate development process and the current structure results in what is referred to as premium slide for a health plan. The California Health Care Foundation recently *released a study*[viii] that provides options for California's regulators to address this barrier and align financial incentives. Health plans could use their own experience coupled with the evidence on the negative impacts of the current rate structure to advocate for changes that would promote the inclusion of CBO services in the health plan benefit to address social determinants of health and improve health outcomes. The Return on Investment (ROI) for health plans to contract with CBOs would be significantly increased under a rate structure that recognizes the value of paying for social services and supports and health plans could work to drive policy and rate changes that acknowledge the benefit to the member, the state and federal government, and the overall costs to the system.

Regulatory & Contractual Barriers

Despite a desire for health plans to address social determinants of health, which often requires partnerships with CBOs, the state and federal regulatory structure has not evolved to fit the desired policies and program implementation. Policy makers and regulators increasingly expect health plans to provide access to social services and supports through programs such as the *Coordinated Care Initiative*[ix], *Whole-Person Care Pilots*[x], and the *Health Homes Program*[xi], and these programs and pilots represent a great opportunity to develop integrated care models across the current care delivery silos. However, the regulatory and contractual requirements have not been adapted to reflect the delivery of care under a social model.

"Integrated Care Services" describes a relationship that puts the health plan at the center of the delivery system with flexibility to use CBOs to cover necessary social services and supports ▶

The term "*Integrated Care Services*" describes a relationship that puts the health plan at the center of the delivery system with flexibility to use CBOs to cover necessary social services and supports. Health plans should identify opportunities to work with policy makers and regulators to examine how to better define the role of CBOs as part of the continuum of care and develop an approach that recognizes the unique regulatory structure that is necessary to create these partnerships.

Following are some areas that health plans and CBOs should advocate with regulators to address:

- Implementation of the In Lieu of Services (ILOS) payment structure to make paying for social services and supports sustainable
- Development of clear guidance on what social services and supports can be funded with health plan dollars
- Re-evaluation of federal prohibitions on paying for housing
- Updates to the case management requirements to allow for the use of additional social service provider types
- Creation of a standard vetting process for CBO provider credentialing, oversight, and quality
- Updates to the network adequacy/access requirements and measurements to reflect the nature of the social services and supports delivery system
- Consistent application of HIPAA regulations and standard data security certification requirements

Overcoming Barriers & Drive System Change

The SCAN Foundation will continue to provide funding for the Coordinated Care Initiative (CCI) Learning Collaboratives through 2020. The Learning Collaborative is a place where the health plans that provide services to the dually eligible population and older adults can think strategically about what resources are necessary to truly integrate social services and supports into the networks. The CCI health plans can use the Learning Collaborative as an opportunity to refine this list and develop resources and advocacy tools that will help drive the necessary system change.

Health plans could use these and other advocacy tools and strategies to communicate with regulators, policy makers, and other stakeholders the realities of the regulatory, contractual, and fiscal challenges explained previously and work collaboratively to develop a strategy that will address both perceived and real barriers to CBO and health plan partnerships. Addressing premium slide and implementing the necessary regulatory flexibility is a first step in promoting the inclusion of social services and supports as part of the plan benefit. Once health plans have these protections in place CBOs can more readily be integrated into either the formal health plan network or informal network of CBOs that plans can refer members to. Absent changes in the rate structure and clear guidance on the regulatory requirements, health plans remain in a position where true integration of CBOs into the networks is not a viable strategy.

Additional Resources

Additional resources that health plans could benefit from as CBO partnerships are established include, but are not limited to, the following:

- A directory of local social service providers and services offered by CBOs
- Universal CBO agreement/contract templates (developed by stakeholders and approved by regulators) with the right balance of criteria and flexibility
- Toolkits and managed care training for CBOs that are cross sector and include information on Medicare
- Funding by foundations or the government for startup grants that can be combined with research to demonstrate ROI
- A managed care training and contract guide for CBOs. Health plans should work with CBOs and other stakeholders to identify how these resources could be developed and if there are funding opportunities that could be leveraged to assist in creating resources that will help drive the necessary internal and external system changes.

Conclusion

The integration of CBOs into health plan networks, on both a formal and informal basis, can help address both the social and medical needs of older adults and dual eligibles. A more coordinated system of care where social services and supports can be readily accessed through the health plan is something that health plans, CBOs, and policymakers can all be aligned on and can work collaboratively to develop. The challenges and success of the current pilot projects and partnerships demonstrates that there is a pathway for creating successful partnerships, however the current system is not conducive to large scale adoption of integrated networks. All stakeholders should examine their role in reducing barriers to increased integration between CBOs and health plans and use the data to advocate for policy changes that will promote the increased development of these partnerships.

TSF would like to thank the following health plans and CBOs for participating in interviews and strategic discussions to inform the development of this blueprint:

Health Plans

- Anthem Blue Cross
- Blue Shield of California Promise Health Plan
- CalOptima
- Community Health Group
- Health Net of California
- Health Plan of San Mateo
- Inland Empire Health Plan
- L.A. Care Health Plan
- Molina Healthcare of California
- Santa Clara Family Health Plan
- Partnership HealthPlan of California
- UnitedHealthcare of California

Community-Based Organizations

- Partners in Care Foundation
- Institute on Aging
- Meals on Wheels Diablo Region
- Jewish Family Services of Los Angeles
- St Barnabas Senior Services
- Bay Area Community Services

[i] https://www.picf.org/

[ii] https://www.thescanfoundation.org/linkage-lab-case-studies

[iii] https://www.ioaging.org/services/all-inclusive-health-care/community-care-settings-pilot-program

[iv] https://www.ioaging.org/services/all-inclusive-health-care/inland-empire-community-living-solutions

[v] https://www.thescanfoundation.org/chronic-care-act-2018-advancing-care-adults-complex-needs

[vi] https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf

[vii] https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-

[viii] medicaid-managed

https://www.chcf.org/wp-content/uploads/2018/03/IntendedConsequencesMediCalRateSetting.pdf

[ix] https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx

[x] https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

[xi] https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

CHAPMAN CONSULTING LLC

The Blueprint for Health Plans was written by Athena Chapman of Chapman Consulting

THE scan FOUNDATION®

The SCAN Foundation
3800 Kilroy Airport Way, Suite 400
Long Beach, CA 90806

Phone: 888.569.7226
www.TheSCANFoundation.org