

Partnership to Align Social Care

A National Learning
& Action Network

Community Care Hubs: Making Social Care Happen

*Background, Evolution, and Value Proposition of Working with a
Local CBO Network Led by a Community Care Hub*

Background and Introduction

Across the healthcare and social care landscapes, there is common recognition of the importance of addressing health-related social needs (HRSNs), such as food insecurity, housing instability, and lack of transportation. To better align social care delivery with healthcare delivery and payment, health plans and systems are partnering with community-based organizations (CBOs) to coordinate and deliver services that address health-related social needs. Contractual arrangements between traditional healthcare entities and CBOs have increased significantly over the past five years, and recent trends indicate growth in the number of CBOs entering contracts with healthcare organizations as part of a network of CBOs performing as a social care delivery system.ⁱ This evolution of multiple CBOs operating as a coordinated network reflects an administrative approach aimed at achieving maximum operational efficiency and effectiveness, as well as economies of scale inherent in an organized network delivery model. Additionally, an organized CBO network model can 'level the playing field' by creating a shared infrastructure that permits smaller CBOs that lack organizational capacity and resources to work directly with healthcare organizations to participate in contracting opportunities.

When CBOs organize into a social care delivery system with the purpose of implementing sustainable, equitable, and scalable interventions, the organization that assumes the lead role within that network is the Community Care Hub (CCH). Community Care Hubs provide the needed infrastructure for CBOs within the network to participate in contracting with healthcare organizations. They also serve as a single point of accountability for healthcare organizations that want to contract with trusted CBOs capable of addressing a spectrum of HRSNs. This network of CBOs, led by a CCH, can offer the size, range of services, requisite data management capacity, healthcare contracting capability, and billing capacity that allow for broader participation of CBOs, operating as an organized social care delivery system, to improve health outcomes.

This resource, developed by the [Partnership to Align Social Care](#) (Partnership), is intended to offer a high-level overview of the background and evolution of Community Care Hubs; identify existing operational CCHs among several well-known organizational models; and identify research that demonstrates the value proposition for healthcare entities to work with CCHs in pursuing opportunities to align healthcare and social care systems. This is one of a number of resources that the Partnership to Align Social Care is developing with the goal of co-designing, enabling, and supporting efficient, sustainable, and equitable social care ecosystems.

What is a Community Care Hub?

Partnership to Align Social Care stakeholders are working together to identify and advance sustainable and scalable models for organizing CBOs into local/regional networks wherein the network lead organization, or Community Care Hub, provides the necessary infrastructure to successfully contract with healthcare entities. A foundational activity for the Partnership was coalescing around a consensus definition of a Community Care Hub:

In general, a Community Care Hub is a community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs. A CCH centralizes administrative functions and operational infrastructure, including, but not limited to, contracting with healthcare organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.

A CCH has trusted relationships with and understands the capacities of local community-based and healthcare organizations and fosters cross-sector collaborations that practice community governance with authentic local voices.

Why Contract with a Community Care Hub?

Partnering with CBO networks, led by Community Care Hubs, is increasingly recognized as an efficient and effective means for healthcare organizations to provide services that address HRSNs. The role of the CCH is particularly important when healthcare organizations are attempting to address HRSNs across demographic areas with varied service needs. CCHs can organize a diverse network of CBOs to cover a broader geography, set of populations, and services, which expands the capacity to address multiple HRSNs for diverse populations beyond the capability of individual CBOs.

The CCH provides administrative oversight and offers one-stop contracting for the delivery of multiple proven interventions and services. Acting as a lead entity, CCHs allow healthcare organizations to efficiently contract with multiple community-based service organizations in a streamlined way and ensure the quality of services delivered across the network. CCHs also provide smaller CBOs with support and infrastructure necessary to deliver services as a part of a network. This infrastructure support can include, but is not limited to, billing assistance, data systems, workforce development, individual CBO capacity building and technical assistance support, and insurance/liability protection.

The importance of addressing HRSNs to both improving individual health outcomes and reducing overall costs is well documented.ⁱⁱ CCHs, along with their CBO provider networks, are experts in delivering social care services that address HRSNs. Additionally, these organizations are responsive to community needs and have built trusted relationships with the individuals they serve. CCHs leverage economies of scale to streamline administrative functions and operational infrastructure. To the extent that CCHs increase efficiency and effectiveness of individual CBOs to address HRSNs, they can also provide a return on investment for health plans and other payers seeking to reduce emergency department

visits, hospital readmissions, and improve clinical outcomes by improving efforts to address social drivers of health.

The Evolution of Community Care Hubs

CCHs have evolved throughout the last 15 years. While different types of CBO networks have emerged, they all rely on a lead organization, or Community Care Hub, to manage partnerships between healthcare organizations and CBOs. Public and philanthropic investments have supported, and continue to support, this evolution.ⁱⁱⁱ

An early and ongoing effort includes investments from the U.S. Department of Health and Human Services, through the Administration for Community Living, as well as from the John A. Hartford Foundation to **support aging and disability network CBOs in learning how to partner with healthcare organizations** to better serve older adults and people with disabilities. These investments have funded technical assistance efforts to build capacity as well as grants to high-performing CBOs, such as [Partners in Care Foundation](#) in southern California and [AgeSpan](#) in Massachusetts, which were already exploring significant contracting relationships with healthcare payers.

Launching in 2012 and running for five years, the **Community-Based Care Transitions Program (CCTP)**, created by Section 3026 of the Affordable Care Act, was a Centers for Medicare & Medicaid Services (CMS) program that tested models for improving care transitions from a hospital to home through hospitals partnerships with CBOs to provide evidenced-based transition services. This program, administered through the Center for Medicare and Medicaid Innovation (CMMI), demonstrated the importance of building and supporting CBO infrastructure to enable sustainable partnerships with health systems. While some CCTP sites are now strong CCHs that have expanded their services, geographic reach, and healthcare partnerships, the CCTP also demonstrated a need to support start-up costs for contracting/partnership efforts between healthcare organizations and CBOs.

In 2014, CMMI also funded a demonstration for the **National Diabetes Prevention Program (DPP)**. Through this demonstration, an organizational Hub–YMCA of the USA–was supported to organize a delivery system of local YMCAs across the country to deliver the intervention. The demonstration proved the efficacy of individual CBOs, organized as a network under a management hub, to deliver evidence-based programs that improve health outcomes and reduce costs. The result of the demonstration led CMS to create a new Medicare benefit to allow CBOs to deliver the National DPP. The program is managed by the Centers for Disease Control and Prevention (CDC) which coordinates with CMS on the Medicare benefit to allow CBOs to be a recognized delivery provider of the National DPP. Recently, CDC and CMS collaborated to formally establish a CCH-like entity, an Umbrella Hub Organization, to sit between healthcare and the community for the delivery of the National DPP.

The **Umbrella Hub Arrangement (UHA)** model was also pilot tested to ensure that the arrangement works outside of the infrastructure of the YMCA of the USA.^{iv} The pilot testing proved that individual CBOs organized as a network can achieve the required scale to operate as a delivery system. This provided the evidence for a recent CMS ruling that formally recognizes the role of an Umbrella Hub Organization (UHO) as an option to contract with healthcare organizations (see more below). CDC and CMS now formally recognized a UHO to centralize a range of administrative functions, including healthcare contracting,

referral management, and centralized claims management on behalf of multiple individual CBOs.^v

In 2017, CMMI initiated the **Accountable Health Communities (AHC) model**, testing the idea that a “community bridge organization” linking healthcare organizations with community-based services could address the HRSNs of Medicare and Medicaid beneficiaries. Bridge organizations served as “hubs” in their communities by identifying and partnering with clinical delivery sites to conduct screenings for HRSNs and connect beneficiaries to community-based service providers. Evaluation of the AHC model has yielded important insights including the need for multi-sectoral partnerships to identify sustainable funding streams for community services. While AHC did not provide payment for social services delivery, CMS continues to build on lessons learned from the model to advance opportunities to address HRSNs in communities, including through the Medicare Shared Savings Program and Medicaid 1115^{vi} demonstrations.

The **Pathways Community Hub** is another well-established type of CCH model supported through the Pathways Community HUB Institute®.^{vii} In this model, the HUB acts as a neutral administrative body taking referrals for potential clients from a healthcare provider or community health worker (CHW) and sending the referral on to a care coordination agency where a CHW begins the Pathways process of addressing social needs.

Examples of Community Care Hubs

Because a Community Care Hub denotes a concept and categorization—rather than a specific model—there are many examples of Community Care Hubs throughout the country. These organizations, and the CBO networks they lead, take various forms. The common thread that each CCH shares is the ability to serve as an anchor organization capable of contracting on behalf of multiple CBOs with healthcare organizations. While some healthcare organizations may choose to contract individually with CBOs—and CCHs would not prevent that option—the CCH structure offers inherent efficiencies to those seeking scalable contracting opportunities to integrate healthcare and social care efforts. CBO network lead organizations implementing the CCH concept are included, but not limited to, the examples below.

[CDC National Diabetes Prevention Program \(National DPP\) Umbrella Hub Arrangements](#)

As detailed above, the CDC’s National DPP relies on umbrella hub arrangements (UHAs) that connect CBOs to healthcare organizations. In the UHA, there is an umbrella hub organization (UHO) that is identified to serve as the sponsoring organization for a network of CBOs that deliver services for the lifestyle change program. The UHO performs a wide variety of administrative functions in a UHA and together, with its CBO network, the UHO can operate as one service supplier, receive reporting, claims, and administrative support, and pursue sustainability to achieve scale.

This program has arguably been the largest test of a CCH to date. CMS and CDC have established the model as an accepted mode of delivery and formally recognized the role of the UHO. Every state Medicaid agency that has allowed National DPP as a benefit now has authorization to contract with the UHO for all administrative operational responsibilities for the UHA. Furthermore, the National Association of Chronic Disease Directors is funded by CDC to expand UHAs that mirror the CCH model. Policy coming from CMS and CDC formally

establishes and recognizes this hub arrangement as a preferred model, which further supports the feasibility, effectiveness, and success of CCHs.

[VAAA Cares: Caring, Cost-Savings, and Credibility in the Commonwealth](#)

VAAACares is a successful program in Virginia providing comprehensive care coordination, care transitions, and other services addressing social drivers of health. The program is a statewide one-stop coalition for referrals, billing, reporting, data analytics, training, and quality assurance comprising 20 area agencies on aging (AAA), four health systems, and five large insurance companies. VAAACares has successfully used the CCH model to bring together CBOs and healthcare organizations to improve health outcomes by reducing the 30-day readmission rate in high-risk older adults from 23.4 percent to 14.4 percent and, in Medicaid beneficiaries, from 25 percent to 7 percent within their program.

[Mid-America Regional Council \(MARC\)](#)

MARC, the AAA of the greater Kansas City area, provides services to older adults and persons with disabilities in two states, nine counties, and 119 cities. MARC serves as the CCH for a network of CBOs addressing health-related social needs and the coordinated delivery of home and community-based services. MARC also operates a centralized referral management system to ensure that there is a streamlined process to conduct the interventions, support of bi-directional data exchange, and a closed-looped referral system with resource navigation services. MARC has a partnership with a prominent local health plan to provide care transitions, evidence-based programs, and a community-based care management intervention to high-risk members in its commercial plans and members enrolled in a new Medicare Advantage plan. These interventions were included in the Medicare Advantage (MA) plan benefits following a successful bid to CMS. The agreement also includes the health plan's largest medical provider group.

[Western New York Integrated Care Collaborative \(WNYICC\)](#)

The Western New York Integrated Care Collaborative (WNYICC) comprises more than 30 CBOs serving individuals of all ages in western and central New York and partners with healthcare plans and providers to improve patients' health. In 2020, WNYICC [contracted](#) with a regional Medicare Advantage plan to provide post-discharge home-delivered meals and incorporated patient satisfaction surveys to facilitate feedback to the health plan. After a successful proof-of-concept, their contract was expanded to include services including [chronic care management](#), an expanded meal benefit, and a social isolation intervention. The model covers the entire western New York State region which includes diverse communities across a wide geography. The CCH model allows small, diverse CBOs to engage in robust contracting models by leveraging the centralized management infrastructure provided by WNYICC.

One of WNYICC's network members, Lifespan of Greater Rochester, implements a [Community Care Connections \(CCC\)](#) program that takes advantage of clinical encounters to link patients to resources that address health-related social needs. Providers make a referral to CCC when a patient is overusing medical care or struggling with a nonmedical issue. Case managers with Lifespan's CCC program follow up with assessments and link the patient to appropriate community-based services. With Lifespan acting as the hub in receiving referrals from physicians and home health, more than 1,200 CCC participants were connected to services between 2016 and 2019. Participants in the program experienced a 28 percent reduction in visits to the ED, a 29 percent reduction in inpatient hospitalizations, and a 23 percent reduction in observation stays in the 90 days after initiating program participation, compared to the 90 days before participation.

[Southern Alabama Regional Council on Aging \(SARCOA\)](#)

To sustain their care transitions services beyond CMS' Community-Based Care Transitions Program, the Southern Alabama Regional Council on Aging (SARCOA) created a non-profit corporation called Community Care Solutions (CCS) that encompasses a statewide network of AAAs and contracted direct services providers. One of their most notable initial contracts was with a major Medicare Advantage plan to provide a comprehensive care coordination service to their members. This contract covers four southeast and central Alabama AAA service regions, encompassing 18 counties that are a mix of urban and rural areas. When COVID-19 hospitalization rates reached surge levels in Alabama, CCS' Medicare Advantage contract expanded their care transitions services to include community-level case management for members admitted to the hospital for COVID-19. These services have enabled Alabama residents hospitalized with COVID-19 to safely return home and supported hospitals in managing immense surges.

SARCOA was also successful in organizing a statewide network of AAAs to develop a centrally managed care management system for persons that require long-term services and supports (LTSS). CCS created a centralized data management and quality assurance infrastructure that enabled the network to secure a contract for fully delegated case management with a Medicaid MCO for all Medicaid beneficiaries receiving LTSS in the state. The contract is a value-based model that includes downside risk. This CBO network operates as a centrally managed unit to drive clinical outcomes to satisfy the value-based contract requirements.

Supporting Research and Resources

The evidence-base supporting the effectiveness and efficiency of the Community Care Hub concept is growing. As evaluations of various types of CCHs are added to the public domain, the [Partnership to Align Social Care](#) will update this resource accordingly.

[Collaboration in Healthcare and Social Service Networks for Older Adults: Association with Healthcare Utilization Measures](#)

This study explored the characteristics of effective collaborative networks of healthcare and social service organizations. Researchers collected data on collaborative ties among healthcare and social service organizations in 20 U.S. communities with either low or high performance on avoidable healthcare use and spending for Medicare beneficiaries. High performing networks were distinguished from low performing networks by two features: 1) Healthcare organizations occupied more central positions within the network (i.e., they had the densest array of connections to other organizations); and 2) subnetworks of co-sponsorship ties were more cohesive (specifically, more centralized around activities such as client referral and needs assessment). Furthermore, AAAs were more centrally positioned than any other type of organization. These findings support the notion that development of deep collaborative ties and formalized partnerships between CBOs and healthcare organizations reduces preventable healthcare use and spending.

[Linking Health and Social Services Through Area Agencies on Aging Is Associated with Lower Healthcare Use and Spending](#)

This study focused on the potential health impacts of AAAs partnering with healthcare organizations and contributing to multi-sector coalitions that promote community health. Partnerships with hospitals located in an AAA's service area were associated with a

reduction of \$136 in average annual Medicare spending per beneficiary, while partnerships with mental health organizations in a AAAs service county saw potentially avoidable nursing home use fall by 0.5 percentage points. When AAAs were funded participants in multi-sector coalitions to promote the well-being and health of older adults, potentially avoidable nursing home use fell by nearly 1 percentage point. These findings suggest that investments in partnerships between AAAs and healthcare organizations can reduce healthcare use and spending for older adults. It should be noted that a number of AAAs currently operate as CCHs.

[Improving Health And Well-Being Through Community Care Hubs](#)

A November 2022 *Health Affairs* article, *Improving Health And Well-Being Through Community Care Hubs*, authored by a cohort of federal agency employees, details the importance of developing, supporting, and investing in multistakeholder collaborations to address social drivers of health. The article also explores policy and funding opportunities to support the implementation of a CCH model. In particular, the authors point to the Partnership to Align Social Care, a national learning and action network, and its role to convene leaders across CBOs, health plans and systems, national associations, philanthropy, and federal agencies to co-design a multifaceted strategy to enable successful partnerships among health care organizations and hubs.

Learn More about the Partnership

This resource was prepared by the Partnership to Align Social Care, a National Learning and Action Network. The Partnership is supported by leaders from the healthcare sector, community-based organizations, national associations, government, and philanthropy. Partnership stakeholders are working together to co-design a sustainable health and social care ecosystem. This co-design process includes strategies to facilitate sustainable and equitable operating arrangements between healthcare organizations and networks of CBOs to deliver social care services. More info about the Partnership is available on the website www.partnership2asc.org.

The Partnership has released additional resources detailing [the Community Care Hub concept](#):

- Slide Deck: [Evolution of the Community Care Hub Model to Align Social Care with Health Care](#)
- [Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies](#)
- [Partnership Webinar Series, Community Care Hubs: Making Social Care Happen](#)

The Partnership's Community Care Hub workgroup will soon release accompanying materials that provide further detail on the functions and standards of a CCH.

Please sign up for [Partnership updates](#) to keep up to date with our work.

ⁱ <https://prodadbi.wpeninepowered.com/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf>

ⁱⁱ https://www.commonwealthfund.org/sites/default/files/2022-09/ROI_calculator_evidence_review_2022_update_Sept_2022.pdf

ⁱⁱⁱ <https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs>

^{iv} <https://coveragetoolkit.org/wp-content/uploads/2022/04/Umbrella-Hub-Demonstration-Learnings-Document.pdf>

^v <https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf>

^{vi} <https://www.healthaffairs.org/content/forefront/lessons-five-years-cms-accountable-health-communities-model>

^{vii} <https://www.pchi-hub.org/>