

Partnership Profile

Elder Services of the Merrimack Valley and North Shore and My Care Family Accountable Care Organization

As states explore new models for integrating health care and social services, aging and disability community-based organizations (CBOs) have an important role to play in providing services that can address social determinants of health (SDOH) and other community living needs. These new contracting opportunities also open up new pathways to sustainability for CBOs engaged in these models of care. This Partnership Profile tells the story of how the aging network in Massachusetts partners with Accountable Care Organizations to provide home and community-based services to the Medicaid population to improve health, improve quality and decrease costs.

Background

In January 2018, Massachusetts designated 17 health care entities as participants in the newly established Medicaid (known as MassHealth in Massachusetts) Accountable Care Organization (ACO) program. The 17 ACOs covered all of Massachusetts under their networks of physicians, hospitals and other health care providers, and were expected to cover more than 900,000 MassHealth members and include approximately 4,500 primary care providers. Under the program, these ACOs worked together to improve health and contain costs by providing integrated health care for individuals enrolled in MassHealth.

While the models of care used by each participating ACO differ, they all embrace expanded substance use disorder treatments and a commitment to providing clinical and cultural support for individuals with long-term services and supports (LTSS) and/or behavioral health needs. Perhaps the most innovative part of this Medicaid ACO program is the investment in integrating community-based social service organizations into the model of care to meaningfully address the SDOH such as access to transportation, adequate nutrition and more among those enrolled in MassHealth.

The Role of the Aging Network in Massachusetts' Medicaid ACOs

A unique aspect of MassHealth's ACOs is that the program recognizes that the SDOH impact patients outside of the clinical systems and that a wide range of services exist in the community to assist people with LTSS or behavioral health needs. To build connections between existing community-based resources and health systems, the ACO program created certified Community Partners, state-designated and certified community-based organizations or networks that work with ACOs to provide care management, care coordination and, in many cases, additional social services for its members. Community Partners work with ACOs to break down health care silos and address the SDOH to improve health outcomes among members. For example, Community Partner navigators have successfully connected behavioral health clinicians in community practices, registered dietitians at family health centers, and diabetes educators in both clinical and social service centers.

By integrating Community Partners into the health care system, the program allows participating ACOs to leverage the experience and relationships these organizations have built in the communities they serve. For example, a Community Partner can help address LTSS needs by helping the ACO locate and engage MassHealth members that the plan hasn't been able to reach using traditional methods, including those who are experiencing homelessness or housing insecurity, or who frequently change their mailing address or contact information. Once they have connected with such a member, the Community Partner can discuss that person's individual goals, barriers to achieving those goals and ways to connect them to existing resources and services that are offered in the community.

ACOs and Community Partners in Action

A young woman with a high-risk pregnancy may identify lack of transportation to her health care provider as the reason she is not regularly attending medical appointments, or a lack of funds for healthy foods as to why she is unable to eat the diet suggested by her physician. The Community Partner may be able to arrange for transportation that is paid for by the ACO to help that member get to their medical appointments and assist the member in applying for appropriate Supplemental Nutrition Assistance Program (SNAP) or other nutrition benefits to meet their nutrition needs. Community Partners are also able to provide health and wellness coaching consistent with the member's individual care plan.

One of the Community Partner's primary roles is to provide care coordination and connection to existing community-based resources to help ACO members achieve their individualized health goals. For more than 40 years, Area Agencies on Aging (AAAs) have met the needs of older adults and people with disabilities in their communities by arranging transportation to non-emergency medical treatment, providing meals and wellness checks to their consumers through local home-delivered meals programs, addressing behavioral health challenges among homebound populations, and assisting with housing challenges such as rent payment and home modifications.

The experience that AAAs have providing these service helps address the challenges ACOs have with engaging and supporting members who are younger and have limited incomes. For AAAs and other CBOs, partnering with ACOs can help them grow and sustain social support services for the community they serve. The longer-term, more meaningful benefit of working with a younger population is that it allows AAAs and other aging services providers to become appropriately involved in long-term wellness and prevention strategies earlier, so that as individuals age, they have greater ability to remain independent in their communities and they know they can rely on the Aging Network to help meet any needs they may have.

The Merrimack Valley Community Partner and My Care Family

In 2019, Elder Services of the Merrimack Valley and North Shore and its disability-focused partner, the Northeast Independent Living Program (NILP), became the network lead entity for a newly certified Community Partner, The Merrimack Valley Community Partner (MVCP). Since receiving its Community Partner certification, MVCP has contracted with MassHealth to participate as an LTSS provider for 11 individual ACOs and managed care organizations covering the greater Haverhill, Lawrence and Lowell areas.

One of these ACOs, My Care Family, consists of 16 primary care provider practices that serve more than 40,000 members—nearly half of whom are children under the age of 21. Members are culturally diverse, collectively speaking more than 20 languages and 70 percent identifying as Hispanic. Members who work with MVCP are between the ages of three and 64. Once an ACO member is added to the program, an MVCP care coordinator or navigator is assigned to work with the member and the health care partner to create a care plan to support the member's goals. To best ensure that the work of the My Care Family ACO and MVCP partnership advances the goals of improved health outcomes, the team identified specific quality measures along with targeted improvement rates for each measure. These measures include: childhood immunization status, immunization for adolescents, asthma medication ratio, comprehensive diabetes care, metabolic monitoring for children and adolescents, initiation of alcohol or other drug of abuse or dependence treatment, and engagement of alcohol or other drug of abuse or dependence treatment.

The initial success of the My Care Family and MVCP partnership eventually led to an expansion of contracted services. In 2020, My Care Family contracted with MVCP to provide both nutrition and housing services to address the SDOH needs of eligible plan members. Housing services include pre-tenancy support services, counseling (e.g., on decision making related to money management for rent payment), assistance with housing applications and assistance with first and last month's rent and security deposits. Nutrition supports include providing medically tailored meals, nutrition assessment and education, evidence-based programming to enhance behavior change and

assistance with grocery shopping, including gift cards to local grocery stores.

Conclusion

Community partners, including AAAs, have successfully been able to expand the reach of their services to meet the health-related social needs of younger populations. Through partnerships with ACOs like the one described above, AAAs have successfully outreached, screened and assessed a Medicaid population and referred them to a wide range of existing community-based resources to address the SDOH. These successes have resulted in the expansion of contracts to provide services to address social needs, including those related to housing and nutrition.

Endnote

- 1 According to the Centers for Medicare & Medicaid Services (CMS), ACOs are “groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high quality care to their Medicaid population,” with an overall goal that patients get the “right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors” (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO>).

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This publication was produced for the Aging and Disability Business Institute by Elder Services of the Merrimack Valley and North Shore. Led by USAging in partnership with the most experienced and respected organizations in the Aging and Disability Networks, the mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations and the health care system. Funded by The John A. Hartford Foundation, The SCAN Foundation and the Administration for Community Living, the Aging and Disability Business Institute provides community-based organizations with the tools and resources to successfully adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Learn more at www.aginganddisabilitybusinessinstitute.org.