Using Medicaid Levers to Support Health Care Partnerships with Community-Based Organizations

People covered by Medicaid experience higher rates of poverty, chronic illness, and disability than individuals who are privately insured.[1] Given the growing acceptance that improving health is as much about addressing social determinants of health (SDOH) as it is about providing high-quality medical care, Medicaid programs are increasingly focused on the social needs of beneficiaries, such as housing and food security. A variety of health care organizations (HCOs) — including health systems, hospitals, providers, insurers, and state or local public health departments — are forming partnerships with community-based organizations (CBOs) in order to more effectively and efficiently address such needs.

With support from the Robert Wood Johnson Foundation, the *Partnership for Healthy Outcomes* brought together Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities to capture and share insights on partnerships between CBOs and HCOs, particularly those that serve low-income and vulnerable populations. Based on a national request for information (RFI) and a subsequent review of more than 200 such CBO-HCO partnerships across the country, this fact sheet shares key learnings about the benefits of these partnerships and offers strategies Medicaid can consider to better support these efforts.[2,3] It features examples from four in-depth case studies of CBO-HCO collaborative efforts across the country to illustrate key characteristics of successful partnerships.

IN BRIEF

More and more Medicaid programs are seeking to address the social needs of beneficiaries as a way to improve health outcomes and reduce unnecessary utilization. Partnerships between community-based organizations (CBOs) and health care organizations (HCOs) offer a key way to focus on underlying social determinants of health (SDOH) for Medicaid populations. This fact sheet outlines strategies to help Medicaid officials encourage such partnerships, including:

- **Financial**: Provide direct funding to help build and sustain CBO/HCO program capacity;
- **Metrics**: Assist in identifying measures and conducting formal evaluations to demonstrate the value of partnership programs;
- **Incentives**: Offer incentives to providers and managed care organizations (MCOs) to address SDOH; and
- **Policy Levers**: Pursue value-based contracts with providers/MCOs, MCO regulations that allow flexibility to cover social services, and State Plan Amendments to cover specific services (e.g., through Medicaid health homes).

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1. What is driving the evolution of cross-sector partnerships?

As value-based payment models increase and more providers are reimbursed based on outcomes, the health care community is increasingly attuned to the social factors that influence health and the total cost of care. Across the country, the federal government and states are testing new care delivery models that address whole person care needs and drive improvements in population health. The State Innovation Models initiative of the Centers for Medicare and Medicaid Innovation (CMMI) is testing delivery system and payment reform approaches that are required to improve population health and support cross-sector partnerships. CMMI's Accountable Health Communities Model is testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' will influence health care costs and reduce health care utilization.[4] In California, Iowa, Michigan, Minnesota, Vermont, and Washington, cross-sector collaborations, called Accountable Communities for Health (ACH), are evolving as a mechanism to improve population health and health equity. Finally, a number of states have Delivery System Reform Incentive Payment initiatives, which are testing payment models that hold Medicaid providers accountable for patient outcomes and often include social service-related improvement strategies.[5] Taken together, these reforms may help build the business case for health care partners, including Medicaid, and CBOs to invest in partnerships.

2. How does Medicaid benefit by supporting CBO-HCO partnerships?

CBO efforts to address the social needs of clients often have an impact on health care outcomes and spending and can directly benefit Medicaid programs.[6,7,8] The Centers for Medicare & Medicaid Services (CMS) found that some programs offered by CBOs — for example, initiatives focused on falls prevention, chronic disease management, and promotion of physical activity — may be helpful in reducing health care costs, most notably emergency department (ED) utilization.[9]

CBO-HCO partnerships create mechanisms to: (1) more efficiently link individuals to clinical and non-clinical services; (2) activate individuals to be more engaged in their care;[10] and (3) enable providers to better address clinical issues by leveraging the expertise and skills that exist in the human services industry. These collaborative efforts can potentially increase access to care and improve health outcomes for Medicaid beneficiaries,[11] while freeing time for providers so they can focus on their patients' clinical needs. The Jefferson County HANDS program in Louisville, Kentucky, for example, offers home visitation to first-time Medicaid-eligible parents to improve health and developmental outcomes for at-risk children. Along with connecting families to a primary care home, clients are referred directly to Family & Children's Place (F&CP) for social services and other available resources. Early enrollment in the HANDS program has shown a positive impact on length of gestation, birth weight, birth defects, and infant mortality.[12] Moreover, HANDS participants who fully engage in the recommended number of home visits are more likely to achieve goals related to infant health and well-being, as well as child health and development.[13]

Bridging Community-Based Human Services and Health Care: Case Study Series

These four case studies, a product of the *Partnership for Healthy Outcomes*, illustrate the potential for diverse and effective CBO-HCO partnership models. The case studies outline key lessons for how successful collaborations deliver services, share information, secure funding, engage communities, and evaluate success. To read the case studies, visit **www.chcs.org/cbo-hco-partnership-case-studies**.

3. What challenges do CBO-HCO partnerships face?

Challenges faced by CBO-HCO partnerships include: (1) establishing sustainable funding models; (2) selecting and collecting partnership impact metrics; and (3) sharing patient-level data.[14] Not all services provided by CBO-HCO partnerships are Medicaid-covered, so partnerships must often blend a variety of funding sources to support their work. Results from the *Partnership for Healthy Outcomes* RFI show that partnerships draw on multiple sources of funding, including health philanthropies, private donors, state and tribal governments, in-kind services, private coverage, and Medicaid.[15] Grant funding is important for start-up costs and some program maintenance, but over the long-term it is not sufficient or reliable to ensure program growth and sustainability. Moving beyond initial piecemeal sources of support to a more stable funding model is essential for partnerships trying to broaden their scope.

Securing sustainable funding depends, in part, on the ability of partnerships to demonstrate their value — in terms of patient outcomes and cost savings — to potential funders and HCO leadership. Identifying metrics that are both meaningful to CBO-HCO partners and can measure effectiveness or cost savings, however, is a complex endeavor for most partnerships. In the Eastern Virginia Care Transitions Partnership (EVTCP), for example, the Bay Area Agency on Aging worked through an iterative process to refine their evaluation approach so that it resonated with hospital executives whose support was required for the program.

Another challenge for CBO-HCO partnerships is calculating and documenting true program costs to support program sustainability. The EVTCP program noted that accounting for all program components and their associated costs is key to informing return-on-investment calculations, as well as building trust among partners.

Most partnerships have patient data-sharing systems in place, but they vary in sophistication. While some have the capacity to share information to communicate progress toward partnership goals, most partnerships only share patient-level data as part of service delivery. Concerns about data privacy and differing technological capabilities between CBOs and HCOs, mean that partners often cannot access all program and patient information, making care delivery and coordination difficult.

4. How can Medicaid and managed care organizations support CBO-HCO partnerships?

While CBO and HCO partners will do most of the heavy lifting to support successful partnerships, states and managed care organizations (MCOs) can consider providing assistance to support the potential improvements in health outcomes and cost savings offered by CBO-HCO partnerships. States and MCOs can offer: (1) financial and technological support to build and sustain program capacity; (2) assistance to identify metrics for evaluation and trend analysis; and (3) provider incentives to address SDOH.

Medicaid covers many of the services that HCOs and CBOs are partnering to provide, such as clinical and behavioral health services, care transition support, and care coordination. EVTCP, for example, evolved from a federal pilot focused on reducing readmission rates among Medicare beneficiaries to a statewide initiative where participating Medicaid MCOs cover care coordination and home assessment for dually eligible members.

Additionally, Medicaid agencies and MCOs have access to utilization data, as well as analytic capacities that CBOs sometimes lack, which are essential to measuring the impact of the partnership on patient outcomes and cost savings as well as population-level impact. Many CBO-HCO partnerships are developing formal assessments to demonstrate cost-savings, and Medicaid and MCOs can provide data and analytic support to assist these evaluations.

At the Medicaid agency level, a number of policy levers can be used to encourage CBO-HCO partnerships, including: (1) offering incentives to address SDOH at the MCO and provider level; (2) implementing value-based purchasing contracts directly with providers or with MCOs; and (3) providing authority through Medicaid MCO regulations (i.e., in lieu of and value-added services) to cover certain social services. States can require Medicaid MCOs to track SDOH initiatives and metrics, and to implement community-based interventions that address social needs. Kansas, for example, is encouraging health plans to assess and address beneficiaries' social needs by integrating SDOH-focused measures into their basic performance and pay for performance programs.[16] In New York, MCO contractors are required to implement at least one SDOH intervention, with MCOs providing upfront financial incentives or bonuses to invest in interventions.[17] State agencies can also provide incentives to MCOs to pilot partnership initiatives that can be scaled across participating MCOs within the state or a region, or encourage MCOs to contract with intermediaries such as ACHs to deliver services and help coordinate care delivery for beneficiaries. Finally, Medicaid agencies can also explore State Plan Amendments to cover certain services, through programs such as Medicaid health homes, which pay for coordinated care across multiple providers, including community partners, for beneficiaries with multiple chronic conditions and/or serious mental illness.

Conclusion

This fact sheet from the *Partnership for Healthy Outcomes* project is intended to help state Medicaid officials as well as Medicaid MCOs consider ways to encourage CBO-HCO partnerships. The findings from the recent analysis of CBO-HCO partnerships present considerations for Medicaid to invest in these partnerships and highlight the financial and population health improvements that Medicaid can realize from supporting these alliances.

For More Information

This fact sheet is a product of the *Partnership for Healthy Outcomes*, a year-long project of Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities with support from the Robert Wood Johnson Foundation. To learn more about the *Partnership for Healthy Outcomes*, access the following resources:

- **Working Together Toward Better Health Outcomes:** This report shares key findings from the RFI survey of more than 200 health care and community-based organizations that are partnering in shared pursuit of better health outcomes.
- **How Health Care and Community-Based Human Services Organizations are Partnering for Better Health Outcomes**: This *Health Affairs* GrantWatch blog post shares a snapshot of early lessons learned from efforts by the *Partnership for Healthy Outcomes*.
- **An Inside Look at Partnerships between Community-Based Organizations and Health Care Providers:** This blog post outlines key drivers for effective partnerships between health care and human service organizations and introduces four case studies highlighting innovative collaborations.
- **Partnership Assessment Tool for Health (PATH):** Designed for CBOs and HCOs in existing partnerships, this tool provides a format to understand progress toward benchmarks characteristic of effective partnerships, identify areas for further development, and guide strategic conversation.

Endnotes

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