Partnership
to Align Social Care

A National Learning
& Action Network

Evolution of the Community Care Hub Model to Align Social Care with Healthcare

Prepared By: Tim McNeill, RN, MPH
COO, Freedmen's Health & Co-Chair, Partnership to Align Social Care
November 2022

Co-Designing A Social Care Delivery System

Leading the Way on Aligning Health and Social Care

Partnership to Align Social Care

A National Learning & Action Network

Building Sustainable CBO Network Capacity

Envisioning an Ideal State

Partnership
to Align Social Care

A National Learning
& Action Network

Partnership to Align Social Care

Mission:

To enable successful **partnerships** and contracts **between health care and community care networks** to **create** efficient and sustainable **ecosystems** needed to provide **individuals with holistic, person-centered social care** that demonstrates cultural humility.

Vision:

A **sustainably resourced, community-centered social care delivery system** that is **inclusive** of all populations and **empowered by shared governance** and financing, multistakeholder accountability, and federal/state/local policy levers.

Partnership
to Align Social Care

A National Learning
& Action Network

Co-Designing a Social Care Delivery System

- **Group of diverse stakeholders** collaborating to **co-design partnerships** between health care and community-based organizations (CBOs)
  - Includes senior leaders from CBOs, health plans, health systems, national associations, and federal leaders engaged as liaisons
  - Includes **leadership and feedback from community leaders** throughout the process to elevate the voice of the community
  - Incorporates and supports the perspectives, needs, and priorities of historically marginalized communities to promote accountability and **guarantee a focus on health equity**

Partnership
to Align Social Care

A National Learning
& Action Network

History of Federal Investments to Support Hub Models

- The Federal Government has been testing various models to support community-clinical linkages to improve health outcomes.
- The evaluation from these models have led to current policy in support of Community Care Hub models.
- There is increased interest in the adoption of Community Care Hub models to leverage economies of scale for implementing sustainable community-level interventions that align with healthcare.

Partnership
to Align Social Care

A National Learning
& Action Network

Community Care Hub

The Partnership's Community Care Hub Workgroup has developed the following definition for a **Community Care Hub**. This definition may continue to be updated:

*A **community-focused entity** that **organizes and supports a network of community-based organizations** providing services to address health-related social needs. A Community Care Hub **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 Community Care Hub 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**.*

Partnership
to Align Social Care

A National Learning
& Action Network

Hub Model and Non-Clinical Service Delivery Investment Timeline

Partnership
to Align Social Care

A National Learning
& Action Network

2012: Community-Based Care Transitions Program (CCTP)

Partnership
to Align Social Care

A National Learning
& Action Network

Community-Based Care Transition Program (CCTP) Demonstration

- **Intervention tested**: Community-Based Organizations partnered with hospitals to implement an evidence-based community-level intervention to reduce hospital readmissions
- CBOs partnered with **448 hospitals nationwide** to participate in the demonstration
  - Most CBOs that led the model were Area Agencies on Aging but included a range of CBOs in each market

Partnership
to Align Social Care

A National Learning
& Action Network

Community-Based Care Transition Program (CCTP) Demonstration

- **Outcome**:
  - "Our empirical findings for RQ-1 indicate that CCTP participants from all sites combined had lower readmission rates and Medicare Part A and Part B expenditures over periods in which these sites were active in the program, relative to comparable nonparticipants (matched comparisons)."
  - ***Successful Demonstration of CBO capacity to contract with healthcare and deliver targeted interventions in various community settings.**
- CMMI Demonstration Webpage: https://innovation.cms.gov/innovation-models/cctp
- Evaluation Link: https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf

Partnership
to Align Social Care

A National Learning
& Action Network

2014 CMMI Demonstration: YMCA of the USA for National Diabetes Prevention Program Implementation

Partnership
to Align Social Care

A National Learning
& Action Network

YMCA of the USA DPP Demonstration Description/Evaluation

- Project Title: Delivery on the promise of diabetes prevention programs
- Funding amount: $11,885,134.00
- Estimated 3-Year Savings: $4,273,807
- Outcome:
  - Demonstration proved that a National network of YMCA **operating under a centralized organizational hub** (YMCA of the USA) can deliver an effective CBO-Driven intervention.
  - Independent **evaluation by the CMS Actuary** led to the Medicare Diabetes Prevention Program benefit and DPP Medicaid coverage in multiple States.
  - Program is primarily **delivered by CBOs** in community settings
- CMMI Demonstration Webpage: https://innovation.cms.gov/innovation-models/participant/health-care-innovation-awards/ymca-of-the-usa
- Evaluation Link: https://innovation.cms.gov/files/reports/hcia-ymcadpp-evalrpt.pdf

Partnership
to Align Social Care

A National Learning
& Action Network

CDC/CMS Policy Changes to Support Umbrella Hub Arrangements

- CDC/CMS National Diabetes Prevention Program Umbrella Hub Arrangements guidance
  - **Issued March 16, 2022**
  - The Umbrella Hub Organization has delegated authority for all operational responsibilities for the Umbrella Hub Arrangement
    - UHO specifies criteria for subsidiary (CBO) participation
    - UHO must have a signed agreement with all parties
    - **UHO has the delegated authority to enter into contracts** in support of the UHA
      ***Including with Medicare, Medicaid, and Medicaid MCOs**
  - Provides regulatory guidance for two (2) Umbrella Hub Arrangement models
    - **Non-Delivery Organizations CAN become an Umbrella Hub** and support up to six (6) subsidiary suppliers the first year and can add additional CBO subsidiaries in subsequent years

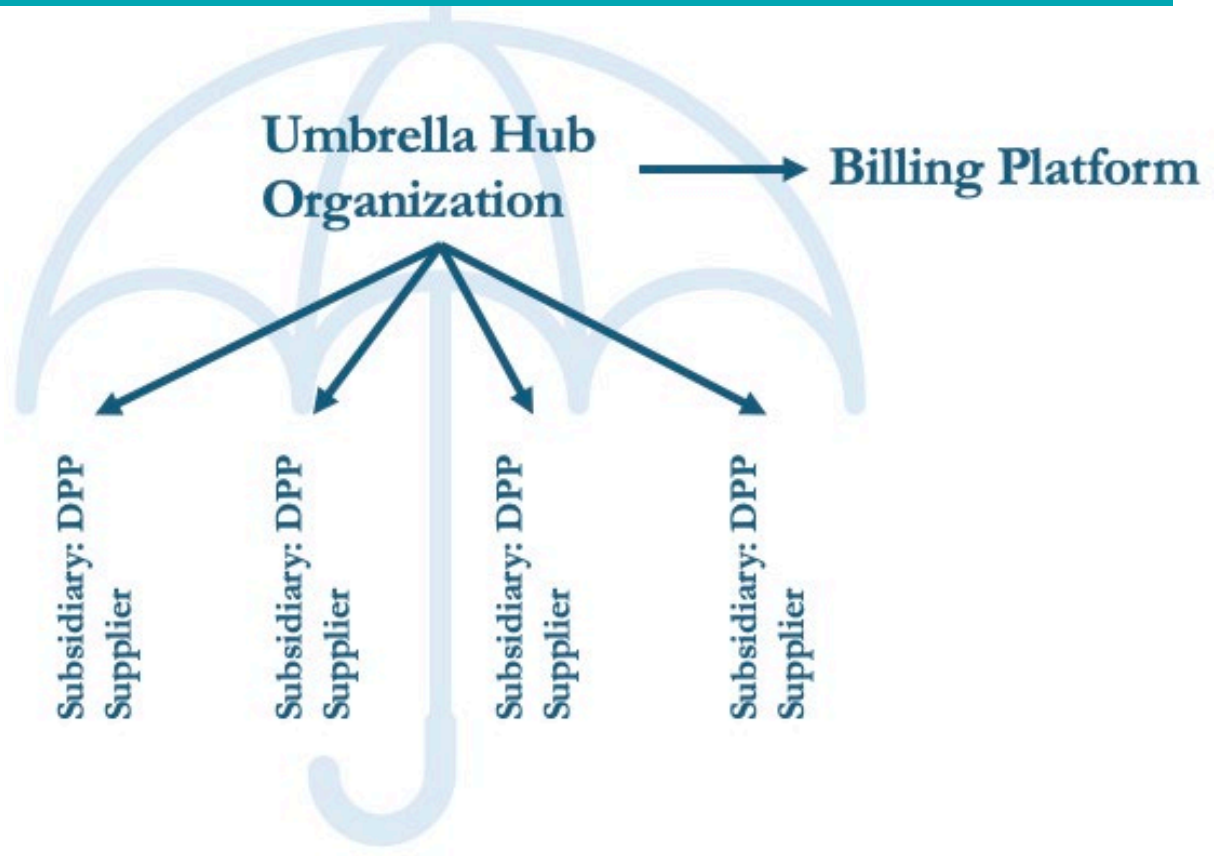
CDC Policy Link: https://nationaldppcsc.cdc.gov/s/article/National-Diabetes-Prevention-Program-Umbrella-Hub-Arrangements-Guidance-and-Application

2022: What is an Umbrella Hub Arrangement (UHA)?

Key Roles in a UHA

- UHO: The UHO is the lead organization with the reach and resources to provide administrative services and coordinate stakeholders.
  - Centralized Contracting for all CBOs in the Hub
  - Centralized Referral Management
  - Centralized Outcome Reporting
- Subsidiary: a DPP Supplier (CBO) in a UHA that delivers the National DPP lifestyle change program and receives administrative support from the UHO.
- Revenue Cycle Management Contractor: UHO will secure an agreement with a third party that will provide the full range of revenue cycle management services to support the billing and collections required to sustain the participants in the UHA.

CMS/CDC Approved Umbrella Hub Model



Partnership
to Align Social Care

A National Learning
& Action Network

Community Care Hub (CCH) for EB Programs +SDOH

- Centralized administrative functions and operational infrastructure to support a range of evidence-based program delivery.
  - **Example: DPP Umbrella Hub + DSMES + SDOH Screening**
- Leverages economies of scale to allow multiple organizations in a defined area to contribute to a shared infrastructure to delivery multiple EB programs.
  - **Example: Shared claims processing and referral management system**
- There is increasing interest in adding capacity to screen for social drivers of health and implement interventions to address Health Related Social Needs.
  - **Key focus: Blending and Braiding multiple resources to achieve long-term sustainability and enhance the value proposition of the CCH**

Partnership
to Align Social Care

A National Learning
& Action Network

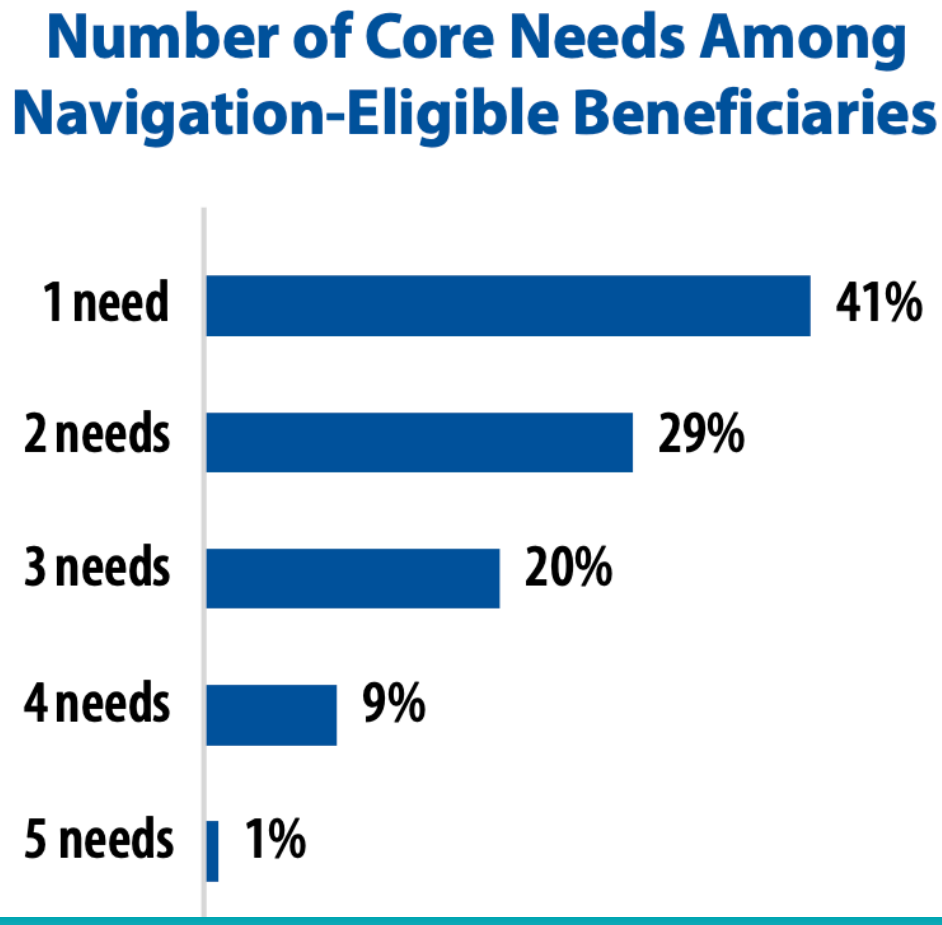
2017: Accountable Health Community Model

Accountable Health Community Model Description

Evaluation

- More than half of navigation-eligible beneficiaries reported more than one core need.
- Food insecurity was the most commonly reported need (median prevalence of 69% across bridge organizations).
- Fully 74% of eligible beneficiaries accepted navigation, but only 14% of those who completed a full year of navigation had any HRSNs documented as resolved.
    - Referrals without interventions
- *Key Finding: Identifying need without a targeted intervention strategy will not have sustainable success in addressing identified needs.
- Evaluation Link: https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt-fg

Significant Need Among the Population



Accountable Health Community Model Findings

Model Overview

- The Accountable Health Community (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by addressing health-related social needs (HRSNs).
- Bridge organizations are required to screen all community-dwelling Medicare and Medicaid beneficiaries.
- 482,967 Medicare/Medicaid Beneficiaries successfully screened using an evidence-based SDOH screening tool

Significant Need Among the Population

Partnership
to Align Social Care

A National Learning
& Action Network

2018: CHRONIC Care ACT

Partnership
to Align Social Care

A National Learning
& Action Network

Bipartisan Budget Act of 2018

- Signed into law
- Includes the CHRONIC Care Act
- Changes required by the Bipartisan Budget Act of 2018 took effect beginning 2020, and subsequent plan years

CMS Guidance to Health Plans on SSBCI Benefits

Meals	Food and Produce
Transportation for Non-Medical Needs	Pest Control
Indoor Air Quality Equipment and Services	Social Needs Benefits
Complimentary Therapies	Services Supporting Self-Direction
Structural Home Modifications	General Supports for living

Partnership
to Align Social Care

A National Learning
& Action Network

CMS Guidance to MA Plans for SSBCI

- Memo dated April 24, 2019
- Broad discretion given to MA plans to develop items and services to be offered as SSBCI
- Service or item must have a reasonable expectation of improving or maintaining the health or overall functions of the chronically ill enrollee
- SSBCI is submitted as a separate proposal in the bid
- SSBCI approved can be disclosed at Open Enrollment
- Services can primarily address social determinants
- SSBCI is treated like traditional plan benefits – appeals, denials apply

Partnership
to Align Social Care

A National Learning
& Action Network

Impact of SSBCI on Growth of CBO Contracting for Social Care Interventions

- Meals and Transportation were services that were frequently included in Medicare Advantage Plan SSBCI benefit strategies.
- Nationally there has been significant investment in CBO capacity to address food insecurity.
- **Outcome**: Small CBOs and CBOs that serve populations with a history of disparities related to rural geography, race and ethnicity, gender status categorically report being unable to secure contracts with MA plans to implement SSBCI
  - Broad increase in contracting with **For-Profit Organizations**: Mom's Meals, Uber, Lyft
  - *"**CBOs have minimal representation** in SSBCI contracting"* - Long-Term Quality Alliance
  - *"Many **CBOs report that For-Profit organizations refer** persons that continue to require assistance **AFTER** the Medicare Advantage Plan stops payment for social care services"* - Meals on Wheels America
- **Evaluation**: https://atiadvisory.com/wp-content/uploads/2022/04/Data-Insight-Growth-in-New-Non-Medical-Benefits-Since-Implementation-of-the-CHRONIC-Care-Act.pdf

Partnership
to Align Social Care

A National Learning
& Action Network

Best Practice Model Derived Learnings from Multiple Federal Investment Evaluations

CCH: Community Care Hub = Health Equity Solution

Consumer Negatively Impacted by Social Drivers of Health

Care Team Completes Limited SDOH Screen and Refers to CCH

CCH acts as Single Point of Referral for a Network of CBOs – Organized Into a **<u>Social Care Delivery System (SCDS)</u>**

CCH Partner Org. Completes a Comprehensive, Evidence-Based SDOH Screen

CCH Team Develops a Person-Centered Plan to Address Social Drivers of Health

CCH Works to Blend & Braid *<u>All Available Resources</u>* to Address Identified Needs:
Public + Private + Healthcare + Philanthropy

CCH Submits Closed-Loop Referral Data: Z-Codes, Social Intervention Codes, and Outcome of Social Care Svcs

CCH + Healthcare Conduct CQI to Document the Impact: Health-Related Social Needs Addressed (Pop Health), ROI, + Measures of Health Equity

Partnership
to Align Social Care

A National Learning
& Action Network

Community Care Hub Operational Examples

Partnership to Align Social Care

A National Learning & Action Network

Oregon

Community Care Hub: Oregon Wellness Network (*Care Transitions and Evidence-Based Programs*)

- Initial funding to establish CCH: CBOs combined availability grant funding to create economies of scale to establish a Statewide Central Hub for contracting
  - Large range of small, medium, and large CBOs working together across all regions of the State
- Multi-Payer Contracts as the Statewide Diabetes Prevention Program Umbrella Hub
  - Medicaid CCOs, Medicare Advantage, Original Medicare (FFS)
  - Leveraged initial CDC grant to establish a Statewide DPP delivery system
- Agreement with the largest health system in the State to provide *care transitions* and referrals to *evidence-based programs*
  - Providence Health System
- *State recently approved for 1115 Waiver that OWN will incorporate into their broad Community Care Hub Model
  - Falls Prevention Program coverage
  - HCPCS Code: S9451
  - Description: Group Fall prevention Program implementation
  - Rate: $12.29 per person in a group setting
  - Rate for 10 participants = $122.90 per session

Partnership to Align Social Care

A National Learning & Action Network

Minnesota

Community Care Hub: Trellis (*Evidence-Based programs and HRSN Interventions*)

- Contract with BCBS-MN
- Statewide Diabetes Prevention Program Umbrella Hub
- After implementation of the DPP Umbrella Hub, Trellis will deploy DSMT and MNT as additional services
- Centralized data management, claims processing, and referral management system that currently operates statewide
  - State Health Department provided grant funds to establish a Centralized IT system to support program delivery, centralized referral management, and centralized claim management
  - IT system has expanded across four (4) States and centrally managed in Minnesota
- Strategic Plan is to provide SDOH screening and HRSN interventions through the statewide network of CBOs under the Trellis Community Care Hub
  - Contract with health plans and hospitals statewide

Partnership to Align Social Care

A National Learning & Action Network

Western New York

Community Care Hub: Western New York Integrated Care Collaborative (WNYICC)

- Initial funding to establish CCH: Grant from the **Health Foundation of Western & Central NY**
- Contract with Independent Health Medicare Advantage Plan + local Medicaid Plans
- DPP (Diabetes Prevention Program)
- DSMT (Diabetes Self-Management Training)
- MNT (Medical Nutrition Therapy)
- Special Supplemental Benefits for the Chronically Ill (Medicare Advantage Only)
  - *Post-Discharge Home-Delivered Meals*
  - *Health Coaching and Social Care Navigation*
  - *Fall Prevention Programs*
  - *Caregiver Programs*
- Provides a centralized IT system that supports 30+ CBOs to meaningfully contract with local health plans: Centralized contracting, IT, data management, and referral management.

Partnership
to Align Social Care

A National Learning
& Action Network

Alabama - SARCOA

Community Care Hub: Community Care Solutions (*Complex Case Management and Care Transitions*)

- Statewide contracting across the State of Alabama
- All AAAs in the State have current NCQA Accreditation for LTSS Case Management:
- State allocated "**No Wrong Door**" funding to achieve Statewide accreditation.

- Network Contracts achieved after NCQA Accreditation
  - Medicaid Managed Care LTSS: **Fully Delegated Case Management** Statewide
  - Medicare Advantage: High utilizer case management (BCBS-AL)
  - Value-Based Contract with downside risk (BCBS-AL), for HEDIS improvement and Total Cost of Care reduction
  - Health Insurance Exchange: High utilizer case management (BCBS-AL)
  - Medicare Shared Savings Program (MSSP): Hospital Care Transition Program (Stratera ACO) and complex case management
  - Physician practice contracting (MIPS): Chronic Care Management (CCM) and Transitional Care Management (TCM) to address social determinants
- Provides a centralized Statewide IT system with initial investment from State Medicaid. Sustainability of the IT system derived from health plan contracting.

Partnership
to Align Social Care

A National Learning
& Action Network

AgeSpan - Massachusetts

Community Care Hub: Began Statewide in MA and has now expanded to cover the New England States (*Complex Case Management and Evidence-Based Programs*)

- Initially contracted for evidence-based programs (CDSME, DSMP)
  - Healthy Living Center of Excellence
  - Contracted with numerous CBOs to deliver interventions statewide
- Established the ability to bill Medicare for MNT
- Contracted with Tuft Health Plan for Statewide Evidence-based program delivery
- Expanded the contract with Tuft Health Plan throughout New England region
  - Contracts now include CBOs across the entire New England Region to participate in delivering local interventions
- Value-based Contract with Medicaid and Medicaid ACOs to address LTSS and Behavioral Health needs for Medicaid beneficiaries.
- Expanding capability for a new 1115 Medicaid Waiver to address the social care needs of populations across the entire age span.
- *Key outcome: Program began by blending and braiding grant funding and was 100% dependent on grants and now have progressively reduced dependence on grants and achieving sustainability
- Desires to establish a New England Regional Model for all services with local partners

Partnership
to Align Social Care

A National Learning
& Action Network

Learn More: Partnership to Align Social Care Community Care Hub Resources

- Website: www.partnership2asc.org/cch-resources
- Community Care Hub Primer: *Background, Evolution, and Value Proposition of Working with a Local CBO Network Led by a Community Care Hub*
- Publication from Manatt Health and the Partnership: *Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies*
- Health Affairs Blog, 11/29/22: *Improving Health and Well-Being Through Community Care Hubs*

Partnership to Align Social Care

A National Learning & Action Network

Co-Chairs

June Simmons
Partners in Care Foundation
jsimmons@picf.org
818-837-3775 x101

Timothy P. McNeill
Freedmen's Health
tmcneill@freedmenshealth.com
202-344-5465

Project Director

Autumn Campbell
acampbell@Partnership2ASC.org
202-805-6202

@Partners2ASC