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Medicaid as a Multiplier

How Intermediaries Can Improve
Federally-funded Partnerships
to Address Social Determinants of Health

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Some have estimated that only 15% of health outcomes are determined by the healthcare system, while the remaining are the result of social, environmental, and economic factors. These factors are collectively called social determinants of health (SDoH)



Introduction

COVID-19 outcomes are an extension of other health inequities: looking at life expectancy alone, Black men live ten years less than white men, and men with the highest 1% of incomes can expect to live 14.6 years longer than those in the bottom 1%.

In the United States, the COVID-19 pandemic not only brought longstanding health inequities to greater awareness, but also exacerbated them, to devastating effect. Black, Native American/Native Alaskan people, and Hispanic/Latinx people were hospitalized at nearly four times the rate of white-identified counterparts.¹ Black and Native American/Native Alaskan people were nearly two times as likely to die from COVID-19 as white people of a similar age.² These COVID-19 outcomes are an extension of other health inequities: looking at life expectancy alone, Black men live ten years less than white men, and men with the highest 1% of incomes can expect to live 14.6 years longer than those in the bottom 1%.³ While factors *within* healthcare systems directly contribute to these inequities, for some time, there has been a growing recognition of the importance of addressing health inequities “upstream.” Some have estimated that only 15% of health outcomes are determined by the healthcare system, while the remaining are the result of social, environmental, and economic factors. These factors are collectively called social determinants of health (SDoH), and are defined by the World Health Organization (WHO) as the “conditions where people are born, grow, live, work, and age.”⁴

Given the impact of these upstream determinants, many healthcare organizations have implemented interventions to influence SDoH and individual-level social needs more directly, and studies show positive impacts on public health and on healthcare costs.⁵ For example:

- In New York State, partnerships between the Montefiore Hudson Valley Collaborative PPS and various community partners led to a 39% reduction in emergency room visits in 2014.⁶ This intervention worked with housing and social-support organizations to address the needs of patients experiencing homelessness.
- In Illinois, the Better Health through Housing Program, a partnership between the University of Illinois Hospital and the Center for Housing and Health, has led to a 57% reduction in emergency room utilization and a 21% decrease in associated healthcare costs.⁷
- In a variety of locations, complex case management to address needs ranging from housing to mental and behavioral health has been shown to reduce hospital stays and specialist visits.⁸

While addressing social determinants may reduce spending and improve equitable outcomes, medical providers do not often possess the in-house skills, resources, or staffing necessary to address the complex non-medical needs of their patients. Nor will Medicaid generally fund these non-medical services without a special waiver. To accomplish this task, healthcare providers often create partnerships with community-based organizations (CBOs) to provide services that address housing, employment, food access, substance use disorder, and alternatives to incarceration. As social-service providers grounded in neighborhoods, community-based organizations are often very well positioned to intervene in these SDoH domains, at the community level or at the individual level of social needs. However, partnerships between healthcare organizations (HCOs) and CBOs do not always meet their full potential.⁹ Among other factors, limited funding, mistrust, and HCOs’ lack of understanding of the work of CBOs may hamper the partnerships’ effectiveness, as we further discuss in the paper.^{10,11} As the Biden Administration provided incentives for greater expansion of Medicaid through the American Rescue Plan Act, and seeks to promote racial equity in health more broadly, more states will explore innovative models to decrease Medicaid costs while improving health outcomes.¹²

In order to advance these goals, it is imperative to understand how to tap the full potential of CBO-HCO partnerships.

One kind of organization that can promote connections, facilitate trust building, and foster collaboration between CBOs and other kinds of entities are community development intermediaries. Beginning in the early 1980s, intermediaries were critical to the growth and establishment of the community development sector as a whole. Over the past forty years, intermediaries have channeled funds from private and public sources into community organizations; provided core operating support, technical assistance, and training to neighborhood groups; helped advocate for national community development policies; and oriented the public sector to better support CBOs and their work.¹³

This paper uses original interviews, case studies, and a literature review to examine Medicaid-funded partnerships that address SDoH, and the role of intermediaries in advancing them. It asks:

- What are the qualities that make for effective partnerships between HCOs and CBOs seeking to intervene on SDoH—i.e. that enhance health outcomes and address health inequities?
- What roles can community development intermediaries play in fostering successful partnerships?

The paper begins with case studies of successful partnerships in California and New York, then analyzes themes from these cases about the challenges and strengths of HCO-CBO partnerships. It then turns to a discussion of the ways that intermediaries can add value to HCO-CBO partnerships and concludes with policy recommendations.

Case Studies of Successful Partnerships

CASE STUDY

Bridges to Health Equity

The Bridges to Health Equity (BHE) program in New York City is designed to overcome challenges that arise at the intersection of housing and health. This program is a multisector collaborative that is convened by the intermediary Local Initiatives Support Corporation's New York City office (LISC NYC), and includes Fifth Avenue Committee, Make the Road New York, and RiseBoro Community Partnership as CBO partners; Healthfirst, MetroPlus, and Empire Blue Cross Blue Shield as managed care organization (MCO) partners; and NYU Langone as the healthcare system partner.

The program aims to develop strategies to overcome challenges at the intersection of health and housing, and has three main objectives: 1) to develop new methods of collaboration across the community-development and health sectors to influence health outcomes in low-income New York City communities, 2) to design systems for information and data sharing, referral, communication, financing, and measurement, so as to support program integration and sustainability, and 3) to provide evidence and guidance to support expansion and replication of this model and to facilitate increased MCO-CBO contracting. To pilot this work, the Bridges to Health Equity program is implementing a community-based intervention that aims to reduce asthma prevalence and poor health outcomes related to asthma in select lower-income neighborhoods in New York City.

In practice, this pilot works through a “no-wrong-door” referral system where an HCO, MCO, or CBO can refer a participant to the program. Once in the program, participants are contacted by community health workers (CHWs) who conduct baseline and follow-up assessments of participants' health and housing. Based upon the needs of participants, CHWs can provide asthma education, offer resources to remove asthma triggers from a home, or connect participants to CBO partners that provide services that address social determinants of health such as food insecurity, legal issues, housing concerns, or under/unemployment.

Community development intermediaries have traditionally supported CBOs as they launch new services, and may play a role in advancing SDoH partnerships.



PHOTO CREDIT: ANNIE O'NEILL

The Bridges to Health Equity (BHE) program was created in 2019 due to New York State's Delivery System Reform Incentive Payment (DSRIP) program, a major Medicaid waiver initiative that promoted community-level collaborations and health system reform [see box, below]. An overall interest in New York State to create community partnerships under the DSRIP waiver, plus strong existing connections between LISC and various organizations (including the NYC Department of Health and Mental Hygiene, various Prospective Payment System organizations, and the New York Academy of Medicine) led to conversations about the development of a collaborative, cross-sector community-based intervention. After receiving funding from the New York State Health Foundation to support the planning, the organizations sought out a way to improve the health outcomes of New Yorkers and settled on an intervention that focused on asthma.

Although the COVID-19 pandemic has affected the BHE program implementation and timeline, early evaluations have demonstrated impact. As of May 2022, the BHE program had completed 256 baseline assessments. Among these 256 participants, the majority reported having poorly controlled asthma and no asthma action plan. Furthermore, almost 90% of participants' homes had asthma triggers (e.g., roaches, mice, mold, etc.). Given the findings from the baseline assessment, the Bridges to Health Equity program set out to improve asthma-related quality of life among participants. The follow-up assessment, which is conducted six months after the baseline assessment, included 118 people and found an increase in Asthma Control Test scores across all age groups—indicating better asthma control. Further, these participants reported fewer asthma triggers within the home, compared to baseline.

In addition to addressing issues specifically related to asthma, the Bridges to Health Equity program recognized that a greater impact on health outcomes would be achieved through a holistic approach that addressed other social determinants. Through the work of the CBO partners, BHE participants were connected to various social services. Early evaluations of these connections indicate that there were improvements in other social determinants of health—among the 118 participants with follow-up assessments, there was a significant decrease in the number who reported food and housing insecurity, and issues related to child care.

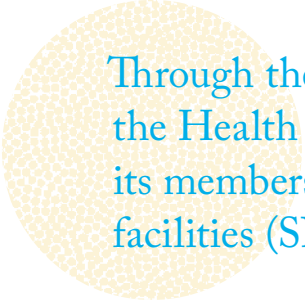
The Delivery System Reform Incentive Payment (DSRIP) Program

Section 1115 Medicaid Demonstration Waivers (Section 1115 Waivers) provide states the ability to pilot new approaches that require flexibility from federal program rules.¹⁴ States have used this increased flexibility to expand coverage to people generally ineligible for Medicaid, change the benefits offered, or implement reforms in the care delivery system. This last type of change is often known as a Delivery System Reform Incentive Payment (DSRIP) program, and these have been implemented in states such as California, New York, Massachusetts, and New Jersey.¹⁵ States with DSRIP waivers are allowed greater flexibility in how they pay for care with the expectation that these new approaches will result in better health outcomes and greater cost savings.¹⁶ Through the use of DSRIP, states can change how they provide care to beneficiaries and create performance-based incentive programs for providers, which may involve community-based providers, as was the case in New York.

Brilliant Corners' Community Care Settings Program

The Community Care Settings Program (CCSP) was launched in 2014 by the Health Plan of San Mateo and is focused on plan members who are currently residing in skilled nursing facilities. This program is a contractual partnership between the Health Plan of San Mateo, the housing-development and supportive-housing organization Brilliant Corners, and the Institute on Aging. Brilliant Corners and the Institute on Aging are contracted by the Health Plan of San Mateo with specific deliverables and payment structures laid out. In this partnership, Brilliant Corners works to house patients while the Institute on Aging—an organization that provides support to elders and adults living with disabilities—performs complex case management and connects individuals to the independent-living services they may need.


Through the Community Care Settings Program, the Health Plan of San Mateo aims to support its members during the transition from skilled nursing facilities (SNFs) back into the community, ensuring members have the services they need to be successful. To achieve this goal, the CCSP uses a three-pronged approach: 1) coordinated case management—the program connects members to community services such as meals, housing assistance, etc., 2) purchase of services—the program pays for needed services that are not covered through other mechanisms, and 3) housing retention and placement—the CCSP places members in affordable housing and ensures housing remains affordable. Over the course of its initial five-year pilot, the program aimed to connect over 800 individuals to housing and care-coordination services.¹⁷



Through the Community Care Settings Program, the Health Plan of San Mateo aims to support its members during the transition from skilled nursing facilities (SNFs) back into the community.

While the Community Care Settings Program was launched in 2014, its beginnings can be traced back to 2008. In 2008, Brilliant Corners worked in San Francisco to successfully move patients from Laguna Hospital into the community. To do so, Brilliant Corners acquired scattered-site units on the market and modified them to meet the needs of patients from the hospital returning to the community. These modifications included creating roll-in showers, bathroom grab bars, etc. While Brilliant Corners was placing patients in housing, the Community Living Fund was doing case management. Meanwhile, in San Mateo County, the Health Plan of San Mateo noticed both the high cost of skilled nursing home facilities and the disparities in quality of life between those residing in SNFs and in the community. In order to correct this situation, the Health Plan founded the Community Care Settings Program in 2014. Given the success of Brilliant Corners in transitioning individuals into the San Francisco community, the Community Care Settings Program sought to do similar work with Brilliant Corners in San Mateo County.

While Medicaid is traditionally prohibited from covering housing costs, the CCSP is able to use Medicaid funding under a pilot initiative of the Medi-Cal 2020 Section 1115 Medicaid Waiver's Whole Person Care program, which is exploring the use of Medicaid funds for housing-related services. In the case of the CCSP, the Health Plan of San Mateo was given funding to place its members in permanent, supportive housing. This funding from Medi-Cal streams from the Health Plan of San Mateo to its CBO partners through a fee-for-service payment model—partners



CBOs have promoted healthy food access in efforts to address issues like hypertension, diabetes, and obesity.

PHOTO CREDIT: ANDREW SPEAR

are paid for each discrete service they provide—and an incentive model where CBOs are rewarded for reaching certain milestones.¹⁸

In order to connect over 800 individuals to supportive community housing, the Community Care Settings Program works by first screening members to ensure they would be successful in the community. Individuals deemed likely to manage well in a community setting are connected to a case manager at the Institute on Aging. This case manager creates a plan for the individual and further assesses the person's needs.¹⁹ Then, this plan is presented to the Pilot Core Group, which includes members of the Health Plan, Institute on Aging, and Brilliant Corners who work through the individualized plan. Brilliant Corners connects individuals to subsidized scattered-site housing and to housing-retention services. Eventually, Brilliant Corners places these individuals in long-term affordable housing, but continues to provide housing-retention services.

Since its inception in 2014, the Community Care Settings Program has transitioned over 190 people from long-term-care settings to the community and decreased member healthcare costs by 50% in the six-month period following the move.²⁰ Furthermore, 90% of those who have transitioned back into the community have remained there after six months, far exceeding the 65% benchmark set by the Health Plan of San Mateo.

Strengths and Challenges of HCO-CBO Partnerships

While the cases above were broadly successful, interviewees involved with the initiatives suggested both qualities that contributed to their successes and challenges that needed to be overcome in order to advance their potential. These findings align with other research on SDOH partnerships, as described below.

Establishing clear roles, and trusting in value-added divisions of labor. One important component of both the Bridges to Health Equity and Community Care Settings partnerships involved role clarity, where divisions of labor were firmly based on each partner’s strengths.

Establishing clear and trusted roles, creating effective coordination vehicles, having CBOs with health-related intervention experience, and the presence of funding and institutional support were all critical components of these successful partnerships.

In New York City, the asthma-focused collaboration brought together three managed care organizations, three CBOs, and a major hospital system. Each type of agency had its own distinct roles, but the involvement of such a large and powerful health system as NYU Langone meant that there was also potential overlap in functions among the partners, as community health workers were also employed by the hospital and might have been tapped to implement the community-facing aspect of the initiative. However, the collaborative recognized that CBOs were uniquely positioned to gain the trust of community residents in providing asthma education, services, and advocacy. They were seen as better situated to gain trust not only because the CBOs had positive reputations and good relationships within the communities they served, but also because they provided other forms of help to referred patients, and these additional service opportunities (beyond asthma) supported patient engagement with the program. As a practitioner reflected:

We intentionally want to kind of tap into all the services that the community organizations provide. So they’re really doing an assessment with the program participants to identify any other needs they have related to social determinants of health and connecting them back to the services. That could be emergency food resources, adult education services, youth services, employment services, legal services, so really a huge range. That’s not . . . a primary purpose of the program but it’s something that’s intentionally a part of it.

In San Mateo, practitioners focused on the importance of effective partnerships with skilled partners who all focused on their own areas of expertise: “I can’t think of a program within Brilliant Corners where we’re doing something on our own.” While case management, healthcare, and housing assistance were the three main components of the model to help transition individuals out of skilled nursing facilities, Brilliant Corners found it important to focus on its own strengths in housing assistance. This was because each component of the program required specific skills corresponding to the three participating agencies’ areas of expertise, and also because distinguishing between agencies’ services meant that program participants did not associate challenges in one area of service provision—for example, problems with a landlord that a housing specialist might need to mediate—with their ability to seek help in another, such as counseling or case management. As one interviewee noted:

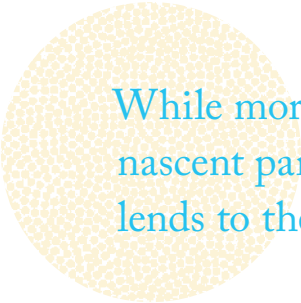
We think it’s very important to separate case management from housing retention. And that is probably what differs with us from many other agencies. We do not combine those two. Usually, you will see case managers have their clients

[whose housing security the case managers also control, being associated with the clients' landlord]. We separate the two and we find that important to build relationships with our clients . . . to have more support and to give someone an opportunity to have more longevity.

According to Brilliant Corners staff, trust in one another's expertise helps the agencies' division of labor play out successfully:

They are trusting that everyone is the expert in what they are supposed to be the expert in. So, for case management, we don't push our noses into case management. A case manager doesn't push their noses into housing retention. There is a trusting relationship, and we all trust that people are the experts to what they are assigned to do.

Echoing this finding, other research on SDoH partnerships has indicated that trust is critical to partnership success. In a study on New York State's DSRIP partnerships, participants sometimes highlighted how trust between individuals and teams allowed for "momentum" in a partnership, but when trusted people left, the partnerships fell apart.²¹ This trust is enhanced by mission alignment: in a study by the Nonprofit Finance Fund that included over 200 organizations involved in an SDoH partnership, the majority of respondents reported that trust and mission alignment were the "thread" weaving together a successful partnership.²²



While more flexible collaborations can be helpful to explore nascent partnerships, having durable partnership structures lends to their success over time.

Creating effective, ongoing coordination vehicles. In both New York and San Mateo, creating distinctive roles within the initiative also required effective coordination across partnership functions.

LISC NYC received an early planning grant from the New York State Health Foundation that involved the CBOs, managed care organizations, and hospitals, and these sessions were important to setting the groundwork as to program expectations. But when the initiative transitioned to the program implementation phase, ongoing meetings and established referral processes were critical to accomplish the coordinated care envisioned by the partnership. In this partnership, coordinated care referrals began with primary care providers who identified patients with high utilization of asthma-related services. The referrals then flowed through the NYU Langone hospital system, and from NYU to the CBOs with which the hospital system held contracts. A practitioner reflected that this referral system was a major accomplishment: "As you can imagine, it's complicated. So, there's a lot of negotiation and refining around exactly how all the information flows and who's receiving what."

The need for coordination is also felt among SDoH partnerships that support patients with complex care needs, as is the situation in San Mateo. In those kinds of initiatives, case conferences are critical to ensure that housing, social-services, and medical teams work



Community Health Workers can connect participants to community partners that provide services that address social determinants of health such as food insecurity, legal issues, housing concerns, or under/unemployment.

PHOTO CREDIT: RUPERT J. WHITELEY

together to ensure that an individual receives the support they need to transition from a skilled nursing facility to housing. As a practitioner stated:

Health Plan of San Mateo really has a panel of people who review the cases they are making. There are nurses. They're making decisions based on each individual's need and whether or not they have the support and the resources that they need to be successful in independent housing. There's a table and many people are sitting there and many people are contributing to ensure that people can live successfully.

Other research has also found that durable partnership structures are another factor that lends to partnership success. While more flexible collaborations can be helpful in exploring more nascent partnerships, as was the case in the early planning for the Bridges to Health Equity collaboration, a more structured partnership—relying on good communication—may be required during implementation, as decision making becomes more centralized and regularized.²³

Having health-related community intervention experience. While many CBOs and service agencies have expertise providing services that contribute to health outcomes, such as housing, employment support, or case management, case study participants noted the need for explicit health-focused intervention experience, or experience interacting with health systems.



Not just general community development expertise but specific experience in health-related interventions on the part of CBOs helped the success of these partnerships.

In New York, the three participating CBOs had previous funding to implement health-focused interventions within the affordable housing units they owned and managed—initiatives such as smoke-free housing, green cleaning, and integrated pest management. Through its promotoras community-health-worker model, Make the Road New York had an active peer-to-peer outreach initiative that helped connect individuals to healthcare, nutritional assistance, and legal services, and that involved coordination with managed care organizations. Through the Two Shades of Green program, the Fifth Avenue Committee worked closely with the NYC Department of Health and Mental Hygiene (among other partners) to integrate smoke-free and green measures into affordable housing. The ultimate goal of this intervention was to reduce asthma triggers found in the housing the Committee managed. For its part, RiseBoro has been working with the NYC Health and Hospitals Corporation through its Food and Nutrition Service Networks and Housing Navigation Network to address obesity, diabetes, and hypertension among Brooklyn residents.²⁴

In San Mateo, Community Care Connections is one of the oldest Brilliant Corners programs, and while the partnership with the Health Plan of San Mateo dates to 2014, it actually builds on work conducted at least five years before. In that prior contract, the agency helped move about 130 patients out of a local hospital whose conditions had led to a lawsuit on behalf of the residents. As previously noted, to assist with the transition to independent living, Brilliant Corners provided physical modifications to scattered-site apartments (such as roll-in showers, grab bars, and other forms of accommodation), as well as other kinds of housing-retention services. It also acted as the primary connection to the landlord, directly paying rent on behalf of the participants, while the tenants paid Brilliant Corners a portion of their income—an element of the model that continues to this day.

Having access to funding and institutional support. Both initiatives benefited from Medicaid-related funding and institutional support within the healthcare or managed care organizations.

In New York, NYU Langone had a committed community partnerships division, the Department of Community Programs, which used DSRIP funding for SDoH interventions. It in fact allocated additional DSRIP resources to involve the Fifth Avenue Committee as an additional CBO partner that was not initially involved with the pilot. NYU's merger with Lutheran Hospital in Brooklyn—which had always viewed itself as more of a community-facing rather than a regional provider—added to this commitment, in the view of one practitioner. In San Mateo, a deep commitment to the program from the MCO (the Health Plan of San Mateo) has ensured effective institutional support. This support is justified because the initiative can produce better outcomes for patients, and because a year at a skilled nursing facility can cost up to \$500,000 per patient.

These findings align with previous research on other SDoH interventions, which have been hampered by limited funding. This limited funding has prevented CBOs, which are already under-resourced, from hiring additional staff; resulted in perceptions of lower-quality interventions; and contributed to CBOs feeling that their work is inadequately valued. This finding is especially significant because value-based care (VBC) arrangements often require CBOs to enter service information into HIPAA-compliant data systems; the creation of this additional information-technology (IT) infrastructure or other data systems requires funding and support.²⁵

How Intermediaries Can Support Effective Community Partnerships

Community development intermediaries can play a role in fostering these characteristics of successful CBO-HCO interventions. As agencies with deep connections to community organizations, as well as experience in bridging between CBOs and external partners—including healthcare organizations²⁶—intermediaries can enhance SDoH partnerships in at least three major ways:

1. Planning and coordinating complex initiatives
2. Building service capacity and leveraging resources
3. Cementing institutional support

Planning and Coordinating Complex Initiatives

SDoH interventions do not always involve partnerships between a single healthcare provider and a single community-based organization; according to a study by the Nonprofit Finance Fund, over 70% of partnerships involved more than two parties. Given the realities of complex, multi-party partnerships, intermediaries can take the function of a “backbone” organization,²⁷ and promote trust, role clarity, and successful coordination—important qualities described above. LISC’s own experiences acting in such a role suggest how intermediaries can help facilitate general communication and also smooth out complex service and referral processes: in the New York City collaboration, LISC staff met regularly with the entire collaborative as well as with individual members, providing support around topics such as the details needed to establish referral mechanisms, given patient privacy and technology considerations. As one LISC practitioner said:

I do monthly meetings with just the CBOs [community-based organizations] plus NYAM [New York Academy of Medicine] as the evaluator. And I’ve done meetings with the Fifth Avenue Committee, RiseBoro, and NYU Langone around some of the really nitty-gritty referral mechanism kind of stuff. Those . . . are the formal structures. And then informally, we convene as needed around any of the particular components of the project.

Building Service Capacity and Leveraging Resources

Community development intermediaries have long supported capacity building among CBOs, which can be an important task as organizations learn to develop new SDoH initiatives. As described in previous research,²⁸ intermediaries can provide responsive one-on-one and group technical assistance to help CBOs learn to implement new kinds of programs. For example, LISC supports the Financial Opportunity Center network, which helps community organizations provide workforce assistance, financial coaching, and public-benefits advocacy.²⁹ The initiative has grown to include over one hundred CBOs and has contributed to better economic outcomes among those who participate.³⁰ Above, we described the importance of building on CBOs’ successful SDoH intervention experiences in launching new initiatives. Because not every CBO possesses this kind of experience, intermediaries can play an important role in bringing SDoH partnerships to scale.

Just as intermediaries support partnerships around affordable housing and community-based social services, they can also be useful in supporting effective community partnerships around SDoH interventions.

Pairing technical assistance with funding is also an important intermediary role. As suggested by their name, intermediaries bring substantial private and public resources to CBOs, which may build upon any funds provided directly through the SDoH intervention. Leveraging additional funding is important, as the true cost of service delivery, including new technology, is not always covered by HCO or MCO payments.³¹ For example, LISC, Enterprise Community Partners, and Habitat for Humanity leverage the Capacity Building for Community Development and Affordable Housing Program, also known as HUD Section 4, to enhance the effectiveness of other funding streams. The program, which requires a three-to-one in-kind or cash contribution, often leverages substantially more than that ratio. In our example, LISC, using private funding, made a capacity-building grant to Fifth Avenue Committee to ensure it was able to join the partnership.

Cementing Institutional Support

Strong institutional commitment from MCOs and HCOs can help advance more successful SDoH initiatives, because partnerships naturally run into administrative obstacles around contracting, referral and data-system processes, and reporting requirements. For example, Brilliant Corners, using the same strategy of housing-retention services to facilitate transition from skilled nursing facilities, believed that it was unable to achieve similar outcomes in its Inland Empire initiative, because the MCO was not as committed to the program as was the Health Plan of San Mateo. Another interviewee, at the Oregon-based Linn Benton Health Equity Alliance, stressed the importance of strong commitments on the part of local MCOs and the Oregon Health Authority in Linn Benton's support of SDoH interventions. While Linn Benton has been able to implement impactful interventions (such as a panel discussion on maternal health that aimed to improve the health outcomes of Black women, or a farmers' market with CBO Casa Latinos Unidos that diminishes food insecurity), the organization expressed that its funding is unstable and frequently cut.

Community development intermediaries have demonstrated success in deepening the commitments of large corporations to local partnerships. For example, within community development finance, intermediaries play a critical role in helping banks and other investors regularly provide capital to CBOs to build affordable housing and to entrepreneurs to support their small businesses. Interviewees reflected that intermediaries might play a similar role with HCOs and MCOs:

LISC came into being because banks were being forced to lend in low-income communities, and didn't know the players, and didn't have the ability, or trust [in those neighborhoods]. LISC sprang up to help all those sectors to build systems and work with one another. This [DSRIP] seems like another challenge where LISC can step up and help build the connections and build the systems to foster collaboration.

Interviewees stressed that an important component to cementing institutional support for SDoH interventions within HCOs and MCOs is demonstrating healthcare savings. Even in advance of that demonstrated success, intermediaries can help boost leadership's confidence in and commitment to new SDoH initiatives, by bringing strong CBOs to partnerships and by showing a commitment to support a successful intervention. This occurred in the Bridges to Health Equity partnership, where LISC helped select the CBO partners, and where its presence made it easier for the HCOs and MCOs to support the pilot.

Realizing the promise of Medicaid partnerships depends on well-resourced and well-coordinated initiatives, and community development intermediaries can support both resources and coordination.

Through complex case management, housing, social-services, and medical teams can work together to ensure that an individual receives the support they need to transition from a skilled nursing facility to housing.



PHOTO CREDIT: RIVER MEDLOCK


Recommendations

This report highlighted the need to promote well-funded, well-coordinated SDoH and social-needs interventions. This means significant resources not only for service provision, but also for planning and capacity building to ensure program effectiveness. Actions by the federal government can both incentivize SDoH partnerships and address the capacity needs of community organizations.

Establish a social determinants of health capacity-building program. Despite playing a critical role in connecting community members to essential support services and programs that address SDoH, many CBOs—which are often led and staffed by members of the communities they serve—struggle to maintain basic operations or expand access to services. Under-resourcing and a lack of capital to support operational capacity undermine the organizations’ effectiveness. The demands of responding to emergency needs of hard-hit communities during the pandemic further stretched frontline community organizations and, in some cases, depleted their resources to provide crucial services.

Dedicated capacity-building resources can help these indispensable organizations regain their stability during this pandemic recovery period and can also help promote equitable access to capital among organizations addressing SDoH that are led by people of color. We recommend the establishment of an SDoH capacity-building program, to be administered through the U.S. Department of Health and Human Services (HHS) that would direct funding to intermediaries to provide desperately needed resources to community-based organizations addressing SDoH. Allowable uses of funding would include direct operational support, loans, grants, and

predevelopment assistance to nonprofit entities seeking to address the five domains of social determinants of health—economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. Grants would also support training, education, and technical assistance to develop the capacity and ability of CBOs, community development corporations (CDCs), and/or community housing development organizations (CHDOs) to implement SDoH-related projects and programs in community development, economic development, and affordable housing.



The federal government plays an important role in helping build community capacity to address social determinants, in funding planning for successful CBO partnerships, in strengthening referral networks, and in sparking participation by hospitals and insurers.

Fund planning and technical-assistance grants that advance evidence-based SDoH interventions. This report noted the need for strong coordination among MCOs, HCOs, and CBOs, and for technical-assistance support to CBOs to deliver new forms of intervention. The Social Determinants Accelerator Act would authorize state, local, and tribal governments to devise innovative, evidence-based approaches to coordinate services and improve outcomes and cost effectiveness. The bill provides funds for the Centers for Medicare & Medicaid Services (CMS) to award up to 25 planning grants and technical-assistance grants to eligible entities for the development of social determinants accelerator plans that address at least one health and one social outcome for a specified focal population. It also establishes the Social Determinants Accelerator Interagency Council and provides funds for the council to: 1) assist the CMS in awarding specified grants, 2) increase coordination among health and social-service programs, and 3) provide program evaluation guidance and technical assistance to increase the impact of social-service programs.

Establish integrated social-needs referral networks in communities. This report noted the need to resource partnerships, especially around data issues that are often key to effective referral processes, and to shared accountability. The establishment of partnerships that leverage local expertise and technology would allow states and localities to sustainably track and align the efforts of medical organizations and community organizations—providing a better understanding of the scope of community needs and the available resources to meet them, a more efficient means to initiate and address requests for assistance, and better methodology to track referrals, accountability, and outcomes. LISC joins Aligning for Health in calling for the establishment of public-private partnerships to facilitate cross-sector referrals, communication, service coordination, and outcome tracking between social-service providers and healthcare organizations by establishing or expanding secure, connected technology networks. The LINC to Address Social Needs Act would do this by authorizing one-time seed funding for states of \$150 million in grants to catalyze action and support the engagements needed for this work to be successful. States would be required to design and implement a plan to make the network financially sustainable.

Strengthen nonprofit hospitals' community health needs assessments. The report noted the need for strong institutional commitments to SDoH interventions. While intermediaries can help foster this commitment, the federal government can also play a role. When the Patient Protection and Affordable Care Act (ACA) was signed into law in 2010, it required nonprofit hospitals to carry out a hospital community health needs assessment (CHNA) every three years in order to

maintain their tax-exempt status. The goal of this process was to push hospitals to go beyond their institutional walls and have a stake in health outcomes of local communities by actively engaging state, local, and community-based entities in developing strategies to address the root causes of health inequity and financing the types of interventions (e.g. investments in healthy housing) that will lead to healthier outcomes. CHNAs include the development of an implementation strategy—a written plan that either describes how the hospital plans to use a portion of its surplus to address the community health need or explains why it does not intend to address an identified health need. While the implementation strategies can influence hospital community benefit agreements, there is no requirement that hospitals expressly draw a link between community-benefit spending policy and their CHNAs. Nor are hospitals required to allocate benefit spending in a way that includes community-building activities, such as physical improvements in housing, assisting small-business development in neighborhoods with vulnerable populations, child-care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, disaster readiness, and alleviation of water or air pollution. A recently published report revealed that community-building activities accounted for only 0.1% of the \$64.3 billion in total benefits that the surveyed nonprofit hospitals provided their communities. Investments in community-building activities are frontline investments that directly address SDoH.

LISC encourages the federal government to revisit the CHNA implementation guidelines and adopt policies that: 1) encourage hospitals to engage community development organizations in the development of their CHNA implementation plans, and 2) positively incentivize nonprofit hospitals to increase the percentage of hospital expenditures allocated to community-building activities.

Incentivize community development activities among health insurers. Commitments on the part of insurers in the case studies above were critical to their success. HHS initiatives like Healthy People 2020, and CMS regulatory actions (including its work with states seeking to integrate SDoH into their contracts with Medicaid managed care organizations and 2020 rules that allow insurers to offer supplemental SDoH-related benefits for Medicare Advantage and Part D plans) have greatly influenced the insurance industry focus on SDoH. LISC welcomes this focus and urges the federal government to build upon the existing momentum. Innovative approaches that incentivize insurers to build partnerships with community-based organizations, social-service agencies, and community development financial institutions have the potential to radically improve community health outcomes. LISC supports federal approaches that will encourage insurers to direct additional resources to building the aforementioned partnerships and invest in community development activities.

Endnotes

- 1 <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/>.
- 2 <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.
- 3 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4866586/>.
- 4 <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
- 5 One major source of funding for SDoH interventions involves value-based care (VBC) payment models within Medicare and Medicaid. In a VBC model, providers are reimbursed in a manner that incentivizes providers to restore their patients to better health. One noteworthy type of VBC are state-run Medicaid accountable care organizations (ACOs). In contrast with fee-for-service (FFS) models, which reimburse providers for the interventions they administer, ACOs (like other managed care organizations) are compensated on a per-capita basis, which incentivizes providers and hospital systems to keep intervention costs down. By connecting beneficiaries to social services, and creating action plans focused on addressing SDoH, ACOs have been able to decrease healthcare utilization for beneficiaries with unmet needs. This strategy has been proven cost effective: in 2017, CMS reported a net savings of \$314 million dollars through Medicare ACOs, including SDoH strategies, according to a 2019 report by the U.S. Department of Health and Human Services Office of the Inspector General (See link). <https://oig.hhs.gov/oei/reports/oei-02-15-00451.pdf>
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- 8 <https://www.ajmc.com/view/impact-of-complex-care-management-on-spending-and-utilization-for-highneed-highcost-medicare-patients>.
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- 10 <http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf>. See page 28.
- 11 https://media.nyam.org/filer_public/9f/5b/9f5b33a3-0795-4a1a-9b90-fa999e9ddf8e/hco_cbo_partnerships_digital.pdf. See page 10.
- 12 <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/>.
- 13 Ronald Ferguson and Sara Stoutland describe these intermediaries as organizations that help connect funding, knowledge, expertise, and resources among organizations working to advance community development. Ferguson, R.F., & Stoutland, S.E. (1999). Reconciling the community development field. In Ferguson, R.F., & Dickens, W.T. (eds). Urban problems and community development. Washington, DC: Brookings Institution Press.
- 14 http://www.statecoverage.org/files/KFF_1115_Medicaid_Demonstration_Waivers.pdf.
- 15 <https://www.kff.org/medicaid/issue-brief/key-themes-from-delivery-system-reform-incentive-payment-dsrip-waivers-in-4-states/>.
- 16 <https://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.
- 17 <https://www.ioaging.org/services/community-care-settings-program>.
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- 20 https://ssir.org/articles/entry/housing_for_health.
- 21 https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1001&context=hsm_book. See page 17.
- 22 <https://www.chcs.org/media/Working-Together-Toward-Better-Health-Outcomes.pdf>. See page 16.
- 23 Ibid.
- 24 <https://riseboro.org/division/health/>.
- 25 https://media.nyam.org/filer_public/9f/5b/9f5b33a3-0795-4a1a-9b90-fa999e9ddf8e/hco_cbo_partnerships_digital.pdf. See page 13.
- 26 See for example <https://www.lisc.org/toledo/our-work/financing/health-impact-fund/>.
- 27 See <https://www.collectiveimpactforum.org/resources/value-backbone-organizations-collective-impact>.
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