State Supports for Community Care Hubs and Networks

This brief shares examples of how states have supported the development of community care hubs (CCHs) and community care networks (CCNs) to better align health and social services in their state and address health-related social needs (HRSNs). Approaches highlighted in this resource include providing seed funding, guidance for conflict-of-interest, leveraging policy levers, supporting information technology (IT) coordination, and other activities.

Demand for Alignment of Health and Social Services

Increased demand for services that address HRSNs stem in part from various health care policy requirements and quality measures. As a result, it is important to ensure that capacity exists within communities to effectively partner with health care organizations to address HRSNs and respond to increased referral volume. Across the country, community-based organizations (CBOs) are increasingly contracting with health care organizations to address HRSNs. Further, there has been a doubling of CBOs contracting as part of a network, from 20% to 40% between 2017 and 2021.[1] These partnerships are critical to addressing unmet social needs, as public funding streams to meet HRSNs are often insufficient and unsustainable. CBO networks provide an opportunity to aging and disability networks to attract new funding that leverages existing CBO core competencies and services.

Needed Partnerships between CBOs and Health Care

When networks of CBOs partner with health care providers, the resulting alignment can lead to better outcomes and lower costs.[2] The health care sector and disability and aging networks increasingly recognize the current system limits and the need for partnerships.

Community care hubs are a part of a state's No Wrong Door System and perform No Wrong Door access functions.

Organizations in disability and aging networks provide access services or are a partner to a state's access system for long-term services and supports (LTSS). To address HRSNs, aging and disability networks should leverage a state's No Wrong Door (NWD) System assets. Local NWD partners such as aging and disability resource centers (ADRCs), area agencies on aging (AAAs), and centers for independent living (CILs) facilitate enrollment in public programs and provide person-centered counseling (PCC) and follow-

[1] Brewster, A. L., Wilson, T. L., Frehn, J., Berish, D., & Kunkel, S. R. (2020). Linking health and social services through area agencies on aging is associated with Lower health care use and spending. *Health Affairs, 39*(4), 587-594. Retrieved August 2023, https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01515

[2] Kunkel, S. R., Lackmeyer, A. E., Graham, R. J., & Straker, J.K. (2022). Advancing partnerships: Contracting between community-based organizations and health care entities. *Scripps Gerontology Center.* Retrieved August 2023, https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf

up for needed services. Supporting partnerships between CBOs and health care organizations prevents duplicative work within the access system and create more opportunities to blend and braid funding to support access to needed services. By engaging in these partnerships, states can enhance NWD principles including the adoption of person-centered principles and person-centered philosophies to better serve people seeking services.

Defining Community Care Hub and Community Care Network

A **community care hub** is a community-focused entity that centralizes administrative functions and operational infrastructure to enable CBO/health care partnerships. Functions of the CCH include but are not limited to:

- contracting with health care organizations;
- payment operations;
- management of referrals;
- service delivery fidelity and compliance; and
- technology, information security, data collection, and reporting.

State NWD System Alignment with CCH Development

CCHs and networks support the NWD goal to increase access and broaden the reach to individuals needing services. Along with other NWD partners, CCHs serve the same population of high cost, high need individuals, regardless of whether they enter the access system via an aging and disability resource center or a health care organization.

CCH development supports the engagement of smaller CBOs with the health care community without having to absorb all the infrastructure requirements and costs. Supporting these networks allows smaller CBOs to participate and receive payment for their services. A CCH has trusted relationships with and understands the capacities of local community-based and health care organizations and fosters cross-sector collaborations that practice community governance with authentic local voices.

A CCH leads a coordinated group of visible, trusted CBOs that has entered a formal partnership with a health care organization. That coordinated group of CBOs is a **community care network (CCN).** As a group led by the CCH, the CCN has the capacity to:

- deliver a broad scope of services;
- expand and evolve populations served;
- build stronger administrative infrastructures;
- capitalize on economies of scale;
- provide expanded geographic coverage;
- offer "one-stop" contracting for variety of services/payers; and
- expand training and quality improvement initiatives.

The sections below highlight examples of how states have supported CCH and CCN development in efforts to address HRSNs and strengthen health and social service alignment in their state.

Align CCH with State Vision to Increase NWD Access Functions and Address HRSNs

The examples below describe how one CCH developed a public health partnership with state partners; and in another state, a CCH found ways to leverage their existing state NWD infrastructure.

Maryland: Maryland Living Well Center of Excellence (LWCE) - MAC INC (AAA), a CCH , has a public health partnership with the Maryland State Health Department, along with 10 county health departments, Maryland Department of Aging, multiple hospitals, Maryland Primary Care Program, Chesapeake Regional Information System for Patients (CRISP) a health information exchange, the Association of State and Territorial Health Officials, and National Association of County Health Officials to provide programming or services and has public health representation on their board. LWCE is leading a state vaccine awareness initiative in partnerships with the University of Maryland Department of Pharmacy, Meals on Wheels and physician practices to reach older adults and people with disabilities to educate, engage, and connect individuals to needed vaccinations.

New York: The Western New York Integrated Care Collaborative (WNYICC), a CCH, leads a CCN with eight county AAAs and the Western New York Independent Living (WNYIL) which coordinates the Region 1 NY Connects Independent Living Centers (ILCs) (also ADRCs) activities in 17 counties. The ILCs work in partnership with the local Office for Aging (OFA)/AAA. In New York, the ADRC network is known as NY Connects. The CCH began to align the programs within their network with the work of the ADRCs. The CCH has NY Connects staff from one AAA and WNYIL trained as health coaches for their Community Health Coaching, Falls Prevention Coaching, Caregiver Support Coaching, and Healthy IDEAS programs. Additionally, the CCH contracts with six of the AAAs to provide their Post-Discharge Meals Delivery Program and several AAAs and WNYIL are contracted to provide evidence-based health promotion programs such as Chronic Disease Self-Management Programs and falls prevention programs (i.e., Tai Chi and Matter of Balance). The CCH also trained the delivery staff across their network on the vast array of services provided by NY Connects to better link clients to their services.

Create Opportunities for Seed Funding

The examples below show how states created funding opportunities to broaden the state's work in addressing HRSNs across diverse populations.

California: California Advancing and Innovating Medi-Cal's (CalAIM) Providing Access and Transforming Health (PATH) initiative supports many CBOs across the state. PATH is a five-year, $1.85 billion initiative to build the capacity and infrastructure of on-the-ground partners, such as CBOs, public hospitals, county agencies, tribes, and others, to successfully participate in the Medi-Cal (California's Medicaid program) delivery system as California implements Enhanced Care Management, Community Supports, and Justice Involved Initiative services under CalAIM. With resources funded by PATH, such as additional staff, billing systems, and data exchange capabilities, community partners will be better positioned to contract with managed care

organizations, bringing their wealth of expertise in community needs to the Medi-Cal delivery system.[3]

Louisiana: Louisiana's Department of Public Safety and Corrections awarded Beacon Community Connections a three-year contract to implement CCHs for reentry in Lafayette and Calcasieu Parishes (Counties). Services through the CCH focus on connecting participants to community resources, providing social care coordination, and using participant financial assistance to resolve social care needs. Up to $1,500 per participant may be used to assist participants in reentry, stabilizing, and thriving independently in their community. Funding may be used for rent or utility deposits, transportation for employment, health care, and support for activities of daily living, clothing and basic needs, food, and other necessities. The CCH will conduct comprehensive case management, supporting formerly incarcerated persons for up to a year as they integrate back into the community.

Maine: Maine's Department of Health and Human Services awarded Healthy Living for Maine (HL4ME), a CCH, a contract to conduct a 15-month planning process to improve access to care in two counties for individuals with HRSNs under their Rural Community Health Improvement Partnership (R-CHIP) to improve short- and long-term outcomes. Patients who have identified but unmet HRSNs often experience problems accessing and using health care services (preventive, chronic, and acute) appropriately, leading to higher costs and poorer health outcomes. R-CHIP is convened by HL4ME and comprises a core group of 12 CBOs, two health systems, and Maine's Central Public Health District covering Somerset and Kennebec Counties. Additional CBOs and health systems have been engaged at various stages of the project.

Pennsylvania: Pennsylvania's Department of Aging awarded two, 18-month public health workforce grants to a CCH in their state. The CCH, operated by the Pennsylvania Association of Area Agencies on Aging (P4A), will use the grant funding to create two pilot projects, covering multiple counties and will assist in establishing partnerships between behavioral health providers, local governmental entities, and the CCN. P4A will retain two Behavioral Health Resource Coordinators to assist with the pilots. The CCH will also build inter-agency partnerships to increase consumer access to services and collaboration between aging organizations and behavioral health providers. One of the pilots focuses on engaging Spanish speaking individuals through a bilingual coordinator.

Provide Conflict of Interest Guidance

The example below shows how one state provided guidance to prevent conflicts of interest and promote compliance with state regulations on revenue and funding.

[3] California Department of Health Care Services. (2023). *CalAIM providing access and transforming heath initiative.* Retrieved August 2023, https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM-PATH.aspx

New York: The New York State Office for the Aging (NYSOFA) published official guidance on revenue diversification for AAAs and service delivery and resource allocation plans. This guidance provides clarity for organizations such as AAAs participating in WNYICC Network to adequately perform and bill activities in compliance with state regulations.

National Increased Attention on Social Drivers of Health (SDOH)

- *U.S. Department of Health and Human Services (HHS) SDOH Playbook and ongoing inter-agency coordination*
- *Medicaid 1115 Waivers in AR, AZ, CA, MA, NJ, NY, OR, RI, WA supporting state investments to address HRSNs*
- *CMS "In Lieu of" Services Guidance to address HRSNs in Medicaid Managed Care*
- *CMS rules: New screening measures for SDOH for hospitals, physicians; Special Needs Plans; and new Advanced Payment Incentives for Medicare ACOs*
- *2024 Medicare Physician Fee Schedule Proposed Rule*

Leverage Policy Levers

The examples below show how states created opportunities for CCHs to leverage Medicaid and Medicare policy levers to reach more individuals to address HRSNs.

Maryland: The Health Equity Advancement Resource and Transformation (HEART) payment was developed by the Centers for Medicare & Medicaid Services (CMS) and Maryland's Project Management Office (PMO) to provide financial support to Maryland Primary Care Program (MDPCP) practices serving socioeconomically disadvantaged populations to improve health outcomes and lower costs. This initiative also promotes the joint CMS and Maryland goal to advance health equity.[4] The HEART payment involves invoicing of up to $110 per month per individual for screenings, services and programs delivered.[5] This payment provides financial investments to MDPCP practices serving people with high medical complexity and high Area Deprivation Index (ADI) areas to address the complex needs of these under-resourced Medicare beneficiaries. HEART provides Maryland Living Well Center of Excellence (LWCE)-MAC INC (AAA), with a list of patients within their program, so LWCE can contact them to offer services. Services include enrollment in evidence-based behavior change and falls prevention programs, link to advance care planning, medication management, home delivered meals, assistance with utility bills, and transportation. Upon receiving referrals through a health information exchange, LWCE documents the completed services and programs and sends status reports back to the referring provider.[6]

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[4] Maryland Primary Care Program. (2022). HEART payment playbook. Retrieved August 2023, https://health.maryland.gov/mdpcp/Documents/MDPCP_HEART_Payment_Playbook.pdf and Maryland Primary Care Program. (2022). *HEART payment primer.* Retrieved August 2023, https://health.maryland.gov/mdpcp/Documents/HEART_Payment_Primer.pdf

[5] Eagle, L. A., & Lachenmayr, S. (2023). *Contracting with primary care to reimburse older adult non-clinical services.* USAging 2023 Conference. Retrieved August 2023, Contracting with Primary Care to Reimburse Older Adult Non-Clinical Services (usagingconference.org)

[6] Eagle, L. A., & Lachenmayr, S. (2023). *Contracting with primary care to reimburse older adult non-clinical services.* USAging 2023 Conference. Retrieved August 2023, Contracting with Primary Care to Reimburse Older Adult Non-Clinical Services (usagingconference.org)

Massachusetts: MassHealth (state Medicaid program) launched the Community Partners program in 2018 as part of a section 1115 demonstration. The demonstration required Medicaid accountable care organizations (ACOs) to contract with state-certified CBO partners to address social needs. These CBOs serve as a single point of contracting for ACOs to access multiple social care providers. AgeSpan, a AAA that is also a CCH, is designated as one of the Community Partners, allowing them to leverage their network to address the needs of ACO members.[7]

New York: New York State's proposed Medicaid section 1115 demonstration has dedicated funding for Social Care Networks (SCNs). The SCNs would consist of a network of CBOs within each region of the state to provide evidence-based interventions that address a range of social care needs. WNYICC, a CCH, has strategically positioned their network to be the regional SCN lead entity for western New York. If selected as a SCN, WNYICC's infrastructure would be leveraged to formally organize partner CBOs, coordinate a regional uniform referral system and network with multiple CBOs and other partners (e.g., health care, behavioral health, local government), create a single point of contracting for social care interventions in value-based payment arrangements, and advise on the best structure for HRSN screening and referral for Medicaid beneficiaries.[8] This includes fiscal administration, contracting, data collection, referral management and CBO capacity building. SCN HRSN services offered will cover a standardized HRSN screening, housing, nutrition, transportation and case management services.

Improve IT System Harmonization

The example below shows how one state leveraged a CCH's software strengths to improve IT coordination across systems.

Minnesota: Minnesota Department of Health (MDH) partners with Trellis, a AAA that is also a CCH, to allocate a portion of its funds from the Centers for Disease Control and Prevention's (CDC) Division of Diabetes Translation to support IT/software activities. The funds are provided through a five-year CDC cooperative agreement entitled "Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease, and Stroke." The allocated funds will support Trellis' software, Juniper, to support their operation as a National Diabetes Prevention Program (NDPP) Umbrella Hub and make it possible for Trellis to bill Medicare, Medicaid, and health plans for NDPP activities. An Umbrella Hub connects CBOs with health care payment systems to seek reimbursement for NDPP activities.

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[7] USAging - Aging and Disability Business Institute. (2021). *Partnership profile: Elder services of the Merrimack Valley and North Shore and My Care Family accountable care organization.* Retrieved August 2023, https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/01/ESMV-Partnership-Profile_10-16-1.pdf

[8] New York Department of Health. (2022). *New York state Medicaid redesign team (MRT) waiver- 1115 research and demonstration waiver.* Retrieved August 2023, https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-04_1115_waiver_draft_amendment.pdf

State Support for CCH and CCNs Can Take Many Forms

In addition to the examples provided in this resource, state supports for CCHs and CCNs could also provide technical assistance of state-created NWD resources such as:

- planning for conflict-free management;
- the state PCC training program or federal PCC training resources;
- data management; and
- training of NWD principles.

The opportunities to support CBO network development are diverse and remain unique to individual states.