April 2013

Issue Brief

Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations

Sharon Silow-Carroll and Diana Rodin
Health Management Associates

ABSTRACT: Some managed care organizations (MCOs) serving Medicaid beneficiaries are actively engaging in community partnerships to meet the needs of vulnerable members and nonmembers. We found that the history, leadership, and other internal factors of four such MCOs primarily drive that focus. However, external factors such as state Medicaid policies and competition or collaboration among MCOs also play a role. The specific strategies of these MCOs vary but share common goals: 1) improve care coordination, access, and delivery; 2) strengthen the community and safety-net infrastructure; and 3) prevent illness and reduce disparities. The MCOs use data to identify gaps in care, seek community input in designing interventions, and commit resources to engage community organizations. State Medicaid programs can promote such work by establishing goals, priorities, and guidelines; providing data analysis and technical assistance to evaluate local needs and community engagement efforts; and convening stakeholders to collaborate and share best practices.

★ ★ ★ ★ ★

OVERVIEW

Responding to severe budget pressures and the Affordable Care Act's impending expansion of Medicaid eligibility, more states are shifting their Medicaid populations into managed care organizations (MCOs). At the same time, however, many states are demanding greater accountability for improving access to care, quality of care, health outcomes, and efficiency.[1] For MCOs, fulfilling all of these goals is a tall challenge, particularly when considering the myriad socioeconomic, cultural, and logistical barriers to care faced by vulnerable populations that often lack access to affordable services and supports in their communities.

In this issue brief we explore how four MCOs serving vulnerable populations are tackling these barriers and changing the way care is delivered, by

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Sharon Silow-Carroll, M.B.A., M.S.W.
Health Management Associates
ssilowcarroll@healthmanagement.com

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1687
Vol. 19

investing in partnerships and a strong community presence. They are Gateway Health Plan (Gateway) in Pennsylvania, HealthPartners in Minnesota, L.A. Care in Los Angeles County, Calif., and Neighborhood Health Plan (NHP) in Massachusetts. Three solely or primarily serve Medicaid and other vulnerable populations, while only about 6 percent of members of the fourth (HealthPartners) are Medicaid beneficiaries. (For more information on the MCOs and how we selected them, see the Appendix.)

These organizations are leaders in community engagement. To obtain information on their interventions and community-based activities, we interviewed MCO staff members as well as directors of community organizations with which they partner. The MCO respondents defined the vulnerable populations they target as follows:

- high-risk members with any of eight chronic conditions or at least two inpatient admissions within the past 12 months;
- plan members with diabetes and a gap in monitoring that disease;
- frail seniors in nursing facilities that are "hotspots" for complex cases that include both social and medical needs;
- plan members eligible for both Medicare and Medicaid who are receptive to home preventive care;
- dual-eligible seniors living in low-income housing;
- seniors with Alzheimer's and dementia;
- racial minorities in neighborhoods with large health disparities by race, regardless of whether they are plan members;
- adults without dental coverage;
- children ages 0–5;
- patients who visit community health centers or other safety-net providers;
- all plan members;
- all residents of a community where many have unmet health care needs.

All of these organizations are reaching out to vulnerable individuals where they live, shop, and pray. They are building relationships with community health, social service, and faith-based organizations, as well as local retail, communications, and transportation entities. They are leveraging their own and their partners' expertise and resources to offer counseling on illness prevention, chronic diseases, nutrition, domestic violence, and self-care; classes on parenting, exercise, literacy, and first aid; screenings for high blood pressure, depression, breast cancer, and diabetes; and team-based, integrated care in homes and day centers. They also are providing funding to expand local dental clinics, strengthening the information technology used by safety-net providers, and supporting local markets that offer healthy foods. And they believe they are seeing signs of success. (Case studies of the four MCOs are available at http://www.healthmanagement.com/news-and-calendar/article/132.)

This brief explores these promising strategies and presents early results reported by the plans. We also identify factors that appear to contribute to successful MCO–community partnerships, as well as policy options for state Medicaid programs that seek to foster these approaches—with the understanding that our sample of MCOs is too small to apply lessons to all MCOs or in all circumstances.

DRIVERS OF THE MCOS' COMMUNITY-BASED EFFORTS

Internal factors such as the history, leadership, and business case of these MCOs appear to be the primary drivers of their community-based efforts. However, external factors also appear to play some role.

Internal Drivers: History, Governance, Visibility, and Return on Investment

The MCOs' history and leadership emphasize community health, and a sustained commitment of resources to that focus. For example, NHP was

founded by community health centers in 1986, which established its emphasis on community health and equity. NHP started to focus on disparities in 2008 at the urging of its board of directors. NHP's mission statement includes promotion of equity, and its annual quality plan (required by the National Committee for Quality Assurance) and its business plan include strategies for promoting community health and reducing disparities. NHP interviewees stressed that strong leadership makes resources available for this mission and "lights a fire" throughout the organization, so everyone is working toward the same goal.

Gateway interviewees emphasized that both leaders and staff are invested in the plan's public health mission and approach. The plan's CEO has a degree in public health, and infuses public heath principles into the plan's philosophy and its Prospective Care Management® (PCM) model. Using a tool that assesses each plan member's behavioral, environmental, economic, medical, social, and spiritual needs, PCM emphasizes being proactive and helping members move beyond narrow health care needs, with the understanding that such a short-term investment pays long-run dividends. Nearly half of Gateway staff members were involved in designing the PCM model, and all employees now undergo PCM education and training.

As a public entity, L.A. Care is governed by a stakeholder board—which includes Medicaid beneficiaries—that drives its community activities and focus. The plan established a Community Health Investment Fund in 2001 to improve the health of the communities it serves, regardless of whether residents are health plan members. For example, the plan has funded expansions of dental clinics to fulfill growing demand for dental care in Los Angeles County. That funding has built the capacity of the broader safety net while also strengthening L.A. Care's own network.

The structure and history of HealthPartners as an integrated, consumer-owned system contributes to its dedication and ability to provide care in the most appropriate patient-centered setting, and to avoid unnecessary hospitalizations and readmissions. The plan is accustomed to having clinicians work outside clinics in nontraditional community-based settings, such as nursing facilities and adult day health centers.

Community engagement helps promote each health plan's brand. Beyond a desire to be "good citizens" by addressing member and community needs, the MCOs acknowledge that community engagement helps attract and retain members, providing a business case for these activities. Investments that build relationships with community providers, in particular, help position the MCOs to benefit as Medicaid coverage expands under the Affordable Care Act.

L.A. Care, for example, cited "visibility and recognition" as key criteria when selecting locations for its Family Resource Centers. These centers offer classes on health, nutrition, disease management, exercise, and parenting; determine area residents' eligibility for public programs; provide preventive care such as flu shots and mammograms; refer residents to health care providers; and help them navigate the health care system (see box on next page).

The MCOs expect community investments to reduce long-term health costs, improving their bottom line. Many interviewees are convinced that preventive care and screening offered through community activities and partnerships will improve the health of plan members and reduce the need for more expensive interventions later, bolstering the plans' financial performance—though they insist the latter is not their primary motivation.

For example, Gateway staff attributes a 9 percent decline in the plan's inpatient admission rate from 2009 to 2012 to both the plan's holistic approach and its community initiatives. HealthPartners interviewees say the plan does not expect a financial return from its community-based activities. However, both the plan and its community partners report that their efforts are producing better-coordinated and patient-centered care, improving the management of chronic illness, and enabling people to receive more care outside the hospital—which can reduce overall costs.

Community Needs and Enrollment Growth Drive Decisions at L.A. Care

To determine the best locations for its Family Resource Centers, L.A. Care uses HEDIS[2] performance measures to identify health disparities among its members, and also examines demographics, access to care, health outcomes, health status, and concentration of individuals receiving public assistance to identify high-risk neighborhoods. The organization then uses several criteria to decide where to site the centers:

Visibility. Locations that could provide visibility and recognition for the plan, particularly those with many people enrolled in public programs, opportunities for membership growth, high population density, good pedestrian access and access to public transportation and freeways, and proximity to commercial and retail centers.

Need. Areas with compelling community needs, particularly those with significant disparities in health care outcomes and access.

Safety-net support. Locations with high-volume health providers through which L.A. Care could offer health education and promotion and disease management services.

Proximity. Proximity to L.A. Care's downtown offices, to allow more effective program oversight.

External Drivers: The MCO Market and State Policies

A history of MCO collaboration, competition, or both—plus state flexibility—help drive the plans' community-based efforts. HealthPartners representatives cited both collaboration and strong competition among MCOs in the Minneapolis–Saint Paul area, along with flexibility to innovate afforded by the state, as fostering new approaches to integrating care for vulnerable populations. HealthPartners' approach aligns well with the aim of the state Medicaid agency to better coordinate and integrate care for people eligible for both Medicaid and Medicare.

State guidelines encouraging health plans to provide community benefits encourage that focus. Neither states nor the federal government traditionally require health plans to provide "community benefits."[3] However, three of the four MCOs we examined are in states that do have guidelines that encourage health plans to work with partners to improve health in their communities:

- Massachusetts has long-standing voluntary guidelines that encourage health maintenance organizations to collaborate with community organizations to identify and address local needs, formalize their approach to this work, and report on their activities annually. These guidelines do not recommend specific activities.[4]
- In Minnesota, health insurers must file "collaboration plans" every four years (and updates every two years) that show how they will support high-priority public health goals, measure and evaluate progress, and collaborate with local public health and other community organizations.[5] The collaboration plans focus on the under-65 population. However, the state is moving toward formal requirements for innovative efforts to integrate care for seniors, with HealthPartners' strategies as one possible model.
- In 2011, Pennsylvania's Medicaid agency began including in its MCO contracts four broad "pillars" to promote community involvement, although these do not include numerical targets or financial incentives. The pillars are: 1) embed care managers in medical practices; 2) develop transitions of care; 3) help primary care physicians achieve medical home status; and 4) work with collaborative learning networks. The state Medicaid agency also uses "efficiency adjustments" that increase or decrease payments to health plans if their region does much better or worse than expected on measures of population health.[6]

California does not have requirements or guidelines for MCOs on community benefits. However, nine counties organize Medicaid managed care under a two-plan model: enrollees can choose between a public "local initiative" plan (including L.A. Care, established by the county in 1997) and a commercial plan. Local initiative plans are accountable to the community through their transparent, public governance model.[7] Further, the local initiative plans are designed to incorporate safety-net providers in their governing boards, quality improvement committees, and peer review and credentialing committees. This ensures that "safety-net needs and concerns have a voice in the operations of local community health plans."[8]

State Medicaid contracts and the state's convener role promote community engagement. The four states also share other Medicaid managed care policies that encourage plans to expand beyond a traditional medical model and engage the community. State Medicaid contracts require MCOs to target high-risk enrollees; coordinate and integrate care for physical, behavioral, and social needs; and meet enrollees' special needs. The Medicaid programs also convene MCOs to collaborate on quality improvement and share best practices, work with other agencies and community providers to integrate services, and promote community health through educational campaigns, region-based financial incentives, and efforts to reduce hospital readmissions.[9]

PROMISING COMMUNITY-BASED GOALS AND STRATEGIES

As noted, the MCOs we studied are pursuing a wide range of strategies to improve care for vulnerable populations through community partnerships. Their efforts reflect three overarching goals: 1) improve health care coordination, access, and delivery; 2) strengthen the community and the local safety-net infrastructure; and 3) promote preventive care and reduce disparities.

Goal 1. Improve Health Care Coordination, Access, and Delivery

MCOs can develop tools to coordinate and track member referrals to social and medical services in the community. For members who are frail or otherwise have difficulty getting to health care providers, MCOs can bring medical services and care coordination to them. Examples include:

- **Community repository.** Gateway developed a database of some 3,000 community resources that care management and member services staff use to refer patients. Health plan staff members continually update the database through local meetings and personal relationships with organizations and through member feedback. Some 40 percent of care management cases rely on the repository.
- **Clinical teams placed in health care "hot spots," including nursing and assisted-living facilities, adult day health centers, and public housing.** HealthPartners places clinical teams at institutional and day facilities with high concentrations of Medicaid patients with complex medical, mental health, and social needs, including those with dementia for whom travel is particularly challenging. These specialized teams provide and coordinate primary, urgent, and behavioral care. An incentive payment program rewards nursing facilities and housing partners for better managing care for their residents. Hospital readmission rates at nursing facilities and low-income housing facilities with such teams dropped nearly 30 percent and 50 percent, respectively (see box on next page).
- **In-home care management and treatment.** Gateway assesses patient data to identify high-risk members, and arranges home visits to them by physicians and nurse practitioners. These clinicians perform comprehensive health assessments, provide care management, and arrange laboratory and other services.
- **Telehealth specialty care initiative.** L.A. Care leads a collaboration that developed Safety Net eConsult, a tool that enables primary care providers and specialists to share information.

Clinical Team in Low-Income High Rise Helps Reduce Readmissions

An onsite HealthPartners team—including a physician, a nurse practitioner, a case manager, and home care staff from the nonprofit Presbyterian Homes—is providing and coordinating care for 42 residents of a low-income high-rise in downtown Saint Paul who have a high rate of mental illness. The team provides care in residents' apartments or an exam room in the building. The team meets regularly to solve problems, and the nurse practitioner reassesses patients' status as needed.

When patients miss appointments, staff can easily reach out to them or visit them in their apartments. Residents have come to see the clinicians as accessible and trusted. From 2009 to 2012, the hospital readmission rate among these residents has dropped from 24 percent to 12 percent. Medicare and Medicaid provide financial support for the program.

Physicians using eConsult resolved about half of requests for specialty care without the need for face-to-face visits with specialists, and wait time for necessary specialty appointments dropped by 60 percent.[10]

Goal 2. Strengthen the Community and Safety-Net Infrastructure

Medicaid managed care plans are part of a broader safety-net system that could better coordinate health care and integrate it with other services, but often lacks the resources to do so. To help close that gap, L.A. Care established a Community Health Investment Fund to equip safety-net providers with the technology and resources to expand access and coordinated care. This fund provides:

- **Grants to expand access to dental care.** L.A. Care has made grants totaling almost $9 million for 91 projects to expand dental clinics and services and establish new clinics for vulnerable populations. These programs were motivated by the urgent need for dental care after adult Medicaid beneficiaries in the state lost dental coverage, and by the recognition that dental and physical health are closely connected. L.A. Care estimates that its latest round of grant funding will support some 66,000 dental visits for about 22,000 people.
- **Funding and leadership for public–private collaboration on exchange of health information.** L.A. Care provides funding and sits on the steering committee for a county-initiated effort to advance the exchange of health information among safety-net providers. By the end of 2013, the Los Angeles Network for Enhanced Services expects to enable the county Department of Health Services, community-based clinics, and safety-net hospitals to exchange information on more than 5 million patients.
- **Vouchers for local markets.** As part of an initiative to reduce high blood pressure and manage diabetes, NHP supports local supermarkets that supply healthy foods by mailing coupons and vouchers for fresh groceries to targeted members.
- **Funding for health events organized by community organizations.** Gateway provides financial support to community organizations that organize events promoting illness prevention, health education, and health care outreach.
- **Community repository.** As noted, Gateway's database facilitates referrals to about 3,000 community agencies that provide safety-net services, including child care, counseling, housing, food assistance, social supports, and transportation.

Goal 3. Promote Prevention and Reduce Disparities

To reduce racial and ethnic disparities in screenings and health outcomes, the four MCOs have developed a number of illness prevention and health education programs in their communities. These include:

- **Neighborhood centers that provide free health education, screenings, and referrals.** Since establishing two Family Resource Centers in high-need neighborhoods in 2007, L.A. Care has recorded nearly 113,000 visits. Most users are repeat visitors. Input from staff and outside organizations suggests that the services are highly valued and fill health care gaps, particularly the exercise and nutrition classes.
- **Home-based screening and self-management.** Gateway analyzes patient data to identify members with gaps in diabetes monitoring, and sends a technician to their homes to help with glucose testing and educate them about self-care. The MCO also sends home screening kits for colorectal cancer to members who are eligible for both Medicare and Medicaid and are willing to pursue preventive care, with instructions tailored to their level of health literacy (see box below).
- **A "care gap" system that alerts care managers.** Gateway care management and member services staff receive specialized alerts based on a member profile system when a member is due for preventive care. Staff members contact the family to arrange appointments. This system supplements quarterly reports that identify households that are due for screenings and members who are frequent no-shows for doctor visits, triggering care management outreach. Gateway reports that this system helped them reach the 98th percentile among providers in prenatal visits.
- **Partnerships and tools that reduce racial and ethnic disparities.** NHP and Gateway have several campaigns to reduce disparities in care and outcomes among African Americans and Latinas:
  - NHP partners with local grocery stores and pharmacies to address high blood pressure and diabetes among African Americans. The MCO places a facilitator in local grocery stores to survey consumers and help raise awareness of good nutrition and healthy eating, and mails coupons and vouchers for fresh produce to members. The health plan also provides diabetes education and glucose and blood pressure screenings at health fairs at local pharmacies, and reimburses members for blood pressure cuffs.
  - To expand postpartum care and early well-child visits among Latinas in neighborhoods with large disparities, NHP is building a coalition among local organizations serving the Latina community, conducting focus groups to identify promising strategies, and training medical staff in cultural competency.
  - NHP has collaborated with local businesses, churches, the YWCA, community health centers, a cancer center, and local media to eliminate disparities

Home Screenings Identify Problems and Trigger Follow-Up

Gateway's home-based screening programs, which identify and target at-risk patients with diabetes or those eligible for both Medicaid and Medicare, show promising results. Among 3,950 members with diabetes visited by nonclinical technicians for testing and education, some 1,200 have completed a blood glucose test. About 14 percent of those tests identified members with high A1c (>10), who were then referred for follow-up care.

Of 3,985 Gateway members who received home screening kits for colorectal cancer in 2011, 22 percent mailed in samples. Of those, 8 percent had abnormal results and were contacted for follow-up care.

Gateway expanded this campaign in 2012, and expects to evaluate its cost-effectiveness in the near future.

in mammography rates among African American women in five counties. The mammography screening rate rose by 4 percentage points over two years, and a racial disparity in screening disappeared. In fact, the screening rate among white women is now below screening rates among other ethnic groups (Exhibit 1).

- Gateway has partnered with a university-based health center to place MCO staff at African American–owned businesses, including barbershops and beauty salons. These staff members conduct blood pressure screenings and educate customers and employees about healthy lifestyles, nutrition, body mass index, and other health topics, using materials created targeting African American women. A Gateway survey showed increasing health knowledge among customers and employees in these shops and salons.

CHALLENGES

The four MCOs have faced several challenges in implementing their community-based strategies:

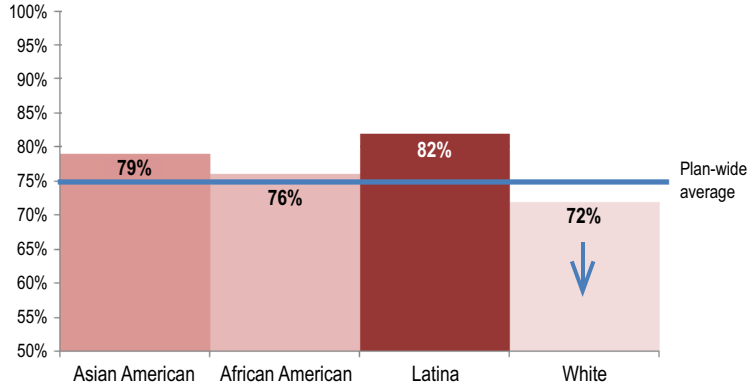
Establishing trusting partnerships takes time and commitment. Partnerships with outside organizations require time to develop and maintain the relationships, establish roles and responsibilities, and implement initiatives. HealthPartners, for example, reported that six to nine months typically elapse from when it first approaches a community organization to when it deploys providers on site.

Evaluating the impact of communitywide interventions can be difficult. The MCOs have faced challenges in assessing the effects of interventions and services that target both plan members and non-members. L.A. Care, for example, has been unable to measure the impact of its Family Resource Centers largely because 68 percent of users are not L.A. Care members. The plan cannot track their health status and use of services.

Without a documented return on investment, sustaining and expanding these programs is difficult. The MCOs also face a chicken-and-egg dilemma: they need support from other entities to build strong initiatives, but they also need to show positive results to garner support. One solution is to start initiatives by building on existing relationships, and to expand the programs once some evidence—even if anecdotal—is in hand.

Funding may be unpredictable. Even with commitment from an organization's leaders, funding for community-based initiatives may be uncertain. For example, the amount available for L.A. Care's Community Health Investment Fund depends on the plan's performance. As a result, funding for priority programs can be unpredictable from year to year.

Exhibit 1. Breast Cancer Screening Among Neighborhood Health Plan Enrollees, by Race and Ethnicity, 2010



Notes: Neighborhood Health Plan created materials targeting African American women. No disparity is shown comparing African American women to white women.
Source: Neighborhood Health Plan.

MCOs may fail to enlist affected groups in organizing new initiatives. The MCOs admit that they sometimes do not involve other entities enough in planning initiatives and solving problems, which dilutes the effectiveness of the initiatives.

Strategies that target the highest-risk members of a health plan pose particular challenges. These include:

- *Contacting patients.* One MCO reported that about one-third of the phone numbers it receives from state records are disconnected or otherwise not functioning.
- *Managing logistics and home visits.* Members with multiple health conditions often have trouble getting to appointments. Meanwhile, the plans report that obtaining consent from members for home visits can be difficult.
- *Ensuring member compliance.* Members with complex health conditions often have trouble managing multiple medications and following care plans.

See the Appendix and case studies for more detail on these activities.

CONCLUSIONS AND POLICY IMPLICATIONS

Managed care organizations that serve Medicaid and other vulnerable populations face particular challenges in reaching and serving their members. These challenges threaten members' access to high-quality primary care, illness prevention, screenings, health education, chronic care, and care management and coordination.

The four MCOs we studied—and many more across the United States—are addressing these challenges by partnering with and supporting community-based health, social service, and faith-based organizations, as well as local retail, housing, and transportation entities. These partnerships leverage both resources and expertise, with potentially significant benefits for plan members and other local residents.

The plans report evidence of success in reducing disparities in screening rates, curbing inpatient readmissions, and improving access to dental, chronic, and interdisciplinary care. MCO interviewees believe—based on participation and feedback from members and staff—that these activities have improved or will improve access to preventive care and coordination of health care and social services.

Overall, however, evidence of the impact of community engagement on health outcomes and efficiencies is limited, particularly for programs that offer services to people outside the MCOs, as they cannot measure service use and health outcomes among those participants. The impact on population health is also difficult to quantify—especially over a short period of time, and with most interventions still serving relatively small numbers of people. Limited resources and methodological challenges also present barriers to evaluating the impact of these programs, even among MCO members.

The MCOs we studied have devoted staff and other resources to improving community health without expecting a short-term return. However, they do acknowledge that community partnerships and initiatives improve the plans' image and build relationships with providers. That, in turn, could help make the MCOs an attractive choice as Medicaid coverage expands under the Affordable Care Act and new individuals select plans. To expand such efforts, stronger evidence of return on investment or other benefits to the plans is needed.

What State Governments Can Do

A key challenge for policymakers is to spur more health plans to improve community health and share information on best practices. While state governments have not been the primary drivers of the initiatives we studied, the MCOs see state government as a valued partner that could help nurture and promote such initiatives.

States that are establishing their own insurance exchanges under national health care reform are working quickly to contract with health plans to meet deadlines, and may therefore be reluctant to create more requirements for MCOs. However, states can set expectations for the new marketplace by issuing

voluntary guidelines on community benefits; asking health plans to include community activities in their proposals to participate in insurance exchanges and Medicaid contracts; establishing priorities, goals, and baselines for community health; and engaging plans and community stakeholders in a collaborative process (see box below).

States could also fund efforts to evaluate community activities by MCOs to identify successful approaches, and provide forums for sharing best practices and technical assistance to promote proliferation. Through health information exchanges, data repositories, and other technologies, states could help health plans assess local needs and identify health care gaps and disparities. States could also pilot payment reforms that reward MCOs for coordinating and integrating community-based providers and services.

The four health plans we studied are rooted in their communities. That does not necessarily mean that larger, multistate health plans are less able to form local partnerships. However, it does mean that those plans must balance standardization across states—which allows sharing of best practices and economies of scale—with the flexibility and tools that allow each subsidiary to identify and address local needs.

Based on our interviews with Medicaid officials and leaders of community-based organizations, it is clear that not all Medicaid MCOs are alike. Some place a strong emphasis on community engagement, while others have much work to do in this area. With growing evidence that MCO–community partnerships promote care coordination, prevention, and a stronger safety net, state governments should seek to encourage and support these activities.

Information That States Could Request to Spur Community Engagement by MCOs

State governments could pose questions to MCOs in several arenas to encourage community engagement. The following are based on key "ingredients" that appear to contribute to successful community partnerships among the four MCOs studied:

Using data to identify gaps and target interventions. Does the MCO use data (HEDIS measures, health care claims, administrative data) to identify gaps and disparities in screenings, health care use, and outcomes related to age, race, ethnicity, and geography? Does the MCO use this information to target interventions toward specific populations and neighborhoods in greatest need?

Learning about local needs through community interaction. Does the MCO supplement data with frequent interaction with community residents and organizations? Do designated staff members attend neighborhood meetings and visit health centers, shops, religious organizations, and other venues to track community needs and gaps in care?

Involving the community in developing solutions. Does the MCO enlist stakeholders in developing solutions to these needs and gaps?

Integrating community health into the MCO's mission and priorities. Does the health plan's mission include a focus on community health? How do plan leaders communicate this priority? Has the plan committed staff time and resources to this focus? Are staff members dedicated to improving the health of the broader population and building relationships in the community?

Developing the right messages and materials. Does the MCO deliver culturally sensitive messages, relying on people with backgrounds similar to those of local residents? Are all educational materials at an appropriate level of health literacy?

Keeping primary care physicians informed. Is the MCO alerting physicians to its community-based initiatives, to encourage them to participate?

APPENDIX: SELECTION, ATTRIBUTES, AND ACTIVITIES OF THE MCOS

Health Management Associates interviewed state Medicaid officials and asked them to identify MCOs that have been leaders in pursuing community-based strategies to improve access and care for vulnerable populations. We then used websites and initial conversations with representatives of 19 MCOs to explore their activities and assess their willingness to share information.

With input from The Commonwealth Fund, we selected four of these MCOs for further study, with the primary goal to investigate a number of different community-based strategies in a range of geographic areas.

We conducted in-depth, semistructured interviews with staff members most knowledgeable about the MCOs' community-based initiatives, and with directors of community-based organizations with which they partner. We also reviewed material on their programs and results.

Appendix Tables 1 and 2 provide details on the plans and their activities.

Appendix Table 1. Overview of the Four Medicaid Managed Care Organizations

Plan	Overview
Gateway Health Plan, Pennsylvania	Gateway Health Plan is a Medicaid MCO serving more than 250,000 children and adults, and an HMO special needs plan serving about 30,000 individuals dually eligible for Medicare and Medicaid. Established in 1992 as an alternative to the state's traditional medical assistance program, Gateway offers coverage in 45 of 67 Pennsylvanian counties (as of January 2013). Its network includes some 100 hospitals, 2,800 primary care physicians (PCPs), and 9,000 specialists and other providers. In 2013 Gateway intends to introduce a special needs plan for people who are partially eligible for both Medicare and Medicaid, and a special needs plan for individuals with cardiovascular disorder, chronic heart failure, and diabetes.
HealthPartners, Minnesota	Founded in 1957, HealthPartners is a consumer-governed nonprofit that is both an insurer and a health system. Its medical group consists of 70 medical and dental clinics, 17 pharmacies, 780 physicians (including 350 PCPs), and 60 dentists. Four HealthPartners hospitals operate in Minnesota and Wisconsin. The HealthPartners health plan has 1.4 million members in total nationwide, with a network of 38,000 care providers in Minnesota, western Wisconsin, South Dakota, and North Dakota. Minnesota's Medicaid program has contracted with MCOs since the 1980s, and with HealthPartners since the mid-1980s. HealthPartners now covers about 84,000 Medicaid enrollees, about 61,000 of whom are enrolled in traditional Medicaid, 18,000 in MinnesotaCare, which offers subsidized insurance, and 5,000 in Minnesota Senior Health Options, which serves those dually eligible for Medicare and Medicaid.
L.A. Care, California	L.A. Care is a public health plan with more than 1,000,000 members in Los Angeles County. In 12 California counties, enrollees in public health insurance choose between a commercial plan and a "local initiative" option. The county established L.A. Care in 1997 as the local initiative plan. L.A. Care serves solely people enrolled in Medi-Cal (Medicaid), Healthy Families (CHIP), L.A. Care's Healthy Kids, an In-Home Supportive Services Workers Healthcare Program, and a Medicare Advantage special needs plan. L.A. Care's network includes about 10,000 providers. The plan is governed by a stakeholder board that includes Medicaid beneficiaries.
Neighborhood Health Plan, Massachusetts	NHP is a not-for-profit MCO founded in 1986 by the Massachusetts League of Community Health Centers (CHCs) and the Greater Boston Forum for Health Action. NHP is a fully licensed HMO serving some 156,000 MassHealth (Medicaid) beneficiaries and 33,000 individuals through Commonwealth Care, a subsidized health insurance program for low- and moderate-income uninsured residents. NHP also serves 57,000 individuals in commercial small group plans and Commonwealth Choice, which offers unsubsidized health insurance to uninsured adults who are not eligible for MassHealth or Commonwealth Care. NHP's network includes more than 3,700 primary care physicians and 13,200 specialists throughout Massachusetts, primarily at CHCs and multi-specialty medical practices (as of June 2012). Partners Healthcare acquired NHP in 2012.

Appendix Table 2. Community-Based Goals and Strategies of the Four Medicaid Managed Care Organizations

Goal 1. Improve Care Coordination, Access, and Delivery

Program and Health Plan	Strategies and Tools	Targeted Population	Community Partnerships
Community repository: Gateway	Online repository of some 3,000 community agencies designed to facilitate referrals Proprietary software program for plan intranet	Care management and health care utilization services for all plan members	Community meetings and events to network with local health and social service providers
In-home care management and treatment: Gateway	Physician or nurse practitioner visits a member at home and conducts comprehensive health assessment and care management Lab draws, and IV infusion therapy when necessary Follow-up visits and 24/7 telephone support until member can self-manage, or no longer desires care management services	High-risk members, including those with multiple chronic conditions or at least two inpatient admissions within the past 12 months	National vendor
Geriatric teams in community nursing facilities: HealthPartners	Teams of nurse practitioners and geriatricians placed in nursing facilities and assisted-living residences provide primary and urgent care, develop care plans, and facilitate transitions Electronic health records shared with partner hospitals	Frail seniors in nursing facilities that are "hotspots" for complex medical and social cases	Nursing facilities, assisted-living residences
Clinical teams in adult day health centers: HealthPartners	Geriatric nurse practitioner, geriatrician, and case manager visit senior daycare center regularly to provide and coordinate behavioral health and medical care	Seniors with Alzheimer's and dementia	Adult day health center, Amherst H. Wilder Foundation
Telehealth specialty care initiative: L.A. Care	Leads collaboration developing eConsult platform to enable safety-net primary care providers (PCPs) and specialists to share information, reducing unnecessary specialty care visits	All users of safety-net health care providers	Los Angeles County Department of Health Services, MedPOINT Management, and safety-net providers

Appendix Table 2. Community-Based Goals and Strategies of the Four Medicaid Managed Care Organizations (continued)

Goal 2. Strengthen the Community and Safety-Net Infrastructure

Program and Health Plan	Strategies and Tools	Targeted Population	Community Partnerships
Dental care access grants: L.A. Care	Grants to local dental clinics and community health centers (CHCs) to support dental services, expand clinic facilities and services, and establish new clinics for vulnerable populations Funding for therapeutic and preventive dental services for adults who lost dental coverage after a state Medicaid policy change in 2009 Partnership with a bank to combine grants with funding from California's tobacco industry settlement to support dental services for children ages 0–5 at six health centers	Adults without Medicaid dental coverage; children aged 0–5; patients who visit health centers in L.A. County	Grantees, including clinics and health centers
Safety-net health information exchange: L.A. Care	Funds and participates on steering committee for Los Angeles Network for Enhanced Services (LANES), a public-private collaboration initiated by L.A. County to allow Department of Health Services and community-based safety-net providers to exchange information	All users of safety-net health care providers	Los Angeles County and safety-net providers
Management of high blood pressure and diabetes: Neighborhood Health Plan	Support for local supermarkets that supply healthy foods, including coupons and vouchers for fresh groceries mailed to plan members	African American residents of targeted neighborhoods, including both plan members and non-members	Local grocery stores
Neighborhood events, screenings, and education: Gateway	Financial support for community organizations that organize events promoting illness prevention, health education, and health care outreach	All users of services provided by community organizations serving low-income people	University of Pittsburgh's Center for Health Equity, other community organizations
Community repository: Gateway	Electronic repository aids referrals to some 3,000 agencies that provide safety-net services, including childcare, counseling, housing, food assistance, social supports, and transportation	Plan members with range of needs, local service agencies	Local health and social service providers

Appendix Table 2. Community-Based Goals and Strategies of the Four Medicaid Managed Care Organizations (continued)

Goal 3. Promote Prevention and Reduce Disparities

Program and Health Plan	Strategies and Tools	Targeted Population	Community Partnerships
Family Resource Centers: L.A. Care	Two neighborhood centers providing free: Exercise classes for adults and children Health education and classes on managing chronic diseases such as diabetes, asthma, obesity, and HIV/AIDS Depression screening Eligibility determination for Medicaid, Women, Infants and Children (WIC), and other programs Classes on nutrition and cooking, parenting (such as for parents of autistic children), how to tap Medi-Cal benefits and the health care safety net, CPR and first aid, self-defense, and reading Support groups for parents and survivors of domestic violence Screenings, including mammograms, and preventive services such as flu shots Referrals to health care providers as needed	Plan members and broader community in high-need neighborhoods	Contracts with health educators, community clinics, County Department of Public Social Services, local housing and health advocacy organizations, independent health promoters (*promotoras*), neighborhood exercise and dance studios, national chronic disease associations, others
Management of high blood pressure and diabetes: Neighborhood Health Plan	Facilitator placed in supermarkets to survey consumers and raise awareness of good nutrition and healthy foods Coupons and vouchers for fresh groceries mailed to members with diabetes Members reimbursed for blood pressure cuffs Health fair at pharmacy with diabetes educators, blood pressure screenings, and glucose monitoring CHC diabetes awareness event with targeted invitations Creation and dissemination of health promotion and illness prevention materials	African American residents of targeted neighborhoods, including both plan members and nonmembers	Local grocery stores, pharmacies, CHCs, national organizations such as American Heart Association and American Stroke Association
Mammography campaign: Neighborhood Health Plan	Posters in bus shelters and subways Brochures in CHCs, churches, and local businesses “Advertorials” in ethnic publications Mobile mammography screening unit Phone-a-thon and 1-800 hotline Birthday card reminders to plan members Reminders to PCPs Use of culturally appropriate materials	African-American women in five-county region with large health disparities, including both plan members and nonmembers	YWCA, local church, Dana Farber cancer center, CHCs, local businesses

Appendix Table 2. Community-Based Goals and Strategies of the Four Medicaid Managed Care Organizations (continued)

Goal 3. Promote Prevention and Reduce Disparities (continued)

Program and Health Plan	Strategies and Tools	Targeted Population	Community Partnerships
Postpartum and early well-child visits: Neighborhood Health Plan	Coalition-building and the use of focus groups to analyze barriers to care and determine specific strategies to overcome them Training in cultural competency for medical staff Culturally appropriate patient materials	Latinas in region with large health care disparities	Family Health Centers, which provide or refer individuals to education, childcare, health, and other services; local WIC offices; other organizations serving target population; funding from Culture InSight (Harvard Pilgrim Foundation)
Preventive screening promotion and alerts: Gateway	Flashing "care gap button" on member profile system alerts Gateway staff if any member is due or overdue for screenings or visits	Care management, member services, and other staff serving all plan members	n/a
Diabetes home screening and self-screening: Gateway	Technicians conduct in-home A1c testing and provide education on self-care Members given in-home test strips and instruction in how and when to use them Care managers and PCPs notified when lab results indicate high glucose levels	Plan members with diabetes and a gap in monitoring	Vendor of durable medical equipment
Home screening kits for colorectal cancer: Gateway	Screening kits sent to members' homes Instructions adjusted for health literacy level	Medicare/Medicaid dual-eligible members with "preventive health tendency"	Lab partner
Neighborhood screenings and education: Gateway	Plan staff placed in barber shops and beauty salons to perform blood pressure screenings and educate customers and employees about healthy lifestyles, good nutrition, body mass index, and other health topics Financial support to community organizations for events on illness prevention, health education, health care outreach	Businesses owned and operated by African Americans in targeted regions	Barber shops, beauty salons, University of Pittsburgh's Center for Health Equity, other community organizations

Note: Many strategies have more than one goal.

NOTES

1 See S. Silow-Carroll, J. Edwards, and D. Rodin, *State Levers for Improving Managed Care for Vulnerable Populations: Strategies with Medicaid MCOs and ACOs* (Lansing, Mich.: Health Management Associates, Feb. 2013), available at http://www.healthmanagement.com/publications/.

2 Most health plans use the Healthcare Effectiveness Data and Information Set (HEDIS) to measure their performance. The National Committee for Quality Assurance developed and maintains the tool.

3 Federal law requires nonprofit hospitals to engage in "community benefit" activities to maintain their tax-exempt status. However, nonprofit health plans have no comparable federal requirements, or standard definitions of which activities provide community benefit. The Affordable Care Act (Section 9007(a), IRC 501(r)(3)(A)) strengthened requirements for the community benefits that hospitals must provide to maintain their nonprofit status. For example, they must conduct regular community health needs assessments with local input, use them to develop plans to meet identified needs, and report on their progress annually.

4 See Office of the Massachusetts Attorney General, *The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations* (Boston, Mass., 2009), available at http://www.mass.gov/ago/docs/healthcare/hmo-guidelines.pdf.

5 See Minnesota Department of Health, *Community Benefit Provided by Nonprofit Health Plans* (St. Paul, Minn., Jan. 2009), available at http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/hlthplancommbenefit.pdf. State legislation in 2011 created an advisory board to better define these requirements and link state health goals and the collaboration plans more formally. However, the legislation streamlined reporting requirements for hospitals and plans rather than adding new ones.

6 Measures include preventable hospital admissions, readmissions, Caesarean sections, low-acuity emergency department visits, and overuse of high-tech radiology. See Silow-Carroll, Edwards, and Rodin, *State Levers,* 2013.

7 As government entities, the local community health plans are subject to public disclosure rules and the Brown Act that promote transparency and a role of brokering communitywide discussion of local health care and health promotion strategies for both Medicaid and non-Medicaid populations. Local community health plans also make investments that demonstrate their stake in the stability and competitiveness of local safety-net providers. See California Endowment, *California's Local Community Health Plans: A Story of Cost Savings, Quality Improvement, and Community Leadership* (Sacramento, Calif.: The California Endowment, Jan. 2010), available at http://www.pachealth.org/docs/100054_CAE_LocalCommunityHealthPlans_7.pdf.

8 Ibid, p. 12.

9 Silow-Carroll, Edwards, and Rodin, *State Levers,* 2013.

10 See http://www.econsultla.com/resources/pcp-overview.pdf.

About the Authors

Sharon Silow-Carroll, M.B.A., M.S.W., is a managing principal at Health Management Associates. She has more than 20 years of experience in researching and analyzing local, state, and national health system reforms; strategies by hospitals to promote quality and patient-centered care; public–private partnerships to improve the health care system; and efforts to meet the needs of underserved populations. She was previously senior vice president at the Economic and Social Research Institute in Washington, D.C., where she directed policy analysis and authored reports and articles on a range of health care challenges. Ms. Silow-Carroll earned a master's degree in business administration at the Wharton School and a master's degree in social work at the University of Pennsylvania. She can be emailed at ssilowcarroll@healthmanagement.com.

Diane Rodin, M.P.H., is a consultant with Health Management Associates. She conducts policy analysis related to access to health care and insurance coverage, particularly with respect to publicly financed coverage and care. Ms. Rodin closely tracks developments in health care reform implementation and state-level innovations in health policy to improve care for vulnerable populations and develops analyses of implications for health policy foundation, state, managed care, and other clients. She previously worked for a state Medicaid director's office. Ms. Rodin received a master's degree in health policy and management from the University of California, Berkeley, School of Public Health.

Acknowledgments

This work was supported by a grant from The Commonwealth Fund. The authors gratefully acknowledge the guidance of Pamela Riley, M.D., M.P.H., senior program officer, Vulnerable Populations, The Commonwealth Fund, and this project's advisory group, composed of the following individuals:

Marsha Gold, Mathematica Policy Research

Kathy Kuhmerker, Association for Community Affiliated Plans

Enrique Martinez-Vidal, AcademyHealth

Kathleen Nolan, National Association of Medicaid Directors

Julia Paradise, Kaiser Family Foundation

Sara Rosenbaum, Department of Health Policy, School of Public Health and Health Services, George Washington University

Lois Simon, Medicaid and CHIP Payment and Access Commission

We also thank the individuals at the four health plans and their community partners who generously offered their time and information. The case studies list these individuals; see http://www.healthmanagement.com/news-and-calendar/article/132.

Editorial support was provided by Sandra Hackman.

www.commonwealthfund.org