How Community Care Hubs Can Transform Health-Related Social Needs

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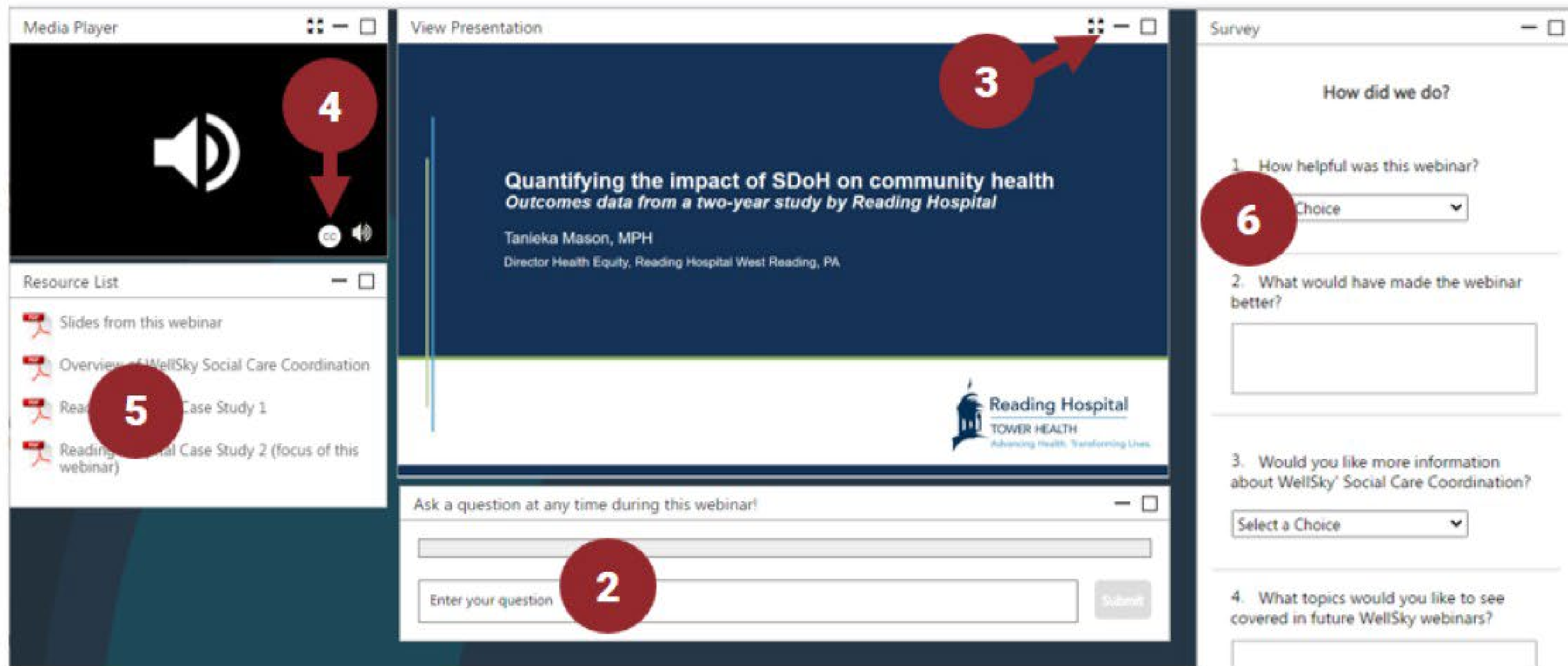
March 22, 2023



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Leading the movement for **intelligent, coordinated** care

Software, analytics, and services to empower providers and payers to achieve **better outcomes and lower costs** across the **acute, post-acute, and community care** continuum

20,000+ clients across the care continuum

ACUTE

- Blood Management
- Inpatient Rehab
- Discharge Planning
- Utilization Management
- Patient Event Notifications

POST-ACUTE

- Outpatient Rehab
- Home Infusion
- Specialty Pharmacy
- HME/ DME
- Home Health
- Hospice
- Palliative Care
- Personal Care
- Long-Term Care & SNF
- LTACH
- Behavioral Health

COMMUNITY

- State Units on Aging
- Area Agencies on Aging
- Continuums of Care
- 2-1-1s
- Community-Based Organizations
- SDOH Connected Network

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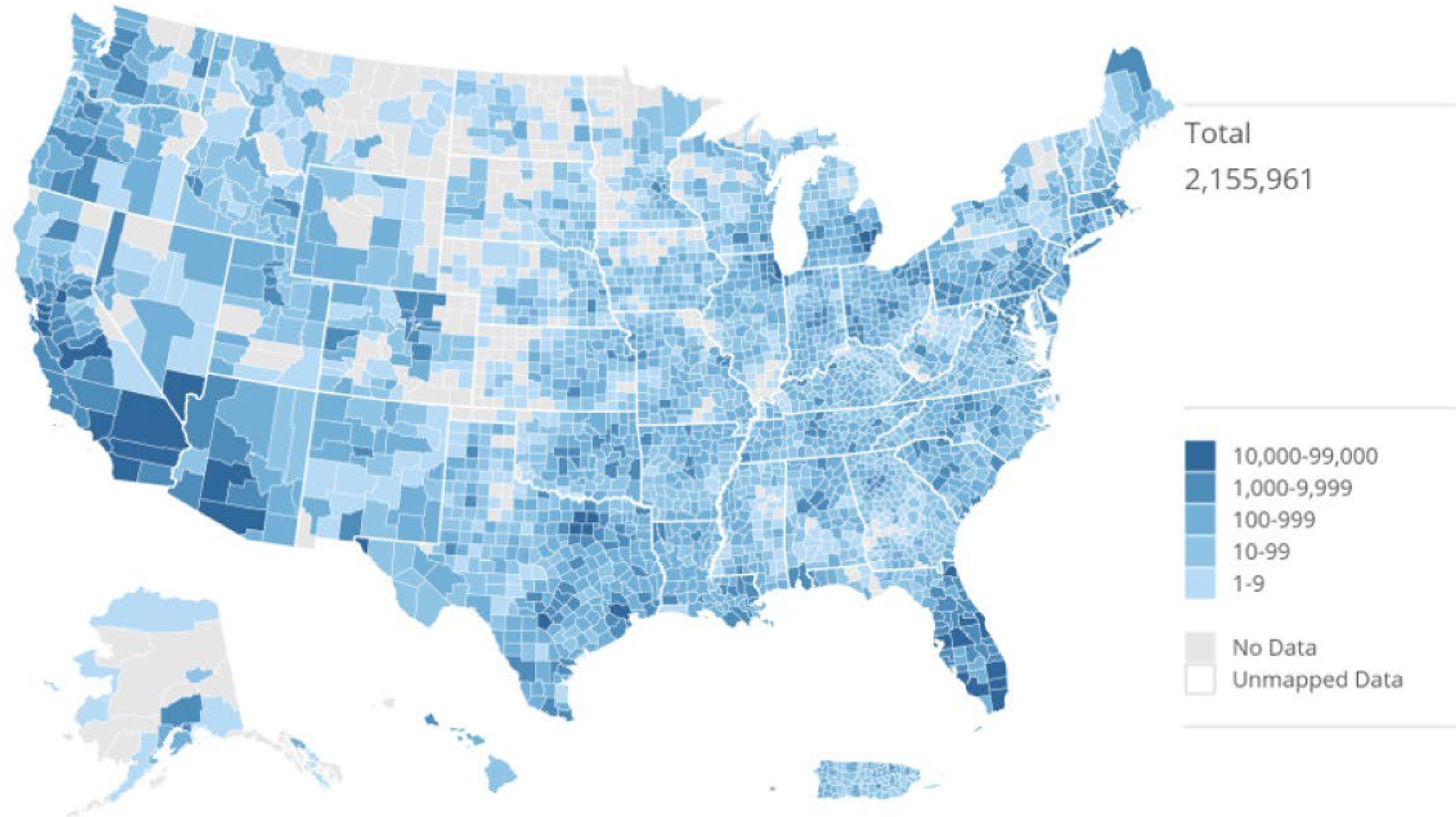
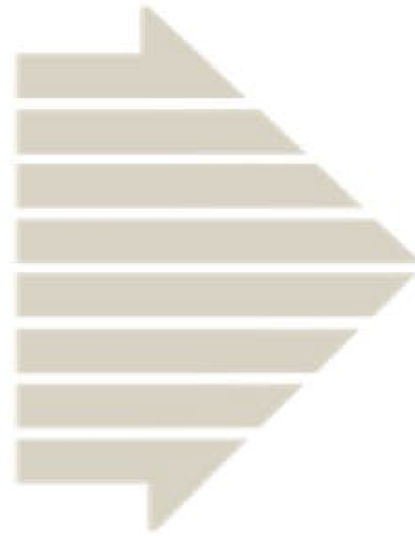
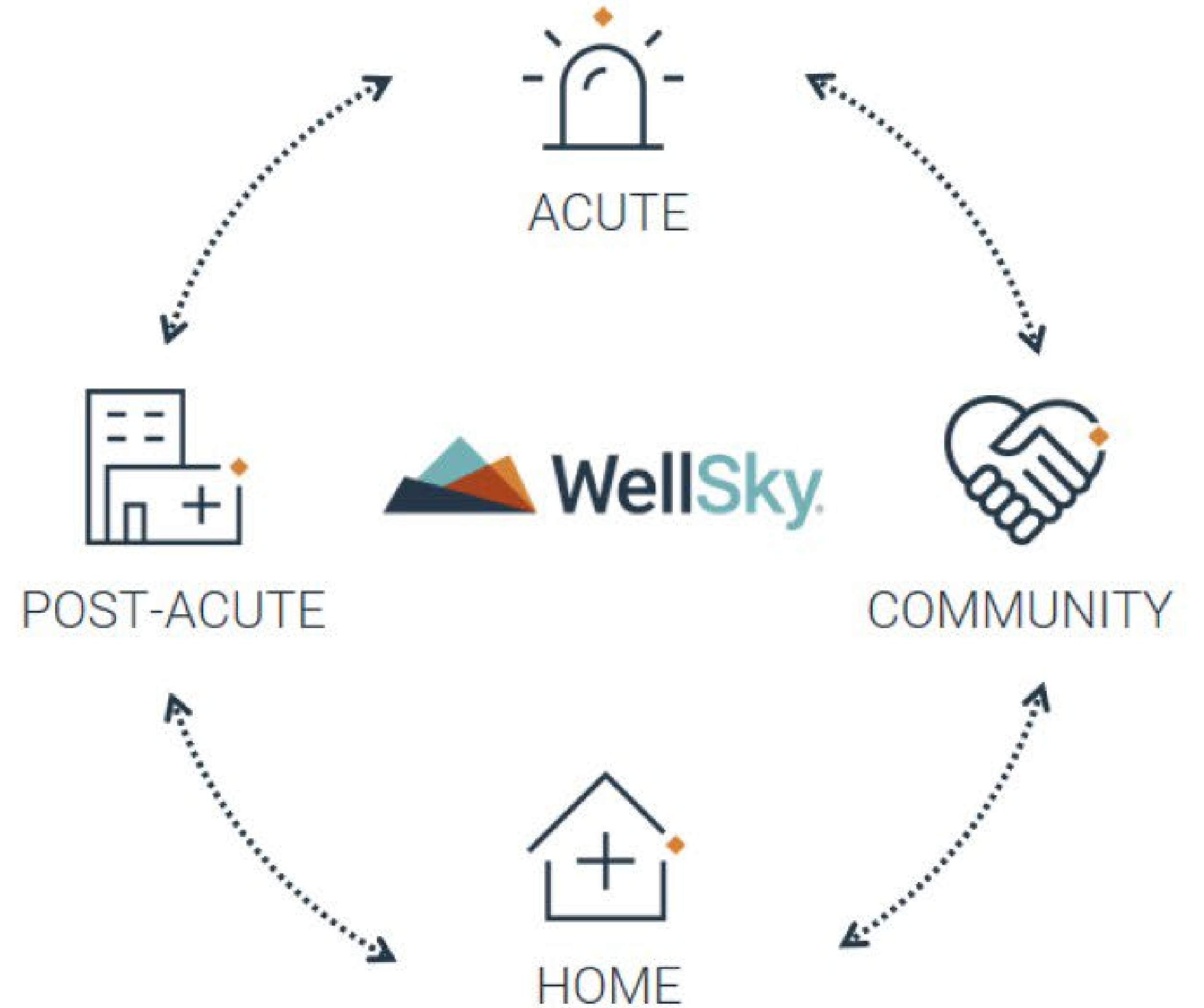
SDOH Connected Network

1 in 3 home-based care visits happen on WellSky and 2,000,000 patients & clients receive care on WellSky each year



WellSky® connects the ecosystem across the **entire continuum of care**





Of states rely on WellSky to manage one or more of:

- Aging & Disability
- Medicaid IDD
- Vocational Rehabilitation
- Adult Protective Services
- Guardianship

Presenters

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manatt

How Community Care Hubs Can Transform Health-Related Social Needs

March 2023

Agenda

- About Manatt Health
- Introduction to Community Care Hubs
- How Community Care Hubs Address SDOH

About Manatt Health

About Manatt

Manatt is a multidisciplinary, integrated national professional services firm known for quality and an extraordinary commitment to clients. We approach client needs holistically, achieving business objectives through a suite of blended legal and consulting offerings.

At a Glance

450

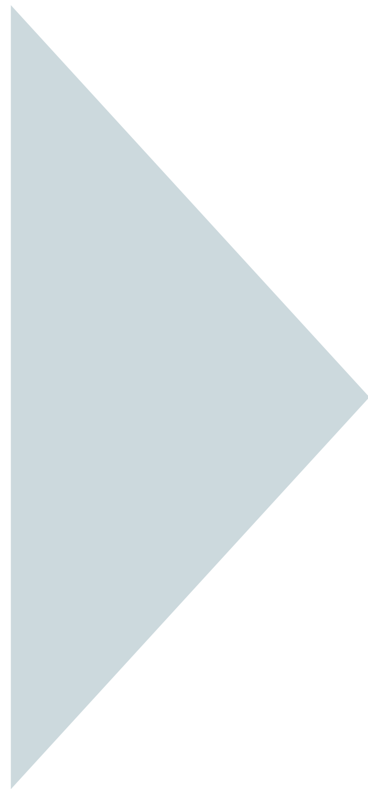
Professionals Firmwide

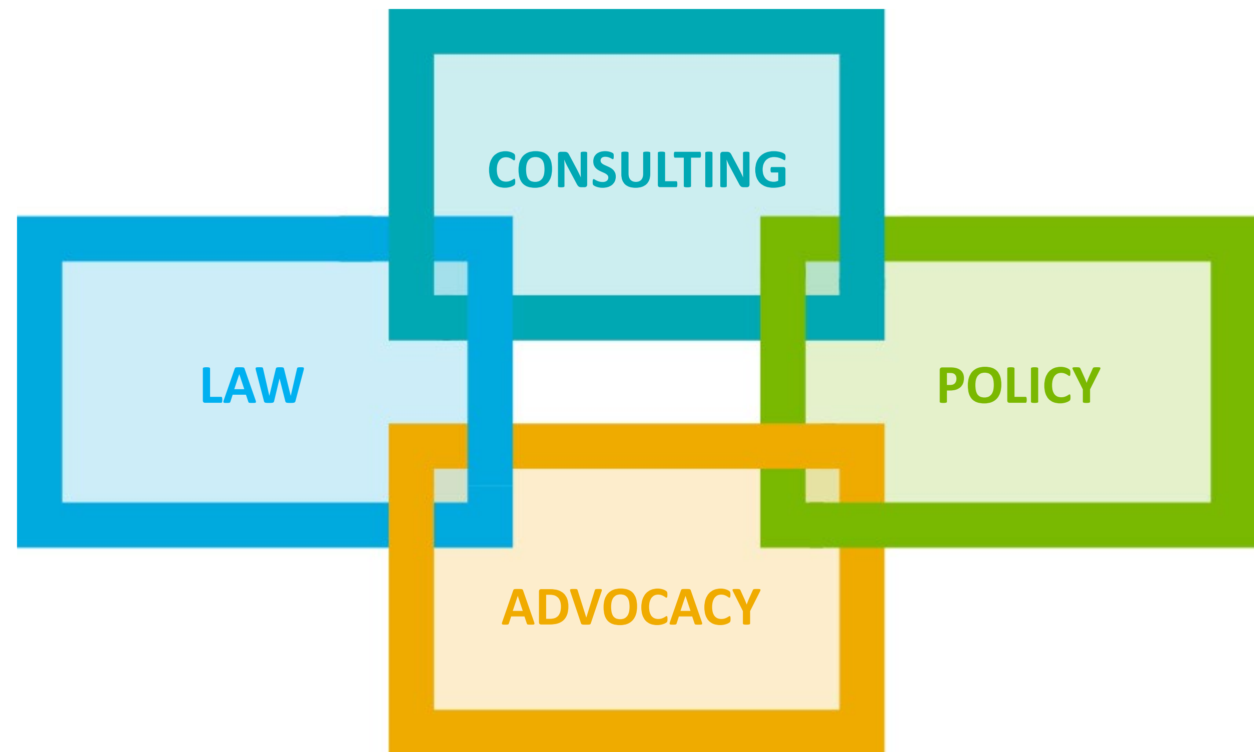
180+

Professionals in Manatt Health

10

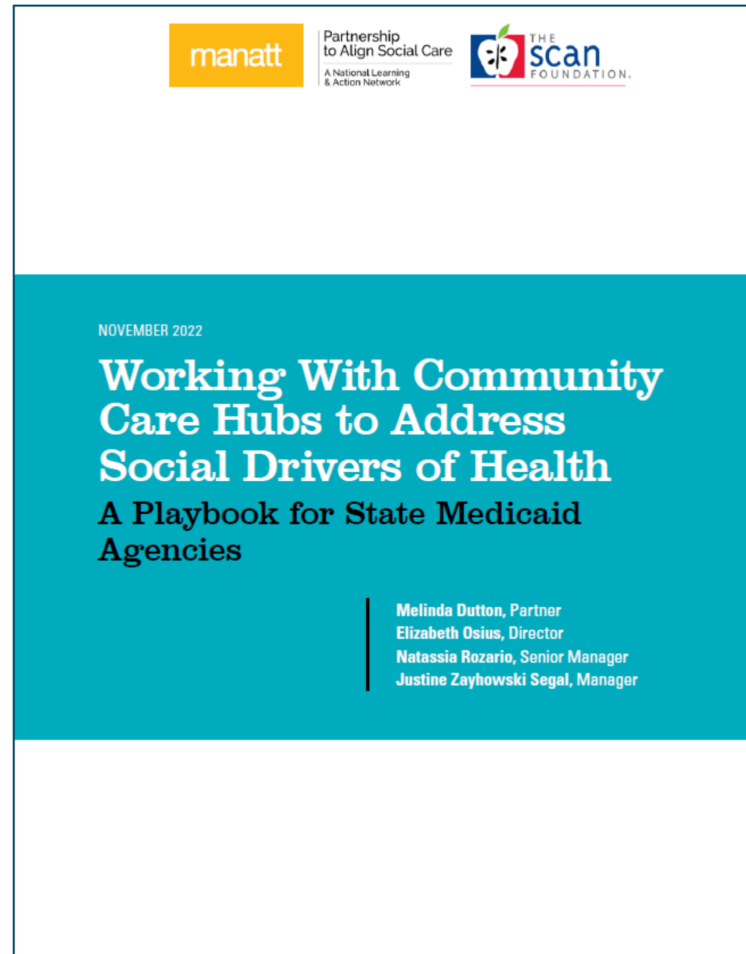
Offices Nationwide





Introduction to Community Care Hubs

Background on Playbook



The Playbook was written by Manatt Health in collaboration with the Partnership to Align Social Care and with generous support from The SCAN Foundation.

Goals of the Playbook

The Playbook's target audience is state Medicaid agencies, ***but it is a valuable resource for everyone actively engaged in addressing SDOH***. The Playbook addresses:

- What a community care hub is
- How community care hubs can help state Medicaid agencies address SDOH
- Practical strategies and resources for engaging with CCHs to address SDOH and improve health and health equity

What is a Community Care Hub?

Definition: A community-centered entity that **organizes and supports** a network of community-based organizations (CBOs) providing services to address health-related social needs. A Community Care Hub (CCH) **centralizes administrative functions and operational infrastructure**, including but not limited to, contracting with health care 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.**

Source: Partnership to Align Social Care

Core Features

- Developing and maintaining a network of CBOs
- Advancing a collective vision for CBO-health care partnerships, SDOH initiatives and health equity
- Centralizing administrative and operational infrastructure
- Managing financial resources

National Community Care Hub Examples

The CCH model has deep roots in efforts to serve populations who are aging and disabled, but continues to evolve.

Area Agencies on Aging and Centers for Independent Living

- Funded by the U.S. DHHS, Administration for Community Living (ACL), AAAs and CILs:
  - Provide information, referral assistance and social care navigation services
  - Manage a local network of CBOs that deliver comprehensive community-based services to older adults and persons with disability
  - Have evolved to form CCHs

Example: Virginia Area Agencies on Aging Cares (VAAACares). Comprised of 25 AAAs. Contracts with Medicaid, Medicare and private MCOs and health systems to provide care transitions, care coordination and case management for LTSS.

Pathways Community HUB model

- The Pathways Community HUB Institute® Model (PCHI® Model):
  - Uses tools to identify and address social and health risk factors at the individual and community levels.
  - Relies on the HUB entity, a neutral entity that provides infrastructure for a network of care coordination agencies that hire CHWs to help address needs ranging from postpartum to housing and behavioral health.

Example: Northwest Ohio Pathways Hub. Consists of 11 care coordination agencies and has funding partnerships with various organizations, including the CDC, Medicaid managed care organizations and local foundations. Established to address high rates of low-birthweight births and infant mortality, especially among Black infants. Has expanded to address diabetes, heart disease, and other chronic conditions.

How Community Care Hubs Address SDOH

How Community Care Hubs Address SDOH

Community Care Hubs can promote efficient, effective and sustainable CBO-healthcare organization partnerships in the following ways:

- Engage Communities
- Expand Community Capacity
- Promote Operational Excellence
- Create Pathways to Financial Sustainability
- Look Upstream

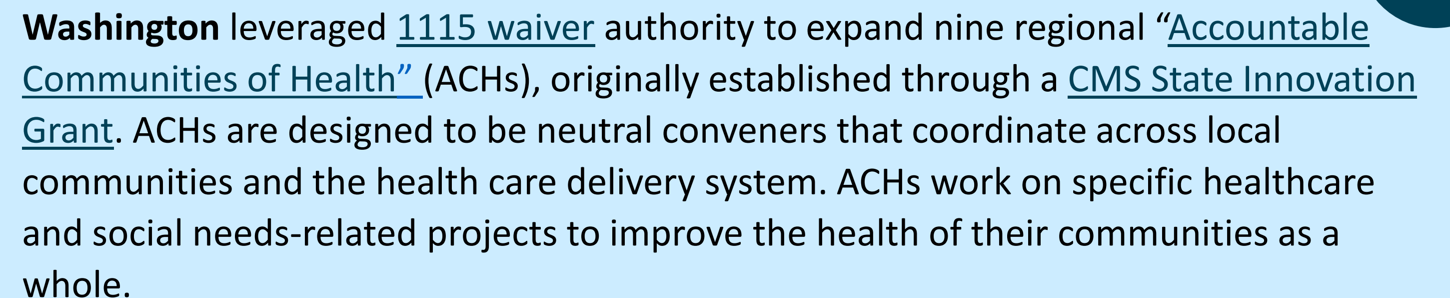
Engage Communities

- **CBOs and healthcare entities have historically operated in silos, with different cultures, missions, funding sources, financing mechanisms and regulatory policies.**
- **CCHs can build buy-in and trust among CBOs and healthcare partners to bridge these two worlds and gather feedback from a diversity of community voices to inform state SDOH efforts.**

Strategies

✓ Support relationship-building among key players

✓ Integrate authentic community voices and equity principles into all stages of planning and implementation



Washington leveraged 1115 waiver authority to expand nine regional "Accountable Communities of Health" (ACHs), originally established through a CMS State Innovation Grant. ACHs are designed to be neutral conveners that coordinate across local communities and the health care delivery system. ACHs work on specific healthcare and social needs-related projects to improve the health of their communities as a whole.

ACHs must submit semi-annual reports in which the ACH attests that its organizational structure has a diverse and representative decision-making body and that it has conducted meaningful communication, outreach and engagement activities for community members. Demonstrated achievement on progress reporting is required for an ACH to earn incentive payments under the state's DSRIP program.

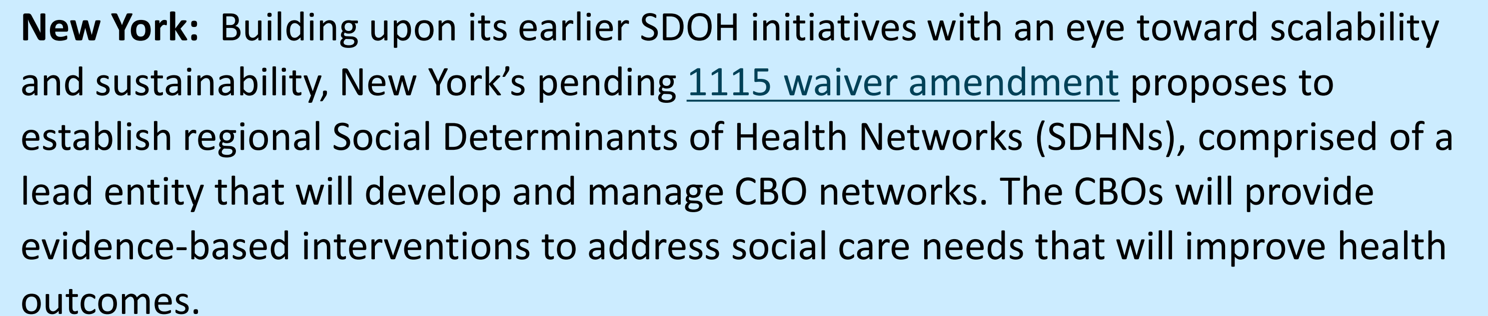
WA ACH Reporting template (July 1, 2021- December 2021)

Expand Community Capacity

- **CCHs and CBOs operate on narrow margins and may need additional resources to enter into new contracts and manage increased demand for services.**
- **CCHs can help deploy capacity expansion investments in their CBO network, including managing requests for and distribution of funding and monitoring its use and impact.**

Strategies

- ✓ Provide upfront funding to support CCHs and CBOs
- ✓ Support training and technical assistance to CCHs, their CBO network, and partnering healthcare organizations



New York: Building upon its earlier SDOH initiatives with an eye toward scalability and sustainability, New York's pending 1115 waiver amendment proposes to establish regional Social Determinants of Health Networks (SDHNs), comprised of a lead entity that will develop and manage CBO networks. The CBOs will provide evidence-based interventions to address social care needs that will improve health outcomes.

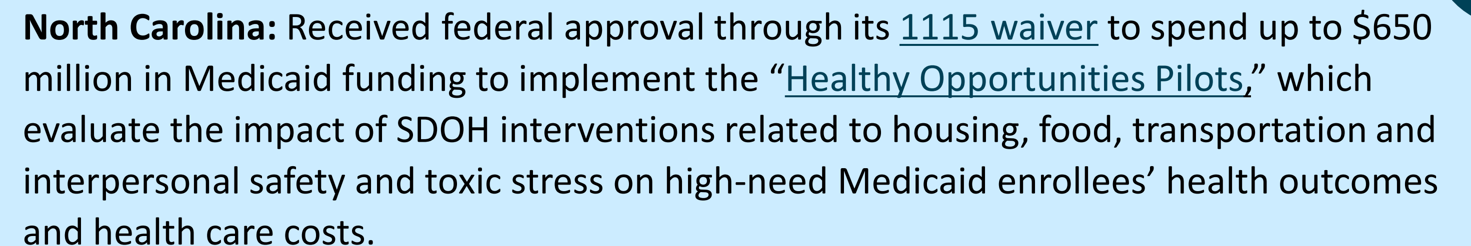
The pending 1115 waiver requested between $92.5 million and $185 million per year for its SDHNs' expenses related to initial network infrastructure, referral systems, staffing, CBO coordination activities, capacity building of CBOs and contracting.

Promote Operational Excellence

- **Efficient and equitable CBO-healthcare partnerships require infrastructure and business practices that promote operational excellence and accountability.**
- **CCHs can help clarify roles/responsibilities in written contracts, gather CBO feedback to inform improvements in the partnerships and support infrastructure selection, investment and implementation.**

Strategies

- ✓ Ensure key players having a clear understanding of each other's roles and responsibilities
- ✓ Balance the need for standardization and accountability with flexibility to adapt to community needs
- ✓ Support the development of the IT and data exchange infrastructure needed for service referrals, payment, program monitoring, evaluation and oversight



North Carolina: Received federal approval through its 1115 waiver to spend up to $650 million in Medicaid funding to implement the "Healthy Opportunities Pilots," which evaluate the impact of SDOH interventions related to housing, food, transportation and interpersonal safety and toxic stress on high-need Medicaid enrollees' health outcomes and health care costs.

In each of the three geographic regions where the Pilots are operational, a Network Lead develops a CBO network that provides social services to eligible Medicaid managed care enrollees.

North Carolina requires its Medicaid managed care organizations (MCOs) to contract with the Network Leads and collaborated with its Network Leads and MCOs to develop model contracts to support Network Lead-MCO and Network Lead-CBO contracting.

Create Pathways to Financial Sustainability

- **Achieving long-term sustainability for CBO-healthcare partnerships can be challenging for various reasons: historic underfunding of social care, complexities of integrating industries that are financed differently, and relying on an emergent evidence base**
- **CCHs can help overcome these barriers—they understand communities' social service demand/costs, are aware of more diverse funding resources (e.g., local philanthropies and programs) and can build consensus on metrics of success**

Strategies

- ✓ Provide adequate reimbursement for health-related services
- ✓ Collaborate with other federal, state, local and non-profit/private organizations to align resources
- ✓ Support evaluation frameworks and outcome measurements to identify long-term value

Ohio:

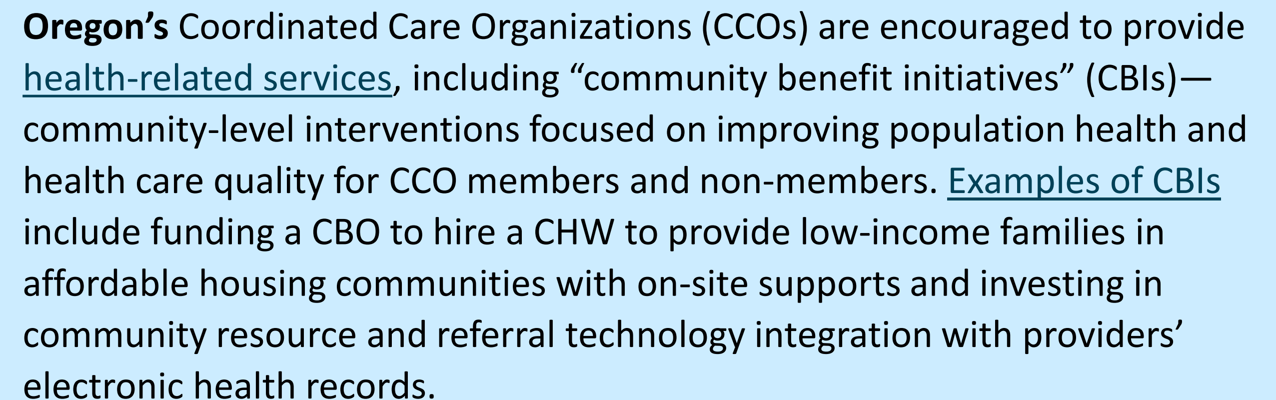
- Ohio's baseline managed care contract requires plans to provide pregnant members with specialized services—including care coordination that links the member to needed employment, housing, education, social and medically necessary services—through community health workers or public health nurses employed by or under contract with a qualified community hub.
- Under the Financial Alignment Initiative, Ohio's three-way contract between the state Medicaid agency, CMS and health plans, Ohio requires its health plans for dually eligible Medicare and Medicaid enrollees to contract with the state's AAAs for coordination of Home and Community-Based Services (HCBS) provided under 1915 waivers.

Look Upstream

State Medicaid agencies seeking to address SDOH and health equity have an opportunity to contribute to broader, collective efforts to invest in their communities—going beyond addressing individuals' immediate social needs. This requires multiple stakeholders—including other federal, state and community partners—coming together and keeping the following principles in mind:

Principles for Upstream Efforts

- ✓ Community revitalization is key to achieving health equity
- ✓ Addressing racism is central to health equity and addressing SDOH
- ✓ Health equity and SDOH solutions require a resilient and diverse workforce

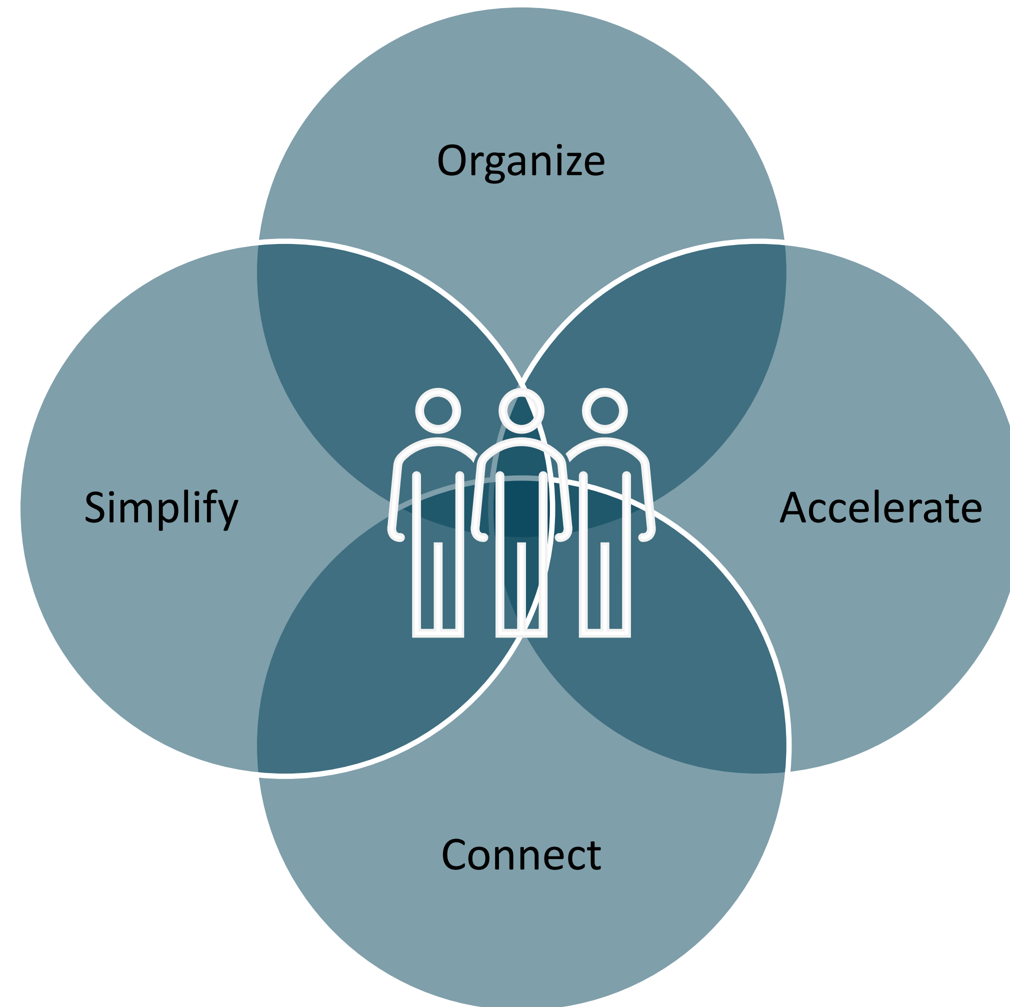


Oregon's Coordinated Care Organizations (CCOs) are encouraged to provide health-related services, including "community benefit initiatives" (CBIs)—community-level interventions focused on improving population health and health care quality for CCO members and non-members. Examples of CBIs include funding a CBO to hire a CHW to provide low-income families in affordable housing communities with on-site supports and investing in community resource and referral technology integration with providers' electronic health records.

As part of the "Supporting Health for All through Reinvestment (SHARE) Initiative," CCOs are also required to invest a portion of net income or revenue on services to address health inequities and the social determinants of health and equity (SDOH-E).

Final Thoughts

While the mix of services/offerings can vary, Community Care Hubs can play a critical role helping to improve health and advance health equity.



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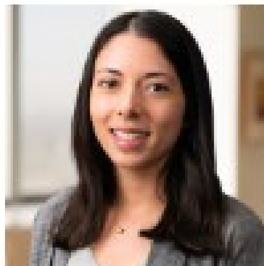

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Leading the movement for intelligent, coordinated social care

WellSky has referral and coordination solutions for every member of the social care continuum

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Questions