Paying For Health-Related Social Needs: Emerging Models Of Funding Every Executive Should Know About

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Speaker 1 0:00

Like I said, this topic of managing performance, both from a clinical and an organizational perspective, has really been, I think, increasingly important and for everyone who's thinking about, what does this have to do with the very interesting times we live in, I will say, in the health and human service field, this whole issue of performance and driving value is going to become more important as we're sort of navigating the change ahead. We had a great turnout. We have, I'm just checking the registration numbers. We have over 600 registrants from 42 states. So you've got lots of opportunity, I think, to share ideas and see what's working. What's working with many different types of organizations in many different places, before we get started, because I don't want to take time from our great keynote panel, which I'm excited to hear from. There are just a couple call outs I want to make for today. Don't forget that starting right after this session, we have our annual whole person care summit, sponsored by alira, starts at 945, in Island two. We have an entire day planned of really looking at the evolution of Whole Person Care value based contracting some of the I would say, new models for financing and delivering service after after lunch, we have a post lunch pick me up. And that's actually by Monica's request, because caffeine and chocolate are two of my basic food groups. So we actually have an ice cream bar, an ice cream bar that will will be holding right after lunch to perk everyone up for the rest of the day, sponsored by our friends at pups software. And I want you to know that we'll be having an executive networking reception tonight, sponsored by alira at 530 in the exhibit hall. So we should have a, I say, a full contingent of everyone coming in first thing tomorrow morning, just calling your attention to we have a great keynote by trace Dr Tracy green. She's the VP of Clinical innovation and product development at care source. They're doing some really innovative things in the Medicaid and long term care management space, so I'm looking forward to hearing from her for we also have tomorrow our annual CFO Summit. I like to point out that our CFO Consortium, which is this year we're doing in collaboration with Continuum cloud, is really designed for any C suite folks who has an interest in kind of better financial management. So even if you're not a CFO, feel free to attend it's we've got a power pack session on a whole range of financial management issues, and did I miss anything else? Oh, yes. And importantly, tomorrow, after lunch, we're shifting gears from ice cream to popcorn. So we'll have a popcorn bar sponsored by fast psych, and I'll be doing a closing, actually, of the of the Performance Management Institute tomorrow at 330 really going to focus

on what I see are the three big moving parts in strategy right now, the new administration, the changes in technology, and a lot of, I would say, stress in the provider delivery system, talking both about the Market Update and a framework for how do you navigate in some uncertain times? So that that will wrap up our day. We have 45 fabulous sessions, and I hope you will join me at most of them. Now, I'm really pleased to introduce our panel we've got, and I will just point them out, and then I will be doing some bigger introductions. Yvonne Copeland, on the far far your right, my far left. She's North Carolina's Director of the Division of Child and Family Well Being. Next to her, my friend Cindy Aler, she is the Chief Operating Officer of Trillium Health Resources. For those of you not familiar with them, Cindy's group is managing one of the Medicaid tailored plans in North Carolina, and next to her back by popular demand, because Stephanie Franklin with Humana, who was our keynote two years ago at the Tech Institute in Las Vegas, but really is bringing the Humana perspective on Social Determinants of Health in the Medicare population, we really wanted to open the meeting focusing on the whole health related social needs piece, because there has been fairly significant change, I think, both in the Medicare and Medicaid programs, and I would add even in commercial populations, with payers recognizing the impact of social needs on health care spending. I mean, really, it comes back to why is cms interested in this? Why are employers interested in this? Well, they're interested in it because people who are housing insecure, people who need food assistance, people with legal problems, depends on your perspective, all have high. Healthcare costs. So we have spent, I think probably a decade now in the field, kind of trying to figure out, what's the model that works? What's the ROI? How do you measure success? That's really going to be the focus of the panel discussion today. And I did promise them I wouldn't slip any surprise questions, but I lied. So we're going to start with Cindy. As I mentioned, Cindy is the Chief Operating Officer of Trillium. They're a tailored plan in North Carolina. And for those of you not from North Carolina, this is a vertical Special Needs plan, Medicaid coverage, and it is for people with serious behavioral disorders. And IDD covers both the behavioral and the physical health side of things. And Cindy, why don't you tell us a little bit about Trillium and most importantly, what do you consider your most innovative SDOH programs? Thank

Speaker 2 5:56

you, Monica, can everybody hear me? Okay, all right, so Trillium covers 46 counties. So about half the state of North Carolina, and as Monica mentioned, our population is folks with severe mental health issues, addiction and intellectual or developmental disabilities. The other unique thing about our 46 counties is that they're all pretty rural. In fact, all but two of them are extremely rural, and so getting services out into that area has been a long term issue for Trillium over over the years that we've been in Medicaid. We were first in 1915 B, and just this past July, became this tailored plan that does physical health and behavioral health, what I would say is we have lots of things that we do that are innovative, because otherwise we wouldn't get services to people. So we have to, we have to be innovative. One of the things I'll just highlight, there are many, and I'll talk about most of them throughout the day. We did a program a few years ago called The healing place of New Hanover County, and my associate Senior Vice President, Christie Edwards, will be talking about this in a session later today, but it really focused on getting people who were disenfranchised from treatment, unhoused, into a living arrangement on this campus, this healing place, Campus that also provided them an opportunity to get into recovery from substance abuse. This particular program offers housing so stable place to live as long as you're working on your recovery. It is an abstinence model, although people do receive outpatient treatment. Mat externally to this and and it also provides food and a structure and community. And community is one of the biggest parts of what makes this model very successful, and helping people find their path to recovery

is because there it's a peer run center. So every everyone, there is someone that's walking that journey, and it has had incredible success. Having people get housed and go through the program, graduate move into sober living, and get a job and get back on their feet. It has extremely good outcomes, and so it addresses a lot of social determinants. The thing about that, even though we're a Medicaid plan, this is not a Medicaid funded in any way resource. We're funding it by braiding the ABC bottle tax, which is a bottle tax on liquor in our state, and that fully funds the program, in addition to some county dollars, some of our counties, who didn't want this population going into their jails, fund beds at the setting for people to get into recovery.

Speaker 1 8:43

Great. Well, that's a great example of kind of a population that falls, often falls through the cracks and is high cost, absolutely, in terms of managing medical needs. Yvonne, I'm going to turn to you. Yvonne Copeland is actually the first director for the newly established North Carolina Division of Child and Family Well Being, which brings together health, behavioral health, early childhood development and nutrition and social programs for children and families using a whole person care approach. So a pretty innovative concept from a state perspective. Maybe you could talk a little bit about your work at the Department, and what do you think is an innovative example of an innovative program that addresses social needs that your department is sponsoring.

Speaker 3 9:25

Sure. Thank you. And good morning. So great to be here in Clearwater. So the division itself is innovative, again, bringing together programs that were previously siloed. Nutrition being typically in social services, health services, typically being in public health, behavioral health, typically in mental health and then early childhood. Who knows where they were. So actually, Secretary at the time, Secretary Mandy Cohen, during COVID, was. Trying to mobilize children, you know, to obviously deal with the pandemic and mobilization. And she could not find them. They were embedded or buried in various divisions across the state. So during COVID, she organized a restructure, a reorg, and that was the division to bring together all of these programs so that we could de silo the department, de silo the programs, the funding, the data, the staff and everything, so that we can have a coordinated approach to serving kids. I would say that we're so in terms of innovation, the design itself, and one of the projects that we're working on is knowing that nutrition is fundamental to health. It's foundational for health. So instead of looking for something new, we're making sure that we're leveraging what we have. We're leaving food on the table. No. Pun. Well, pun intended. Pun intended. So there are many people, and we're looking at three data sets, WIC, which is within our portfolio, FNS, snap, which is in our portfolio, and Medicaid, three big data sets. All of those individuals, populations within those data sets should be eligible for every program. So we're looking at individuals in FNS, that are in WIC, that are eligible but yet not enrolled in FNS, individuals in Medicaid that are eligible but yet not enrolled in FNS. Snap, and then we're targeting those that population, we found that we could double the size of the WIC program, and we did some outreach, text messaging to reach out to those folks, and we were able to increase participation in WIC. The huge, huge opportunity is in the Medicaid space. If we can outreach to all of the individuals in Medicaid, over 3 million in North Carolina, only 1.6 individuals enrolled in FNS snap. So we see there's a big opportunity there, most likely. So we're looking at that increasing food security for those individuals

will obviously increase health outcomes on the Medicaid side. And we'll talk a little bit about that later. Oh, great. Well, thanks. With the data exercise, yep,

Speaker 1 12:25

yes, now we're going to turn to Stephanie and turn a bit to the Medicare population. As I mentioned, Stephanie was our keynoter two years ago and really spoke to the Humana Medicare Advantage initiatives to address health related social needs, I'd like you to maybe give an, you know, an update on, you know, kind of humans Medicare footprint, what they're doing with social needs, and maybe highlight one of the initiatives.

Speaker 4 12:49

Sure, thank you. Thank you for having me. I'm happy to be back. So for those who are not familiar with Humana, we are a national both health insurance provider as well as a health services provider. We have about 16 point 4 million medical lives that we cover across all 50 states, DC and Puerto Rico. We're headquartered in Louisville, which Kentucky, where I'm from, but but we do have a very, very broad reach that includes over 6 million Medicare Advantage members. And I a Medicaid portfolio that's growing. We have almost one in one and a half million Medicaid members across 11 states, currently expanding to 13 this year, so that that part is growing. On the health services side, you may have heard of center Well, that is our we have centerwell primary care, with currently upwards of 300 and growing senior focused primary care clinics, as well as home health and the center well pharmacy, which is a mail order pharmacy. So quite a different scope. And my team, the health, health, equity and social impact team, is situated in corporate so we work really across all of those products for the most part. And there's been a lot of evolution in both the things that Medicare Advantage is allowed to do, but also a lot in the evolution in the payment structure and some of those head winds to the business that have really had a lot of fluctuation in how we've addressed it addressed social needs over the last few years. So most people are going to think it's weird for me to say that value based care, in and of itself, is an SDOH initiative, but we really believe that value based care where we're playing for we're paying for outcomes where have aligned incentives and aligned goals around health. Health are really, is really the best, most innovative way for us to get to address those whole person needs at the level of the individual patient. I invite you to check out humans, 11th annual value based care report that came out last week. We currently have about 70% of our Medicare Advantage members attributed to a value based primary care provider. In Medicaid, it's even higher. I think it varies by state, but in in Florida, for example, it's about 90% which is pretty similar to the other states as well, and it's not just aspirational that I say that it addresses. It improves the value based care, improves access for even the most underserved populations we've had. We've done studies that found that while there, I'm going to get look, because I don't want to get the stats wrong, but that patients in our primary care senior focused primary care providers had 17% more primary care visits, low income beneficiary, low income patient, patients had 21% more than regular MA And our black members had 39% more PCP visits than other ma members. So we do think that particularly the way we're implementing this and expanding the reach of those senior focused primary care or meeting the needs of our most disadvantaged members. I'm going to put it. You'll hear me talk about data a lot too in data and technology and how important that is a big, major way that we actually enable value based care is through the exchange and flow of data, including social needs data. So if you were here two years ago, or in Vegas two years ago, you heard me talk a lot about humans, SDOH data infrastructure in the

way we collect and govern and make that data interoperable within our systems for population health analytics, et cetera, a big part of piece of this strategy is also sharing that back out with the primary care providers and the Care team to make sure that they have a whole person view of their patients, their patient panel, both at the point of care in their quality dashboards, so that they can be sure they're addressing all those needs. Too good.

Speaker 1 17:35

Well, thanks. Well, I do want to come to both the two, I think, important questions that I always ask when I look at this kind of move towards social determinants of health, and I'm going to start with the first one. So how do each of you decide what social need to address? You know, there's a lot of options, you know, housing programs and gym memberships and food assistance and heat assistance, and, you know, the laundry list of kind of social, SDOH, types of programs is long, so for each of you, and maybe we'll do it in reverse order. Stephanie, start with you. How do you decide this is an initiative we should do? Yeah,

Speaker 4 18:11

so we always start with the health outcome that in mind. What? What health outcome, total cost of care or primary care visits, what have some sort of stars, quality measure. Start with that measure in mind. Use the data, the vast amounts of data that we have to understand. Who's the population that is having the not meeting the goals for that measure, and then kind of work backwards. Why are they not achieving that? What's the root cause? Are there social need barriers to access? Are there social risk factors that are interfering with managing their chronic condition? From there, we frequently look at, go to the literature, what we know in the evidence base, but also, what do we have within our portfolio to help address those, those needs? And you know, what's important now, because we've had some time to test these solutions, is we have to really believe that the return on value, and not just ROI, but the return on value of whatever that is is going to outweigh the cost. Some of these get very expensive. And we are. We are 100% government business, so we can't we're we have to spend tax dollars wisely, essentially, and so, you know, we have to have some sort of reasonable expectation around that. We also have an implementation question. We're at your I'm having on my ma hat right now. So we're your Medicare Advantage plan. You may not want us to do the thing for you. We may not be allowed to by the federal government or by the states. So we have to think about, how is it that. We would actually implement this, that is, can get very complex. And, you know, do we have to? That's one reason that this, the put, trying to put the the the resources and the incentives and the data closest to the members is where we put that emphasis. We always test it. And so there's, it can take a long time, essentially, to get to the point where we're ready to, you know, scale and keep something paid. Yeah, I think that's, you know, it can. It's a long it's a long process. Now the burden is pretty high, I would say, for the Medicare Advantage space, but a big I will put out the one caveat that there are some things that we tested along the way that our members loved, and so in the voice of the consumer, that what what our members are telling us both improves their quality of life and also keeps them coming back to the plan is a really important so what

Speaker 1 21:07

are those? What if I can interdict what things do members love in kind of some of your ancillary programming

Speaker 4 21:16

the so we have a benefit called the healthy options allowance. It's on our it's, it's, it's on almost, pretty much all of our dual eligible Special Needs Plans, some other select plans as well. And it is, it's a stipend. It's a monthly stipend to it started off paying for food, and we've expanded it to pay for other other basic needs. But one of the ways that we've been able to innovate with that is expanding the portfolio, the items, the menu of items that you can pay for, but also thinking about, how do we expand access to more retailers, more diverse set of retailers, making it really easy to use. Thanks.

Speaker 1 22:00

And Cindy, I'll turn to you kind of how do you decide to Trillium, which innovative program I know you and know you have 500 innovative programs in your head. Which one do you do next? Yes,

Speaker 2 22:13

that's a great question. So not unlike Stephanie, we use data through population health assessment to give us a heartbeat on what is going on in in our area about a decade ago. So I'm, I'm in a local government plan, whereas we're small by comparison to plans like humana. We're only in North Carolina. We're not nationwide or anything like that. And I've had, I've had the opportunity to serve in this job for 30 years about and so over that time, you really learn a lot about the communities that you're serving versus maybe when you're moving around a lot in different jobs. I have had the same job for a very long time, and so I know a lot of the stakeholders and but truly I'm like, like all plans, does Population Health Assessment gaps in care, surveys like that, and so I'm going to highlight one of them. Back in a decade ago or so, we were looking at the number of children that were going into higher levels of care, prtf group homes, those types of settings that are really cost so high cost of care for those members also not a great it's not great to have to leave your family and move into those types of settings for some children, that's traumatizing. And so we looked at the data and and decided that what we really needed to do was this root cause analysis, like, when does this start and why for children? And so we went all the way back to birth to five was really the window. And as Yvonne talked about earlier, where was early intervention in the mix? Well, it was nowhere. When it came to children with emerging mental health or intellectual or developmental disabilities. It was nowhere like there was nothing really going on for that population other than the Part C of idea, which was inadequate at best in our state. And so, because we were a health health plan, then a 1915 beef see behavioral health carve out, we decided that we would tackle that issue and leverage EPSDT to bring in an evidence based practice called child first. And why that's important and tied to social determinants is it is a model that goes to the families, so it completely mitigated the transportation barriers our new moms had in getting the treatment that they needed. It also treats the Dyads. It treats mom as that caregiver and the child in that zero to five range. And so that model implemented about a decade ago has now demonstrated the children that started in that model haven't gone on to have out of home place. Maintenance, right? So it's preventative care, it mitigated some of the problems people had in accessing care. So increasing access, we've maintained model fidelity with the provider partners that deliver that care throughout throughout and we are now expanding that ourselves into some new territory we just acquired in our state. But the other thing that is great, and probably for me, the Hallmark, is other plans this, this recent cycle of funding, have adopted that to expand it so it's

almost statewide. And so for me, that has been just an amazing opportunity and and changing the lives of children and families in a generational way.

Speaker 1 25:42

Thanks. That's an impressive story in terms of the analysis that led to that. And how long have you been doing that plan? Did you say

Speaker 2 25:50

the child first program has been in place since been about decades a decade 14, all

Speaker 1 25:58

right? And Yvonne, how about you? How do you decide? You know, in this kind of new role in the state, you know what social determinants to tackle and what programs to do?

Speaker 3 26:08

Well, in North Carolina, we operate an 1115, Medicaid demonstration waiver for social determinants of health. We've been doing so since 2018 and we went through an extensive process. Essentially, we went to the community and we went to the research and the data. We did it all. I want to share a little bit about the waiver. Again, we serve 33 counties. We cover 33 counties with the waiver, all rural as sending Cindy mentioned in three regions. The waiver was approved in 2020 18. At that point, we started to figure out, what are we going to what are we going to provide, what are we going to do? Did a an extensive market analysis to find out where the research was being done on needs, on social determinants of health, and there was very little to be found. So we contracted with the Commonwealth Foundation, went ahead, did more research, got all of the information and data we could find, and realized that that really wasn't enough to tell what was. To get a sense of the pulse in North Carolina, we released an RFI received tons of information, huge response. Still couldn't figure out what the need was, and more importantly, also couldn't figure out what the potential capacity was. So we started to hit the streets. We went to every community. We worked with the community help. Two years of stakeholder meetings, community meetings, what do you need? And more importantly, what do you provide? Community based organization, what do you do? And that was probably the biggest challenge to get a food pantry to quantify, to define what they provide, you know, what they what value they bring to the community, and to price it. Because in addition to term determining need, we had to determine capacity, what resources are here. So we did all of that at the same time, developed a hot, hot spot map, if you will, based on the need. And then we were able to define where, decide where we're going to place, the waivers, if you will. And we landed on four domains, food, housing, transportation and interpersonal violence. Interpersonal violence includes things like toxic stress as well. We provided, we developed 28 services within those four domains, and there's a fee schedule listed on the healthy opportunities pilot website, so you can go there and look at what services we've reimbursed for, and the amounts. That will give you a good idea about the what we are valuing. I will say that is the process. I think it's been challenging. We also received an so we launched, actually launched the pilots in 2022 and I'll share a little bit about some of those outcomes a little bit later, but that's what we decided we had to find out, not just the need, but the capacity, because

so often we identify need and have no resources to address them, and we knew we had to go to the community for that well. And

Speaker 1 29:21

I do think, for folks who aren't aware of it, North Carolina is one of the few states that actually has a fee schedule for social services along with a fee schedule for health care services. So it is a more structured, I think, more structured approach to doing the social service interventions. But I want to Yvonne, I want to continue, because my was going to turn to talking about ROI, and as long as you're talking about the program, you know, kind of with that waiver and these, you know, you've been running this since 2022 do you know, how are you going to measure ROI, for the waiver and for actually providing paid social services? Great.

Speaker 3 29:59

Question. So again, only two years under our belt, we have a CMS approved process for measurement and evaluation that basically includes rapid cycle assessments that we do on an ongoing basis to assess. You know, where do we need to improve? Also includes periodic evaluations, or what we call interim evaluations. We just concluded 118 months into the program, we were able to determine that we were able to reduce health care expenditures by $85 per hop, healthy opportunities, pilot enrollee per month in 18 months in 33 counties. In addition, we were able to reduce hospitalizations and reduce ED visits. Also, we were able to reduce hunger, food insecurity, some of the housing service needs as well as transportation. So our early evaluation is quite positive. However, there are some challenges. So I don't want to make it sound like it's that rosy, because, and I'll just be honest in full disclosure, every community is different, and you know, the amount of resources available, available and capacity, it has taken us time to build that up. And our model is quite unique, and we'll hear a little bit more about that later. And I think it is the model that, the structure, the infrastructure, that is required to do this, you know. So we're seeing good ROI right now, and that's what's backing out the cost of the services. Okay,

Speaker 1 31:46

okay, I was going to ask if that was net of the service class. So that is impressive. Cindy, how about you? What you know? How do you measure ROI for innovative, initial social determinants initiatives and decide what to expand and what to discontinue.

Speaker 2 32:01

So it's interesting. We have 17 of the 33 counties Yvonne is talking about through healthy opportunities. So I didn't decide to talk about that because I knew she was going to. But we're definitely a party to that, I think, for us as a tailored plan. We're only seven months old. We really haven't had a lot of opportunity to evaluate ROI on any of the things that we're doing, because we're just too new at it in in terms of where I think we are just, you know, we're we look at key performance indicators, and right now, a lot of those are based on buying equity and paying for access for people. One, one example that is is related to the healthy opportunities pilot is this past year we bought a box truck for the food boxes to be delivered, right? And so what the what we're looking at there is the same ROI that Yvonne is talking about, relative

to the people getting food and having good nutrition, but, but in terms of our investment right now, it's largely into infrastructure, building things, so there's not really been a chance to evaluate. What we're trying to do is build the things that are needed first and and our evaluation is, did we get them built? Are they in place? And then we will get moved forward with some key performance indicators. Okay, so we're just really new in that, in that space, and the projects we were doing prior to the 1115 waiver that we're on as a tailored plan now are so different, dramatically different, that we're not doing those projects anymore.

Speaker 1 33:37

Okay? So they've changed. Actually, the menu of what you're doing has changed as part of it, because

Speaker 2 33:41

it incorporates now an integrated care approach. It resets everything which was just wonderful.

Speaker 1 33:51

Well, Stephanie, you've had a long kind of history of doing data, social determinants, support programs for people in Medicare, maybe you can talk about your internal review process. What does ROI look like? How does Humana decide which programs to expand or contract? You know? What does that look like? And what do you

Speaker 4 34:09

measure? Yeah, so I, you know, I touched on some of these factors when we were deciding what to pay for on the front end, have to have a health outcome or metric in mind. We along the way, we will measure, we will always measure patient or member engagement and satisfaction. So not just will they engage the first time. Will they stay engaged if necessary. We always collect data, like net promoter score. We monitor complaints, because there are often unintended consequences when something is well, good example this, I don't think this is just Humana, but one of the primary, one of the top drivers of complaints about Medicare Advantage plans to CMS is the transportation benefit, the non emergent transportation. Benefit, because we all have to contract, and it's very hard to ensure that that driver that day shows up with what the human in the Humana way. So, you know, things like that, of course, we have to, you know, does is the intervention accomplishing the desired outcome. But I want to kind of hone in on a couple things. Is one is that engagement piece, the box truck, is so such a good example, because I remember quite acutely an early food insecurity initiative that we had from from Humana, and we are partnering. It was actually in Florida, and we sponsored a, like a, I think it was, I think it was, I can't remember if it was meals or grocery, like a mobile grocery, but no one came. And we advertised it. We called people, and no one came. And then someone asked, Well, where was it like? How did we get there? And we were like, Oh, the people that we need to get the food also don't have transportation to get the food. And it was such a basic aha moment. But then we were like, Okay, well, we can't just address one need at a time. We need to look at what are the holistic needs of that patient to really make sure, or that member to make sure that we are they are not only getting the food, which is what we want them to get for the health outcome, but we're addressing transportation, the child care, what have you to get them there to begin with. The other thing that I will call out for Humana, and I'm sure large plans too is many a

good idea, and successful pilot test have gotten squashed because it was too administratively complicated. We are a national plan. I can't We can't run from Louisville one tiny like community based initiative that only works in this one community. There's no one in Louisville to there's no one in corporate to do that. There aren't enough of us. So we really do have to think about what scalable or who can we contract with and and it can be a great idea, but if we have to create a brand new team to sustain it, then it's likely not going to be something that we're able to maintain well

Speaker 1 37:35

on your if I can ask, you know, I know Humana does a large number of SDOH kind of support programs. What's tops on your list? Which programs do you think you have consistently had the best ROI? That was a surprise question.

Speaker 4 37:51

That was a surprise question. I mean, I'm going to say a cop out one, which is the value based care. I think that we've had the best, the best ROI of really trying to empower primary care providers to be the quarterback of their patients care, and empowering them with the data and the flexibility that they need to do that now we are partners in that. We have provider engagement executives, we have lots of data. We provide resources and technical assistance to help move on that path that includes things like, you know, we have a Humana community navigator powered by find help. It's Our Community Resource referral platform, things like that. We can be that partner. But I think that has been the most clear, successful way that we've been able to address holistic needs, but really trying to we've had a we've made a lot of progress in just every trying doing our best, particularly for the most, particularly for the associates who are engaging with the most at risk populations just having the resources at their fingertips. We can't fully promise a No Wrong Door, but we we do our best to have everyone who's on customer service answering the call, who's care manager, etc, having resource knowing what benefits are available, knowing what community resources are available, knowing what to listen for for social needs.

Speaker 1 39:22

Thanks. Well, I want to shift the discussion a little bit to the providers and partners who work with you to do these things. And I have actually a specific question for Yvonne. So you know, im impressed with the North Carolina kind of fee schedule approach to paying for social determinants. But tell me a little bit. I have to believe that that was a pretty difficult transition for community based organizations to go from you have a block of money to now you need to bill for every incident when you provide something. Can you talk a little bit about that transition, and who stayed in and who fell out? And. Kind of any and any advice for people looking at doing the same thing.

Speaker 3 40:04

Okay, oh my gosh. And Cindy, you may be able to share some some examples as well for the area that you cover, but that's the biggest lift. That's that's the biggest change, you know, it's basically taking organizations that are providing valuable services that don't even know how much it costs to run their operation. They don't know they don't think in terms of units of measure of costing hours time. So it really

is a shift, and that's why I'm going to have to share a little bit. We don't, we didn't rely solely on them for that. We had to support them. We had to provide that technical assistance to them. We, of course, had to, you know, glean the information from them, but you know, to do the rate setting and the cost analysis. So that had to be done for them, I'll be honest. Because we need them. We need them to do what they know how to do, which is run their operation from a service delivery perspective. And we brought a lot of technical assistance to the table. And the framework, the model, actually has somewhat of an administrative component to it. So they don't have to worry about billing, they don't have to worry about, you know, that now they have to report, you have to invoice, you know? But you're not actually following that process through. So there's a lot of infrastructure that is required to do this. If you think you just saying, if you think you can do this alone, it doesn't happen. You can't it's a community. It's a system that has to work together. So we have developed a system. The payment mechanism is the 1115, and by the way, I want to say that we had a state appropriation of $640 million for our healthy opportunities pilot, that accounts for about a third of what it costs to operate it, you know. So it's a massive undertaking, and that's at 30 at 33% if you will, of the 100 counties and we are going to expand statewide. So I want to say that it takes a lot of support, a lot of technical assistance, to organizations that just want to do good for the community. But in time, they will develop into they'll develop the business acumen, and they will also have the value for their services. I don't know, Cindy, I hate to jump, but no,

Speaker 1 42:48

please. It's it, like I said, I think it's a huge topic, because as we're trying to translate healthcare services in a fee for service model to social services in a fee for service model, it's the big question.

Speaker 3 43:00

And can I also add one more thing, please? Not only so not only is the issue about the business acumen that they that they need to have, but we want to be careful about

Unknown Speaker 43:15

possibly medicalizing

Speaker 3 43:18

these social services. That is the risk that we run. We're turning them into units, a 15, you know, 15 minute unit for some if you look at the fee schedule, and we have to be careful not to overlay that medical cost model on top of it, because that doesn't work either, right? That doesn't, it doesn't work either. So I just it's a balance. It's a delicate balance, and we're figuring it out, which is why the evaluation and the measurement is important all along, and we are. We have to shift. We are pivoting quarterly, quite frankly.

Speaker 1 43:56

And if I can ask to the community based organizations like the new model,

Unknown Speaker 44:02

I also didn't tell I'm

Speaker 3 44:04

gonna say, I'm gonna say we have, I'm gonna say we have 160 community based organizations. And the healthy opportunities pilot, we have hundreds of community based organizations across North Carolina. Okay, that's fair.

Speaker 2 44:20

So what I would add to this, just so we're one of the organizations, the health plans in North Carolina, for Medicaid, all process the claims for healthy opportunities. They come from the HSO, I think it is or lead, lead agency to us for processing for our members on

Speaker 1 44:38

Could you give an example? Is it like a food pantry visit? What are the types of claims you're processing

Speaker 2 44:44

transportation? It is the food boxes. It may be that they went in and picked those up at a food bank. They might have got them at a food distribution center. They might have had them delivered to their home, depending on what they signed up for. There's lots of options to make sure that folks. Get it, and then those providers that deliver that invoice the lead agency, and then that lead agency files the claims with us, and then we pay them. We have the thing inside the health plan that's been remarkable is how many staff it takes to manage the referrals and to manage the incoming invoices. So the first thing that I think sort of shocked us about healthy opportunities when it went live was the pent up demand. Right? You just don't know how many people are out there that are hungry, until you offer food, and then you can find, find that even your neighbors might have been people that didn't have food, right? And I think that's been one of the things in our state. And there's lots of places that didn't have they were truly food deserts. There wasn't healthy food, but there wasn't any food. I mean, it was nowhere to get food that that was in any way healthy. So there's been a lot of food distribution and and food oriented opportunities that have popped up with this pilot. It is, it is always something that concerns us and, and I think this is what Yvonne is talking about when she talks about medicalizing it. So you've got somebody that's doing a good thing because they want to do a good thing, and now you offer to pay for that good thing with Medicaid, and now they're turning into a Medicaid provider, and that changes them, and that that is probably one of the things that is the hardest to navigate, not changing that culture of wanting to help into a culture of making money right on doing a thing and and I think some groups opted out of being participation in this because they didn't want to change the way they did it to conform to being able to bill Medicaid, and that impacted capacity, because you might have thought they'd be in but no, they're not. At the same time, new businesses have started just to address these social determinants of health. New businesses, or businesses have expanded. In some cases, our behavioral health providers now also provide transportation for the people that are coming to their outpatient clinics as a part of the service delivery,

right? And so they're billing healthy opportunities for transportation and, or any empty and, and at the same time they're they're seeing the person. So it's, it's been truly an opportunity of innovation in this space, lots of different partners, lots of organizations doing things in that are non traditional for the type of organization they are when it comes to food and transportation, those are probably two of the biggest pent up demands and things that we process. It is literally 1000s of referrals that are coming through us for these these opportunities. It has been a really profound change in those counties that are getting it. And as we look toward expansion of that, you know, the the ability to expand on both sides inside the health plan, through care management, making those referrals, and then outside. To gain the capacity to do that across all of North Carolina is actually kind of daunting, because where we are with it today is enormous. In just 33 which is a third representation of the state and doesn't even include some of the larger urban areas, it's all rural, but I imagine that that the food access in those urban areas for individuals who are in poverty is going to explode, right? And so being being able to be mindful and planful and thoughtful about how to roll that out in such a way that the system doesn't get overwhelmed, is going to take some real intensive planning.

Speaker 3 49:03

Yeah, go ahead, me in a comfortable chair because, yeah, I have my coffee now I'm talking Okay, so, but just to sort of put some numbers behind what Cindy was saying, with 37,000 hop enrollees, healthy opportunity enrollees in those 33 counties, 29,000 enrollees have been served over the eight over the two years, I'll say 761,000 services have been delivered, and 96% of those services have been paid for. That's what the health plan is doing. And I just want to be clear on the structure so the Department of Health and Human Services we oversee, we design, oversee the design and implementation of the program. We contract with the health plans, with Cindy tailor plans and standard plans to manage the capitation right. They receive a capped amount allocation to run the program, also to pay the bills, to pay the invoices, they contract with, which is a new piece of the system that we've procured. They contract with a network lead. It's a new entity. It's the only one in the nation. Essentially, we needed someone. We had to build out the infrastructure. We're leveraging existing infrastructure departments here. Health plans are here, but we have nobody to medic to manage the network. That's always the hardest part, to grow the network, to manage the network, to do the top the that conversion we were talking about. We had to procure that, create that and buy that. So that is the new component Cindy is working with, the health plans are working with, and they, of course, are working with the human service organizations, the community based organizations to do this work and deliver the services. So it's a it's a beautiful thing to create a system within a system, but we had to add that component and but we're not naive enough to think that that's it, you know. And for the very reason, I just want to be clear about the impact, you know, 761,000

Unknown Speaker 51:28

services delivered,

Speaker 1 51:30

and 96% that was not what you expected. That's right,

Unknown Speaker 51:33

not in 18 months.

Speaker 1 51:37

Well, I want to shift you both bring up interesting points about you know, we have a lot of folks in the room working with organizations that deliver services of some type, and are probably contractors for any of you in delivering that. And I'll start with Stephanie a little bit. So if there's an entrepreneurial executive in the audience here who has a great idea for a social determinants, a health related social needs program. I don't know if that's jail in our housing wrap around, probably

Unknown Speaker 52:06

already my LinkedIn inbox, yeah.

Speaker 1 52:08

So, so what you know? What do they need to do to actually pitch an idea to humana? I'm assuming at the local plan level, I don't know, you tell us,

Speaker 4 52:17

Oh no, most decisions are made at the corporate level. So, you know, it's so interesting listening to this conversation, because my customer for Medicare Advantage is CMS, and CMS has not given us. This is the value of food. This is in the mandate, in the permission space to have delivery of social needs services as an outcome that's not a CMS identified outcome for us, CMS we are, we are cap. We are paid a capitated rate, and we are accountable for managing those, those beneficiaries, their total cost of care. And we do have an incentive from the stars rating program to improve, to achieve certain prevention and chronic care management outcomes, right and then playing performance, or some things like that, the reward for that is on a lag. So we invest one year and then two years later, one three years later, get the bonus payment. So it's, you know, we have to wait and for that to get that additional potential in, like reward for it. So and the often talked about special supplemental benefit for the chronically ill, which we're allowed to file is one for the chronically ill. So we have to start with that chronic condition and the non primarily health related benefits that we're allowed to offer. We we have to provide like sub. We have to sub like provide evidence to CMS that that that benefit, that evidence can drive a specific outcome of improving or maintaining health of that chronically ill member. So I just wanted to, like, I frequently get asked like, Well, why doesn't Medicare Advantage just pay for food? Well, we're we're in Cindy's place, so I CMS hasn't told us to do that, and so I'm not, so that's not in our permission space right now. We have creative ways to address those needs, but that's really why I keep emphasizing the benefits of value based care, managed care along the care continuum.

Unknown Speaker 54:45

All that being said,

Speaker 4 54:47

we love great ideas, but that's one reason that we are give our provider networks the flexibility that they need. So if there's a value based provider that is really where we'd. Hope to situate some of those services otherwise for other providers. So we have a very comp we're data driven and customer focused. So under having a someone approach us making sure that you understand the population and the health outcome that you're going to address, and in how and have a good idea about how that would be implemented within all of this craziness that I just explained, I think that is really the the kind of the core requirements,

Speaker 1 55:38

so administrative, they have to have, just to recap. So to pitch something to Humana, you need to understand which plan, Medicaid or Medicare, the infrastructure piece sounds like, and what target population and what's the likely outcome. Am I close? That's exactly it. Yeah, okay, because I'm sure you'll be getting a lot of proposals after this meeting. So I'm just warning you. And Cindy, how about you? If someone I'll let you speak for all North Carolina health plans. But if someone's innovative and wants to come to North Carolina and they have this great idea they think will help you, what's the process for them? Yes.

Speaker 2 56:18

So we actually have on our website a place where anyone can, at any time, provide us a proposal, and those are reviewed on a monthly basis, believe it or not, for for things that they want us to fund. And we have a innovative development department within Trillium that that looks at all of those types of innovative requests. So you can find that link on our website if you're interested. But what I would say about actually getting the fund so you can pitch anything, right? Actually getting the funding is a little different and and so what I would say right now is happening with providers who are pitching ideas to us is our members in this tailored plan configuration are, it's sort of like finding needles in a haystack, right? Because we only serve around 60,000 members total in our half of the state that that Trillium serves. And so if you think about that, like finding a tailored plan member is, you know, one out of 30 people, and you got to figure out where that person is, and those 30 people across a lot of rural territory. And so what we're finding right now is last one, I got a provider sent one of these in, wanting to do some stuff in a school based therapy construct, right? Well, in a school there's all kinds of children with all kinds of health insurance plans, right from parents paid plans, from their jobs and commercial to the seven, eight, whatever it is, Medicaid plans in North Carolina and and so which I only need to fund my kids in that setting, and I'd not gonna this particular provider. Was like, well, we want to be able to serve every kid. And I said, then you're gonna have to get paneled with every insurance carrier in the state, not just Medicaid, right? Because Medicaid is not the only group of kids in a school setting. You need to be paneled with the insurer. They were like, well, forget it. Then we can't possibly do all that. Meanwhile, the school wants a provider that is insurance blind, right? They don't want the parents, don't want the deductibles, they don't want to have all the drama about that. So it has been very we do have school based therapy in almost all 46 counties, but it has been a labor of love to get those providers to the place where they are literally paneled with every insurance. Know how to bill it, know what the co pays are all the things necessary to

actually provide school based therapy to a population of children that have diverse coverage. And so I use that as one example, because my kids or adults are harder to find and in our state because this tailored plan thing is so new, just launching in July, people haven't quite comprehended yet that that we're only serving a tiny number of members. In fact, in every speech that we do in public, we talk about we used to have the whole Medicaid for our coverage area. Prior to 2021 we had all Medicaid, but it was a behavioral health carve out, and so now we have all medica, all we have tailored plan Medicaid, which is this very defined, targeted population across 46 counties, and it's behavioral health and physical health, but it's such a small number of people that some of the projects people want to do won't work in our scale because we're so small in a targeted population.

Speaker 1 59:52

Well, any advice before I shift to my kind of last question, I know we're almost out of time. Any advice for our groups, for entrepreneurial per. Providers who are interested in expanding, I see lots of folks who say, I do medical primary care, I do behavioral health, and I want to expand into doing more innovative social needs based programs. Any words of advice for them,

Speaker 2 1:00:16

I think they should, should get a dialog started about how to do that, at least for our part of North Carolina, start a dialog with the health plan about what you're doing, the outcomes it is achieving. You know, being able to measure those is very important, and that's probably the place most people get off. They have a great idea. They want to do a great thing. It's a heartfelt kind of movement there. There's no they don't have the data, they don't have the outcomes, they don't have the cost of care. They don't show a return on investment. They don't those aren't parts of what they're thinking about. That's that's what we're interested in. So know that and but, but bring your idea forward, because, as Yvonne said, sometimes we'll invest in that infrastructure to get you there, if it's the right idea,

Speaker 3 1:01:04

yeah, I was, I would agree with that, and I would say, use our data. You know, we one of the reasons why we're doing the healthy opportunities pilot, obviously, is to, you know, serve North Carolinians, but it's also a pilot to demonstrate what what we can do. So use our data. It's very public. It's posted, you know, it's compelling, and if you're going to provide that service, then you can that data will apply, you know? So we are going to continue to be as transparent as we can, I believe. So I would say, look at North Carolina, and look at the pilot, and use some of the data. Look at the fee schedule, look at the services. We're going to have, some utilization dashboards, you know, look at what's being offered. I agree with Cindy, food and transportation, public and private. You can't, you know, you can't beat and talk to your health plan about what what a solution might be, and where they have a problem. Because, honestly, everybody wants a solution, and even at the state will will go to your state. Let me just say this advocate, talk to your state partners. None of this can happen as Humana just said. Stephanie just talked about, they're limited, you know, in terms of what they can do, but if your state gets the flexibility that it needs, then we can be creative together. Then we can be creative together. So, yeah, I would talk to your state.

Speaker 1 1:02:37

Well, my last question is about the future, because everyone is trying to take out their crystal ball and read the tea leaves of what's coming. Yeah, and, and so one of the things, both and big changes, I think, a foot for Medicare and Medicaid as we look ahead. You know, my question about this kind of meeting health related social needs, and, you know, this dates me, but when I started in the field, Medicaid and Medicare never paid for anything social. It was like the great iron wall, you know, medical only, nothing else you know. Now we've had a decade of really some pretty interesting experiments. I mean, there are now 11 states that are doing, going to be doing jail in reach there are probably 22 states that are doing housing wrap around. I mean, a big shift in a short period of time. I think a lot of this is going to end up being decided in the future by state legislators, as opposed to CMS and and my question for the three of you is, do you think state legislators are bought into the ROI story? And you know, what do you see as the trajectory for educating people about some of the you know, what sounds like very solid outcomes, but I'm not sure they're widely shared among among policy and legislators at different levels. And I did not tell them I was asking this question either. So

Unknown Speaker 1:04:01

anyone care to go on the record? Well, ours

Speaker 3 1:04:02

are definitely North Carolina. North Carolina General Assembly is definitely bought in, okay, obviously be, you know, 640 million they appropriated to this initiative, to the to the healthy opportunities pilot. They believe in it. And we, it's up to us to prove that, you know, prove that it works over time. And you know, I think we're going to face the same challenges, which is capacity, which is capacity, and so there is opportunity, because, again, you're only as good as your network, and there are still going to be areas where there where there's not access. So I think there's tons of opportunity, and even if you have to figure out how it works for you or partner with, you know, partner with a. Other organizations, if you know that you can support a food pantry or, you know, have an alliance with them in some way, and that's going to help your your client base, that that's going to help the people that you're serving, because it will then partner, you know, I'm it, this is a grassroots kind of thing, but I know legislators, at least in North Carolina, and I'm shout out to them, shout out to them. I mean it. I mean it, they have been supportive, and I and I hope that they continue to do so. I don't know what the future holds, but you can't do it without them, because it does take it does take a state and a federal

Speaker 1 1:05:43

Well, Stephanie, you're in a little different position because, well, because you now have capitated contracts at the local level in the value based initiatives. Do you think the the community based primary care organizations are bought into this concept.

Unknown Speaker 1:06:02

Are they going to pay for this out of their cap rate?

Speaker 4 1:06:05

I will. I mean, we, I think we are seeing that already bringing now, I think I don't know that anyone has figured out the exact right model yet. We're still tinkering on how to really, truly have whole person care at the primary care level. But we we're increasingly seeing more of a care team, more integration of both, primary care, behavioral health, social worker, social needs, care, more communication, pulling in and having everyone practice at the top of their license and their expertise and together. So I think that's where we're going. That's where everyone wants. I think we have a capacity of Social Services issues. We have a capacity of care provider issues because we don't necessarily have enough nurses and patient navigators and CHWs out there to support this for everybody. But I, you know, I do. I think that everyone wants, I think doctors want to practice medicine and they want their patients to be healthier, and so we see a lot of awareness, but it's more about like, whose responsibility is it to do it and if we can make it where? Well, it's not yours, dr, so and so, personal responsibility, but it's your responsibility to be in the care team.

Speaker 1 1:07:35

Well, I could continue this for another hour, but we are out of time. I hope you'll join me in thanking our panelists. We're gonna, we're gonna take a 15 minute break just to you know the fate my favorite session follows this. The three of us and me will be in a discussion room, and you can play stamp stamp stump the panel. We also launched, we launched the whole person care summit right after this, so check your program for what's next.