



# Navigating New Partnerships:

Community Based Organizations and other Third-Party Entities under Medicaid Managed Care in California



# About Independent Living Systems

**Independent Living Systems (ILS)** is a leading health care delivery and care solutions organization focused on the community-based support of complex member populations in the Medicare, Medicaid and Dual-Eligible sectors.

Founded in 2001, ILS has been operational in California since 2012.

## Third Party Administration

Revenue Cycle Outsourcing

- Utilization Management
- Claims Processing
- Capitation Management

## Managed Care Plans

Medicaid

- Long Term Care
- I/DD and SMI
- HIV

Medicare

- DSNP
- ISNP/IESNP

## Value-Based Contracting

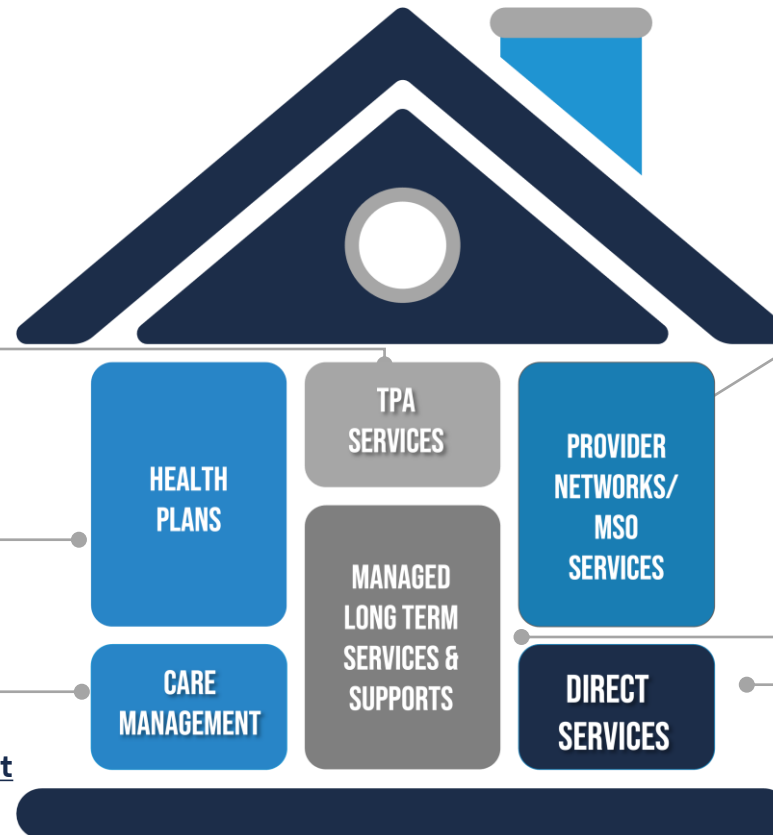
1. Builds and manages medical and social supports provider networks.
2. Provides technology and administrative support.
3. Incentivizes positive outcomes.

## NCQA Accredited Programs

1. Provides care management and home and community-based services to seniors
2. Rebalances members from institutional settings back to the home

## Services Directly to the Home

1. Home Health
2. Home Delivery Meals
3. Home Delivery DME
4. Home Delivery Pharmacy



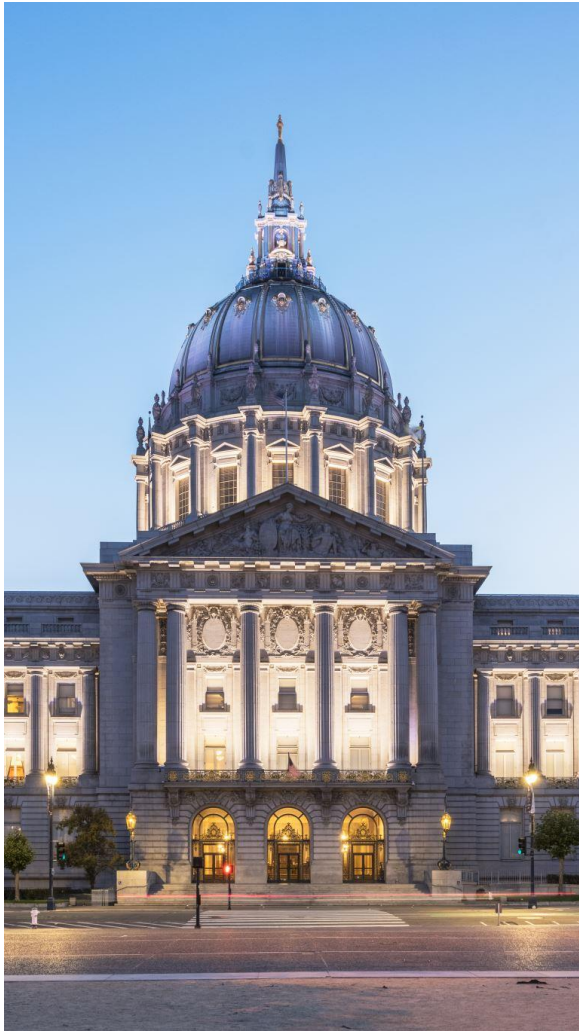
## Comprehensive Care Management

1. Health Risk Assessments
2. Care plan development
3. Ongoing management and coordination
4. Care gap Identification



# CMS and Community-Based Organizations

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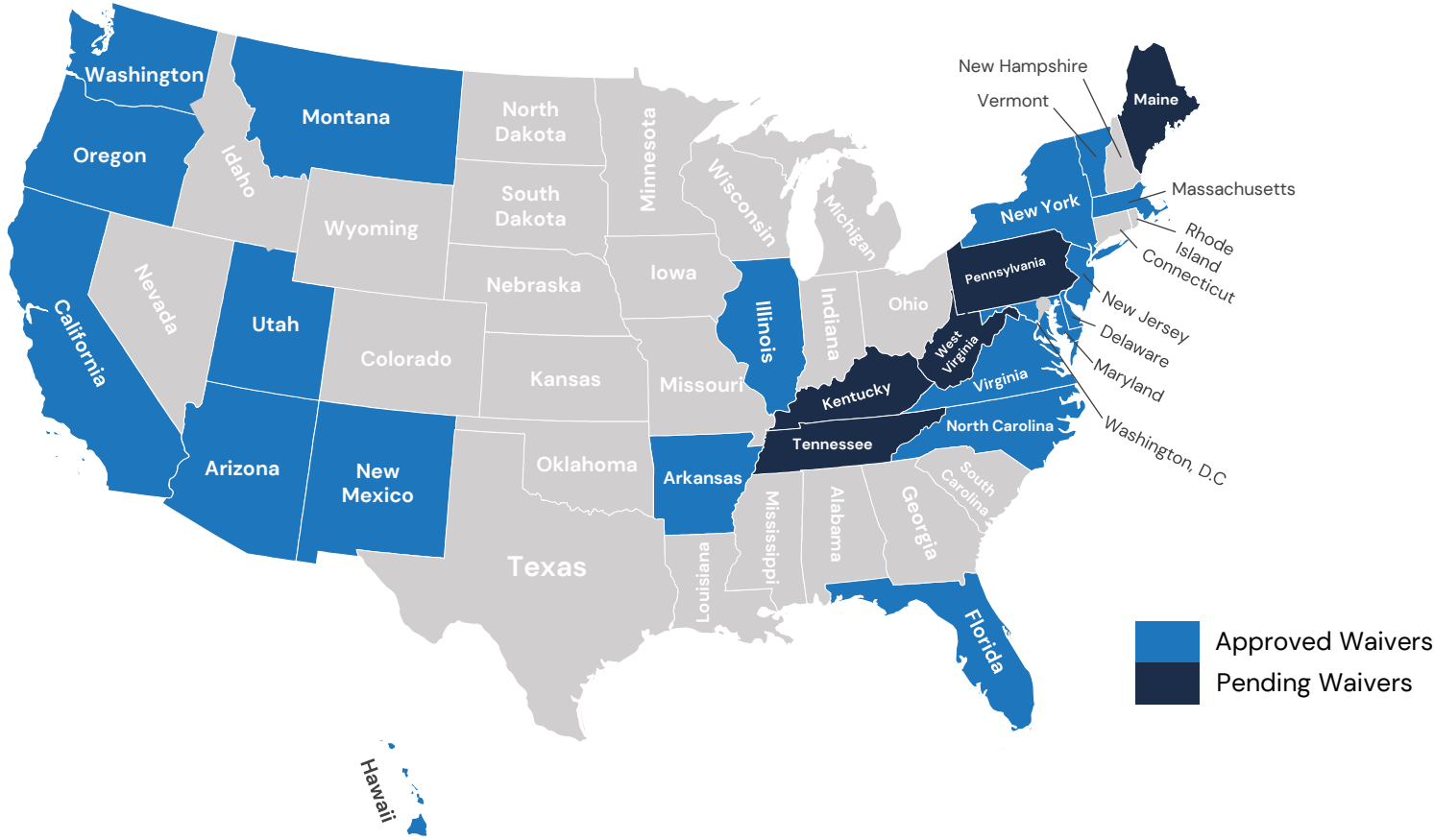


“Medicaid can be an integral part of a collaboration with community-based programs, including state and local housing agencies, social service organizations, programs funded by the Administration for Community Living, programs funded by the Administration for Children and Families, public health agencies, faith-based organizations, and other community-based entities. The effectiveness of these activities is based on collaboration across the many entities that serve low-income individuals with SDOH needs.”

**CMS State Health Official Letter addressing Social Determinants of Health (SDOH) – Jan 2021**



# CMS and CBOs: SDoH Waivers



# CalAIM in Context

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The CalAIM is just one of a few programs designed to integrate support of health-related social needs through CBO/MCP partnerships. Some other initiatives include:

## Massachusetts:

- Selected CBOs and provided them with DSRIP funds.
- Required ACOs to work with selected CBOs to provide care management and care coordination
- Proposed network sufficiency requirements for new waiver

## North Carolina

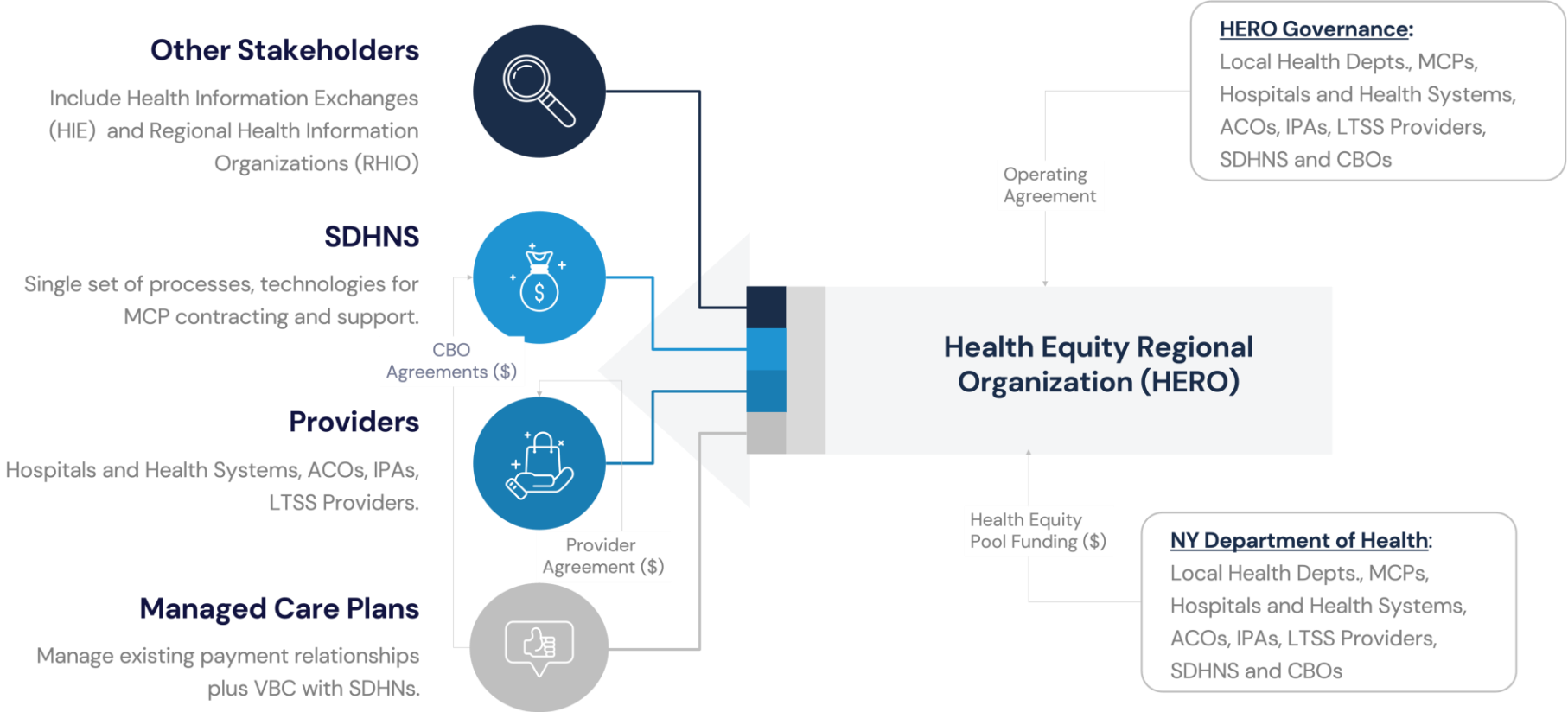
- Procured and selected three Network Leads (formerly called “lead pilot entities”).
- Required MCPs to coordinate with all relevant Network Leads for covered HRSN.
- Developed model contracts (between MCPs/network leads, and network leads./CBOs) and provided a fee schedule for the 29 interventions provided by the pilots.
- Built CBO network “Adequacy” and “Sufficiency” into program considering size and diversity of CBOs in pilots.

## New York Health Equity 1115 Waiver

- Health Equity Regional Organizations (HEROs): Formalized regional partnerships among MCPs, hospitals, CBOs organized through SDHNs and other stakeholders, to inform the continued movement to more advanced VBP models.
- Social Determinant of Health Networks (SDHNs): Coordinated networks of CBOs that address social care needs in a region, create a supportive IT and business processes infrastructure, and adopt interoperable standards for social care data exchange.

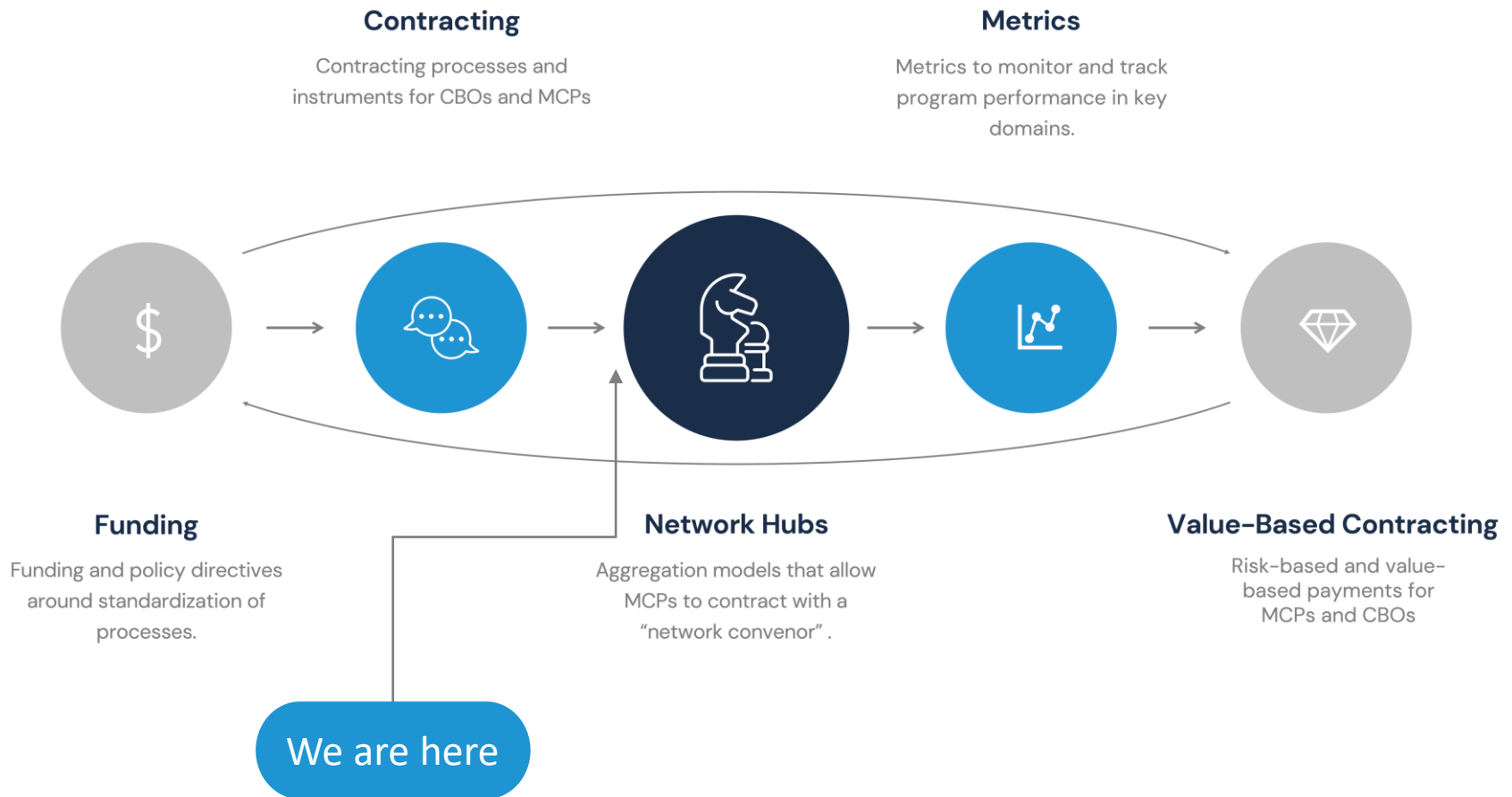


# NY Health Equity 1115 Waiver



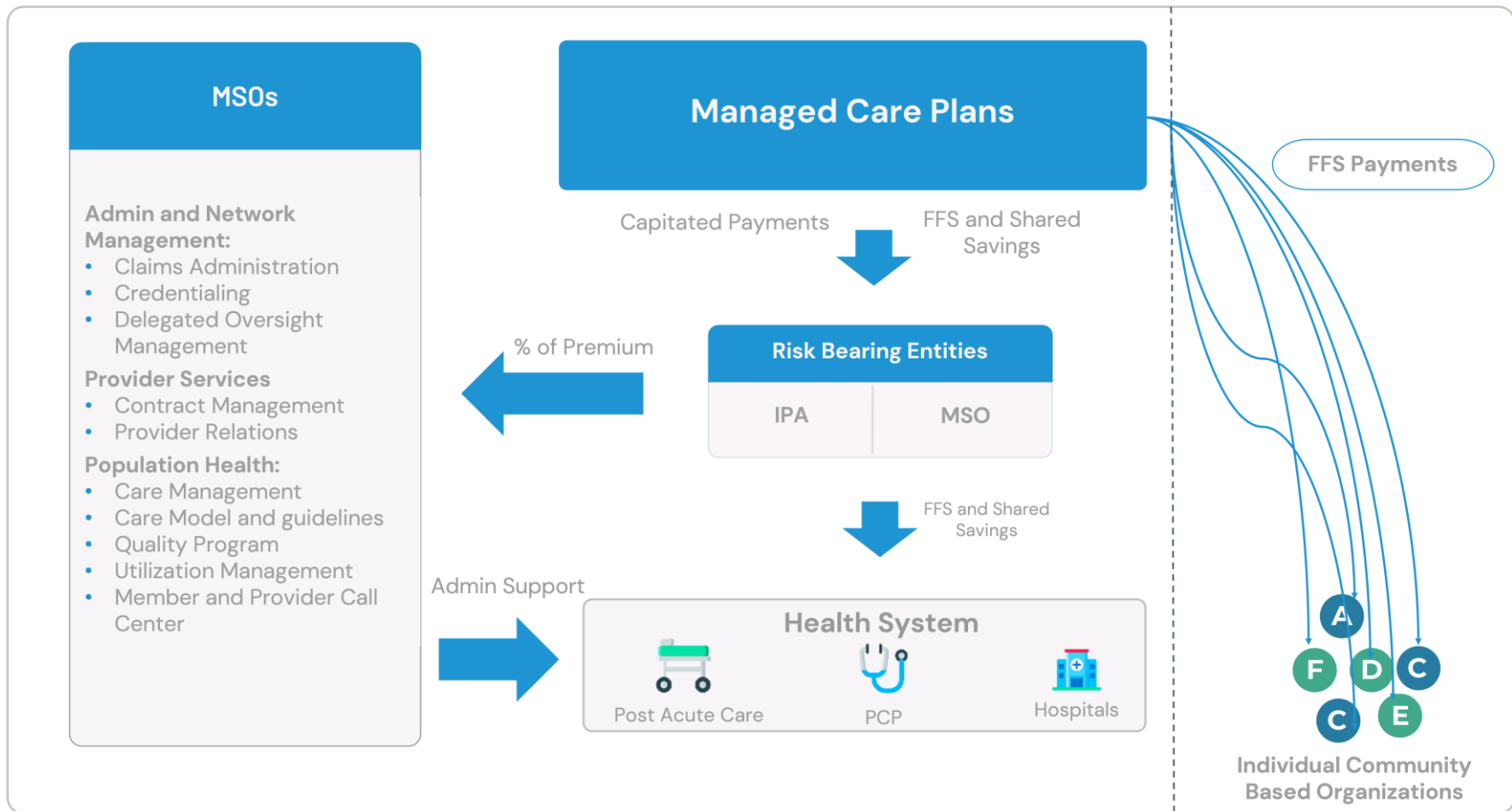
# From the Latest SDoH/CBO Models

Operating under a relatively new waiver, CalAIM has many of the building blocks in place, but other programs such as NY have taken things further:



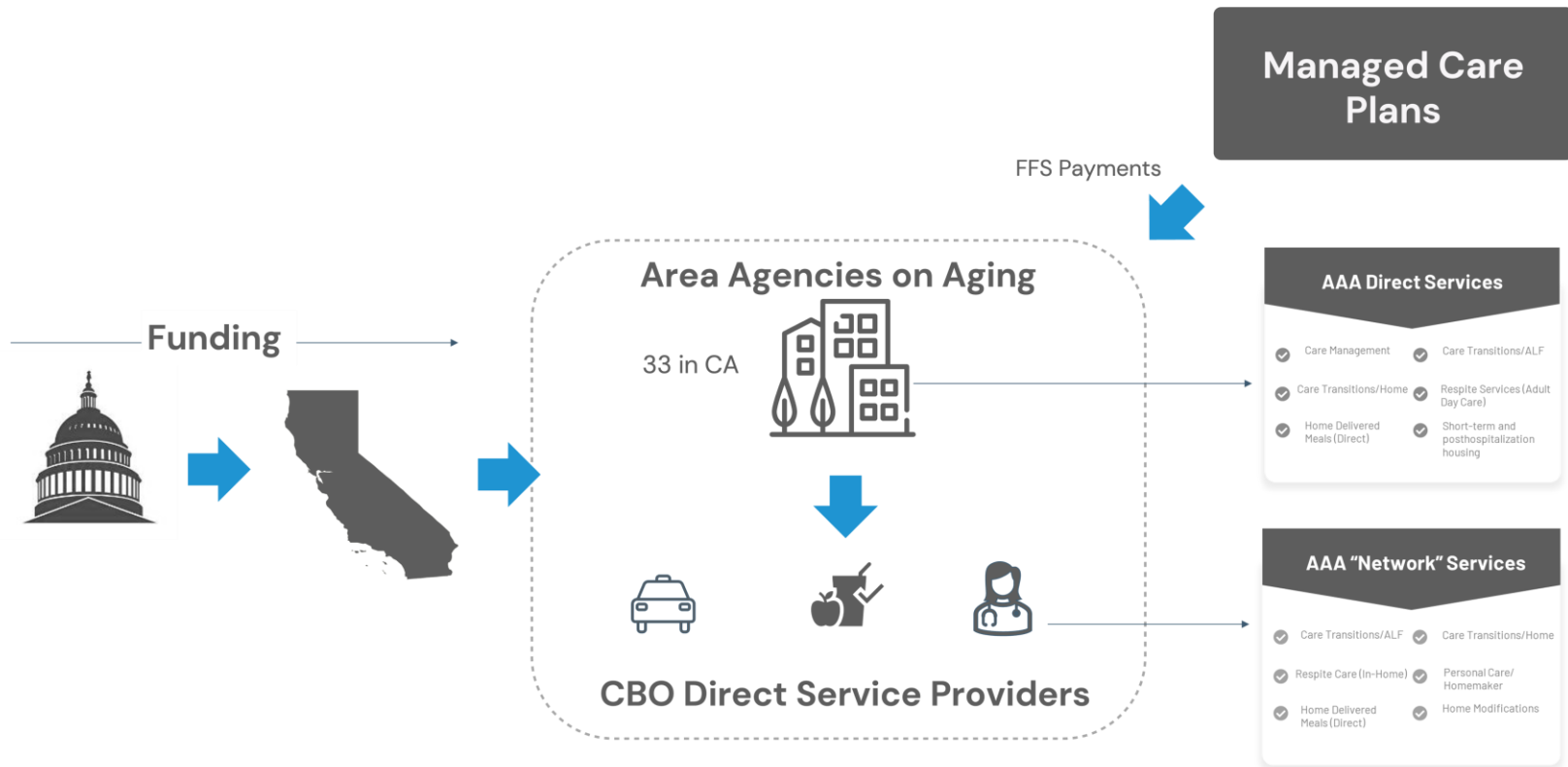
# CalAIM: Care Management Hubs

Under CalAIM MCPs are required to partner with community-based organizations to provide a wide-array of enhanced care management and non-clinical community services. But can CBOs and the MCPs now accountable for their work serving the MediCal population speak the same language?



# Care Management Hubs

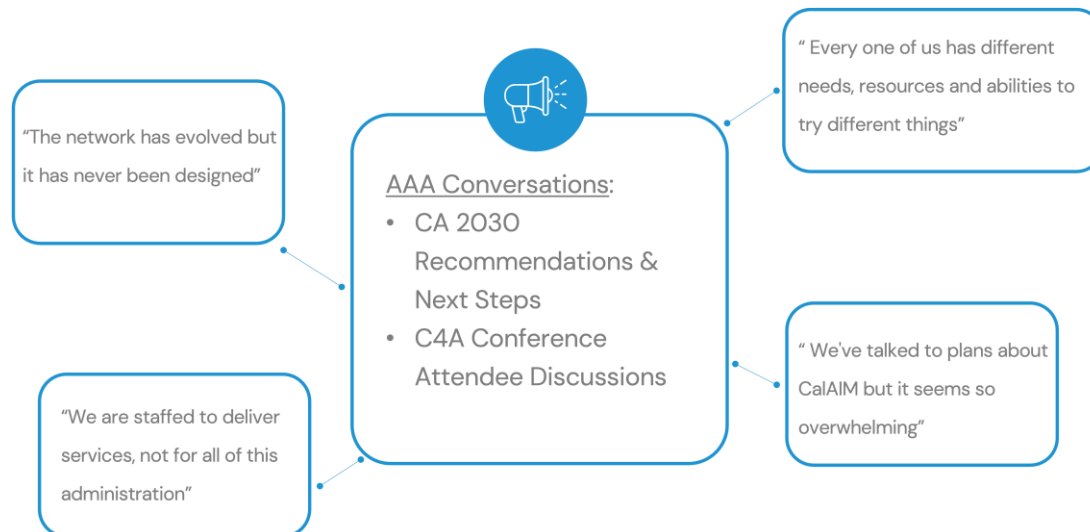
The 33 California Area Agencies on Aging have locally responsive services, practices and programs that address community-specific needs around ECM/CS for the aging population and some, not all, have contracted with MCPs as hybrid network-convenors offering both direct and sub-contracted services:



# Care Management Hubs

Not all AAAs are created equally with some structured as large City government ventures (Los Angeles) others as rural nonprofits (Lassen, Modoc, Shasta, Siskiyou, Trinity):

- Smaller organizations less able to take on financial risk, build staff skill sets and increase bandwidth.
- Many are intimidated by the prospect of administratively supporting multiple MCP contract
- AAA's in CalAIM are still navigating the data-exchange and reporting requirements required to support managed care.
- Historical payment structures that reimburse on a cost basis and do not require billing for individual services.



# From Hubs to Network Lead Entities

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A network lead entity (NLE) serves as a neutral convener, creating a network of CBOs for the purpose of contracting with MCPs and other healthcare organizations. An NLE serves as the hub for coordinating services, providing a consistent approach to delivery across a geographic area and provides technology and administrative support and oversight. Under CalAIM the NLE Model provides MCPs with a single entity that:

- Maintains a standardized contract with each MCP across multiple CBOs and geographies
- Credentials/vets each individual participating organization
- Provides a single transactional gateway for the network by:
  - Processing inbound referral for outreach, enhanced care management and community supports
  - Assigning each referral to individual organizations and reporting status and final disposition back the MCPs on consolidated Member Information Files and Return Transmission Files
  - Distributing funds to each organization upon claims/invoice submission and submitting consolidated claims in the NLE's name to MCPs
- Monitors individual provider performance



# ILS and Kaiser Permanente: Network Lead Entity

ILS has partnered with Kaiser Permanente (KP) since 2014 to provide community-based care management services. In 2024, this role was expanded with ILS engaged as one of KPs Network Lead Entities (NLE), supporting the development of a community partner network for Enhanced Care Management (ECM), Community Supports (CS), and Community Health Worker (CHW) services in 32 counties.

## Centralized Service Coordination

Centralized coordination of services through the NLEs while KP retains oversight of eligibility, member notifications, quality, and grievances.

## Comprehensive Network Coverage

Three statewide NLEs provide comprehensive coverage and enable timely access to ECM, CS, and CHW services.



Network Lead Entity

## CBO Collaboration

NLEs provide ECM, CS, CHW services in close collaboration with community-based organizations with geographic and population of focus expertise.

## CBO Support

NLEs provide a glide-path for CBOs in supporting managed care through technology, administrative and financial supports.



# Network Lead Entities in California

To date, ILS has supported the referral of nearly 30,000 MediCal members into a network of over 150 ECM and Community Supports providers

| Population  | Female        | Male          | Other     | Total         |
|---|---------------|---------------|-----------|---------------|
| Adult-Birth Equity                                  | 2,418         | 1             |           | 2,419         |
| Adult-Experiencing Homelessness                     | 1,585         | 1,582         | 2         | 3,169         |
| Adult-High Utilizer                                 | 2,262         | 1,545         | 5         | 3,812         |
| Adult-IDD   | 22            | 20            |           | 42            |
| Adult-LTC Eligible At-Risk for Institutionalization | 1,975         | 1,078         |           | 3,053         |
| Adult-NF Residents Transitioning to Community       | 48            | 61            |           | 109           |
| Adult-Other   | 5,523         | 3,620         | 1         | 9,144         |
| Adult-SMI or SUD                                    | 2,460         | 1,402         | 1         | 3,863         |
| Adult-Transitioning from Incarceration              | 3             | 9             |           | 12            |
| Child/Youth-Birth Equity                            | 65            |               |           | 65            |
| Child/Youth-Child Welfare                           | 154           | 116           | 2         | 272           |
| Child/Youth-Experiencing Homelessness               | 145           | 152           |           | 297           |
| Child/Youth-High Utilizer                           | 382           | 305           |           | 687           |
| Child/Youth-Other                                   | 349           | 378           |           | 727           |
| Child/Youth-SED or CHR or Psychosis                 | 244           | 134           |           | 378           |
| Child/Youth-SMI or SUD                              | 57            | 32            |           | 89            |
| <b>Grand Total</b>                                  | <b>17,692</b> | <b>10,435</b> | <b>11</b> | <b>28,138</b> |



# Network Lead Entity : Building the Network

Network comprised of local providers who know their patients and the communities they live in. Under CalAIM, a diverse array of care management and community supports are provided that are aligned with the strengths of local CBOs.



## Enhanced Care Management (ECM) and Community Supports

- Housing Transition Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care
- Day Habilitation Programs
- Caregiver Respite Services
- Transition/NF Diversion to ALFs
- Transition Services/NF to Home
- Personal Care and Homemaker
- Home Modifications
- Medically Tailored Meals
- Sobering Centers
- Asthma Remediation



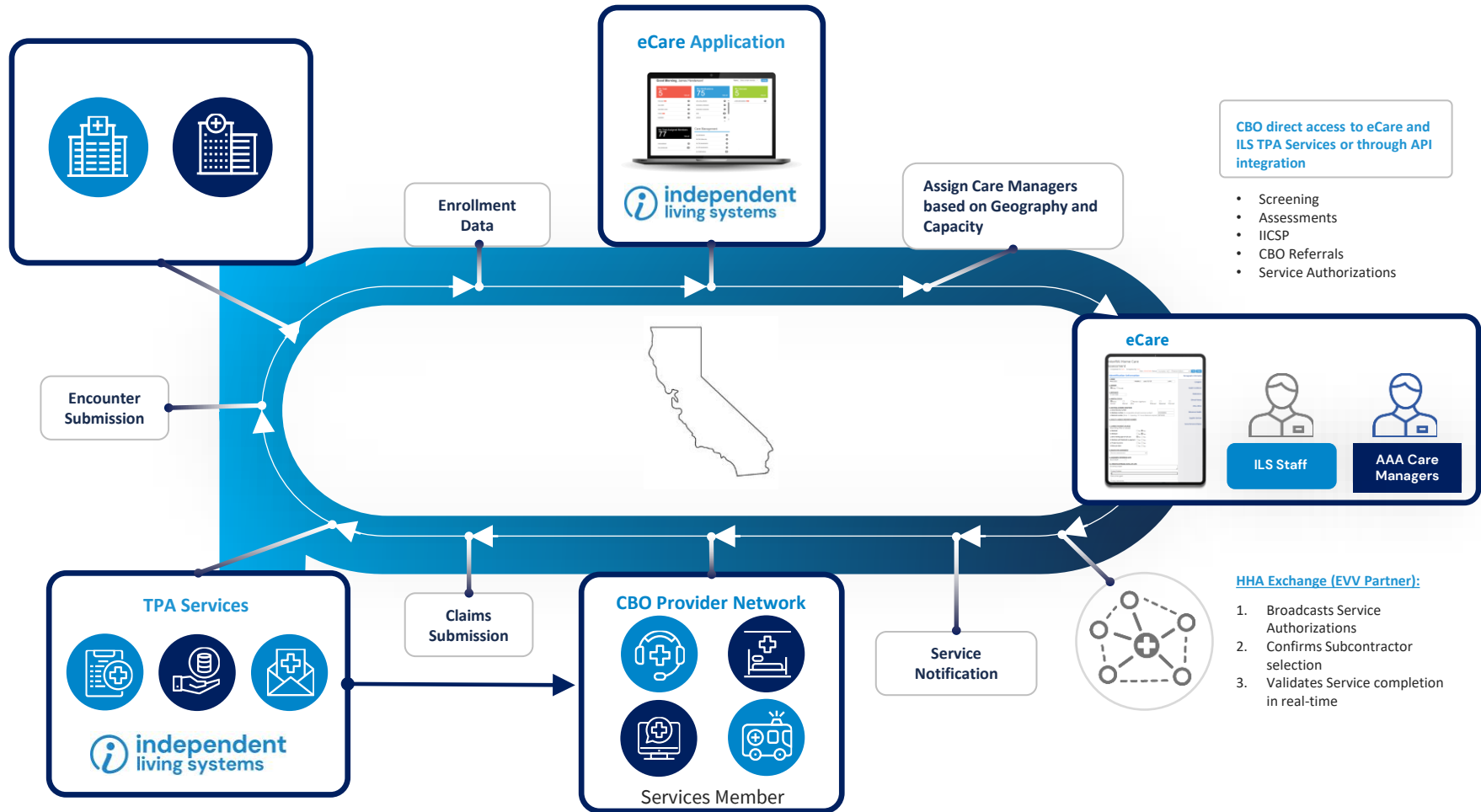
## Organizations

- Community Mental Health Service Programs
- Area Agencies on Aging
- Centers for Independent Living
- Faith based organizations
- County Department of Health and Human Services office
- Local Health Departments
- Non-profit service organizations
- Adult Protective Services
- Legal Services.



# Network Lead Entity : The Operating Model

ILS and other NLE's buffer the complexity of State Medicaid processes offering CBO partners EHR access, the ability to complete data entry in online portals or even to upload spreadsheets for billing.



# Next Steps: Quality Measures

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DHCS monitors and evaluates outcomes for MCP Members through the use of preliminary quality measures captured on the ECM and Community Supports Quarterly Implementation Monitoring Report. Data is collected on:

- Membership and Service Provision .
- Provider Capacity
- Grievances and Appeals

This data as well as overarching network compliance (timeliness of claims submission, encounter completeness etc.) can form the basis for initial evaluation of NLE performance and ultimately be used to support pay for performance contracting. However, states will eventually be required to conduct a retrospective evaluation of these “in lieu of services” that assess:

- Cost-effectiveness
- Impact each service had on utilization of state plan-covered services or settings, and
- Impact on health equity initiatives

As the program matures , these measures should be down streamed to network lead entities.



# Quality Measures Example: South Carolina

| Measure  | Description   | Impactful?                          |
|--|---|-------------------------------------|
| Effective Delivery of Services   | Measures the number of continuously enrolled eligible individuals.  | <input checked="" type="checkbox"/> |
| Increased Rates of Social Risk Factor Screening and Connection to Appropriate Services | Measures the correlation between the assessed needs of individuals and the services they were connected to based on the assessment.   | <input checked="" type="checkbox"/> |
| Improved Social Risk Factors   | Measures the quantitative increase or decrease in needs across re-assessed and continuously enrolled populations.   | <input checked="" type="checkbox"/> |
| Healthcare Utilization   | Analyses relate to improving clinical outcomes that may plausibly be affected by the social risk factors that members experience.   | <input checked="" type="checkbox"/> |
| Clinical Outcomes  | Analyses relate to improving healthcare utilization by addressing the social risk factors that Pilot members experience, across all eligibility categories.   | <input type="checkbox"/>            |
| Cost of Care   | Measures how healthcare costs changed with program participation, among all participants and across different populations of focus. Costs considered included both medical care costs and costs recorded in invoices for program services | <input checked="" type="checkbox"/> |

# Next Steps: Payments

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# FCC Membership Projections

The use of CBO networks coordinated by a network lead entity can streamline contracts for MCPs across myriad CBOs, as well as offer technical and translational support to CBOs as they enter the health care space.

